Child and Adolescent Mental Health Services

22 September 2022

jerseyauditoffice.je

R.151/2022

C&AG
JERSEY AUDIT OFFICE

Contents

Summary 3

Introduction 3

Key Findings 4

Conclusions 6

Objectives and scope of the review 7

Detailed findings 9

Design of CAMHS 9

Pattern of CAMHS delivery 17

Overall governance arrangements 21

Performance and risk management 32

How CAMHS performs 36

Referrals management 41

Appendix One – Audit Approach 49

Appendix Two – Summary of Recommendations 52

Summary

Introduction

1. Improving mental health and wellbeing is a major public health challenge. In part, this is because the underlying issues tend to be complex, and people's needs can be different. Evidence suggests that mental health problems in childhood and adolescence have a significant impact on physical health, education and on the ability to find and sustain employment.

2. The Government of Jersey has stated in the Government Plan 2022-2025 that '*the physical, emotional, and mental health of the Island's children and young people remain of the highest priority*.'

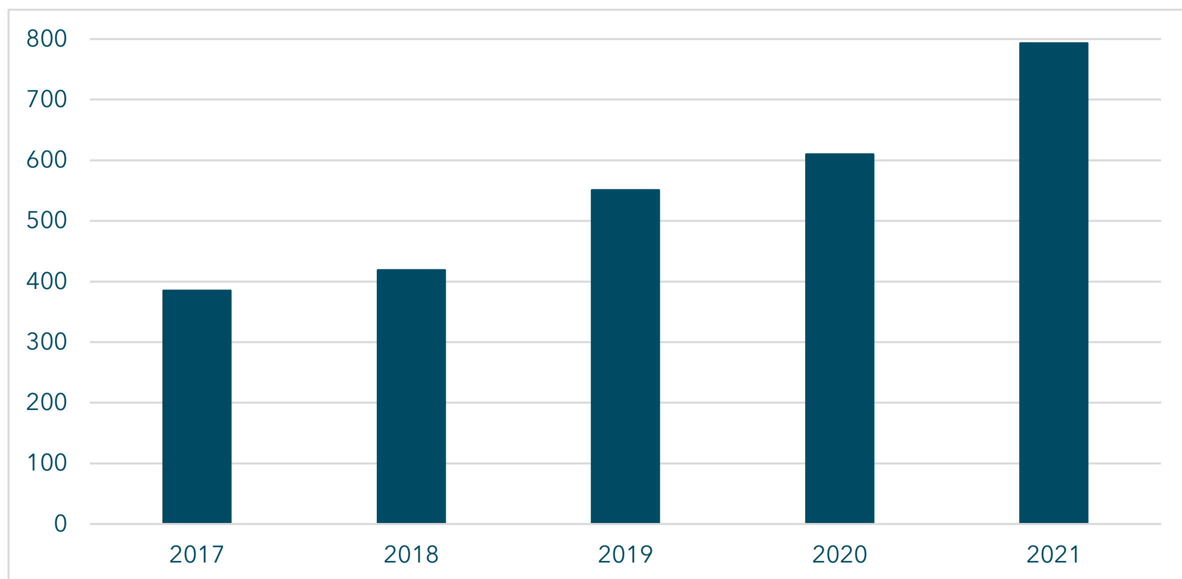
3. Child and Adolescent Mental Health Services (CAMHS) comprises specialist mental health services for children and young people (up to the age of 18) and their families. CAMHS provides a range of services including assessment, diagnosis and treatment for children and young people experiencing:

   - emotional difficulties
   - behavioural difficulties
   - relationship difficulties; and
   - developmental difficulties.

4. CAMHS also provides specialist community-based services for those experiencing specific mental health issues such as psychosis and eating disorders. Services include individual therapy, family therapy, parent counselling and group therapy (where children, young people or carers with similar difficulties are seen together in groups).

5. The number of referrals to CAMHS has risen over recent years as shown in Exhibit 1. There continues to be a high level of demand for CAMHS.

Exhibit 1: Number of accepted CAMHS referrals



Source: Government of Jersey

6. The Government Plan 2022-2025 includes planned investment of over £8 million for the implementation of a new model of care for children and young people's emotional wellbeing and mental health. As part of this new model of care, CAMHS is being redesigned.

7. My review has considered all aspects of CAMHS provision including services delivered by partners both on and off-Island. It has focussed on the responsibilities of the Children's Health and Wellbeing Service within the Integrated Services and Commissioning function of the Children, Young People, Education and Skills Department (CYPES). It has not considered the work of other CYPES functional areas such as children's social work or child and family support.

Key Findings

8. The key findings from my review are as follows:

   - the Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022-2025 (the Strategy) was launched in February 2022 by CYPES. The Strategy sets out a clear picture of what needs to be achieved and what 'good' looks like. It includes prioritised action and how improvements can be monitored and measured. The approach to developing the Strategy has been comprehensive, thorough and well governed
   - there are early signs that new ways of managing referrals and the evolving service structure for CAMHS are having a positive impact on waiting times

- most community CAMHS is provided by the Government. Commissioning of community services from other on-Island providers is relatively under-developed but opportunities for partnership working are increasingly being identified

- for those small numbers of children and young people who require inpatient mental health care, Jersey does not have a dedicated facility. There are two developments intended to relieve this sub-optimal arrangement – Clinique Pinel and the Our Hospital Project. The timescales for these developments are not clear although I have been informed that the current forecast for the opening of Clinique Pinel is the end of 2022

- in circumstances where facilities on-Island are not adequate to meet the child or young person's need, services are commissioned from the UK. I identified some weaknesses with these commissioning arrangements

- governance arrangements for CAMHS have not been robust and have not operated effectively. Since June 2019, the Health and Community Services Department (HCS) and CYPES have had joint responsibility for delivering CAMHS. However there has not been a robust, agreed Memorandum of Understanding (MoU) in place to govern this relationship and to assure the safe and high-quality delivery of services. Whereas draft versions of the MoU have been considered and 'agreed in principle', there is no one version that all signatories to the MoU have approved. In addition, the Terms of Reference (ToRs) for the required Governance and Oversight Group have never been finalised and the Group has not fulfilled its overarching role of securing and assuring clinical and professional standards

- new governance arrangements are being established in 2022 - however the ToRs for key groups and boards within the new structure are yet to be finalised

- there has been no overarching and co-ordinated approach to consideration of CAMHS performance and risk data. There has been a disconnect in the management of 'clinical' (which is viewed as HCS's responsibility) and 'operational' (CYPES) performance and risk information. Alignment of data and information, to enable joint clinical and operational oversight of the quality of services, has been lacking

- for both CYPES and HCS, the range and quality of service data relating to CAMHS is recognised as in need of improvement. The data requirements of the Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022-2025 are, I understand, now identified and being built into data sets for both CAMHS and for Public Health. The Children's Health and Wellbeing Operational Policy dated March 2022 sets out an aspirational

Minimum Data Set (MDS) for CAMHS. The MDS is dependent on systems changes currently being implemented

- compared to UK benchmarks, in 2019/20 the CAMHS caseload was twice as high as the UK average. The benchmark data indicated that Jersey CAMHS keeps children and young people on caseloads for longer than elsewhere. However, until recently, Jersey has included children and young people with Attention Deficit Hyperactivity Disorder (ADHD) in its CAMHS caseload information (unlike the UK). The most recent benchmarking data is not yet published but should be more comparable

- the Children's Health and Wellbeing Transformation Programme has assessed the staffing need for CAMHS. There is a current vacancy level of more than 21% of Full Time Equivalent (FTE) establishment staff against the planned establishment for CAMHS as set out in the Strategy

- the guidance on how to manage situations where children and young people 'did not attend' (DNA) their CAMHS appointment is not consistent with best practice and is not sufficient to ensure children and young people are safe and that they receive appropriate services and care; and

- performance data for the first quarter of 2022 shows the re-referral rate within CAMHS at 25%. At face value this means that a quarter of the children and young people who leave CAMHS were re-referred - however there are some known data quality issues with this reported rate. Data for June 2022 indicates a rate of 16%. The Children's Health and Wellbeing Service is more confident in the recent data, but the reasons underlying re-referrals are still being assessed.

Conclusions

9. The Government has committed to investment in the Children's Health and Wellbeing Transformation Programme, including CAMHS, through the Government Plan 2022-2025. This investment is supported by a robust Strategy launched in February 2022.

10. Governance, data collection, risk and performance management for CAMHS have been weak. For the Strategy to lead to a step change in service quality and range of provision it will need to be supported by stronger and more effective governance and other arrangements and more specific and detailed implementation plans.

Objectives and scope of the review

11. The review has evaluated:

- overall governance arrangements for CAMHS, including consideration of:
  - how recommendations made in the C&AG Report *Governance Arrangements for Health and Social Care – Follow up* (2021) that are relevant to CAMHS are being monitored and implemented
  - whether responsibilities and accountabilities are clearly set out and agreed, including in transition services between CAMHS and Adult Mental Health Services (AMHS)
  - how the oversight of performance information drives improvement; and
  - how performance improvement is being overseen
- service design including consideration of:
  - the range of services offered
  - how the range of services has been designed to meet known and anticipated need
  - the design of transition services between CAMHS and AMHS
  - how learning from previous reviews has helped to shape the range of services offered; and
  - the engagement of multi-agency partners in the design of services
- referrals management including consideration of:
  - who can make referrals
  - how pathways from all referrers are set out and communicated; and
  - how criteria for referral acceptance are agreed and implemented
- service delivery: how does the service as delivered:
  - compare with the service as designed and with best practice; and
  - maximise the use of available resources
- service resourcing: how do resourcing decisions:

    - work across States of Jersey departments; and
    - ensure a joined-up service for children, young people and their family and carers
- the effectiveness of commissioning and partnership arrangements, including consideration of:
    - how decisions are made on which services to commission, which services are provided by Government and which services are provided in partnership with third sector organisations
    - how the commissioning of services compares to best practice; and
    - how partnership arrangements compare to best practice
- performance management and oversight, including consideration of:
    - how the services are monitored and reported
    - whether the targets and measures being monitored are designed to ensure better outcomes for children and young people
    - the current and planned performance against key indicators
    - how performance and targets compare with best practice
    - how services are benchmarked; and
    - how partnership performance indicators are measured, managed and monitored.

12. The review has considered all aspects of CAMHS provision including services delivered by partners both on and off-Island. It has focussed on the responsibilities of the Children's Health and Wellbeing Service within the Integrated Services and Commissioning function of CYPES. It has not considered the work of other CYPES functional areas such as children's social work or child and family support.

Detailed findings

Design of CAMHS

Drivers for change in CAMHS

13. The design and operation of CAMHS have been the focus of a number of reviews. The service recognises that there is significant public, media and political interest in Children and Young People's mental health issues and CAMHS provision. It acknowledges concerns regarding waiting times for treatment, use of agency staff, lack of consistency in support and service performance.

14. Exhibit 2 sets out key milestones for CAMHS including Scrutiny and other reviews.

Exhibit 2: Key CAMHS milestones

Date	Event / milestone
June 2014	Health, Social Security and Housing Scrutiny Panel published its review of CAMHS. The Scrutiny Report made 10 recommendations for changes and improvements be taken forward, in particular relating to: Early intervention; Emergency access and in-patient services; Governance and information management.
2015	Mental Health Strategy 2015-2020 published followed by Mental Health Improvement Plan. The Strategy included commitments to: - develop a robust Quality Assurance and Governance system for mental health services in Jersey - introduce a quality framework; and - produce an annual Quality Report for the public.
June 2019	CAMHS transferred to CYPES as part of the Target Operating Model (TOM).
Nov 2019	Children's mental health redesign and strategy development commences.
April 2020	Ministerial decision to decommission secure beds and create three CAMHS inpatient beds at Greenfields, as emergency contingency (due to COVID-19 pandemic). This facility was closed in July 2020.

Date	Event / milestone
Mid 2020 – end of 2020	Children and Young People Mental Health redesign business case submitted, requesting funds from the Government Plan 2021-2024, to start in 2021. The Government Plan 2021-2024 stated that, in anticipation of recurrent growth funding from 2022, CAMHS would: *re-prioritise existing health and CYPES resources to release upfront investment to initiate the implementation of redesigned CAMHS in order to improve support for children and young people experiencing mental ill-health.*
Dec 2020	Children and Young People Mental Health redesign business case approved with funding being made available from 2022
March 2021	CAMHS submitted a business case to the Government's Covid Wellbeing and Recovery Programme, requesting £955,000. The main purpose of this business case was to provide agency staff to deal with the increase in need, complexity and the backlog of assessments. The business case was agreed in March 2021 and provided funding for: • measures specific to issues associated with COVID-19 and recovery: for example, implementing KOOTH, an online support system from an external provider; and • some exploratory work against the 2020 redesign business case – for example developing the neurodevelopmental pathway, mental health support in schools.
April 2021	First Head of CAMHS appointed (now Head of Children's Health and Wellbeing, incorporating CAMHS).
May 2021	Four-year draft Children and Young People's Emotional Wellbeing and Mental Health Strategy out for consultation
June 2021	A Joint Needs Assessment (JNA) was undertaken to assess the need for children's mental health services in Jersey.
Nov 2021	Perinatal pathway and Neurodevelopmental pathway completed and signed off.
Dec 2021	CAMHS Covid Wellbeing project closed.
Dec 2021	Funding as agreed for 2022–2025 in Government Plan now focussed on implementing the Strategy. The newly formed Children's Health and Wellbeing functional area extended 'CAMHS' to include: • Early Intervention • CAMHS Specialist (the original CAMHS service with modifications) • CAMHS Duty and Assessment (including emergency and intensive services); and • Quality and Assurance.

Date	Event / milestone
Jan 2022	Service Manager Quality and Assurance appointed.
Feb 2022	Service Manager Duty and Assessment appointed. CAMHS Duty and Assessment moves into the Children and Families Hub. Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022–2025 launched.
April 2022	Health and Social Security Scrutiny Panel issues follow-up report. Reports some progress but more to be done.

Source: Jersey Audit Office analysis

Needs Assessment

15. In June 2021 a Joint Needs Assessment (JNA) was undertaken to '*assess the primary data available and set it out in a way that clearly demonstrated the needs associated with the emotional wellbeing and mental health of children and young people in Jersey*'. This identified relevant data, including projected population, population by age band, ethnicity and language, living arrangements and schooling and pupil characteristics - for example those in receipt of the Jersey Premium and those with Special Educational Needs (SEN).

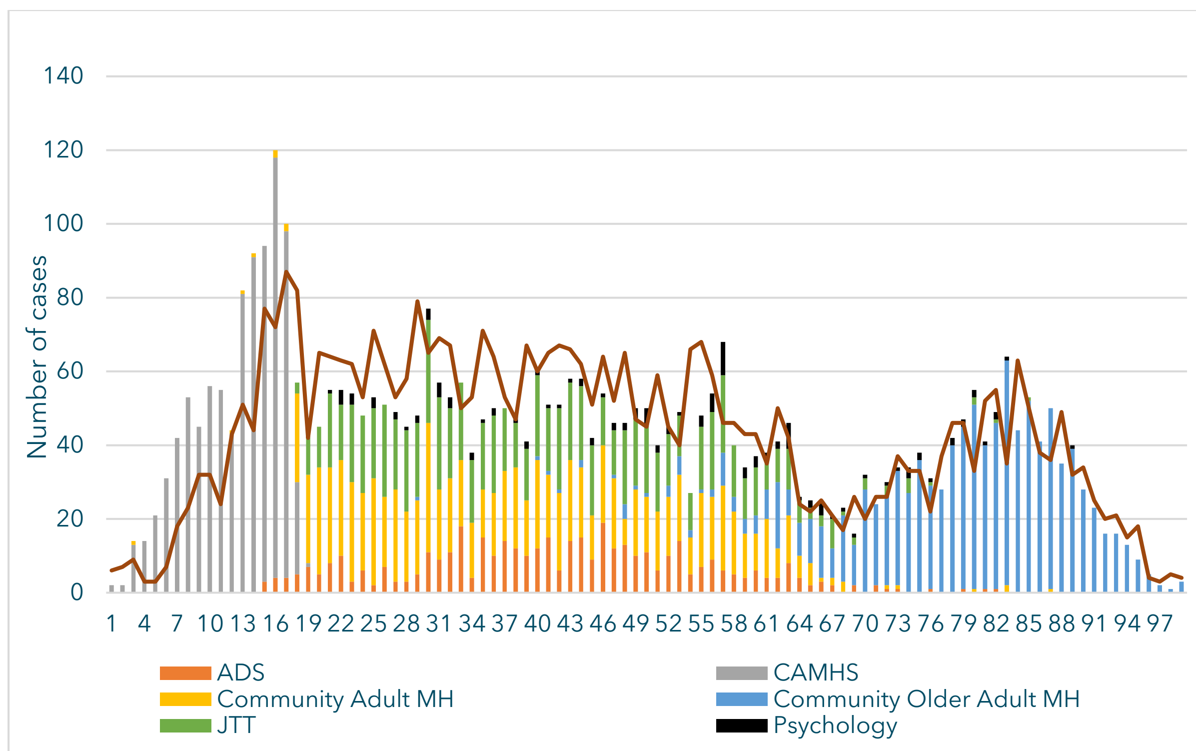
16. It also identified risk factors including:

- economic and socio-economic
- ethnicity and culture
- family status, tenure, income
- children in need of protection
- parental mental health or other long-term illness
- children with disabilities; and
- alcohol consumption and drug use.

17. While the identified risk factors would indicate a comprehensive approach to using available intelligence and risk assessment to predict need, there was little in the JNA to show that data specific to Jersey regarding these wider determinants of mental health were available or had been used to assess future demand for services.

18. Analysis of data on referrals to all mental health services in Jersey in the year to January 2021 demonstrates the increase in referrals to CAMHS compared with other services. In Exhibit 3 the horizontal axis is age of service user and brown line shows total referrals by age in the year to 31 January 2019, for comparison.

Exhibit 3: JNA analysis of total referrals to Jersey Mental Health services

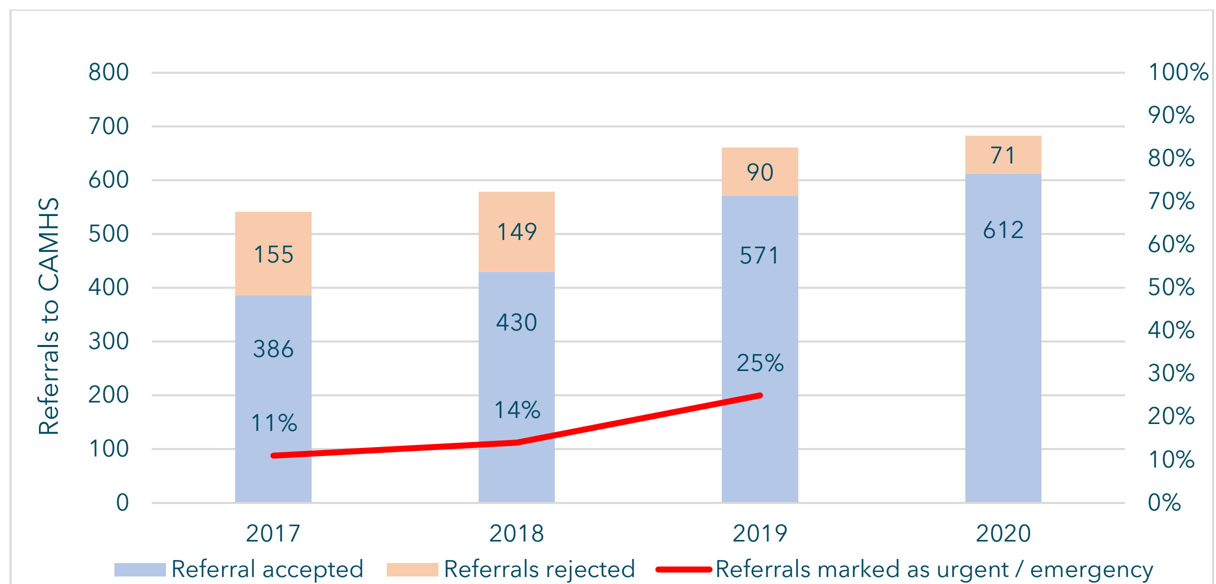


JTT is Jersey Talking Therapies and ADS the Alcohol and Drugs Service
Source: Jersey's Joint Needs Assessment issued June 2021

19. The JNA also analysed the characteristics of referrals to CAMHS. In the period 2017 to 2020 an increasing proportion of referrals was accepted onto caseloads and a higher percentage were marked as 'urgent or emergency' (see Exhibit 4).

C&AG
JERSEY AUDIT OFFICE

Exhibit 4: Characteristics of referrals to CAMHS 2017 to 2020



Source: Jersey's Joint Needs Assessment issued June 2021

Service development

20. In 2020, a business case submitted by CYPES seeking investment from the 2021-2024 Government Plan set out:

- an increase in waiting times
- an increase in complexity of referrals
- Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) referrals increasing
- a gap in support for neurodevelopmental disorders and disabilities, perinatal mental health and paediatric health psychology
- relatively high rates of alcohol-specific hospital admissions for under 18s
- the lack of early intervention services, intensive community support, home treatment and psychiatric liaison; and
- known issues in achieving an effective and efficient transition pathway from CAMHS to adult mental health or other services.

21. The Government accepted the need for investment in redesign and capacity but rejected the start date of 2021. There was though a commitment that Government Plan funding would be agreed for 2022-2025.

22. At the end of 2020, CAMHS submitted a business case for funding from the Government's Covid Wellbeing and Recovery Programme. In March 2021 the

requested £995,000 was confirmed. This enabled some progress in key areas set out in the original 2020 business case.

23. The Government Plan 2022-2025 includes investment of £6 million over three years from 2022, with £2.25 million recurring from 2025 onwards. In addition, it includes investment in intensive support, out of hours and inpatient provision for CAMHS amounting to £13.4 million over four years 2022-2025.

24. The resulting Children's Health and Wellbeing Transformation Programme encompasses development and stratification of mental health services for children and young people. The intention is to provide a more comprehensive continuum of services.

25. The Programme also encompasses:

- development of neurodevelopmental and perinatal mental health services
- improved transition arrangements as children and young people move into adult mental health or other support services
- medical cover for governance and leadership; and
- improved quality and performance management.

Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022-2025

26. In February 2022 the Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022-2025 (the Strategy) was launched. The Strategy sets out a clear picture of what needs to be achieved and what 'good' looks like. It includes prioritised action and how improvements can be monitored and measured.

27. I have reviewed the Strategy against elements of good practice in strategy development (see Exhibit 5). The Strategy performs well in all areas.

Exhibit 5: Review of the Strategy against good practice

Critical reflection

- The Strategy starts with a look at gaps and weaknesses in current service provision. New structures and changes to the use of resources align with identified issues.
- Three surveys were used to gather views from children and young persons, from parents and carers and from professionals. More than 450 responses where received and feedback has clearly informed the proposed model of care. However, Jersey's Youth Parliament concluded that more could have been done to ensure all voices were heard.

Clear, balanced objectives

- The Strategy aligns with the Children and Young People's Plan 2019-2023 and its five guiding principles.
- It identifies four priorities and sets out what 'good' looks like.
- The level and use of stakeholder engagement supports a balanced approach based on need and impact.

Medium and longer term

- The Strategy includes fundamental redesign of service delivery with a view to solving immediate issues (in particular long waiting times).
- It also identifies changes to support medium and longer term improvements through, for example, increasing the delivery of services within multi-agency partnerships.

Focussed, actionable content

- The Strategy clearly targets key objectives and draws a coherent picture of what it seeks to achieve. It uses a model developed by the UK NHS's Child and Maternal Health Observatory to describe its approach.
- The Strategy defines specific service developments with overall ambition and specific actions against these. It is clear on how these form a continuum.

Owned

- The focus on wide stakeholder involvement in its development has resulted in broad ownership.
- The Strategy has a summary version which is more child / young person friendly, also provided in Portuguese, Polish and Romanian.
- Development of a Strategic Advisory Panel (SAP), including service users and community providers, to oversee implementation is important to maintaining ownership.
- The launch of the Strategy and of the SAP have been communicated and celebrated.

Deliverable

- The action plan sets out a clear pathway to delivering the objectives.
- A Programme Board is being established to manage progress. It is important that the approach has both strong governance and discipline but also built-in flexibility and opportunities for learning.
- How this aligns with responsibilities of the Governance and Oversight Group is however not clear.

Source: Jersey Audit Office evaluation against identified good practice

28. The approach to developing the Strategy has been comprehensive, thorough and well governed. A particular emphasis for the development has been a clear focus on engagement and co-production. The Youth Parliament was included in this engagement through a workshop and subsequent meeting.

Recommendation

R1 Strengthen:

- the use of Jersey specific risk data and wider determinants of health in forecasting demand for children's mental health services (both capacity and services needed); and
- cross-departmental measures of the impact of interventions, including as part of the Jersey Performance Framework.

Pattern of CAMHS delivery

Community CAMHS

29. CYPES's specialist CAMHS provides targeted intervention through a range of evidenced based treatments, including but not limited to:

- brief solution focussed therapy
- Cognitive Behavioural Therapy (CBT)
- Cognitive Analytic Therapy (CAT)
- creative therapies, including art therapy
- Dialectical Behaviour Therapy (DBT)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- evidence based group interventions including working with partner agencies
- Family Therapy
- Interpersonal Therapy (IPT)
- psychiatric intervention
- Psychodynamic psychotherapy
- medication provision and administration using shared care arrangements (where possible) with primary care GPs; and
- advice and skills programmes for parents/carers, schools and professionals.

30. Commissioning of community services from other on-Island providers is relatively under-developed in Jersey but opportunities, including for partnership working, are increasingly being identified and implemented. Currently, the services to support children and young people's mental health commissioned by Children's Health and Wellbeing are:

- Kooth - online counselling and emotional wellbeing support service for young people aged from 11 to 25. By February 2022, 975 young people had used the service and more than 90% would recommend it to a friend
- MIND Jersey - commissioned by CYPES to assess the needs of children and young people who have been referred to CAMHS but whose mental health needs are at a lower level. By October 2021 MIND Jersey had undertaken 17

assessments and of these, five no longer required CAMHS support. In December 2021 the contract with MIND Jersey was extended to the end of 2022. It was also broadened to include assessment of children and young people with ADHD; and

- two services providing assessment for Autism Spectrum Disorder (ASD):
  - Island Autism; and
  - Options Autism 8.

Inpatient CAMHS delivered by the Government of Jersey

31. For those children and young people who require inpatient mental health care, Jersey does not have a dedicated facility. Whilst the number of service users who require inpatient care is relatively low, it is recognised that current arrangements are not adequate. There are plans for improvements but the timeframe for all developments is not yet confirmed.

32. Those children and young people who have a medical emergency and need inpatient care are admitted to Robin Ward at the hospital. This is the children's ward, providing paediatric and nursing care but not specialist mental health services. There is a policy in draft, *Clinical Management of Children and Young People with a Mental Health Disorder in an Acute Hospital setting.*

33. Currently, Orchard House – an Adult Mental Health facility – is the only other on-Island inpatient facility used by CAMHS. Risks for those under the age of 18 who use this facility are assessed on a case-by-case basis to determine the safeguarding and safety mitigations required.

34. There are two developments intended to relieve this sub-optimal arrangement:

- Clinique Pinel, which will be refurbished to replace Orchard House, will have a bed area and day space specifically for anyone under the age of 18 who needs hospital care; and
- the 'Our Hospital' project currently includes dedicated space for inpatient care for children and young people with mental ill-health.

Commissioned residential CAMHS – on Island placements

35. There are currently no on-Island residential, therapeutic facilities for children and young people with complex issues which include mental ill-health. CYPES has considered provision of a therapeutic children's home but has not yet concluded on the best way forward.

36. In 2021 an on-Island partner developed a specific residential service for children and young people. Hope House offered a 28-day residential treatment programme *'focussed on resilience and preventative wellbeing initiatives such as structure, exercise and coping skills'*. However, Children's Health and Wellbeing has not been able to place any children or young people at Hope House: while it is registered as a children's home, it is not a therapeutic children's home, so does not have the approvals, facilities or staffing to meet the needs of children with the most complex needs.

37. This situation demonstrates the importance of a joined up, consultative and evidence-based approach to service development. New governance structures being established in 2022 are intended to better enable this (see Exhibit 8).

Commissioned inpatient and residential CAMHS – off-Island placements

38. In circumstances where facilities on-Island are not adequate to meet the child or young person's need, services are commissioned from the UK.

39. For all off-Island mental health placements, Independent Placement Panels (IPPs) consider submissions and make decisions. CAMHS off-Island requests are taken to the Children's IPP which sits 'as and when' a clinician identifies the need for services not available in Jersey.

40. The Procurement Strategy used in decision making for off-Island placements includes a 'due diligence' process, comprising a list of areas to be considered when choosing a service provider. Officers are aware that more could be done to ensure consistency in the way the listed items – for example the providers' Care Quality Commission (CQC) and Ofsted ratings and service user feedback – are used in decision making.

41. For children and young people, typically numbers identified as requiring off-Island care are low – at the time of my fieldwork for example there was only one placement in the UK. The Interim Director General for CYPES has asked for a review of criteria used by the IPP to ensure these align with best practice.

42. Having recognised the increase in incidence of eating disorders, the IPP is aware that there is low capacity within the UK to meet Jersey's need. The Interim Director General for CYPES has identified that a specific plan is required involving formal arrangement with a dedicated off Island provider. This is being taken forward currently.

43. In 2021 the newly appointed Head of Children's Health and Wellbeing undertook a visit to a young person receiving services off-Island. The outcome is set out in the case study at Exhibit 6.

Exhibit 6: Outcome of a visit to review a CAMHS off-Island placement

In 2021 the Head of Health and Wellbeing undertook a visit to a UK- provider of specialist residential CAMHS. A 'core' package of care had been commissioned for this service user.

In discussion, the young person raised the issue that, while the facility offered an education service, the young person did not currently have access to that. There was an additional fee of £175 per day which had not been covered.

Funding was subsequently arranged, but this raises the following questions:

- why didn't the 'core' package commissioned from this provider include access to education, and why did no one notice this until it was raised by the young person? and
- would this have been spotted by the commissioner or raised by the provider if the visit had not happened?

What is clear is that mechanisms for ensuring high quality placements that meet the holistic needs of children and young people, have been lacking.

Recommendations

R2 Establish service needs and criteria for evaluating opportunities for services to be commissioned for delivery in partnership with - or exclusively from - community providers.

R3 Ensure improvements to on-Island inpatient care for children and young people are implemented, including by setting and monitoring Key Performance Indicators (KPIs) to demonstrate improved service user experience.

R4 Ensure that the IPP considers and commissions services to meet all needs of the service user when deciding on a package of care.

R5 Ensure that the 'due diligence' items set out in the Procurement Strategy are supported by high quality information and are used consistently when making decisions about off-Island placements.

Overall governance arrangements

44. Governance arrangements for CAMHS have not been robust and have not to date operated effectively.

45. Since June 2019, HCS and CYPES have had joint responsibility for delivering CAMHS. However there has not been a robust, agreed MoU in place to govern this relationship and to assure the safe and high-quality delivery of services. Whereas draft versions of the MoU have been considered and 'agreed in principle' at various departmental management groups, there is no one version that all signatories to the MoU have approved.

Departmental responsibilities for CAMHS

46. In 2015 my predecessor reported as part of her *Review of Community and Social Services*:

> *a lack of appropriate governance for managing 'business as usual' services. In Children's Services [*which included CAMHS*] there were no robust arrangements in place to identify and then address declining service standards.*

47. Until 2019, both children's and adults' mental health services were managed as part of community-based health services by the Department for Health and Social Services (HSSD).

48. In 2019 the structure of Jersey Government departments changed in line with the OneGov Target Operating Model (TOM). Under the TOM, the management of CAMHS moved to the newly formed CYPES. The stated objectives for this move were:

- to achieve a fully integrated children's system with clear, effective pathways that work for children and their families, which is child focussed, delivered in the right way in the right place and at the right time
- to keep a strong focus on early intervention
- to remain multi-professional and multi-agency, requiring collaborative and partnership working; and
- for specialist clinical teams to work within a framework which includes clinical governance, legal frameworks and NICE (the UK's National Institute for Health and Care Excellence) guidelines.

49. At the time, it was agreed that:

- while CYPES became responsible for day-to-day management of CAMHS, HCS retained:
    - general and clinical management of CAMHS doctors and medical staff, as part of its Women, Children and Families Care Group; and
    - budget and a level of accountability for inpatient care both in Jersey and for off-Island placements; and
- in moving the service, opportunities would be taken to redesign pathways of care to more effectively meet the range of needs of children and young people being referred to CAMHS.

Governance and Oversight Group

50. In June 2019, a MoU between CYPES and HCS was drafted for the provision of CAMHS. The draft MoU established a joint Governance and Oversight Group to assure implementation of the MoU. Whilst the Governance and Oversight Group was established at this point, the MoU has been redrafted several times and there is no one version that all signatories to the MoU have approved.

51. The role, membership and functions of the Governance and Oversight Group have changed in the various iterations of the draft MoU. In the period to April 2022 there have been four redrafts. However, it is not clear that any version of the Terms of Reference (ToRs) has been signed off and adopted.

52. None of the draft versions of the ToRs for the Governance and Oversight Group specifically set out how the Group would ensure that the stated objectives of the move of CAMHS to CYPES would be met.

53. Reviewing the available Minutes and Agenda papers from the eight meetings of the Group between July 2019 and July 2022, it is evident that it has not fulfilled its overarching role of securing and assuring clinical and professional standards. This is not least because the Group has not met in line with the minimum requirements of the various draft MoUs and draft ToRs (see Exhibit 7).

Exhibit 7: Minimum schedule and actual meetings of the Governance and Oversight Group

Monthly schedule	Intended meetings	Actual meetings
July 2019		
Aug 2019		
Sept 2019		
Oct 2019		
Nov 2019		
Dec 2019		
Jan 2020		

Quarterly schedule	Intended meetings	Actual meetings
Q2 2020		
Q3 2020		
Q4 2020		
Q1 2021		
Q2 2021		
Q3 2021		
Q4 2021		Awayday held
Q1 2022		
Q2 2022		
Q3 2022		

Source: Jersey Audit Office analysis

54. The meetings that have happened have the following characteristics:

- early lack of clarity on leadership. The Minutes of the first meeting of the Governance and Oversight Group show that it was agreed that the two Directors General would be co-Chairs, covering recurring six month periods. However, the Director General for CYPES was not at this meeting. In August 2019 it was 'agreed off-line' that the Directors General need not attend the Group meetings. As responsibilities and accountabilities had not changed, the basis for this decision is not clear. At the September 2019 meeting a key agenda item - to update on progress in integrating CAMHS into CYPES as part of the TOM - could not be covered as the Director General for CYPES was not present

- early progress stalled. For example, an item raised at the first meeting – that there was a risk of fragmentation in clinical governance arrangements and that roles and responsibilities needed to be clarified – had an immediate response. A draft *CAMHS Integrated Clinical and Professional Governance Framework* was considered at the next meeting. However, this was never finalised – gaps in responsibilities set out in the document include staff training, quality improvement and the management and assurance of patient experience

- the meeting agendas were not well aligned to the Group's responsibilities. In January 2020, very significant items were managed under 'Any Other Business'. These included review and ratification of policies, service

performance, CAMHS consultant workforce and leadership, service redesign, off-Island placement process and senior management cover arrangements

- few papers are taken to the Group meetings and updates have been chiefly verbal. For example, at the January 2020 meeting, the agenda items on workforce, KPIs, Health and Safety and Issues for escalation were all verbal; and
- notes of meetings were taken but due to the gap between meetings, it is not straightforward to track the delivery of agreed actions. Some actions were never delivered – key among these is that Directors General for HCS and CYPES (when no longer required to attend the Group) were to receive the meeting Minutes. There is nothing to show this was actioned.

55. In October 2021 the Governance and Oversight Group members attended an 'away day'. The outcome from the day was a set of joint principles:

- think Child and Family (not department and profession)
- no surprises
- share intelligence / insight
- maintain a joint policy, programme and project pipeline/plan
- presume to collaborate; and
- invest in the relationships (formally [structures] and informally).

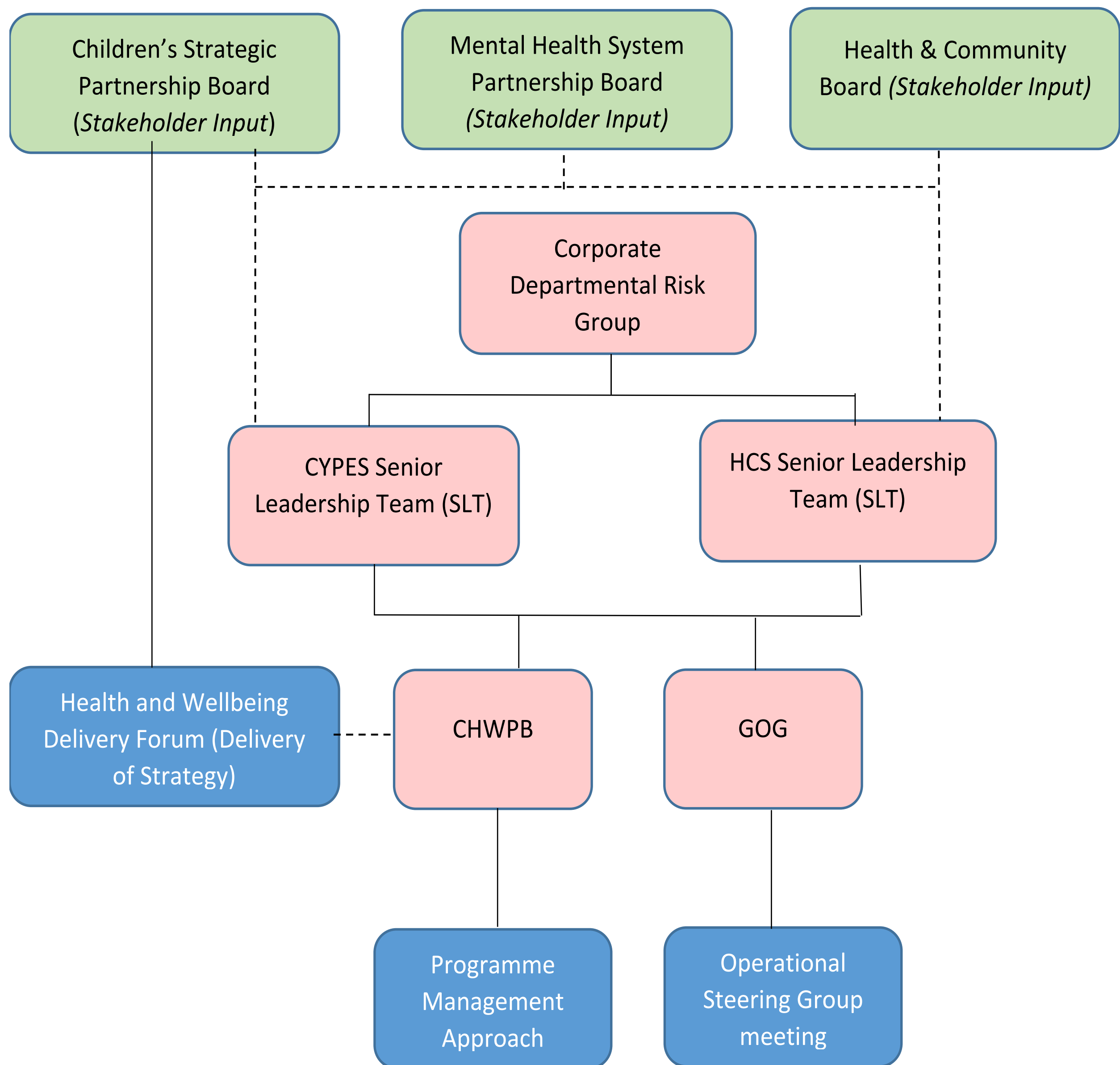
56. The Governance and Oversight Group has met once since the 'away day', in early July 2022. At this meeting the Group concluded that the latest draft MoU and the Group's draft ToRs need further updating. It is not clear whether updates will explicitly take forward the joint principles.

Revisions to governance arrangements in 2022

57. In early 2022 a draft governance structure to support the Children's Health and Wellbeing Transformation Programme was proposed. The proposal as a whole makes clear that the Director General for CYPES and the Director General for HCS remain jointly responsible for the transformation of children, young people and family's community health services.

58. The structure as adopted is set out in Exhibit 8.

Exhibit 8: Governance structure including the Children's Health and Wellbeing Transformation Programme



Key:

- Team delivering the project
- Oversight and accountability
- Stakeholder input

CHWPB - Children's Health and Wellbeing Programme Board

GOG - Governance and Oversight Group.

Source: Draft Children's Health and Wellbeing Transformation Programme Approach

59. In addition, a Strategic Advisory Panel (SAP) made up of young people, parents, carers and professionals was launched in May 2022. SAP will advise on the delivery of the Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022-2025.

60. The Mental Health System Partnership Board is a new Board established in 2022 with the purpose of collectively developing an integrated mental health system for Jersey. The membership and Terms of Reference of the Board are yet to be finalised.

61. It is planned that the Board will:

- review progress against the existing Mental Health Improvement Plan; and
- oversee development of integrated mental health services, based on the priorities and objectives for the system partners collectively.

62. The Board will report to the HCS Board and the Public Health Programme Development Group. The draft ToR does not set out how the Board will ensure that the integrated mental health system is linked to the developments within the Jersey Care Model.

63. The CHWPB is a new body. It is planned that the CHWPB will oversee Children's Health and Wellbeing Transformation Programme developments.

64. In April 2022 the CHWPB had its first meeting. It was however poorly attended. Of the 18 people invited, five attended. There were ten apologies but no response from three Board members. A key member of the group – the Programme Manager – has yet to be appointed. A second meeting in June 2022 was better-attended and had a clear agenda.

65. The Terms of Reference for the CHWPB are still draft.

Arrangements for receiving and implementing C&AG recommendations

66. There is no effective process in place to identify and monitor progress against C&AG recommendations relevant to CAMHS.

67. The July 2019 MoU between HCS and CYPES set out that a key assurance focus was to monitor:

> *progress against C&AG and Scrutiny report recommendations relevant to children's mental health services and facilities.*

68. The Governance and Oversight Group meeting in September 2020 included an action to 'pick up C&AG legacy' recommendations. Despite this, the Group has not considered C&AG or Scrutiny recommendations at any of its meetings.

69. My Report *Governance Arrangements for Health and Social Care – Follow up* (2021) includes recommendations pertinent to all health and social care services provided by or commissioned by the Government of Jersey. These recommendations have not been formally considered for any CYPES service.

70. An assessment of activities against key recommendations was prepared by officers from Children's Health and Wellbeing as part of this review. In Exhibit 9 I summarise and evaluate the response.

Exhibit 9: CAMHS actions against relevant recommendations from my report *Governance Arrangements for Health and Social Care – Follow up (2021)*

Recommendation	Summary action / progress	Comment
R5 Publish an Annual Quality Account for all health and social care services provided by Government	CAMHS plan to publish a Jersey annual report from 2023. A CAMHS minimum data set has been identified and work is ongoing to implement this.	Plans for a 2023 annual report to include quality indicators are reliant on the successful implementation of the minimum data set.
R7 Ensure that robust arrangements are in place to update the data supporting the Jersey Performance Framework on a more regular basis	Care Partner (Community CAMHS data management system) is currently being updated to allow improved data collection.	How Routine Outcome Measures data for CAMHS will be integrated into the Jersey Performance Framework – so that activity and quality information is aligned and published in one place – is not yet clear.
R8 Document a long-term strategy for health and wellbeing to be delivered across Government, health and social care services and key partners. Progress against the long-term strategy should be reported publicly	The Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022–2025 was co-produced with key stakeholders. It provides a framework and action plan to deliver the agreed vision and outcomes. Indicators are identified in the Strategy. An annual report is planned to be published in 2023.	This is good progress.

Recommendation	Summary action / progress	Comment
R13 As part of the implementation of the Jersey Care Model, explore ways of sharing information and learning from complaints across all parts of the health and social care system, including from primary care providers	The Children's Health and Wellbeing Service is utilising and engaging with the Customer Feedback Management System (CFMS) for complaints and compliments.	Not enough is done to ensure complaints and compliments data for CAMHS is collated and evaluated, or that action is taken and lessons are learned. In 2020 the Governance and Oversight Group queried reports which stated there were no outstanding complaints. The Group has not considered this since February 2021.
R14 Redefine the expected behaviours supporting the Team Jersey Values into a language specific to the delivery of health and social care services for HCS staff	CAMHS has an all-staff weekly team meeting where expected values and behaviours are reiterated. CYPES is considering integrating the agreed service outcomes performance measures into staff performance appraisals.	The aim to incorporate outcome performance measures into staff appraisals is a positive development. However, the principles established at the Governance and Oversight Group 'away day', facilitated by Team Jersey, are not yet used as a benchmark for appraising behaviours and attitudes within CAMHS.
R15 Implement a more comprehensive quality and safety programme across all health and social care services	CYPES has a Health and Safety Risk Management plan.	The Health and Safety Risk Management plan is not a comprehensive quality and safety programme. It does not reflect, for example: • the move to incorporate ROM and pre- and post-intervention measures and how this is expected to improve quality and safety for service users • the need to understand relatively high levels of re-referrals; or • service-wide learning from complaints and other feedback.

Recommendation	Summary action / progress	Comment
R16 Extend further the scope and nature of routine public reporting of the performance of all elements of health and social care, including through the Government of Jersey website, taking into account performance reporting in other jurisdictions	Information about children, young people and family health and wellbeing is available on the Government of Jersey Website including information on the Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022–2025 Indicators are identified in the Strategy.	There is no information about actual performance on this site except that included in the Strategy as the basis for service re-design. Plans to issue an Annual Quality Account in 2023 are intended to significantly increase the CAMHS performance data that is reported publicly. The content for this though is still being finalised.
R17 Improve the arrangements for the management of risks by: • documenting the risk appetite for the key risks identified on the risk register • ensuring that risk mitigation actions are aimed at managing risks within the identified risk appetite • clarifying the interaction between the HCS approach to risk and the Government ERM approach • improving the audit trail through the assurance committees and the HCS Board as to how risks have been managed on and off the risk register; and • ensuring the HCS Board reviews the top health and social care system risks on a systematic basis at least twice a year	I comment on the management of risks at operational level in the next section of this report.	The Governance and Oversight Group does not have a good view of risks. It has not escalated any CAMHS risk to either HCS or CYPES SLTs or to the HCS Board. There is more to do to ensure: • CAMHS risks – clinical and operational – are properly managed through departmental risk systems in line with accountabilities and responsibilities • the full risk picture is routinely seen by the Governance and Oversight Group; and • risk reporting for CAMHS is included in the consideration of top health and social care system risks by the HCS Board.

C&AG
JERSEY AUDIT OFFICE

Recommendation	Summary action / progress	Comment
R18 Ensure that the quality and safety programme to be implemented includes a comprehensive strand of work aimed at developing the capacity and capability of all those involved in delivering governance across health and social care	The MoU between the CYPES and HCS is intended to ensure a clear Governance Framework is in place.	The MoU has never been finalised. The various drafts of the MoU have not been successful in ensuring clear governance arrangements for CAMHS in practice. The Governance Framework is still draft.

Source: Jersey Audit Office analysis of Children's Health and Wellbeing Services' information return

71. The Government's centralised process which manages my recommendations, the C&AG Recommendation Tracker, requires a single lead to be nominated for each recommendation. It does though allow recommendations to be listed as relevant to more than one department. Currently all *Governance Arrangements for Health and Social Care – Follow up* recommendations are only listed as relevant to HCS.

Recommendations

R6 Agree, adopt and communicate a Memorandum of Understanding between CYPES and HCS for the governance and operation of CAMHS.

R7 Agree, adopt and communicate a Terms of Reference for the joint Governance and Oversight Group, ensuring that this documents:

- how all accountabilities are satisfied
- how the joint principles identified at the 'away day' will be carried forward; and
- how the stated objectives of the move of CAMHS to CYPES will be assured.

R8 Agree, adopt and communicate Terms of Reference for newly developed governance groups including the Mental Health System Partnership Board and the Children's Health and Wellbeing Programme Board. Ensure that these Terms of Reference document the groups' relationships to:

- the Jersey Care Model; and
- the 'Our Hospital' project.

R9 Ensure arrangements are in place to monitor and manage compliance with all governance processes.

R10 After a suitable period, evaluate how effectively all governance processes are working in practice.

R11 Document and implement a comprehensive quality and safety programme across CAMHS.

R12 Establish a process to ensure that all relevant departments, not just the lead department, are aware of and properly engaged in implementing actions in response to accepted C&AG recommendations. Include this process in the Tracker Manual which covers roles, responsibilities, accountabilities and Tracker operation.

Performance and risk management

Responsibilities

72. There has been no overarching co-ordinated approach to consideration of CAMHS performance and risk data. To date, there has been a disconnect in the management of 'clinical' (which is viewed as HCS's responsibility) and 'operational' (CYPES) performance and risk information. Alignment of data and information to enable joint clinical and operational oversight of the quality of services, has been lacking. For example, there has not been a straightforward way to assess the impact on operations of changes in clinical practice.

73. Following implementation of the TOM in 2019, some key departmental systems and processes were not quickly joined up. In January 2020 it was agreed that Datix (HCS's risk management system) would be the single point of reference for CAMHS risks, to consolidate all CAMHS risk logs. The new CYPES risk manager, appointed in 2022, does not however have access to Datix. This increases the likelihood that risks will be missed.

74. Some elements of performance and risk are reported within departmental CYPES and HCS structures but:

    - the existing departmental performance and risk assurance frameworks are not operating effectively for CAMHS, including because roles and responsibilities for CAMHS are not fully agreed and operational; and
    - there is no overarching, co-ordinated cross-departmental approach.

75. The Governance and Oversight Group has not established systems or processes to enable it to provide any assurance on CAMHS performance, including management of risks. Instead, there has been:

    - poor correlations of meeting agenda items to the responsibilities of the Group
    - inadequate information either requested or considered
    - no setting or review of standards or KPIs
    - an inadequate process for developing and ratifying policies
    - little consideration of risks; and
    - no reporting or escalation from the Group.

76. Very little performance or risk information has been discussed at meetings to date.

77. Despite their accountabilities, there has been no effective mechanism in place to assure the Directors General for HCS and CYPES about the performance or quality of CAMHS. The current Interim Director General for CYPES has acknowledged that information about service quality is not driving improvements or continuous learning in the way it should.

Consideration of CAMHS performance and risk information

78. Within CYPES, the Directorate Leadership Team (DLT) meetings were replaced with weekly Senior Leadership Team (SLT) meetings in 2022. The SLT meetings incorporate, once in each month, a Performance Board and a Quality Assurance Board. I have not however been able to evaluate what or how CAMHS performance and risk information has been considered at either DLT or SLT meetings: for the period reviewed (2019-2021) DLT notes of meetings are partial, and SLT notes from January 2022 are currently only available as an automatic transcription from a recorded meeting. Decisions made and actions agreed have not been separately recorded.

79. CYPES risk meetings have comprised an overall discussion of risks in terms of numbers for each service area and consideration of trends. There are though no formal notes of discussions or decisions made at these meetings. Establishing a Performance Board and a Quality Assurance Board are important developments in managing CYPES' care-facing services, including CAMHS. However, there is more to do to ensure the performance and risk information considered is sufficiently granular to be meaningful and to indicate required actions.

80. The CYPES Informatics Team intends to develop a detailed set of dashboards to support CYPES' daily and weekly operational performance management. The timescale for this planned improvement is not however set out. There are clear opportunities to improve the level of detail in performance reporting – for example reporting against compliance with 'triage' waiting times as set out for urgent and routine referrals rather than just as an average.

81. HCS remains responsible for CAMHS clinical quality assurance. HCS's Women, Children and Families Care Group manages CAMHS doctors and medical staff. Clinical competence is overseen in the same way as for other consultants in HCS, including annual performance appraisal and job planning, revalidation for registration and routine supervision.

82. HCS's Mental Health Care Group holds the budget for off-Island inpatient services and HCS is represented at the Children's IPP where off-Island placements are discussed and agreed. However, until July 2022, HCS's Director for Mental Health and Adult Social Care was not part of any group which considered community-based CAMHS performance and risk information. He is now a member of the

Governance and Oversight Group and the new Mental Health System Partnership Board.

Data Quality

83. For both CYPES and HCS, the range and quality of service data relating to CAMHS are recognised as in need of improvement. The data relating to CAMHS performance has, to date, been chiefly about waiting times and activity.

84. Jersey CAMHS has been a member of the NHS Benchmarking Network since 2015 but, unlike most other network members, has not been able to provide more qualitative data based on outcomes and service user experience.

85. In February 2020 an internal review of CAMHS data and systems identified a number of risks and issues. Key planned improvements are dependent on changes being made to data recorded on Care Partner (CAMHS 'host' information system). A pilot for these changes commenced in February 2022. I understand that new data forms and training to support their use are currently being rolled out.

Planned improvements in performance reporting

86. The Children's Health and Wellbeing Operational Policy dated March 2022 sets out an aspirational Minimum Data Set (MDS) for CAMHS. The plans to implement the MDS are however dependent on changes being implemented in Care Partner and successfully rolled out.

87. CYPES' Head of Informatics and the Children's Health and Wellbeing Quality and Assurance Managers are ambitious to improve performance dashboards. Ideas are being developed to incorporate new data such as pre- and post- intervention measures and particularly to enable closer monitoring of the impact and experience of new service models.

88. There is however no joined up and formalised plan, agreed across all those responsible and accountable for CAMHS. The data requirements of the Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022-2025, including those that relate to risk factors, are, I understand, now identified and being built in to data development for both CAMHS and Public Health.

89. There is room for improvement in capturing and analysing data and information which will help identify potential inequalities in access to CAMHS. Currently, referral data includes the child or young person's age, school and General Practitioner. It also notes primary language and whether a translator is needed. This information is not analysed to spot patterns in referrals. There remains scope to gain significant intelligence by recording and analysing risk-based information about, for example:

- ethnic origin; and
- factors such as being a young carer or having a disability.

Recommendations

R13 Agree, map out and implement roles, responsibilities and arrangements for CAMHS performance management across all areas of Government and all relevant structures, covering:

- setting standards
- identifying and capturing data for Key Performance Indicators
- establishing ambitious targets and benchmarking arrangements
- monitoring and overseeing performance against standards and targets
- reporting; and
- taking action to resolve identified weaknesses and implement improvements.

R14 Agree, map out and implement roles, responsibilities and arrangements for CAMHS risk management across all areas of Government and all relevant structures. As part of this, review arrangements for ensuring all risks relevant to CAMHS are logged and can be appropriately cross-referenced in one document.

R15 Set standards for documenting the output and outcome of CYPES strategic and key operational management meetings. As a minimum this should include attendance, items to be logged as risks, decisions made and actions agreed. Ensure these are appropriately accessible so that they can be meaningfully used by officers.

R16 In finalising a Minimum Data Set for CAMHS, make it sufficiently comprehensive to encompass all data to be routinely collected, including as a priority data to identify potential inequalities in access to services.

R17 Formalise plans to improve the richness and quality of performance dashboards within Children's Health and Wellbeing. Ensure the needs of all parts of the governance and advisory structure are considered, including the Annual Report planned for 2023.

How CAMHS performs

90. CAMHS data for the year to May 2022 is set out in Exhibit 10.

Exhibit 10: CAMHS data as reported to the CYPES Performance Board in June 2022

Measure	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Monthly referrals to CAMHS	89	105	104	73	98
Average length of stay CAMHS: Robin Ward (days)	3.4	2	0.8	-	2.7
Average waiting time for CAMHS assessment (weeks)	4	3.8	4.5	3	3
Quarterly average waiting time assessment (neuro-developmental) weeks	-	-	25.3	-	-
% re-referrals to CAMHS (within 12 month of discharge)	25%	30%	13%	26%	24%

Source: Informatics manager CYPES

91. There are early signs that new ways of managing referrals and the evolving service structure for CAMHS are having a positive impact on waiting times.

92. This data was presented 'live' to the CYPES Performance Board. There is no written narrative to accompany the data. I have not seen a note of risks identified, decisions made, or actions agreed following this data presentation.

Benchmarking performance

93. Jersey has been part of the NHS Benchmarking Network since 2015. Results for key CAMHS data for the period April 2019 to March 2020, compared with network averages, are set out in Exhibit 11.

Exhibit 11: Jersey CAMHS data for 2019/2020 compared with UK national mean values

Indicator and performance	Jersey	UK national mean	Comment
Referrals per 100,000 population	2,927	3,872	The rate of referrals for Jersey is relatively low. In 2019/20 most UK CAMHS accepted self-referrals but Jersey did not.
Acceptance rate for assessment	87%	79%	The acceptance rate for assessment in Jersey was relatively high. At the time of the benchmarking exercise there was no early intervention team in Jersey. The numbers accepted into the Early Intervention Team will be excluded from the benchmarking data in subsequent years.
Conversion rate for treatment	83%	70%	The conversion rate for treatment in Jersey is also relatively high.
% of referrals marked as 'urgent'	25%	12%	A significantly higher proportion of Jersey's referrals are marked as 'urgent'.
Numbers on the CAMHS caseload per 100,000 population (0-18) Referrals accepted per 100,000 population (0-18) Number of discharges per 100,000 population (0-18)	3,239 2,542 2,552	1,638 2,998 2,279	That the number of referrals 'added to the books' each year is lower than average but the caseload is twice as high as average, indicates that Jersey CAMHS keeps children and young people on caseloads for longer than is typical in the network. This is partly due to those with ADHD being counted (almost 50% of caseload). These children are more often than not, not discharged from the service as prescriptions come via the medics and nurse prescribers in the team. Clinical supervision includes discussion of caseloads and individual cases. I am not though aware of any documented review of caseloads or caseload management against standards and criteria.

Indicator and performance	Jersey	UK national mean	Comment
Contacts per 100,000 population (0-18) Cost per contact Contacts per clinician (FTE)	59,601 £121 1,033	24,124 £276 339	The definition of 'contact' is loosely drawn. Frequent telephone and other forms of contact with specific groups of service users can skew this indicator.
Community CAMHS workforce per 100,000 population (0-18) Cost per 100,000 population	67 £7.1 million	95 £6.1 million	The CAMHS workforce in Jersey has been decreasing. The costing data might indicate a relatively rich skill-mix. Implementation of the new Strategy is changing the balance of the workforce.

Source: NHS Benchmarking Network CAMHS data 2019/20

94. I have not seen any action plan linked to the 2019/20 NHS Benchmarking Network data.

95. Jersey has just submitted data for the 2021/22 NHS Benchmarking Network analysis and this is planned to be reported in October 2022.

Workforce planning

96. Delivering the new service models will require a significant increase in staffing. Analysis has shown that Jersey has fallen behind the typical rate of increase for CAMHS staffing levels:

- the UK NHS CAMHS workforce has doubled in size since 2012 (NHS Benchmarking June 2021). In 2019/21, the total CAMHS workforce per 100,000 population aged under 18 for Jersey was 67 compared to the UK national average of 95; and

- the Jersey CAMHS team in 2021 was small compared to other islands at 22.35 FTE. The Isle of Man, which is 25% smaller than Jersey has 23.5FTE. Guernsey (45% smaller) has 18 FTE.

97. The Children's Health and Wellbeing Transformation Programme has assessed staffing need, including how the roles for some existing staff would change. An impact analysis was completed with some existing posts identified as needing consultation and discussion.

98. The final proposal is to increase CAMHS FTE from 28.58 to 64.58 (including the Head of Service).

99. The recruitment is phased '*to ensure it is within funding limits for 2022*'. However, I have not seen a timetable for intended recruitment, or a summary document setting out which posts:

- remain vacant despite a recruitment campaign; and
- have not yet been out for recruitment.

100. A June 2022 staff diagram for Children's Health and Wellbeing shows vacant posts by service area (see Exhibit 12).

Exhibit 12: Children's Health and Wellbeing: establishment and vacancies by service

Service area - establishment	Vacancies - at June 2022
Duty and Assessment: 11.5 FTE	Vacancies 2.5 FTE (22% of establishment): Nurse Practitioner (0.5 FTE), Health Care Assistants (HCAs) (2 FTE)
Early Intervention: 12 FTE	Vacancies: 2 FTE (16% of establishment): Support Workers (2 FTE)
Specialist CAMHS: 30.68 FTE	Vacancies: 8 FTE (27% of establishment): Support Worker (2 FTE), Clinical Nurse Prescriber (1 FTE), Dietician (1 FTE), HCAs (2 FTE), Associate Specialist (1 FTE) and CAMHS practitioner (1 FTE)
Quality and Assurance: 9.4 FTE	Vacancies: 1 FTE (11% of establishment): Admin Assistant (1 FTE)
Total including Head of Children's Health and Wellbeing: 64.58 FTE	**Total vacancies: 13.5 FTE (21% of establishment)**

Source: Jersey Audit Office analysis

101. There have been examples of good practice in recruitment of CAMHS staff, including early support in 'on-boarding' and in team building. One notable example is that the interview panel to recruit a nurse who specialises in Eating Disorders included a service user with lived experience of an eating disorder. Members of Youthful Minds, MIND Jersey's participation group, have regularly been part of recruitment panels.

102. There is however recent learning to be taken from issues with retaining staff in Jersey's Children's Social Care Services. Despite an apparently successful UK-wide

recruitment campaign in 2019, in November 2021 the Government had to launch a second campaign after more than half of the staff hired in 2019 resigned: of the 20 social work qualified posts filled in 2019, only nine remained. To fill the gap, £2 million had been spent on agency workers.

103. It is not clear how learning from this experience has been documented, communicated or changes actioned.

Recommendations

R18 When using online 'live' data at a meeting or group, ensure sufficient information is recorded so that:

- risks identified, decisions made and actions agreed are clear; and
- the basis for those decisions and actions is evident – for example a screen shot of the relevant data.

R19 Ensure that learning from Jersey's participation in the NHS Benchmarking Network for CAMHS is routinely captured as part of action plans to improve data quality and performance.

R20 Implement a process for regular CAMHS caseload review to ensure that caseloads are managed consistently and in line with agreed criteria.

R21 Risk assess recruitment practices against relevant lessons from the issues experienced in retaining social workers and take mitigating actions to reduce the risk to CAMHS recruitment and retention.

Referrals management

104. Changes recently implemented are intended to improve the management of referrals to CAMHS. Early indications are that these have been generally well received but that there are issues to resolve.

Process

105. The majority of Children's Health and Wellbeing referrals are now processed through the Children and Families Hub. This is an established facility which provides information, advice and support for families and young people. The aim of the Hub is to make sure that the right help is given at the right time.

106. Since 21 February 2022 the Children and Families Hub has had a Mental Health and Wellbeing practitioner on duty as part of the Hub team. This is intended to strengthen the holistic response to referrals.

107. Exhibit 13 shows elements of the management of referrals as set out in the Children's Health and Wellbeing Operational Policy and how these compare with good practice.

Exhibit 13: Children's Health and Wellbeing referral management compared to good practice

Area	Operational Policy	Comparison and comment
Submitting referrals	Referrals are made by completing an online 'request for support' form which asks: • What are you worried about? • What is going well for the family and what resources / services are already in place? • What are the views of the child(ren) and family? • What needs to change and what support is needed?	Using a straightforward and accessible form is good practice. However, since its introduction in February there have been teething problems with the level of information provided. Also, the new form cannot be pre-populated from the system used by GPs (EMIS) which has been a source of frustration. There have been examples of duplicate referrals and currently systems are not effective in resolving such duplication. **Potential for improvement:** Consider: • providing examples to help referrers phrase their concerns; and

JERSEY AUDIT OFFICE

Area	Operational Policy	Comparison and comment
		• a post-implementation review. As part of this, analyse the use of 'urgent' by those making referrals and issues with duplicate referrals.
Who can make a referral	Health Professionals Educational Psychologists School Counsellors Educational Welfare Officers SENCos (Special Educational Needs Co-ordinators) Probation Officers Social Workers; and General Practitioners (GPs).	The list is comprehensive. It does not specifically include teachers but I understand that teachers can directly refer children and young people. New referral processes mean that children and families can self-refer to CAMHS. It is too soon to understand the impact that this is having on accessibility and service delivery. **Potential for improvement:** Establish criteria against which to monitor the impact of self-referrals, including as part of understanding inequalities of access to CAMHS.
Involving the GP	If the referrer is not the family's GP, the GP is made aware that a referral has been made. The GP will also be sent reports including the initial assessment, initial appointments, care plan, progress report and case closure report.	This is good practice.
Logging data	As the Hub uses the Mosaic system to store data, the Hub clinician will ask the Health and Wellbeing administrator to open an additional entry on TrakCare and Care Partner.	There is a risk of error in the manual transfer of data between systems. CYPES is aware of this risk but a solution is yet to be developed. **Potential for improvement:** Explore options for automating the process.

Area	Operational Policy	Comparison and comment
Criteria for acceptance into CAMHS	The Specialist Community CAMHS team works with children and young people aged up to 18 who have moderate to severe presentations (a list of potential disorders is included).	The newly designed continuum of services within Children's Health and Wellbeing means that those children and young people who need specialist CAMHS interventions are more easily identified.
Monitoring	All referrals are reviewed at a weekly Children's Health and Wellbeing management meeting to ensure oversight by the multi-professional management team. There is though limited detail on what information will be proactively shared with the child or young person and their family, once a referral is accepted.	The regular review of referrals and waiting lists represents good practice. However, notes from the meetings do not include decisions made and action to be taken. The Royal College of Psychiatrist's Quality Network for Community CAMHS (2020) proposes that for non-urgent assessments, the team makes written communication in advance to young people that includes: • name and title of who they will see • explanation of the assessment process • information on who can accompany them; and • how to make contact for any queries – for example access to an interpreter, changing an appointment. The UK's Care Quality Commission includes in its assessment: • Do [services] ensure that patients and families know that they can contact the service if the patient's condition deteriorates? **Potential for improvement:** • Keep a log of decisions made and action agreed at referral management meetings. • Ensure that processes to keep in touch with those referred for assessment meet good practice.

Area	Operational Policy	Comparison and comment
Waiting times	If an urgent response is indicated due to significant mental health risk (P1), a Duty and Assessment Service practitioner will make contact and respond to the referral the same day (within 9am-5pm hours). If no immediate action is indicated, then the referral is triaged for assessment as follows: P2: Urgent - 48 hours P3: Soon - 10 days P4: Routine - 36 days.	These standards represent good practice. They are though contained in an internal document and are not set out for the public. The UK has mandated national standards for waiting times for young people with psychosis (two weeks) and for those treated in the community for an eating disorder (emergency: first contact within 24 hours; urgent: one week; otherwise four weeks). **Potential for improvement:** • Ensure referral triage target times are widely understood. • Although this is implicit in the triage process described, explicitly set standards for young people with psychosis and with eating disorders.
Discharge	Clinicians will produce a closure summary report detailing presenting issues, treatment summary and outcome including pre- and post- intervention measure reports and feedback conclusion. A copy of this will be sent to the GP, referrer, and child, young person and / or family.	Good practice would also include explicit information on: • how to stay well • a summary of how the child or young person felt about being discharged; and • whether they achieve the goals they identified, or modified the goals. **Potential for improvement:** Add these specific items to a discharge plan.

Source: Jersey Audit Office assessment of referral management as set out in Children's Health and Wellbeing Operational Policy (March 2022)

Disengagement from services

108. I have found two descriptions of how situations where children and young people who 'did not attend' (DNA) their appointment should be managed:

- the Children's Health and Wellbeing Operational Policy includes that:

the service will work proactively to offer appointments at times to suit and in environments that suit. Following three instances of DNAs a letter will be sent expressing concern and further efforts made to reflect on why and adapt approaches. Cases will only be closed if alongside several DNAs there is a lack of engagement, and no risk to closing the case; and

- the MIND Jersey contract states that:

cases will be closed when a young person or family repeatedly fails to attend or complete the intervention.

109. I consider that, whatever the actual practice in these instances, the guidance as set out is not sufficient to ensure children and young people are safe and that they receive appropriate services and care. Evidence from serious case reviews in the UK has demonstrated that missed healthcare appointments are an indicator of possible neglect and can be early indicators of wider safeguarding concerns.

110. None of the Referral Management meetings I have reviewed has considered rates of 'DNA' or the incidence of specific barriers to attendance. I set out in Exhibit 14 principles which I feel should drive policy for children and young people's services in this area.

Exhibit 14: Principles to guide policy for care services for children and young people

Children and (potentially) young people differ from adults in that they do not take responsibility for their own health needs. It is therefore important to consider children as 'was not brought' (WNB) as opposed to 'did not attend'.

Children and young people have a right to receive appropriate healthcare and it is the responsibility of parents / carers to access this on their behalf. The United Nations Convention on the Rights of the Child states that "Children have the right to good quality health care" (Article 24).

It is the responsibility of professionals to work effectively to engage with parents /carers / children and young people. Effective intervention is significantly influenced by the quality of engagement that the child / young person and their parents /carers have with the professional.

It is important for professionals to seek to understand why parents / carers do not bring their child for an appointment, in order to address any barriers that there may be to them attending.

Early intervention and prevention is the key to safeguarding children. Staff members need to be more curious about the reasons why a child is not being brought and to look for patterns of incidence. They should thoroughly explore potential options for support and have clear mechanisms for recording events in order to identify themes, patterns and trends.

Source: Jersey Audit Office Identified Good Practice

111. Data from the NHS Benchmarking Network shows that Jersey's rate of DNA (using the terminology as it is reported) was 9% for the period 2019/20. This is slightly

better than the NHS average rate of 10%. This data though is not helpful in understanding patterns and trends so that barriers and risks can be addressed.

Re-referrals

112. Referrals to CAMHS are noted as re-referrals if they occur within 12 months of the child or young person being discharged from the service. This is the case whether or not the reason for referral or the person making the referral is the same as before.

113. NHS Benchmarking Network data shows that for the period 2019/20, Jersey's rate of re-referrals was 11%, lower than the benchmarked average of 15%. However, performance data for the first quarter of 2022 shows the re-referral rate at 25%. This indicates that a quarter of the children and young people who leave Jersey's CAMHS (generic) services are re-referred. However there are some known data quality issues with this reported rate. The rate reported at June 2022 was 16%.

114. This reasons underpinning the re-referral rate are still being assessed.

Transition from CAMHS

115. CAMHS criteria include that the service is for young people to their 18th birthday. Feedback from one of the surveys undertaken in 2021 to support development of the Strategy included that young people felt that:

- they had not been sufficiently involved in decisions made about transitioning to adult services
- they did not feel ownership of their care plans; and
- they had not had adequate support during and after the transition process.

116. The draft transition protocol provided to me as part of my review, which is intended to support those young people who need to transfer to Adult Mental Health Services (AMHS) or other support services, is not yet complete or operational.

117. It sets out that work will begin with young people aged 16 who have a high likelihood of requiring services as an adult. The principles include that:

- referrals into AMHS occur no later than 17 years and 6 months, except where it is agreed that needs are best met within CAMHS
- at least one face to face meeting will be held for the young person with their CAMHS key worker and the key worker from the service to which they will move for further care

- for young people aged 17+ who are not likely to require a service from AMHS, a support plan will be developed
- a Lead Practitioner will work with young people to support them in their transition from CAMHS to AMHS; and
- a transition co-ordinator will hold cases across both services to ensure seamless transition.

118. There are identified issues with fixing an age for transition – including the plans that the young person has for higher education off-Island, which might be better supported by a later transition from CAMHS to UK or other local services.

119. The Health and Social Security Scrutiny Panel review of Mental Health Services reported in April 2022 that routine meetings are now in place between CAMHS and AMHS, but that there is as yet no agreed and finalised protocol.

120. Development of a transition policy and protocol is included in the ToRs for the Children's Health and Wellbeing Programme Board, through funding from the 2022-2025 Government Plan. I understand a new, more flexible, transition policy is in draft but is yet to be ratified.

Recommendations

R22 Undertake a post implementation review of the new process for receiving CAMHS referrals to understand whether:

- including examples would help referrers phrase their concerns and improve information provision
- use of 'urgent' by those making referrals is in line with expectations; and
- there are issues caused by duplicate referrals.

R23 Establish criteria against which against to monitor the impact of self-referrals, including as part of understanding inequalities of access to CAMHS and other Children's Health and Wellbeing services.

R24 Explore options for automating the process of logging referral information across multiple systems (Mosaic, Care Partner and TrakCare), to reduce the risk of error.

R25 Keep a log of decisions made and action agreed at the weekly Health and Wellbeing Service Referral Management meetings, including any actions to update the risk register.

R26 Ensure that arrangements to keep in touch with those referred and accepted for assessment meet good practice.

R27 Ensure 'triage' target times are widely understood by, and performance is reported to, referrers and the public.

R28 Although this is implicit in the triage process described, explicitly set and communicate waiting times standards for assessment for young people with psychosis and with eating disorders.

R29 Set out clear discharge protocols to provide explicit and tailored information on:

- how to stay well
- a summary of how the child or young person felt about being discharged; and
- whether they achieved the goals they identified or modified the goals.

R30 Reconsider the approach to children and young people who 'were not brought' for appointments, both for 'in house' and commissioned services. Ensure that the emphasis is on safety and the child's right of access to healthcare.

R31 Prioritise an understanding of the reasons for re-referrals to CAMHS and set out any required actions in response.

R32 Finalise the protocol and arrangements for young people transitioning from CAMHS to AMHS and other services, ensuring decisions on timing are criteria rather than age driven. Establish a process to oversee compliance which includes service user feedback.

Appendix One

Audit Approach

The review included the following key elements:

- review of relevant documentation provided by the States of Jersey; and
- interviews with key officers within the Government of Jersey, the Office of the Children's Commissioner and MIND Jersey.

More than 150 documents were reviewed. Key documents included:

- Drafts of the Memorandum of Understanding between CYPES and HCS
- Drafts of the Terms of Reference for the Governance and Oversight Group
- Governance and Oversight Group meeting notes and agenda papers including draft Integrated Governance Frameworks
- Government Plans 2021-2024 and 2022-2025
- Procurement Strategy and notes from the Children's Individual Placement Panel
- CAMHS COVID Wellbeing and Recovery Programme management
- NHS Benchmarking Network report 2019/20
- Scrutiny Review of Mental Health service - report published in April 2022
- Children and Young People's Emotional Wellbeing and Mental Health Strategy 2022-2025
- Strategy development supporting documents:
    - Business Cases for CAMHS additional funding 2020 and 2021
    - Survey outcomes
    - Needs Assessment
    - Communications Plan; and
    - Workshop attendees
- CAMHS Staff structure June 2022
- CAMHS / AMHS Transition Protocol (draft)

- Mental Health Strategy 2015-2020 and Mental Health Improvement Plan
- Draft ToRs for: Children's Health and Wellbeing Partnership Board; Strategic Advisory Panel; Mental Health System Partnership Board
- Children's Health and Wellbeing Operational Policy – March 2022
- CAMHS Inpatient Operational Procedure (draft)
- Agenda and other papers as available from:
    - CYPES: Operational Risk Management meetings; Operational Steering Group meetings; the Quality Assurance Board; and the Performance Board
    - HCS: Quality and Risk Assurance Committee October 2019 – May 2022; and Women, Children and Families Care Group Quarterly Reviews from July 2019
    - Contracts management meetings with on-Island CAMHS partners; and
    - CAMHS Referral Management meeting notes to end June 2022.

The following people and organisations contributed information through face to face meetings, by email, in conference calls and / or by phone:

- Business Manager, CYPES
- Consultant Psychiatrist, HCS
- Chief Nurse
- Chief Executive Officer, MIND Jersey
- Director General (Interim), CYPES
- Director for Public Health
- Executive Director of Mental Health and Adult Social Care, HCS
- Group Director for Integrated Services and Commissioning, CYPES
- Head of Commissioning, CYPES
- Head of Informatics, CYPES
- Office of the Commissioner for Children and Young People
- Risk Manager, CYPES
- Service Manager: Duty and Assessment, CYPES

- Service Manager: Family and Community, CYPES
- Service Manager: Specialist CAMHS, CYPES
- Service Managers: Quality and Assurance, CYPES

The fieldwork was carried out by an affiliate working for the Comptroller and Auditor General.

Appendix Two

Summary of Recommendations

R1 Strengthen:

- the use of Jersey specific risk data and wider determinants of health in forecasting demand for children's mental health services (both capacity and services needed); and
- cross-departmental measures of the impact of interventions, including as part of the Jersey Performance Framework.

R2 Establish service needs and criteria for evaluating opportunities for services to be commissioned for delivery in partnership with - or exclusively from - community providers.

R3 Ensure improvements to on-Island inpatient care for children and young people are implemented, including by setting and monitoring Key Performance Indicators (KPIs) to demonstrate improved service user experience.

R4 Ensure that the IPP considers and commissions services to meet all needs of the service user when deciding on a package of care.

R5 Ensure that the 'due diligence' items set out in the Procurement Strategy are supported by high quality information and are used consistently when making decisions about off-Island placements.

R6 Agree, adopt and communicate a Memorandum of Understanding between CYPES and HCS for the governance and operation of CAMHS.

R7 Agree, adopt and communicate a Terms of Reference for the joint Governance and Oversight Group, ensuring that this documents:

- how all accountabilities are satisfied
- how the joint principles identified at the 'away day' will be carried forward; and
- how the stated objectives of the move of CAMHS to CYPES will be assured.

R8 Agree, adopt and communicate Terms of Reference for newly developed governance groups including the Mental Health System Partnership Board and the Children's Health and Wellbeing Programme Board. Ensure that these Terms of Reference document the groups' relationships to:

- the Jersey Care Model; and

- the 'Our Hospital' project.

R9 Ensure arrangements are in place to monitor and manage compliance with all governance processes.

R10 After a suitable period, evaluate how effectively all governance processes are working in practice.

R11 Document and implement a comprehensive quality and safety programme across CAMHS.

R12 Establish a process to ensure that all relevant departments, not just the lead department, are aware of and properly engaged in implementing actions in response to accepted C&AG recommendations. Include this process in the Tracker Manual which covers roles, responsibilities, accountabilities and Tracker operation.

R13 Agree, map out and implement roles, responsibilities and arrangements for CAMHS performance management across all areas of Government and all relevant structures, covering:

- setting standards
- identifying and capturing data for Key Performance Indicators
- establishing ambitious targets and benchmarking arrangements
- monitoring and overseeing performance against standards and targets
- reporting; and
- taking action to resolve identified weaknesses and implement improvements.

R14 Agree, map out and implement roles, responsibilities and arrangements for CAMHS risk management across all areas of Government and all relevant structures. As part of this, review arrangements for ensuring all risks relevant to CAMHS are logged and can be appropriately cross-referenced in one document.

R15 Set standards for documenting the output and outcome of CYPES strategic and key operational management meetings. As a minimum this should include attendance, items to be logged as risks, decisions made and actions agreed. Ensure these are appropriately accessible so that they can be meaningfully used by officers.

R16 In finalising a Minimum Data Set for CAMHS, make it sufficiently comprehensive to encompass all data to be routinely collected, including as a priority data to identify potential inequalities in access to services.

R17 Formalise plans to improve the richness and quality of performance dashboards within Children's Health and Wellbeing. Ensure the needs of all parts of the governance and advisory structure are considered, including the Annual Report planned for 2023.

R18 When using online 'live' data at a meeting or group, ensure sufficient information is recorded so that:

- risks identified, decisions made and actions agreed are clear; and
- the basis for those decisions and actions is evident – for example a screen shot of the relevant data.

R19 Ensure that learning from Jersey's participation in the NHS Benchmarking Network for CAMHS is routinely captured as part of action plans to improve data quality and performance.

R20 Implement a process for regular CAMHS caseload review to ensure that caseloads are managed consistently and in line with agreed criteria.

R21 Risk assess recruitment practices against relevant lessons from the issues experienced in retaining social workers and take mitigating actions to reduce the risk to CAMHS recruitment and retention.

R22 Undertake a post implementation review of the new process for receiving CAMHS referrals to understand whether:

- including examples would help referrers phrase their concerns and improve information provision
- use of 'urgent' by those making referrals is in line with expectations; and
- there are issues caused by duplicate referrals.

R23 Establish criteria against which against to monitor the impact of self-referrals, including as part of understanding inequalities of access to CAMHS and other Children's Health and Wellbeing services.

R24 Explore options for automating the process of logging referral information across multiple systems (Mosaic, Care Partner and TrakCare), to reduce the risk of error.

R25 Keep a log of decisions made and action agreed at the weekly Health and Wellbeing Service Referral Management meetings, including any actions to update the risk register.

R26 Ensure that arrangements to keep in touch with those referred and accepted for assessment meet good practice.

R27 Ensure 'triage' target times are widely understood by, and performance is reported to, referrers and the public.

R28 Although this is implicit in the triage process described, explicitly set and communicate waiting times standards for assessment for young people with psychosis and with eating disorders.

R29 Set out clear discharge protocols to provide explicit and tailored information on:

- how to stay well
- a summary of how the child or young person felt about being discharged; and
- whether they achieved the goals they identified or modified the goals.

R30 Reconsider the approach to children and young people who 'were not brought' for appointments, both for 'in house' and commissioned services. Ensure that the emphasis is on safety and the child's right of access to healthcare.

R31 Prioritise an understanding of the reasons for re-referrals to CAMHS and set out any required actions in response.

R32 Finalise the protocol and arrangements for young people transitioning from CAMHS to AMHS and other services, ensuring decisions on timing are criteria rather than age driven. Establish a process to oversee compliance which includes service user feedback.

LYNN PAMMENT
Comptroller and Auditor General

Jersey Audit Office, de Carteret House, 7 Castle Street, St Helier, Jersey JE2 3BT
T: +44 1534 716800 E: enquiries@jerseyauditoffice.je W: www.jerseyauditoffice.je