GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

Specialised Services
Service Specification: CP150

In-patient Child and Adolescent Mental Health Services (CAMHS): General Adolescent Unit (GAU) and High-Dependency Unit (HDU)

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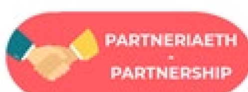

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Statement

Welsh Health Specialised Services Committee (WHSSC) commission in-patient CAMHS including a General Adolescent Unit (GAU) and a High-Dependency Unit (HDU) for young people aged 12 to 18 years in accordance with the criteria outlined in this specification.

In creating this document WHSSC has reviewed the requirements and standards of care that are expected to deliver this service.

Disclaimer

WHSSC assumes that healthcare professionals will use their clinical judgement, knowledge and expertise when deciding whether it is appropriate to apply this document.

This document may not be clinically appropriate for use in all situations and does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

WHSSC disclaims any responsibility for damages arising out of the use or non-use of this document.

1. Introduction

This document has been developed as the Service Specification for the planning and delivery of in-patient Child and Adolescent Mental Health Services (CAMHS): General Adolescent Unit (GAU) and High Dependency Unit (HDU). Specific differences in the service specification for the HDU are contained in Appendix 1.

In-patient CAMHS GAU and HDU is for young people aged 12 – 18 years old and resident in Wales. This service will only be commissioned by the Welsh Health Specialised Services Committee (WHSSC) and applies to young people ordinarily resident in Wales, or otherwise the commissioning responsibility of the NHS in Wales. This excludes young people who whilst resident in Wales, are registered with a GP practice in England, but includes young people resident in England who are registered with a GP Practice in Wales.

1.1 Background

Child and Adolescent Mental Health Services (CAMHS) are planned and commissioned based on a tiered system consisting of the following four levels:

Tier 1 - Universal services

These include general practitioners, primary care services, health visitors, school nurses and early years' provision. Such professionals should be able to:

- promote mental well-being
- recognise when a child or young person may have developmental or mental health problems that a universal service cannot meet

Universal services are commissioned by health and local authority children's services and may be provided by a range of agencies.

Tier 2 - Targeted services

These services include mental health professionals working singularly rather than as part of a multi-disciplinary team (MDT). This may include CAMHS professionals based in schools, or paediatric psychologists in acute care settings. In addition, Tier 2 services include school counsellors and voluntary sector youth counselling services.

Targeted services include services provided for children and young people with milder problems. These are often provided by primary mental health workers (as outreach from Tier 3 CAMHS) who may work with the child or young person directly or indirectly by supporting professionals working in universal services. Targeted services also include those provided to specific groups of children and young people who are at increased risk of developing

mental health problems (e.g. youth offending teams and looked after children's teams).

Tier 3 - Specialist CAMHS

These are MDTs of CAMH professionals providing a range of interventions. Access to the specialist team is often via referral from a GP, but referrals may also be accepted from schools and other agencies, and in some cases self-referral.

Specialist CAMHS can include teams with specific remits to provide for particular groups of children and young people including:

- CAMHS learning disability teams
- Community forensic CAMHS
- Adolescent substance misuse teams
- Intensive treatment teams working to prevent admission to hospital
- Paediatric liaison teams providing CAMHS input to children and young people in acute care settings.

Specialist services are usually commissioned and provided by the health sector, although there is generally a contribution from other agencies.

Tier 4 - Highly specialist services

These include day and in-patient services, some highly specialist out-patient services. Such services are often provided on a regional or supra-regional basis. In-patient CAMHS hospital care is then further divided into different levels of service provision dependent on the degree of security required to safely meet the mental health needs of the young person.

In-patient CAMHS hospital care

Current literature acknowledges variation of definition when describing mental health in-patient settings[1] and we have relied on definitions from the Mental Health Network NHS Confederation, National Association of Psychiatric Intensive Care Units and NHS England Specialised Commissioning to produce this service specification. This is to ensure consistency of nomenclature and a shared understanding between services and across nations.

General Adolescent Unit (GAU)

GAUs provide in-patient care without the need for enhanced physical or procedural security measures however may also include an extra care or high dependency area either within the ward or adjacent to it.

[1] Gwinner and Ward, 2013 P.I.C.U., H.D.U., A.O.A. What treatment do we provide? Current descriptions of the function of intensive care for inpatient psychiatric health care

Psychiatric Intensive Care Unit (PICU)

PICUs manage short-term behavioural disturbance associated with a disturbed mental state which cannot be contained within a CAMHS GAU. Behaviour will include serious risk of either suicide, absconding with a significant threat to safety, aggression and/or vulnerability due to agitation or sexual disinhibition. PICUs will also accept young people with forensic profiles and associated risks to others. Levels of physical, relational and procedural security should be similar to those in low security.

Low Secure Unit (LSU)

LSUs treat young people with mental and neurodevelopmental disorders at lower but significant levels of physical, relational and procedural security. Young people may belong to one of two groups, those with 'forensic' presentations involving significant risk of harm to others and those with 'complex non-forensic' presentations principally associated with behaviour that challenges, self-harm and vulnerability.

Medium Secure Unit (MSU)

MSUs treat young people with mental and neurodevelopmental disorders (including learning disability and autism), who present with the highest levels of risk of harm to others (and often to themselves) including those who have committed grave crimes.

In accordance with the Mental Health Act Code of Practice for Wales, the definition of a mental disorder includes young people diagnosed with, or suspected to have, a form of personality disorder.

WHSSC commissions all Tier 4 CAMHS care on behalf of the 7 Health Boards in Wales. This specification (CP150) is only applicable to in-patient CAMHS General Adolescent Unit (GAU) care and adjacent High-Dependency Unit (HDU) care. This specification applies to both GAU and HDU services however additional requirements specific to the HDU are included in Appendix 1.

1.1 Aims of the service

The overall function of in-patient CAMHS GAU and HDU is to provide mental health assessment, care and treatment for young people in Wales with severe and complex mental health needs that cannot be safely managed within a community setting. Individualised admission goals should be agreed between the in-patient MDT and each young person, along with their family or carers and their community care team as appropriate. Whilst the aims of admission will therefore differ for each young person in accordance with their needs, the care provided should facilitate:

- Age-appropriate cognitive, social, physical and emotional development.

- Empowerment of the young person and their family and/or carers by developing knowledge and skills for the longer term management of their difficulties.
- A therapeutic environment that can appropriately support young people to better understand and address their mental health needs and which seeks to reduce their levels of risk whilst effectively managing significant levels of vulnerability.

These aims should be delivered in keeping with the following principles:

- Young people are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety, promoting recovery and having due regard for their human rights.
- Young people should move through levels of service as clinically appropriate, aiming for treatment as close to home as possible with discharge back to a lower tier of community CAMHS as soon as it is safe to do so.
- Clear and consistent pathways for care within in-patient CAMHS should be in place. This is important as it will assist in reducing unnecessary variations in care provision and outcomes.
- The in-patient CAMHS GAU and HDU service must minimise restrictive practices and should promote mental health recovery through hope, unconditional positive regard and regarding young people and their families or carers as equal partners in their care and treatment planning.
- The service should engage in continuous quality improvement, ensuring that views and feedback of the young people and families are utilised to inform service improvement and development. Provision must be made for young people and families with communication difficulties such as sensory loss and barriers to understanding such as a learning difficulty or disability.

Additional service aims are specific to the HDU element of the service are contained in Appendix 1.

1.2 Aims of this document

The aim of this service specification is to define the requirements and standards essential for delivering in-patient CAMHS care (GAU and HDU).

The objectives of this service specification are to:

- detail the specifications required to deliver in-patient CAMHS: GAU and HDU for young people who are ordinarily resident in Wales, or otherwise the commissioning responsibility of the NHS in Wales as laid out in Section 1.
- ensure minimum standards of care are met within the in-patient GAU and HDU

- ensure equitable access to in-patient CAMHS: GAU and HDU.

1.3 Relationship with other documents

This document should be read in conjunction with the following documents:

- **NHS Wales**
  - All Wales Policy: Making Decisions in Individual Patient Funding requests (IPFR).

- **WHSSC policies and service specifications**
  - WHSSC CAMHS Tier 4 Transition Protocol

- **NHS England Specialised Commissioning**
  - Tier 4 Child and Adolescent Mental Health Services (CAMHS) (General Adolescent Services)

- **Other published documents**
  - A Healthier Wales: our Plan for Health and Social Care, *Welsh Government* 2018
  - Guidance on the reporting and handling of Serious Incidents and other patient related concerns/No Surprises *Welsh Government,*
  - Mental Health Crisis Care Concordat, *Welsh Government and Partners*, 2016
  - Positive and proactive care: reducing the need for restrictive interventions; *Department of Health*, 2014
  - What to do if you're worried a child is being abused; *Department of Health*, 2006
  - 0-18 years: guidance for all doctors *General Medical Council,* 2018

2. Service Delivery

The Welsh Health Specialised Services Committee commission the service of an in-patient CAMHS General Adolescent Unit (GAU) and High-Dependency Unit (HDU) for young people aged 12 or over up until their 18th birthday with mental health needs requiring in-patient care, in-line with the criteria identified in this specification.

For residents of North Wales and North Powys, in-patient CAMHS GAU and HDU are located at the North Wales Adolescent Service (NWAS) on the Abergele Hospital site, Abergele and services are provided by Betsi Cadwaladr University Health Board. For residents of South Wales, including South Powys, in-patient CAMHS GAU and HDU are located at Ty Llidiard on the Princess of Wales Hospital site, Bridgend and services are provided by Cwm Taf Morgannwg UHB.

Both the GAU and the HDU will operate 24 hours a day, 365 days a year.

2.1 Access Criteria

In-patient CAMHS GAU and HDU will consider referrals which meet the following criteria:

- Young people aged 12 or over, up until their 18th birthday. Young people approaching their 18th birthday will be considered according to the Child and Adolescent Mental Health Admissions Guidance (2015) from the Welsh Government.
- Young people who have a primary diagnosis of mental disorder, or are clinically suspected to have a mental disorder after further assessment. The definition of mental disorder is "any disorder or disability of the mind" in keeping with the Mental Health Act (2007).
- Young people whose needs cannot be better met by lower tiers of community CAMHS services, including intensive community support and crisis resolution/home treatment teams.

Referrals will be accepted for young people with comorbid difficulties such as neurodevelopmental disorders, mild learning disability, drug and alcohol problems, physical and sensory disabilities and difficulties, or those with social care problems as secondary needs.

Young people being referred for treatment of an Eating Disorder would routinely be expected to have already been discussed with a specialised Eating Disorders service where they are eligible for this (SPEcialised Eating Disorder (SPEED) team, Eating Disorder Outreach Service (EDOS), except where the urgency of the presentation precludes this.

Young people with the following presentations will only be admitted to the CAMHS in-patient GAU or HDU if the service assess that they are able to safely meet the needs of the individual. Consultation between the CAMHS

in-patient GAU or HDU and an appropriate specialist professional or team such as FACTS, Young Persons Drug and Alcohol Service (YPDAS) or Neuro-Developmental Services may help in clarifying how the needs of the individual may be best met. If the young person is not able to be safely cared for or the expertise to meet their specialist needs is not available then referral to an alternative specialist in-patient service should be considered where this does not breach Equality legislation.

- Young people who present with behavioural disturbances and/or high risk to themselves as a result of an already-diagnosed Acquired Brain Injury, neurological condition or organic disease.
- Young people who are deaf (born or acquired) whose first language is British Sign Language.
- Young people with a primary diagnosis of substance misuse.
- Young people with a primary diagnosis of conduct disorder.
- Young people with a risk profile where the primary risk is that of harm to others. This would include severe physical aggression and violence, sexually-harmful behaviours and arson.
- Young people with behavioural disturbances and/or high risk self-injurious behaviours that are associated with an Autistic Spectrum Condition (ASC).

Additional access criteria for the HDU are contained in Appendix 1.

2.2 Exclusion Criteria

In-patient CAMHS GAU and HDU will not consider referrals for the cohorts of young people below. Whenever the service declines a referral, a prompt written rationale will be provided to the referring clinician.

The service will not accept referrals for:

- Young people 18 years of age or over.
- Young people with a moderate or severe Intellectual Disability as determined by an IQ level of less than 50 or as understood by their functional skills and adaptive behaviour.
- Young people whose mental health needs can be met by community CAMHS, including intensive treatment teams. This will include young people who are experiencing placement break-down or lack of appropriate care, supervision or accommodation but whose mental health needs can continue to be met through the provision of community care rather than hospital treatment.
- Young people currently placed in secure settings who are assessed as continuing to require that level of security.
- Young people who, regardless of their current care setting, are assessed as requiring a secure care environment by either the GAU or HDU MDT. This may be for example, due to a history of persistent and violent attempts to abscond with severe associated risks.

- Young people who present with chronic high risk to themselves, who have already received a full multi-disciplinary assessment and formulation from the in-patient service in either the GAU or the HDU, and whose current presenting risk is not believed to be due to a diagnosable mental disorder.
- Young people who present with a risk profile where the primary risk is their vulnerability and require safeguarding for example, those at risk of sexual exploitation or gang-related behaviour.
- Young people whose physical healthcare needs are of a greater complexity or acuity than their mental healthcare needs. The decision about the priority of presenting needs will require discussion and agreement between the health professionals involved in the young person's care.

Additional exclusion criteria for the HDU are contained in Appendix 1.

2.3 Referrals

Additional information relating specifically to referrals to the HDU is contained in Appendix 1.

Each referral is unique and will require collaborative working between referring and receiving clinicians. In the event that agreement between the involved services cannot be reached, WHSSC, as commissioner of the service, can be contacted during working hours.

Referrals will be accepted from any Tier 3 Community CAMHS Consultant Psychiatrist or from other Tier 3 CAMHS clinicians with the endorsement of a CAMHS Consultant Psychiatrist. Referrals may also originate as transfers from PICUs and Low Secure CAMHS hospitals. Responsibility for the care of the young person remains with the referring service until the point of admission to in-patient care. Referral pathways are contained in Annex i.

The service should have a referral form that includes as a minimum, current mental state, comprehensive information on all known risks, psychiatric history and treatment response, detention status including identifying the nearest relative and who holds parental responsibility. The service should monitor the appropriateness of referrals and provide regular feedback to referrers on inappropriate referrals, identifying any trends or potential educational needs.

Referrers may select whether to refer to the GAU or to the HDU. However, the ultimate decision as to the most appropriate setting for the young person will lie with the in-patient Senior MDT.

Referrers should first contact the in-patient CAMHS service by telephone to request a telephone screening. This should be undertaken by a Senior Clinician within 2 hours of the request being made and is intended to

establish that in-patient care appears to be indicated and to agree the degree of urgency. This decision should be based on presenting risks and severity of symptoms. If a pre-admission assessment is agreed, the referring team will follow-up the screening call with an electronic referral form prior to the assessment time.

Urgent referrals: assessment should take place within 12 hours of concluding the telephone screening. Admission should take place as soon as possible following decision to accept.

Routine referrals: assessment should take place within 24 hours of concluding the telephone screening. Admission should take place as soon as possible following decision to accept.

Pre-planned: there is agreement that the young person can safely be expected not to require admission within the next 3 days.

The service should always endeavour to assess and admit as soon as it is safe and appropriate to do so. The decision to admit will need to take account of the staffing, acuity and case-mix of the ward and take into consideration the best interests of all young people affected on a case-by-case basis.

2.4 Pre-admission assessment

The pre-admission assessment is undertaken in the most appropriate location for the young person, taking into account their preferences, travelling ability and risks. The pre-admission assessment is multi-disciplinary in nature, includes family members wherever appropriate, gives full consideration to individual treatment needs and establishes the goals of admission.

In exceptional circumstances, where there is overwhelming evidence within the referral and associated documents that the young person requires admission and a face-to-face assessment is not practical, then the in-patient CAMHS Senior MDT may review the referral using the available clinical information and decide to admit on the basis of that alone. This may happen in urgent or emergency situations or when practical issues such as distance and timings dictate. This should be a last resort as it reduces the possibility of clarifying the objectives of admission and avoiding an unnecessary admission.

Where the outcome of the pre-admission assessment is that admission is not indicated to either the GAU or HDU, the service should provide recommendations to the referring clinician on suitable interventions that could be considered and risk-management advice. This should be communicated verbally as soon as reasonably possible following the assessment and followed up by way of a timely clinical assessment letter.

On occasions, the outcome of the pre-admission assessment could be an indication for in-patient CAMHS care but the GAU or HDU is unable to admit a young person. This could be due to the acuity of the ward, lack of bed capacity or an identified need for more specialised or secure provision. In these instances, a gatekeeping electronic letter will be provided to support the referring service to apply for funding from WHSSC for a non-NHS Wales bed.

The gatekeeping letter should contain, at a minimum:

- the reasons why admission to an NHS Wales Tier 4 CAMHS in-patient service is not possible
- advice on the level of security required
- recommendations in relation to any specialist interventions or services required.

The service should ensure that a decision regarding the outcome of the pre-admission assessment is communicated to referrers verbally as soon as reasonably possible and followed up in writing addressed to the referrer, young person and, where appropriate, their family or carers.

Transfers of care between the in-patient CAMHS GAU and HDU will take place through internal transfer processes decided at operational level. The young person's family and Care-Coordinator should be involved in the decision wherever possible or informed in a timely manner. Internal transfers will not require completed referral forms nor pre-transfer assessments however, a record should be kept by the service regarding the number of internal transfers. The decision to transfer between the GAU and HDU should be multi-disciplinary and the rationale clearly documented in the young person's clinical record.

2.5 Admission

The provider should ensure that:

- Admissions are able to take place 7 days a week, inclusive of public holidays.
- Wherever possible, admissions will take place during day time hours in a calm and well managed way. Admissions may take place outside of normal working hours dependent on the needs and individual circumstances of the young person. Admissions during the night and early hours should be avoided to reduce the distress and disorientation that may occur as a result for the young person and those already in the unit.
- From the point of admission, all young people have an identified Consultant Child and Adolescent Psychiatrist overseeing their in-patient care, although the Responsible Clinician may be from another discipline.

- The goals and outcomes of admission are, wherever possible, agreed with the young person and their family and/or carers using the Goal-Based Outcome Tool. Where it is not possible or appropriate, the reason for this should be recorded within the young person's clinical record. Further attempts should be made to engage the young person in goal-setting exercises as soon as it becomes clinically appropriate.
- At the first clinically-appropriate opportunity, information describing the ward and its purpose is offered to young people and their families. This should be available in a format suitable to their needs. The information should include:
  - main interventions and treatments available
  - contact details for the ward and hospital and how the MDT will maintain contact with them
  - how to raise concerns, submit compliments or lodge a complaint
  - how to access the Independent Mental Health Advocate (IMHA)
- As soon as it is clinically-appropriate, young people should be orientated to the ward environment, introduced to key members of staff and informed of applicable procedural information such as prohibited items. The timescale for undertaking this will depend on the clinical presentation and needs of each individual young person.

2.6 Facilities

The provider should ensure that:

- The in-patient CAMHS GAU and HDU are located near other hospital facilities that enable ease of access to other healthcare services, including Accident and Emergency.
- The GAU and HDU have separate ward entrances.
- There is a key/fob management system in place which accounts for all secure keys/fobs including spare/replacement keys/fobs which should be held under the control of a senior manager.
- Staff members, young people and visitors can raise alarms using assistance buttons, strip alarms, or personal alarms. There is a clearly documented and tested procedure for the use of alarms which includes guidance for young people on how to call for help using the alarm.
- Facilities should be developmentally-appropriate for the majority of young people using the service.

The provider should also ensure that the service has the following facilities:

- Single bedrooms with en-suite bathroom facilities.
- Dining room.
- Designated educational facilities.
- A designated area or room (de-escalation space) specifically for the purpose of reducing arousal and/or agitation.

- Short-term accommodation for families.
- A room that can be used as a multi-faith room.
- Occupational Therapy space.
- Rooms available for keyworker and therapy sessions.
- Outdoor space/Garden areas.
- Lockable storage facilities for personal property and for young people, staff and visitors to store prohibited items.
- Treatment room which is suitably designed and equipped for physical examination and minor medical procedures.
- Nursing office that is not accessible to young people, within which, confidential information can be stored securely.
- A family visiting room that is outside the main body of the ward so that younger children can visit if appropriate.
- Laundry facilities.
- Internet access and telephone communication (subject to individual risk assessment).

Additional information relating specifically to facilities in the HDU is contained in Appendix 1.

2.7 Environment

The provider should ensure that:

- The premises and facilities are fit for purpose and adhere to WHBN 03-02 Facilities for Child and Adolescent Mental Health Services
- The environmental design of the clinical area gives due regard to the safety of young people and is robust enough to withstand (within reason) daily degradation through clinical use.
- An audit of environmental risk is conducted annually and a risk-management strategy is agreed.
- The unit is in a good state of repair and maintenance is carried out in a timely manner.
- Staff members and young people are able to control the heating, ventilation and lights.
- The environment is one which promotes confidentiality for young people and maintains their dignity and privacy.
- A clean, safe and hygienic environment is maintained for young people, staff and visitors.
- The environment is designed with young people in mind whilst accounting for the primary clinical purpose.

Additional information relating specifically to the environment of the HDU is contained in Appendix 1.

2.8 Equipment

The provider should ensure that:

- Emergency medical resuscitation equipment is available immediately (available for use within the first minutes of a cardiorespiratory arrest) and is maintained and checked according to Health Board policies.
- Specialist clinical risk-management equipment such as anti-ligature hooks, safety clothing and haberdashery, metal-detecting wand and pressure cushions and mattresses are available and accessible. These should be maintained and checked according to Health Board policies.
- Relevant assistive equipment, such as wheelchairs and handrails, are available if required to meet individual needs and to maximise independence.
- Each young person has sufficient educational materials required for each Key Stage e.g. textbooks, DVD’s and interactive learning materials/software. There should be an adequate number of computers available for educational purposes within the Education facility.
- Equipment is provided to facilitate remote working for staff undertaking assessments at other locations. This may include items such as email-enabled phones and laptops with remote internet access.
- There is provision within unit meeting rooms for professionals to attend meetings remotely, for example video-conferencing facilities.
- There is Closed Circuit Television (CCTV) equipment to monitor the public spaces of the building and communal areas of the ward.

2.9 Staffing and training

The provider should ensure that:

- Staff are easily identifiable. The wearing of a full uniform should be considered.
- The clinical workforce is multi-disciplinary and consists of a core team of the following professionals:
    - Psychiatry (Consultant and Trainee posts)
    - Clinical Psychology
    - Psychological Therapies
    - Social Work
    - Occupational Therapy
    - Family Therapy
    - Education
    - Nursing

- There is sufficient access to other necessary disciplines (such as Dietetics, Pharmacy, Speech and Language Therapy, Physiotherapy, Creative Therapists etc.)
- Telephone access to senior clinical and managerial support is available out-of-hours. This should include telephone access to Consultant Child and Adolescent Psychiatry.
- Staffing rotas attempt to provide as much consistency as possible to the young people on the ward.
- There is a recruitment policy to ensure vacant posts are filled quickly with well-qualified candidates who have successfully undergone an Enhanced Disclosure and Barring Service (DBS) check.
- The unit is staffed by permanent staff, and bank and agency staff are used only in exceptional circumstances. Where bank and agency staff are used, they have experience in working with young people with mental health needs and receive an induction covering the physical, relational and procedural security measures of the ward and the risk management and ward management plans for each young person. Regular bank or agency staff should be offered access to training and clinical supervision alongside permanent staff members.
- There are additional members of the non-clinical workforce e.g. cleaners, administration staff to allow the ward to function optimally. This should include access to a MHA administrator.
- Non-clinical staff have received mental health awareness training.
- Education provision for young people is delivered by qualified teachers, including specialist subject teachers. There should also be access to other education professionals as required e.g. careers advisor, Educational Psychologist.
- All staff are compliant with mandatory training requirements to the level commensurate with their professional designation and position.
- All qualified clinical staff should be trained and up-to-date with Intermediate Life Support and Safeguarding Level 3.
- Specific training on the skills and knowledge required for CAMHS in-patient care should be offered to all clinical staff.
- The staff team receives training, consistent with their roles, on risk assessment and risk management. This is refreshed in accordance with local guidelines. This includes, but is not limited to, training on:
    - Safeguarding vulnerable adults and children
    - Assessing and managing suicide risk and self-harm
    - Prevention and management of aggression and violence
    - An appropriate process for risk assessment and formulation such as the WARRN.
- There is a budget for staff training and continuous professional development is supported and promoted.

- Clinical staff have a thorough knowledge of key theories relevant to adolescent development and mental well-being.
- Clinical staff have expertise specific to the clinical area. This includes, but is not limited to:
  - Care of high-risk eating disorders including Naso-Gastric feeding and familiarity with Junior MARSiPAN
  - In-patient delivery of psycho-therapeutic groups and approaches.
  - Positive Behaviour management
  - Creation of a therapeutic milieu
- All members of the clinical staff team receive individual line management and regular group supervision.
- All members of the clinical staff team have access to Safeguarding supervision.
- Staff who deliver clinical supervision receive appropriate training in how to do so and there is a local agreement on the most appropriate model and format for clinical supervision.

Additional information relating specifically to staffing and training in the HDU is contained in Appendix 1.

2.10 Assessment, care and treatment

Additional information relating specifically to assessment, care and treatment in the HDU is contained in Appendix 1.

Assessment

The provider should ensure that:

- A ward-based risk assessment and management plan is completed within the first 24 hours of admission and regularly reviewed. The MDT should begin to undertake the following proportionate assessments as soon as possible after admission:
  - Psychiatric assessments (this should include mental state and psychiatric diagnosis, treatments and responses to date).
  - Psychological assessments (e.g. cognitive and personality assessments).
  - Nursing assessments (which should include engagement with professionals and peers, social functioning, risk assessments and physical health assessments).
  - Occupational therapy assessments (e.g. sensory profile, assessing daily living skills and adaptive functioning skills).
  - Family/systemic assessment (e.g. an assessment of family functioning and the supporting network).
  - Multi-disciplinary risk assessment and formulation.
  - Social circumstances assessments as relevant.

  - Dietary assessment if appropriate.
  - Collection of Routine Outcome Measures as specified in Section 4.1 Quality Indicators
- A formulation is produced based on the information gained from the above assessments
- The formulation is shared with the young person, their family and/or carers, and other professionals involved in the young person's care as long as it would not be detrimental to their mental health and there are the necessary consents in place.
- The formulation underpins the ward care plan and intensive treatment that the young person receives whilst in in-patient CAMHS GAU or HDU as well as their Care and Treatment Plan. The formulation should therefore, be well structured and readily understood.

Care Planning

Unless specifically agreed, the service will not undertake the Care Coordination role under the Mental Health (Wales) Measure. The responsibility for Care Co-ordination will therefore remain with the community Care Coordinator. The in-patient CAMHS GAU and HDU will however, accept full clinical responsibility for duration of an admission.

The provider should ensure that:

- A ward care plan is created for each young person within one week of admission and updated as the young person is further assessed and begins to make therapeutic progress. The ward care plan should be updated as often as required to ensure that it accurately reflects the needs of the young person. It should provide a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to the young person, their family and/or carers, and other professionals. It should be focused on a specific condition or set of symptoms and individualised to enable the young person to move progressively through a clinical experience to positive outcomes.
- Each young person should receive weekly MDT review that gives consideration to their risks and progress towards identified goals.
- Each young person is allocated regular time with a designated key worker.
- In addition to the development of a ward care plan, a Care and Treatment Plan (CTP) review is organised as soon as practical after admission in conjunction with the young person's Care Coordinator. The CTP review must, according to the requirements of the Mental Health (Wales) Measure, have multi-agency input where applicable. It must be completed in collaboration with the young person and, where appropriate, is agreed and shared with their parent(s) or carer(s). Both the ward care plan and the CTP should reflect the

agreed goals as well as recording instances of divergence in agreeing goals and outcomes.

Therapeutic interventions and clinical progress

The provider should ensure that:

- Regular feedback is provided to parents, carers and Care Coordinators on the therapeutic progress of the young person. The frequency and format of this should be agreed early-on during the admission. The process of providing feedback should take into account legal guidance and case law about capacity, consent and information-sharing.
- The service endeavours to provide sufficient notice of upcoming reviews or home leave.
- Interventions to address needs identified in the CTP will use latest best evidence and adhere to appropriate NICE guidelines and clinical standards.
- Interventions are delivered by appropriately qualified and supervised clinicians and therapists
- A range of therapeutic activities are available for young people, both during weekday working hours and in the evenings and at weekends. Such therapies are delivered by registered healthcare professionals including nurses and occupational therapists with specialist skills working with young people in acute psychiatric in-patient care, and support staff (e.g. an activities co-ordinator). Suggested interventions may include:
    - Maintaining good physical health
    - Maintaining good diet and fluid intake
    - Monitoring medication effects
    - Sleep hygiene
    - Personal hygiene
    - Assessment of, and assistance with, daily living skills
    - Physical exercise and physical activities
    - Collaborative problem solving
    - Promoting pro-social behaviour
    - Hobbies, arts and crafts
    - Sporting and leisure activities
    - Drama, art and music groups
    - Mindfulness, distraction and relaxation techniques
    - Promotion of acquisition of new skills.
    - Relapse-prevention.

Advocacy

The provider must ensure that:

- Access to an Independent Mental Health Advocate (IMHA) for every young person is available and facilitated. The advocacy service should be commissioned to work towards the self-advocacy model, should have experience in working with children with mental health problems and must comply with part 4 (four) of The Mental Health (Wales) Measure.

Education

The provider must ensure that:

- Where young people are well enough to access education, they are supported to do so.
- Educational provision is Estyn-registered and subject to their statutory regulations.

The provider should ensure that:

- Young people receive an assessment of their academic needs within the first week of admission or as soon as they are well enough to engage with it.
- The education provided is in accordance with what is commissioned and funded by the local authority.
- The education provider establishes relationships with relevant schools, colleges and other education providers to support the young person's transition into in-patient CAMHS, their education whilst they are in hospital and their aftercare and transition back to their usual place of education.
- Education is offered on a full-time basis, or as close to full-time as appropriate taking into account the health needs of the young person.
- Education must be suitable to the young person's age, ability and aptitude and any additional learning needs they have, and must include appropriate and challenging teaching in English, maths and science (including Information and Communication Technology) on a par with mainstream schools.
- Education staff regularly attend MDT meetings.

Physical healthcare

When considering the physical healthcare of young people accessing in-patient CAMHS, the following should be taken into account:

- Their mental state, developmental or learning difficulties may not allow them to communicate to family, carers or staff in a way in that allows prompt appropriate assessment and treatment.
- If a young person is agitated this may temporarily obstruct a thorough physical examination.

- Pre-existing medical conditions are at risk of being overlooked and mismanaged.
- Young people are considerably more vulnerable to the effects of psychotropic medication, including metabolic syndromes and severe clinical pictures i.e. neuroleptic malignant syndrome.

The provider should ensure that:

- Young people have their physical healthcare needs met through a full range of primary healthcare interventions that include health promotion and physical health screens and appropriate support to access secondary care where required.
- There are established and agreed care pathways for accessing Paediatric and general medical intervention. These should specify the local protocols for young people who are physically and psychiatrically well-enough to attend a General hospital site but also those who are assessed as not able to do so and will require their physical healthcare needs met in-situ. Protocols should take into account the difficulties which can emerge in transferring care to the acute medical setting and consider the potential for counter-therapeutic re-enforcement of self-harm.

Emergencies

The provider should ensure that:

- There is a locally-agreed protocol for summoning emergency healthcare.
- All medical and qualified nursing ward-based staff are trained and competent in the use of Intermediate Life Support.
- All other clinical staff are trained and competent in the use of Basic Life Support.
- Resuscitation equipment as listed previously is available, correctly stocked and checked regularly in accordance with local policies.
- There is a clear local protocol about the circumstances when, exceptionally, police attendance is requested in order to manage a young person’s behaviour within a setting. The protocol should make clear that care and support staff are responsible for alerting police officers to any specific risks or health problems that a young person may have as well as monitoring the young person’s physical and emotional wellbeing and alerting police officers to any specific concerns.

Risk management

Risk assessment is a dynamic, continuous, multidimensional process. As far as possible, a proactive approach to risk should be adopted, in which potential risks are anticipated and addressed in advance. The young person

should be seen as a partner in risk assessment and management. The nature of the difficulties that young people present with in Tier 4 CAMHS, as well as their age, will often make it hard for the interaction between staff and young people to be a true partnership, but it is important to strive to achieve this and to maximise the potential of establishing good engagement and an inclusive approach.

The provider should ensure that:

- Appropriate supportive frameworks such as the Welsh Applied Risk Research Network risk-assessment and formulation tool are utilised in clinical practice.
- Risk assessment is multi-disciplinary in nature and used to inform a robust risk management plan for each young person.
- Daily MDT handovers are structured, with a focus on risk and safety. There are clear structures for communication to the wider MDT of any identified concerns.

Safeguarding

The provider should ensure that:

- The service undertakes all appropriate actions in relation to the protection of children and young people (whether under the care of the in-patient CAMHS GAU/HDU or not).
- There is compliance with All Wales Safeguarding Procedures and the Area Safeguarding Board procedures.
- The child protection status of each young person is known.

Reducing Restrictive Practices

'Restrictive practices are a wide range of activities that stop individuals from doing things that they want to do or encourages them to do things that they don't want to do. They can be very obvious or very subtle.' (Care Council for Wales, 2016)

Restrictive practice encompasses a broad range of environmental conditions and clinical interventions that may breach a young person's Human Rights and must therefore be justified as being proportionate and legal.

The provider should ensure that:

- Practice is developed in line with the principles laid out in Positive and proactive care: reducing the need for restrictive interventions (Department of Health, 2014) and that the least restrictive, suitable intervention for any given situation is selected.
- Any restrictive methods aimed at reducing and eliminating behaviours that challenge should have due regard for the human rights of both young people and staff and should take into account the:

  - young person's preference, if known
  - young person's needs
  - young person's physical condition
  - environment of care
  - staff's duty to protect all those under their care

  Aggregated information from reviews of the use of restrictive practices is used to consider future measures to avoid incidents which could lead to its use.
- Training around the prevention and management of violence and aggression adheres to the Training Standards published by the Restraint Reduction Network.
- Emerging national guidance is adopted. (This particularly relates to the proposed Welsh Government 'Reducing Restrictive Practices Framework'.)

Observations

The practice of nursing observation in mental health care is designed to ensure the safety and well-being of both young people and staff. The frequency and conditions of monitoring are described according to different levels of enhanced observation. There is no universally-agreed framework for the different levels and the service is therefore expected to adhere to locally agreed operational policy. NICE does however offer guidance on the

The provider should ensure that:

- There is a locally-agreed and ratified policy which it adheres to.
- Consideration is given to the needs of the young person when providing higher levels of observation; experience of previous trauma may mean that such observations could be counter-therapeutic.
- Observation level reviews should occur regularly and be fully documented in the health record. Reviews must ensure that the emphasis is to work with the young person at the lowest possible level of restriction.

Restrictive physical interventions; restraint and rapid tranquilisation.

Restrictive physical interventions must only ever be used when all other reasonable avenues for resolving the situation without use of force have been exhausted. Physical 'safe-holding' and physical restraint may be used in mental health settings to prevent immediate harm to service-users and staff where de-escalation has not been successful. Rapid tranquillisation is the terminology used to describe when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them.

A focus on the child or young person's safety and welfare should underpin any use of restrictive physical intervention but will need to be balanced against respecting the safety and dignity of all concerned, including other children, young people or adults present.

The provider should ensure that:

- Training provided in physical restraint adheres to the Training Standards published by the Restraint Reduction Network.
- Staff are taught a form of restraint that is considered safe for use with children who are still developing, physically and emotionally.
- The young person's preferences, advance statements and opinions are taken into consideration.
- The young person's physical condition and history are taken into account.
- The young person's experience of restraint is considered and all efforts made to maintain their privacy and dignity.
- There are clear guidelines for staff to maintain the physical wellbeing of a young person during and after any restrictive physical intervention, including position and the monitoring of vital signs.
- Restrictive physical interventions are recorded in as much detail as possible, both in clinical care notes and incident reports.
- There is a local process for providing post-intervention support to young people and staff involved in restrictive physical interventions.

Serious Incidents (SIs)

The provider must ensure that:

- The Welsh Government guidance on the reporting and handling of SIs/'No Surprises' is adhered to.
- SIs are reported to the young person's Care Coordinator (and local CAMHS service where the Care Coordinator is not a CAMHS clinician) as soon as possible or within 48 hours maximum.
- SIs are reported to the WHSSC Quality Team as soon as possible and within 48 hours maximum. A copy of the closure report to Welsh Government should also be shared with the WHSSC Quality Team.
- There is a system in place for post-incident support and review, which allows the organisation, staff and young people to learn from the experience. Such procedures should cater for the needs of:
  - young people involved in the incident
  - staff involved in the incident
  - carers and family, where appropriate
  - other young people in the clinical environment where the incident occurred

- The service works across divisional and organisational boundaries to share learning from SI investigations.
- The opportunity to report and learn from 'near miss' or 'no harm' incidents is not be overlooked. SI trends and themes should be analysed to inform quality improvement work. SIs and emerging thematic work should be subject to local governance arrangements such as Quality and Patient Safety Boards.
- Accountability for Serious Incident processes, including investigations, is held at senior management level.

2.11 Community Leave and Discharge

Community Leave

Community leave, particularly home leave, is important in helping young people maintain family and community relationships whilst in an in-patient setting and is an important element of the transition to community care.

The provider must ensure that:

- Section 17 of the MHA is adhered to for all detained young people.

The provider should ensure that:

- Parents, carers and the young person's Care Coordinator (and local CAMHS service where the Care Coordinator is not a CAMHS clinician) are informed of all episodes of community leave with as much notice as possible.
- Each planned community leave is risk assessed and managed with due regard for the duty of care the provider has to the young person.
- There are opportunities for receiving feedback on the experience and outcome of community leave.

Transition to Adult Services

The provider should ensure that:

- Transitions to Adult Mental Health Services (AMHS) are initiated for those young people who are nearing their 18th birthday and do not already have a transition plan in place. This should be led by the young person's Care Coordinator however the in-patient CAMHS GAU or HDU should provide reports, review invitations and information as appropriate to support the process.
- The 'Good Transition Guidance' released by the Together for Children and Young People programme should be followed.
- The WHSSC CAMHS Tier 4 Transition Protocol is followed.
- Where locally agreed and ratified policy exists, that this is adhered to.

Discharge

The criteria for discharge should be individualised but take place either when the young person has achieved their admission goals(s) or it is agreed by the Tier 3 and 4 care teams that a continued admission is unlikely to offer further benefit. All young people and their families are supported to take an active role in their discharge planning and would normally be discharged into the following settings:

- Tier 3 Community CAMHS
- Secure Tier 4 in-patient CAMHS (Low or Medium Secure hospital)
- Secure non-NHS provision e.g. secure Children's Home
- Adult Mental Health Services (primary, secondary or tertiary care)

The provider should ensure that:

- The decision to discharge or transfer a young person is agreed wherever possible with the young person, their family, Tier 3 CAMHS Consultant Psychiatrist and Care Coordinator.
- Where applicable, organisations responsible for aftercare under Section 117 arrangements are involved in discharge planning and decision-making.
- The service has an operational policy which includes appropriate safeguards about 'discharge against medical advice'.
- The service provides as much notice as possible to community services (where applicable) to ensure that there is opportunity for recommended post-discharge follow-up to be arranged. The service ensures, through good communication with other services, that young people and their families/carers are aware of the arrangements for follow-up.
- A full discharge summary, including the formulation and associated clinical recommendations, is provided within 7 days of the discharge date.

When young people are transferred to other in-patient provision, the in-patient CAMHS GAU or HDU has lead responsibility in arranging the transfer including completion of referral forms.

The provider must ensure that:

- Section 19 of the MHA is complied with for all detained young people

The provider should ensure that the service:

- Collaborates with the alternative provider to facilitate transfer.
- Takes all necessary steps to prepare the young person and parents/carers for transfer as well as working collaboratively with the Health Board of residence CAMHS.

- Provides a full handover including assessment reports, care plan, risk, treatment received and response.
- Arranges appropriate transport and any required escort consistent with the young person's risk assessment.

Additional information relating specifically to discharges from the HDU is contained in Appendix 1.

Delayed Discharges

If a young person is delayed from being discharged from the service other than for clinical reasons, the service is responsible for escalating this internally to identify how the delay can be overcome. This may involve liaison at a high level with other agencies. The WHSSC Quality Team should be informed of any young person experiencing a delay in their discharge once the delay exceeds 10 days.

2.12 Business continuity

The provider should ensure that:

- There is a comprehensive business continuity plan setting out the arrangements for maintaining service integrity and the safety of young people and staff in the event of operational, security or systems failure. The business continuity plan should incorporate any plans agreed with the police and other emergency services and should address:
    - Chain of operational control
    - Communications
    - Patient and staff safety and security
    - Maintaining continuity in treatment
    - Young person and staff accommodation

2.13 Significant Future Demographic Changes

There are no anticipated demographic changes at the time of writing however the development or redesign of inter-dependent services, along with changes to national health or social care policy may influence the needs of young people being referred to the in-patient CAMHS GAU and HDU. Formal and informal routes of communication should be established between the provider and WHSSC and utilised to facilitate horizon-scanning work.

2.14 Interdependencies with other services or providers

In-patient CAMHS GAU and HDU are part of a spectrum of services that meet the needs of young people with mental health needs. Interfaces with other services and agencies must strive to achieve the vision of “seamless

care" outlined in "*A Healthier Wales*" (Welsh Government, 2018) and to ensure parity of practice and flexibility in terms of available in-patient beds.

Interdependent services at national level include:

- Nationally recognised providers of specialist secure adolescent medium and low secure in-patient care for young people with mental or neurodevelopmental disorders, including learning disability or autism.
- Youth justice custodial settings (Young Offender Institutions (YOIs),
- Secure Training Centres (STCs) or secure children's homes)
- Secure welfare settings
- Community Forensic CAMHS providers
- Other providers of highly specialist residential or educational care for young people.

Interdependent services at regional and sub-regional levels include:

- Providers of mental health inpatient care for young people or those providing other secure care on youth justice or welfare grounds.
- Senior managers in children's social care in different local authorities
- Youth justice services, Youth Offending Services and youth and crown courts.
- NHS and independent providers of non-secure in-patient care
- Providers of residential care
- Providers of special education
- Police, in particular senior officers responsible for youth justice, but also teams particularly involved with young people (e.g. child abuse investigation units).
- 3rd sector organisations working with young people, particularly those who are hard to engage.
- Crown Prosecution Service, in particular decision-makers in relation to youth crime.
- Safeguarding leads in all organisations (e.g. named and designated professionals, local authority and education safeguarding leads).
- All services working with children and young people (e.g. CAMHS, social care, education, substance misuse, youth justice).
- Adult mental health and forensic mental health services including those for people with neurodevelopmental disorder including Learning Disability and Autism.

3. Service Standards

The service must be delivered in-line with the criteria identified in this specification. The service will be expected to meet the standards designed by the Quality Assurance and Improvement Service (QAIS) and will be reviewed against them on an annual basis.

3.1 Legislation

- The service must adhere to the following legislation:
    - Children Act (2004)
    - Human Rights Act (1998)
    - Mental Capacity Act (2005)
    - Mental Health Act (1983)
    - Mental Health (Wales) Measure 2010
    - Rights of Children and Young Persons (Wales) Measure 2011
    - Social Services and Wellbeing (Wales) Act 2014
    - United Nations Convention on the Rights of the Child (1989)
    - Well-being of Future Generations (Wales) Act (2015)
    - Welsh Language (Wales) Measure 2011

3.2 National Standards

The service should aim to adhere to the following standards and guidelines:

- All Wales Safeguarding Procedures 2008
- All Wales Safeguarding Supervision Policy 2017
- EU General Data Protection Regulations 2016
- Good Transition Guidance; *Together for Children and Young People*, 2017
- Junior Management of Really Sick Patients with Anorexia Nervosa (Junior MARSIPAN) *Royal College of Psychiatrists,* 2016
- Mental Health Act Code of Practice for Wales *Welsh Government,* 2016
- NICE guidelines for relevant diagnostic conditions, settings and scenarios
- Quality Standards for Cardiopulmonary Resuscitation, Practice and Training: Mental health – inpatient care *Resuscitation Council (UK),* 2017
- Service Standards (Tenth edition); *Quality Network for In-patient CAMHS (QNIC),* 2019
- Standards of any applicable professional bodies; Nursing and Midwifery Council (NMC), General Medical Council (GMC)
- Restraint Reduction Network Training Standards 2019. *Restraint Reduction Network,* 2019
- WHBN 03-02 Facilities for Child and Adolescent Mental Health Services; *NHS Wales Shared Services Partnership,* 2017

4. Quality and Patient Safety

4.1 Quality Indicators

The provider will be expected to monitor and report against the following quality indicators. Indicators are subject to further development and change.

Data should be submitted on a quarterly basis to:
whssc.information@wales.nhs.uk

Indicator Number	Indicator	Data source
Clinical outcomes		
QICAMHS01	Number of incidences of Restrictive Physical Intervention	Provider data
QICAMHS02	Percentage of Care Coordinators who attend CTP meetings (in person or remotely)	Provider data
QICAMHS03	Percentage of young people who have been meaningfully engaged with the Goal Based Outcomes tool (GBO).	Provider data
QICAMHS04	Percentage of young people who, with consent, have their MDT assessment and formulation of needs shared with the service they are discharged to, in writing, within 7 days of discharge.	Provider data
QICAMHS05	Percentage of young people who have CGAS score completed within 7 days of admission and again on discharge.	Provider data
Other clinical outcome measures may be usefully employed but have not been specified here so as to ensure that clinical judgment can be used to select the most appropriate tool for individuals.		

Patient Experience		
QICAMHS06	All young people and their families/carers are offered the CHI-ESQ experience of service questionnaire.	Annual submission of results and corresponding actions taken
QICAMHS07	Percentage of young people who, prior to being discharged, have a date set for contact with Tier 3 CAMHS within 7 days.	Provider data
Structure and Process		
QICAMHS08	Percentage of referrals responded to by Senior Clinician within 2 hours	Provider data
QICAMHS09	Percentage of urgent assessments admitted within 24 hours (of decision to admit)	Provider data
QICAMHS10	Percentage of young people discharged within 8 weeks	Provider data
QICAMHS11	Ratio of substantive staff to agency staff or bank staff	Provider data
QICAMHS12	Percentage of staff who have received clinical supervision as per Health Board policy	Provider data
QICAMHS13	Percentage of required staff compliant with Level 3 Safeguarding Children training	Provider data
QICAMHS14	Percentage of required staff compliant with Intermediate Life Support training	Provider data

4.2 Quality intelligence

In addition to the indicators above, the following quality-related information must also be shared with WHSSC within the given timeframes.

- Serious Incidents / No Surprises – 48 hours of occurrence. Report must include the original Datix report, SI Notification to Welsh Government and subsequently followed by the Closure report to Welsh Government.
- Complaints – within 48 hours of receipt. This will encompass copies of all written complaints and details of any verbal complaints that cannot be resolved on the spot.
- Delayed Discharges / Delayed Transfers of Care (DTOC) – Any DTOC over 10 days should be reported within 48 hours of reaching the 10 day point.

5. Performance monitoring and Information Requirement

5.1 Performance Monitoring

WHSSC will be responsible for commissioning services in line with this policy. This will include agreeing appropriate information and procedures to monitor the performance of organisations.

5.2 Key Performance Indicators

The provider will be expected to monitor and report against the following performance and activity indicators. Indicators are subject to further development and change.

Data should be submitted on a monthly basis to:
whssc.information@wales.nhs.uk

Indicator Number	Indicator	Data source
KPICAMHS01	Total number of referrals	Provider
KPICAMHS02	Number of occupied bed days (excl. leave days)	Provider
KPICAMHS03	Number of leave days	Provider
KPICAMHS04	Number of admissions	Provider
KPICAMHS05	Number of discharges	Provider
KPICAMHS06	Health Board of Residence of young people admitted since last report	Provider

5.3 Date of Review

This document is scheduled for review before TBC where we will check if any new evidence is available.

If an update is carried out the policy will remain extant until the revised policy is published.

6. Equality Impact and Assessment

The Equality Impact Assessment (EQIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable Welsh Health Specialised Services Committee to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re-assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity and language (Welsh).

This policy has been subjected to an Equality Impact Assessment.

The Assessment demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

7. Putting Things Right: Raising a Concern

7.1 Raising a Concern

Whilst every effort has been made to ensure that decisions made under this policy are robust and appropriate for the patient group, it is acknowledged that there may be occasions when the patient or their representative are not happy with decisions made or the treatment provided.

The patient or their representative should be guided by the clinician, or the member of NHS staff with whom the concern is raised, to the appropriate arrangements for management of their concern.

If a patient or their representative is unhappy with the care provided during the treatment or the clinical decision to withdraw treatment provided under this policy, the patient and/or their representative should be guided to the LHB for NHS Putting Things Right. For services provided outside NHS Wales the patient or their representative should be guided to the NHS Trust Concerns Procedure, with a copy of the concern being sent to WHSSC.

7.2 Individual Patient Funding Request (IPFR)

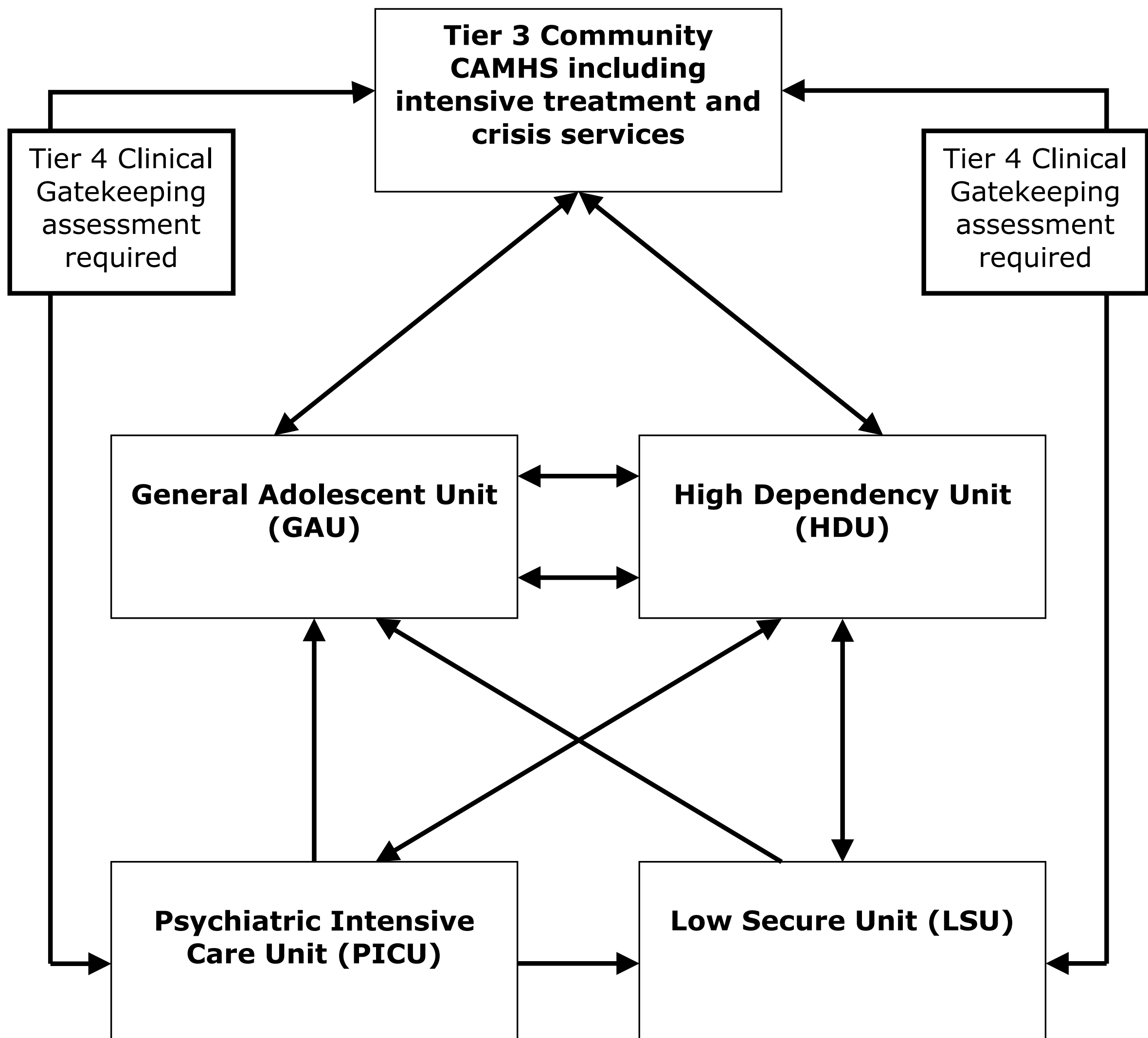
If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

If an IPFR is declined by the Panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, arrangements can be made for an independent review of the process to be undertaken by the patient's Local Health Board. The ground for the review, which are detailed in the All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR), must be clearly stated

If the patient wishes to be referred to a provider outside of the agreed pathway, and IPFR should be submitted.

Further information on making IPFR requests can be found at: Welsh Health Specialised Services Committee (WHSSC) | Individual Patient Funding Requests

Annex i Referral pathways



Appendix 1 - In-Patient CAMHS HDU

1. Background

The distinctions between GAU, Extra Care, HDU and PICU are subtle but significant. High-Dependency care differs from the previous Extra Care provision on the basis that the ward is permanently staffed and offers increased procedural, relational and physical security. Due to these restrictions, young people admitted to the ward should normally be detained under the Mental Health Act unless they are able to give capacious consent to the placement and are free to leave the ward when they wish to do so.

The HDU does not meet the standards required of a PICU or Low Secure environment such as having an entrance via a double-door airlock and the use of a seclusion room[2]. These, and other additional security measures, enable PICUs to accept young people admitted with forensic risk presentations. The HDU will not constitute a designated 'place of safety' within the terms of the Mental Health Act and therefore will not be able to admit young people detained under Section 136 of the Act. These are important limitations of the HDU and to work outside of them would endanger the care and safety of all young people on the ward.

The HDU will ensure that higher levels of risk can be managed and to safeguard the less restrictive nature of the GAU. The HDU will provide higher intensity of care and supervision than can be offered by the GAU. This will be for a time-limited period of 8 weeks in a more structured, containing and protective environment where young people can address their mental health needs in safety and with dignity. The HDU protective approach consists of the three interdependent domains of security which are managed jointly. These are:

- Physical: The security mechanisms (e.g. locking systems, security fences) and other physical barriers.
- Relational: The understanding and use of knowledge about individual patients, the service environment and the overall population dynamic.
- Procedural: The timely, correct and consistent application of effective operational procedures and policies.

[2] National Association of Psychiatric Intensive Care Units and Low Secure Units (NAPICU) 2015 National Minimum Standards for Psychiatric Intensive Care Units for Young People

2. Service Delivery

2.1 Aims of the service

The function of the HDU is the thorough assessment, formulation and intensive short-term management of acute mental disorder and behavioural disturbance within an integrated care pathway. Assessment, care and treatment will be provided for a period of up to 8 weeks, for young people who, due to a mental disorder, present with symptoms, behavioural needs and risks that cannot be managed safely in less restrictive settings. In circumstances where an admission extends longer than 8 weeks, there should a multi-disciplinary review and clear agreement with the young person's Care Coordinator, CAMHS community team, other involved professionals and their family and/or carers regarding the purpose and benefits of extending the admission

The primary focus of treatment should be on helping the young person to reduce the frequency and severity of high risk destructive and self-destructive behaviours, while reducing the need for high frequency monitoring and containment. The provision of high-dependency care does not seek to eliminate the risk but to reduce it to a level that enables treatment at a lower level of protection and containment. This requirement, and how it will be measured, should be agreed as part of the admission process.

As risk behaviour reduces, the focus on independent functioning should increase, thus facilitating a step-down to the GAU and/or discharge. The ward should aim to transfer the young person to the GAU or to the community as soon as is safely possible or where this is not possible, provide clear rationale for transfer to a higher level of care provision and security.

The aim(s) of each admission will vary depending on the presenting mental health needs and risk profile of the young person however the outcome of all admissions should be at least one of the following:

- Reduction in frequency, duration or severity of acute behavioural disturbance that allows the young person to be safely transitioned back to a GAU environment or the community.
- Reduction or stabilisation of risk to self and, where possible, (re)engagement with an appropriate treatment programme that allows the young person to return to the community or to a GAU environment. The emphasis should be on achieving the reduction or stabilisation of risk rather than elimination of risk, particularly for those young people who present with chronic risk to self.
- Comprehensive multi-disciplinary assessment and formulation that provides a clear contextual understanding of the young person's current difficulties and risks and recommendations about the

approaches, interventions and environments that service-users, families/carers and services can implement to support them.
- Comprehensive multi-disciplinary assessment that evidences a need for longer-term secure care. This may be a secure healthcare setting such as a Low or Medium secure hospital, or a secure welfare placement.

2.2 Access Criteria

In addition to the criteria given for access to the in-patient CAMHS GAU, the following conditions must also be met for access to the HDU:

- Unless the young person is able to give capacious consent for the admission, and is free to leave the ward when they wish to do so, they should usually be detained under the Mental Health Act. The Section of the Mental Health Act which the young person is subject to must be one which stipulates assessment or treatment in a mental health hospital. (Section 136 is therefore not included in this).
- Taking into account all available risk information, the young person is not assessed as being likely to require the use of seclusion facilities or the presence of a double-door air-lock to ensure their safety and well-being and/or the safety and well-being of others (peers, visitors or staff). They must be assessed by the admitting ward as having a risk profile that can be safely managed without the need for either of the above security measures.

And present with one of the following:

- Acute behavioural disturbance (agitation, over-activity, aggression, unpredictability, disinhibition) in the context of a mental disorder.
- Acute exacerbation of risk to self in the context of a mental disorder; young people engaging in self-harm or suicidal behaviours of high potential lethality, regardless of intent or motivation.
- Chronic or gradually incremental high risk to self in the context of a mental disorder which has become unmanageable in a community setting or the GAU due to very low or non-existent engagement in a Tier 3 or Tier 4 treatment programme.
- Young people presenting with a need for short-term hospital treatment of a mental disorder but who have a risk profile indicating a requirement for a more protective and containing environment than the GAU is able to offer. This may be the case where there is comorbid mental illness and personality disorder.

2.3 Exclusion Criteria

In addition to the criteria given as exclusions for the in-patient CAMHS GAU, the following criteria would exclude a referral from being accepted:

- Young people currently under a section of the Mental Health Act that does not include hospital assessment and treatment. This would therefore exclude young people placed on Section 136 unless it was converted to a section 2 or section 3.
- Young people currently placed in secure settings who are assessed as continuing to require that level of security. Whilst the HDU will provide a higher level of protection and containment than the GAU, it is not categorised as a secure setting.

2.4 Referrals

Referrals will be accepted from the same sources as specified for the GAU. Whilst in high-risk situations, admission will need to be accommodated within short time-frames, the High-Dependency care ward is not an emergency mental health service and young people requiring immediate care and containment will need to be admitted to an age-appropriate care setting locally until admission can be agreed and arranged. The location of these is decided by individual Health Boards.

The maximum time frames provided for the GAU apply equally to the HDU however the service should always endeavour to admit sooner than this as long as it is safe and appropriate to do so.

2.5 Facilities

In addition to the facilities listed for the GAU, the provider should ensure that:

- Secure lockers are provided for young people within the ward where restricted items of risk can be stored.
- Secure lockers are available to families, carers and other visitors in which to store restricted items.

2.6 Environment

There is an enhanced level of environmental security in the HDU in comparison to the GAU. The HDU provides a therapeutic, locked environment.

In addition to the environmental specification listed for the GAU. The provider should ensure that:

- The HDU has high impact resistant surfaces and finishes and tamper proof, anti-ligature fittings.
- All doors are designed to prevent holding, barring or blocking.
- Clinical areas have wide corridors (that allow staff to escort or move young people who are being restrained) with unrestricted lines of sight, and with no concealed and unsecured areas.
- There is a secure external perimeter that is sufficient to safeguard those young people who attempt to abscond.

- Outdoor furniture, fencing and fittings should be fixed and able to withstand attempts to dismantle, be used as a weapon or to exit the service.

2.7 Staffing and training

In addition to the staffing and training specification listed for the GAU, the provider should ensure that:

- The HDU is permanently staffed on a separate basis to the GAU (although the flexible deployment of staff between the two settings can be authorised by a senior member of clinical staff.)
- There is a minimum staffing level of 1 member of ward staff to 1 young person, increasing to a ratio of 3:1 for the most highly disturbed young people. There must always be sufficient staffing levels to ensure the safety of young people.
- The staff team has expertise relevant to the clinical area. This includes, but is not limited to:
  - The use of psychopharmacology in severe mental illness, including use of Pro Re Nata (PRN) medication and Rapid Tranquilisation.
  - The legal requirements of the Mental Health Act.
  - The management of violence, aggression and behaviours that challenge.
  - Trauma-informed care.

2.8 Assessment, care and treatment

Given the time-limited nature of care in the HDU, the interventions and treatments, informed by the formulation, will need to be time-limited and intensive. Thus, the young person and their family and/or carers may require multiple sessions per week. The treatments and interventions should primarily address the high risk symptoms and behaviours that exclude the young person from functioning in less restrictive environments and the community.

The provider must ensure that:

- All young people have an identified Tier 4 Consultant Child and Adolescent Psychiatrist as the Responsible Clinician.

2.9 Discharge

The discharge of a young person from the HDU must be dictated by the nature of their presentation and needs, however admissions should generally not last longer than 8 weeks. Protracted assessments or delays in securing accommodation will cause uncertainties for the young person which may increase risks, jeopardise improvements in mental health and detrimentally impact on the young person’s experience of the service.

The provider should ensure that:

- Any admission that is likely to last longer than 8 weeks is subject to robust clinical review which focuses on locating and engaging with appropriate alternatives.