Child and Adolescent Mental Health Services Residential Units Wales:

A Review of Safeguards and Standards of Care

Follow up Inspection

July 2000
CONTENTS

Section 1: INTRODUCTION 1

Section 2: OVERVIEW REPORT
Key Findings - North Wales 7
Key Findings - South Wales 17
Key Findings - Conclusions 29

Section 3: NORTH WALES REPORT
North Wales Introduction 33
North Wales Report 34

Section 4: SOUTH WALES REPORT
South Wales Introduction 66
South Wales Report 67

APPENDICES
Appendix 1: Specification for the project
Appendix 2: Standards and criteria and addenda
Appendix 3: Documents consulted as part of the review
Appendix 4: Timetable of visits and meetings for the review
Appendix 5: Members of the review team
SECTION 1
INTRODUCTION
1. PURPOSE OF THE REVIEW

1.1 In February 1998 the Secretary of State for Wales invited HAS 2000 to conduct a review of residential child and adolescent psychiatric services in Wales and, in particular, to report on the safeguards and standards of care at the two adolescent inpatient units. These safeguards and standards were to be judged against those set out in the policy guidance, "The Health of Children in Wales". The review was also required to consider other complementary services, such as social services, primary health care, other child and adolescent mental health services and services provided by the independent sector, from the perspective of the needs of the young people in the units.

1.2 The report of the HAS 2000 review was published in December 1998. In his covering letter to the review report, dated 8 January 1999, the Secretary of State for Wales stated that he had asked health professionals from his department to conduct a series of early visits to check compliance with those issues HAS 2000 had identified for immediate action. He also indicated that departmental professionals would check that basic safeguards were in place on those adult wards which accommodated adolescents. These compliance visits took place in early 1999.

1.3 On 1 July 1999 the Secretary of State's responsibility for these functions transferred to the National Assembly for Wales. Within the Assembly, Jane Hutt is the Assembly Secretary responsible for health and social services. She confirmed the intention that HAS 2000 should undertake a further review of progress in implementing the recommendations of the 1998 report and HAS 2000 was commissioned to do so in November 1999.

1.4 A copy of the full specification for the progress review agreed between HAS 2000 and the National Assembly for Wales is attached in Appendix 1.

2. CONDUCT OF THE REVIEW

2.1 THE STANDARDS

2.1.1 HAS 2000 conducted the progress review against a set of standards which were used for the 1998 review. These had been derived from a careful analysis of a wide range of relevant national policy and guidance documents. For the progress review, the National Assembly for Wales and the agencies concerned in North and South Wales provided relevant documents which had been produced since the first review. These were analysed and appropriate statements were used as a basis for the addenda to the standards. These documents are included in Appendix 2. Standards and criteria include statements of good practice relating to child and adolescent psychiatry, and the quality of care and education of children and young people in hospital and residential settings.

2.1.2 The standards were agreed with the then Welsh Office in May 1998. All who participated in the review were provided with a copy of the standards or were aware of them. The standards and criteria are incorporated into Sections 2 and 3 of this report and can also be found in Appendix 2.
2.2 THE SCOPE OF THE REVIEW VISITS

2.2.1 The review team visited North Wales during the period 28 - 30 November 1999. Field work in North Wales included:

- A progress review of the work of Cedar Court adolescent unit, Colwyn Bay, managed by Conwy and Denbighshire NHS Trust.

- A progress review visit to the Hergest Unit, an acute psychiatric ward managed by North West Wales NHS Trust.

- A series of meetings with representatives of North Wales Health Authority, Conwy and Denbighshire NHS Trust, North West Wales NHS Trust, local authority social services departments from the six unitary authorities, and local community health councils.

2.2.2 The review team visited South Wales during the period 1 - 3 December 1999 and field work there included:

- A progress review of the work of the Harvey Jones Unit, Cardiff, managed by Cardiff and District Community NHS Trust.

- A progress review visit to Ward East 2A at Whitchurch Hospital, also managed by Cardiff and District Community NHS Trust.

- A series of meetings with representatives of Bro Taf Health Authority, the providing trust, the four local authority social services departments and local community health councils.

2.2.3 The detailed timetables of the review visits are attached as Appendix 4.

2.3 REVIEWS OF UNITS

2.3.1 During their visits to the units the review team collected and analysed relevant background information and operational material relating to the current policies and work at the units. Interviews and discussions were conducted with a range of managers and practitioners from all disciplines. Informal interviews were also arranged with a selection of young people resident at the units, and their parents. The design and quality of the treatment environment was examined.

2.3.2 This wealth of first hand material provided the evidence on which the review team have been able to make judgements about the degree to which the units' practices met the standards and criteria. This material also assisted the review team with their assessment of the extent to which the recommendations of the 1998 review had been met.

2.3.3 The documents examined by the review team are included in Appendix 3.
2.4 **THE REVIEW TEAM**

2.4.1 To conduct the various review activities, and to cover the full range of professional subjects and issues, a multi-disciplinary review team was recruited by HAS 2000. This team, which was led by a consultant child and adolescent psychiatrist, also included a senior nurse with direct experience of inpatient work with adolescents, a senior community nurse with child protection experience and a former member of the Department of Health's Social Services Inspectorate with extensive experience in the residential child care field. This team conducted both the 1998 review and the 1999 progress review, thus providing continuity of judgement. The team were also supported by the joint chief executive of HAS 2000, himself a consultant psychiatrist. Facilitation of the review visit and the team's work was undertaken by a Service Development Adviser and a Review Administrator from HAS 2000.

2.4.2 Membership of the review team is attached in Appendix 5.

3. **REPORTING THE REVIEW**

3.1 Following the visit to Wales, reports on the work of the Cedar Court and Harvey Jones units and the two adult wards were prepared. The structure of these two reports follows closely the review standards framework.

3.2 The overview report provides a summary of the key findings and issues arising from the review.

4. **ACKNOWLEDGEMENTS**

4.1 Throughout all the aspects of their work, the review team experienced a high level of co-operation, openness and willingness to exchange information on the part of health and local authorities, trust and unit managers, professional and practitioner staff at all levels and the young people and their parents. This introduction provides a further opportunity to thank all those concerned with both the review and the progress review.

4.2 Members of the review team also had discussions with members of the National Assembly for Wales' child and adolescent mental health services strategy advisory group. This provided the opportunity to share information, and main issues, from the work of the strategy group and the review team.

4.3 The review team and staff at the Health Advisory Service would also like to extend their gratitude to all those who assisted in the planning and organisation of the follow up review. This includes those from the National Assembly for Wales, North Wales Health Authority and Bro Taf Health Authority, North West Wales NHS Trust, Conwy and Denbighshire NHS Trust, Cardiff and District Community NHS Trust, and both Cedar Court and the Harvey Jones Unit.
SECTION 2
OVERVIEW REPORT
KEY FINDINGS - NORTH WALES

1. INPATIENT PROVISION AND ADMISSION POLICIES

The 1998 review team concluded that there was inadequate provision in North Wales Health Authority area to meet the full range of adolescent psychiatric illness.

1.1 This remains the situation although a range of solutions have been developed by the health authority and trusts which mean that adolescents with serious mental health problems are offered services. However, there is not adequate provision for those patients who require treatment without their consent or whose psychiatric illness is of a nature which necessitates physical control. There is also no provision available for secure mental health care for adolescents. Cedar Court admits only those adolescents who, in practice, will show the necessary degree of co-operation.

1.2 The policy at Cedar Court continues to be one of prioritising on grounds of appropriateness of treatment and degree of urgency, rather than setting explicit criteria. Many of the patients admitted to Cedar Court would, in a metropolitan area, be managed as day patients. This is difficult in rural North Wales, with one inpatient unit, due to problems of transport. Despite this, there does seem to be more demand for day care, and patients from the length of the North Wales coastal strip attend the unit. That being said, there are clearly adolescents whose needs can only be met by the provision of inpatient care. Local community child and adolescent mental health services continue to have rather variable waiting times for first appointments, indicating an inadequacy of local resourcing or a failure to apply clear referral criteria and agreements with referrers about who should have priority.

1.3 The Hergest Unit at Bangor continues to admit a small number of young people aged 16 or 17 years. No young person under the age of 16 years has been admitted to the unit in the past 1½ years. In addition there have been a number of admissions to paediatric wards of children and adolescents with primary diagnoses of a mental or behavioural disorder. The average length of stay of these admissions is normally less than 2 days. Any patient under the age of 16 years at the Hergest Unit is admitted under the care of a consultant child and adolescent psychiatrist. This commendable practice is also extended to most 16 year olds and to any patient who was under the care of a child and adolescent psychiatrist before admission.

1.4 There remains no emergency service on an 'out of hours' basis, although current Cedar Court patients can call the unit. Other local mental health services do not have access to Cedar Court 'out of hours'. In general any urgent cases are admitted without unacceptable delay and beds can usually be made available at either Cedar Court, the Hergest Unit or the paediatric unit.

1.5 Discussions are underway which involve the health authority, the trust and others regarding the best solution to deal with the perceived unmet need of those adolescents with severe psychiatric illness requiring treatment under the Mental Health Act and/or physical restraint/sedation. A number of options might be considered. Whilst it is for the North Wales Health Authority to determine this issue, the review team are pleased to offer possible options and comment on these.
Option i. Cedar Court provides a service largely (though not entirely) for those patients with emotional disorders who will co-operate sufficiently to benefit from the treatment programme. Adult mental health units provide a service for those who require physical restraint / sedation / treatment under the Mental Health Act. Adult mental health services would do their best to meet as many of these quality standards as possible.

Option ii. Cedar Court continues to provide service as option (i). An area of an adult ward is formally designated as the preferred provider for those adolescents whose needs cannot be met by Cedar Court due to the need for treatment under the Mental Health Act. This presumably would facilitate efforts to raise 'adolescent' quality standards.

Option iii. As option (ii), but Cedar Court becomes a day service / specialist outpatient resource.

Option iv. Cedar Court changes so as to be able to provide treatment for those with higher levels of disturbance who require treatment under the Mental Health Act. This would only be possible if Cedar Court moved to another site.

- Option (i) has the advantage of being (partly) achievable and more or less cost neutral, but adult units would be unable to meet all the required standards.

- Options (ii) and (iii) look attractive in the short term, but in the longer term would be likely to result in the loss of the current service provided by Cedar Court.

- Option (iv) may be difficult to achieve in terms of involving major change. It would, however, produce a service more in line with that in units currently operating through much of the UK and would provide a service configuration with a greater chance of longer term sustainability.
2. **STAFFING**

The 1998 review concluded that Cedar Court generally met all the standards related to staffing, although the multi-disciplinary aspects of the work needed strengthening. The review team supported the unit's resolve to develop a more comprehensive programme of staff training and development.

2.1 At Cedar Court in December 1999 there was a full multi-disciplinary and multi-agency team of staff, who were able to offer a wide range of therapeutic approaches. Following the HAS 2000 Review in 1998 the trust increased the unit's establishment to allow for 2 waking night duty staff.

2.2 In general, resident patients require little close or constant observation. This reduces pressure on management to bring in any additional staff. However, if the unit opens at the weekend, the two staff required to work on the unit will have time off during the week and this can interfere with planned clinical treatment sessions. Constraints on the staffing budget do lead to some inflexibility in approach.

2.3 There are clear lines of accountability, both within Cedar Court and to relevant external line managers. Staff appraisals take place regularly and structures are in place to ensure that all staff receive appropriate support and supervision, both individually and in groups. Some nursing staff receive a frequency of supervision which is less than desired. This is partly due to the nurses' duty rotas. Frequency of supervision is audited by nurse management.

2.4 At Cedar Court the unit staffing establishment allows for an RMN to be on duty at all times. Seven nurses have completed, and a further three nurses are on course to complete ENB603 training. Additional funds have been made available to support this. This training is accepted as relevant to the work at Cedar Court. The unit has also fully engaged with the health authority's child protection training strategy and all nursing staff have completed child protection training at induction level. There have also been a range of in-house training events targeted at various aspects of child protection.

2.5 At the Hergest Unit considerable attention has been paid to the training needs of nursing staff who are likely to come into contact with young people. Although the unit does not fully meet the criterion for this standard, there is clear evidence of real attempts to address these issues within the constraints of an adult psychiatric ward. The link nurse, whilst enhancing her own training, has established working links with Cedar Court whereby it is possible to access supervision and advice from the senior nurse whenever a young person under the age of 16 years is admitted.
3. CHILD PROTECTION MATTERS

The 1998 review concluded that Cedar Court was well appraised of the range and impact of child protection issues and worked within health authority and local area child protection committee (ACPC) structures and procedures. The review team recommended further dissemination of child protection awareness to all members of staff at the unit.

3.1 Managers and staff at Cedar Court continue to maintain a high level of awareness and knowledge of child protection issues, and this has been enhanced since the 1998 Review by the employment of the unit social worker, who is funded jointly by the six unitary authorities. The unit has a set of unit child protection procedures which are in line with ACPC guidance. The procedures are clear and comprehensive. The unit maintains good working relationships with designated professionals from the health authority and trust.

3.2 The North Wales Health Authority takes a strong lead on child protection matters within its boundaries. The designated doctor and nurse provide excellent professional leadership. A recent service specification "Children's Services - Programme of Care: Child Protection and Related Services" (July 1999) has been widely circulated to local health groups, trusts and private hospitals.

3.3 The North Wales Health Authority has also developed guidance (still in draft form) concerning the handling of allegations against professionals. Cedar Court has incorporated this guidance into its unit procedures.

3.4 The North Wales Health Authority has developed a child protection training strategy which has been adopted by the trusts and other agencies. The strategy sets out the level of knowledge or awareness required of each staff or professional group. Cedar Court has fully co-operated with this strategy and all nursing staff have completed child protection training at induction level. Other in-house training events, delivered by Cedar Court social work staff, police, trust named nurse and social services department colleagues, have focused on child abuse indicators, inter-agency roles and responsibilities, recognition and referral procedures. Three nurses have also undertaken child protection modules within their own professional development courses.

3.5 The review team consider that the child protection work at Cedar Court has strengthened over the past year, by virtue of better inter-agency linkage achieved by the appointment of the unit social worker, by the promulgation of improved procedures and protocols for handling key abuse issues, and by the development of the training programme.

3.6 At the Hergest Unit the review team noted developing awareness of the issues and a desire to respond as far as possible to child protection requirements. The North West Wales NHS Trust has recently appointed a trust named nurse who provides clinical supervision on child protection matters to the Hergest Unit link nurse. She, in turn, provides similar supervision to other nursing colleagues at the unit. There are plans to ensure that all nurses have received at least basic training in child protection. At the time of the progress review visit it was estimated that about one fifth of the nurses had received this and as a result it was possible that each nursing shift would include at least one nurse who had been so trained.
4. **ADOLESCENTS' AND FAMILIES' VIEWS OF THE SERVICE.**

The 1998 review concluded that Cedar Court's approach facilitated the appropriate involvement of the adolescents, but noted that there was some difference of opinion between the adolescents interviewed about this. The review team also recommended a more consistent approach to the provision of information on young persons' rights, complaints and helplines. The 1998 review team were also very concerned that, when needing to handle very difficult behaviours on the unit, there was always the risk of patients being detained or treated without their consent and without the safeguards provided by the Mental Health Act.

4.1 The review team noted that these issues had been actively addressed by Cedar Court, the health authority and the trust. Both adolescents and their parents considered that they were fully involved in the programme of treatment and praised the service which was offered. Parents confirmed their involvement with the consultation process, pre-admission visits and regular case reviews. All these activities were highly valued. Parents felt helped and supported by Cedar Court and considered that the unit communicated well with them and accommodated their needs.

4.2 The young people also confirmed their understanding of their illness, the treatment programme and the role played by different members of staff. The young people interviewed confirmed their involvement through formal review meetings, sessions with key workers and other staff members, and their contribution, via patient representatives, to unit 'policy' meetings.

4.3 The review team also noted a marked improvement in the manner in which information is provided to each adolescent. A pre-admission pack is provided for each patient. This includes a range of literature related to their rights under the UN Convention, the trust's complaints procedures, details of helplines and the National Youth Advocacy Service. The latter organisation provides direct services to the unit. This innovation is commended by the review team. The information is also available on public display boards in the unit.

4.4 Cedar Court will not provide a programme of treatment without patient and parental co-operation and consent, which is manifested through the signing of a contract for treatment. As a consequence, the unit does not admit or treat patients where this co-operation is not offered, although every effort is made to achieve agreement. Patients who will not agree may be admitted to adult mental health wards or paediatric wards, or not admitted at all.

4.5 Cedar Court remains unable to admit adolescents who require physical security or the provisions of the Mental Health Act 1983. As well as professional considerations, issues of planning consent have meant that adolescents requiring security cannot be placed at Cedar Court. As noted in Key Finding 1.5 discussions are currently in hand which aim to find the best solution for this perceived area of unmet need.
5. SAFEGUARDS

The 1998 review concluded that the staff at Cedar Court were properly sensitive to safeguarding matters, but that some further strengthening of practice and procedures would build on current arrangements. The use of 'time away' did give the review team cause for some reflection and more work was required in the development of a risk assessment framework for adolescent leave and absence from the unit. There were also some gaps in the recruitment and police check arrangements which warranted urgent attention.

5.1 Arrangements to protect the rights and interests of the patients and their parents remained in place. Standards of communication and co-operation with parents and patients were very sound and were considered mutually supportive. The trust's complaints procedure was made known to both parents and adolescents and the young people confirmed their satisfaction with the manner in which complaints were handled by unit management.

5.2 The trust has now contracted with the National Youth Advocacy Service to provide a fortnightly visiting service and an individual mediation service, but the present location of the patients' telephone does not allow for any degree of privacy. Unit management may wish to consider the introduction of improved arrangements here.

5.3 The trust has a policy on the management of aggression. At Cedar Court there is a strong ethos against the use of restraint as a means of control. The unit has incorporated the trust's approach to the handling of aggression in its procedures, but no relevant training in restraint techniques has been provided for nursing or social work staff. In line with the unit's treatment ethos, training courses in de-escalation and 'breakaway' training have been arranged. There is no unit wide system for monitoring incidents of violent behaviour, but records are maintained on individual case files.

5.4 Cedar Court operates to a clear code of behaviour which is accepted by patients and their parents. Since the 1998 review visit the arrangements for 'time away' have been made safer by the introduction of daily contact with the young person when at home. The period of 'time away' has been reduced to one or two days as a norm. The young people confirmed that they welcomed this modification to practice. The review team still have some concerns about the safety and effectiveness of this sanction, despite the introduction of these additional safeguards.

5.5 A new procedure for making 'risk assessments' in circumstances when adolescents are absent from the unit without leave has been introduced. This procedure reflects practice guidance issued jointly by North Wales police and social services, "Children Missing from Care in North Wales". The unit takes this matter very seriously and adheres to tight reporting timescales.

5.6 Effective procedures are now in place to police check all staff working at Cedar Court, whatever their status or discipline. At the time of the progress review, police checks in North Wales were taking 12 weeks to complete. This has caused, or has the potential to cause, recruitment problems for the trusts. However, the trust is determined to adhere to safeguarding principles and is prepared to manage any adverse consequences of this policy.
5.7 The trust and the unit have taken active steps to ensure that the young people are fully safeguarded by sound professional practice, appropriate protection procedures and robust personnel and recruitment policies and practices. There appear to be a number of mechanisms available for the discussion and resolution of safeguarding issues. As well as new procedures for the investigation and handling of allegations against professionals, the health authority has advised all trusts to develop a 'whistle blower' policy. The Conwy and Denbighshire NHS Trust policy has been incorporated into Cedar Court procedures. The review team welcomed these developments, but felt that further clarification of their application in practice would be helpful.

5.8 The review team found that the situation at the Hergest Unit, despite best efforts by trust management and unit staff, remains one where the needs of adolescent patients are less than fully safeguarded. The unit is visited twice a week by a worker from an advocacy service, but the service remains primarily geared to the needs of adult patients. There are appropriate procedures, again promulgated essentially for the needs of adults, to control the management of aggression and nursing practice for adolescent patients in seclusion, or in the six-bedded intensive care area. The trust also aims to police check all staff who work on the unit, including nursing staff (both permanent and bank), domestic staff and porters and volunteers. The review team were informed that the North Wales police had been reluctant to carry out these checks, a situation which was the subject of correspondence between the trust chief executive and the chief constable.
6. MULTI-DISCIPLINARY AND MULTI-AGENCY WORKING

The 1998 review thought that the North Wales Health Authority would be strongly advised to prepare a new and forward looking strategy for child and adolescent mental health. The review team noted the degree of organisational disruption which had been caused by authority reconfigurations in both the health and local authority sectors and the climate of uncertainty which had accompanied these changes. There were major concerns about the resource environment in both sectors. However, professional staff from all sectors evidenced a commitment to work together and plan for better services in the future. The phenomenon of children and young people cared for in the independent residential child care sector was a major issue for concern.

6.1 The North Wales Health Authority has produced a new draft strategy (September 1999) for child and adolescent mental health services (CAMHS) in their area. This strategy statement has also been supported by the production of a service specification for tiers 2 and 3 of an authority-wide CAMHS service. The strategy has been developed with a constructive inter-agency commitment including strong contributions from the local authority (social services and education) and local health group (general practitioner) sectors.

6.2 The review team noted that working relationships between health commissioners and providers and the unitary authorities had much improved over the past year. This has been particularly marked with respect to relationships with Cedar Court. However, some concern continued to be expressed by social services about the continuing difficulties in satisfactorily marrying CAMHS and social services cultures. Some feared that, due to difficulties in accessing CAMHS, social workers' awareness of the potential within this sector of service was falling.

6.3 Whilst there has been a good deal of excellent joint working around child protection, social services still think that CAMHS are reluctant to work with very challenging young people and these are left to be dealt with by social services, at some considerable cost in terms of both people and finance.

6.4 The directors of social services in the 6 unitary authorities plan to meet and consider patterns of purchasing outside their own local authority boundaries. Social services are seeking more consultation time from community CAMHS. However, all agencies appreciated that they and their potential partners were confronted with very constrained financial regimes and that there would appear to be little scope for extensive redevelopment. Agencies reported that it was now necessary to develop those projects which would attract specific grant or project support. They drew attention to the absence, within the Welsh context, of specific development monies for CAMHS.

6.5 Work has continued with the development and updating of Children's Services Plans for the 6 unitary authorities. It was reported that, in general, there was more openness between authorities and agencies, and a willingness to talk and plan together, other than in Flintshire. Developments in joint planning, assessment and other professional practices are currently facilitated by the National Assembly of Wales' Children First Initiative and the need for agencies involved with child protection services to work together in response to new government child protection guidance. These initiatives appear to have led to enhanced inter-agency and inter-disciplinary working.
6.6 Since the 1998 review the 6 unitary authorities have agreed to jointly fund a full time social worker post at Cedar Court. Combined with the work of the child therapist this addition has greatly enhanced the quality and range of multi-disciplinary work at the unit. The different disciplines are clear about their respective contributions to the treatment approach. The new social worker post has greatly improved the quality of liaison with the social services departments. As well as clarifying Cedar Court's role and function, she has been able to offer local authority colleagues some additional advice and consultation, which is appreciated.

6.7 The Conwy Education Authority provides a very well resourced and staffed educational unit at Cedar Court. This is financed on a 'fee recoupment' basis from the young person's home local education authority (LEA). Teaching staff at Cedar Court play a full role in the treatment regime, and contribute to unit management meetings and training.

6.8 At the Hergest Unit there is evidence of good multi-disciplinary working. There is no formal on call rota for child psychiatry (apart from specifically for the inpatient unit at Cedar Court). However, a consultant will give advice if available. There is good joint working between the child and adolescent psychiatrists and the paediatricians, and evidence of training and supervision links with the team at Cedar Court. However, there is no educational provision for patients on the Hergest Unit. For those on the paediatric ward the provision is informal, and more geared towards the needs of younger children. This is a potential problem for those few young people admitted to the paediatric wards for protracted periods.
7. DESIGN AND SAFETY OF ENVIRONMENT

The 1998 review found that Cedar Court offered a pleasant, domestic environment for young people, with good living accommodation which was maintained in very good order. However, the building did not allow for the adequate supervision of more disturbed patients. There were also concerns about the safety and security of the perimeter of the unit and issues of access control. The review team concluded that, at the time, these issues appeared to be satisfactorily resolved by management, rather than physical solutions. However, the trust were advised to keep such security issues subject to ongoing assessment and review.

7.1 The unit retains its well cared for image. The patients are offered a very conducive environment in which to live - in both its internal and external aspects. Most of the bedroom accommodation is in single rooms, with two shared rooms, one each in the boys', and the girls' sections. Adolescents may go to their bedrooms during daytime hours if accompanied by a member of staff. Otherwise they are not allowed to use their bedrooms during the day, as it is argued that confidential work in the offices and meeting rooms below can be overheard. Otherwise the young people can use the accommodation freely and sensibly.

7.2 The security arrangements remain as reported in 1998. Some upgrading of the perimeter security is planned, for example a CCT camera on the front entrance and a digital locking system on the doors. At present no-one may access the building legally without staff being aware of this. The charge nurse is the health and safety representative for RCN members, and works closely with the health and safety adviser. All internal finishes, glazing etc. are to robust domestic standard, which is appropriate for a unit where there are little violent acting out or incidents requiring physical control of patients by staff.

7.3 At the Hergest Unit it is policy to allocate a single room to young people under the age of 16 years. In practice, this arrangement is offered to all patients under the age of 18 years. Young people share the same facilities as adult patients, but it is policy to maintain levels of observation which ensure that the young patient's whereabouts are known at all times.
KEY FINDINGS - SOUTH WALES

1. INPATIENT PROVISION AND ADMISSION POLICIES

The 1998 review found that the recent history of the Harvey Jones Unit was one characterised by an inability to sustain a consistent level and quality of service. There were serious resourcing issues which compounded a range of staffing problems and the ability of the unit to provide a fully supportive 7-day service. The review team also advised that written procedures should be prepared which describe the criteria and process for admission of adolescents under 18 years to general psychiatric wards.

1.1 The review team were informed that the provision of local community child and adolescent mental health services (CAMHS) was patchy. The levels of resourcing vary between districts, with the situation in Cardiff and the Vale of Glamorgan weakened in part by the decision to strengthen the Harvey Jones Unit nursing complement by transfer of community psychiatric nurses (CPNs) from the community. This transfer took place as a result of the increased acuity of the patients being looked after within the Harvey Jones Unit. The situation is shortly to be improved by an infusion of new finance, to be provided by Bro Taf Health Authority.

1.2 The review team concluded that a consequence of this poor and uncertain resourcing of local services is that, at times, patients are admitted to inpatient care who might otherwise be managed in the community if CAMHS were better resourced.

1.3 Although the Harvey Jones Unit is now resourced to operate as a 7-day unit, the capacity of the unit to provide a range of therapeutic interventions has been reduced with the weakening of the multi-disciplinary team. Currently staff at the unit can offer individual and family therapy, group therapies and anxiety management. The continued uncertainty in respect of social work and education staff posts currently funded by Bro Taf Health Authority impacts on the future development of multi-disciplinary work and the range of therapeutic activity offered.

1.4 The Harvey Jones Unit has a clear, written admission policy which indicates that young patients with severe mental health problems can be considered for admission. As a consequence the admission of under 16 year olds to adult wards in the Cardiff area is a rare event. In an emergency 16 to 18 year olds may be admitted to adult wards and assessed for suitability for transfer to the Harvey Jones Unit.

1.5 The Harvey Jones Unit has a short waiting list, which is prioritised by degree of severity. Urgent cases are often seen within 48 hours and this can be followed by immediate admission. Any potential admission may be turned away on account of non-availability of 'beds', as well as the unit's lack of capability to provide for certain disorders. An example is the situation regarding dietetic cover. The unit has cover of 2 sessions per week. However, the post holder is on maternity leave, and with no dietician available, patients with anorexia nervosa may not be accepted. It is hoped that the sessions will be increased to 6 per week.
1.6 Since the 1998 review, the Cardiff and District Community NHS Trust have promulgated guidelines and criteria for admission of young people under the age of 18 years onto adult psychiatric wards. These guidelines clearly state the procedures for care of adolescents on adult wards and indicate that if the young person is under 16 years of age then they should be placed under the care of a consultant child and adolescent psychiatrist. These guidelines were seen to inform work on Ward E2A and the Intensive Care Unit at the Whitchurch Hospital.
2. **STAFFING**

The 1998 review concluded that a major initiative was required of the managing trust if a more stable and consistent staff team and approach were to be secured. The review found that quality and continuity of care was adversely affected by use of bank staff, staff sickness and the practice of short term contracting of staff. Action also needed to be taken to sustain the multi-disciplinary nature of the service.

2.1 Despite energetic action on the part of the Bro Taf Health Authority and Cardiff and District Community NHS Trust to achieve stable and continuous funding for a full complement of multi-disciplinary staff at the unit, uncertainties about ongoing funding arrangements continue. Finance has been made available by Bro Taf Health Authority in the current financial year for the employment of a range of social work, therapeutic and educational staff. Some finance has been provided by health authorities in South Wales other than Bro Taf, but this has not been wholly secured on a recurring basis. Serious uncertainty remains in respect of the continued funding for the social worker, family therapist and second teacher beyond March 2000.

2.2 The deficiencies and uncertainties regarding the multi-disciplinary team have affected the treatments which can be provided. There is a problem with behavioural management and this involves a risk of such management becoming punitive rather than therapeutic. Family therapy is currently provided but the continuation of this depends on the funding of the social work post. There is currently no member of staff with cognitive behaviour therapy (CBT) training. However, CBT is offered by the consultant child psychiatrist, who has had training in this.

2.3 Since the 1998 review there has been a significant increase in the nursing establishment at Harvey Jones Unit. This process is ongoing and has brought nursing levels up to a safer level. The nursing structure has also changed with clearer definitions in roles and responsibilities of senior nursing officers. The nursing staff report a considerable improvement in continuity of care, the creation of a safer environment and a more cohesive team. The nursing team demonstrated a great deal of enthusiasm and commitment to the provision of a professional, caring service. They appeared motivated and felt positive about the changes which have been triggered by the 1998 review.

2.4 Levels of permanent nursing staff have significantly increased since the 1998 review. Bank and agency nursing staff are now used to increase nursing levels and provide flexibility. Lines of professional accountability are clear and staff supervision is provided on several levels. There is also provision for external supervision. A senior nurse manager co-ordinates the arrangements for both clinical and line management supervision.

2.5 There have been additional funds made available for nurse recruitment and career development. At Harvey Jones Unit this has resulted in improved availability of trained or qualified staff. During day shifts there may be three or more qualified staff on duty and always a minimum of one nurse (RMN trained) available. There are four nurses who hold ENB 603 qualification or equivalent. A further five nurses will undertake Diploma Module courses in "Adult and Adolescent Development in Crisis" over the next two years.
2.6 Staff at the Harvey Jones Unit have sought to develop their skills and knowledge base through further opportunities for training and study. Nursing staff have participated in study days to improve skills in dealing with self harm, eating disorders, family therapy and brief focused therapy. A majority of the Harvey Jones staff, of all disciplines, have attended a workshop focused on "Working with Families". The Harvey Jones Unit also has a very clear strategy for training in child protection. Child protection is a standard item in the induction programme for all new staff and all nursing staff at the unit have completed further child protection training at single agency level.

2.7 Since the 1998 review the number of qualified nursing staff on ward E2A at Whitchurch Hospital has increased. There are now sufficient staff to ensure that, in most instances, two qualified nursing staff are available for each shift. The team still does not include professionals in child and adolescent psychiatry and it still remains the case that none of the nurses working on the general psychiatric wards have undertaken a recognised post basic training course in child and adolescent psychiatric nursing. However, all staff on Ward E2A have now received child protection training at the single agency level.
3. CHILD PROTECTION MATTERS

The 1998 review found that senior staff at the Harvey Jones Unit were familiar with child protection procedures for recognising and dealing with abuse. However, the review team thought that nursing staff at the unit had only a basic familiarity with these matters and that further training and development in these issues should be made available.

3.1 The Bro Taf Health Authority has published a specification for a district-wide service in Child Protection which draws on national guidance. The specification provides comprehensive coverage of arrangements to meet all aspects of the child protection system. Both the health authority and trusts have identified designated and named professionals to meet their respective child protection responsibilities.

3.2 The Cardiff and District Community NHS Trust has recently issued Good Practice Guidelines in Child Protection (final draft October 1999) and these were available on the unit. The named nurse confirmed that this draft has been approved by the trust and now awaits funding for printing prior to distribution. There appear to be two omissions from this draft related to (a) absence of specific guidance in relation to abuse by professionals and (b) no guidance on conduct of Part 8 reviews. Both these matters were covered in the South Wales ACPC guidelines and need to be cross referenced in trust publications.

3.3 The Harvey Jones unit are aware of, and sensitive to, child protection issues and the status of young people. Copies of the South Wales ACPC Guidelines were located at appropriate points throughout the unit. The unit has developed its own set of child protection procedures but these are now dated. The review team learnt that they were to be reviewed in February 2000. Current procedures need elaboration to include suspicions and allegations against professionals, and child on child abuse. The procedures also need to be checked for compatibility with ACPC guidelines.

3.4 Senior staff at the unit expressed confidence that appropriate action had been taken in the past when child protection proceedings were deemed necessary. Staff had demonstrated that they were alert to suspicions or allegations of abuse and had been able to take appropriate action by making referrals and participating in follow-up.

3.5 The trust's child protection good practice guidelines provide an indication of the levels of child protection training required of various staff groups. The policy is for all new trust staff to attend induction training in child protection.

3.6 The Harvey Jones Unit has developed a clear strategy for child protection training. Child protection is a standard item at the induction of all new staff and all nursing staff at the unit have now completed a one day course at the second single agency level. This programme was designed and delivered on site by designated and named professionals. Two members of the nursing staff have participated in inter-agency training during the past year, with two more to attend in summer 2000. Annual refresher events are also planned.

3.7 All nursing staff on Ward E2A have received child protection training at the single agency level. A copy of the Cardiff ACPC child protection procedures was available on the ward.
4. **ADOLESCENTS' AND FAMILIES' VIEWS OF THE SERVICE**

The 1998 review concluded that although there were arrangements in place to ensure that patients and their parents were fully involved in the planning and progress of the treatment programme, a consistent quality of service in this area was not achieved. The quality of information available also needed attention.

4.1 In 1999 the review team found that patients and their families were involved and expressed satisfaction with their treatment. In general, parents expressed satisfaction with the formal opportunities for involvement in their child's care and treatment programme. Parents felt able and free to approach staff on a day to day basis with any concerns and reported receiving satisfactory responses. Parents did voice concern and dissatisfaction with the use of 'suspension' and one parent was concerned about the nature and quality of communication when the young person was absent without leave.

4.2 There would appear to be a number of opportunities for young people to learn about and become involved in the diagnosis and treatment of their illness. Young people felt they were free to discuss their situation and any worries with professionals. Community meetings, assessments and review meetings all provided suitable opportunities for their involvement. Clearly the nature of this involvement will be determined by the young person's developmental stage and severity of illness.

4.3 The young people and their parents reported being given information including information about helplines prior to and at admission, although it appeared that, in the case of some young people, their age and severity of illness prevented full understanding. A new information leaflet (September 1999) has been prepared but it would appear that the unit needs to promote this with greater care as some parents and young people could not recall being given this leaflet.

4.4 The review team received mixed evidence concerning the degree to which the young patients understood their rights and this appeared to vary between individuals. For some it was clear that they fully understood their rights, were aware of their key workers and knew how and who to complain to if need be. For other young people matters were much less clear and they appeared to have little recognition of their rights and avenues for complaint.

4.5 The unit is now able to provide to a certain extent for Welsh speaking young people. Two of the 27 staff speak Welsh, although more written information and recreational material in Welsh are required. The review team were informed that there remained an issue related to the need for interpreters for patients whose first language was Somali.

4.6 The consent of young people and their parents is seen as explicit by the terms and nature of their co-operation with the therapeutic programme. The review team felt that consent could be recorded in a more vigorous and formal manner and be related to the relevant consent framework imposed by either the Mental Health Act or the Children Act.
5. SAFEGUARDS

The 1998 review concluded that the rights and interests of young people accommodated at the Harvey Jones Unit were not safeguarded and that in a number of areas safeguarding practice by the trust and at the unit fell short of essential requirements. There were concerns about complaints procedures, patient advocacy, the handling of aggression and unacceptable behaviour, and the management of absence. There were also deficiencies in staff screening arrangements and in the capacity to sustain a stable staff team.

5.1 There are developing arrangements for ensuring that the interests of young patients are safeguarded at the Harvey Jones Unit. Many of these have been devised since the 1998 review visit and remain still to become firmly embedded in everyday practice. The unit still experiences some feelings of instability due both to recent history of high turnover of unit staffing and to future uncertainty induced by continuing reorganisation in the NHS in Wales. Overall, however, the unit is a safer place than in 1998.

5.2 The trust has a complaints procedure and parents and adolescents can use it. Adolescents reported that they had not been given this information at their admission but parents thought that they had.

5.3 A helpline number is prominently displayed in the reception area and there is a telephone trolley on the unit which can be used by patients in relative privacy. However, there is, as yet, no access to a suitable advocacy service. The trust has opened discussion with the NSPCC about the provision of a more comprehensive advocacy and independent inspection service, but the review team were informed that resource considerations may preclude the degree to which this project can be advanced.

5.4 There is a trust policy on the management of aggression and a unit policy on physical intervention. Staff at the Harvey Jones Unit are appropriately trained in these techniques. Most staff have undertaken a five-day training course in care and responsibility, and refresher training is planned.

5.5 The Harvey Jones Unit has a system of sanctions which are used to contain anti-social behaviour. There is concern about the safety of these, especially the use of suspension. Staff use sanctions to control unacceptable behaviour such as swearing at staff or not co-operating with the unit programme. These sanctions include loss of privileges such as watching TV, playing pool or going to the shops. There was a document, "Operational Guidelines: Suspension", dated May 1998. The team were informed, however, that nursing staff have suspended a patient without reference to medical staff. A parent also reported her dissatisfaction with the lack of notice when her son was sent home in the evening. Some later clarification of this matter with medical staff suggested that a decision to suspend would involve medical staff, but this may be the duty doctor, who would not know the patient or their home circumstances. The team concluded that current practice poses unacceptable risk and warrants examination and a review of policy and practice. This view was expressed to the chief executive of the trust and the unit consultant at the conclusion of the visit and appropriate action has been taken by the trust.

5.6 The trust has promulgated a missing person protocol. This has been activated on a number of occasions in the past few months. The protocol assumes the involvement of the police and inter-agency liaison in this area is reported to be very satisfactory.
5.7 The trust has now instituted a system of police checks which effectively cover all disciplines and grades. No staff are appointed without reference and police checks. Police checks in South Wales currently take 4-6 weeks and trust personnel management consider that this is containable from a recruitment and retention perspective. The trust does not employ unchecked staff, except in exceptional situations dictated by clinical needs e.g. at times of severe crisis in staffing levels. On those occasions any unchecked staff would not be allowed to work on a one-to-one basis with the young patients until checked.

5.8 The trust has produced a 'whistle blowing' procedure and staff, at all grades, are advised by it to report their concerns direct to the chief executive of the trust. Staff felt encouraged to express their views and this has led to frank and open discussion during reviews and supervision. Staff also felt able to seek advice from outside the unit if necessary.
6. **MULTI-DISCIPLINARY AND MULTI-AGENCY WORKING**

The 1998 review fielded some differences in perception about the quality and effectiveness of joint planning for children's services and CAMHS between health and social services agencies. Attention was drawn to the consequence of health and local authority restructuring and to pressures on the resource base being experienced by both sectors. The review team also learnt about the perceived inability of social services departments to access CAMHS for the disturbed and difficult adolescents for whom they are responsible, and the necessity to provide for this group by resort to less satisfactory placements in secure accommodation or out of area independent settings.

6.1 Bro Taf Health Authority has produced a draft framework document for CAMHS (October 1999). This is the culmination of a review of CAMHS by members of a multi-agency project group commissioned by the health authority. A final draft is to be produced, in line with guidance from the National Assembly for Wales in respect of CAMHS generally, throughout all sectors, agencies and tiers of the service. The health authority has also restructured internally and as a result has created a children's team which brings together all health services for children under one directorate. This has been welcomed and has led to improved co-ordination.

6.2 The commissioning of the Harvey Jones Unit is problematic for both the health authority and the trust. The unit effectively provides a service for much of South Wales, but is funded almost entirely by Bro Taf Health Authority. A small amount of revenue has now been provided on a recurring basis by two other South Wales health authorities and on a non-recurring basis by a third health authority. This is not sufficient to reflect the pattern of use of the service and the impact of this additional finance is further eroded by high capital charges which accrue due to the location of the Harvey Jones Unit. The review team were informed that in practice only 60% of any incoming revenue is actually devoted to meeting the running costs of the treatment programme.

6.3 There is a pressing need for more equitable and secure funding of the Harvey Jones Unit, which recognises its role as a de facto regional unit. A strong lead from the National Assembly for Wales would probably be needed for this to happen. The review team concluded that a regional funding mechanism for the unit would allow Bro Taf Health Authority to re-allocate those funds recouped by more equitable arrangements into the development of the community CAMHS.

6.4 The Cardiff and District Community NHS Trust has undertaken a comprehensive review of CAMHS (June 1999). This document sets out a business case for the further development and strengthening of the Harvey Jones Unit within an enhanced CAMHS service. The document does not specify the level of consultation, nor the expectations of collaboration and joint action with other agencies. However, the review team considered that there was much work still to do in this area as other agencies continue to express concern at the 'isolation' of the Harvey Jones Unit and its irrelevance to their own plans and provisions.
6.5 It was generally reported that the inter-agency context remained difficult, especially at a higher strategic level. Health authority and trust officials reported improved levels of consultation and communication at operational and middle management levels. Unitary local authorities in the Bro Taf area have reviewed and updated their Children's Services Plan for the year 1999/2000. There is good evidence of active inter-agency work and commitment to these plans. Apart from the plan for Rhondda Cynon Taff County Borough, the plans say little about CAMHS services. The Bro Taf draft strategy for CAMHS is seen as an important milestone document and future developments may need to await the outcome of subsequent discussions on its implementation.

6.6 As mentioned in section 6.2, the work of the unit is funded predominantly by the Bro Taf Health Authority. There is no financial contribution to the unit from the local authority sector. It has proved exceptionally difficult for the health authority to engage the relevant unitary authorities in any agreement on the funding of the social work posts by the local authority sector. Authorities agree that in present circumstances of constrained resources for children's social services, they are unable to prioritise funds to support activities at the Harvey Jones Unit. The view that the unit operates on a de facto regional basis also militates against any sympathetic response to funding requests from individual local authorities.

6.7 The Cardiff Education Authority provides funding for the greater proportion of the present complement of teaching staff, although Bro Taf has had to contribute in order to sustain a viable education service. Despite this, there are difficulties in the provision of education with a significant decrease over the past years in educational resources and current uncertainties about ongoing funding of teaching posts. Numbers of students at Harvey Jones Unit are sometimes low, and some of the adolescents are over 16 years old and thus do not attract support funding by their home local education authorities. It was reported that even for those patients under 16 years local education authorities try to argue over payment. However, the physical environment for education remains satisfactorily arranged and resourced.

6.8 The review team discussed these issues with a representative of the Cardiff Education Department. He confirmed that the education department was under financial pressure but also expressed the view that the relationship between education, the health authority and Harvey Jones Unit should be improved and become more collaborative so that a more creative solution could be found. If it was agreed that two teachers were required to provide continuity, flexibility and a range of subjects, then it might be possible to access their expertise for the wider use of the education department. It was noted that it could be difficult if non-patients were to attend the unit, but perhaps the teaching staff could assist at other schools, particularly if numbers at Harvey Jones were low. Despite this uncertain background, the teaching staff appeared to remain well committed and enthusiastic, with impressive work displays by their students in evidence. The teachers also play a full role in the management of the unit and care planning.
The Harvey Jones Unit remains committed to multi-disciplinary working, but this has been difficult to sustain. High levels of uncertainty remain in this area, given the unwillingness of funders outside the health sector to contribute. The health authority has funded a social worker post until April 2000 and this has, in the short term, reintroduced an important dimension to the unit's therapeutic work. Absence of social work provision appeared to have affected communication with respect to individual patients' admission and discharge from the unit. Although the reintroduction of this post has begun to improve matters, local social services departments claim to be unaware of some admissions and discharges. The social worker has contact with social services area teams but is unable to undertake any general liaison or public relations work on behalf of the unit with local authorities.
7. DESIGN AND SAFETY OF ENVIRONMENT

The 1998 review considered that there were serious shortcomings in the quality of the physical environment at the Harvey Jones Unit and the general appearance of the accommodation was suggestive of a degree of neglect, lack of care and management co-ordination.

7.1 The review team is pleased to report that compared to the situation at the 1998 review there was much evidence of upgrading of the living accommodation and general milieu of the unit. There were welcome improvements in the decorative condition and the furniture.

7.2 The unit has a room and corridor layout which is conducive to high levels of supervision if required. The unit is continuing to adapt structurally to meet various dependency needs and although there is obviously limited privacy offered to those young people occupying the dormitories, some screening appears superficially effective. Visiting parents, however, complained strongly about arrangements for meetings with their children.
KEY FINDINGS - CONCLUSIONS

1. The review team were pleased to conclude that there was considerable evidence to demonstrate that, since the 1998 review, all relevant agencies and units had worked hard to respond positively to the original review findings and recommendations. All managers and staff concerned are to be commended for their efforts and for the general improvements in safeguarding of adolescents which have resulted. In North Wales the generally satisfactory picture which emerged in 1998 has been confirmed, with some welcome strengthening to those areas which had been identified as needing development. In South Wales there have also been noticeable improvements, but the general situation remains beset with continuing uncertainty about the future viability of the Harvey Jones Unit.

2. The review team were concerned about the negative impact that continuing organisational change has had on the ability to provide a secure and effective service. In both North and South Wales, reconfiguration of boundaries and responsibilities within the health sector, and continuing financial constraint within both the health and local authority sectors, have meant that planned improvements in services have been impeded or made more difficult to achieve. Many of the outstanding problems, especially those relating to multi-agency working, require a period of organisational stability for them to be resolved. The review team also fielded views which suggested that a clearer and more consistent lead on these matters which united health, social services and education interests should be provided by the National Assembly for Wales. The team considered that a strategic view for the development of child and adolescent mental health services in Wales was required, and they welcome the draft strategy of the Assembly's child and adolescent mental health services strategy advisory group, which provides such a view.

3. The situation in North Wales, at both Cedar Court and on the Hergest Unit, has improved in all respects since the 1998 review. The key issue remains concern for the part which Cedar Court should play in the future range of CAMHS services in the region and the extent to which alternative inpatient facilities will need to be developed which have the capacity to provide quality standards of care and treatment for adolescents. This issue is being actively addressed by North Wales Health Authority.

4. The situation in South Wales gives rise to continuing concern about the ability of the Harvey Jones Unit to sustain an appropriately staffed and resourced service in both the immediate future and over the longer term. The review team concluded that the perception of the unit as a de facto regional resource needs to be grasped and more secure funding arrangements achieved. The present uncertainty about financial stability clearly affects the provision of services at both the Harvey Jones Unit and in the community, limits the range of treatment offered, and undermines the morale and sense of purpose of the multi-disciplinary team.

5. The Cardiff and District Community NHS Trust and staff at the Harvey Jones Unit have worked hard to raise levels of safeguarding at the unit and on the adult wards which admit adolescents. This work has led to improvements, but some aspects of safeguarding practice still require development and strengthening. The review team were particularly concerned about the practice of suspension at the Harvey Jones Unit, which appeared to pose unacceptable risk to the young people. This warrants a review of policy and practice.
6. It appears inevitably that 16 - 17 year olds will continue to be admitted to adult psychiatric wards. Standards, or a code of practice, should be developed and adapted to minimise the risks when this happens. The National Assembly for Wales could build on the excellent work which has already been done in Wales, particularly at the Hergest Unit.
SECTION 3
NORTH WALES REPORT
INTRODUCTION

Section 3 provides a description of the 'evidence' gathered by the review team which visited North Wales between 28 - 30 November 1999. The progress review was guided by the set of standards used in the 1998 review. (Addenda to two of the standards, related to the safe-guarding of children in the classroom, have been added). The 'evidence' has been reported within this agreed framework of standards and criteria.

This report relates primarily to the service provided at Cedar Court adolescent service and to relevant activities of the North Wales Health Authority, the Conwy and Denbighshire NHS Trust, which manages Cedar Court and the six unitary local authorities in North Wales. A progress review visit was also undertaken to the Hergest acute adult psychiatric unit in Bangor. This unit is managed by the North West Wales NHS Trust.

North Wales Health Authority commissions services for a catchment population of about 650,000, of whom about 100,000 are primarily Welsh speakers. At the time of the review the health authority was coterminous with six local authorities (Gwynedd, Conwy and Ynys Mon, Flintshire, Denbighshire and Wrexham). The North East Wales, North West Wales, and Conwy and Denbighshire NHS Trusts each provide community based child and adolescent mental health services to residents in their respective areas.

Cedar Court adolescent service is the adolescent inpatient unit which serves the whole of North Wales. Cedar Court, a large ex nursing home set in a residential area in Colwyn Bay, opened in March 1997 following the closure of Gwynfa. The unit has twelve residential places and six day places.

The Hergest Unit is situated within the grounds of a general hospital in Bangor. It is managed by North West Wales NHS Trust, which provides adult mental health services to part of North Wales. The unit comprises three eighteen bedded acute psychiatric wards and a separate six bedded intensive care area. North West Wales NHS Trust also provides adult admission beds (about twenty-four) in peripheral centres associated with the community mental health service.
1. **INPATIENT PROVISION AND ADMISSION POLICIES**

| 1.1 | **STANDARD** | Adolescents are admitted to hospital only if the care they require cannot be provided as well at home, in a day clinic or on a day basis |
| 1.1.1 | **Criterion** | There is adequate, local provision of a range of domiciliary, community and day services so that adolescents are not admitted inappropriately.  
(Are adolescents admitted, or kept in hospital, because of inadequate local resources?) |

Many of the patients admitted to Cedar Court would, in a metropolitan area, be managed as day patients. This is difficult in rural North Wales, with one inpatient unit, due to problems of transport. Despite this, there does seem to be more demand for day care and patients from the length of the North Wales coastal strip attend the unit. That being said, there are clearly adolescents whose needs can only be met by the provision of inpatient care.

Local community child and adolescent mental health services (CAMHS) continue to have rather variable waiting times for first appointments (e.g. 20 months, 2 at one year, 10 months, 14 weeks), indicating an inadequacy of local resourcing or a failure to apply clear referral criteria and agreement with referrers about who should have priority.

**Hergest Unit:** The patient information system for the Hergest Unit identified 10 admissions (of 6 patients) of young people aged 16 or 17 years over the past 20 months. No young person under the age of 16 has been admitted to the Hergest Unit during this period. In addition there had been a number of admissions to the paediatric wards at Gwynedd Hospital of children and adolescents with primary diagnoses of a mental or behavioural disorder. There had been 35 admissions to paediatric wards during the past year. The children presented a range of disorders including eating disorder, depression, chronic fatigue and psychosomatic disorders. Occasionally children may be inpatients on the paediatric wards for up to 3 months, but it should be noted that the average length of stay for these admissions was less than 2 days (1.77 days).

| 1.1.2 | **Criterion** | There are clear written admission criteria which emphasise that adolescents are admitted only if the care they require cannot be provided at home, in a day clinic or on a day basis.  

*Admission criteria encompass:  
i. psychiatric severity and condition;  
ii. potential scope for intervention).  
(If a unit ever admits children under the age of 11, admission policies should pay particular regard to this.) |
The policy at Cedar Court continues to be one of prioritising on grounds of appropriateness for treatment and degree of urgency, rather than setting explicit criteria.

<table>
<thead>
<tr>
<th>1.2 STANDARD</th>
<th>There is adequate provision for NHS inpatient treatment of adolescents who require it. Such facilities are staffed by those with experience of treating adolescents with such disorders.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.2.1 Criterion</td>
<td>There is adequate provision for specialised services to meet the needs of adolescents with a full range of psychiatric illnesses (including those with eating disorders and those who need long term psychiatric care.)</td>
</tr>
</tbody>
</table>

There is not adequate provision for those patients who require treatment without their consent or whose psychiatric illness is of a nature which necessitates physical control and/or sedation. Cedar Court will only admit those who in practice, will show the necessary degree of co-operation to benefit from the treatment programme.

| 1.2.2 Criterion | There is provision, or arrangements for provision can be made when needed, for those who require secure mental health care. |

There is no provision available for secure mental health care for adolescents in North Wales.

| 1.2.3 Criterion | Adolescents referred to these units, whose needs would be best met by admission, are not turned away on resource grounds. |

At the time of the review visit there were 5 cases on the waiting list; only one of these for inpatient treatment. It is not known to what extent the restrictive admission practices at Cedar Court have limited referral behaviour.

| 1.2.4 Criterion | There are not unacceptable delays between referral and assessment or between assessment and admission of adolescents to these units. |

Urgent cases tend to be admitted without undue delay provided they meet the criteria. In general there are no unacceptable delays and beds can usually be made available at Cedar Court, the Hergest Unit or the paediatric unit. Urgent cases can be admitted to Cedar Court within 3 days.

| 1.2.5 Criterion | Where units close at weekends, appropriate arrangements are made for the patients. |

Cedar Court remains open at the weekend if necessary. If closed, staff are available to provide a range of support, including telephone accessibility, for adolescents and their parents.

| 1.2.6 Criterion | No young person under the age of 16 is admitted to an adult psychiatric inpatient unit, unless there are major extenuating circumstances. Such admissions should be negotiated by a consultant child and adolescent psychiatrist. |
Community child and adolescent psychiatrists report that if one of their patients who is under the age of 16 years is admitted to an adult ward, then they expect to co-ordinate care.

**Hergest Unit:** The Hergest Unit has a clear procedure whereby any patient under the age of 16 years is admitted under the care of a consultant child and adolescent psychiatrist. In practice, this is extended to most 16 year olds and also to any patient who was under the care of a child and adolescent psychiatrist before admission. All patients under the care of a community child and adolescent psychiatrist are admitted to Gwalchmai ward. The Gwalchmai ward manager is the nominated 'link nurse' for CAMHS. Other 16 and 17 year old patients are admitted to the ward of their particular catchment area under the care of a general adult psychiatrist.

Although it is unusual for a young person under the age of 16 years to be admitted to an adult psychiatric unit, it is not possible to conclude that this always takes place as the consequence of "exceptional and major extenuating circumstances".

| 1.3 | **STANDARD** | Hospital units to which adolescents are admitted are easily accessible to families without need to travel significantly further than to other similar amenities. |
| 1.3.1 | **Criterion** | Adolescents and families are able to access the service. |

Cedar Court provides financial support to patients and their parents who are encouraged to travel to the unit for meetings etc. Day patients are transported to the unit by a local taxi firm on behalf of the ambulance service. All taxi drivers are police checked.

| 1.3.2 | **Criterion** | The service acknowledges access difficulties and provides appropriate assistance. This should include special arrangements being made for families to be able to stay close to the adolescent unit overnight when this is appropriate. |

There is no facility for parents to stay overnight.

| 1.4 | **STANDARD** | Accommodation and facilities are appropriate to the needs of adolescents. |
| 1.4.1 | **Criterion** | Adolescent units are separate from both adult and children's units. |

Cedar Court is a stand alone inpatient unit, located in a residential area in Colwyn Bay. The accommodation and range of facilities provided are suitable for the particular group of young people who attend or who are resident at the unit.
<table>
<thead>
<tr>
<th></th>
<th>STANDARD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5</td>
<td>NHS inpatient settings to which adolescents are admitted follow Section 85 of the Children Act 1989.</td>
<td></td>
</tr>
<tr>
<td>1.5.1</td>
<td>Criterion</td>
<td>NHS Trusts have, and comply with, procedures for their duty to inform the responsible social services department when it is intended to provide, or accommodation is provided for a child, by a child and adolescent mental health service, for a consecutive period of at least three months, and when such a child leaves the accommodation.</td>
</tr>
</tbody>
</table>

This policy is in place, but is rarely needed in the circumstances of admission and care at Cedar Court.

<table>
<thead>
<tr>
<th></th>
<th>STANDARD</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6</td>
<td>NHS Trusts take all reasonable steps to ensure that relevant local agencies know under what conditions, and how, the NHS adolescent residential unit can be accessed in an emergency.</td>
<td></td>
</tr>
<tr>
<td>1.6.1</td>
<td>Criterion</td>
<td>There are written instructions in all local settings where emergency psychiatric assessments are made, e.g. Accident &amp; Emergency departments, about the appropriate referral of adolescents who may need emergency psychiatric care.</td>
</tr>
</tbody>
</table>

There is no emergency service on an out-of-hours basis, although current Cedar Court patients can call the unit. Other local mental health services do not have access to Cedar Court for 'out of hours' emergencies.
2. STAFFING

<table>
<thead>
<tr>
<th>2.1</th>
<th>STANDARD</th>
<th>NHS inpatient units for adolescents are adequately staffed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1</td>
<td>Criterion</td>
<td>Staffing comprises a core multi-professional team consisting of: psychiatrists, including a senior psychiatrist fully trained in child and adolescent psychiatry; psychologist(s) and nurses who are appropriately trained.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are effective arrangements for the involvement of social workers, whether or not they are members of the core team. Units may also employ staff from other backgrounds (e.g. occupational therapists, art therapists, psychotherapists etc.) depending on the needs of the patients and the therapeutic culture of the unit.</td>
</tr>
</tbody>
</table>

At Cedar Court there is a full team of multi-disciplinary and multi-agency staff.

| 2.1.2 | Criterion | Staff numbers are sufficient to provide a wide range of short and medium term psychotherapy and psychiatric treatments. |
|       |          | Cedar Court offers a wide range of therapeutic approaches ranging from psycho-dynamic treatments, group psychotherapy, structural and strategic family therapy, dialectic behaviour therapy and milieu therapy. |
| 2.1.3 | Criterion | There is sufficient flexibility in staffing numbers to accommodate the changing dependency needs of adolescents accommodated in the facility. |

Flexibility in approach is restricted. Bank staff are rarely used. If the unit has to open at the weekend those staff involved will have time off during the week, thus interfering with clinical treatment sessions planned.

Following the HAS 2000 review in 1998 the trust has increased the unit's establishment to allow for 2 waking night duty staff.

In general, the resident patients demand little close or constant observation. This reduces pressure on management to bring in any additional staff. If open at weekends, 2 members of staff work on the unit.

| 2.1.4 | Criterion | Staff are managed effectively in order to support the purpose and the function of the unit. Lines of accountability are clear and working practices maximise continuity of care. |
|       |          | There are clear lines of accountability, both within Cedar Court and to relevant external line managers, e.g. social worker to social services department. |
Staff appraisals take place regularly and this activity is seen to enhance the quality of service delivery.

There are structures in place to ensure that all staff receive appropriate support and supervision, both individually and in groups. Some nursing staff receive a frequency of supervision which is less than desired. This is partly due to the nurse's duty rotas. The frequency of supervision is audited by the charge nurse.

The unit staffing establishment allows for an RMN to be on duty at all times. Since the 1998 HAS 2000 review an extra E grade nurse has been appointed.

The senior nurse (I grade) manages both the Cedar Court nursing team and the community based nursing teams. He is supported by 3 F grade nurses. In all, the establishment is for 15 whole time equivalent nurses. This provides 4/5 nurses per day shift (with 2 qualified) and 2 nurses at night.

**Hergest Unit:** Considerable attention has been paid to the training needs of the nurses at the Hergest Unit who are likely to come into contact with young people. Although the unit does not meet the criterion for this standard, there is clear evidence of real attempts to address these issues within the constraints of an adult psychiatric ward. The link nurse is in the process of improving her own training and has established a working link with Cedar Court whereby she can access supervision and advice from the Senior Nurse, who is ENB603 qualified, whenever a person under the age of 16 is admitted.

The senior nurse reported that the National Assembly for Wales has accepted that the ENB603 course was more relevant to work at Cedar Court than RSCN.
Seven nurses at Cedar Court have completed ENB603 and 3 other nurses are part way through this course of training. Additional funds (£15,000) have been made available for training in the past few years. The charge nurse (F) has nearly completed his ENB603 course.

2.3 **STANDARD**  
All staff in contact with adolescents have some training to ensure an appropriate level of awareness of the needs of adolescents.

2.3.1 **Criterion**  
All professional staff are trained in skills necessary to work effectively in partnership with parents. These skills include the ability to counsel parents effectively.

The patients' families are closely involved throughout the programme of treatment. The child therapist sees families on the initial home visit. Nursing staff do not have specific training in this area. After the initial assessment a detailed "formulation" is compiled and filed in medical notes.

2.3.2 **Criterion**  
All staff in contact with adolescents are trained, and updated, in awareness of the predisposing risk factors which may lead to abuse, and are continually alert to the circumstances in which adolescents might be harmed.

Cedar Court has fully adopted the North Wales Health Authority Child Protection training strategy. Nursing staff have completed Child Protection awareness training at induction level.

There have been in-house training events concerning child abuse indicators, roles and responsibilities, recognition and referral procedures. These sessions have been delivered by Cedar Court social work staff, police, trust named nurse, and social service department staff. Further inter-agency training is planned for relevant staff. Additionally, 3 nurses have undertaken the child protection module within their own professional development courses. A record of child protection training undertaken by all staff at the unit was available.

**Hergest Unit:** There are plans to ensure that all nurses on the Hergest Unit have received at least basic training (½ day) in child protection. At the time of the visit it was estimated that 10-15 of the 70 nurses had received this. Priority has been given to nurses working on Gwalchmai ward, with the result that for each nursing shift there would normally be at least one nurse who had received this training.

Staff from Cedar Court had also organised a 1 day training event on child protection and dealing with adolescents for the staff team on Gwalchmai ward.

2.3.3 **Criterion**  
Health service professionals understand, and are familiar with, the procedures for recognising and dealing with abuse.

See comments under 2.3.2.
3. **CHILD PROTECTION, MANAGEMENT OF ALLEGATIONS / SUSPICIONS AND PARTICIPATION IN INTER-AGENCY PROCEDURES**

### 3.1 **STANDARD**

NHS adolescent inpatient units are aware of the child protection status of adolescents admitted.

The review team confirmed that staff at Cedar Court were fully aware of the child protection status of patients. This was confirmed by both the trust named nurse and the social worker.

### 3.2 **STANDARD**

The health authority takes the strategic lead for health on inter-agency working on child protection matters and co-operates with other agencies in planning, purchasing and monitoring services under the Children Act 1989.

#### 3.2.1 **Criterion**

The health authority has identified a senior doctor, a senior nurse with a health visiting qualification and a senior midwife as the "senior professionals" on the ACPC and to co-ordinate all aspects of child protection within the district.

The North Wales Health Authority takes a strong lead on child protection matters within its boundaries. The designated doctor and nurse provide excellent professional leadership. A recent service specification, "Children's Services - Programmes of Care: Child Protection and Related Services" July 1999, has been widely circulated to local health groups, trusts and private hospitals. This document details the health authority's expectations of trusts in relation to children in need and those in need of protection. It specifies requirements in terms of prevention, recognition and referral and involvement with inter-agency procedures. Roles and responsibilities of professionals are clear, as are audit arrangements.

#### 3.2.2 **Criterion**

Child protection is included in contracts agreed between the health authority and NHS Trusts, and monitoring arrangements have been set up to satisfy themselves that procedures are followed.

Relevant contracts between the health authority and health providers do include this aspect.

### 3.3 **STANDARD**

NHS Trusts ensure that systems are in place which enable the trust and its staff to comply with local ACPC procedures and with those in "Working Together Under the Children Act".

#### 3.3.1 **Criterion**

Each NHS Trust providing child health services has identified a named professional (doctor and nurse/midwife) for child protection matters who is responsible for ensuring child protection supervision on a regular basis and day to day advice and support.

All the newly configured trusts (North West Wales NHS Trust, North East Wales NHS Trust, Conwy and Denbighshire NHS Trust) have appointed a named doctor and nurse, and in those trusts which provide acute paediatric and maternity services, child protection link nurses are identified in those departments.
**Hergest Unit:** The North West Wales NHS Trust has recently appointed a trust named nurse for child protection who provides clinical supervision on child protection matters to the Hergest Unit link nurse. She in turn provides supervision to other nursing colleagues on the unit.

| 3.3.2 | Criterion | Trusts and individual departments have in place robust policies and procedures which are compatible with ACPC guidelines, including the conduct of Part 8 reviews. These are dated, indicate when and by whom they will be reviewed and their effectiveness is monitored. |

Cedar Court had a set of unit child protection procedures which are in line with Area Child Protection Committee (ACPC) guidance. The procedures were clear and comprehensive. In respect of Part 8 reviews, unit guidance referred only to the need to offer co-operation within the process. The unit had no direct experience of the review process and had not felt the need to develop any handling protocol.

| 3.3.3 | Criterion | Local ACPC guidelines, Working Together Under the Children Act, Clarification of Arrangements, Medical Responsibilities and Guidance to Senior Nurses are available and accessible to all staff members. |

Copies of relevant government child protection guidance were available at Cedar Court, including the latest draft of "Working Together to Safeguard Children".

| 3.3.4 | Criterion | Written and detailed NHS procedures include guidance on dealing with suspicions or allegations of abuse, either intra or extra familiar, or involving a professional; on documentation or on seeking advice from designated or named professionals. |

The relationship between Cedar Court and the trust's named nurse is well established. The health authority has developed comprehensive guidance re: allegations against professionals. This is still in draft form.
Hergest Unit: There are plans to ensure that all nurses on the Hergest Unit have received at least basic training (one half day) in child protection. At the time of the visit it was estimated that 10-15 of the 70 nurses had received this. Priority has been given to nurses working on Gwalchmai ward, with the result that for each nursing shift there would normally be at least one nurse who had received this training.

Staff from Cedar Court had also organised a 1 day training event on child protection and dealing with adolescents for the staff team on Gwalchmai ward.

The health authority has developed a child protection training strategy which has been adopted by the trusts and other agencies. The strategy sets out clearly the level of knowledge required by each staff or professional group.

At unit level, the multi-disciplinary team have set up an education programme for all staff who come into contact with children and adolescents. This includes child protection. The programme is also provided at the Ablett Centre - a psychiatric inpatient unit.

3.4 **STANDARD**  *NHS Trusts have an implemented strategy for child protection education and training which considers the needs of all staff who are likely to come into contact with children, or families with children. The strategy identifies the training appropriate to the roles of staff groups including the need for updating and clinical supervision (see also 2.3.2).*

3.4.1 **Criterion**  *Child Protection is a standard item at the induction of new staff.*

3.4.2 **Criterion**  *There is single agency training specific to the area of work involved.*

3.4.3 **Criterion**  *Inter-agency training relates to indications of abuse recognition, referral and participation in inter-agency procedures.*

* (It is recommended that "agencies should establish joint annual training programmes on child abuse issues with access for all professional groups in direct contact with children and adolescents").

3.5 **STANDARD**  *Where there is actual or suspected abuse within an establishment accommodating adolescents, a process of investigation, assessment and planning on an inter-agency basis is carried out.*

3.5.1 **Criterion**  *There are procedures in place for handling allegations of abuse against staff, other patients or visitors, including contact visits by relatives or friends.*
These procedures are in place at Cedar Court and were examined by the review team.

| 3.5.2 | Criterion | The unit follows the procedures for Working Together in individual cases produced by their local ACPC. |

The Senior Nurse and Social Worker at the unit confirmed that ACPC procedures would be closely followed in the event of an allegation. Procedures indicate appropriate contact officers and action leads. This information is available to both Cedar Court and accident and emergency departments.

| 3.5.3 | Criterion | When a case of abuse leads to death, or a child protection issue of public concern, the unit co-operates with the ACPC in conducting a review. |

Cedar Court procedures require co-operation with any Part 8 review. The Senior Nurse and Child Therapist are to attend a training event on Part 8 reviews.

| 3.5.4 | Criterion | The unit informs the National Assembly for Wales if there is a reason to believe that an offence has been committed against a patient by a member of staff or by a carer. |

North Wales Health Authority has issued a procedural document "Recommended Policy and Practice for the Investigation of Allegations Against Professionals in Relation to Children" June 1999. From a perusal of this document, it is clear that such allegations are to be taken in the first instance to the chief executive and other relevant senior trust personnel.

| 3.5.5 | Criterion | The possible implications for other adolescents in the establishment are always considered and protection plans actioned whenever necessary. This includes the protection of adolescents from abuse by other adolescents and allegations or suspicions of abuse by one adolescent, concerning another adolescent, being dealt with through the usual inter-agency procedures. |

This issue, which is covered by ACPC guidelines, has been considered by Cedar Court staff.
4. THE VIEWS OF ADOLESCENTS (AND THEIR FAMILIES)

Both adolescents and their parents considered that they were fully involved with the programme of treatment and praised the service which was offered. They found the initial home visit very helpful and it successfully engaged the young person. Parents felt helped and supported by Cedar Court, and considered that the unit communicated well with them and accommodated their needs.

Hergest Unit: All patients, when admitted to the Hergest Unit, are given a booklet which describes the unit and its procedures. Every young person is also given a card with the telephone number of the National Youth Advocacy Service.

During interviews with review team members, the young people confirmed their understanding of their illness and the treatment programme. The process which commences at the pre-admission home visit, continues through a programme of review and daily unit meetings. All the adolescents were aware of the names of their key worker and named nurse.

4.1 STANDARD The views of adolescents and their families influence the planning and delivery of services and the environment in which care is given.

4.1.1 Criterion Mechanisms are in place to achieve this end and are effective.

4.2 STANDARD The rights of adolescents to be heard are respected.

4.2.1 Criterion Adolescents receive such information about all aspects of their diagnosis, treatment and changes to treatment, as is appropriate to their age and understanding (e.g. Explanation of reason for admissions, written information about medication, role of staff members, etc.).

4.2.2 Criterion Adolescents are able to communicate in the language of their choice and receive information in that language.

There is access to an interpreter when needed, communication aids are available as required.

4.2.3 Criterion Adolescents are fully informed and counselled about their rights under the Children Act and as patients according to the Patient's Charter.

A range of relevant information is given to each adolescent in a pre-admission pack. This includes an information leaflet on the UN Convention on the Rights of Children, information about the Advocacy Service, and the NHS complaints arrangements as applied by the trust. This information was also displayed on notice boards adjacent to the common / dining room.
Adolescents are provided with information and the telephone number of helplines (in card form). This link is to the National Youth Advocacy Service [See Standard 5.3]

4.3 **STANDARD**  
*The adolescent and his/her family are fully consulted and involved in making decisions which affect the life of the adolescent involved.*

4.3.1 **Criterion**  
*Adolescents play an appropriate and active role in making decisions about their care at every stage from assessment to diagnosis and treatment, and their views are recorded.*

The young people interviewed confirmed their involvement through formal review meetings, day to day 'sessions' with staff members and their input, via patient representatives, to unit 'policy' meetings.

4.3.2 **Criterion**  
*Parents are involved with the planning of care at every stage from assessment to diagnosis and treatment, and their views are recorded. Parents also have the chance to discuss their worries with the health professionals treating their child. The way this is done must take account of the young person's age and right to confidentiality.*

The parents interviewed confirmed their involvement in the consultation process, pre-admission visits and regular case reviews. All these activities are highly valued.

4.3.3 **Criterion**  
*Adolescents know who their Key Worker / Primary Nurse is.*

All adolescents were aware of who was their Key Worker and the role which they played.

4.3.4 **Criterion**  
*Due regard is taken in care planning for adolescents of their ethnic, religious and cultural backgrounds.*

Note is made of relevant cultural factors in the care of adolescents.

4.4 **STANDARD**  
*Treatment is conducted within the appropriate legal framework.*

4.4.1 **Criterion**  
*The consent of the adolescent and parent/guardian is (whenever possible) obtained to treat adolescents under the age of 16 years.*
The policy at Cedar Court is not to provide treatment without patient and parental co-operation and consent which is manifested through the signing of a contract for treatment. As a consequence Cedar Court does not admit or treat patients where this co-operation is not offered, although every effort is made to achieve agreement. Patients who will not agree may be admitted to adult mental health wards. Other young people are admitted to paediatric wards. It was not clear whether all those adolescents who do not consent are admitted to some form of provision.

Discussions are under way which involve the health authority, the trust and others regarding the best solution to the perceived unmet need - namely those adolescents with severe psychiatric illness requiring treatment under the Mental Health Act and/or physical restraint/sedation. There appear to be a number of options, as follows:

Option i. Basically the Status Quo. Cedar Court provides a service largely (though not entirely) for those patients with emotional disorders who will co-operate sufficiently to benefit from the treatment programme. Adult mental health units provide a service for those who require physical restraint/ sedation / treatment under the Mental Health Act. Adult mental health services would do their best to meet as many of these quality standards as possible.

Option ii. Cedar Court continues to provide service as above. An area of an adult ward is designated as the preferred provider for those adolescents whose needs cannot be met by Cedar Court e.g. due to the need for treatment under the Mental Health Act. This option would presumably facilitate efforts to raise 'adolescent' quality standards.

Option iii. As Option (ii), but Cedar Court becomes a Day Service / specialist outpatient resource.

Option iv. Cedar Court changes so as to be able to provide treatment for those with higher levels of disturbance who require treatment under this Act. This would only be possible if Cedar Court moved to another site.

- Option (i) has the advantage of being (partly) achievable and more or less cost neutral, but adult units would be unable to meet required standards.

- Options (ii) and (iii) look attractive in the short term, but in the longer term would both be likely to result in the loss of the current service provided by Cedar Court.

- Option (iv) may be difficult to achieve in terms of involving major change. It would produce a service move in line with units currently operating through much of the UK and would provide a service configuration with a greater chance of longer term sustainability.
5. SAFEGUARDS

| 5.1  | STANDARD | The rights, guarantees and standards of care, set out in the Children and Young Person's Charter, are applied for adolescents, parents, families and carers of adolescents.

Those not explicitly covered by other standards/criteria are:

i. parents' right to visit ward before admission;

ii. parents told before admission about education which adolescents of school age will receive if they stay for a long time;

iii. choice of food "from a children's menu which is healthy and suits all dietary needs"

iv. right to wear own clothes;

v. involvement in decisions about discharge planning including knowing the name of workers involved in follow up.

Arrangements to protect the rights and interests of the patients and their parents remain in place. Parents of young people, when interviewed, confirmed their satisfaction with the procedures and felt that their rights were recognised and respected. Young people had a right to wear their own clothing. There were fewer complaints about food compared to the 1998 visit. Standards of communication and co-operation with parents and patients were very sound and mutually supportive.

| 5.2  | STANDARD | Adolescents and their parents/carers have full access to the NHS complaints procedure.

| 5.2.1 | Criterion | Adolescents, and their parents/carers receive written information about how to complain written in a form and language they can understand.

The trust complaints procedure was made known to the adolescents and their parents. They were provided with relevant information leaflets. This information was on public display.

| 5.2.2 | Criterion | There are arrangements for monitoring the incidence and outcomes of complaints.

A record of complaints received is maintained. As with the 1998 visit, the majority of complaints related to the quality, efficiency and confidentiality of the taxi service. The Charge Nurse had taken on the role of Transport Co-ordinator and this had substantially improved matters.
The young people confirmed their satisfaction with the manner in which complaints were handled.

<table>
<thead>
<tr>
<th>5.3 STANDARD</th>
<th>Adolescent patients are made aware of how to access advice and support from outside the unit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3.1 Criterion</td>
<td>There is access to telephone helplines.</td>
</tr>
</tbody>
</table>

There is a pay-phone accessible to adolescents and details are provided about helplines. The siting of the telephone, however, does not allow for any degree of privacy. Each young person is issued with a card which carries the telephone number of the National Youth Advisory Service.

| 5.3.2 Criterion | There is access to independent advocacy services. |

The trust has contracted with the National Youth Advocacy Service to provide a fortnightly visiting advocacy service and an individual mediation service. There had been 4 referrals to this service in the past 4 months. These referrals had all been resolved to the satisfaction of the complainants.

**Hergest Unit:** A worker from an advocacy service visits the unit twice each week. However this service is geared towards the needs of adult patients.

| 5.3.3 Criterion | Adolescents are informed of the telephone number of the appropriate social services department. |

The telephone numbers of local social services departments are displayed on the notice board adjacent to the common room.

<table>
<thead>
<tr>
<th>5.4 STANDARD</th>
<th>There are procedures for the management of violent or potentially violent patients, including whether control and restraint is to be used, and, if so, how it is to be applied.</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.4.1 Criterion</td>
<td>There is a trust policy on management of aggression.</td>
</tr>
</tbody>
</table>

The Conwy and Denbighshire NHS Trust has a policy on the management of aggression. However, at Cedar Court there is an ethos which is translated into practice of not using restraint as a means of control.

**Hergest Unit:** The procedures for the control and management of aggression by the young people are the same as those which apply to adults. Young people may be nursed in the 6 bedded intensive care area (although it was reported that the unit had not been used for this purpose during the last year). Young patients could also be subject to seclusion. This practice is governed by a detailed protocol.

| 5.4.2 Criterion | Staff are appropriately and sufficiently trained to comply with trust procedures and their competence is regularly checked. |
Although Cedar Court's policy on the handling of aggression presumes the possible use of physical restraint, no training is provided for nursing or social work staff. In line with the unit's treatment ethos, training courses in de-escalation and 'breakaway' training which emphasises de-escalation techniques have been arranged.

| 5.4.3 | Criterion | Systems are in place for monitoring the use of procedures for the management of violent or potentially violent patients and for reviewing practice. |

There are no systems for monitoring incidents of violence. Reports of critical incidents are, however, placed on patients' individual files.

**Addenda to section 5.4 of the standards**

| 5.4.4 | Criterion | Schools have a policy about the use of physical force. All members of staff who may have to intervene physically with pupils understand clearly the options and strategies open to them. Members of staff know what is acceptable and what is not. Parents are informed. |

The team can report that no physical force is used on pupils in the educational unit at Cedar Court.

| 5.4.5 | Criterion | Immediately following any incident in which force is used to control or restrain a pupil, the member of staff concerned reports the matter verbally to the head or a senior member of staff. The member of staff provides a written report as soon as possible afterwards. |

Teachers provide a verbal report of any incident.
5.4.6 **Criterion**  
*Schools keep a record of all incidents, preferably in an incident book.* The report of the incident includes:

- i. the name(s) of the pupil(s) involved, and when and where the incident took place;
- ii. names of any other staff or pupils who witnessed the incident;
- iii. the reason that force was necessary (e.g. to prevent injury to the pupil/another pupil/member of staff);
- iv. how the incident began and progressed, including details of the pupil’s behaviour, what was said by each of the parties, the steps taken to defuse/calm the situation, the degree of force used, how that was applied, and for how long;
- v. the pupil's response, and the outcome of the incident;
- vi. details of any injury suffered by the pupil, another pupil, or a member of staff and of any damage to property.

A record is maintained of incidents.

5.4.7 **Criterion**  
*Parents are informed of an incident involving their child where force is used, and are given an opportunity to discuss it.* The head, or member of staff to whom the incident is reported, considers whether that is done straight away or at the end of the school day; and whether parents are told verbally or in writing.

(The review team did not obtain the relevant information to comment on this criterion.)

5.5 **STANDARD**  
*There are policies determining the unit staff’s response to unacceptable behaviour by adolescents.*

5.5.1 **Criterion**  
*These measures are not in contravention of the rights of the patient.*

Cedar Court operates to a clear code of behaviour which is accepted by patients and their carers. Since the HAS 2000 visit in 1998 the arrangements for 'time away' have been made more safe by the introduction of daily contact being made with the young person when at home. The period of 'time away' has also been reduced to one or two days as a norm. The young people confirmed that they welcomed these modifications to the practice. Although these measures do not contravene the rights of patients, some concerns about the safety and the effectiveness of this sanction still remain.
Addendum to section 5.5 of the standards

5.5.2 Criterion  The school's behaviour policy promotes respect for others, including respect for different ethnic, religious and cultural backgrounds. It makes clear the school's intolerance of bullying, racial or sexual harassment or any other form of improper behaviour. The main points of the policy are communicated to pupils and parents.

The education unit at Cedar Court has a clear policy on bullying, anti-racist behaviour and other forms of unacceptable behaviour.

5.6 STANDARD  There are policies and procedures regarding patients absence with or without permission.

5.6.1 Criterion  For every patient there is documented decision making regarding leave status. This is informed by a risk assessment.

All patients have a clear 'leave status' and this is based on an individual risk assessment.

5.6.2 Criterion  There is evidence parent/carers have been involved in these decisions.

Each adolescent's leave status is agreed with their parents.

5.6.3 Criterion  There is an effective missing persons procedure and effective practice for their return to the unit.

A new procedure for making 'risk assessments' in circumstances when adolescents go absent without leave has been introduced. This reflects guidance provided in the joint North Wales police and social services protocol "Children Missing from Care in North Wales", December 1998. Cedar Court still adhere to their own timescales for alerting police and taking action. These timescales are tighter than those advised in the above protocol.

5.7 STANDARD  Liaison with social services ensures that the welfare of adolescents resident in health care establishments is addressed in accordance with the Children Act 1989.

(Guidance on Section 85 of the Children Act states that social services departments should be cautious about exposing a child to a regime where sedation is used to control behaviour in any case and should be very cautious when major tranquillisers are involved.)

5.7.1 Criterion  Bilateral agreements exist which set out parameters for possible treatments for adolescents covered by Section 85 of the Children Act or otherwise the responsibility of the local authority.
The situation remains as reported in 1998. Any agreement between the unit and local authority social workers with case responsibility on the nature of treatment would be on a case by case basis.

**5.8 STANDARD** The selection and vetting of staff follow the procedures described in LAC (93)17/WOC 54/93 and are consistent with the recommendations of the Warner and Utting reports.

**5.8.1 Criterion** Effective procedures are in place to ensure disclosure of criminal background of those with access to adolescents.

**5.8.2 Criterion** There is evidence of a strong emphasis on a principles-led approach to staff recruitment and selection - no 'quick fixes' or 'cutting corners'.

(In addition the Clothier report recommends that:

i. for all those seeking entry to the nursing profession, in addition to routine references, the most recent employer or place of study should be asked to provide at least a record of time taken off on grounds of sickness;

ii. nurses should undergo formal health screening when they obtain their first posts after qualifying.)

Effective procedures are now in place to police check all staff working at Cedar Court, whatever their status or discipline. Currently police checks in North Wales are taking up to 12 weeks to complete. This has caused, or has the potential to cause, recruitment problems for the trusts. The Conwy and Denbighshire NHS Trust has adopted a rigid, principles driven, approach to this area of personnel work and is prepared to accept any perverse consequences of this policy.

All taxi drivers are police checked and carry identity badges which they are required to present on each occasion that they transport a patient to the unit.

**Hergest Unit:** The trust aims to police check all staff who work on the unit, including nursing staff (permanent and bank), domestic staff, porters and volunteers. The review team were informed that the North Wales police had been reluctant to carry out these checks. The trust chief executive is in correspondence with the chief constable about this matter.

**5.9 STANDARD** Clinical staff participate in clinical audit.

(Might include audit of the use of medication, adverse events; application of evidence-based practice.)

Clinical staff at Cedar Court participate in clinical audit.

**5.10 STANDARD** UKCC standards relating to the control and administration of drugs are applied.
UKCC drugs control and administration are applied at Cedar Court.

<table>
<thead>
<tr>
<th>5.11 STANDARD</th>
<th>There are procedures in place to ensure that statutory requirements are complied with, including:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>i. the Mental Health Act (also guidance on the supervision register)</td>
</tr>
<tr>
<td></td>
<td>ii. the Children Act</td>
</tr>
<tr>
<td></td>
<td>iii. the Nurses, Midwives and Health Visitors Act</td>
</tr>
<tr>
<td></td>
<td>iv. the Medicines Act</td>
</tr>
<tr>
<td></td>
<td>v. the Sex Offenders Act</td>
</tr>
<tr>
<td></td>
<td>vi. statutory requirements of professional regulation (including up to date registration status of professional staff).</td>
</tr>
</tbody>
</table>

The care and treatment regime at Cedar Court generally conforms with the Children Act. Cedar Court now maintain a record of nurse registration and re-registration dates. There is also a record of those nurses nationally whose names have been removed from the UKCC register.

| 5.12 STANDARD | There is evidence at all levels that the lessons, from recent developments aimed at safeguarding adolescents living away from home in local authority care, are being considered and applied in this NHS residential setting (including Warner, Utting and the Report of the Examination Team on Child Care Procedures and Practice in North Wales.) |

| 5.12.1 Criterion | There are effective in-house and external monitoring arrangements for detecting problems identified by recent reports into the care of adolescents in residential care. |

There appear to be a number of mechanisms for the discussion and resolution of difficult matters. There are new (June 1999) health authority policies and procedures for the investigation of allegations against professionals. These are based on Welsh Office guidance issued in January 1999.

| 5.12.2 Criterion | There is evidence of open and frank communication between staff. Management encourages this and combats anti-staff cultures. There is a willingness to accommodate 'whistle-blowing' and staff are encouraged to communicate concerns and are afforded full legal and employment protection when acting in good faith. |
The health authority has advised each trust to develop a 'whistle blower' policy. At Cedar Court this policy has been incorporated into unit procedures. Staff are advised and urged to report their concerns to their line manager in the first instance but it was not clear to reviewers how this was handled at senior management level.
6. MULTI-DISCIPLINARY AND MULTI-AGENCY WORKING

6.1 STANDARD There is commitment at all levels to co-ordinating the care and education for adolescents. Health, social, education and independent sector agencies work in close collaboration. The continuum of care should include the transition to adult services; prevention, acute care, continuing care and rehabilitation should be regarded as part of the same spectrum.

6.1.1 Criterion There is evidence of good communication and joint working between relevant National Assembly for Wales Groups and Departments.

(This criterion is not considered to be relevant to this unit report.)

6.1.2 Criterion National Assembly for Wales policy and guidance relating to the care of children and adolescents is consistent and avoids 'perverse incentives'.

(This criterion is not considered to be relevant to this unit report.)

6.1.3 Criterion The National Assembly for Wales keeps joint planning for children's services under review to ensure that the Audit Commission's recommendations in "Seen but not heard" are addressed.

(This criterion is not considered to be relevant to this unit report.)

6.1.4 Criterion The health authority has designated a senior officer, with recognised experience in children's issues to be responsible, in liaison with GP fundholders, for commissioning all health services for adolescents. This person plays a key role in ensuring that care is co-ordinated.

The key officials at health authority level are the director of patient care and the director of public health through the consultant and other staff who lead on children's services. The director of public health leads on child and adolescent mental health service (CAMHS) issues for the health authority.

6.1.5 Criterion When services are provided by several providers, the health authority contracts with one provider to oversee the service, sub contracting as necessary.

The health authority contracts for inpatient services for adolescents with the Conwy and Denbighshire NHS Trust. Community based CAMHS are provided by North West Wales, North East Wales and Conwy and Denbighshire NHS Trusts.
The health authority have produced a draft strategy for CAMHS (September 1999). This draws heavily on the work of Dr Thalanamy who has conducted a needs assessment survey in North West Wales (June 1999).

**6.1.6 Criterion** The health authority, local authority and voluntary organisations have considered ways to improve joint action at all levels, particularly in:

i. defining and assessing need;

ii. prioritising between needs;

iii. identifying the adolescents concerned;

iv. planning services.

The draft strategy statement has also been supported by the production by the health authority of a CAMHS Service Specification for tiers 2 and 3 of an authority-wide service.

**6.1.7 Criterion** The health authority has produced a local strategy for health which includes services for adolescents.

The health authority and the six unitary authorities agreed eligibility criteria for continuing health care (April 1999). This agreement covers children (Section 8), but it is not explicit about those children and adolescents specifically covered by CAMHS services. It was reported that the continuing care criteria for children were to be the subject of further review.

**6.1.8 Criterion** The health authority has ensured that GPs (fundholders and non-fundholders) have been full and active participants in the planning of adolescent services.

General practitioners are represented on planning fora through participation on local health groups (LHGs).

**6.1.9 Criterion** Health and local authorities and GP fundholders have published joint and continuing care agreements which include adolescents.

The health authority and the six unitary authorities agreed eligibility criteria for continuing health care (April 1999). This agreement covers children (Section 8), but it is not explicit about those children and adolescents specifically covered by CAMHS services. It was reported that the continuing care criteria for children were to be the subject of further review.

**6.1.10 Criterion** The health and local authority have agreed respective responsibilities for meeting the continuing care needs of adolescents and arrangements for hospital discharge.

(Each year they should confirm jointly their best estimates of the likely number of the children / young people who will need continuing health and social care and their respective commitments in terms of finance and activity.)
It was reported that working relationships between health commissioners and providers, and the unitary authorities had much improved over the past year. This has been particularly marked with respect to relationships with Cedar Court. The health authority draft strategy document included representation from social services and education on its Advisory Group. This strategy is to be further developed as part of the authority's Health Improvement Plan (HImP). The aim is to include preventative and primary care aspects. There is evidence of joint commissioning and evidence of cross-boundary working.

Some concern was expressed by social services about the continuing difficulties in satisfactorily marrying CAMHS and social service department cultures. Some feared that, due to difficulties in accessing CAMHS, social workers' awareness of this service sector was falling. Whilst there has been a good deal of excellent joint working around child protection, social services departments still feel that CAMHS are reluctant to work with very challenging young people and these are left to be dealt with by social services, at some considerable cost in terms of both people and finance.

The directors of social services in the 6 unitary authorities plan to meet and consider patterns of purchasing outside their own local authority boundaries. Social services departments are seeking more consultation time from community CAMHS. However, all agencies appreciated that they and their potential partners were confronted with very constrained financial regimes and that there would appear to be little scope for extensive redevelopment. Agencies reported that it was now necessary to develop those projects which would attract specific grant or project support. They drew attention to the absence, within the Welsh context, of specific development monies for CAMHS.

Work has continued with the development and updating of Children's Services Plans for the 6 unitary authorities. It was reported that, in general, there was more openness between authorities and agencies and a willingness to talk and plan together. Flintshire Social Services reported continuing difficulties in engaging the local CAMHS in joint planning for children's services.

<table>
<thead>
<tr>
<th>6.1.11 Criterion</th>
<th>Local authorities have consulted fully health authorities about the local Children's Service Plan.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6.1.12 Criterion</th>
<th>Agencies agree respective responsibilities for financial contributions for meeting care needs.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6.1.13 Criterion</th>
<th>Good quality and sensitive arrangements are in place for transferring responsibility for a young person's care between agencies and between different parts of the NHS.</th>
</tr>
</thead>
</table>

The review team received no evidence to suggest that such arrangements were not in place. Generally patients and their parents were very satisfied with the manner and care taken to ensure sensitive transfer, particularly at admission and discharge.
The transition from child to adult services appears to work well.

Developments in joint planning, assessment and other professional practices are currently facilitated by the National Assembly of Wales' Children First Initiative and the need for agencies involved with child protection services to work together in response to new government child protection guidance. These initiatives appear to have led to enhanced inter-agency/disciplinary working, for instance through the newly created social work post at Cedar Court. Assessment work at Cedar Court is on a shared professional basis, but such a situation is not evident in community CAMHS.

This information is provided, in various formats, in the 6 Children's Services Plans.

The main programme of inter-agency/disciplinary training is in child protection.

The Conwy Education Authority provides a very well resourced and staffed educational unit at Cedar Court. This is financed on a 'fee recoupment' basis from the young person's home local education authority (LEA). Teaching staff at Cedar Court play a full role in the treatment regime, and contribute to unit management meetings and training.
**Hergest Unit:** There is no educational provision for patients on the Hergest Unit. For those on the paediatric ward the provision is informal and more geared towards the needs of younger children. This is a potential problem for those few young people admitted to the paediatric wards for protracted periods.

**SECTION 3: NORTH WALES REPORT**

<table>
<thead>
<tr>
<th>6.3</th>
<th>STANDARD</th>
<th>There is effective multi-disciplinary work within the residential units.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.3.1</td>
<td>Criterion</td>
<td>The different disciplines are clear regarding their roles in the assessment and treatment process.</td>
</tr>
<tr>
<td>6.3.2</td>
<td>Criterion</td>
<td>The different disciplines are clear regarding how they contribute to the ongoing development of the service.</td>
</tr>
</tbody>
</table>

Since the 1998 review the 6 unitary authorities have agreed to jointly fund a full time social worker post at Cedar Court. Combined with the work of the child therapist this addition has greatly enhanced the quality and range of multi-disciplinary work at the unit. The different disciplines are clear about their respective contributions to the treatment approach. Senior professionals on the team play both general roles (e.g. working as a patient's key worker) and specialised roles related to their discipline. The new social worker post has greatly improved the quality of liaison with the social services departments. As well as clarifying Cedar Court's role and function, she has been able to offer local authority colleagues some additional advice and consultation, which is appreciated.

**Hergest Unit:** There is evidence of good multi-disciplinary working. There is no formal on call rota for child psychiatry (apart from specifically for the inpatient unit at Cedar Court). However, a consultant will give advice if available. There is good joint working between the child and adolescent psychiatrists and the paediatricians, and evidence of training and supervision links with the team at Cedar Court. A child and adolescent psychiatry case is presented at the monthly paediatric team meeting.
As in the 1998 review, the co-ordination and communication between agencies at individual case level appears very constructive. This co-ordination properly recognises the young person's care status.

<table>
<thead>
<tr>
<th>6.4</th>
<th>STANDARD</th>
<th>There is effective multi-agency co-operation over the treatment and care of individual adolescents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4.1</td>
<td>Criterion</td>
<td>The various agencies involved with a particular adolescent co-ordinate and communicate in a way which facilitates each other's good work, in particular with reference to admission, discharge and after-care.</td>
</tr>
<tr>
<td>6.4.2</td>
<td>Criterion</td>
<td>There are proper arrangements, for ongoing care planning with the appropriate social services department, when a young person in a unit is:</td>
</tr>
</tbody>
</table>

i. a child "looked after" by a social services department;

ii. a child "accommodated" by the health authority unless detained under any provision of the Mental Health Act;

iii. a young person aged over 16 years who needs aftercare (Section 24 [2]).
7. DESIGN AND SAFETY OF ENVIRONMENT

7.1 STANDARD Adolescent units have implemented the recommended standards for the safety and security of patients

The security arrangements remain as reported in 1998. Some upgrading of the perimeter security is planned, for example a CCT camera on the front entrance and a digital locking system on doors. At present no one may access the building legally without the staff being aware of this. The charge nurse is the health and safety representative for RCN members and works closely with the health and safety adviser. All internal finishes, glazing etc. are to robust domestic standard which is appropriate for a unit where there is little violent acting out or incidents requiring physical control of patients by staff.

7.2 STANDARD Inpatient psychiatric units which accommodate adolescents meet modern standards for design and quality of environment provided (including privacy and security).

7.2.1 Criterion Adolescent wards are specifically designed with facilities for separate toilet areas, space for recreation and education and access to a telephone

There are separate male/female lavatories on the first floor, but ground floor facilities are shared.

**Hergest Unit:** It is policy to allocate a single room to young people under the age of 16 years who are admitted to the Hergest Unit. In practice, this arrangement is offered to all patients under the age of 18 years. Young people share the same facilities as adult patients, but it is policy to maintain levels of observation which ensure that the young patient's whereabouts are known at all times.

7.2.2 Criterion Patients all have the option of having a single bedroom.

Most of the bedroom accommodation is single rooms. There are two double rooms.

7.2.3 Criterion The layout of the unit enables adequate supervision as determined by the degree of disturbance of the patient.

The adolescents are supervised at night and duty staff make periodic but irregular checks throughout the night.

7.2.4 Criterion The layout of the unit and the regime adopted should allow for a degree of privacy appropriate to the mental state of the patient. This includes sensitivity to gender issues including the provision of separate toilet and washing facilities.

Adolescents are not allowed in to their bedrooms during working hours. The reason given for this was that voices in downstairs rooms are audible and in this way confidential therapeutic conversations could be overheard. Adolescents may however go to their bedrooms if accompanied by a member of staff.
The unit retains its well cared for image. The patients are offered a pleasant environment in which to live - in both its internal and external aspects.
SECTION 4

SOUTH WALES REPORT
INTRODUCTION

Section 4 provides a description of the 'evidence' gathered by the review team which visited South Wales between 1 - 3 December 1999. The progress review was guided by the set of standards used in the 1998 review. (Addenda to two of the standards relating to the safeguarding of children in the classroom have been added). The 'evidence' has been reported within this agreed framework of standards and criteria.

This report relates primarily to the service provided at the Harvey Jones Unit. The report also covers relevant activities of the Cardiff and District Community NHS Trust. Mention is made of the adult psychiatric wards at Whitchurch Hospital to which adolescents are sometimes admitted; Cardiff and District Community NHS Trust has a policy of admitting adolescents to East 2A Ward whenever possible.

Bro Taf Health Authority commissions services for a catchment population of 739,600. At the time of the review it was coterminous with four local authorities (Cardiff, Merthyr, Rhondda Cynon Taff and the Vale of Glamorgan.)

Child and adolescent mental health services are provided within the Bro Taf area by two trusts (Pontypridd and Rhondda NHS Trust and Cardiff and District Community NHS Trust), each of which provides community child and adolescent mental health services to their local populations.

The Harvey Jones Unit is the adolescent inpatient unit serving South Wales. It is managed by Cardiff and District Community NHS Trust. Harvey Jones is located within the grounds of Whitchurch Hospital. The unit has fourteen beds and admits children and young people between the ages of eleven and eighteen.

Cardiff and District Community NHS Trust also provides mental health services for working age adults to 70,000 of the population of South Wales. The adult psychiatric beds which serve this catchment population are based at Whitchurch Hospital. The beds are located in four wards and a separate five bedded psychiatric intensive care unit.
1. INPATIENT PROVISION AND ADMISSION POLICIES

<table>
<thead>
<tr>
<th>1.1 STANDARD</th>
<th>Adolescents are admitted to hospital only if the care they require cannot be provided as well at home, in a day clinic or on a day basis.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1 Criterion</td>
<td>There is adequate, local provision of a range of domiciliary, community and day services so that adolescents are not admitted inappropriately.</td>
</tr>
<tr>
<td></td>
<td>(Are adolescents admitted, or kept in hospital, because of inadequate local resources?)</td>
</tr>
</tbody>
</table>

The review team were informed that the provision of local community child and adolescent mental health services (CAMHS) was patchy. Services in Gwent, Swansea, and the Northern Bro Taf area are better resourced than those in Cardiff and the Vale of Glamorgan. The situation in Cardiff and the Vale has been weakened in part by community psychiatric nurses (CPNs) being brought back from the community to staff the Harvey Jones Unit. The Bro Taf Health Authority have recently provided new money to improve Cardiff CAMHS services. There is a plan to appoint 3 CPNs (Grade G), and 3 support workers, to be overseen and supervised by the Senior Clinical Nurse Co-ordinator at Harvey Jones; 1.5 WTE staff grade doctors; and 1.5 WTE administrative support workers.

The review team were informed that a consequence of poor resourcing of local services is that at times, patients are admitted who might otherwise be managed in the community if CAMHS were better resourced.

<table>
<thead>
<tr>
<th>1.1.2 Criterion</th>
<th>There are clear written admission criteria which emphasise that adolescents are admitted only if the care they require cannot be provided at home, in a day clinic or on a day basis.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admission criteria encompass:</td>
</tr>
<tr>
<td></td>
<td>i. psychiatric severity and condition;</td>
</tr>
<tr>
<td></td>
<td>ii. potential scope for intervention.)</td>
</tr>
<tr>
<td></td>
<td>(If a unit ever admits children under the age of 11, admission policies should pay particular regard to this.)</td>
</tr>
</tbody>
</table>

There is a written admission policy.

**Ward E2A:** "Guidelines for Adolescents Requiring Emergency Inpatient Psychiatric Care (Adolescents on Adult Wards)" 25-03-99 contains criteria for admission for people under the age of 18. Criteria have been agreed by general mental health and child and adolescent psychiatry.

It was reported that 24 hour nursing support for adolescent patients on general psychiatric wards was available from the Harvey Jones Unit team, where appropriate. The team were told that all new staff are informed of the policy.
The capacity of the unit to provide a range of therapeutic interventions has been reduced with the weakening of the multi disciplinary team. Currently staff at the unit can offer individual and family therapy, group therapies and anxiety management. Due to continuing uncertainty in respect of the future posts currently funded i.e. family therapist (by the trust) and social worker and part of a teaching post (by the health authority) these services will be affected if posts are not funded on a more permanent basis. The planned recruitment of occupational therapy and clinical psychology staff will improve the ability to provide a range of treatments.

There are arrangements for specialised care and treatment to be purchased out of area, e.g. at the Gardner Unit.

**Cardiff and District Community NHS Trust:** One young person (17 1/2) has been admitted to the adult Intensive Care Unit (ICU) since the first visit.

Since the last review the ICU has been extensively refurbished, making it a much more pleasant environment. The number of beds is currently reduced to 3 in order that adequate staffing levels can be maintained (1:1).

Potential admissions may be turned away on account of non-availability of 'beds', or because of the capacity of the unit to provide for certain disorders e.g. with no dietician currently available, patients with anorexia nervosa may not be accepted.

The waiting list is prioritised. Urgent cases are often seen within 48 hours and this can be followed immediately by admission. There are usually about 5 patients on the waiting list.
Harvey Jones now provides a 7 day service.

<table>
<thead>
<tr>
<th>1.2.5 Criterion</th>
<th>Where units close at weekends, appropriate arrangements are made for the patients.</th>
</tr>
</thead>
</table>

The admission of 16 year olds to adult wards is rare in the Cardiff area. In an emergency 16 to 18 year olds may be admitted to adult wards and assessed for suitability for transfer to the Harvey Jones Unit. The review team does not have information regarding admission of adolescents to adult wards in other parts of South Wales.

**Ward E2A:** "Guidelines for Adolescents Requiring Emergency In-Patient Psychiatric Care (Adolescents on Adult Wards)" (25-03-99)

- states clearly the procedure for care of adolescents admitted to adult wards;
- states that when adolescents under the age of 16 require admission it should be the responsibility of the consultant in child and adolescent psychiatry to arrange admission and that once admitted, they will continue to be the Responsible Medical Officer.

There were no admissions of people under 16 to adult wards in the period.

<table>
<thead>
<tr>
<th>1.3 STANDARD</th>
<th>Hospital units to which adolescents are admitted are easily accessible to families without need to travel significantly further than to other similar amenities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3.1 Criterion</td>
<td>Adolescents and families are able to access the service.</td>
</tr>
</tbody>
</table>

Travel to the unit is satisfactory if using a car, but travel by public transport presents difficulties. Within the Bro Taf area, travel north to south is harder than from east to west. Day patients are brought to the unit by hospital transport. Travelling expenses are reimbursed for those parents on 'benefit' and further assistance may be available from social services.

<table>
<thead>
<tr>
<th>1.3.2 Criterion</th>
<th>The service acknowledges access difficulties and provides appropriate assistance. This should include special arrangements being made for families to be able to stay close to the adolescent unit overnight when this is appropriate.</th>
</tr>
</thead>
</table>

There are no provisions for parents to stay over night at the unit, except in emergency circumstances when a parent may sleep on a mattress on the floor or use local bed and breakfast accommodation.
The Harvey Jones Unit is in the grounds of an adult psychiatric hospital. However, the unit has a separate entrance and address. The unit has access to some of the main hospital facilities e.g. gym, physiotherapy.

Social services departments are informed on an individual basis, as required under the Children Act.

There is no emergency service, but there is an ability to respond urgently. In the past year 3 patients have been admitted within 24 hours. Emergencies may result in admission to adult wards in which case this can result in an assessment for suitability for transfer to the Harvey Jones Unit within 24 hours.
2. STAFFING

<table>
<thead>
<tr>
<th>2.1 STANDARD</th>
<th>NHS inpatient units for adolescents are adequately staffed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Criterion</td>
<td>Staffing comprises a core multi-professional team consisting of: psychiatrists, including a senior psychiatrist fully trained in child and adolescent psychiatry; psychologist(s) and nurses who are appropriately trained.</td>
</tr>
</tbody>
</table>

There are effective arrangements for the involvement of social workers, whether or not they are members of the core team. Units may also employ staff from other backgrounds (e.g. Occupational therapists, art therapists, psychotherapists etc.) depending on the needs of the patients and the therapeutic culture of the unit.

The current multidisciplinary team comprises 1.2 whole time equivalent consultant psychiatrists, 1 specialist registrar and 2 part time senior house officers. There is an art therapist (11 hours) and trainee psychotherapist (2 sessions). The education unit is staffed by 2 full time teachers; one of these posts is temporarily funded in part by the health authority. The health authority also made funding available (until 31-03-2000) for a full-time social worker, and the trust funds a part-time family therapist (2 sessions).

The selection and appointment of a full time clinical psychologist was imminent. Funding has been achieved from other health authorities in South Wales, sufficient to appoint a part-time dietician, part-time occupational therapist and additional art therapist. There remains a serious level of uncertainty regarding continuation of the funding for the social worker, family therapist and second teacher beyond March 2000. The funding from one of the other health authorities is not so far on a recurring basis.

Representatives of local social services departments expressed concern that communication by the unit with them was poor and that frequently they were unaware of the admission of young people from their areas to the Harvey Jones Unit.

Ward E2A: Since the last review the number of qualified staff on E2A has increased. It still remains the case that the team does not include professionals in child and adolescent psychiatry. There are sufficient staff on E2A to ensure that, in most cases, there are two qualified nursing staff on each shift.

| 2.1.2 Criterion | Staff numbers are sufficient to provide a wide range of short and medium term psychotherapy and psychiatric treatments. |
The deficiencies and uncertainties regarding the multi-disciplinary team have affected the treatments which can be provided. There is a problem with behavioural management and this involves a risk of such management becoming punitive rather than therapeutic. An example was that one patient talked of sanctions such as confiscation of personal property or being grounded for swearing at staff. Hopefully this will be addressed by the appointment of a clinical psychologist. Family therapy is provided at present but the continuation of this depends on the funding of the social work post. There is currently no member of staff with cognitive behaviour therapy (CBT) training. However, the consultant child psychiatrist, who has had training in CBT, offers this.

On the more positive side, nursing staff have participated in study days to improve skills in dealing with self harm, eating disorders, family therapy and brief focused therapy.

| 2.1.3  | **Criterion** | There is sufficient flexibility in staffing numbers to accommodate the changing dependency needs of adolescents accommodated in the facility. |
| 2.1.4  | **Criterion** | Staff are managed effectively in order to support the purpose and the function of the unit. Lines of accountability are clear and working practices maximise continuity of care. |

Levels of permanent nursing staff have been significantly increased since the 1998 review. Bank and agency nursing staff can be used to increase nursing levels and provide flexibility.

| 2.1.5  | **Criterion** | There is evidence of regular and effective staff support and supervision. |

The lines of professional accountability were clear and nursing staff were familiar with the line management arrangements.

| 2.2   | **STANDARD** | The nursing staff working on inpatient units for adolescents are appropriately trained. |
| 2.2.1 | **Criterion** | There is at least one nurse holding the RMN qualification on duty at all times. |

There is always a minimum of one nurse (RMN) on duty. During day shifts there may be three or more qualified staff on duty.

| 2.2.2  | **Criterion** | Ideally nurses have undertaken a recognised post-basic nursing course in child and adolescent psychiatric nursing (ENB603). It is essential that those nurses working in a senior nurse manager capacity have this additional qualification. |
There are four nurses who hold the ENB603 qualification or equivalent. The National Assembly for Wales have agreed that a double credit diploma module in "Child and Adolescent Development in Crisis" is considered a suitable alternative to ENB603. There are currently three nurses booked to undertake the diploma module course in year 2000 and a further two nurses the following year.

**Ward E2A:** It remains the case that none of the nurses working on the general psychiatric wards have undertaken a recognised post basic nursing course in child and adolescent psychiatric nursing.

<table>
<thead>
<tr>
<th>2.2.3</th>
<th>Criterion</th>
<th>There should be nursing staff holding the RSCN or Project 2000 Child Branch qualification within the nursing team.</th>
</tr>
</thead>
</table>

There have been additional funds made available for nurse recruitment. Nursing staff report that the trust provides excellent support for nurse training and professional development.

<table>
<thead>
<tr>
<th>2.2.4</th>
<th>Criterion</th>
<th>The National Assembly for Wales ensures that the shortfall in numbers of RMNs qualified to specialise in paediatric psychiatry is addressed by increased funding for the Diploma in Child and Adolescent Psychiatry.</th>
</tr>
</thead>
</table>

Since the 1998 review there has been a significant increase in the nursing establishment at Harvey Jones Unit. This process is ongoing and has brought nursing levels up to a safer level. The nursing structure has also changed, with clearer definitions in roles and responsibilities of senior nursing officers. The nursing staff report a considerable improvement in continuity of care, the creation of a safer environment and a more cohesive team. The nursing team demonstrated a great deal of enthusiasm and commitment to the provision of a professional, caring service. They appeared motivated and felt positive about the changes which have been triggered by the 1998 review.

<table>
<thead>
<tr>
<th>2.3</th>
<th><strong>STANDARD</strong></th>
<th>All staff in contact with adolescents have some training to ensure an appropriate level of awareness of the needs of adolescents.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>2.3.1</th>
<th>Criterion</th>
<th>All professional staff are trained in skills necessary to work effectively in partnership with parents. These skills include the ability to counsel parents effectively.</th>
</tr>
</thead>
</table>

Staff at Harvey Jones are experienced in working with parents. New professional staff, of all disciplines, attend a two-day workshop on "Working with Families", which is part of the induction programme at the unit.

**Ward E2A:** A staff nurse has undertaken a "Family Interventions" course. She felt that this would help her counsel parents.

<table>
<thead>
<tr>
<th>2.3.2</th>
<th>Criterion</th>
<th>All staff in contact with adolescents are trained, and updated, in awareness of the predisposing risk factors which may lead to abuse, and are continually alert to the circumstances in which adolescents might be harmed.</th>
</tr>
</thead>
</table>
A risk assessment of each patient is made on the basis of clinical judgement. There is no formalised risk assessment screening tool. The trust is looking to develop such a policy and screening tool and CAMHS services will adapt this to suit their needs. A record of observation levels, appropriate to each individual patient, is recorded in nursing and medical notes. The suitability of the level is agreed on a multi-disciplinary basis. All staff have now had child protection training and evidence of this was provided.

**Ward E2A:** All staff on E2A have now received Level 2 child protection training. The Nurse Practice Development team at the trust are responsible for monitoring training and ensuring that there is a continual uptake.

| 2.3.3 Criterion | Health service professionals understand, and are familiar with, the procedures for recognising and dealing with abuse. |

The Harvey Jones Unit has a clear strategy for child protection training. Child protection is a standard item at the induction of all new staff and all nursing staff at the unit have now completed a one day course at the second level of child protection training. This programme was designed and delivered on site by designated and named professionals. Two members of the nursing staff have participated in inter-agency training during the past year. Annual refresher events are also planned. Examples were provided which demonstrated that staff are alert to suspicions or allegations of abuse and are able to take appropriate action.

The social worker expressed concern that inter-agency training is not planned for more staff.
3. CHILD PROTECTION, MANAGEMENT OF ALLEGATIONS/ SUSPICIONS AND PARTICIPATION IN INTER-AGENCY PROCEDURES

| 3.1 STANDARD | NHS adolescent inpatient units are aware of the child protection status of adolescents admitted. |

Professionals at Harvey Jones are aware of the child protection status of the young people.

| 3.2 STANDARD | The health authority takes the strategic lead for health on inter-agency working on child protection matters and co-operates with other agencies in planning, purchasing and monitoring services under the Children Act 1989. |

| 3.2.1 Criterion | The health authority has identified a senior doctor, a senior nurse with a health visiting qualification and a senior midwife as the "senior professionals" on the ACPC and to co-ordinate all aspects of child protection within the district. |

The Bro Taf Health Authority has identified a Designated Doctor and Nurse. A senior midwife is also available for consultation e.g. to advise on obstetric issues.

| 3.2.2 Criterion | Child protection is included in contracts agreed between the health authority and NHS Trusts, and monitoring arrangements have been set up to satisfy themselves that procedures are followed. |

Bro Taf Health Authority has published a specification for a district-wide service in child protection (June 1998) which draws on national guidance. The specification includes roles and responsibilities of health professionals in relation to prevention, recognition, assessment and inter-agency working. The specification also sets out audit and monitoring requirements. The health authority has also published a specification for the provision of health services to Looked After Children.

| 3.3 STANDARD | NHS Trusts ensure that systems are in place which enable the trust and its staff to comply with local ACPC procedures and with those in "Working Together Under the Children Act". |

| 3.3.1 Criterion | Each NHS Trust providing child health services has identified a named professional (doctor and nurse/midwife) for child protection matters who is responsible for ensuring child protection supervision on a regular basis and day to day advice and support. |
There are named professionals in all trusts covered by Bro Taf, with two named nurses in Cardiff. There remain some unresolved difficulties in agreeing time commitments for named doctors.

| 3.3.2  | **Criterion** | Trusts and individual departments have in place robust policies and procedures which are compatible with ACPC guidelines, including the conduct of Part 8 reviews. These are dated, indicate when and by whom they will be reviewed and their effectiveness is monitored. |

The trust has recently issued Good Practice Guidelines in Child Protection (final draft October 1999) and these were available on the unit. The named nurse confirmed that this draft has now been approved by the trust and now awaits funding for printing prior to distribution.

There appear to be two omissions from this draft related to (a) absence of specific guidance in relation to abuse by professionals and (b) no guidance on conduct of Part 8 reviews. Both these matters are covered in the South Wales Area Child Protection Committee (ACPC) guidelines and need to be cross-referenced in trust publications.

The Harvey Jones Unit has developed procedures which are specific to the unit, but these need elaboration to include suspicions and allegations against professionals, and child to child abuse. The procedures also need to be checked for compatibility with ACPC guidelines. Unit procedures were dated and were due for review in February 2000. However, some recent experience of managing incidents on the unit which had a child protection dimension, indicated that unit staff were aware of and utilised appropriate procedures correctly.

| 3.3.3  | **Criterion** | Local ACPC guidelines, Working Together Under the Children Act, Clarification of Arrangements, Medical Responsibilities and Guidance to Senior Nurses are available and accessible to all staff members. |

Copies of the ACPC Guidelines were located in a variety of points throughout the unit. All other professional documents, plus a set of Children Act Guidance were available in the unit's resource room.

**Ward E2A:** A copy of the Cardiff Child Protection Procedures was available on the ward.

| 3.3.4  | **Criterion** | Written and detailed NHS procedures include guidance on dealing with suspicions or allegations of abuse, either intra or extra familiar, or involving a professional; on documentation or on seeking advice from designated or named professionals. |
The trust child protection guidance includes sections on recognition and referral of intra-familial abuse and arrangements for accessing advice from the named nurse. There appears to be no specific guidance relating to extra-familial abuse, in particular, allegations of abuse by professionals. This is covered in guidance for senior nurses, midwives and health visitors (1997) which was available at the unit. This guidance, however, is not trust specific. The named nurse and Harvey Jones Unit staff confirmed that there were appropriate levels of consultation and support available in respect of child protection issues.

3.4 STANDARD

NHS Trusts have an implemented strategy for child protection education and training which considers the needs of all staff who are likely to come into contact with children, or families with children. The strategy identifies the training appropriate to the roles of staff groups including the need for updating and clinical supervision (see also 2.3.2).

3.4.1 Criterion

Child Protection is a standard item at the induction of new staff.

The trust's child protection Good Practice Guidelines provide a brief indication of the levels of child protection training and the required topics to be covered at each level. The document indicates that all new trust staff are required to attend induction training in child protection. (See para 2.3.3)

3.4.2 Criterion

There is single agency training specific to the area of work involved.

The provision of single agency training in child protection at Harvey Jones was confirmed: a record of training uptake and future plans is maintained.

3.4.3 Criterion

Inter-agency training relates to indications of abuse recognition, referral and participation in inter-agency procedures.

(It is recommended that "agencies should establish joint annual training programmes on child abuse issues with access for all professional groups in direct contact with children and adolescents").

Two members of nursing staff at the unit attended inter-agency child protection training in 1999. It is planned that a further two senior members of the nursing staff will undertake this training in June 2000.

3.5 STANDARD

Where there is actual or suspected abuse within an establishment accommodating adolescents, a process of investigation, assessment and planning on an inter-agency basis is carried out.

3.5.1 Criterion

There are procedures in place for handling allegations of abuse against staff, other patients or visitors, including contact visits by relatives or friends.
See comment at 3.3.2. Procedures for dealing with allegations against staff need to be elaborated and strengthened.

### 3.5.2 Criterion

The unit follows the procedures for Working Together in individual cases produced by their local ACPC.

There is confidence, confirmed by the named nurse and the social worker therapist, that appropriate action had been taken in the past in terms of appropriate referral and participation in follow up when child protection proceedings were deemed necessary.

### 3.5.3 Criterion

When a case of abuse leads to death, or a child protection issue of public concern, the unit co-operates with the ACPC in conducting a review.

Neither the trust's nor the Harvey Jones Unit's guidance cover the issue of Part 8 reviews. Bro Taf child protection service specification indicates an expectation of co-operation with that process.

### 3.5.4 Criterion

The unit informs the National Assembly for Wales if there is a reason to believe that an offence has been committed against a patient by a member of staff or by a carer.

There is no specific guidance available which relates to the manner by which the National Assembly for Wales is informed of such an incident.

### 3.5.5 Criterion

The possible implications for other adolescents in the establishment are always considered and protection plans actioned whenever necessary. This includes the protection of adolescents from abuse by other adolescents and allegations or suspicions of abuse by one adolescent, concerning another adolescent, being dealt with through the usual inter-agency procedures.

The social work therapist reported that multi-disciplinary risk assessments are undertaken in respect of known or suspected young abusers prior to admission to the unit.
4. THE VIEWS OF ADOLESCENTS (AND THEIR FAMILIES)

Patients and their families were involved and expressed satisfaction with their treatment. Within the unit regular community meetings provide a forum for the young people to express their views on a range of relevant issues.

4.1 STANDARD The views of adolescents and their families influence the planning and delivery of services and the environment in which care is given.

4.1.1 Criterion Mechanisms are in place to achieve this end and are effective.

The young people and their parents report being given information prior to and at admission, although it appeared that, in the case of some young people, their age and severity of illness prevented full understanding.

4.2 STANDARD The rights of adolescents to be heard are respected.

4.2.1 Criterion Adolescents receive such information about all aspects of their diagnosis, treatment and changes to treatment, as is appropriate to their age and understanding (e.g. Explanation of reason for admissions, written information about medication, role of staff members, etc.)

The young people and their parents report being given information prior to and at admission, although it appeared that, in the case of some young people, their age and severity of illness prevented full understanding.

4.2.2 Criterion Adolescents are able to communicate in the language of their choice and receive information in that language.

There is access to an interpreter when needed, communication aids are available as required.

The unit is now able to provide for Welsh speaking young people. There are two Welsh speaking staff members. One young person and the parent of another expressed appreciation of this, particularly in regard to the impact on the quality of therapy. The review team were informed that there was a bigger issue in the need for interpreters for patients whose first language is Somali.

4.2.3 Criterion Adolescents are fully informed and counselled about their rights under the Children Act and as patients according to the Patient's Charter.

The review team received mixed evidence concerning the degree to which the young patients understood their rights and this appeared to vary between individuals. For some it was clear that they fully understood their rights, were aware of who were their key workers and knew how and who to complain to if need be. For other young people matters were much less clear and they appeared to have little recognition of their rights and avenues for complaint.
Ward E2A: Staff on the ward would not normally provide information to young people about the Children Act, however, they would look to their colleagues at Harvey Jones to do this.

There is information about helplines (see also 5.3). This is displayed in the unit and published in the unit's Admission Information Leaflet. However, some parents and young people interviewed did not recall being given this leaflet, which was produced in September 1999. Patients are provided with the helpline number on a card.

Ward E2A: On the ward there was a poster indicating a young people's advocacy service, information about the ward's general advocacy service and numerous, well displayed leaflets about issues affecting young people (alcohol, drugs, sexual health).

There would appear to be a number of opportunities for young people to learn about and become involved in the diagnosis and treatment of their illness. Young people felt they were free to discuss their situation and any worries with professionals. Community meetings, assessment and review meetings all provide suitable opportunities for their involvement. Clearly the nature of this involvement will be conditioned by the young person's developmental stage and severity of illness.

In general, parents expressed satisfaction with the formal opportunities for involvement in their child's care and treatment programme. Parents felt able and free to approach staff on a day to day basis with any concerns and they reported receiving satisfactory responses. As noted at 5.5 parents have voiced concern and dissatisfaction with the use of 'suspension'. Another was concerned about the nature and quality of communication when the young person was absent without leave.

All young people on the unit knew who their key worker was.
The consent of young people and their parents is seen as explicit by the terms and nature of their co-operation with the therapeutic programme. The review team felt that consent could be recorded in a more rigorous and formal manner.

The Harvey Jones Unit operates within a consent framework imposed by both the Mental Health Act and the Children Act.
5. SAFEGUARDS

5.1 STANDARD

The rights, guarantees and standards of care, set out in the Children and Young Person's Charter, are applied for adolescents, parents, families and carers of adolescents.

Those not explicitly covered by other standards/criteria are:

i. parents' right to visit ward before admission;
ii. parents told before admission about education which adolescents of school age will receive if they stay for a long time;
iii. choice of food "from a children's menu which is healthy and suits all dietary needs"
iv. right to wear own clothes;
v. involvement in decisions about discharge planning including knowing the name of workers involved in follow up.

i. Parents are invited to visit the Harvey Jones Unit prior to admission and are fully involved with their children's treatment plan.

ii. Parents confirmed that they were informed and involved with the educational plan.

iii. The food provided for Harvey Jones is selected from an adapted adult menu at the main hospital. There is little or no choice of menu, especially for vegetarians. Some patients are on 'special diets' related to their clinical needs. The review team fielded a range of complaints about the quality of food and catering arrangements. Patients considered that the food was not appropriate for adolescents and would welcome more variety and choice of meals and snacks. Patients felt it was necessary to supplement the diet with food provided by themselves.

iv. Patients may wear their own clothing.

v. Patients and their families are closely involved in plans for their discharge from the unit.

Ward E2A: All patients admitted to E2A are involved in discharge planning and this includes adolescents. They are given names, contact addresses and telephone numbers for follow up support.

5.2 STANDARD

Adolescents and their parents/carers have full access to the NHS complaints procedure.

5.2.1 Criterion

Adolescents, and their parents/carers receive written information about how to complain written in a form and language they can understand.

The trust has a complaints procedure and parents and adolescents can use it. Adolescents reported that they had not been given this information at their admission, but parents thought that they had.
There is a leaflet available and copies of this were displayed in the reception area. These leaflets were in English and a number of Asian languages, but not Welsh.

**Ward E2A:** There are now two ways of making a complaint - written and verbal.

| 5.2.2  | **Criterion** | **There are arrangements for monitoring the incidence and outcomes of complaints.** |

The few formal complaints which have been made were taken very seriously. In the past few months there have been 2 instances where it has been necessary for trust management to deal with serious complaints about the quality of practice at the unit. One of these generated child protection concerns with consequent involvement of the local child protection service. Both complaints were resolved satisfactorily.

| 5.3  | **STANDARD** | **Adolescent patients are made aware of how to access advice and support from outside the unit.** |
| 5.3.1  | **Criterion** | **There is access to telephone helplines.** |

The helpline phone number for "Childline" is prominently displayed in the reception area and there is a telephone trolley on the unit which can be used by the patients in relative privacy.

| 5.3.2  | **Criterion** | **There is access to independent advocacy services.** |

There is no access to a suitable advocacy service. The trust has opened discussion with the NSPCC about the provision of a more comprehensive advocacy and independent inspection service, but the review team were told that this may be too highly priced given current resources available to the trust.

**Ward E2A:** The advocacy service at the main hospital is very adult orientated. It is hoped that this service might develop a more child and adolescent focused approach in the future.

| 5.3.3  | **Criterion** | **Adolescents are informed of the telephone number of the appropriate social services department.** |

The telephone numbers of some social service departments are displayed in the reception area, but this list is not comprehensive given that the catchment area for the unit extends beyond Bro Taf.

| 5.4  | **STANDARD** | **There are procedures for the management of violent or potentially violent patients, including whether control and restraint is to be used, and, if so, how it is to be applied.** |
| 5.4.1  | **Criterion** | **There is a trust policy on management of aggression.** |

There is a trust policy on the management of aggression and a unit policy on physical intervention.
Staff at the Harvey Jones Unit are appropriately trained in 'management of aggression' techniques. A training programme provides for three levels of intervention: level 1 (½ day) provides training in diffusion techniques, level 2 (1 day) focuses on advanced and 'breakaway' and level 3 (3 days) comprises training in physical control techniques in a context of care and responsibility. All nursing staff have undertaken level 3 training and refresher training for those staff is already planned.

Care and responsibility incident forms are completed when necessary and such incidents are also recorded in the patient's kardex. Following a recent incident of restraint which had resulted in a child protection investigation (which was not substantiated), the staff at the Harvey Jones Unit have actively reviewed practice in this area. Anxieties which are generated by such incidents can be discussed with the multi-disciplinary team.

**Addenda to section 5.4 of the standards**

The teachers' policy regarding physical force is that in their day to day dealings, they make no physical contact with patients. If physically attacked, they first make very effort to verbally placate, and then to walk away from the situation, to call on nurses who are trained in physical restraint.

Immediately after such an incident an official incident record form would be filled in and given to a senior member of the nursing staff, with a verbal report of what happened. Copies would subsequently be sent to the health and safety services of Cardiff Education Authority.
A record of the incident would be kept in the school diary, covering points i) to vi) above.

Contact with parents would take place after discussion with the senior nurse.

The Harvey Jones Unit has a system of sanctions which are used to contain anti-social behaviour. There is concern about the safety of these, especially the use of suspension. Staff use sanctions to control unacceptable behaviour such as swearing at staff or not co-operating with the unit programme. These sanctions include loss of privileges such as watching TV, playing pool or going to the shops. Young people may be suspended from the unit if their behaviour is unacceptable and other sanctions have been tried and proved unsuccessful.
There were operational guidelines on suspension. The team were informed, however, that nursing staff have suspended a patient without reference to medical staff. A parent also reported her dissatisfaction with the lack of notice when her son was sent home in the evening. Some later clarification of this matter with medical staff suggested that a decision to suspend would involve medical staff, but this may be the duty doctor, who would not know the patient or their home circumstances.

The team concluded that current practice poses unacceptable risk and warrants examination and a review of policy and practice. This view was expressed to the chief executive of the trust and the unit consultant at the conclusion of the visit, and appropriate action has been taken by the trust.

Addendum to section 5.5 of the standards

| 5.5.2 | Criterion | The school's behaviour policy promotes respect for others, including respect for different ethnic, religious and cultural backgrounds. It makes clear the school's intolerance of bullying, racial or sexual harassment or any other form of improper behaviour. The main points of the policy are communicated to pupils and parents. |

Within the educational area of the Harvey Jones Unit, the staff believe that by virtue of their emotional and/or psychiatric conditions, patients display behaviours which would be considered unusual and unacceptable in mainstream schools. They consider, therefore, that their behaviour policy has to be sufficiently flexible to accommodate this.

Their mission statement summarises their priorities regarding their roles as teachers within the unit.

Within the classroom patients are treated with courtesy and consideration, and are expected to reciprocate to the best of their ability. If a patient becomes excessively disruptive, he or she is asked to leave the room for a limited length of time, and is expected to return, having spoken to a nurse, and when sufficiently calm. Under exceptional circumstances, nurses will be called to escort the pupil from the classroom. The incident would then be discussed in the afternoon meeting, or at the following day's community meeting.

The equal opportunities policy, and the policy against bullying, promote respect for others, as referred to in criterion 5.5.2. These topics also provide the subject matter for some social skills sessions.

| 5.6 | STANDARD | There are policies and procedures regarding patients absence with or without permission. |
| 5.6.1 | Criterion | For every patient there is documented decision making regarding leave status. This is informed by a risk assessment. |

The leave status of patients is discussed in review meetings. Parents are involved in agreeing weekend leave arrangements. A note of these agreements is placed on the care plan. There is no explicit risk assessment related to mobility and the review team advise that this is introduced to increase patient safety.
Parents confirmed that they were involved in discussions about mobility and weekend leave. As noted (5.5.1) there were concerns about the degree and nature of involvement in the circumstances of a 'suspension'.

The trust has promulgated a missing persons protocol. This has been activated on a number of occasions in the past few months. The protocol assumes the involvement of the police and inter-agency liaison in this area is reported to be very satisfactory.

Standing bilateral agreements do not exist. Each social services department placing a young person at the Centre would ensure that there was adherence to this section of the Act.

The selection and vetting of staff follow the procedures described in LAC (93)17/WOC 54/93 and are consistent with the recommendations of the Warner and Utting reports.

Effective procedures are in place to ensure disclosure of criminal background of those with access to adolescents.

There is evidence of a strong emphasis on a principles-led approach to staff recruitment and selection - no 'quick fixes' or 'cutting corners'.

(In addition the Clothier report recommends that:
i. for all those seeking entry to the nursing profession, in addition to routine references, the most recent employer or place of study should be asked to provide at least a record of time taken off on grounds of sickness;
ii. nurses should undergo formal health screening when they obtain their first posts after qualifying.)
The trust has now instituted a system of police checks which effectively cover all disciplines and grades. No staff are appointed without references and police checks. Police checks in South Wales currently take 4-6 weeks and trust personnel management consider that this is containable from a recruitment and retention perspective. The trust does not employ unchecked staff, except in exceptional situations dictated by clinical need e.g. at times of severe crisis in staffing levels. On those occasions any unchecked staff would not be allowed to work on a one-to-one basis with the young patients until checked.

5.9 STANDARD Clinical staff participate in clinical audit.

(Might include audit of the use of medication, adverse events; application of evidence-based practice).

Medical and nursing disciplines are involved in clinical audit and research.

5.10 STANDARD UKCC standards relating to the control and administration of drugs are applied.

There is trust policy and UKCC guidelines are adhered to in the administration of drugs.

5.11 STANDARD There are procedures in place to ensure that statutory requirements are complied with, including:

i. the Mental Health Act (also guidance on the supervision register)

ii. the Children Act

iii. the Nurses, Midwives and Health Visitors Act

iv. the Medicines Act

v. the Sex Offenders Act

vi. statutory requirements of professional regulation (including up to date registration status of professional staff.)

i. There is a trust policy on the Mental Health Act.

v. The trust dealt with this matter in May 1999.
There are developing arrangements for ensuring that the interests of young patients are safeguarded at the Harvey Jones Unit. Many of these have been devised since the 1998 review visit and remain still to become firmly embedded in everyday practice. The unit still experiences some feelings of instability due both to recent history of high staff turnover and also to future uncertainty induced by continuing reorganisation in the NHS in Wales. Overall, however, the unit is a safer place than in 1998.

The trust has produced a 'whistle-blowing' procedure and staff, of all grades, are advised by it to report their concerns direct to the chief executive of the trust. On the broader front staff feel encouraged to express their views and this leads to frank and open discussion during reviews and supervision. Staff also feel able to seek advice from outside the unit if necessary.
6. MULTI-DISCIPLINARY AND MULTI-AGENCY WORKING

6.1 STANDARD There is commitment at all levels to co-ordinating the care and education for adolescents. Health, social, education and independent sector agencies work in close collaboration. The continuum of care should include the transition to adult services; prevention, acute care, continuing care and rehabilitation should be regarded as part of the same spectrum.

6.1.1 Criterion There is evidence of good communication and joint working between relevant National Assembly for Wales Groups and Departments.

(This criterion is not considered to be relevant to this unit report.)

6.1.2 Criterion National Assembly for Wales policy and guidance relating to the care of children and adolescents is consistent and avoids 'perverse incentives'.

(This criterion is not considered to be relevant to this unit report.)

6.1.3 Criterion The National Assembly for Wales keeps joint planning for children's services under review to ensure that the Audit Commission's recommendations in "Seen but not heard" are addressed.

(This criterion is not considered to be relevant to this unit report.)

6.1.4 Criterion The health authority has designated a senior officer, with recognised experience in children's issues to be responsible, in liaison with GP fundholders, for commissioning all health services for adolescents. This person plays a key role in ensuring that care is co-ordinated.

The Bro Taf Health Authority has designated the director of public health as responsible for taking forward the strategy for CAMHS. A Development Officer for Mental Health Provision has also been appointed. The post responsibilities are divided 50/50 between CAMHS and the development of the adult service.

Bro Taf Health Authority has produced a draft framework document for CAMHS (October 1999). This is the culmination of a review of CAMHS by members of a multi-agency project group commissioned by the health authority. A final draft is to be produced, in line with guidance form the National Assembly for Wales in respect of CAMHS generally, throughout all sectors, agencies and tiers of the service.
The health authority has also restructured internally and as a result have created a Children's Team which brings together all health services for children, under one directorate. This has been welcomed and has led to improved co-ordination. The Children's Team are currently examining links with adult mental health.

**6.1.5 Criterion** When services are provided by several providers, the health authority contracts with one provider to oversee the service, sub contracting as necessary.

CAMHS inpatient services are managed at the Harvey Jones Unit by the Cardiff and District Community NHS Trust. However, the commissioning of the Harvey Jones Unit is problematic for both the health authority and the trust. The unit effectively provides a service for much of South Wales, but it is funded almost entirely by Bro Taf Health Authority. A small amount of revenue has now been provided on a recurring basis by two other South Wales health authorities and on a non-recurring basis by a third health authority. This is not sufficient to reflect the pattern of use of the service and the impact of this additional finance is further eroded by high capital charges which accrue due to the location of the Harvey Jones Unit. In practice the review team were informed that only 60% of any incoming revenue is actually devoted to meeting the running costs of the treatment programme.

There is a pressing need for more equitable and secure funding of the Harvey Jones Unit, for example legitimising its role as a de facto regional unit. A strong lead from the National Assembly for Wales would likely be needed for this to happen. The review team concluded that a regional funding mechanism for the unit would then allow Bro Taf Health Authority to re-allocate those funds recouped by more equitable arrangements into the development of community CAMHS.

**6.1.6 Criterion** The health authority, local authority and voluntary organisations have considered ways to improve joint action at all levels, particularly in:

i. defining and assessing need;
ii. prioritising between needs;
iii. identifying the adolescents concerned;
iv. planning services.

The Cardiff and District Community NHS Trust has undertaken a comprehensive review of CAMHS (June 1999). This document sets out a business case for the further development and strengthening of the Harvey Jones Unit within an enhanced CAMHS service. The document does not specify the level of consultation or the expectations of collaboration and joint action with other agencies. However, the review team considered that there was much work still to do in this area, as other agencies continue to express concern at the 'isolation' of the Harvey Jones Unit and its irrelevance to their own plans and provision.

**6.1.7 Criterion** The health authority has produced a local strategy for health which includes services for adolescents.
The health of children and adolescents, including issues of adolescent mental health, are included in the Bro Taf interim Health Improvement Programme (HImP) for children. The health authority has had three different chief executives during the past 18 months. Each of these has had a commitment to prioritising services for children, as demonstrated by the development and continuing implementation of a combined child health service specification. However, there was also a perception that some uncertainty in direction had resulted from these changes in leadership. The present incumbent is seen as providing a more secure lead.

Local health groups (LHGs) were established in April 1999. They are coterminous with the unitary authorities and all LHG Boards have senior officer representation from local social services departments. The LHGs have all created children's services teams at local level and these are contributing to the identification of need and the planning of services. LHGs confirmed their commitment to reaffirm a vision for CAMHS in their communities. LHGs and representatives of the Local Medical Committee also participate fully in the development of child protection services through involvement with local ACPCs.

The existing continuing care policy document makes no direct mention of the needs of young people with mental health problems. It is necessary to extrapolate these from the general principles stated.

It was reported that the joint agreement had recently been revised after 3 years and now includes adolescents.

---

6.1.8 **Criterion** The health authority has ensured that GPs (fundholders and non-fundholders) have been full and active participants in the planning of adolescent services.

6.1.9 **Criterion** Health and local authorities and GP fundholders have published joint and continuing care agreements which include adolescents.

6.1.10 **Criterion** The health and local authority have agreed respective responsibilities for meeting the continuing care needs of adolescents and arrangements for hospital discharge.

(Each year they should confirm jointly their best estimates of the likely number of the children / young people who will need continuing health and social care and their respective commitments in terms of finance and activity.)

6.1.11 **Criterion** Local authorities have consulted fully health authorities about the local Children's Service Plan.

92
It was generally reported that the inter-agency context remained difficult, especially at a higher strategic level. Health authority and trust officials reported improved levels of consultation and communication at operational and middle management levels. Unitary local authorities in the Bro Taf area have reviewed and updated their Children's Services Plans for the year 1999/2000. This is good evidence of active inter-agency work and commitment to these plans. Apart from the plan for Rhondda Cynon Taff County Borough, the plans say little about CAMHS services. The Bro Taf draft strategy for CAMHS is seen as an important milestone document and future developments may need to await the outcome of subsequent discussions on its implementation.

Officials in both health and social services felt that true joint planning still remained to be achieved. Whilst being enjoined by the National Assembly for Wales to ensure 'inclusivity' in any approach to planning and service delivery, local mechanisms to achieve this are still buffeted by constant changes of remit, boundaries and personnel.

**6.1.12 Criterion**

Agencies agree respective responsibilities for financial contributions for meeting care needs.

As noted in 6.1.5 the work of the unit is predominantly funded by the Bro Taf Health Authority with some contribution from other South Wales health authorities. There is no financial contribution to the unit from the local authority social services sector. The Cardiff Education Authority provides funding for the greater proportion of the present complement of teaching staff, although Bro Taf has had to contribute in order to sustain a viable education service.

It has proved exceptionally difficult for the health authority to engage the relevant unitary authorities in any agreement on the funding of the social work post by the local authority sector. Authorities agree that in present circumstances of constrained resources for children's social services, they are unable to prioritise funds to support activities at the Harvey Jones Unit. Their general perception is that the Harvey Jones Unit is not used as a treatment resource by their child care staff. Again, the view that the unit operates on a de facto regional basis also militates against any sympathetic response to funding requests from individual local authorities.

**6.1.13 Criterion**

Good quality and sensitive arrangements are in place for transferring responsibility for a young person's care between agencies and between different parts of the NHS.

The transfer of young people between different services within the NHS appears to be acceptable and parents confirmed their satisfaction with these arrangements. There does appear to be some conflict between written agreements and what is reported in relation to inter-agency transfers.

**6.1.14 Criterion**

Good liaison ensures that, if the change from child to adult services occurs at different times for the various agencies involved and for particular aspects of health care, good liaison between services ensures that problems and difficulties are minimised.

The review team concluded that these arrangements were generally satisfactory.
As noted, there have been reconfigurations of trust boundaries and responsibilities since the 1998 review and further changes are planned. This has affected the ability to maintain momentum in the planning process. It was felt that there had been a degree of blight in the planning and decision making processes. The Bro Taf Health Authority and Cardiff and District Community NHS Trust have been working hard, however, to minimise these effects.

Information about services, in variable format, is available in Children's Services Plans and directories.

Child protection has been the only area of training available to Harvey Jones Unit staff which has inter-agency significance. However, as noted under 3.4, this has primarily been delivered on a single agency basis.

There are difficulties in the provision of education with a significant loss of educational resource. Several years ago the educational unit was designed as a school with a complement of three full-time teachers. There is now one permanent full-time teacher, plus one full time temporary (2 terms) teaching post which is funded jointly by the education authority and Bro Taf Health Authority pending a more permanent solution. This uncertainty regarding the teaching complement has created a difficult situation for all.

The physical environment in which teaching and learning is experienced remains satisfactorily arranged and resourced.

An official from the education department confirmed that their department is under financial pressure. Numbers of students at Harvey Jones Unit are sometimes low and some of the adolescents are over 16 years old and thus do not attract support funding by their home local education authorities. It was reported that even for those patients under 16 years, local education authorities try to argue over payment.
The education official felt that the relationship between education, the health authority and the Harvey Jones Unit should be improved and become more collaborative so that a more creative solution could be found. If it was agreed that two teachers were required in order to provide continuity, flexibility and a range of subjects, then it might be possible to access their expertise for the wider use of the education department. It was noted that it could be difficult if non-patients were to attend the unit, but perhaps the teaching staff could assist at other schools, particularly if numbers at Harvey Jones were low.

Despite this uncertain background, the teaching staff appear to remain well committed and enthusiastic with impressive work displays by their students in evidence. The teachers also play a full role in the management of the unit and care planning.

| 6.3   | STANDARD | There is effective multi-disciplinary work within the residential units. |
| 6.3.1 | Criterion | The different disciplines are clear regarding their roles in the assessment and treatment process. |
| 6.3.2 | Criterion | The different disciplines are clear regarding how they contribute to the ongoing development of the service. |

There has been a serious dilution of the multi-disciplinary provision at the unit, following the retirement of the social worker and the departure of the psychologist. These posts were not filled. The health authority has funded a social worker post until April 2000. The post was filled in August 1999 by the secondment of a member of social work staff from the Preswylfa Child and Family Centre. The social worker has contact with social services area teams, but does not undertake any general liaison or public relations work with local authorities. The reason given for this is the number of authorities involved. She deals with these on a case by case basis.

The unit is committed to multi disciplinary working, but this has been difficult to sustain. High levels of uncertainty remain in this area, given the reluctance of other health authorities and agencies outside the health sector, to contribute.
The gap in social worker provision appears to have affected communication with respect to individual patients admitted to or discharged from the unit. Although the reintroduction of the social worker has begun to improve matters, local social services departments claimed to be unaware of some admissions and discharges.

<table>
<thead>
<tr>
<th>6.4</th>
<th><strong>STANDARD</strong></th>
<th>There is effective multi-agency co-operation over the treatment and care of individual adolescents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4.1</td>
<td><strong>Criterion</strong></td>
<td>The various agencies involved with a particular adolescent co-ordinate and communicate in a way which facilitates each other’s good work, in particular with reference to admission, discharge and after-care.</td>
</tr>
<tr>
<td>6.4.2</td>
<td><strong>Criterion</strong></td>
<td>There are proper arrangements, for ongoing care planning with the appropriate social services department, when a young person in a unit is:</td>
</tr>
</tbody>
</table>

i. a child "looked after" by a social services department;

ii. a child "accommodated" by the health authority unless detained under any provision of the Mental Health Act;

iii. a young person aged over 16 years who needs aftercare (Section 24 [2].)
7. DESIGN AND SAFETY OF ENVIRONMENT

7.1 STANDARD Adolescent units have implemented the recommended standards for the safety and security of patients.

The building is secured by staff on duty at the front entrance and reception area. The front door is locked at night. The unit is accessed by coded keypad.

7.2 STANDARD Inpatient psychiatric units which accommodate adolescents meet modern standards for design and quality of environment provided (including privacy and security.)

7.2.1 Criterion Adolescent wards are specifically designed with facilities for separate toilet areas, space for recreation and education and access to a telephone.

There are separate WCs for young men and women, a recreation room and good recreational facilities. Patients have use of a trolley telephone which can be taken into private areas if necessary.

7.2.2 Criterion Patients all have the option of having a single room.

Not all patients have access to single rooms. There are two four-bedded dormitories. Two single bedrooms have been redesigned to incorporate ensuite bathing and toilet facilities.

7.2.3 Criterion The layout of the unit enables adequate supervision as determined by the degree of disturbance of the patient.

The unit presents a room and corridor layout which is conducive to high supervision levels if required. The unit is continuing to adapt structurally to meet various dependency needs, for example with the two self-contained single bedroom suites and the room which has been adapted for young people who require restraint in conditions of privacy.

7.2.4 Criterion The layout of the unit and the regime adopted should allow for a degree of privacy appropriate to the mental state of the patient. This includes sensitivity to gender issues including the provision of separate toilet and washing facilities.

There is obviously limited privacy offered to those young people occupying the dormitories, although some screening appears superficially effective. Visiting parents complained strongly about arrangements for meetings with their children.
Compared to the situation at the 1998 review there was much evidence of upgrading of the living accommodation and general milieu of the unit. There were welcome improvements in the decorative condition and the furniture.
APPENDICES
Appendix 1 - Specification for the project
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES
RESIDENTIAL UNITS IN WALES:

A REVIEW OF
SAFEGUARDS AND STANDARDS OF CARE

Specification for a Review by HAS 2000

18 November 1999
1. Background

In June 1998, HAS 2000 were invited by the Secretary of State for Wales to conduct a review of residential child and adolescent psychiatric services in Wales. When publishing the findings of the review team the Secretary of State announced that he intended to ask health professionals from the Welsh office to conduct a series of visits to check compliance with the issues identified by HAS 2000 as requiring early attention. He also stated that he intended to invite HAS 2000 to undertake a further inspection of the same Units towards the end of 1999 to report on progress in implementing the longer term recommendations contained in the HAS report dated September 1998. On 1 July 1999 the Secretary of State transferred responsibility for these functions to the National Assembly for Wales. The terms of the review have been discussed and agreed between representatives of HAS 2000, the relevant Health Authorities and NHS Trusts and the Welsh Office.

2. Purpose of the review

The purpose of the review is to:

2.1 Report on the progress in implementing the recommendations contained in the HAS report dated September 1998 for proper safeguarding and standards of care for children and adolescents receiving treatment in line with that set out in the "Health of Children in Wales" for children and young people from Wales, who are receiving in-patient psychiatric care.

The review will consider other services, such as social services, primary health care, other child mental health services and the independent sector only from the perspective of the needs of young people in the residential units.

The review will cover the following areas:

Admission Policies

1. The admission arrangements for young people (under 18 years) in Wales who have mental health problems of a severity sufficient to require in-patient care.
Staffing

2. Adequacy of staffing in terms of:
   i. Staffing numbers (including at night and weekends).
   ii. Staffing mix (in terms of grade, gender and input from different disciplines).
   iii. Training of staff to work with children.

Child Protection and Treatment of Abuse

3. Policies, procedures and practice relating to:
   i. Working with children who have a history of abuse (as survivors or abuser).
   ii. The handling of allegations of abuse against staff, other patients or visitors, including contact visits by relatives and friends.
   iii. The safety of young people on site, leaving the sites unaccompanied (including obtaining clear parental consent for this) and at weekends.
   iv. The interplay of child protection, disciplinary, complaints and criminal investigation procedures.

The views of young people

4. How the views of young people, and their families are incorporated into the planning and delivery of care on an individual basis and in a wider context.

Safeguards

5. Policies, procedures and practice relating to:
   i. Access by young people to the NHS complaint procedure, advocacy and support.
   ii. The safeguarding of young people who are voluntary patients, including periods when they are not on the Unit with specialist CAMHS staff looking after them.
   iii. Care and responsibility.
   iv. Notifying social services of children accommodated by the NHS. (The impact of the closure of Child and Adolescent Mental Health Services (CAMHS) facilities at weekends will be assessed in terms of the effect of safeguards and standards of care).
   v. The implementation, when appropriate, of lessons from recent developments aimed at safeguarding children living away from home in local authority care.
vi. The selection and vetting of staff.

vii. Control and administration of drugs.

viii. Compliance with Statutory requirements and other Directives, including:

- The Mental Health Act 1983;
- The Children Act 1989;
- The Nurses, Midwives and Health Visitors Act 1997;
- The Medicines Act 1968;
- Welsh Office Circulars.

Multi-disciplinary and Multi-agency Working

6. Adequacy of access to:

i. Primary health care including health visitors, general practitioners and dental services.

ii. Other child health services such as paediatric and school health services.

iii. An independent visitor and other advocacy services.

iv. Other agencies including social services and education.

v. Multi-disciplinary and multi-agency care planning and management (including these in-patients who are concurrently in local authority care and those whose home is distant from the provider services).

Safe environment

7. Standards for design and quality of environment provided (including privacy and security) and safety for young people including young women in mixed Units and young people of both sexes in adult settings for part of the time.

Adolescents and Adult Wards

8. The main focus will be on the 2 CAMHS residential units in Wales. However, the review will also consider some of the above issues in relation to young people admitted to a sample of adult psychiatric wards to ensure that safeguards staffing and standards of care are appropriate.

3. Conduct of the Review

The HAS 2000 will review the CAMHS residential units in Wales, against the set of standards developed and applied during the 1998 review. HAS 2000 will also take into account the findings of the Review Team during its inspection in 1999 and visits made by Assembly officials during 1999 to CAMHS units and other psychiatric wards that occasionally accommodate adolescents.
Although the review is not intended to cover the whole of CAMHS provision, it would be incomplete if it did not consider the wider context in which in-patient care is provided. Issues such as the quality of joint planning and inter-agency working; the extent to which the views of young people and parents influence service planning; and delivery and the exercise of statutory duties cannot be adequately evaluated if a review is confined to local practices of junior staff within a single care setting. Some standards will therefore relate to the activities of senior managers in the trusts, health authorities and local authorities. This aspect of the work will be informed by the policy and procedure documents as well as information gathered at meetings and interviews.

There will be 4 components (or overlapping stages) to the review.

3.1 Definition of Standards

The standards used in the 1998 review will be supplemented by an analysis of new guidance from and agreed with the National Assembly for Wales in advance. Copies of the 1998 standards and the supplementary analysis will be provided to the National Assembly for Wales, the health authorities and the NHS Trusts.

3.2 Gathering of Information

A complete set of relevant policies and procedures from the National Assembly for Wales and from health authorities, trusts and local authorities involved in the care of young people who might be admitted to one of the 2 residential units or the sample adult wards will be collected.

It should include local plans for children in need, appropriate service plans produced by the local authorities and the health authorities' Local Strategy for Health and continuing care agreements produced jointly by health and local authorities and local health groups.

This stage will be completed by 10 December 1999.

4. The Review Visits

The review teams will visit:

• Cedar Court, in North Wales, which is managed by Conwy and Denbighshire NHS Trust;

• The Harvey Jones Unit at Whitchurch Hospital in South Wales, which is managed by Cardiff and District Community NHS Trust;

• The Hergest Unit of North West Wales NHS Trust, which is an acute adult psychiatric ward to which adolescents are occasionally admitted; and

• Ward East 2A at Whitchurch Hospital also managed by Cardiff and District Community NHS Trust.

• Meetings will also be held with health care purchasers;

• and the National Assembly of Wales.
A multi-professional team will be recruited for the review. This team will comprise senior and experienced people and will include a:

i. social care worker with detailed knowledge of child protection issues;
ii. consultant child and adolescent psychiatrist;
iii. paediatrician (not a visiting member of the team);
iv. senior nurse with adolescent mental health expertise; and
v. health visitor with child protection expertise.

The team will be the same as that which conducted the 1998 review. It is a requirement that all members of the inspection team have undergone a police check and have been checked against the Consultancy Index held by the Department of Health.

Any unplanned changes to the team will be agreed with the National Assembly for Wales. The team will be supported by a HAS 2000 service development adviser (SDA) and review administrator. Dr Paul Lelliott, Joint Chief Executive of HAS 2000 will also be a member of the team but will not necessarily be present throughout the entire period of the Review. The Review Administrator will liaise with a named local contact person in each site. Interviews will been conducted with key people (senior managers of health authorities, local authorities and trusts) and visits made to the 2 residential units and the sample adult wards. The SDA will be responsible for briefing and training the Review team, including briefing on key issues derived from their analysis of policy and procedure documents.

5. **Timing**

The visits and interviews will take place between 28 November and 3 December, 1999 after which a draft report will be compiled.

The Review Team will meet and interview key staff from relevant organisations, including meetings with the young people who receive care at the units and, when appropriate, their families.

Without compromising rigour or objectivity, HAS 2000 will endeavour to conduct the Review in a way local workers perceive as being constructive as well as expert.

The mechanism agreed between all agencies involved in the 1998 inspection for referring to the appropriate authority any allegation of abuse received by the Review Team will also be used during this inspection.

6. **Presentation**

The final Report for the National Assembly for Wales should be written in the expectation it may be published. A draft final report will be presented to Assembly officials in January 2000. The final report will be completed by 1 March 2000. As the report will be published in bilingual form, there will need to be close liaison between HAS and National Assembly officials in February 2000 about translation arrangements.
7. **Costs**

Detailed costings are given in the attached schedule. Payment will be 50% on agreement of the specification for the Review; and 50% on delivery of the final report.

8. **Monitoring**

The National Assembly for Wales will convene a Project Board to liaise with HAS 2000 and oversee the contract. A meeting will be arranged between the National Assembly for Wales and HAS 2000 before the field work stage to ensure the Review Team are satisfied with the arrangements for visits and interviews. The HAS, or the National Assembly for Wales, may request additional meetings where necessary. The HAS undertake to inform the National Assembly for Wales immediately if any factors requiring urgent attention come to light during the Review.
Appendix 2 - HAS 2000 Standards for Child and Adolescent Health Services Residential Units in Wales: Review of Safeguards and Standards of Care (including addenda)
CHILD AND ADOLESCENT MENTAL HEALTH SERVICES RESIDENTIAL UNITS WALES:

A REVIEW OF SAFEGUARDS AND STANDARDS OF CARE

STANDARDS TO GUIDE THE REVIEW TEAM

DRAFT 4: 27/11/99

This set of standards is still a draft. In its current form it is not intended as a complete statement of standards for CAMHS residential units but as a guide for the review team.

Standards and criteria marked with an asterisk * are considered by the review team to be of such breadth that it may be difficult for the team to make definitive statements about the extent to which they are met on the basis of the review visit. The team will, however, seek information about the issues to which they refer.

Dr Paul Lelliott
Joint Chief Executive - The Health Advisory Service
VALUES AND PRINCIPLES

These statements have been developed bearing in mind:

The Rights of the Child (UN Convention):

"A mentally ... Disabled child should enjoy a full and decent life in conditions which ensure dignity, promote self-reliance and facilitate the child's participation in the community" (Article 23)

- Non-discrimination in terms of race, religion and culture etc.
- Best interests of the child to be considered;
- Rights to privacy;
- Access to information relating to him/herself;
- Protection from exploitation, including sexual abuse and drugs;

and the Children Act 1989:

- The welfare of the child is paramount;
- The child should be brought up in his/her own family wherever possible;
- Parents with children in need should be helped. Help should be given in partnerships with parents to meet each child's individual needs;
- Children should be protected for abuse by effective intervention;
- Children should be informed about what happens to them and participate in decision making when appropriate.
1. **INPATIENT PROVISION AND ADMISSION POLICIES**

1.1 **Standard:** Adolescents are admitted to hospital only if the care they require cannot be provided as well at home, in a day clinic or on a day basis.

   1.1.1 **Criterion:** There is adequate, local provision of a range of domiciliary, community and day services so that adolescents are not admitted inappropriately.

      *(Are adolescents admitted, or kept in hospital, because of inadequate local resources?)*

   1.1.2 **Criterion:** There are clear written admission criteria which emphasise that adolescents are admitted only if the care they require cannot be provided at home, in a day clinic or on a day basis:

      (admission criteria encompass:

      i. psychiatric severity and condition

      ii. potential scope for intervention)*

      *(if a unit ever admits children under the age of 11, admission policies should pay particular regard to this)*

1.2 **Standard:** There is adequate provision for NHS in-patient treatment of adolescents who require it. Such facilities are staffed by those with experience of treating adolescents with such disorders.

   1.2.1 **Criterion:** There is adequate provision for specialised services to meet the needs of adolescents with a full range of psychiatric illnesses (including those with eating disorders and those who need long-term psychiatric care)

   1.2.2 **Criterion:** There is provision, or arrangements for provision can be made when needed, for those who require secure mental health care.
1.2.3 Criterion: Adolescents referred to these units, whose needs would be best met by admission, are not turned away on resource grounds.

Criterion: There are not unacceptable delays between referral and assessment or between assessment and admission of adolescents to these units.

Criterion: Where units close at weekends, appropriate arrangements are made for the patients.

Criterion: No young person under the age of 16 is admitted to an adult psychiatric inpatient unit unless there are major extenuating circumstances. Such admission should be negotiated by a consultant child and adolescent psychiatrist.

1.3 Standard: Hospital units to which adolescents are admitted are easily accessible to families without need to travel significantly further than to other similar amenities.

1.3.1 Criterion: Adolescents and families are able to access the service.

1.3.2 Criterion: The service acknowledges access difficulties and provides appropriate assistance. This should include special arrangements being made for families to be able to stay close to the adolescent unit overnight when this is appropriate.

1.4 Standard: Accommodation and facilities are appropriate to the needs of adolescents.

1.4.1 Criterion: Adolescents units are separate from both adult and children's units.

*(see also standards 7.1 and 7.2)*
1.5 Standard: NHS inpatient settings to which adolescents are admitted follow Section 85 of the Children Act 1989.

1.5.1 Criterion: NHS trusts have, and comply with, procedures for their duty to inform the responsible SSD when it is intended to provide or accommodation is provided for a child, by a child and adolescent mental health service, for a consecutive period of at least 3 months, and when such a child leaves the accommodation.

(Section 85 is not expected to apply to children who go home at the weekend)

1.6 Standard: NHS trusts take all reasonable steps to ensure that relevant local agencies know under what conditions, and how the NHS adolescent residential units can be accessed in an emergency.

1.6.1 Criterion: There are written instructions in all local settings where emergency psychiatric assessments are made, eg accident and emergency departments, about the appropriate referral of adolescents who may need emergency psychiatric care.
2. STAFFING

2.1 Standard:  NHS inpatient units for adolescents are adequately staffed.

(At the time of drafting these standards the review team were not aware of any authoritative statement about staffing levels. The review team will however be guided by a draft report prepared by a working party of the Royal College of Psychiatrists - this included reference to minimum staffing levels, including at night.)

2.1.1 Criterion:  Staffing comprises a core multi-professional team consisting of: psychiatrists, including a senior psychiatrist fully trained in child and adolescent psychiatry; psychologist(s) and nurses who are appropriately trained (see standard 2.2). There are effective arrangements for the involvement of social workers, whether or not they are members of the core team. Units also employ staff from other professional backgrounds (eg. OT, art therapists, psychotherapists etc) depending on the therapeutic culture of the unit.

2.1.2 Criterion:  Staff numbers are sufficient to provide a wide range of short, medium-term psychotherapy and psychiatric treatments.

2.1.3 Criterion:  There is sufficient flexibility in staffing numbers to accommodate the changing dependency needs of adolescents accommodated in the facility.

2.1.4 Criterion:  Staff are managed effectively in order to support the purpose and function of the unit. Lines of accountability are clear and working practices maximise continuity of care.

2.1.5 Criterion:  There is evidence of regular and effective staff support and supervision.
2.2 **Standard:** The nursing staff working on inpatient units for adolescents are appropriately trained.

2.2.1 **Criterion:** There is at least one nurse holding the RMN qualification on duty at all times.

2.2.2 **Criterion:** *Ideally* nurses have taken a recognised post basic nursing course in child and adolescent psychiatric nursing (ENB603). It is essential that those nurses working in a senior nurse manager capacity have this additional qualification.

2.2.3 **Criterion:** There should be nursing staff holding the RSCN or Project 2000 child branch qualification within the nursing team.

(The "Health of Children in Wales" [pp. 94-95] states that "there should always be at least two nurses - holding the RSCN or Project 2000 Child Branch qualification - on duty in hospital children's departments and wards" and goes on to say that "the standard relating to nurses having the skills to care for children also applies to mental health").

2.2.4 **Criterion:** The National Assembly for Wales ensures that the shortfall in numbers of RMNs qualified to specialise in paediatric psychiatry is addressed by increased funding for the Diploma in Child and Adolescent Psychiatry.

2.3 **Standard:** All staff in contact with adolescents have some training to ensure an appropriate level of awareness of the needs of adolescents.

2.3.1 **Criterion:** All professional staff are trained in the skills necessary to work effectively in partnership with parents. These skills include the ability to counsel parents effectively.

2.3.2 **Criterion:** All staff in contact with adolescents are trained, and updated, in awareness of the predisposing risk factors which may lead to abuse, and are continually alert to the circumstances in which adolescents might be harmed.

2.3.3 **Criterion:** Health service professionals understand, and are familiar with, the procedures for recognising and dealing with abuse.
3. CHILD PROTECTION, MANAGEMENT OF ALLEGATIONS/SUSPICIONS AND PARTICIPATION IN INTER-Agency PROCEDURES.

3.1 Standard: NHS adolescent inpatient units are aware of the child protection status of adolescents admitted.

3.2 Standard: The health authority takes the strategic lead for health on inter-agency working on child protection matters and co-operates with other agencies in planning, purchasing and monitoring services under the Children Act, 1989.

3.2.1 Criterion: The health authority has identified a senior doctor, senior nurse with a health visiting qualification and a senior midwife as the "senior professionals" on ACPC and to co-ordinate all aspects of child protection within the district.

3.2.2 Criterion: Child protection is included in contracts agreed between the HA and NHS trusts and monitoring programmes have been set up to satisfy themselves that procedures are followed.

3.3 Standard: NHS trusts ensure that systems are in place which enable the trust and its staff to comply with local ACPC procedures and with those in "Working Together under the Children Act".

3.3.1 Criterion: Each NHS trust providing child health services has identified a Named Professional (doctor and nurse/midwife) for child protection matters who is responsible for ensuring child protection supervision on a regular basis and day to day advice and support.

3.3.2 Criterion: Trusts and individual departments have in place robust policies and procedures which are compatible with ACPC guidelines, including the conduct of Part 8 reviews. These are dated, indicate when and by whom they will be reviewed and their effectiveness is monitored.

3.3.3 Criterion: Local ACPC guidelines, Working Together under the Children Act, Clarification of Arrangements, Medical Responsibilities and Guidance to Senior Nurses are available and accessible to all staff members.
3.4 Standard: NHS trusts have an implemented strategy for child protection education and training which considers the needs of all staff who are likely to come into contact with children, or families of children. The strategy should identify the training appropriate to the roles of staff groups including the need for updating and clinical supervision (see also 2.3.2).

3.4.1 Criterion: Child protection is a standards item of induction of new staff

3.4.2 Criterion: There is single agency training specific to the new area of work involved.

3.4.3 Criterion: Inter-agency training relates to indications of abuse recognition, referral and participation in inter-agency procedures.

(It is recommended that "agencies should establish joint annual training programmes on child abuse issues with access for all professional groups in direct contact with children and adolescents!).

3.5 Standard: Where there is actual or suspected abuse within an establishment accommodating adolescents, a process of investigation, assessment and planning on an inter-agency basis is carried out.

3.5.1 Criterion: There are procedures in place handling allegations of abuse against staff, other patients or visitors, including contact visits by relatives or friends.

3.5.2 Criterion: The unit follows the procedures for working together in individual cases produced by their local ACPC.

3.5.3 Criterion: When a case of abuse leads to death, or a child protection issue of public concern, the unit co-operates with the ACPC in conducting a review.
3.5.4 Criterion: The unit informs the National Assembly for Wales if there is reason to believe that an offence has been committed against a patient by a member of staff or by a carer.

3.5.5 Criterion: The possible implications for other adolescents in the establishment are always considered and protection plans actioned whenever necessary. This includes the protection of adolescents from abuse by other adolescents and allegation or suspicions of abuse by one adolescent concerning another adolescent, being dealt with through the usual inter-agency procedures.
4. THE VIEWS OF ADOLESCENTS AND THEIR FAMILIES

4.1 Standard: The views of adolescents, and their families influence the planning and delivery of services and the environment in which care is given.

4.1.1 Criterion: Mechanisms are in place to achieve this and are effective

4.2 Standard: The rights of the adolescent are heard and respected.

4.2.1 Criterion: Adolescents receive such information about all aspects of their diagnosis, treatment and changes to treatment as is appropriate to their age and understanding.

(eg. explanation of reason for admissions, written information about medication, role of staff members etc.)

4.2.2 Criterion: Adolescents are able to communicate in the language of their choice and receive information in that language.

(There is access to an interpreter when needed, communication aids are available as required.)

4.2.3 Criterion: Adolescents are fully informed and counselled about their rights under the Children Act and as patients according to the Patient's Charter.

4.2.4 Criterion: Adolescents are given information about help-lines.
4.3 Standard: The adolescent and his/her family are fully consulted and involved in making decisions which affect the life of the adolescent involved.

4.3.1 Criterion: Adolescents play an appropriate and active role in making decisions about their care at every stage from assessment to diagnosis and treatment, and their views are recorded.

(eg. opportunities for adolescents to have their views heard at team meetings, adolescents involved in care planning.)

4.3.2 Criterion: Parents are involved with the planning of care at every stage from assessment to diagnosis and treatment, and their views are recorded. Parents also have the chance to discuss their worries with the health professionals treating their child. The way this is done must take account of the young person’s age and right to confidentiality.

4.3.3 Criterion: Adolescents know who their key worker/primary nurse is.

4.3.4 Criterion: Due regard is taken in care planning for adolescents of their ethnic, religious and cultural backgrounds.

4.4 Standard: Treatment is conducted within the appropriate legal framework

4.4.1 Criterion: The consent of the adolescent and parent/guardian is (whenever possible) obtained to treat adolescents under the age of 16 years.

4.4.2 Criterion: Treatment provided without the consent of the adolescent occurs within the context of the appropriate legal framework.
5. SAFEGUARDS

5.1 Standard: The rights, guarantees and standards of care, set out in The Children and Young Person's Charter, are applied for adolescents, parents, families and carers of adolescents.

Those not explicitly covered by other standards/criteria are:

i. parents' right to visit ward before admission;

ii. parents told before admission about education which adolescents of school age will receive if they stay for a long time;

iii. choice of food "from a children's menu which is healthy and suits all dietary needs"

iv. right to wear own clothes;

v. involvement in decisions about discharge planning including knowing the name of workers involved in follow up.

5.2 Standard: Adolescents and their parents/carers have full access to the NHS complaints procedure.

5.2.1 Criterion: Adolescents, and their parents/carers receive written information about how to complain written in a form and language they can understand.

5.2.2 Criterion: There are arrangements for monitoring the incidence and outcomes of complaints.

5.3 Standard: Adolescent patients are made aware of how to access advice and support from outside the unit.

5.3.1 Criterion: There is access to telephone helplines.

5.3.2 Criterion: There is access to independent advocacy services.

5.3.3 Criterion: Adolescents are informed of the telephone number of the appropriate social services department.
5.4 Standard: There are procedures for the management of violent or potentially violent patients, including whether control and restraint is to be used, and, if so, how it is to be applied.

5.4.1 Criterion: There is a trust policy on management of aggression.

5.4.2 Criterion: Staff are appropriately and sufficiently trained to comply with trust procedures and their competence is regularly checked.

5.4.3 Criterion: Systems are in place for monitoring the use of procedures for the management of violent or potentially violent patients and for reviewing practice.

5.5 Standard: There are policies determining the unit staff's response to unacceptable behaviour by adolescents.

5.5.1 Criterion: These measures are not in contravention of the rights of the patient.

5.6 Standard: There are policies and procedures regarding patients absence with or without permission.

5.6.1 Criterion: For every patient there is documented decision making regarding leave status. This is informed by a risk assessment.

5.6.2 Criterion: There is evidence parent/carers have been involved in these decisions.

5.6.3 Criterion: There is an effective missing persons procedure and effective practice for their return to the unit.
5.7 **Standard:** Liaison with social services ensures that the welfare of adolescents resident in health care establishments is addressed in accordance with the Children Act 1989.

(Guidance on Section 85 of the Children Act states that social services departments should be cautious about exposing a child to a regime where sedation is used to control behaviour in any case and should be very cautious when major tranquillisers are involved.)

5.7.1 **Criterion:** Bilateral agreements exist which set out parameters for possible treatments for adolescents covered by Section 85 of the Children Act or otherwise the responsibility of the local authority.

5.8 **Standard:** The selection and vetting of staff follow the procedures described in LAC (93)17/WOC 54/93 and are consistent with the recommendations of the Warner and Utting reports.

5.8.1 **Criterion:** Effective procedures are in place to ensure disclosure of criminal background of those with access to adolescents.

5.8.2 **Criterion:** There is evidence of a strong emphasis on a principles-led approach to staff recruitment and selection - no 'quick fixes' or 'cutting corners'.

(In addition the Clohtier report recommends that:

i. for all those seeking entry to the nursing profession, in addition to routine references, the most recent employer or place of study should be asked to provide at least a record of time taken off on grounds of sickness;

ii. nurses should undergo formal health screening when they obtain their first posts after qualifying.)
5.9 Standard: Clinical staff participate in clinical audit.

(Might include audit of the use of medication, adverse events; application of evidence-based practice).

5.10 Standard: UKCC standards relating to the control and administration of drugs are applied.

5.11 Standard: There are procedures in place to ensure that statutory requirements are complied with, including:

i. the Mental Health Act (also guidance on the supervision register)

ii. the Children Act

iii. the Nurses, Midwives and Health Visitors Act

iv. the Medicines Act

v. the Sex Offenders Act

vi. statutory requirements of professional regulation (including up to date registration status of professional staff.)

5.12 Standard: There is evidence at all levels that the lessons, from recent developments aimed at safeguarding adolescents living away from home in local authority care, are being considered and applied in this NHS residential setting (including Warner, Utting and the Report of the Examination Team on Child Care Procedures and Practice in North Wales.)

5.12.1 Criterion: There are effective in-house and external monitoring arrangements for detecting problems identified by recent reports into the care of adolescents in residential care.

5.12.2 Criterion: There is evidence of open and frank communication between staff. Management encourages this and combats anti-staff cultures. There is a willingness to accommodate 'whistle-blowing' and staff are encouraged to communicate concerns and are afforded full legal and employment protection when acting in good faith.
6. MULTI-DISCIPLINARY AND MULTI-AGENCY WORKING

6.1 Standard: There is commitment at all levels to co-ordinating the care and education for adolescents. Health, social, education and independent sector agencies work in close collaboration. The continuum of care should include the transition to adult services; prevention, acute care, continuing care and rehabilitation should be regarded as part of the same spectrum.

6.1.1 Criterion: There is evidence of good communication and joint working between relevant National Assembly for Wales Groups and Departments.

6.1.2 Criterion: National Assembly for Wales policy and guidance relating to the care of children and adolescents is consistent and avoids 'perverse incentives'.

6.1.3 Criterion: The National Assembly for Wales keeps joint planning for children's services under review to ensure that the Audit Commission's recommendations in "Seen but not heard" are addressed.

6.1.4 Criterion: The health authority has designated a senior officer, with recognised experience in children's issues to be responsible, in liaison with GP fundholders, for commissioning all health services for adolescents. This person plays a key role in ensuring that care is co-ordinated.

6.1.5 Criterion: When services are provided by several providers, the health authority contracts with one provider to oversee the service, sub contracting as necessary.

6.1.6 Criterion: The health authority, local authority and voluntary organisations have considered ways to improve joint action at all levels, particularly in:

i. defining and assessing need;

ii. prioritising between needs;

iii. identifying the adolescents concerned;

iv. planning services.
6.1.7 Criterion: The health authority has produced a local strategy for health which includes services for adolescents.

6.1.8 Criterion: The health authority has ensured that GPs (fundholders and non-fundholders) have been full and active participants in the planning of adolescent services.

6.1.9 Criterion: Health and local authorities and GP fundholders have published joint and continuing care agreements which include adolescents.

6.1.10 Criterion: The health and local authority have agreed respective responsibilities for meeting the continuing care needs of adolescents and arrangements for hospital discharge.

*(Each year they should confirm jointly their best estimates of the likely number of the children / young people who will need continuing health and social care and their respective commitments in terms of finance and activity.)*

6.1.11 Criterion: Local authorities have consulted fully health authorities about the local Children's Service Plan.

6.1.12 Criterion: Agencies agree respective responsibilities for financial contributions for meeting care needs.

6.1.13 Criterion: Good quality and sensitive arrangements are in place for transferring responsibility for a young person's care between agencies and between different parts of the NHS.

6.1.14 Criterion: Good liaison ensures that, if the change from child to adult services occurs at different times for the various agencies involved and for particular aspects of health care, good liaison between services ensures that problems and difficulties are minimised.

6.1.15 Criterion: The NHS Trust/unit ensures that:

i. key NHS personnel participate in the planning process for adolescents in need;

ii. multi disciplinary and multi-agency assessment procedures prevent the need for separate assessments
6.1.16 Criterion: There is a service directory of those responsible for planning and providing children's services locally

6.1.17 Criterion: There is evidence of joint training of staff in procedures and practices which would benefit from this.

6.2 Standard: *Local education authorities provide adequate education to school age adolescents in the NHS residential facility.*

6.2.1 Criterion: There are arrangements for unit educational staff to play a full and appropriate part in the unit's management and contribute to the care planning for individual adolescents.

6.3 Standard: *There is effective multi-disciplinary work within the residential units.*

6.3.1 Criterion: The different disciplines are clear regarding their roles in the assessment and treatment process.

6.3.2 Criterion: The different disciplines are clear regarding how they contribute to the ongoing development of the service.

6.4 Standard: *There is effective multi-agency co-operation over the treatment and care of individual adolescents*

6.4.1 Criterion: The various agencies involved with a particular adolescent co-ordinate and communicate in a way which facilitates each other's good work, in particular with reference to admission, discharge and after-care

6.4.2 Criterion: There are proper arrangements, for ongoing care planning with the appropriate social services department, when a young person in a unit is:

i. a child "looked after" by a social services department;

ii. a child "accommodated" by the health authority unless detained under any provision of the Mental Health Act;

iii. a young person aged over 16 years who needs aftercare (Section 24 [2]).
7. DESIGN AND SAFETY OF ENVIRONMENT

7.1 Standard: Adolescent units have implemented the recommended standards for the safety and security of patients

7.2 Standard: Inpatient psychiatric units which accommodate adolescents meet modern standards for design and quality of environment provided (including privacy and security).

7.2.1 Criterion: Adolescent wards are specifically designed with facilities for separate toilet areas, space for recreation and education and access to a telephone

7.2.2 Criterion: Patients all have the option of having a single bedroom.

7.2.3 Criterion: The layout of the unit enables adequate supervision as determined by the degree of disturbance of the patient.

7.2.4 Criterion: The layout of the unit and the regime adopted should allow for a degree of privacy appropriate to the mental state of the patient. This includes sensitivity to gender issues including the provision of separate toilet and washing facilities.

7.2.5 Criterion: The physical appearance of the unit is such as to create an appropriate impression on service users.
HEALTH ADVISORY SERVICE
(HAS 2000)

Child & Adolescent Mental Health Services Residential Units in Wales: Review of Safeguards and Standards of Care

Addenda to standards to guide the review team: November 1999

SAFEGUARDS
Addenda to standard 5.4.

5.4.4 Criterion: Schools have a policy about the use of physical force. All members of staff who may have to intervene physically with pupils understand clearly the options and strategies open to them. Members of staff know what is acceptable and what is not. Parents are informed.¹

5.4.5 Criterion: Immediately following any incident in which force is used to control or restrain a pupil, the member of staff concerned reports the matter verbally to the head or a senior member of staff. The member of staff provides a written report as soon as possible afterwards.¹

5.4.6 Criterion: Schools keep a record of all incidents, preferably in an incident book. The report of the incident includes:

i. the name(s) of the pupil(s) involved, and when and where the incident took place;

ii. names of any other staff or pupils who witnessed the incident;

iii. the reason that force was necessary (e.g. to prevent injury to the pupil/another pupil/member of staff);

iv. how the incident began and progressed, including details of the pupil's behaviour, what was said by each of the parties, the steps taken to defuse/ calm the situation, the degree of force used, how that was applied, and for how long;
v. the pupil's response, and the outcome of the incident;

vi. details of any injury suffered by the pupil, another pupil, or a member of staff and of any damage to property. ¹

5.4.7 Criterion: Parents are informed of an incident involving their child where force is used, and are given an opportunity to discuss it. The head, or member of staff to whom the incident is reported, considers whether that is done straight away or at the end of the school day; and whether parents are told verbally or in writing. ¹

Addendum to standard 5.5.

5.5.2 Criterion: The school's behaviour policy promotes respect for others, including respect for different ethnic, religious and cultural backgrounds. It makes clear the school's intolerance of bullying, racial or sexual harassment or any other form of improper behaviour. The main points of the policy are communicated to pupils and parents. ²

REFERENCES


Other documents consulted


* "Parent" throughout the circular includes those who have parental responsibilities including, in the case of looked after children, the local authority.
Appendix 3 - Documents consulted as part of the review
## Documents consulted as part of the review

**From The National Assembly for Wales**

<table>
<thead>
<tr>
<th>TITLE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assembly information booklet - your guide to the assembly</td>
<td>1999</td>
</tr>
<tr>
<td>Caring for young people and the vulnerable - guidance for preventing abuse of trust</td>
<td></td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Resources Assessment - Value for Money Unit</td>
<td>November 1998</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services in Wales: Report on the safeguards and facilities for children accommodated within mental health services: an overview of compliance visits.</td>
<td>August 1999</td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services: Proposal for higher education for nurses</td>
<td></td>
</tr>
<tr>
<td>Child and Adolescent Mental Health Services Residential Units in Wales - A Report of Compliance Visits</td>
<td>February 1998</td>
</tr>
<tr>
<td>Estimated prevalence figures for individual child and adolescent mental health problems and disorders in Wales</td>
<td>6 October 1999</td>
</tr>
<tr>
<td>Estyn - Note of visit Harvey Jones Adolescent Unit Cardiff</td>
<td>October 1999</td>
</tr>
<tr>
<td>Guidance and model of principles on sexual activity within relationships of trust: Survey</td>
<td>October 1999</td>
</tr>
<tr>
<td>Learning how to make children safer: An analysis for the Welsh Office of serious child abuse cases in Wales</td>
<td>1999</td>
</tr>
<tr>
<td>Making your mark on Wales - What the National Assembly can do for you</td>
<td>6 May 1999</td>
</tr>
<tr>
<td>Mental Health Act 1983: Code of Practice</td>
<td>March 1999</td>
</tr>
<tr>
<td>National Assembly for Wales: Assembly Information Booklet - Your guide to the assembly.</td>
<td></td>
</tr>
<tr>
<td>National Assembly for Wales (draft) Child and Adolescent Mental Health Services Strategy</td>
<td>February 2000</td>
</tr>
<tr>
<td>Response to the report of the Welsh Office Compliance Team to Cedar Court and the Hergest Ward, Ysbyty Gwynedd</td>
<td></td>
</tr>
<tr>
<td>Response to the Welsh Office Compliance team visit to review the safeguards and standards at the Harvey Jones Unit following the HAS 2000 Report, (Cardiff and District Community NHS Trust)</td>
<td></td>
</tr>
<tr>
<td>Response of working group to Health Advisory Service (HAS) 2000 review of safeguards and standards in residential child and adolescent psychiatry in Wales</td>
<td>8 January 1999</td>
</tr>
<tr>
<td>Responses to review of safeguards and standards of care from Bro Taf Health Authority</td>
<td>1999</td>
</tr>
<tr>
<td>Statistical report: Mapping Social Exclusion in Wales</td>
<td>June 1999</td>
</tr>
<tr>
<td>Taking Care Taking Control - training pack</td>
<td></td>
</tr>
<tr>
<td>The Children First Programme in Wales: Transforming Children's Services [Welsh Office Circular 20/99]</td>
<td>April 1999</td>
</tr>
<tr>
<td>The Government's response to the children's safeguards review</td>
<td>November 1998</td>
</tr>
<tr>
<td>The use of reasonable force to control or restrain pupils [Welsh Office Circular 37/98 (Education Act 1996)]</td>
<td>December 1998</td>
</tr>
</tbody>
</table>
## From North Wales

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>TITLE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglesey Local Health Group</td>
<td>Questionnaire results - Social Services, LHG Prioritisation, Perception of Availability and Perception of Quality</td>
<td>1999</td>
</tr>
<tr>
<td>Cedar Court Adolescent Service</td>
<td>Annual report 1998/99</td>
<td>1998</td>
</tr>
<tr>
<td>Cedar Court Adolescent Service</td>
<td>Adolescent Service Operational Policy (Part 1: Service Description)</td>
<td>July 1997</td>
</tr>
<tr>
<td>Cedar Court Adolescent Service</td>
<td>Adolescent Service Operational Policy (Part 2: Policies)</td>
<td>July 1997</td>
</tr>
<tr>
<td>Conwy County Borough Council</td>
<td>Children's Services Plan</td>
<td>1999</td>
</tr>
<tr>
<td>Gwynedd Community Health Trust*</td>
<td>Policy for supervision of patients detained under the sections of the mental health act and informal patients who require greater than normal observation</td>
<td></td>
</tr>
<tr>
<td>Gwynedd Community Health Trust*</td>
<td>Seclusion Procedure</td>
<td>April 1998</td>
</tr>
<tr>
<td>National Youth Advisory Service</td>
<td>Information pack</td>
<td></td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>1998/1999 Contract for Clinical Services with Clwydian Community Care Trust**</td>
<td>June 1998</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>1999/2000 Interim long-term agreement for clinical services with Conwy and Denbighshire NHS Trust</td>
<td>November 1999</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>A (draft) mental health strategy for North Wales</td>
<td>September 1999</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Annual Report 1998/1999</td>
<td>1999</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Children's Service - Programmes of care: Child Protection and Related Services</td>
<td>July 1999</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Director of Public Health's Annual Report 1998</td>
<td>1998</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Draft - Child and adolescent mental health service specification</td>
<td></td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Draft Strategy for Child and Adolescent Mental Health Services in North Wales</td>
<td>September 1999</td>
</tr>
<tr>
<td>SOURCE</td>
<td>TITLE</td>
<td>DATE</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Eligibility criteria for continuing health care and guidance on social services responsibility for continuing social care.***</td>
<td>April 1999</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>List of individuals within the six social services departments with responsibility for child and adolescent mental health</td>
<td></td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Local Health Groups contact information</td>
<td>November 1999</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Organisational Chart</td>
<td>October 1998</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Recommended policy and procedures for the investigation of allegation against professionals in relation to children (Adapted from Welsh Office Document Jan 1998) Draft 2</td>
<td>June 1999</td>
</tr>
<tr>
<td>North Wales Health Authority</td>
<td>Submission for Part II of the examination for the membership of the faculty of public health</td>
<td>June 1999</td>
</tr>
<tr>
<td>North Wales Professional Advisory Group - CAMH</td>
<td>Minutes of meetings: 12/05/99; 29/06/99; 03/08/99; 07/09/99;</td>
<td>July 1999</td>
</tr>
<tr>
<td>North East Wales NHS Trust</td>
<td>Child Protection Arrangements</td>
<td></td>
</tr>
<tr>
<td>North West Wales NHS Trust</td>
<td>Admission statistics of children admitted with mental health problems to: Hergest; Paediatric wards at Gwynedd Hospital</td>
<td>November 1999</td>
</tr>
<tr>
<td>North West Wales NHS Trust</td>
<td>Clinical Governance Baseline Survey</td>
<td></td>
</tr>
<tr>
<td>North West Wales NHS Trust</td>
<td>Confidential child protection liaison form</td>
<td>November 1999</td>
</tr>
<tr>
<td>North West Wales NHS Trust</td>
<td>Guidance regarding the admission of children under 18 years old to the Hergest Unit</td>
<td>November 1999</td>
</tr>
<tr>
<td>North West Wales NHS Trust</td>
<td>Mental Health Act Commission - Patient focused visit to the North West Wales NHS Trust on 26th and 27th May 1999</td>
<td>June 1999</td>
</tr>
<tr>
<td>North West Wales NHS Trust</td>
<td>Organisational Chart</td>
<td></td>
</tr>
<tr>
<td>North West Wales NHS Trust</td>
<td>Procedure re the visiting of patients at the Hergest Unit</td>
<td>November 1999</td>
</tr>
<tr>
<td>North West Wales NHS Trust</td>
<td>Proposed training in child protection for Hergest Staff</td>
<td>October 1999</td>
</tr>
<tr>
<td>Police / Social Services</td>
<td>Joint Protocol - Children missing from care in North Wales</td>
<td>December 1998</td>
</tr>
<tr>
<td>University of Wales, Bangor</td>
<td>Drink, drugs and our young people - Young people's use of, and opinions about, cigarettes, alcohol and drugs</td>
<td>1999</td>
</tr>
<tr>
<td>SOURCE</td>
<td>TITLE</td>
<td>DATE</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Bro Taf Health Authority</td>
<td>A framework document for child and adolescent mental health services</td>
<td>October 1999</td>
</tr>
<tr>
<td>Bro Taf Health Authority</td>
<td>NHS Responsibility for meeting continuing health care needs - policy</td>
<td>July 1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Agency nurse recruitment information</td>
<td></td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Child and Adolescent Health Directorate - Organisational chart</td>
<td></td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Children admitted to adult wards - nursing admission process draft</td>
<td></td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Guidelines for adolescents requiring emergency in-patient psychiatric care (Adolescents on Adult Wards)</td>
<td>March 1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Harvey Jones Adolescent Unit - Draft restriction of liberty policy</td>
<td></td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Harvey Jones Adolescent Unit - therapy reductions in in-patient service provision (1996 - Feb 1999)</td>
<td>1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Harvey Jones Adolescent Unit - Monitoring under 18s admitted to Cardiff and District Trust</td>
<td>1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Harvey Jones Adolescent Unit - Mandatory training for nursing staff</td>
<td>1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Harvey Jones Adolescent Unit - C &amp; R Record</td>
<td>1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Harvey Jones Adolescent Unit - Training and team building</td>
<td>1998</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Harvey Jones Adolescent Unit - nursing staff changes (May 1998, February 1999, December 1999)</td>
<td></td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Harvey Jones Adolescent Unit - Police checking information</td>
<td>1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Help us to help you - how to comment and complain</td>
<td></td>
</tr>
</tbody>
</table>
### From South Wales (Continued)

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>TITLE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Information on the admission of under 18 year olds to adult wards Jan - Dec 1999</td>
<td>Dec 1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Mental Health Services for children and adolescents</td>
<td>June 1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>NSPCC Wales Independent Investigation Unit service specification and agreement</td>
<td>9 September 1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>NSPCC Wales Independent Investigation Unit service specification and agreement - response</td>
<td>9 September 1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Parent information leaflet - Harvey Jones Adolescent Unit</td>
<td></td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Policy for the disclosure of criminal background of those with access to children</td>
<td></td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Policy on the giving of sexual health information to individual school age children</td>
<td>November 1999</td>
</tr>
<tr>
<td>Cardiff and District Community NHS Trust</td>
<td>Young people's health centres - Cardiff and the Vale</td>
<td></td>
</tr>
<tr>
<td>Cardiff Community Healthcare****</td>
<td>Complaint registration form</td>
<td></td>
</tr>
<tr>
<td>Cardiff Community Health Council</td>
<td>Your independent voice on the health service - leaflet</td>
<td></td>
</tr>
</tbody>
</table>
From South Wales (Continued)

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>TITLE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhondda Cynon Taf County Borough Council</td>
<td>Children's Services Plan - Draft Update 1999</td>
<td>1999</td>
</tr>
<tr>
<td>South Glamorgan Health Authority****</td>
<td>Whitchurch Hospital - management of violent or potentially violent persons</td>
<td>September 1998</td>
</tr>
</tbody>
</table>

*This trust no longer exists
**This trust no longer exists
***This document has been jointly agreed with: Conwy County Borough Council; Denbighshire Borough Council; Flintshire Borough Council; Cyngor Gwynedd Borough Council; Wrexham County Borough Council, Ynys Mon County Council.
**** This trust no longer exists
***** This Health Authority no longer exists
Appendix 4 - Timetable of visits and meetings for the review
## NORTH WALES

**Sunday 28th November, 1999 - Team A (All members of the review team)**

Locations: Llandudno

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.00pm - 5.00pm</td>
<td>Team Briefing</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
<tr>
<td>5.00pm - 6.00pm</td>
<td>Key representatives (CEO, Director) from the agencies in N Wales</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• North Wales HA</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 6 Social Services Depts.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Trusts - NW Wales and Conwy &amp; Denbighshire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eve</td>
<td>Team Meetings</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
</tbody>
</table>
### NORTH WALES cont.

#### Monday 29th November - Team A

Locations: Bangor, Llandudno

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00am - 10.30am</td>
<td>Tour of Hergest AMI Unit Meet with Paediatrician</td>
<td>Hergest Unit Gwynedd Hospital</td>
<td>Penrhosgarnedd, Bangor, Gwynedd LL57 2PW</td>
</tr>
<tr>
<td>10.30am - 12.30am</td>
<td>Meet with Key representatives from North West Wales NHS Trust</td>
<td>Managers Room Gwynedd Hospital</td>
<td>Penrhosgarnedd, Bangor, Gwynedd LL57 2PW</td>
</tr>
<tr>
<td>12.30pm</td>
<td>Lunch at Hergest Unit</td>
<td>Managers Room Gwynedd Hospital</td>
<td>Penrhosgarnedd, Bangor, Gwynedd LL57 2PW</td>
</tr>
<tr>
<td>1.30pm</td>
<td>Return to Hotel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.00pm - 4.00pm</td>
<td>Representatives from CHCs, Voluntary Sector and Advocacy Service at Hergest Unit</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
<tr>
<td>Eve</td>
<td>Team meetings</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
</tbody>
</table>
## NORTH WALES cont.

### Monday 29th November - Team B

**Locations:** Colwyn Bay

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
</table>
| 9.00am - 1.00pm | Visit to Cedar Court Adolescent Unit  
Meet with Key Staff  
- Dr Barry Keihn (Ch. & Adol. Psychiatrist)  
- Mrs Bronwyn Platt (Child Therapist)  
- Mrs Pamela Stanley (Head Teacher)  
- Mrs Sarah Davies (Social Worker)  
- Mr Peter Johnson (Charge Nurse)  
- Mr Steve Riley (Senior Nurse) | Cedar Court | 65 Victoria Park, Colwyn Bay LL29 7AJ |
| 1.00pm - 2.00pm | Lunch                                                   | Cedar Court | 65 Victoria Park, Colwyn Bay LL29 7AJ |
| 2.00pm - 4.00pm | Meetings with Children and Families                    | Cedar Court | 65 Victoria Park, Colwyn Bay LL29 7AJ |
| 4.00 pm - 5.00pm | Meeting with Community Based Psychiatrists             | Cedar Court | 65 Victoria Park, Colwyn Bay LL29 7AJ |
| 4.30pm - 5.00pm | Meeting with National Youth Advocacy  
Service (NYAS) | Cedar Court | 65 Victoria Park, Colwyn Bay LL29 7AJ |
| Eve           | Team meetings                                           | Imperial Hotel | The Promenade, Llandudno, North Wales LL30 1AP |
## NORTH WALES cont.

### Tuesday 30th November - Team A

Locations: Mold, Llandudno

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00 - 11.00pm</td>
<td>Key representatives from North Wales Health Authority - including Designated Doctor and Designated Nurse and representative from Local Health Groups</td>
<td>Committee Room 2</td>
<td>Preswylfa - Hendy Road, Mold, Flintshire CH7 1PZ</td>
</tr>
<tr>
<td>11.00pm - 1.00pm</td>
<td>Lunch &amp; Travel to hotel</td>
<td>Committee Room 2</td>
<td>Preswylfa - Hendy Road, Mold, Flintshire CH7 1PZ</td>
</tr>
<tr>
<td>1.00pm - 3.00pm</td>
<td>Officers from the 6 North Wales Unitary Authorities Departments responsible for co-ordinating Child Protection &amp; Social Workers whose work relates to Cedar Court (with team B)</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
<tr>
<td>Eve</td>
<td>Team meetings</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
</tbody>
</table>
## NORTH WALES cont.

### Tuesday 30th November - Team B

Locations: Mold, Llandudno

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00 - 11.00pm</td>
<td>Key representatives from Conwy and Denbighshire NHS Trust</td>
<td>Seminar Room</td>
<td>Colwyn Bay Community Hospital, Hesketh Road, Colwyn Bay</td>
</tr>
<tr>
<td>12.00pm - 1.00pm</td>
<td>Lunch</td>
<td>Seminar Room</td>
<td>Colwyn Bay Community Hospital, Hesketh Road, Colwyn Bay</td>
</tr>
<tr>
<td>1.00pm - 3.00pm</td>
<td>Officers from the 6 North Wales Unitary Authorities Departments responsible for co-ordinating Child Protection &amp; Social Workers whose work relates to Cedar Court (with team A)</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
<tr>
<td>Eve</td>
<td>Team meetings</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
</tbody>
</table>
### NORTH WALES - SOUTH WALES

**Wednesday 1st December 1999 - Team A**

**Locations:** Llandudno, Cardiff

<table>
<thead>
<tr>
<th>Meeting / Activity</th>
<th>Time</th>
<th>Venue</th>
<th>Address</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team meeting</td>
<td>9.00am - 11.00am</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
<td>Circle Way East, Llandebyrn, South Glamorgan CF3 7XF</td>
<td></td>
</tr>
<tr>
<td>Travel from Llandudno to Cardiff</td>
<td>11.00am - 4.00pm</td>
<td>Imperial Hotel</td>
<td>Meat House Hotel</td>
<td></td>
</tr>
<tr>
<td>Meeting with key representatives (CEO, Director) from the agencies in South Wales</td>
<td>5.00pm - 6.00pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bro Taf HA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cardiff and District Community NHS Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All 4 Social Services Departments - Vale of Glamorgan, Rhondda, Merthyr &amp; Cardiff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Eve**

| Team meetings | | | | |
**NORTH WALES - SOUTH WALES cont.**

**Wednesday 1st December 1999 - Team B**

Locations: Llandudno, Cardiff

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00am - 11.00am</td>
<td>Team meeting</td>
<td>Imperial Hotel</td>
<td>The Promenade, Llandudno, North Wales LL30 1AP</td>
</tr>
<tr>
<td>11.00am - 4.00pm</td>
<td>Travel from Llandudno to Cardiff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.00pm - 6.00pm</td>
<td>Meeting with representatives of CHCs</td>
<td>Moat House Hotel</td>
<td>Circle Way East, Llanderyn, South Glamorgan CF3 7XF</td>
</tr>
<tr>
<td>Eve</td>
<td>Team meetings</td>
<td>Moat House Hotel</td>
<td>Circle Way East, Llanderyn, South Glamorgan CF3 7XF</td>
</tr>
</tbody>
</table>


**SOUTH WALES cont.**

**Thursday 2nd December - Team A**

**Locations : Cardiff**

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00am - 9.15am</td>
<td>Meet Clinical Coordinator at Whitchurch</td>
<td>Front Hall, Whitchurch Hospital</td>
<td>Park Road, Whitchurch, Cardiff</td>
</tr>
</tbody>
</table>
| 9.15am - 10.30am | Adult MH wards to which Children and Young People are sometimes admitted  
|              | Accompanied by Miss Daphne James                                                  | E2A (Adult Ward)  
|              | Whitchurch Hospital                                                               |                                 | Park Road, Whitchurch, Cardiff     |
| 10.30am - 11.00am | Intensive Care Unit - Accompanied by  
|              | Miss Daphne James                                                                 | Whitchurch Hospital             | Park Road, Whitchurch, Cardiff     |
| 11.00 - 12.00 | Adult MH wards to which Children and Young People are sometimes admitted  
|              | Accompanied by Miss Daphne James                                                  | E1 (Adult Ward)  
|              | Whitchurch Hospital                                                               |                                 | Park Road, Whitchurch, Cardiff     |
| 12.00pm - 1.30pm | Travel to Harvey Jones Unit & Lunch                                                | Harvey Jones Unit               | Whitchurch Hospital, Park Road, Whitchurch, Cardiff |
| 1.30         | Look round Harvey Jones Adolescent Unit                                          | Whitchurch Hospital             | Park Road, Whitchurch, Cardiff     |
| Eve          | Team meetings                                                                     | Moat House Hotel                | Circle Way East, Llanederyn, South Glamorgan CF3 7XF |
### SOUTH WALES cont.

**Thursday 2nd December - Team B**

**Locations:** Cardiff

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00am - 9.15am</td>
<td>Welcome and Coffee</td>
<td>Harvey Jones Adolescent Unit</td>
<td>Whitchurch Hospital, Park Road, Whitchurch, Cardiff</td>
</tr>
<tr>
<td>9.15am - 9.50am</td>
<td>Meet with Consultants - Dr Gillian Davies and Dr Peter Halford&lt;br&gt;Meet with Key Staff -&lt;br&gt;Dr Pam Duthie (Specialist Registrar)&lt;br&gt;Ms Martina Telders (Art Therapist)&lt;br&gt;Dr Gill Bradbury (SHO)&lt;br&gt;Dr Cath Curran (SHO)&lt;br&gt;Mr Andrew Cresswell (Senior Clinical Nurse Co-ordinator)&lt;br&gt;Mr Keith Gould (Unit Manager)&lt;br&gt;Mrs Elaine Simpson (Nurse Therapist)</td>
<td>Dr Halfords Office - Harvey Jones Adolescent Unit</td>
<td>Whitchurch Hospital, Park Road, Whitchurch, Cardiff</td>
</tr>
<tr>
<td>10.00am - 10.40am</td>
<td>Meet teaching staff&lt;br&gt;Mr Andy Lloyd (Headteacher)&lt;br&gt;Mrs Mary Hobson (Teacher)&lt;br&gt;Meet with Nursing Staff</td>
<td>Dr Duthie’s Office</td>
<td>Whitchurch Hospital, Park Road, Whitchurch, Cardiff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr Halford’s Office</td>
<td></td>
</tr>
</tbody>
</table>
### SOUTH WALES cont.

#### Thursday 2nd December - Team B Continued

**Locations : Cardiff**

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
</table>
|               | Mrs Maislis Davies (Senior Social Work Practitioner / Family Therapist)  
Miss Jean Tonsett (Family Therapist) | Dr Davies' Office             | Dr Davies' Office                |
| 10.45am - 11.20am | Admin Staff - Ms Kelly Watts (Hospital Services Assistant) | Dr Halford's Office           | Whitchurch Hospital, Park Road, Whitchurch, Cardiff |
| 11.30 - 12.00  | Mrs Eileen Beecham Team Leader Education                    | Dr Halford's Office           | Whitchurch Hospital, Park Road, Whitchurch, Cardiff |
| 12.00pm - 12.30pm | Lunch                                                        | Harvey Jones Adolescent Unit  | Whitchurch Hospital, Park Road, Whitchurch, Cardiff |
| 12.30pm - 6.00pm | Meetings with children and families                         | Harvey Jones Adolescent Unit  | Whitchurch Hospital, Park Road, Whitchurch, Cardiff |
| 6.00pm        | Travel to team Hotel                                        |                               |                                              |
| Eve           | Team meetings                                               | Moat House Hotel              | Circle Way East, Llanderyn, South Glamorgan CF3 7XF |
### SOUTH WALES cont.

**Friday 3rd December - Team A**

**Locations:** Cardiff

<table>
<thead>
<tr>
<th>Time</th>
<th>Meeting / Activity</th>
<th>Venue</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.00am - 10.30am</td>
<td>Bro Taf Health Authority and Representatives from Local Health groups</td>
<td>Churchill House&lt;br&gt;Bro Taf HA HQ</td>
<td>Churchill Way, Cardiff</td>
</tr>
<tr>
<td>10.30am - 11.00am</td>
<td>Travel time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.00am - 12.30pm</td>
<td>Cardiff and District Community NHS Trust</td>
<td>Post Graduate Seminar Room</td>
<td>Whitchurch Hospital, Cardiff</td>
</tr>
<tr>
<td>12.30pm - 1.30pm</td>
<td>4 Social Services departments</td>
<td>Post Graduate Seminar Room</td>
<td>Whitchurch Hospital, Cardiff</td>
</tr>
<tr>
<td>1.30 onwards</td>
<td>Lunch Team meetings</td>
<td>Moat House Hotel</td>
<td>Circle Way East, Llanederyn, South Glamorgan CF3 7XF</td>
</tr>
</tbody>
</table>
Appendix 5 - Members of the review team
### Dr Paul Lelliott - Joint Chief Executive/Specialist Adviser

Dr Lelliott currently works (in a job share) as a consultant general psychiatrist in a sectorised mental health service in London.

For the past nine years he has worked part-time at the Royal College of Psychiatrists' Research Unit (College Research Unit) and has been its director since 1994. The College Research Unit employs 15 staff and has an active programme of research and development work. Its achievement have included the development of a brief outcome measure (HoNOS) for use in routine clinical practice to enable the monitoring of the first Health of the Nation target; the development, for the Clinical Standards Advisory Group, of a set of standards for services to severely mentally ill people; the development of an instrument to monitor the Care Programme Approach and the establishment of a clinical effectiveness programme which is developing clinical guidelines.

Dr Lelliott led a consortium, which also includes the Royal College of Nursing, the British Geriatrics Society and the Office for Public Management, which successfully tendered to take over the Health Advisory Service from 1st April 1997.

### Jenny Finch - Service Development Adviser

Jenny is a Service Development Adviser at the Health Advisory Service (HAS 2000). She is first author of HAS's standards for mental health services for older people, and joint author of the standards for its other client groups, having edited them all.

She has managed systematic service reviews of mental health services for older people, adult mental health services and child and adolescent mental health services. She is also the organisation's lead on its information needs, and established its library.

Jenny has considerable experience in devising and implementing health and social care policy, having worked for several years in health and local authorities. Prior to her current post, she was Joint Planning Officer in Croydon, where she played a major role in addressing inequalities and health through the planning and implementation of multi-agency programmes in the most deprived areas.

Her extensive experience in community development includes the establishment of two community health projects, which applied community development methods in health promotion.

She has run a number of training events for health and social care planners and practitioners and members of voluntary organisations in group-work and inter-agency working.

Jenny is also a linguist, and a qualified translator.
Appendices

Dr Anthony Jaffa - Consultant in Child and Adolescent Psychiatry

Tony Jaffa qualified in medicine at Nottingham University Medical School. After gaining experience in paediatrics he trained in general psychiatry in Bristol and then in child and adolescent psychiatry on the Tavistock Clinic rotation, in and around London. His first consultant post was at St. George's Hospital, Battersea Child Guidance Clinic and in the Adolescent Community Team in Wandsworth. In 1993 he moved to Cambridge to take up his current post as Consultant in Child and Adolescent Psychiatry. This involved working in Douglas House Adolescent Unit and more recently in the Phoenix Centre for adolescents with eating disorders. He was the lead consultant for the Child and Adolescent Psychiatry department from 1996 to 1999.

Tony Jaffa has a particular interest in service development and has written on this and other related topics. He is the co-author of a paper, which has been adopted by the Royal College of Psychiatrists as its guidance on the staffing of multidisciplinary inpatient child and adolescent psychiatry units. He has led an HAS review team commissioned by the Welsh Office to look at inpatient adolescent psychiatry facilities in Wales. The resulting report has been published by the Welsh Office. He is currently part of a research team funded by the Department of Health to investigate the provision and use of child and adolescent inpatient care, and to develop standards for service provision in this area.

Tony Jaffa is currently on the executive Committee of the Royal College of Psychiatrists Child and Adolescent Faculty. He is the educational supervisor for the Specialist Registrars in Child and Adolescent Psychiatry in Cambridge.

Mrs Gilly Parry - Senior Nurse, Child Protection, Gateshead NHS Trust Designated Nurse

Gill trained as a registered general nurse in Newcastle in the early 1960's, following which she worked as a staff nurse in the renal dialysis department at the Royal Victoria Infirmary, Newcastle.

She spent 5 years in East Africa, raising her own children and working with voluntary agencies on a number of nutrition schemes, a mother and baby unit and medical dispensary, and finally as the nurse responsible for day to day health care of staff and students of a combined secondary school and teacher training college.

In 1978 she undertook health visitor training and worked as a health visitor and community practice teacher in the North East, until taking up her current post in 1993. Throughout her health visiting career, she has been involved in practice development, standard setting and audit, and promoting multi-disciplinary and multi-agency working.

Her current post involves membership of the area child protection committee and various sub-committees and chair of the monitoring sub-committee. She has responsibilities to advise the health authority, trust and staff members on issues relating to child protection, development and maintenance of guidelines and standards.

She has enjoyed a long involvement with the CPHVA at both local and national level.
Angela Sergeant - Senior Clinical Nurse Specialist

Having initially trained and practiced as a general nurse, Angela Sergeant undertook her RMN training in 1985.

On completion, she worked as a Staff Nurse on an NHS Residential Unit for disturbed children and families. The unit also specialised in the care of psychotic mothers and their babies. She undertook the ENB 603 course in 1988 and worked for a year in Child and Family Services in the community. She was promoted to Sister G Grade level in 1989.

In 1990, she began working in Adolescent Psychiatry and was soon promoted to Nurse Manager H Grade position. Her roles included overall management responsibility for 25 nursing staff, budget holder and line management of catering and domestic staff. She was responsible for the development of policies and procedures and involved in the development of a business case for service expansion. She also undertook contract negotiations with purchasers and was often presenting at conferences, the Specialist Eating Disorder Programme, which she co-developed.

After working abroad in 1984, she returned to Leigh House Hospital and resumed her role as Senior Nurse. She was promoted to I Grade - Senior Nurse Specialist in 1997.

She has undertaken further ENB training such as 997/998 and is a trainer for the ENB 603 course locally.

Her role includes acting as Specialist Adviser on national studies, such as the Royal College of Psychiatrists Inpatient Study. She has been a reviewer for HAS 2000 in 1998 for a Welsh Office Review.

Her current role includes overall management of nursing team and standards of care and she is currently actively involved in the commissioning process for the development of a new purpose built Adolescent Psychiatric Unit, due to expansion of the current service in which she works.
Following social work training, David Lambert spent his early professional career as a residential child care officer with a number of local authority Children's Departments. This was followed by a period of six years as a Senior Lecturer in Residential Child Care running a one year course for unqualified residential social workers. He was then appointed as the Principal of a residential home and school for seriously disturbed adolescent boys.

David Lambert began his career with the Department of Health (then DHSS) Social Services Inspectorate in 1975. For the first ten years this involved managing the Department's business with the Counties of Hampshire, Kent and the Isle of Wight. He specialised in the implementation of Children's Services policies. During this period he also conducted an inspection of the States of Jersey Children's Department.

In 1984 David Lambert assumed responsibility, as an Assistant Chief Inspector SSI, for the DH Social Care Region for London. The Regional Office secures DH's relationships with the 33 London Boroughs and other agencies, promotes the implementation of government policy for the personal social services and monitors and advises on management performance and professional practice. During this period the regional office facilitated the full implementation of the Community Care Act and the Children Act reforms in London. A part of his corporate duties, David Lambert also managed and coordinated SSI's national programme of work in the Children's Service field and managed the first inspection of the Youth Treatment Service.

Following retirement from SSI, David Lambert acts as the independent Chair of the Norfolk Area Child Protection Committee and is the Chairman of the Charterhouse group of therapeutic Communities.