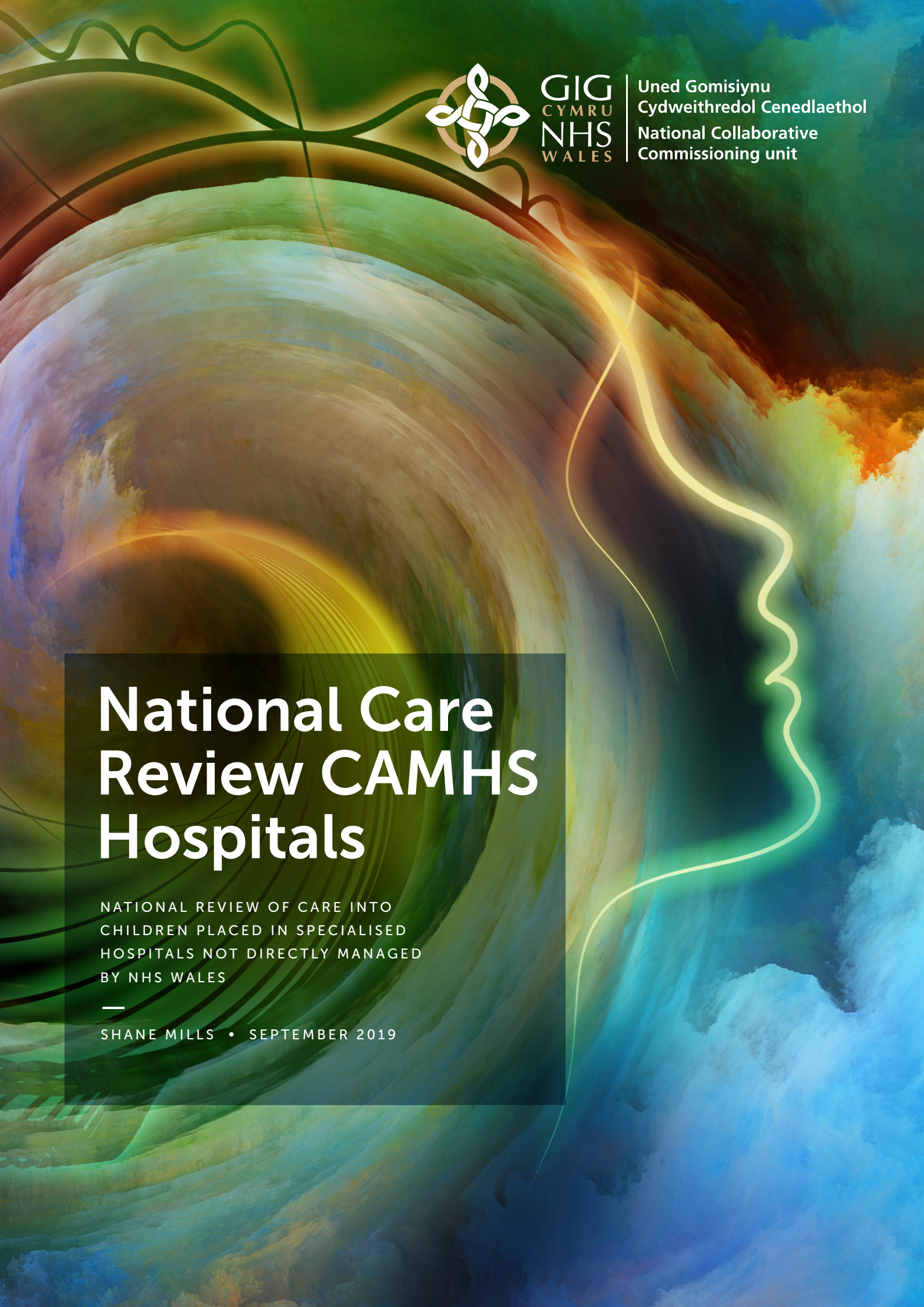

GIG CYMRU NHS WALES

Uned Gomisiynu Cydweithredol Cenedlaethol
National Collaborative Commissioning unit

National Care Review CAMHS Hospitals

NATIONAL REVIEW OF CARE INTO CHILDREN PLACED IN SPECIALISED HOSPITALS NOT DIRECTLY MANAGED BY NHS WALES

SHANE MILLS • SEPTEMBER 2019

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With thanks to the NHS Quality Assurance and Improvement Service of the National Collaborative Commissioning Unit for their support to undertake this National Care Review.

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About this Report

This National Care Review was written by
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This National Care Review has been commissioned by Professor Jean White CBE, Chief Nursing Officer, Welsh Government and Nurse Director, NHS Wales.

Reviews were undertaken and support provided by clinicians and administrators of the National Collaborative Commissioning Unit.

The reviews were all undertaken from 3 June to 7 June 2019.

The information within this Review relates to circumstances and records available on the day of the reviews only.

Although for comparison reasons, wherever possible, both number and percentages have been given in this Review, the overall numbers are small and the reader should ensure that no misleading conclusions are taken from the generated high percentages.

For simplicity, the descriptor 'Child'/'Children' is used throughout this report to denote the patient group which is under 18 years old, although 'adolescent' and 'young adult' can also describe those who are 16 to 18 years old.

Contents

Summation of findings

The following is a summation of findings and recommendations across all areas of this National Care Review.

Admission Pathway:
Although the current admissions may be appropriate, consideration should be given as to whether there is any opportunity for the development of alternative care pathways to prevent/reduce future admissions between secure children's homes and medium secure care, NHS Wales CAMHS acute units and PICU/low secure units.

Care Coordination:
We must ensure that all children have a care coordinator, case manager, or other professional to maintain frequent contact with services. These persons must ensure that: all of the child's needs are being met, they act as an advocate, ensure any complaint or incident is investigated and that any restrictive intervention is necessary and proportionate.

Care Planning:
We must ensure all Care and Treatment Plans are co-produced by the child, and reviewed regularly. Local care teams must ensure they are involved in developing and reviewing the Care and Treatment Plans.

Commissioning Outcomes:
We should ensure that there is a robust set of outcomes agreed between the commissioner and provider for all placements. We should ensure progress towards meeting these outcomes is closely monitored so we can ensure all journeys through care for children placed in CAMHS hospitals is as rapid as possible.

Diagnosis:
We should ensure that services consider the needs of children with an Autism Spectrum Condition as different, although sometimes interconnected, from those with a mental illness.

Leave:
We should ensure all children, where it is safe and therapeutic, are enabled to engage in community or home leave.

Length of Current Admission:
Some lengths of stay, especially in low secure, appear extensive. We should ensure that all children stay no longer than necessary for the provision of appropriate assessment, care and treatment.

Levels of Care:
We should ensure the issues around the following are explored: Safety – all but 2 children were in the anticipated range for their care type, with one being lower than expected and one being higher. Activities – all children were in the anticipated range for their care type.
Medication – all but one child was in the anticipated range for their care type, with 1 being higher than expected.

Medication:
We should ensure that all medications are regularly reviewed to ensure they are prescribed at the minimal dose possible to achieve the desired reduction in symptoms. We should ensure that medication being administered for the purpose of subduing disturbed behaviour has been used only as an intervention of last resort. We should explore all opportunities to reduce the use of PRN.

Medication Side Effects Monitoring:
We should ensure all children in receipt of prescribed psychotropic or hypnotic medications are regularly monitored for potential side effects using a recognised tool and regular physical health checks are undertaken if appropriate.

Mental Health Act:
This information demonstrates that we have pathways in place to ensure children with criminal justice and mental health issues receive appropriate assessment and care. We must ensure that these pathways are accessible for all children and that they are as robust as possible.

Primary and Urgent Healthcare:
We should ensure that all children have access to primary healthcare services on a regular basis and as required. We should ensure that environments of care are safe so as to minimise the requirement to access urgent care services. We should ensure all children have access to emergency care when required.

Quality [Care Planning]:
Overall, a holistic and personalised approach is taken by most providers to assess the individual, meet their needs and make sure that they are in control and informed. We need to ensure that all units hold regular reviews of care and treatment.

Quality [Education]:
All units attempted to meet the educational needs of the child whilst balancing against risk and safety concerns. Assessments need to include educational needs and pre-admission issues.

Quality [Nutrition]:
Overall, units provide a healthy and well-balanced diet and access to dietetic support. Some issues were not identified through the initial assessment processes.

Quality [Pharmacological Interventions]:
Overall, medication is actively being dispensed, administered, monitored and externally audited. There was a lack of process to identify possible side-effects of medication and instead an over-reliance on staff skills.

Quality [Physical Health]:
Physical health checks are undertaken on the majority of units, with many producing robust physical health plans. All children should have a physical health care plan.

Quality [Restrictive Interventions]:
Overall, restraint is being used proportionally and appropriately but needs to be individualised, discussed and documented as part of the care and treatment plan. Seclusion is used infrequently, but when it is used it needs to be for the shortest possible time. Blanket bans are common. All blanket restrictions should be regularly reviewed to ensure they are necessary and carefully balanced against personal freedoms.

Quality [Staff]:
Overall, staff are highly skilled, experienced and trained although reliance on agency staff should be reduced. Children feel staff are supportive.

Quality [Safety Observations]:
Overall, safety observations were regularly reviewed to ensure that they are justified, fulfilled and documented.

Quality [Safety and Welfare]:
Overall, risk assessment and management is undertaken and regularly reviewed. Safeguarding processes are in place. Children's opinions and suggestions are sought.

Quality [Therapeutic Interventions]:
All children had access to a variety of individual and group psychological and therapeutic support.

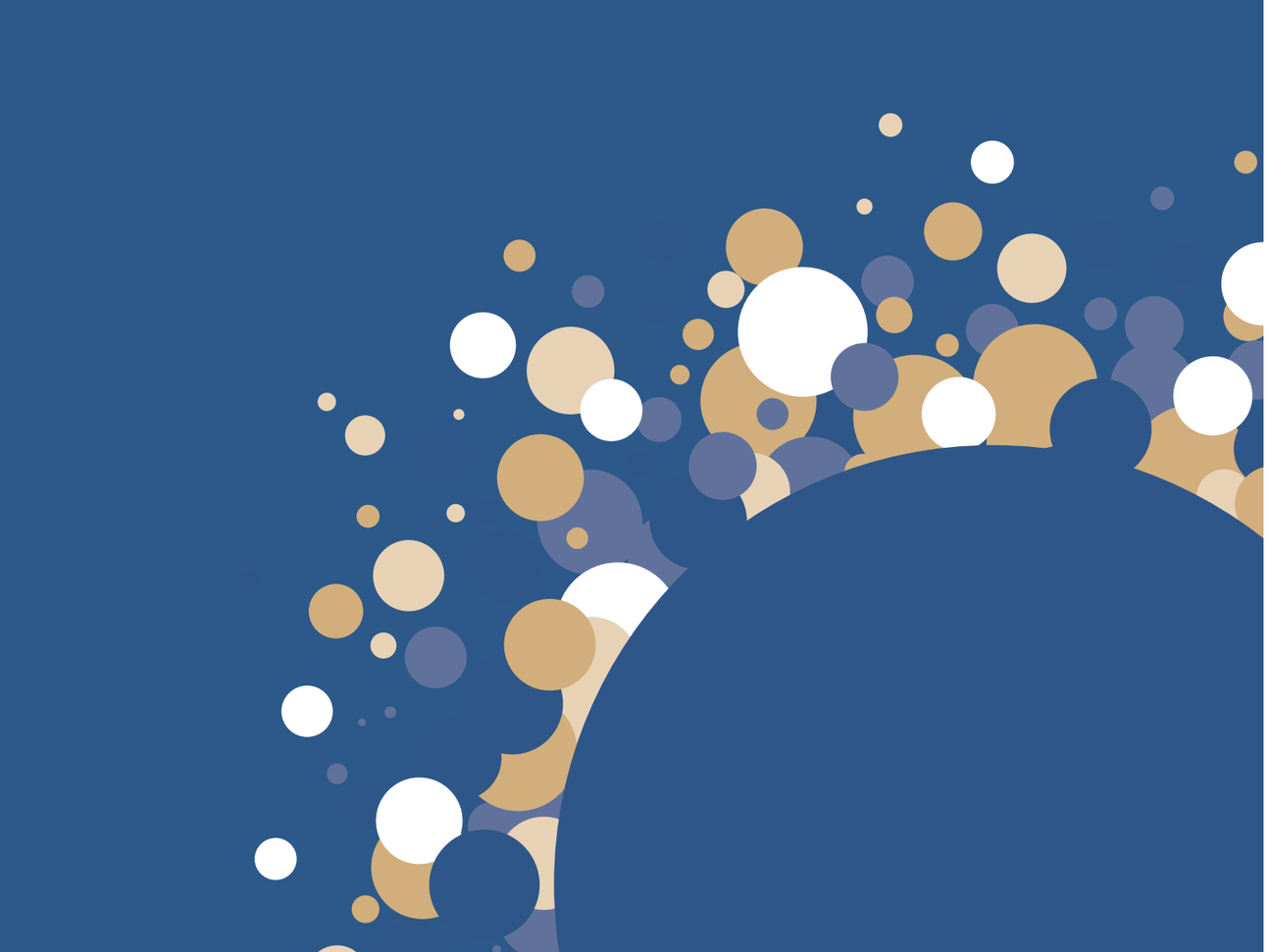
Restrictive Interventions – 'Blanket' Restrictions:
We should ensure that all blanket restrictions are considered, proportionate, documented, reviewed and applied for the minimum period necessary.

Restrictive Interventions – Restraint/ Segregation:
We should ensure that the single incident of prone restraint was undertaken as an action of last resort. We should explore the high levels of incidents of 'verbal de-escalation' to ensure that all actions are being taken to promote a positive culture and atmosphere on the wards. We should explore the high levels of incidents of 'hands on (not restraint)' to ensure that this is not, by nature or degree, restraint. We should explore the frequent use of 'time out' to ensure they are not, by nature or degree, seclusion. We should ensure all incidents of 'seclusion' are a last resort, undertaken in a suitable environment, robustly recorded and for the minimal period necessary.

Risk Behaviours:
We should ensure that providers are taking all appropriate actions to reduce the high levels of verbal aggression, especially with male children. We should ensure providers are taking all appropriate actions to reduce the high levels of threatening behaviour, especially with male children. We should ensure providers are taking all appropriate actions to reduce the high levels of violent behaviour, especially with male children. We should ensure providers are taking all appropriate actions to reduce the high levels of deliberate self harm, especially with female children. We should continue to closely monitor the risky behaviour of children in hospitals to ensure this behaviour is appropriately managed and reduced through the use of a person-centred, values-based approach by experienced, skilled and trained staff.

Therapy:
We should ensure that each provider employs and deploys a multi-professional team to formulate, assess, treat and review clinical, therapeutic and psychosocial interventions and approaches in order to provide effective, evidence-based care within a culture of positive regard and hope for every child.

National Review of Care into Children Placed in Specialised Hospitals Not Directly Managed By NHS Wales



1 Background

'CAMHS' stands for Child and Adolescent Mental Health Services and are the services that assess and treat children with emotional, behavioural, intellectual or mental health difficulties.

Future in Mind (2015)[1] emphasised the need for "improved care for children and young people in crisis so they are treated in the right place, at the right time and as close to home as possible". This includes "implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate", to avoid unnecessary admissions to inpatient care. However, there is recognition that there will always be some children "who require more intensive and specialised inpatient care".

In May 2019, Professor Jean White CBE, Chief Nursing Officer, Welsh Government and Nurse Director, NHS Wales, commissioned the Director of Quality and Patient Experience at the NHS Wales National Collaborative Commissioning Unit to undertake a National Care Review of children receiving specialised hospital care. The Review would cover CAMHS inpatient services commissioned from external (not NHS Wales hospitals) providers such as NHS England or the independent hospital sector.

This National Care Review would ensure children were receiving:

- Care for the minimal time required in the right environment to meet all needs.
- Care which empowers, enables and involves.
- The right level of support to reduce risk, promote independence and improve quality of life.
- Prescribed medication at the minimum dose required to achieve the identified clinical outcomes and that side effects were being closely monitored.
- Safe, effective and high quality care, with minimal use of restraint or other restrictive practices.
- Outcome-focussed interventions by a range of skilled and experience staff.

[1] Future in Mind (2015) Promoting, protecting and improving our children and young people's mental health and wellbeing. NHS England.

2 Services

CAMHS inpatient services usually fall within what is generally known as 'Tier 4' services. These are services which are defined as specialised provision commissioned in Wales by the Welsh Health Specialised Services Committee.

Tier 4 specialist CAMHS has historically been synonymous with psychiatric inpatient services, although recently it is understood as being multi-faceted with multi-agency services that can include in-reach, outreach, intensive and crisis community initiatives, day provision, therapeutic fostering and other services that may be described as "wrap around"[2].

Children who require admission to hospital must have access to appropriate care in an environment suited to their age and development[3]. Admission to a CAMHS inpatient unit will usually be considered when the level of risk, complexity and/or severity of mental health need cannot be safely or appropriately managed in a community setting[4].

A CAMHS inpatient unit provides care and treatment for children below the age of 18. Inpatient treatment is generally offered when outpatient care has been unsuccessful or when the difficulties are so severe that the family is unable to manage at home or cope at a particular time[5]. Children may or may not be detained under the Mental Health Act to receive inpatient care.

The type of services covered in this National Care Review are:

Medium secure: Services are specifically designed to meet the needs of children who require a secure environment because they present a serious risk to themselves or others, combined with the potential to abscond.

Low secure: Services are provided for those children who have complex problems and present a level of risk to themselves and others, that require specialist environmental security measures and so cannot be safely cared for in acute inpatient wards.

Psychiatric Intensive Care Unit: (PICU) Services caring for children with short-term behavioural disturbance which cannot be contained within an acute service. This behaviour will be associated with a serious risk of harm, either to themselves or others.

Acute wards: These services provide care for children when community-based services cannot meet their needs safely and effectively because of their level of risk and/or complexity and where they need continuous nursing and medical care.

[2] Kurtz, Z (April 2009). The evidence base to guide development of tier 4 CAMHS. Department of Health.
[3] Department of Health (2004), The mental health and psychological well-being of children and young people.
[4] Somerset Partnership NHS (July 2010), Information for professionals – access pathway for specialist CAMHS.
[5] Sergeant, A. (2009) Working within CAMHS in-patient units. National CAMHS Support Service.

3 Methodology

"*The possession of accurate, relevant and useable information from which the safety and quality of services can be ascertained is the vital key to effective commissioning*"[6].

Given the requirement to prioritise this Review, as requested by the Chief Nursing Officer, all children were visited between 3 and 7 June 2019.

Each visit was led by a clinician from the NHS Wales Quality Assurance Improvement Service of the National Collaborative Commissioning Unit. Each of these visits entailed undertaking a ward quality audit, discussion with staff and an individual progress review undertaken on each child.

Nearly 300 pieces of information were gathered from the clinical notes for each child and entered into the 'Individual Progress Review' document developed by the Team.

The Review information was collated and analysed by the support team and then verified by the Review coordinator. Research to support the Review was undertaken by the Review author.

There were also specific quality environment and care issues that were audited by the team. The commissioners (WHSSC) were invited to participate in every visit. Due to time constraints, the local care team and the child's family and carers were not contacted prior to the Reviews.

3234
Total pieces of information
collected as part of this review

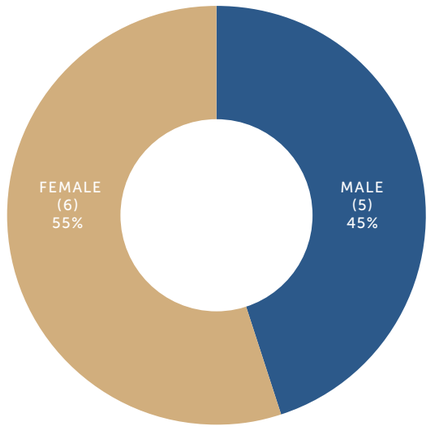
[6] Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

4 Gender

There were 11 children receiving care from services covered by this Review.

Research has shown that females of all ages are more likely to be diagnosed with a mental disorder than males.[7] In 2014, 22% of females aged 16-24 and 13% of males self-reported having had at least one mental health diagnosis in their lifetime.

As shown in **Figure 1**, six children covered by this Review are female and five are male.



● FIGURE 1: GENDER

5 Age

The age range of children seen as part of this Review was 14 to 17 years old. The average age, for both male and female children, was 16 years old.

[7] Hamblin, E. (2016) Manifestations and responses Gender and children and young people's emotional. National Children's Bureau.

6 Providers

There are currently eight providers, managing eight hospitals outside of Wales, caring for the 11 children forming part of this National Care Review.

The non-NHS provision that has previously been available within Wales was removed from the National Framework due to quality issues in 2018.

Four children in four hospitals are managed by NHS England and seven children in four hospitals are managed by the non-NHS sector (three private sector hospitals and one charitable sector hospital).

The cropped map below shows the geographical position of the eight hospitals.

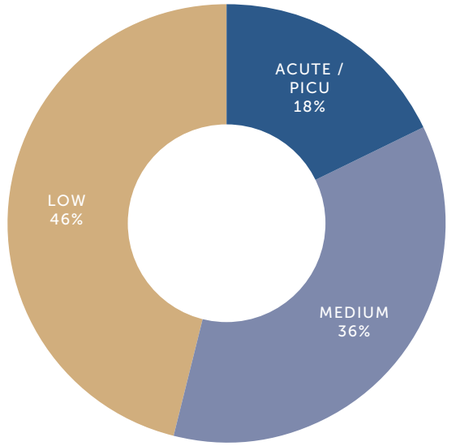
7 Type of care

Of the 11 children, the significant majority, nine are cared for in secure hospitals with five in low secure and four in medium secure care, as shown in **Figure 2**.

These type of services are not currently available from within NHS Wales.

The North Wales Adolescent Service and Ty Llidiard, the NHS Wales CAMHS inpatient services, are acute care services.

Only two children covered in this Review are cared for in acute care services (with one of these in a PICU environment).



● FIGURE 2: TYPE OF CARE

8 Admission pathway

Generally, within specialised mental health and learning disability healthcare services, the continuum of care ranges from community-based care to high secure hospitals, with jurisdictions through these services differing in care delivery methodologies and service management hierarchies.

At the less restrictive end of these services many children live in their own home, with community-based care provided under by a local multi professional team. Community-based care will be the default service option for most children. Some children live in social care accommodation.

For children requiring more direct support during a time of crisis, there are specific community services focused on risk assessment and short term interventions.

Inpatient care is required when it is unsafe to care for a child in the community due to acute symptoms/needs and when access to nursing and support staff twenty-four hours a day is required.

There are a range of inpatient units which offer open, locked or secure care depending on the requirement to restrict egress and provide environmental, relational or procedural security.

The personal care journey for the 11 children covered by the review, which resulted in them requiring care by specialised inpatient care, is shown in **Figure 3**.

18% of children were admitted from home, whilst 81% were admitted from another bed-based facility.

NUMBER OF CHILDREN	CHILD HAS BEEN ADMITTED TO THE CURRENT UNIT (SHOWN IN LEFT HAND COLUMN) FROM THE LOCATIONS BELOW			
	HOME	NHS WALES CAMHS UNIT	SECURE CHILDREN'S HOME	YOUNG OFFENDERS INSTITUTION
Percentage Total %	18%	36%	36%	9%

● FIGURE 3: ADMISSION PATHWAY

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

Although the current admissions may be appropriate, consideration should be given as to whether there is any opportunity for the development of alternative care pathways to prevent/reduce future admissions between:

- Secure children's homes and medium secure care
- NHS Wales CAMHS acute units and PICU/low secure

9 Diagnosis

Formulating a diagnosis with children is complex and requires time and multi-professional inputs. There are a wide range of possible diagnoses, but for the purposes of this National Care Review they have been grouped into two: 'mental health' and 'Autism Spectrum Condition'.

Autism Spectrum Condition (ASC) is a lifelong disability that affects how someone sees the world, processes information, and relates to other people[8].

Mental Health (MH) is a term for children who have difficulties with emotional or behavioural wellbeing.

In this review 82% of children have a mental health diagnosis whilst 18% have an Autism Spectrum Condition. 80% of males and 83% of females have a diagnosis of mental illness. 20% of males and 17% of females have an Autism Spectrum Condition.

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

We should ensure services consider the needs of children with an Autism Spectrum Condition as different, although sometimes interconnected, from those with mental illness.

[8] https://www.childrenssociety.org.uk/mental-health-advice-for-children-and-young-people/autism-and-asc

10 Mental Health Act

In many cases when children are treated in hospital they have agreed to be there (an informal or voluntary admission), however there are cases when a child can be detained, also known as 'sectioned', under the Mental Health Act (1983) and treated, if required, without their agreement.

The Mental Health Act (1983), amended in 2007, is the main piece of legislation that covers the assessment, treatment and rights of people with a 'mental disorder'.

The Mental Health Act (1983) has over a hundred sections but the ones relevant to the children covered by this National Care Review are[9]:

Section 3: This is a treatment section. The initial period for which detention is authorised is six months, but it can be renewed for a further six months and then for further periods of 12 months.

Section 37: This is a section imposed by a Crown Court after a child has been convicted of an imprisonable offence other than murder. The effect is largely the same as an admission under Section 3 and is usually for treatment.

Section 38: This is a section imposed by either a Crown Court or Magistrates Court. It is usually given after a conviction but before being sentenced. It is an 'interim' order and it can last for an initial period of 12 weeks and then, if necessary, be extended (up to 12 months). It is usually for assessment.

Section 47/49: This is a section for a child who has received a sentence from a court and has been imprisoned. The section transfers the child from prison to a hospital for treatment and means that the Ministry of Justice is responsible for granting leave and allowing discharge from hospital.

[9] General section Information from http://www.mentalhealthlaw.co.uk/Summary_of_the_detaining_sections

Figure 4 demonstrates that 91% of the children are detained under a section of the Mental Health Act. All children in secure care are detained under the Mental Health Act (as is usual with adults). The most common detention order is a Section 3.

NUMBER OF CHILDREN	INFORMAL	SECTION 3	SECTION 37	SECTION 38	SECTION 47/49
Percentage Total %	9%	55%	9%	9%	18%

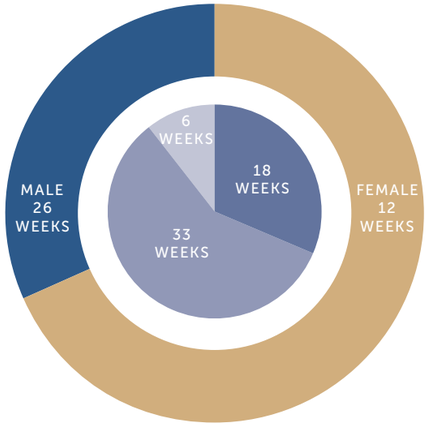
● FIGURE 4: MHA STATUS

11 Length of current Admission

In most cases the length of stay is calculated only when the person is discharged but, for the purpose of this National Care Review, it has been calculated from the date of admission to the current provider until 3 June 2019.
The length of each current admission, in weeks, with the current provider for the 11 children is shown in **Figure 5**.

The information gathered demonstrated:

- The average length of the current admission for all children is 19 weeks.
- For children in medium secure care, the average length of the current admission is 18 weeks.
- For children in low secure care, the average length of the current admission is 33 weeks.
- For children in acute care, the average length of the current admission is 6 weeks.
- For male children the average length of the current admission is 26 weeks and for females it is 12 weeks.



- For children in **medium secure care**, the average length of the current admission is 18 weeks.
- For children in **low secure care**, the average length of the current admission is 33 weeks.
- For children in **acute care**, the average length of the current admission is 6 weeks.
- For **male children** the average length of the current admission is 26 weeks.
- For **females** it is 12 weeks.

● FIGURE 5: LENGTH OF CURRENT ADMISSION* IN WEEKS (EACH LINE DENOTES A SINGLE CHILD)

**NOTE: Length of stay can vary enormously depending on the children's needs, response to treatment, complexity and/or risk. Children can require assessments that take weeks or interventions that take many months. For some children on specific sections of the Mental Health Act discharge is at the discretion of the Ministry of Justice.*

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

Some lengths of stay, especially in low secure, appear extensive. We should ensure that all children stay no longer than necessary for the provision of appropriate assessment, care and treatment.

12 Care Coordination

Care coordination is the process of helping a person with a mental illness to access a range of different services in a way that helps them get better, and works towards their recovery. It involves interactions between different clinicians and health care providers, the child, their carers, family members and other significant persons.

Part 2 of The Mental Health (Wales) Measure 2010 proposes that the care coordinator is central to the individual's journey through secondary mental health services.

It would be expected that a child who has been placed in a hospital setting would have a care coordinator, or someone from the local services, who would maintain regular contact and ensure that their needs are being met.

In terms of the 11 children seen as part of this National Care Review:

- Two children do not have the name of a local care coordinator recorded.
- Nine children do have the name of a local care coordinator recorded.
- Of these children, four have a CAMHS nurse as a care coordinator.
- Of these children, two have a social worker as a care coordinator.
- Of these children, three have another professional such as a medical doctor or psychologist as a care coordinator.

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

We must ensure that all children have a care coordinator, case manager, or other professional to maintain frequent contact with services. These persons must ensure that: all of the child's needs are being met, they act as an advocate, ensure any complaint or incident is investigated and that any restrictive intervention is necessary and proportionate.

13 Care Planning

A Care and Treatment Plan (CTP) is a written plan covering what children want to achieve in certain areas of their life and what support mental health services will provide to enable them achieve this.

In terms of the 11 children seen as part of this National Care Review:

- All children had a CTP in place.
- All of the CTPs identified all children's health needs.
- Nine of the CTPs evidenced that the child had been involved in developing the plan.
- Nine of the CTPs evidenced that there had been a clear and robust recent review.
- None of the CTPs evidenced that the local care team had been involved in developing the plan.

NATIONAL CARE REVIEW RECOMMENDATION/ FINDING

We must ensure that all Care and Treatment Plans are coproduced by the child, and reviewed regularly.

Local care teams must ensure they are involved in developing and reviewing the Care and Treatment Plans.

14 Commissioning Outcomes

The NCCU acknowledges existing research produced in conjunction with service users, clinicians, voluntary organisations and academics who have raised concerns that the narrow pursuit of outcomes for health and wellbeing, within recovery models, distracts from the needs of the individual and leads to mechanistic, 'cookie-cutter' approaches to care.[10]

Nevertheless, it is a cornerstone of good commissioning that services understand exactly what is expected of them so that they can deliver timely, effective, evidenced-based interventions in high-quality environments with skilled and experienced staff.

Therefore, when we undertake these National Care Reviews we do not examine specific individual clinical outcomes but determine the 'commissioning outcomes' intended by the commissioner and/or local care team from the hospital admission.

These 'commissioning outcomes' are grouped into the following seven areas:

- The hospital will reduce/minimise the child's display of violence, aggression or behaviours that challenge others.
- The hospital will reduce/minimise/ control the child's self-harm incidents or self-harm ideology.
- The hospital will reduce dependency and promote the child's independence through life skills.
- The hospital will empower the child through hope, positive regard and psychosocial interventions.
- The hospital will reduce/minimise the child's symptoms of mental illness through pharmacology.
- The hospital will achieve positive outcomes for the child through specific psychological therapies.
- The hospital will reduce/minimise the risk of harm to the child from vulnerability due to impaired cognition.

The number of outcomes per child can be, but is not necessarily, a signifier for complexity, with a child requiring a significant number of outcomes on admission to hospital having significant and extensive needs.

Figure 6 shows the 'commissioning outcomes' required on admission to the CAMHS service by gender and type of care.

The information gathered demonstrated:

- The lowest number of outcomes for a single child was three.
- The highest number of outcomes for a single child was seven.
- Male children had, on average, five outcomes each.
- Female children had, on average, six outcomes each.
- The outcomes with the highest percentage across all genders and types of care were 'empower through hope, positive regard and psychosocial interventions, with all children requiring this outcome.

[10] Kings Fund (2019) Outcomes for Mental Health Services, What really matters?

- The outcome with the lowest percentage across all genders and types of care was the 'reduction in risk of harm due to vulnerability' with one child requiring this outcome. This outcome is normally linked to persons with intellectual disabilities.
- Nine children require the hospital to reduce/minimise the child's display of violence, aggression or behaviours that challenge others. Four of the male children and five of the female children require this outcome.
- Nine children require the hospital to reduce/minimise/control the child's self-harm incidents or self-harm ideology. Three of the male children and six of the female children requiring this outcome.
- Nine children require the hospital to 'reduce/minimise the child's symptoms of mental illness through pharmacology'. Three of the male children and six of the female children require this outcome.
- Nine children require the hospital 'achieve positive outcomes for the child through specific psychological therapies'. Four of the male children and five of the female children require this outcome.

		REDUCE/MINIMISE VIOLENCE, AGGRESSION, BEHAVIOURS THAT CHALLENGE	REDUCE/MINIMISE/ CONTROL SELF-HARM, SELF-HARM IDEOLOGY	REDUCE DEPENDENCY AND PROMOTE INDEPENDENCE THROUGH LIFE-SKILLS	EMPOWER THROUGH HOPE, POSITIVE REGARD, PSYCHOLOGICAL INTERVENTIONS	REDUCE/MINIMISE SYMPTOMS OF MENTAL ILLNESS THROUGH PHARMACOLOGY	ACHIEVE POSITIVE OUTCOMES THROUGH SPECIFIC PSYCHOLOGICAL THERAPIES	REDUCE/MINIMISE RISK OF HARM TO SELF FROM VULNERABILITY DUE TO IMPAIRED COGNITION
M	5	4	3	2	5	3	4	
F	6	5	6	5	6	6	5	1
% IN MEDIUM SECURE WITH OUTCOME		75%	75%	50%	100%	50%	100%	
% IN LOW SECURE WITH OUTCOME		100%	100%	60%	100%	100%	100%	20%
% IN ACUTE/PICU WITH OUTCOME		50%	50%	100%	100%	100%		
TOTAL NUMBER WITH OUTCOME		9	9	7	11	9	9	1
% OF TOTAL WITH OUTCOME		82%	82%	64%	100%	82%	82%	9%

● FIGURE 6: COMMISSIONING OUTCOMES REQUIRED OF ADMISSION

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

- We should ensure that there is a robust set of outcomes agreed between the commissioner and provider for all placements.
- We should ensure progress towards meeting these outcomes is closely monitored, so we can ensure all journeys through care for children placed in CAMHS hospitals are as rapid as possible.

15 Therapy

In order to achieve the outcomes that underpin the reason for admission and to meet the complex needs of the children placed in these care facilities, it would be expected that an extensive multi-disciplinary team is employed.

The members of this team formulate, assess, treat and review clinical, therapeutic and psychosocial interventions and approaches to provide effective, evidence-based care within a culture of positive regard and hope.

Figure 7 shows the number of children receiving one or more therapy sessions per gender, type of care and therapist staff type.

The theoretical maximum number of therapists involved with a single child using the National Care Review dataset is nine although it would be very unusual for this number of therapists to be involved in a single case. The number to be expected in CAMHS inpatient care is around three or four, although this is highly dependent on the child's needs.

The information gathered for this Review demonstrated:

- The lowest number of therapists involved in a child's care was one.
- The highest number of therapists involved in a child's care was six.
- The average number of therapists involved in a child's care was three.
- Male children had, on average, three therapists involved in their care.
- Female children had, on average, four therapists involved in their care.
- The therapist staff groups most often involved were Occupational Therapists (nine cases) and Clinical Psychologists (eight cases).

		CLINICAL/FORENSIC PSYCHOLOGY	PSYCHOLOGY ASSISTANT	NURSE THERAPIST/ COUNSELLOR	OCCUPATIONAL THERAPIST	OT ASSISTANT/TI	SOCIAL WORKER THERAPIES	SPEECH & LANGUAGE THERAPY	PSYCHIATRIST DELIVERED THERAPY	OTHER CLINICAL THERAPY
M	5	3	2		4	3	1		2	2
F	6	5	2	1	5	4	2	1		1
% MEDIUM SECURE		50%	75%	25%	100%	75%	50%		50%	50%
% LOW SECURE		80%	20%		60%	60%	20%	20%		20%
% ACUTE/PICU		100%			100%	50%				
TOTAL		8	4	1	9	7	3	1	2	3
%		73%	36%	9%	82%	64%	27%	9%	18%	27%

● FIGURE 7: NUMBER OF CHILDREN RECEIVING ONE OR MORE THERAPY SESSIONS BY THERAPIST TYPE

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

We should ensure that each provider employs and deploys a multi-professional team to formulate, assess, treat and review clinical, therapeutic and psychosocial interventions and approaches, which will provide effective, evidence-based care within a culture of positive regard and hope for every child.

16 Primary and Urgent Healthcare

Although the children are receiving care and treatment in a hospital setting, there is still the requirement to ensure access to primary care services in case the child requires treatment from a GP, dentist or optician. There may also be the requirement to access urgent or emergency care from a hospital, GP or dentist.

Figure 8 shows the number of children who have accessed primary healthcare services, or who have required unplanned access to urgent care services whilst admitted to their current hospital.

The information gathered for this Review demonstrated:

- All children required access to one or more primary care services.
- Four children required access to one or more urgent care services.
- Four females but no males required one or more attendances at Accident & Emergency Departments.
- Three females but no males required emergency GP care.
- All of the urgent care interventions were required from children in low secure care, none were required from those being cared for in medium secure or acute care.

		PRIMARY CARE			URGENT CARE		
		GP FOR CHECK-UP/ ROUTINE APPT.	DENTIST CHECK-UP	OPTICIANS CHECK-UP	CHILD REQUIRED URGENT DENTAL TREATMENT	CHILD REQUIRED A&E	CHILD REQUIRED EMERGENCY GP TREATMENT
M	5	5	4	4			
F	6	5	5	1	1	4	3
% MEDIUM		100%	75%	75%			
% LOW		100%	100%	40%	20%	80%	60%
% ACUTE		50%	50%				
% MALE		100%	75%	75%			
% FEMALE		100%	100%	40%	20%	80%	60%
TOTAL		10	9	5	1	4	3
%		91%	82%	45%	9%	36%	27%

● FIGURE 8: ACCESS TO PRIMARY AND/OR URGENT HEALTHCARE

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

We should ensure that all children have access to primary healthcare services on a regular basis and as required. We should ensure that environments of care are safe so as to minimise the requirement to access urgent care services. We should ensure all children have access to emergency care when required.

17 Levels of Care

The Nurse Staffing Levels (Wales) Act 2016 became law in Wales on 21 March 2016. It requires the Welsh Government to issue guidance setting out the methods/processes by which NHS organisations will be expected to determine nurse staffing levels that are appropriate and are safe all times. This includes nursing services directly provided by the NHS and nursing services that the NHS in Wales have commissioned. In order to support the appropriate staffing levels, it is essential to understand the intensities of care required for the patient cohorts being managed by the staffing group.

The NCCU have developed 3 'Levels of Care' that measure and score the intensity of staff input required by individual children to ensure:

Safety: The Levels of Care required to manage the safety of children or to minimise the possibility of the child harming peers or staff. This Level also denotes the care inputs required to ensure the children can access the community regularly and safely.

Activity: The Levels of Care required to ensure that the child's personal care, strength based activities and nutritional needs are met. It also denotes the Level of Care required for the encouragement of independence and reduction in dependency.

Medication: The Levels of Care required to ensure children are concordant with any prescribed medication or healthcare regime and receive oversight/intervention from a suitably qualified and experienced staff member.

Scores in the three areas range from 5 (highest level of staff intensity required to meet the child's needs) to 1 (lowest level of staff intensity required to meet the child's needs).

Figure 9A shows the percentage of children within each section of each Level of Care across the **Safety** domain. Note that children can have an entry in more than one section in more than one Level.

The information gathered for this Review demonstrates that **Level 3**: Potential risk of harm to self and requires prescribed intermittent observation is the section with the highest number of children (4).

● FIGURE 9A: SAFETY

LEVEL OF CARE: SAFETY		
LEVEL 5	Continuous observation/support – 1:1 or above for 24 hours / day due to risk of harm to **self**	9%
	Continuous observation/support – 1:1 or above for 24 hours / day due to risk of harm to or from **others**	
	Continuous observation/support – 1:1 or above for 24 hours / day due to vulnerability or inability to communicate	
LEVEL 4	Observation within the unit during specific periods or specific areas (daytime / night time / communal areas / bedroom, etc.) – 1:1 or above – due to risk of harm to **self**	
	Observation within the unit during specific periods or specific areas (daytime / night time / communal areas / bedroom, etc.) – 1:1 or above – due to risk of harm to or from **others**	
	Observation within the unit during specific periods or specific areas (daytime / night time / communal areas / bedroom, etc.) – 1:1 or above – due to vulnerability or inability to communicate	18%
LEVEL 3	Potential risk of harm to self and requires prescribed intermittent observation	36%
	Potential risk of harm to or from others and requires prescribed intermittent observation	27%
	Community access requiring dedicated support at 1:1 or above due to risk to self / others	9%
LEVEL 2	Escorted community access only	9%
	Individual requiring cohorted supervision	
	Requires minimal / general observation, ongoing support, reassurance or intervention	
LEVEL 1	Unescorted community access	9%
	Requires no specific supervision within the unit	

Figure 9B shows the percentage of children within each section of each Level of Care across the **Activity** domain. Note children can have an entry in more than one section in more than one Level.

The information gathered for this Review demonstrates that the **Level 1**: *Self Caring/ Independent* is the section with the highest number of children (8).

● FIGURE 9B: ACTIVITY

LEVEL OF CARE: ACTIVITY		
LEVEL 5	Totally dependent for all activities of living as unable to participate in own care	
LEVEL 4	Requires care from minimum of 2 staff for nearly all ADL's, manual handling, repositioning	
LEVEL 3	Requires care from 1 staff for nearly all ADL's, manual handling, repositioning	
	Requires assistance with personal care lasting more than 30 mins	
	Requires assistance with mobility, repositioning with 1-2 staff and use of aids	
LEVEL 2	Requires assistance with some activities of daily living	
	Requires prompting with most or all activities of daily living	27%
	Requires assistance with feeding or fluid management	9%
LEVEL 1	Requires prompting with some activities of daily living	9%
	Self-catering / independent	73%

Figure 9C shows the percentage of children within each section of each Level of Care across the **Medication** domain. Note children can have an entry in more than one section in more than one Level.

The information gathered for this Review demonstrates that the **Level 2**: Assistance taking medication (reminding and/or administered by staff) is the section with the highest number of children (9).

● FIGURE 9C: MEDICATION

LEVEL OF CARE: MEDICATION		
LEVEL 5	Invasive monitoring, drips, IVI regime	9%
LEVEL 4	Complex medication regime requiring frequent changes / PEG feeding	
LEVEL 3	Complex medication requiring nurse / clinical oversight.	9%
	Individual requires support to take medication (more than 30 mins)	
	Individual prescribed antipsychotic/hypnotic PRN within last 7 days	
LEVEL 2	Assistance taking medication (reminding and/or administered by staff)	82%
LEVEL 1	Self-medicating for symptom control	

In order to formulate a general representation of the Level of Care, we calculated the highest Level of Care for each child across each of the three domains.

Figure 10 shows the total Levels of Care across the Safety, Activities and Medication domains for all children. The information gathered for this Review demonstrated the following Levels of Care:

- The average Levels of Care for all children was **3** (Safety, Potential risk of harm to self/others and requires regular observation), **1** (Activity, safe caring or requires prompting only), **2** (Medication- requires prompting only).
- The average Levels of Care for male children was **3** (Safety, Potential risk of harm to self/others and requires regular observation), **1** (Activity, safe caring or requires prompting only), **2** (Medication - requires prompting only).
- The average Levels of Care for female children was **4** (Safety, Potential risk of harm to self/others and requires continuous observation), **1** (Activity, safe caring or requires prompting only), **3** (Medication - requires a qualified nurse oversight or requires prompting support).
- The average Levels of Care for children cared for in a medium secure environment was **3** (Safety, Potential risk of harm to self/others and requires regular observation), **1** (Activity, safe caring or requires prompting only), **2** (Medication - requires prompting only).
- The average Levels of Care for children cared for in a low secure environment was **4** (Safety, Potential risk of harm to self/others and requires continuous observation), **1** (Activity, safe caring or requires prompting only), **2** (Medication - requires prompting only).
- The average Levels of Care for children in acute environments (+PICU) were **3** (Safety, Potential risk of harm to self/others and requires regular observation), **2** (Activity, requires some assistance), **4** (complex regime).

	SAFETY LEVEL OF CARE	ACTIVITIES LEVEL OF CARE	MEDICATION LEVEL OF CARE
M	13	6	10
F	19	9	16

● FIGURE 10: ACCUMULATIVE LEVELS OF CARE

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

We should ensure that the issues around the following are explored:

- Safety: All but two children were in the anticipated range for their care type, with one being lower than expected and one being higher.
- Activities: All children were in the anticipated range for their care type.
- Medication: All but one of the children were in the anticipated range for their care type, with one being higher than expected.

18 Risk Behaviours

Sometimes children in CAMHS hospitals display behaviours which put themselves and/or others at risk of harm. They may leave the hospital without notifying staff, behave aggressively, be sexually inappropriate towards peers or staff and try to harm other children, staff, property or themselves.

Children referred to CAMHS may have higher frequency and severity of aggression compared with non-referred peers. Aggression has been strongly associated with poor peer relationships and low prosocial behaviour[11].

Violent and aggressive behaviour on wards can be influenced by environmental and contextual factors[12]. Unclear policy and guidelines, overcrowding, poor ward design, inexperienced staff, poor staff retention, and poor information sharing can all contribute to violent or aggressive behaviour[13, 14]. Studies have also shown a link between aggression and violence and staff characteristics including negative interactional styles, provocative and authoritarian behaviour, and poor communication skills[15, 16].

Risk Behaviours captured by the National Care Review dataset are:

- Child has been verbally aggressive towards staff or peers.
- Child has damaged property purposefully.
- Child has displayed threatening behaviour towards staff or peers.
- Child has been violent towards others but caused no physical harm.
- Child has been violent towards others causing physical harm.
- Child has deliberately self-harmed.
- Child has absconded from the hospital/leave.
- Child has been sexually inappropriate towards staff or peers.
- Child has suffered harm from peers due to their own vulnerability.

[11] Connor DF, McLaughlin TL. (2006) Aggression and diagnosis in psychiatrically referred children. Child Psychiatry Hum Dev.
[12] Duxbury J (2002) An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: A pluralistic design. Journal of Psychiatric and Mental Health Nursing; 9: 325–337.
[13] The short-term management of disturbed/violent behaviour in psychiatric in-patients and emergency department guidelines. (2015) NICE.
[14] National Audit of Violence. (2005) Healthcare Commission.
[15] Duxbury J, Whittington R (2005) Causes and management of patient aggression and violence: staff and patient perspectives. Journal of Advanced Nursing; 50: 469–478.
[16] Glover R (2005) Special section on seclusion and restraint: Commentary: reducing the use of seclusion and restraint: A NASMHPD priority. Psychiatric Services; 56: 1141-1142.

These behaviours have been categorised according to intensity/effect:

- **Low intensity**, causing no obvious physical harm/emotional distress to child, peers or staff. Minimal damage to property. Minor disruption to ward ambiance or processes.

- **Medium intensity**, causing physical harm/emotional distress to child, peers or staff. Moderate damage to property. Disruption to ward ambiance or processes.

- **High intensity**, causing serious physical harm/emotional distress to child, peers or staff. Significant damage to property. Major disruption to ward ambiance or processes.

Figure 11 shows the intensity and frequency of risk behaviours exhibited by each child. The information is displayed in a colour coded intensity/frequency general impact grid as shown below:

NEGLIGIBLE	LOW	LOW	MODERATE	MODERATE
LOW	LOW	MODERATE	MODERATE	MAJOR
LOW	MODERATE	MODERATE	MAJOR	CATASTROPHIC

The information gathered for this Review demonstrated:

- Nine children, five males and four females, had been verbally aggressive. Four children, two males and two females, had been verbally aggressive recently.

- Five children, three males and two females, had damaged property purposefully, three children, two males and one female, had damaged property recently.

- Eight children, five males and three females, had displayed threatening behaviour towards staff or peers. Four children, two males and two females, had displayed threatening behaviour towards staff or peers recently.

- Seven children, five males and two females, had displayed violent behaviour but caused no physical harm. Three children, two males and one female, had displayed violent behaviour but caused no physical harm recently.

- Seven children, four males and three females, had displayed violent behaviour and caused harm. Three children, one male and two female, had displayed violent behaviour and caused harm recently.

- Ten children, four males and six females, had self-harmed deliberately, four children, all females, had self-harmed deliberately recently, no males and 4 females.

- Three children, one male and two females, had absconded from the hospital or whilst on leave. One female child had recently absconded from hospital or whilst on leave.

- Two children, one male and one female, had been sexually inappropriate. One male child had been sexually inappropriate recently.

- Six children, three male and three female had suffered harm from others due to their vulnerability. One male child had suffered harm from others due to their vulnerability recently.

FIGURE 11

CHILD HAS BEEN VERBALLY AGGRESSIVE TOWARDS STAFF OR PEERS	NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT: MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)	0					
LOW INTENSITY		1		1	1	
MEDIUM INTENSITY		1				1
HIGH INTENSITY						
Female (6)	2					
LOW INTENSITY			1			1
MEDIUM INTENSITY		1				
HIGH INTENSITY		1				

NOTE: 'Recently' means within 90 days of the Review team visit.

CHILD HAS DAMAGED PROPERTY PURPOSEFULLY

		NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT: MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)		2					
	LOW INTENSITY					1	
	MEDIUM INTENSITY			1			
	HIGH INTENSITY		1				
Female (6)		4					
	LOW INTENSITY			1			
	MEDIUM INTENSITY					1	
	HIGH INTENSITY		1				

CHILD HAS DISPLAYED THREATENING BEHAVIOUR TOWARDS STAFF OR PEERS

		NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT: MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)		0					
	LOW INTENSITY		1				
	MEDIUM INTENSITY		1	1		1	
	HIGH INTENSITY		1				
Female (6)		3					
	LOW INTENSITY						
	MEDIUM INTENSITY		1			1	
	HIGH INTENSITY			1			

CHILD HAS BEEN VIOLENT TOWARDS OTHERS BUT CAUSED NO PHYSICAL HARM

		NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT: MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)		0					
	LOW INTENSITY		2	1			1
	MEDIUM INTENSITY						
	HIGH INTENSITY		1				
Female (6)		4					
	LOW INTENSITY						
	MEDIUM INTENSITY		1				
	HIGH INTENSITY			1			

CHILD HAS BEEN VIOLENT TOWARDS OTHERS CAUSING PHYSICAL HARM

		NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT: MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)		1					
	LOW INTENSITY						
	MEDIUM INTENSITY		2		1		
	HIGH INTENSITY		1				
Female (6)		3					
	LOW INTENSITY						
	MEDIUM INTENSITY		1				
	HIGH INTENSITY			1			

CHILD HAS DELIBERATELY SELF-HARMED

		NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT: MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)		1					
	LOW INTENSITY		2				
	MEDIUM INTENSITY		2				
	HIGH INTENSITY						
Female (6)		0					
	LOW INTENSITY						
	MEDIUM INTENSITY		1	1	1	1	
	HIGH INTENSITY		1	1			

CHILD HAS ABSCONDED FROM THE HOSPITAL / LEAVE

		NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT: MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)		4					
	LOW INTENSITY		1				
	MEDIUM INTENSITY						
	HIGH INTENSITY						
Female (6)		4					
	LOW INTENSITY		1				
	MEDIUM INTENSITY						
	HIGH INTENSITY				1		

CHILD HAS BEEN SEXUALLY INAPPROPRIATE TOWARDS STAFF OR PEERS		NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)	4						
	LOW INTENSITY						
	MEDIUM INTENSITY			1			
	HIGH INTENSITY						
Female (6)	5						
	LOW INTENSITY		1				
	MEDIUM INTENSITY						
	HIGH INTENSITY						

CHILD HAS SUFFERED HARM FROM PEERS DUE TO THEIR OWN VULNERABILITY		NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT
Male (5)	2						
	LOW INTENSITY		1			1	
	MEDIUM INTENSITY		1				
	HIGH INTENSITY						
Female (6)	3						
	LOW INTENSITY		2				
	MEDIUM INTENSITY		1				
	HIGH INTENSITY						

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

We should ensure that the issues around the following are explored:

- We should ensure providers are taking all appropriate actions to reduce the high levels of verbal aggression, especially with male children.
- We should ensure providers are taking all appropriate actions to reduce the high levels of threatening behaviour, especially with male children.
- We should ensure providers are taking all appropriate actions to reduce the high levels of violent behaviour, especially with male children.
- We should ensure providers are taking all appropriate actions to reduce the high levels of deliberate self harm, especially with female children.
- We should continue to closely monitor the risky behaviour of children in hospitals to ensure this behaviour is appropriately managed and reducing through the use of a person-centred, values-based approach by experienced, skilled and trained staff.

19 Restrictive Interventions – 'Blanket' Restrictions

In mental health or learning disability inpatient services, it is sometimes necessary to restrict access to areas or items in order to prevent harm coming to the children or staff. Restrictions must always be proportionate to the harm that staff are seeking to prevent.

'Blanket' restrictions are rules or policies that restrict a child's liberty and other rights, which are routinely applied without individual risk assessments to justify their application. The 2015 Mental Health Act Code of Practice allows for the use of blanket restrictions only in certain very specific circumstances[17].

Blanket restrictions should be avoided unless they can be justified as a necessary and proportionate response to the risks identified for particular children. The impact of a blanket restriction on each child should be considered and documented in the child's records. Any blanket restriction should never be introduced or applied in order to punish or humiliate, but only ever used as a proportionate and measured response to an identified risk; it should be applied for no longer than can be shown to be necessary.

Within secure services, blanket restrictions can form part of the broader package of environmental, procedural and relational security measures associated with a child's identified need for enhanced security, in order to manage high levels of risk to peers, staff and members of the public.

Blanket Restrictions captured by the National Care Review dataset are:

- Restricted access to bedrooms;
- Restricted access to areas of service e.g. Kitchen;
- Restricted access to all outdoor spaces;
- Restricted access to own finances;
- Restricted access to communication devices. e.g. mobile phones;
- Subject to visitor restrictions;
- Restricted access to risk items.

Figure 12 shows the blanket restrictions in place in each unit.

The information gathered for this Review demonstrated:

- The average number of blanket restrictions in place was three.
- The lowest number of blanket restrictions in place in a single service was 0, the highest was five.
- Medium secure had the highest number of blanket restrictions in place and acute care the lowest, which is as expected.
- The blanket restriction most often in place was Restricted access to risk items.
- The blanket restriction least often in place was Restricted access to own finances.

[17] Mental Health Act 1983 Code of Practice for Wales Review Revised 2016. Section 8.9-8.14.

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

- Some blanket restrictions appeared disproportionate, we will ensure all blanket restrictions are reviewed by the providers.
- We will continue to ensure that all blanket restrictions are: considered, proportionate, documented, reviewed and applied for the minimum period necessary.
- We will ensure that all blanket restrictions are documented in the young person's care plan and is reviewed on a regular basis.
- Blanket restrictions which are in place should be considered by the commissioner and discussed with the family and care co-ordinator prior to admission.

		RESTRICTED ACCESS TO OWN BEDROOM	RESTRICTED ACCESS TO AREAS OF SERVICE. E.G. KITCHEN	RESTRICTED ACCESS TO ALL OUTDOOR SPACES	RESTRICTED ACCESS TO OWN FINANCES	RESTRICTED ACCESS TO COMMUNICATION DEVICE EG MOBILE PHONE	SUBJECT TO VISITOR RESTRICTIONS	RESTRICTED ACCESS TO RISK ITEMS
M	5	4	4	1	1	3	2	3
F	6	5	3	2	1	4	1	1
% MEDIUM			100%	25%	25%	100%	75%	100%
% LOW			20%	20%	20%	40%		40%
% ACUTE			50%	50%		50%		100%
TOTAL		0	7	3	2	7	3	11
%		0%	64%	27%	18%	64%	27%	100%

● FIGURE 12: BLANKET RESTRICTIONS

20 Restrictive Interventions – Restraint/Segregation

Restrictive interventions can be defined as planned or reactive acts that restrict an individual's movement, liberty, or freedom to act independently in order to take immediate control of a risky situation, where there is a real possibility of harm to the person or others, if no action is undertaken.

Restrictive interventions should only be used when other strategies have been tried and found to be unsuccessful, or in an emergency when the risks of not employing a restrictive intervention are outweighed by the risks of using it. They should be seen as just one part of a broader strategy to address the needs of children whose actions are harmful or potentially harmful.

Restrictive interventions should always seek to achieve outcomes that reflect the best interests of the child whose behaviour is of immediate concern, and of any others who might be affected by that behaviour. Whether used on a planned or an emergency basis, they should be used only to prevent injury, to avert serious damage to property and to enable appropriate delivery of essential care in a dignified manner. They should involve the minimum degree of force for the briefest amount of time with due consideration of the self-respect, dignity, privacy, cultural values and individual needs of the child.

The Welsh Code of Practice states that prone [face down] restraint is only used in exceptional circumstances and where is it essential to maintain the safety of the patient and others[18].

Services should ensure that staff are trained in the management of violence and aggression using a training programme designed specifically for staff working with children. Training programmes should include the use of psychosocial methods to avoid or minimise restrictive interventions whenever possible[19].

Figure 13 shows the restrictions in place in each unit.

The information gathered for this Review demonstrated that:

*[*NOTE: 'Recently' means within 90 days of the Review team visit]*

- Ten children had been subject to a form of restrictive intervention and eight had been subject recently;
- Nine children had been subject to verbal de-escalation and seven had been subject recently;
- Eight children had been subject of physical intervention (hands on guidance but not restraint) and four had been subject recently;
- Eight children had been subject to some form of restraint and six had been subject recently;
- Five children had been subject of restraint, although they were not placed on the floor and three had been subject recently;

[18] Mental Health Act 1983 Code of Practice for Wales Review Revised 2016. Section 26.29.
[19] Managing violence and aggression in children and young people (2017) NICE.

- Six children had been subject of restraint that involved being placed on the floor face up (supine) and three had been subject recently;
- One child had recently been the subject of restraint that involved being placed on the floor face down (prone);
- Seven children had been subject to some form of segregation and four have been segregated recently;
- Three children had been subject to 'time out' in a bedroom or 'quiet room' and two had been subject recently;
- Four children had been subject to seclusion in a specially designed area and two had been subject recently.

	NUMBER OF MALES (5) NUMBER OF FEMALES (6)	NO HISTORY	HAS HISTORY BUT NOT IN LAST 90 DAYS	INFREQUENT: ONCE OR TWICE IN LAST 90 DAYS	FREQUENT: MONTHLY	VERY FREQUENT: WEEKLY	EXTREMELY FREQUENT	% WITH RECENT HISTORY (WITHIN LAST 90 DAYS)
Verbal De-escalation	Male	1		1		2	1	80%
	Female	1	1	1	1	1	1	67%
Hands on Guidance (not restraint)	Male	3		1		1		40%
	Female		2	1	2	1		67%
Restraint (not floor)	Male	3		1		1		40%
	Female	3	2	1				50%
Supine Floor Restraint	Male	3	1			1		20%
	Female	2	2		2			67%
Prone Floor Restraint	Male	5						
	Female	5			1			17%
Time out	Male	4		1				20%
	Female	4	1				1	33%
Seclusion	Male	2	2		1			20%
	Female	5		1				17%

● FIGURE 13: RESTRICTIVE PRACTICE

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

- We should ensure that the single incident of prone restraint was undertaken as an action of last resort.
- We should explore the high levels of incidents of 'verbal deescalation' to ensure all actions are being taken to promote a positive culture and atmosphere on the wards.
- We should explore the high levels of incidents of 'hands on (not restraint)' to ensure they are not, by nature or degree, restraint.
- We should explore the frequent use of 'time out' to ensure that it is not, by nature or degree, seclusion.
- We considered that one incident of recent seclusion was for a longer period of time than necessary and are undertaking an investigation.
- We will continue to monitor seclusion to ensure all incidents are a last resort, undertaken in a suitable environment, robustly recorded and for the minimal period necessary.
- We will ensure that all incidents of seclusion are documented in the care plan and discussed with families and the local care team.
- We will strengthen the contractual obligations of reporting of seclusion.

21 Medication

The phrase 'Psychotropic drugs' is an umbrella term for psychiatric medicines that alter chemical levels in the brain which impact mood and behaviour. These group of medications include anti-psychotic medication, anti-depressant medication and mood stablisers. Anxiolytics, sedatives and hypnotics are medicines that work on the central nervous system to relieve anxiety, aid sleep, or have a calming effect.

The use of such medications should always be monitored closely and only after other approaches such as, therapies and psychosocial education have been tried.

Some medications can also be used as a 'chemical restraint'. Chemical restraint refers to the use of medication which is administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.

The use of such medications for the management of behaviour should only be used as an intervention of last resort after deescalation techniques and positive support interventions have been attempted. The physical health of the child should be monitored closely during and after their use.

Figure 14 shows the regular and as-required psychotropic and hypnotic medications prescribed for each child.

**NOTE: The abbreviation 'PRN' is used in the narrative and table below, standing for Pro Re Nata, a common Latin phrase meaning "as needed". The administration times are determined by the child's needs. Also NOTE for ease Anxiolytics, sedatives and hypnotics have been grouped together as 'hypnotics' in the narrative below.*

The information gathered for this Review demonstrated:

- Eleven children have been prescribed regular psychotropic or hypnotic medication;
- Seven children have been prescribed PRN psychotropic or hypnotic medication;
- Eight children have been prescribed anti-psychotic medication, two have been prescribed anti-psychotics PRN;
- Four children have been prescribed anti-depressant medication although none as PRN;
- One child has been prescribed mood-stablisers although not as PRN;
- Three children have been prescribed anxiolytics, sedatives or hypnotics medication, seven had been prescribed anti-psychotics PRN. Two of the PRN prescriptions were for intra-muscular injections;
- Eight children had been prescribed more than one of the possible four families of medications (anti-psychotic/anti-depressant/mood-stablisers/anxiolytics, sedatives and hypnotics);
- One child had been prescribed three of the possible four families of medications (anti-psychotic/anti-depressant/mood-stablisers/anxiolytics, sedatives and hypnotics).

MEDICATION		MALE	FEMALE
NUMBER OF CHILDREN		5	6
Anti-psychotics	No history of regular or PRN use	1	2
	Number on regular use	4	4
	Number on PRN (can be on regular also)	1	1
	PRN use Very Frequent: Weekly	1	
	PRN use Extremely Frequent: Daily		1
	% on regular use	80%	67%
	% on PRN	20%	17%
	% on Recent (within 90 days of review) PRN	20%	17%
Anti-depressants	No history of regular or PRN use	5	2
	Number on regular use		4
	% on regular use		67%
Mood stabilisers	No history of regular or PRN use	4	6
	Number on regular use	1	
	% on regular use	20%	
Anxiolytics, sedatives & hypnotics	No history of regular or PRN use	1	3
	Number on regular use	1	2
	Number on PRN (can be on regular also)	4	3
	PRN use Infrequent: once or twice in last 90 days	2	1
	PRN use Frequent: Monthly	1	
	PRN use Extremely Frequent: Daily	1	2
	% on regular use	20%	33%
	% on PRN	80%	50%
	% on Recent (within 90 days of review) PRN	80%	50%

FIGURE 14: PSYCHOTROPIC & HYPNOTIC MEDICATION

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

- We should ensure that all medications are regularly reviewed to ensure that they are prescribed at the minimal dose possible to achieve the desired reduction in symptoms.
- We should ensure that medication being administered for the purpose of subduing disturbed behaviour has been used only as an intervention of last resort.
- We should explore all opportunities to reduce the use of PRN.

22 Medication Side-effects Monitoring

As well as potential benefits, in general many medications have side-effects and anti-psychotic, anti-depressant, mood-stablisers, anxiolytics, sedatives and hypnotics are no different.

Individuals with mental health problems may be less articulate and less likely to question a prescription, a change in the medication regimen, potential side effects or whether monitoring is required. This, together with the fact that some of these individuals might have reduced capacity, places additional responsibilities on mental healthcare staff to monitor medication effects[20].

Prescribed medication should be monitored regularly for effectiveness, side effects, impact on physical health and on daily life. Monitoring can be through the use of specifically designed checklists and questionnaires or by undertaking physical monitoring such as blood tests or electrocardiograms.

Figure 15 shows the monitoring of side effects of psychotropic or hypnotic medications prescribed or each child.

The information gathered for this Review demonstrated there was no evidence that three children, who had been prescribed regular psychotropic or hypnotic medication, had a side effect tool completed.

	CHILDREN ON PRESCRIPTION	SIDE EFFECTS MONITORING TOOL COMPLETED	RELEVANT BLOOD TESTS	CARDIAC MONITORING / ECG	SIDE EFFECTS MONITORING TOOL COMPLETED (%)	RELEVANT BLOOD TESTS (%)	CARDIAC MONITORING / ECG (%)
Children on anti-psychotic / anti-depressant / mood stabilisers / Anxiolytics, sedatives and hypnotics	11	8	10	6	73%	91%	55%

● FIGURE 15: MEDICATION SIDE EFFECTS MONITORING

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

We should ensure that all children in receipt of prescribed psychotropic or hypnotic medications are regularly monitored for potential side effects using a recognised tool and that regular physical health checks are undertaken if appropriate.

[20] Maidment ID, Lelliott P, Paton C. Medication errors in mental healthcare: a systematic review. Qual Saf Health Care. 2006: 15(6):409–413. doi:10.1136/qshc.2006.018267.

23 Leave

Inpatient services have a responsibility for preparing children for a successful return to the community and periods of leave can form an essential component of this preparation. Any decision to agree a period of leave has to balance the contribution that leave makes to the child's recovery against considerations for the health and well-being of both the child and others.

As the child progresses through their personal journey of care, leave may shift from being escorted by staff into the local community or home area, to having leave with no staff (unescorted), to overnight leave to home or another care facility as part of a transition plan.

Although children not subject to a section of the Mental Health Act have the right to leave the ward at any time, the service has a duty of care towards them including responsibility for their safety and well-being. Children who are subject to a section of the Mental Health Act are granted leave by their psychiatrist for defined periods.

Figure 16 shows the current escorted, unescorted and overnight leave granted for children by type of care.

The information gathered for this Review demonstrated:

- One child in medium secure had recently had escorted community leave. No children in medium secure; had unescorted or overnight leave.
- Five children in low secure had escorted community leave although only two had that leave recently. One child in low secure had unescorted leave recently and none had overnight leave.
- Two children in acute care had recently had escorted community leave. No children in acute care had unescorted leave or overnight leave.

			CURRENTLY HAS NO LEAVE	HAS HAD LEAVE BUT NOT IN LAST 90 DAYS	LEAVE MONTHLY	LEAVE WEEKLY
Escorted Community Leave	M	5	2	1	1	1
	F	6	1	2		3
Unescorted Community Leave	M	5	4		1	
	F	6	6			
Overnight Leave	M	5	4	1		
	F	6	6			

● FIGURE 16: LEAVE

NATIONAL CARE REVIEW RECOMMENDATION/FINDING

We should ensure that all children, where it is safe and therapeutic, are enabled to engage in community or home leave.

24 Information 'CID' Connectivity and Interdependency

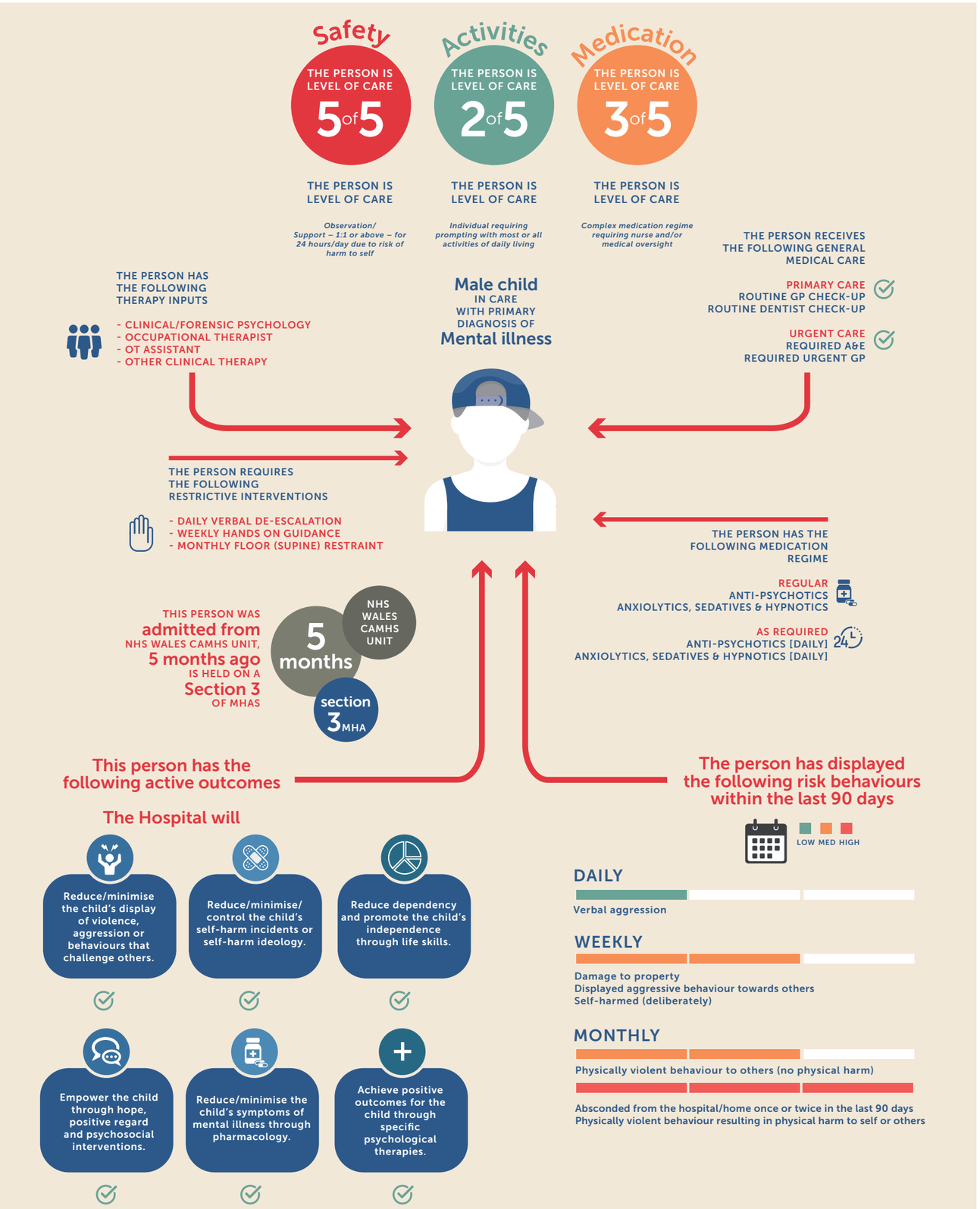
The information on each child gained as part of this National Care Review is reconstructed as a 'CID'.

This 'information connectivity and interdependency matrix' is a method of depicting the child's current care inputs and outcomes in order to determine whether the restrictions, medication and levels of care appear rational and proportionate.

We used this 'CID' to make a suggestion on the overall appropriateness of the child's current placement in relation to their needs.

A CID for a single child under this National Care Review is shown on the following page.

The CID on the following page shows a child who appears to be in an appropriate placement with multiple risk behaviours, interventions and outcomes. In this case we would advise careful monitoring of the PRN, restrictive interventions and urgent care use.



25 Quality Review

A pivotal aspect of the National Care Review was to review the quality of care provision for the 11 children.

Those units which form part of the NHS Wales National Collaborative Framework for CAMHS Hospitals were already subject to robust quality assurance and improvement processes.

The audit reviewed such documentation as: clinical notes, medication charts and risk assessments. The auditors also held discussions with members of the multi professional team and, wherever possible, the child and family/carers. Each audit also involved an environmental check.

Due to the nature of this National Care Review, a condensed version of the standard hospital review used by the team was utilised. This version focused on ten pre-identified themes as set out below:

- Staff
- Care Planning
- Pharmacological Interventions
- Physical Health
- Restrictive Interventions
- Therapeutic Interventions
- Safety Observations
- Safety & Welfare
- Education
- Nutrition

Any areas of concern were raised on the day of audit with the provider.

The sections below are summaries of the areas of good practice and areas requiring improvement in connection to each theme.

25.1 Quality Review Theme: Staff

- ☑ Many children stated that staff were "excellent" and "can't do enough".
- ☑ Some family members felt well supported by staff.
- ☑ On many units staff stated they felt focused on patient welfare.
- ☑ On many units staff training was a high priority.
- ☑ In the majority of units there was a high level of staff compliance with mandatory training requirements.
- ☒ In some units there was a high use of bank/ agency staff.
- ☒ One site had inadequate compliance with restrictive interventions training.

OVERALL THEME

Overall staff are highly skilled, experienced and trained; although reliance on agency staff should be reduced.

Children feel staff are supportive.

25.2 Quality Review Theme: Care Planning

- ☑ All children have a pre-admission report completed.
- ☑ All units held weekly multi-professional meetings to discuss the child's care plan.
- ☑ All children were invited to attend the care planning meeting.
- ☑ Many care plan reviews involved the child's family.
- ☑ Majority of units had a process for identifying 'unmet' needs.
- ☑ On one unit staff met every morning to discuss the last 24hrs and revise any care plans.
- ☒ Two units did not adhere to the care and treatment planning requirements of the Mental Health (Wales) Measure 2010.
- ☒ Two units did not have a monthly multi-professional review of care plans.

OVERALL THEME

A holistic and personalised approach is taken by most providers to assess the individual, meet their needs and make sure that they are in control and informed.

We need to ensure all units hold regular reviews of care and treatment.

25.3 Quality Review Theme: Pharmacological Interventions

- ☑ All units had processes in place to monitor and audit the dispensing and administrating of medication.
- ☑ All unit medication processes are externally audited by a pharmacist.
- ☑ All medication dispensing areas did not permit unauthorised access and were away from the main ward area to allow for privacy.
- ☒ Not all units provide 'easy read' leaflets on medication.
- ☒ Not all units used side effects monitoring tools.

OVERALL THEME

Medication is actively being dispensed, administered, monitored and externally audited.

There was a lack of process to identify possible side effects of medication and instead an overreliance on staff skills.

25.4 Quality Review Theme: Physical Health

- ☑ All units had processes in place to monitor and audit the dispensing and administrating of medication.
- ☑ The majority of units provided robust, timely, effective and continual physical health checks.
- ☑ The majority of units reviewed physical healthcare needs at the regular multi-professional meetings.
- ☒ One unit did not provide robust, timely, effective and continual physical health checks.
- ☒ Some units did not have physical health care plans in place.

OVERALL THEME

Physical health checks are undertaken on the majority of units with many producing robust physical health plans.

All children should have a physical health care plan.

25.5 Quality Review Theme: Restrictive Interventions

- ☑ Following an incident of physical interventions many units facilitate a de-briefing.
- ☑ All units have a seclusion room.
- ☑ All units informed person of parental responsibility and commissioners if physical interventions are used.
- ☑ All units reviewed any use of physical interventions and seclusion.
- ☒ One unit, which had used seclusion, could not demonstrate that it had been used for the shortest possible time.
- ☒ Many units did not ensure that specific and personalised de-escalation techniques formed part of the child's risk management plans. Many units had 'blanket' bans in place. Risk items were not identified from a personal perspective.
- ☒ On one unit, blanket restrictions in place appeared disproportionate.

OVERALL THEME

Restraint is being used proportionality and appropriately but needs to be individualised, discussed and documented as part of the care and treatment plan.

Seclusion is used infrequently, but when it is used it needs to be for the shortest possible time.

All blanket restrictions should be regularly reviewed to ensure they are necessary and carefully balanced against personal freedoms.

25.6 Quality Review Theme: Therapeutic Interventions

- ☑ All units had an established psychology team in place.
- ☑ Individual psychological interventions, based on formulation and assessment, were available for all children.
- ☑ Group psychological interventions such as: anxiety, self-esteem, low mood and emotional regulation were available to children.
- ☑ All units clearly documented when children have disengaged from therapies, the rationale for that dis-engagement and re-engagement opportunities.
- ☑ All children had access to support from occupational therapy.
- ☑ All units provided individual and group activities.
- ☑ All children had a named nurse.

OVERALL THEME

All children had access to a variety of individual and group psychological and therapeutic support.

25.7 Quality Review Theme: Safety Observations

- ☑ On all units, observation records reviewed were complete and accurate. Observation records included: information on risk issues, risk levels and clear details of observation levels and interventions to inform staff undertaking observation duties.
- ☑ On most units, qualified nursing staff can increase observation levels if risk behaviours occur.
- ☑ On all units, the decision to reduce observation levels is only undertaken as part of a full multi-professional team meeting.
- ☑ On one unit, staff encouraged the children to take responsibility by co-producing a safety plan.

OVERALL THEME

Safety observations were regularly reviewed to ensure that they were justified, fulfilled and documented.

25.8 Quality Review Theme: Safety & Welfare

- ☑ On all units, children have opportunities to voice their opinion, concerns, and suggestions via various forums.
- ☑ On all units, safeguarding leads/child protection leads are identified and details made available.
- ☑ On all units, staff have undertaken safeguarding training to an acceptable level.
- ☑ All children had a formulated risk assessment in place.
- ☑ All units discussed risk at the multi professional team meeting.
- ☒ On one unit, the risk prevention actions detailed in the risk management plan had not been undertaken.

OVERALL THEME

Risk assessment and management is undertaken and regularly reviewed.

Safeguarding processes are in place.

Children's opinions and suggestions are sought.

25.9 Quality Review Theme: Education

- ☑ The majority of units met the educational needs of the child.
- ☑ The majority of units offered a range of educational activities.
- ☒ Some units did not identify educational needs on admission.
- ☒ Not all children had access to an approved educational examination facility.
- ☒ Not all units showed evidence of making attempts to contact previous educational services to discuss academic achievements.

OVERALL THEME

All units attempted to meet the educational needs of the child whilst balancing against risk and safety concerns.

Assessments need to include educational needs and pre-admission issues.

25.10 Quality Review Theme: Nutrition

- ☑ All units provided access to a dietician.
- ☑ All units use nutritional monitoring tools.
- ☑ All units offered hot and cold drinks on demand.
- ☑ All children had been encouraged to eat a healthy well balanced diet.
- ☒ One unit did not identify a nutritional need within a child's care plan.
- ☒ Not all issues were identified on admission.

OVERALL THEME

Overall, units provide a healthy and well-balanced diet with access to dietetic support.

Some issues were not identified through the initial assessment processes.

26 Conclusion

A summation of the findings across all areas of this National Care Review can be found at the beginning of this document.

A number of areas that require further action or consideration in order to deliver optimum quality and experience of care have been identified.

In terms of the quality of care, areas of good practice and areas that require improvement have been identified.

If necessary, providers have been given remedial action plans to address any concerns or issues identified.

In nine of the eleven cases, the information available through this National Care Review found that the current placement was appropriate to meet the child's care needs.

In two of the eleven cases, we identified that the placement outcomes had been met/almost met and that the child was ready to move to a lower level of dependency.

Finally, steps should be taken to address all areas of this National Care Review that require further action.

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