Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Y PWYLLGOR ANSAWDD, DIOGELWCH A PHROFIAD
QUALITY, SAFETY AND EXPERIENCE COMMITTEE

DYDDIAD Y CYFARFOD: DATE OF MEETING:	07 December 2023
TEITL YR ADRODDIAD: TITLE OF REPORT:	NHS Wales Executive: Review of Psychology and Psychological Interventions for Children and Young People.
CYFARWYDDWR ARWEINIOL: LEAD DIRECTOR:	Andrew Carruthers, Director of Operations
SWYDDOG ADRODD: REPORTING OFFICER:	Angela Lodwick, Assistant Director, Mental Health and Learning Disabilities

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Gwybodaeth/For Information

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In September 2022, Hywel Dda University Health Board was escalated to targeted intervention from enhanced monitoring for finance and planning. Quality and performance remained in enhanced monitoring following concerns around urgent and emergency care, planned care including cancer, critical care, infection control (C-diff), neurodevelopment and child and adolescent mental health services.

Since September 2020, the health board have struggled to make sustainable improvements for the psychology and psychological intervention offer to children and young people (under 18s). As part of their Enhanced Monitoring status, they have requested help from the NHS Executive to undertake an accurate understanding of pathways, demand, activity and waiting lists, and undertake a review of Psychology and Psychological Intervention delivery for children and young people in HDUHB.

This SBAR summarises actions taken by Hywel Dda University Health Board (HDUHB) in response to the recommendations following the review.

Cefndir / Background

Following a range of national developments to improve access to and quality of psychological therapy delivered in Wales over the past decade, the Psychological Therapies in Wales - Policy Implementation Guidance (PIG, 2012) and the Review of Psychological Therapies, it was agreed that national standards and accompanying guidance should be developed for Wales alongside an agreed approach to national data collection.

Matrics Cymru was subsequently published in 2017, followed by Matrics Plant: Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales with an accompanying Matrics Plant Implementation Plan in 2021 by the National Psychological Therapies Management Committee and Public Health Wales.

In order to gain an accurate understanding of activity and waiting lists, the Welsh Government has commissioned the NHS Wales Executive Performance and Assurance Division to undertake a review of Psychology and Psychological Interventions

Aims

• To understand the consistency and variation in the psychology and psychological intervention offer to children and young people (under 18s) in Hywel Dda UHB

. • To clarify the pathways to access and the demand, activity, capacity and waiting lists in the service and the relationship to the Mental Health Measure Part 1b (intervention) target

. • To highlight and share both good practice and challenges in service delivery

The review aimed to understand how services are organised including areas of consistency and variation between policy, performance, and clinical guidelines in each Health Boards service offer, waiting times, reporting arrangements, and performance management processes.

Sefyllfa / Situation

Phase 1: Gathering of in scope service information

The Health Board was asked to provide a range of documents and complete a workbook developed by the NHS Wales Executive to provide a description of their service scope, operational delivery processes, waiting times, and performance management and reporting arrangements. The desktop information provided was reviewed by the NHS Wales Executive. Bespoke questions were created to undertake semi-structured 2-hour interviews with service leads (managerial and clinical) to clarify any gaps or areas of uncertainty.

The review team met with Clinicians from Paediatric Psychology on 31 August 2023, and Managers from the Women and Children's Directorate on 1 September 2023, and with Clinicians and Managers and Professional Leads in CAMHS in two separate meetings on 4 September 2023. No representatives from the Bereavement Service or Palliative Care were present in these meetings, so information included in this report relates to written information submitted to the review team.

Phase 2: Analysis of information gathered during Phase 1

Triangulation of information to provide an overview of the Health Board's current psychology and psychological intervention provision, its alignment with Matrics Plant and the Mental Health Measure Parts 1 and 2, and respective reporting requirements.

Phase 3: Report Writing

1. Production of a local briefing reflecting service process and reporting arrangements, identification of any variation between HDUHB psychological intervention service delivery, processes and national guidance, and a summary of recommendations to enable timely implementation of improvement activities.
2. 2. Based upon findings and recommendations further improvement and intervention work to be supported by the NHS Wales Executive Performance and Assurance team will be determined.

Recommendations

1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure.
2. The HB should ensure that all services delivering psychology and psychological interventions to CYP have service specifications in place.
3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.
4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between Specialist Child and Adolescent Mental Health Service (SCAMHS) and Paediatric Psychology.
5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.
6. The HB should ensure that staff have access to accessible, appropriate accommodation to enable staff to work efficiently and safely and to maximise capacity.
7. The HB should review how it meets the Code of Practice guidance regarding Care Coordination in line with the current service structure, to meet the needs of patients and the service.
8. The HB should embed demand and capacity principles into the management of all services. The HB may wish to access further demand and capacity training from the NHS Wales Executive or other training providers.
9. The HB should ensure that patient feedback, involvement and outcome measures are used across all directorates in service evaluation and planning

Next steps

A joint action plan will be formulated by the SCAMHS in collaboration with Child Health /Paediatrics to meet the recommendations outlined above over seen by the respective service leads - Ms Angela Lodwick, Assistant Director MHLD and Ms Lisa Humphrey, General Manager.

The time scale for this is to be completed during December 2023 and will be presented to the Director for MHLD and Director for Operations for final approval at the end of December 2024.

A series of meetings will be arranged to implement the actions within the stated time scales during 2024.

Argymhelliad / Recommendation

For QSEC to note the report and agree for an update to be presented to the Committee on the action plan and progress in February 2024.

Amcanion: (rhaid cwblhau) Objectives: (must be completed)	
Committee ToR Reference: Cyfeirnod Cylch Gorchwyl y Pwyllgor:	2.3 Provide assurance that the Board has an effective strategy and delivery plan(s) for improving the quality and safety of care patients receive, commissioning quality and safety impact assessments where considered appropriate.
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	
Parthau Ansawdd: Domains of Quality Quality and Engagement Act (sharepoint.com)	7. All apply
Galluogwyr Ansawdd: Enablers of Quality: Quality and Engagement Act (sharepoint.com)	6. All Apply
Amcanion Strategol y BIP: UHB Strategic Objectives:	All Strategic Objectives are applicable
Amcanion Cynllunio Planning Objectives	
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Objectives Annual Report 2021-2022	4. Improve Population Health through prevention and early intervention, supporting people to live happy and healthy lives

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	
Rhestr Termau: Glossary of Terms:	
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Ansawdd, Diogelwch a Phrofiod: Parties / Committees consulted prior to Quality, Safety and Experience Committee:	

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: **Financial / Service:**	Not Applicable
Ansawdd / Gofal Claf: **Quality / Patient Care:**	Yes
Gweithlu: **Workforce:**	Not Applicable
Risg: **Risk:**	Not Applicable
Cyfreithiol: **Legal:**	Yes
Enw Da: **Reputational:**	Yes
Gyfrinachedd: **Privacy:**	Not Applicable
Cydraddoldeb: **Equality:**	Yes

Review of

Psychology & Psychological Interventions for

Children and Young People

Hywel Dda University Health Board

September 2023

Mae Gwelliant Cymru, Cydweithrediad GIG Cymru, yr Uned Gyflawni, a'r Uned Cyflawni Cyllid bellach yn rhan o Weithrediaeth GIG Cymru.
www.gweithrediaeth.gig.cymru

Improvement Cymru, NHS Wales Collaborative, Delivery Unit, and Finance Delivery Unit are now part of the NHS Wales Executive.
www.executive.nhs.wales

Context

In September 2022, Hywel Dda UHB was escalated to targeted intervention from enhanced monitoring for finance and planning. Quality and performance remained in enhanced monitoring following concerns around urgent and emergency care, planned care including cancer, critical care, infection control (C-diff), neurodevelopment and child and adolescent mental health services.

Since September 2020, the health board have struggled to make sustainable improvements for the psychology and psychological intervention offer to children and young people (under 18s). As part of their Enhanced Monitoring status, they have requested help from the NHS Executive to undertake an accurate understanding of pathways, demand, activity and waiting lists, and undertake a review of Psychology and Psychological Intervention delivery for children and young people in HDUHB.

Background

Following a range of national developments to improve access to and quality of psychological therapy delivered in Wales over the past decade, the Psychological Therapies in Wales - Policy Implementation Guidance (PIG, 2012) and the Review of Psychological Therapies, it was agreed that national standards and accompanying guidance should be developed for Wales alongside an agreed approach to national data collection.

Matrics Cymru was subsequently published in 2017, followed by Matrics Plant: Guidance on the Delivery of Psychological Interventions for Children and Young People in Wales with an accompanying Matrics Plant Implementation Plan in 2021 by the National Psychological Therapies Management Committee and Public Health Wales.

Matrics Plant has been designed for practitioners working in psychological services for children, young people and families to assist in the development, planning and delivery of a Wales wide approach to providing psychological services to children, young people and their families, inclusive of neurodevelopmental profile, physical health needs, disability, legal status, living arrangements, method of communication, preferred language, or any other characteristic. It sets national standards for service delivery to support education, training and workforce development alongside evidence tables which offer guidance on the safe and efficient delivery of effective, evidence-based care. It also provides guidance for capacity management, workforce re-design and advice on governance issues. It acknowledges that when working with a child or young person, their family and other agencies supporting them, the recipient of the intervention will not always be the child or young person.

In order to gain an accurate understanding of activity and waiting lists, the Welsh Government has commissioned the NHS Wales Executive Performance and Assurance Division to undertake a review of Psychology and Psychological Interventions.

Aims

- To understand the consistency and variation in the psychology and psychological intervention offer to children and young people (under 18s) in Hywel Dda UHB.
- To clarify the pathways to access and the demand, activity, capacity and waiting lists in the service and the relationship to the Mental Health Measure Part 1b (intervention) target.
- To highlight and share both good practice and challenges in service delivery.

An appreciative inquiry approach was employed to facilitate fact-finding and planning aspects of the review, seeking to provide a constructive approach and impact positively on service provision.

Objectives

1. To understand how the offer of psychological interventions in HDUHB compare to Matrics Plant, including the range of therapeutic modalities delivered, and the current demand, capacity, and activity.

2. To understand in which services psychological therapies are delivered to CYP, including mental health services defined as Part 1 or Part 2 under the Mental Health Measure and therapies delivered in general hospital or community settings.

3. To review the current pathways and processes in line with the Matrics Plant Implementation Plan and to identify variance between policy and practice.

4. To understand any risks or issues associated with waiting times or access to psychological interventions, including any evidence of patient harm and mitigation of harm and risk.

5. To capture and share areas of good practice relating to waiting list management and delivery of psychological interventions.

6. To understand current service delivery challenges, including the current and future availability of professionals and professional skill mix.

7. Provide HD UHB with recommendations to improve quality and efficiency, reduce unwarranted variation, and improve data capture to accurately reflect service performance based on current delivery of psychological interventions.

The review consisted of 3 phases:

Phase 1: Gathering of in scope service information

The Health Board was asked to provide a range of documents and complete a workbook developed by the NHS Wales Executive to provide a description of their service scope, operational delivery processes, waiting times, and performance management and reporting arrangements. The desktop information provided was reviewed by the NHS Wales Executive. Bespoke questions were created to undertake semi-structured 2-hour interviews with service leads (managerial and clinical) to clarify any gaps or areas of uncertainty.

The review team met with Clinicians from Paediatric Psychology on 31st August 2023, and Managers from the Women and Children's Directorate on 1st September 2023, and with Clinicians and Managers and Professional Leads in CAMHS in two separate meetings on 4th September 2023. No representatives from the Bereavement Service or Palliative Care were present in these meetings, so information included in this report relates to written information submitted to the review team.

Phase 2: Analysis of information gathered during Phase 1

Triangulation of information to provide an overview of the Health Board's current Psychology and psychological intervention provision, its alignment with Matrics Plant and the Mental Health Measure Parts 1 and 2, and respective reporting requirements.

Phase 3: Report Writing

1. Production of a local briefing reflecting service process and reporting arrangements, identification of any variation between HDUHB psychological intervention service delivery, processes and national guidance, and a summary of recommendations to enable timely implementation of improvement activities.

2. Based upon findings and recommendations further improvement and intervention work to be supported by the NHS Wales Executive Performance and Assurance team will be determined.

Key Findings

Service structure

- The HB offers the majority of psychology and psychological interventions to children and young people (CYP) via SCAMHS. Paediatric Psychology, Bereavement Counselling and Palliative Care are smaller services offering psychology and/or psychological interventions to CYP. A range of evidence based psychological therapies are available across the HB.

- The small size and capacity of the Paediatric Psychology team was acknowledged as a challenge by the HB which limited the service available.

- Staff and managers described teams across the HB as resilient and supportive.

- The Part 1 scheme does not reflect the current service delivery and access arrangements for psychological interventions.

- To support access to psychological interventions in SCAMHS, there are service specifications in place describing the services delivered, pathways and eligibility criteria. There are no service specifications in place for Paediatric Psychology, Palliative Care or the CYP element of the Bereavement Service.

- In SCAMHS and Paediatric Psychology, CYP are offered an initial assessment or formulation. SCAMHS is the only service with national targets to meet for initial assessment. It met both access targets in July 2023.

Psychological interventions

- The service considers patient's needs and preferences when assessing the most appropriate psychological intervention. Outcome measures are used and in SCAMHS there are opportunities for service user representatives to contribute to service planning and recruitment.

- SCAMHS and Paediatric Psychology offer direct intervention to CYP and their families. Room availability was a significant constraint in delivering therapy and could determine whether therapy was offered virtually or face to face. Services offer group and individual therapy, considering patient need and severity of issue as part of the formulation.

- SCAMHS offers regular network consultations and one-off consultation as a fundamental part of service delivery. Paediatric Psychology also offer consultation, subject to capacity in the team.

- The HB commissions Kooth for open access online support, which can support CYPs who are waiting for, or during their intervention.

Workforce

- All staff reported being able to access clinical and managerial supervision with some clinical supervision purchased externally. Paediatric Psychology lacked senior professional leadership at the time of the review.

- SCAMHS has a training strategy and steering group in place with a range of training in place to support the workforce. Paediatric Psychology does not have access to a protected training budget and lacks senior professional leadership which would support this. The HB would welcome additional national training resources.

- SCAMHS reported successful recruitment over recent years which had improved the staffing position in the service. Paediatric Psychology is a small service with significant risks to maintaining its current capacity,with some recent resource confirmed to provide cover.

Demand and capacity

- SCAMHS uses CAPA to support demand and capacity work, staff have job plans and there are clear processes and oversight of waiting list management. Activity data is captured, with a suggested number of intervention sessions per modality. Paediatric Psychology do not have job plans and have recently started some demand and capacity work with access to data currently limited.

- All waiting lists for assessment and interventions in SCAMHS are monitored via HB performance processes. Not all of this data is required to be reported nationally. There are significant waits for partnership appointments in SCAMHS, with the HB reporting the numbers are reducing. Paediatric Psychology holds a waiting list within the team and it is not subject to HB performance processes.

- SCAMHS reported that neither of the electronic systems produce real time data for demand and capacity work and there is a reliance on excel spreadsheets.

Care Coordination and transitions

- Psychologists and eligible psychological therapists are able to Care Coordinate in SCAMHS. The service reported bottlenecks to access Care Coordination in some areas leading to delays to psychological interventions and subsequent challenges following therapy.

- There are challenges in the service relating to Care Coordination being undertaken by the clinician with the most appropriate skills and experience.

- In SCAMHS, additional support for patients whose mental health deteriorates during psychological intervention is accessed directly via a clear pathway.

Paediatric Psychology refer to SCAMHS via SPoC, with no fast track route for CYP experiencing a crisis.

- SCAMHS reported some challenges with facilitating transitions to adult CMHT and psychological therapy. The CAMHS transition worker and peer mentor roles were seen as positive enablers for this process.

Service planning

- The HB has a PTMG, although it has not met in recent months. Colleagues from the Women and Children's Directorate will attend from the next meeting.

- The service uses Matrics Plant, NICE Guidelines and other national guidance and policy to inform service delivery and improvements.

- There is a HB wide Children's Planning Forum in place which was viewed positively.

- There is a limited understanding within the HB of how patients and services could benefit from greater joint working between directorates, and which services required development solely within the Women & Children's Directorate. There was a desire to improve joint working expressed.

- There are opportunities to deliver a service in Welsh, with some reliance on Language Line.

Recommendations

1. The HB should review and update the Part 1 Scheme with partner agencies, to reflect key areas of service development and clarify how the service structure is aligned with the Measure.

2. The HB should ensure that all services delivering psychology and psychological interventions to CYP have service specifications in place.

3. The HB should ensure equitable availability of appropriate psychological interventions across directorates, in line with Matrics Plant, and to eliminate gaps in service. This could be achieved by expanding the Paediatric Psychology service, improving pathways to SCAMHS interventions from Paediatric Psychology, or both.

4. The HB should explore opportunities for improved psychological interventions and patient outcomes by sharing resources and professional expertise, to enhance joint clinical work between SCAMHS and Paediatric Psychology.

5. The HB should ensure equity of training availability and budgets, supervision, and professional leadership between directorates to ensure all staff have equal opportunities for development and support.

6. The HB should ensure that staff have access to accessible, appropriate accommodation to enable staff to work efficiently and safely and to maximise capacity.

7. The HB should review how it meets the Code of Practice guidance regarding Care Coordination in line with the current service structure, to meet the needs of patients and the service.

8. The HB should embed demand and capacity principles into the management of all services. The HB may wish to access further demand and capacity training from the NHS Wales Executive or other training providers.

9. The HB should ensure that patient feedback, involvement and outcome measures are used across all directorates in service evaluation and planning.

1. Service structure

The Joint Commissioning Panel for Mental Health (2013)17 outlines the tiered structure of Child and Adolescent Mental Health Services (CAMHS), differentiating the four tiers based on how a child or young person accesses the service. Five types of services are described here (figure 1). It is anticipated these will be available in all health boards across Wales… It is not the intention that children, young people and families should only ever be supported by one of these types of services. It is essential for seamless working that different aspects of these services be available as necessary to jointly support a child, young person, or family when appropriate.

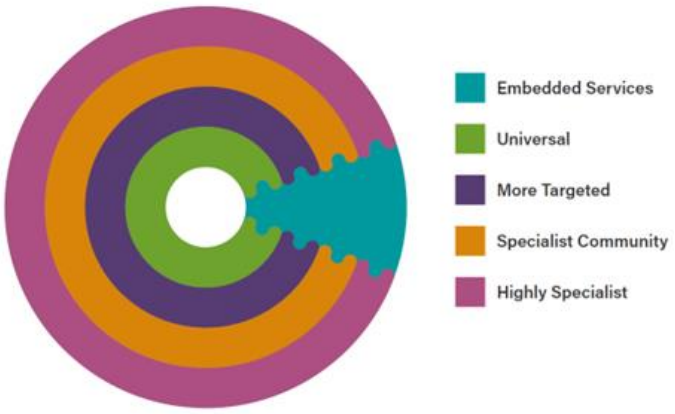


Figure 1 **Matrics Plant**

1.1 Specialist Child and Adolescent Mental Health Services (SCAMHS)

SCAMHS comprises of a number of teams within both primary and secondary CAMHS and sits within the Mental Health & Learning Disabilities Directorate. It offers services to children and young people (CYP) up until their 18th birthday, with limited provision up to 19 years old for some psychological interventions. There is an Assistant Director for MH& LD (S-CAMHS) with overall responsibility for the Quality, Safety, Performance and Delegated budget accountability. There are a number of therapy lead posts within the service, reporting to the Specialist Lead for Psychological Therapies, Service Leads, or Service Managers, who in turn report to the SCAMHS Service Delivery Manager.

Psychological interventions are delivered across the wider SCAMHS teams by Psychologists and Psychological Therapists. Teams within SCAMHS include School in Reach (SiR), Primary Mental Health (PMH), SCAMHS, the Psychological Therapies Service, Forensic CAMHS, Crisis Assessment and Treatment Team, Eating Disorder Team, Early Intervention in Psychosis team (EIP), Therapeutic Intervention Service for Sexually Harmful Behaviour (TISSHB – Carmarthenshire only) and the Dialectical Behavioural Therapy (DBT) team.

The service has in place service specifications for the teams that make up the wider SCAMHS, which include referral pathways, eligibility criteria and detail of interventions delivered for each team or service.

1.2 Paediatric Psychology

The Paediatric Psychology service sits within the Women & Children's Directorate. It is a small team comprised of a Consultant Clinical Psychologist, a Clinical Psychologist, Assistant Psychologist, Clinical Secretary, and an Administrator. These staff do not share a common line or team manager. However, overarching service management is provided by the Community Paediatric Service Delivery Manager. At the time of the review there was no service specification or operational policy for Paediatric Psychology in place.

1.3 Bereavement Support

The Carmarthenshire Bereavement Support Service sits under the Community directorate and provides a service to children and young people in Carmarthenshire only. There is a service lead responsible for clinical leadership arrangements for quality, safety, performance, and budget management/accountability.

The service also currently includes a CYP counsellor for Ceredigion. In addition, a pilot is in place with SCAMHS, PMH, SiR and Carmarthenshire Bereavement Support Service to support, and embed the role of a CYP bereavement counsellor within their team. The Service also supports the specialist paediatric palliative care family counsellor (charitable funds project), providing clinical supervision and case load management. There is no service specification or operational policy in place for CYP.

1.4 Palliative Care Interventions

A part time psychological therapist/counsellor is situated within the Palliative care service in Paediatrics. This post is not connected to the wider Paediatric Psychology service and there is no operational policy, and no data was reported to be collected to the service.

Table 1 below broadly describes the teams delivering therapy and where they sit within the structure.

	Part 1
	Part 2
	Part 1 & Part 2
	N/A

Table 1

	Mental Health & Learning Disabilities Directorate					Community Directorate	Women & Children's Directorate		
Tier 0	**School In Reach (SiR)**				**Therapeutic Intervention Service for Sexually Harmful Behaviour (TISSHB)**	**Child Bereavement Service**	**Paediatric Health Psychology**	**Paediatric Diabetes**	**Palliative Care**
Part 1	**Primary Mental Health (PMH)** Part 1b interventions								
Part 2	**SCAMHS** Partnership	**SCAMHS** Specialist Psychological Intervention	**EIP**	**Eating Disorders**					
	DBT								
	Forensic CAMHS								

2. Workforce structure

The HB were asked to provide details of the workforce delivering psychological interventions to children and young people. The staff in the Women & Children's Directorate can be seen in table 2 and the staff in the MH&LD Directorate can be seen in table 3. Workforce information was not provided from the Bereavement Support service.

Table 2

Women and Children's Directorate					
Team	**Profession**	**Grade**	**Budgeted WTE**	**Actual WTE**	**Comments**
Paediatric Psychology	Counselling Psychologist	8C	1	1	0.4WTE external temporary funding
	Clinical Psychologist	8A	1	0.9	
	Assistant Psychologist	5	1	1	Fixed term external funding until Jan 2024.
Palliative Care	Psychological Therapist	6	0.6	0.6	Humanistic/person centred therapy

Table 3

Mental Health and Learning Disabilities Directorate					
Team	**Profession**	**Grade**	**Budgeted WTE**	**Actual WTE**	**Comments**
SCAMHS, PMH & School In Reach	Clinical Psychologist	8C	0.6	0.6	Psychology Lead in SCAMHS & EIP
	Clinical Psychologist	8a	7.8	7.1	2.8WTE due to start shortly.
	Assistant Psychologist	5	9.6	9.6	Work across PMH and SCAMHS.
	HCSW	3	4.4	4.4	
	PMH and SIR practitioners	6	18.55	18.55	
SCAMHS Psychological Therapies	Psychological Therapist	8A	3	3	Service/Team Leads for Psychological Therapies, CBT and Systemic Family Therapy.
	Psychological Therapist	7	2	2	Art Therapist
	Psychological Therapist	7	1	1	CBT Therapist
	Psychological Therapist	6	3	3	CBT practitioner
	Psychological Therapist	7	0.8	0.8	Systemic and Family Therapist
	Psychological Therapist	6	2	2	Systemic and Family Practitioners
	Psychological Therapist	7	0.91	0.91	Cognitive Analytic Therapist
	Psychological Therapist	6	0.2	0.2	Cognitive Analytic Practitioners
	Senior Social Work Therapeutic Practitioner	7	1	1	Team Lead
	Social Work Therapeutic Practitioner	6	4	4	
	Administration	3	1.3	1.3	CLA admin (0.5) Service admin (0.8)
Forensic CAMHS	Clinical Psychologist	8C	0.4	0.4	Clinical Lead
	Psychological Therapist	7	0.2	0.2	
	Administration	3	0.2	0.2	
DBT	Clinical Psychologist	8C	0.2	0.2	Clinical Lead
	Clinical Psychologist	8A	0.1	0.1	
	Psychological Therapist	8A	0.2	0.2	
	Psychological Therapist	7	1.2	1.2	DBT
	Psychological Therapist	6	3.2	2.7	1WTE due to start shortly
	Assistant Psychologist	5	1	1	
	Administration	3	0.5	0.5	

Findings

- SCAMHS has a number of service specifications in place describing the services delivered, pathways and eligibility criteria.
- There are no service specifications in place for Paediatric Psychology, Palliative Care or the CYP element of the Bereavement Service.
- The Paediatric Psychology service is a small service within the Women and Children's Directorate.

3. Referral and Triage

3.1 SCAMHS

The service provided the review team with copies of referral pathways for all teams delivering psychological therapies. There are a variety of routes that a child or young person requiring psychological intervention may follow, depending on their level of need, risk, and geographical area. The service provided clear written structures and pathways in place for each therapeutic modality.

Broadly speaking, children and young people going through the Single Point of Contact (SPoC) for SCAMHS will receive an assessment or Choice appointment. If a CYP then requires a psychological intervention, this will be delivered through PMH or via a series of Partnership appointments in SCAMHS. If more specific psychological intervention is required following Partnership, this is delivered via the Psychological Therapies Team. Access to psychological intervention can also start with a consultation with a specialist team. Other SCAMHS teams or commissioned services may have direct routes in to receive psychological interventions.

i. The DBT service reported it has widened its referral criteria to enable direct referrals to be received from PMH, CATT and SCAMHS. Previously CYP were required to be open and Care Coordinated by SCAMHS, but there were long waits for the service for these CYP presenting with high-risk behaviours.

ii. Art therapy receive referrals for short term pieces of work following a Choice assessment, or for additional specific work during core partnership. Referrals are accepted following a discussion with the art therapist and within the MDT to ensure a therapeutic match.

iii. The CAT therapist and two trainees sit across all three counties. Clinicians in SCAMHS refer by discussing in an MDT or contacting the therapist directly for a consultation.

iv. To access Psychology in SCAMHS, referrals are received via the SpoC and following a Choice appointment are discussed in the MDT. CYP are usually allocated for Partnership first but can be referred directly to specific interventions with a Psychologist.

v. CBT is available in locality SCAMHS teams and CYP can access this via both Partnership and specific intervention following discussion at MDT. There is a clear intervention structure in place. Referrals can also be received from the eating disorder team and EIP. PMH are able to refer for consultation. Referrals for CBT groups are accepted from both PMH and SCAMHS.

vi. Social Work Therapeutic Practitioners sit within each locality and offer generic work and specific Child Looked After (CLA) liaison and support to

the network and clinicians. The Social Workers screen referrals and gather further information and receive either a Choice appointment or a consultation. The Psychologist can be referred to by the Social Work therapy team for team formulation, network consultation or reflective practice.

vii. The EIP service delivers a service to young people aged 14-24 years and operates under Part 1 and 2 of the Measure. CBT for psychosis and behavioural family interventions are available and the service is linked to SCAMHS and PMH.

viii. Forensic CAMHS provide input to CYP displaying behaviour that could put others at risk. It receives referrals from SCAMHS and requires CYP to be Care Coordinated. It also offers consultation to the wider SCAMHS service.

ix. TISSHB is available for young people open to Social Services with sexually problematic or harmful sexual behaviour. It is accessed via consultation with the Clinical Lead, followed by multi-agency consultation, assessment and then specialist intervention. It is available in Carmarthenshire only.

3.2 Paediatric Psychology

The HB reported there was no documentation in place regarding eligibility criteria or thresholds for psychological intervention. The service described offering psychological input for CYP with an ongoing physical health condition or developmental difficulty alongside psychological distress. Paediatric Diabetes is the only service which has dedicated Psychology support as part of their MDT.

The service receives referrals from Clinicians completing a referral form, letter, or referrals are agreed informally in MDT meetings. All referrals are discussed in Psychology Meetings, with the allocation of assessment/intervention dependent on severity of presentation and clinician capacity. Specific psychological screening is provided to all young people with diabetes. The service reported that Paediatric Psychology would like to be able to offer a psychological service to paediatrics but did not currently have the resource.

3.3 Bereavement Counselling

Referrals to the service are received on a referral proforma and triaged by a Senior Co-ordinator prior to being passed to the CYP counsellor to check appropriateness for intervention or refer on to SCAMHS if risk factors are highlighted.

3.4 Palliative Care

The service reported that a patient opt in system was in place, with appointments booked in chronologically and patients were given a choice of date and time.

Findings

- There are clear written pathways to access psychological intervention and therapy across SCAMHS teams.
- Paediatric Psychology reported there was no documentation in place regarding eligibility criteria or thresholds for psychological intervention.
- Referral management processes were described by Bereavement Counselling and Palliative Care.

4. Allocation & Assessment

Each service working with children, young people and families will usually undertake a proportionate assessment of emotional wellbeing and mental health need and develop a formulation with the child, family, or service as appropriate. This supports an understanding of the factors that are contributing to the maintenance of the presenting issue. Factors internal to the child may be also highly relevant, including their social, emotional, and physical development, temperament and personality, physical or learning disability and long term or severe medical conditions.

Matrics Plant

4.1 SCAMHS

The service reported that most SCAMHS teams operated an opt in process and that patients are booked in chronological order. There was a system in place for administrative staff to book appointments, with clinicians able to book follow up appointments as required. Patients are offered a choice where possible with appointment times and dates, with urgent consultations booked on a weekly basis. All CYP referred receive an assessment or formulation, following which the weekly MDT will discuss and agree an outcome. Assessments can take place over a number of appointments. Where there is a disagreement between professionals, this will usually be resolved through discussion and advice from Psychiatry or Psychology colleagues. There are no standard response times for allocation in place.

The service aimed to offer patient choice where possible, and in these cases would discuss the choices available and support CYP to match an intervention with their goals & preferences.

There were limited opportunities to flex staff capacity between different areas if a particular therapy was needed. The ability to allocate the clinician with the skills or training required depended on a number of factors, for example the numbers waiting for a service and capacity due to vacancies. However, staff reported that they will endeavour to meet the CYP's needs, and staff are often trained in multiple therapeutic modalities so can deliver a variety of interventions as an adjunct if needed.

The HB reports data against two access targets. Part 1a of the Measure captures the numbers who were assessed each month (activity) in PMH and how long they

waited, with a target of 80% in 28 days (Figure 2). SCAMHS also reports against an access target of 80% within 28 days, but this is calculated against the total number still waiting (current waiting list) (Figure 3). The service met both these targets in July 2023.

Figure 2

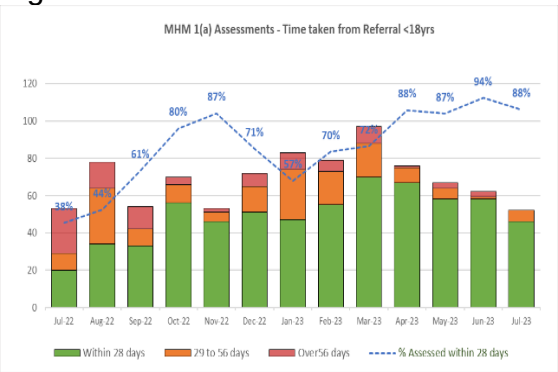
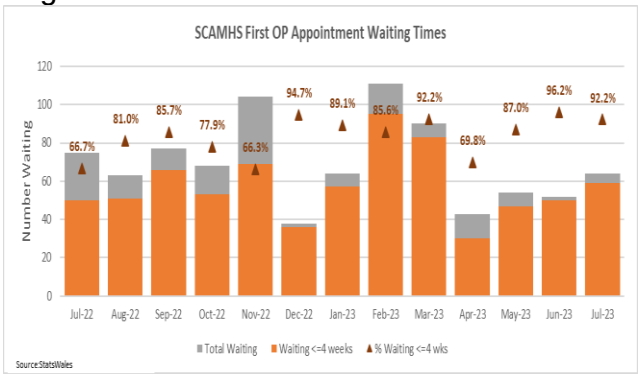


Figure 3



4.2 Paediatric Psychology

The team will discuss referrals with the MDT to ensure they are appropriate or to offer support and advice to the referring clinician prior to accepting the referral. The team were keen to be able to expand their role into other MDTs however did not have the capacity to undertake this. Following acceptance of a referral, the team hold a waiting list until a team member has capacity to be allocated a case. There are no standard response times for allocation or assessment in place.

The service has a dedicated Clinical Psychologist for Paediatric Diabetes, and this staff member therefore is allocated for referrals from that team. Referrals for psychological input from other teams are shared between the Consultant Psychologist and Assistant Psychologist.

A patient opt in process was in place for the diabetes service. The service was unable to offer bookings in chronological order due to a lack of clinical space across localities. There is administrative support in place to support bookings and patients are given some flexibility with times and dates of appointments although this is limited due to room shortages. The service did not have access to SMS reminder service.

All CYP referred receive an assessment or formulation. The initial contact with a CYP may serve as both an assessment and an intervention, due to the limited capacity of the team.

4.3 Palliative Care

The service reported that a patient opt in service was available, with patients booked in chronological order and offered choice regarding the time and date.

Findings

- All services reported the use of an opt in process with administrative support for patient bookings.
- All services reported offering some patient choice with regard to appointment time and date.
- In both SCAMHS and Paediatric Psychology, CYP are offered an initial assessment or formulation.
- In SCAMHS, there was consideration of which practitioner was best placed to undertake the initial assessment based on need.
- Paediatric Psychology are only able to offer a service to Paediatric Diabetes due to the small capacity of the team.
- There were no standard response times in place for allocation or specialist assessment in place in the HB. SCAMHS has national targets to meet for initial assessment.

5. Psychological Interventions

Psychological interventions are purposeful courses of action driven by a formulation which itself will be based on an assessment of need and informed by one or more psychological theories. The formulation should consider where in the child or young person's system an intervention can be most effective for improving psychological resilience and wellbeing. As such, evidence-based psychological interventions encompass a wide range of courses of action including:

- *Targeted training to upskill key members of a child or young person's system.*
- *Network consultation to support the development of a shared framework for understanding and responding to the child or young person's specific presentation.*
- *One off or ongoing consultative support to an individual or specific team intervention with main carers/parents.*
- *Intervention directly with child or young person.*

Matrics Plant

5.1 Direct intervention

The HB provided information on the range of therapies delivered to children and young people and their parents and carers across the services.

5.1.1 SCAMHS

Staff working in SCAMHS are expected to be trained to deliver a range of psychological interventions within Partnership sessions. In addition, there are a range of staff trained to deliver Specific psychological interventions to CYP following an assessment and based on goals identified by the young person as important to them. Direct psychological intervention with parents and carers was delivered as a standard component in some therapeutic interventions.

Psychological interventions offered include CBT, Systemic Family Therapy, Dialectical Behaviour Therapy (DBT), Cognitive Analytical Therapy (CAT), Acceptance and Commitment Therapy (ACT), Eye Movement & Desensitisation Therapy (EMDR), Solution Focused Therapy (SFT), and Art Therapy. There is variation in the modalities offered between localities depending on the training and qualifications staff have in each area. The service has written structures detailing the number of appointments offered, review frequency and pathways out of the service.

Some examples of interventions include a Brief Behavioural Activation group, a two-hour parent/carer/supporter psychoeducation session on understanding low mood, the rationale for behavioural activation and how to support a young person experiencing difficulties with low mood. CBT interventions will most often include parents and carers as part of the intervention and in line with the evidence base. Couples therapy with both parents/caregivers and /or individual therapy with a parent are available to strengthen the system around the child. Non-Violent Resistance approaches are available to support parents to become more resourceful and resilient to manage the violent behaviour of the child. Attachment-based family therapy is available to help the parents and child to repair and create a new narrative describing the relationship. And an Open-Dialogue Approach will be added to the skills set, to support the delivery of psychological interventions to families dealing with psychosis.

5.1.2 Additional CAMH Services

CAMHS reported a range of additional projects in place providing supportive interventions to CYP.

i. Kooth

Kooth is commissioned by the HB to deliver online early intervention and prevention to any CYP living within the HD area.

ii. SilverCloud

SilverCloud is an online CBT service available across Wales, including CYP resident in HD. CYP aged 16 and over are able to self-refer, which can be used in conjunction with support from SCAMHS. Young people aged 11-15 can be referred by a professional. In addition, the service can be used as a step-down option on discharge from SCAMHS.

iii. Arts Boost Project

The Arts Boost project has funding by the Arts Barring Foundation through the ‘Celf a’r Meddwl / Arts and Minds’ programme for the Arts in Health Team. This programme supports the HB in providing creative opportunities for CYP over the age of 12 living with mild to moderate mental health difficulties who are waiting to receive psychological interventions provided by the Health Board’s PMH Team.

iv. MIND EIP group

A Peer Group with MIND and the EIP service for young people to build social connections, develop skills and confidence.

v. EIP Art Therapy Group

An art therapy group delivered by an SCAMHS psychotherapist.

vi. Future Minds Forum

This forum enables young people's voices to be heard in the development of CAMHS, with co-production as a core value.

5.1.3 Paediatric Psychology

Paediatric Psychology reported using a formulation-based range of modalities in their work, delivering direct interventions to CYP and their families. These included CBT, Solution Focused Brief Therapy, Systemic Approaches, ACT, PCP, CFT and DBT (although were not offering a full DBT programme). There were also specific diabetes related interventions offered including the Tree of Life. The service was keen to deliver trauma informed and preventative approaches, however the availability of different modalities was inhibited by the small size of the team and limited joint working with other therapy provision in the HB.

5.1.4 Palliative Care

Palliative Care reported the part time therapist was trained in delivering humanistic/person centred therapy, delivering interventions to CYP and their families.

5.1.5 Bereavement Counselling

Support & specialist bereavement counselling was reported to be provided to CYP and their families.

5.1.6 Mode of Delivery

Staff across the HB offer both online and face to face interventions to ensure patients have choice and to maximise attendance and dependent on it being clinically safe, appropriate and age appropriate. Staff in both Paediatric Psychology and SCAMHS reported that room availability was a significant constraint in delivering therapy and this could drive whether therapy was offered virtually or face to face. There was a shortage reported of appropriate room space which was soundproofed and available for regular booking to deliver face to face therapy, or a lack of private space with appropriate IT to undertake virtual therapy.

The SCAMHS DBT service reported that they had evaluated online and face to face interventions and found that engagement with parents and CYP was not always as good when delivering online therapy and it could be challenging undertaking practical aspects of the intervention. However, it had increased participation due to convenience.

Staff across SCAMHS & Paediatric Psychology stated that they assess whether a group or individual therapy is necessary, considering patient need and severity of issue as part of the formulation. SCAMHS also reported that groups were sometimes used as a waiting list intervention.

Findings

- SCAMHS deliver a range of specific psychological interventions to CYP following an assessment and based on goals identified by the young person as important to them. Direct psychological intervention with parents and carers was delivered as a standard component in some therapeutic interventions.
- Paediatric Psychology reported using a formulation-based choice of modalities in their work, delivering direct interventions to CYP and their families.
- Palliative Care and Bereavement Counselling offer a single modality intervention in each of their services.
- Staff across the HB offer both online and face to face interventions to CYP.
- Room availability was a significant constraint in delivering therapy and this could drive whether therapy was offered virtually or face to face.
- Staff stated that they assess whether a group or individual therapy is necessary, considering patient need and severity of issue as part of the formulation.

5.2 Consultation & Formulation

Where the presenting concerns are expressed by adults in the child or young person's system rather than by the child or young person themselves. It is essential that the expertise and support that exists within the tiered system is available to practitioners in embedded services in the form of easy to access consultation, advice, and role appropriate supervision, as well as skilled psychological and other practitioners being embedded within these systems.

Matrics Plant

Consultation and formulation are a significant aspect of Psychology and psychological therapies practice and intervention and aim to facilitate an understanding of a person's distress and difficulties to support recovery. Psychological formulation is a collaborative process that can be used in addition to, or instead of, a diagnostic process and details the matters that have come together to create and maintain the presenting need.

5.2.1 SCAMHS

The service reported that both network consultations and one-off consultation are available from Psychology across the teams in CAMHS, including Psychology in locality teams, LD CAMHS, PMH, SiR and the CLA service. It is clearly referenced in job plans provided to the review team.

The service provided numerous examples of the ways in which consultation is provided within CAMHS and to partner agencies. Examples provided included CAMHS LD service provided 10 initial consultations in the first 7 months of 2023, with some further follow up consultation. PMH and SiR provide monthly consultations to all state secondary schools and pupil referral units. The Substance Use team meet regularly with professional networks via the Risk Management and Transition meetings and provide additional multi agency consultations outside of this where needed. Consultation, multi-agency formulations and Positive Behavioural Plans were available for residential staff drawing on attachment theory and therapeutic and developmental parenting models. One off consultation was also available to any professional/team, which could be followed up with further consultation or direct intervention.

5.2.2 Paediatric Psychology

The service reported that, dependent on the formulation of a CYP's needs, they are able to offer network consultation and one-off consultation.

5.2.3 Palliative Care

The service reported that they are able to offer network and one-off consultation but provided no further detail.

5.2.4 Bereavement Counselling

The service reported that they are able to offer one off consultation in the form of information and guidance to professionals.

5.3 Targeted training

> *Targeted training is an intervention that can be offered to the adults who are part of the child's or young person's life to enable them to better understand and respond to the child's or young person's needs. (This) allows the context in which the child or young person is developing to be adjusted to create conditions in which the child or young person can achieve better developmental outcomes. Targeted training can be considered to be both a preventative intervention and an intervention offered following assessment and formulation.*
>
> **Matrics Plant**

5.3.1 SCAMHS

The service reported that targeted training could be provided by secondary or primary CAMHS. Numerous examples were provided to the review team. These included provided training on OCD to education staff in a Special Needs school. The

SiR service provide training to education staff, including pupil referrals units, school counsellors and school nurses.

The service provides 'Network Training' events with specific training in relation to best practice with regards to a CYP's presentation or diagnosis. The CLA team provides support to carers/staff in therapeutic parenting in their day-to-day interactions with young people. DBT intervention includes targeted DBT skills training to members of the wider system, either through individual sessions or groups.

5.3.2 Paediatric Psychology

The service reported that they were able to deliver targeted training, dependent on the formulation of a CYP's needs.

5.3.3 Palliative Care

The service reported that they were able to deliver targeted training, but no further information was provided.

5.3.4 Bereavement Counselling

The service reported that they were able to deliver targeted training, but no further information was provided.

Findings

- SCAMHS offers regular network consultations and one-off consultation as a fundamental part of service delivery.
- Paediatric Psychology reported that they are able to offer network consultation and one-off consultation dependent on the formulation of a CYP needs and capacity of the team.
- All areas reported offering target training. SCAMHS were the only service who described this work with examples of targeted training delivered.

6. Transfers & Transitions and Discharge

6.1 SCAMHS Transitions to Adult Mental Health

The HB reported some challenges with facilitating transitions to adult CMHT and psychological therapy. SCAMHS stated that it was difficult to ensure Adult mental health colleagues attended transition meetings and they wouldn't do so prior to the CYP's 18th birthday in some localities. There were examples shared of the service escalating issues, including to the to the Children's Commissioner, especially where the CYP did not have a diagnosis. The SCAMHS transition worker was seen as a positive enabler for this process, as well as a peer mentor role that had been developed. However, there remained significant differences in service between SCAMHS and AMHS which made transition challenging. SCAMHS reported that some CYP's mental health had deteriorated to the point of requiring an admission at the point of transition. Some SCAMHS therapies continue for CYP up to the age of

19, which also could result in challenges in accessing crisis support if the CYP was waiting for Care Coordination from adult services.

Challenges were also reported from Paediatric Psychology with regards to transferring CYP to Adult ADHD services due to long waiting lists in the service.

6.2 SCAMHS and Paediatric Psychology

Paediatric Psychology stated that there was very limited routine joint work arrangements or shared resources with SCAMHS in place. There are quarterly meetings now in place with SCAMHS regarding CYP with Type 1 Diabetes Disordered Eating. Referrals made to SCAMHS from Paediatric Psychology follow the same pathway as any other referral. The Women and Childrens directorate would welcome closer working relationships between the two areas.

SCAMHS reported that it would be helpful to improve joined up services with Paediatric Psychology to improve the service to CYP with physical health problems and medically unexplained symptoms. SCAMHS noted that there were CYP with diabetes accessing the SCAMHS DBT programme, but this was managed on a case-by-case basis rather than having a formal joint working structure to support it.

SCAMHS also reported that there were meetings in place between the two services to focus on meeting the needs of CYP with complex needs to enable a more collaborative and holistic response. There had also been shared training (between ND and SCAMHS) and some training between the services. SCAMHS acknowledged there was more work to be done to improve joint working between services, and opportunities were limited due to the small size of the Paediatric Psychology service.

6.3 Crisis and Liaison

SCAMHS reported that there were pathways in place to refer CYP directly to the Crisis and Liaison teams when they needed to access additional support for patients whose mental health deteriorated during therapy. Some therapists reported that they could be asked to provide some additional support for a CYP in mental health crisis and offered flexible support where possible. Paediatric Psychology reported that there was no fast-track pathway to access SCAMHS in this scenario and CYP are referred via the usual pathways to the SPoC.

6.4 Other service interfaces

SCAMHS teams reported numerous interfaces in place in and between their service and wider services and agencies. These included Psychology staff linking in with community psychology colleagues (including for example SiR and Forensic) to avoid duplication and develop child centred plans. The Social Work Therapy team have bi-monthly meetings with the CLA nurse which was reported to improved joined up and timely responses.

There remained areas where the interfaces required improving. These included the need for a challenging behaviour service, which had been identified as a significant gap falling between agencies. Also, the need for intervention and support for CYP with an ND diagnosis was seen as a considerable gap in provision between agencies.

Paediatric Psychology reported that they visited the paediatric ward every few weeks to provide support with planned admissions. There was no system currently in place for the ward to ask for an urgent referral or opinion due to capacity, and this was considered a gap in service that would be valued by Paediatricians.

6.5 Discharge

The HB reported that once specialist therapy had ended, there would be a discussion with the locality SCAMHS team and a CTP review to decide further action. It was recognised that CYP feel held in SCAMHS and there was a need for more services to refer on to at the point of discharge, despite preparatory work being done with CYP and their families. This was felt to be improving with services such as SiR being in place. There were also challenges in discharge from the service if the young person was prescribed a medication that the GP was unwilling to provide without SCAMHS involvement or a shared care protocol.

Findings

- SCAMHS reported some challenges with facilitating transitions to adult CMHT and psychological therapy. The CAMHS transition worker and peer mentor roles were seen as positive enablers for this process.
- There was limited joint work arrangements or shared resources between SCAMHS and Paediatric Psychology. The very small capacity of Paediatric Psychology limits opportunities to improve this, however both services acknowledged that there would be benefits from more routine and structured joint work.
- Paediatric Psychology reported that there was no fast-track pathway to access SCAMHS from their service, with CYP are referred via SPoC.
- Paediatric Psychology do not have capacity for the Paediatric ward to request an urgent referral or opinion, and this was considered a gap in service that would be valued by Paediatricians.
- School In Reach was considered a valuable service to support discharge from SCAMHS with an acknowledgement that more was still required, including the need for shared care protocols to support GP prescribing.

7. Alignment with the Mental Health (Wales) Measure 2010

> *The stepped care model for mental health is described in the Mental Health (Wales) Measure 2010 National Service Model for Local Primary Mental Health Support Services. Stepped/tiered care services adopt an incremental approach to service provision, best described as pyramidal in structure, with high volume, low intensity interventions being provided at the base of the pyramid to people with the least severe difficulties. Subsequent steps are usually defined by increasing levels of case severity and increasingly intensive forms of treatment rather than levels of contextual complexity.*
>
> **Matrics Plant**

HBs are required to define where mental health services sit within the Measure, under Part 1 or Part 2, with an up to date Part 1 scheme which defines the range of services delivered under Part 1. There is no option for a middle ground between these two categories, despite common informal reference to “primary plus” or “Part 1.5” in Wales. At present, many Part 1 schemes require updating across Wales to reflect the significant growth and evolution of services in the decade since the inception of the Measure. Therefore, without an updated Part 1 scheme, any HB will lack of clarity as to where some teams and services sit within the Measure.

7.1 Part 1 & Part 2 Service Structure

> *2.6 The requirements of Parts 2 and 3 of the Measure are not dependent upon the way in which services are configured or delivered, but rather are determined on the basis of whether the service which is being provided (or would be provided if the person co-operated appropriately) is intended to address an individual’s mental health problem.*
>
> *1.12 In order to ensure that care and treatment is most effective in maximising recovery, the assessment, planning and delivery of that care is to be holistic. In formulating the care and treatment plan, care coordinators need to focus on the needs of the relevant patient, rather than the services that currently exist and could therefore be provided.*
>
> **Code of Practice – MHM Part 2 & 3**

In SCAMHS, there is access to Psychology and psychological intervention under both Part 1 and Part 2. Most CYP access this under Part 1, including:

- PMH psychological Interventions – Part 1b
- Consultation and formulation
- Targeted training
- SCAMHS Partnership Interventions
- Psychology
- Specialist Psychological Therapies

Part 2 psychological interventions include:

- Consultation and formulation
- DBT
- Psychology
- Specialist Psychological Therapies

These different structures affect the pathways that patients follow to access therapy and at times dictate whether a patient needs to be Care Coordinated under Part 2 to access certain modalities or teams.

The HB has previously reported that their Part 1 scheme needs updated to reflect the current service structure. Whilst there is data collected and reported on the numbers of young people Care Coordinated, there is no equivalent data on the numbers of young people open to SCAMHS under Part 1.

7.2 Care Coordination

> *3.29 The care coordinator need not be the person who has the most involvement with the relevant patient, although in practise this is often the case… good practice would be to ensure that the person with the most appropriate skills and experience is appointed as the care coordinator.*
>
> **Code of Practice – MHM Part 2 & 3**

The HB reported that eligible Psychologists and psychological therapists in SCAMHS who meet the criteria to undertake the Care Coordinator role, undertake this function where appropriate. Allocation was reported to be challenging in some teams due to lack of eligible clinicians. The HB reported this position was now greatly improved now due to recruitment of eligible professionals, although some teams reported an ongoing issue. Staff training was being rolled out to improve staff awareness of the Measure.

The HB monitors the Care Coordination caseload using excel spreadsheets and via monthly monitoring meetings, and report most young people having an up to date Care and Treatment Plan (CTP) in place. HD's nationally reported data for Care Coordination can be seen in Figure 4, with 100 CYP under Part 2 and 97% with an up to date CTP in July 2023 (target 90%). Figure 5 shows the number of CYP being identified as Part 2 or discharged from Part 2 each month.

Figure 4

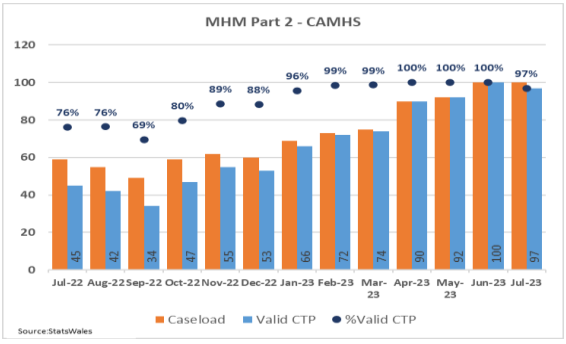
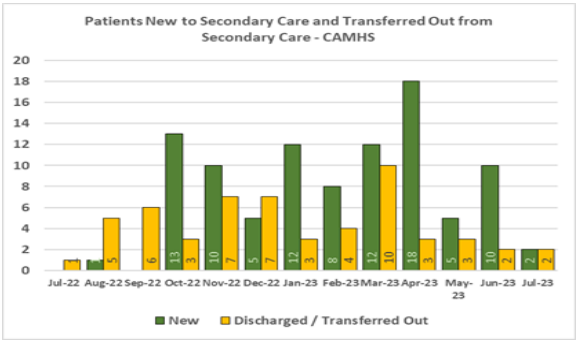


Figure 5



Staff reported that there were some bottlenecks remaining in the system, with long waits for partnership in some localities leading to delays for Care Coordination and therefore a delay for therapy. This data is not currently reported nationally, though a snapshot of numbers waiting for partnership was reported to the review team, with 94 CYP waiting, and can be seen in table 4 on page 35.

There remained challenges reported regarding which professional was the most appropriate to undertake the Care Coordination role, with therapies such as DBT explicitly requiring the Care Coordination role to be undertaken by a different clinician than the professional delivering psychological therapy. The DBT team reported that as a result of Care Coordination delays, the team had started undertaking the role of Care Coordination when required to improve access to DBT for young people.

However, this was reported to lead to several risks. For example, following the completion of therapy, there was no fast-track pathway back to the locality SCAMHS team to ensure timely transfer. As a result, the team reported discharging patients from Part 2 back to the GP, despite young people's ongoing risks and needs indicating the need for ongoing SCAMHS support. Another example provided was if a CYP disengaged from treatment, the DBT team continued to hold Care Coordination without providing input.

Hywel Dda – Part 1 & 2	**September 2023**
Part 1 Scheme reflects current service structure	✗
Psychologists Care Coordinate	✓
Psychological Therapists Care Coordinate	✓
Psychological interventions delivered under Part 1	✓
Psychological interventions delivered under Part 2	✓
NB the ticks and crosses denote whether a function exists, and not whether it is subject to law or guidance. This enables straightforward comparison with services across Wales.	
Findings: • The Part 1 Scheme requires updating to reflect current service structure and clarify the interventions delivered under Part 1 and Part 2. • The HB monitors Care Coordination performance and exceeded the target in July 2023. • Allocation was reported to be challenging in some teams due to lack of eligible clinicians, with an improved position but staff reported bottlenecks remain. This data is not currently nationally reported, with the HB reporting 94 waiting for partnership in August 2023. • The DBT service had created new pathways into DBT as a result, which was also leading to some unintended risks following the completion of therapy.	

8. Recruitment, Training and Supervision

In practice, this means having practitioners within the workforce who:

Are able to deliver a service in Welsh, are trained to recognised standards with the competences necessary to deliver psychological interventions effectively within the service context in which they work, are delivering interventions which make sense in respect of the presenting needs and are supported by the best possible evidence, are operating within a well-governed system which offers regular high quality, psychological supervision (model-specific where appropriate) support and relevant Continuing Professional Development (CPD).

Matrics Plant

8.1 Recruitment

SCAMHS reported that Psychology and psychological therapies recruitment had been successful again this year. This was attributed to the provision of Assistant Psychologist posts and trainee Clinical Psychology placements, resulting in people returning to work in the HB. The Grow Your Own scheme with the South Wales Doctorate in Clinical Psychology Training Course, supported by HEIW, was expected to further support recruitment.

The Paediatric Psychology team reported uncertainty about the team's future, with a small fragile staff group reliant in part on temporary and external funding. Without a commitment to additional or extended funding, the service was expecting their resource to reduce to 0.6WTE clinicians by early 2024. Service Management confirmed to the review team that some additional substantive resource had been sourced to support the team. The recent addition of administrative support to the team, including office space, was welcomed to support with the day to day running of the team.

Findings

- SCAMHS reported successful recruitment over recent years which had improved the staffing position in the service.
- Paediatric Psychology is a small service with significant risks to maintaining it's current capacity,with some recent resource confirmed to provide cover.

8.2 Training

Training and skills development are key to:

The delivery of psychological therapy and supervision.

Increasing the capacity of the current and any new workforce to deliver effective interventions at both the required quality and volume.

Matrics Plant

8.2.1 Paediatric Psychology

The service reported that at the time of the review there was no training strategy or budget to support staff training in the directorate and the team were not aware of funding or training opportunities across the HB. Mandatory training is monitored through line management, and specialist training approved by service delivery manager as and when requested by staff. Staff also reported that they sought out free training or webinars to support their development where possible.

A gap was reported with regards to professional leadership due to a vacancy, which when recruited into could support improved PADRs, training plans and training provision. Paediatric Psychologists were not connected to training budgets or provision that could be available via Adult Health Psychology or SCAMHS. Staff reported that the key modalities they would wish to have training in were ACT and Systemic Therapy.

8.2.2 SCAMHS

SCAMHS reported that there was a training steering group in place which was attended by managers and clinicians. There is a focus in the service on ensuring staff were trained in SCAMHS core competencies (CAPA core generic skills). The service was developing catalogue of resources to support these core competencies in an SCAMHS academy, with links to tools and staff who can support this. The service reported there had been good feedback so far from staff. There was also an aim to deliver CAPA training again.

The wider SCAMHS training strategy focused on growing its own staff. The service was engaged with the essential SCAMHS programme and SCAMHS module in Bangor University and in addition was accessing training being developed by HEIW. It was noted that the requirements for training and supervision could be a heavy load and the service would benefit from an improved national approach to training resources.

SCAMHS also delivers training to other services including schools, Police, A&E, Paediatrics and Local Authorities. The service reported developing a national resource on working with CYP with neurodiversity and had developed joint training on Tics and Tourettes with Paediatrics.

Staff reported that funding was available for the post graduate diplomas in CBT and CAT which is offered on an expression of interest basis, with an equitable process in deciding who attends. Some staff stated that they had applied for follow up training or for therapy resources to be purchased but had not had these approved. Some staff reported self-funding to complete certain training that was in their PADR, with particular challenges noted for EMDR training and limited availability of supervisors. There was a desire expressed for further training and resources in systemic therapy. Staff reported that at times they were unable to buy resources to support the delivery of training, for example the DBT manual to support the therapy for CYP with a learning disability.

Findings

- SCAMHS has a training strategy and steering group in place with a range of training in place to support the workforce.
- Paediatric Psychology does not have access to a protected training budget and lacks senior professional leadership which would support this.
- The HB would welcome additional national training resources.

8.3 Supervision

> *It is essential that any practitioner delivering a formal psychological intervention or therapy has access to appropriate clinical supervision to ensure it is being delivered to an appropriate standard. Clinical supervision should be regular and ongoing and take account of modality and profession specific minimum standards.*
>
> **Matrics Plant**

Matrics Plant sets out the requirements for supervision at each level or tier of intervention, from skilled practitioners, clinical supervision to an accredited supervisor in the field.

8.3.1 Paediatric Psychology

The service reported that the Consultant Psychologist has peer supervision and self-funded external supervision and provides supervision to the Psychologist in the team. Both the Psychologist and Consultant Psychologist provide supervision to the Assistant Psychologist. In addition, managerial supervision was available from the Service Manager. The service reported that at the time of the review there was a gap in professional leadership, with a vacancy in the Head of Psychology post and a lack of clarity regarding professional leadership lines.

8.3.2 SCAMHS

All staff reported being able to access supervision. The service reported that the aim is for the majority of staff to have in house supervision unless staff have specific roles, for example Forensic CAMHS. The Leads for therapeutic modalities in psychological therapies offer training and supervision internally to staff which reduces need for external supervision. All senior psychological therapists are accredited supervisors, and Psychologists can offer trainee placements which requires introductory and advanced supervision, updated regularly.

There were challenges in accessing some supervision or funding for supervision reported by the service. The DBT team have a 2-hour weekly consultation (peer supervision) group built into the model. The service was working towards accredited DBT service, however this required external supervision and funding. Some CBT supervision was being provided externally due to the need for BABCP accredited supervisors. And EMDR supervision was reported to meet the minimum standards but couldn't meet the gold standard of having input from a consultant due to a

national shortage and costs. Some modalities reported a fragile supervision provision reliant on a single member of staff.

The service reflected on the challenge of managing the balance of the Assistant Psychologists' case load, who were sometimes undertaking specialist work under the supervision of a psychologist but without the training or specialist supervision. The service reported that they were offering CBT developmental posts due to challenges in recruiting CBT therapists but acknowledged that this doubled the supervision requirements which was challenging to accommodate.

Findings

- All staff reported being able to access clinical and managerial supervision.
- Paediatric Psychology lacked professional leadership at the time of the review.
- Most supervision is available internally, with some purchased externally. One member of staff reported self funding external supervision.

9. Service perspectives

9.1 SCAMHS

Teams across SCAMHS reported being proud of the relationships they had developed between agencies and teams, the expansion of services and good patient and family outcomes. Teams reported improving access to psychological interventions in teams and embedding the no wrong door approach. They reported they had valued, supportive and committed colleagues. The CBT service described taking a flexible and imaginative approach to enable access to CBT whilst there were recruitment challenges, for example delivering groups or parent led interventions.

Staff and managers highlighted the challenges with estates and limited availability of suitable rooms to undertake clinical work in, including issues with a lack of soundproofing which affected confidentiality, and patient access issues. These issues were impacting on the ability to deliver an effective service, increasing waiting lists and affecting staff morale.

The SCAMHS management and leadership team reflected on achievements with recruitment and retention in the service, for example having a low vacancy rate in Psychology when compared to the national position. It was acknowledged that staff worked hard, had come together and been resilient over the pandemic and that innovative ideas had emerged in this time using online solutions such as online training and virtual clinics. Services were acknowledged to be valued by partner agencies, such as TISSH and SMS, with flexible and assertive engagement of CYP.

The HB was proud to have secured money from the Arts Council for the Arts Boost project which had been put forward for a patient experience award. The service reported that financial constraints limited the provision of laptops and mobile phones to staff, software enabling calls from laptops. Electronic case notes were reported to be a welcome improvement and improved patient care as information from all teams was available to staff.

9.2 Paediatric Psychology

The Paediatric Psychology team felt appreciated by their Paediatric colleagues, and considered themselves resilient, enthusiastic, and supportive. They were proud of the work they undertook with CYP and reported good patient outcomes. The team had significant concerns about the small size of the team, the operational management and professional leadership arrangements and the very limited access to office and clinical space which inhibited their work. As a result of these issues, the service was fragile, and the team felt unsupported. The team reported that these concerns had been raised formally to senior management in the HB.

The Women and Children's directorate management acknowledged the issues faced by the Paediatric team and had secured some recent improvements with providing admin support and some office space and protecting or backfilling some posts in the team. They were proud of the team's increasing integration of Paediatric Psychology with the community paediatric team and acknowledged that it was a challenging area but a valued service and acknowledged there was significant work to be done to support and grow the service.

Findings

- Staff and managers described the teams as resilient and supportive.
- Estates and room space for the teams were reported to affect service capacity to deliver psychological interventions.
- The small size and capacity of the Paediatric Psychology team was acknowledged as a challenge by the HB.

10. Management of Psychological Therapy Services

10.1 Psychological Therapies Management Committee (PTMC)

Health Boards are expected to have a PTMC which feeds into the national PTMC. The Health Board call this the Psychological Therapies Management Group (PTMG), with agreed Terms of Reference and attendance from professionals, managers, and service user representatives. The PTMG has oversight of national strategy including Matrics Cymru and Matrics Plant and its role is to ensure that appropriate, evidence-based therapies are delivered and that the practitioners delivering the interventions are appropriately trained, with the relevant registration. There is no budget attached to the PTMG and delivery of targets remains the responsibility of operational management.

The HB reported that the PTMG had not met in recent months, with the last two meetings being cancelled, due to recruitment into the vacant Head of Psychology post. Representatives from both SCAMHS and the Women and Children's Directorate are members of this meeting, although the latter have not yet attended as the meetings had not been held since they had been invited. A representative from SCAMHS Future Minds also attends PTMG.

10.2 Demand and Capacity Approaches

10.2.1 SCAMHS

SCAMHS uses the CAPA model as a process to manage demand and capacity across most teams. In PMH, whilst CAPA is not applied, demand and capacity approaches are embedded. Most Psychologists and all psychological therapists across the teams have job plans in place which are reviewed and used to calculate available capacity. Referral and demand data for most Psychology and psychological interventions are not collated separately to the overall SCAMHS demand, with the service collecting demand broken down on a team or locality basis. However, art therapy and CAT do collect and collate their data separately due to the way the service is configured.

The service uses a collaborative demand and capacity tool to forecast which is now embedded within the locality teams and enables trends in demand to be tracked. There are monthly meetings in place to monitor performance with regards to this. Some demand and activity data were shared with the review team, evidencing that this data is collated and used as service management information. Data included detail about referral source, presenting complaint, and types of clinical activity per staff member.

The service reported that the aim is to create access to equitable psychological interventions and maintain balance, despite challenges with capacity and demand. The service has accessed demand and capacity training from the NHS Executive.

The service reported that neither of the electronic systems, Care Partner or WPAS, can produce real time demand data that the service needs. Therefore, the service uses excel spreadsheets for PCAMHS and SCAMHS teams. Although there is no service wide system in place to collate outcome data, the psychological therapies service is piloting the WG outcome measure collation workbook. This is an excel spreadsheet.

Demand tracking has enabled the service to identify where additional resource is needed, for example with increased capacity added in Pembrokeshire, and a DBT service now in place.

Clinical activity data is collected in a variety of ways in CAMHS. Psychologist's activity is collated manually on a monthly basis and sent to the team leads. Whilst Psychology activity is not analysed separately, it can be if required. PMH and SiR activity data is directly inputted to WPAS by administrators and clinicians. FCAMHS reported that activity data was reported for direct work, but not consultations. The service reported that the absence of a fully automated system to collate this data led to it not being used as effectively as possible.

The service reported trying to be flexible to manage bottlenecks, moving Assistant Psychologist capacity between teams, or offering group interventions. Despite this some areas do have longer waiting lists, with Pembrokeshire identified as an area with higher demand and longer waits.

At the time of the review, the service was piloting a text reminder service which was helpful in managing activity levels and waiting lists. The use of Consultant Connect in the Perinatal service was seen as a positive way to manage demand. Some of the specialist psychological therapies did not have waiting lists. This was described as a result of using consultation to manage demand for higher risk presentations.

10.2.2 Paediatric Psychology

The Women & Children's Directorate reported that undertaking demand and capacity work was challenging due to the limited operational capacity to support the service lead and admin. More recently this resource has been put in place (with a Band 7 and a Band 5) and work was now happening to move this forward. The HB reported that at the time of the review the HB was unclear as to model that was needed for the service and therefore it was a challenge identifying current service gaps. The HB was trying to capture a baseline demand for psychology with Paediatricians counting referrals, however, they reported they were working with WPAS to enable referrals to be electronically recorded for paediatric psychology by December 2023.

The service was able to capture partial activity data, with appointments uploaded to WPAS, but other clinical activity such as consultations were not captured. Discharges from Psychology are recorded. Three separate waiting lists were held for Diabetes, other acute and community, although the service was only being offered to diabetes.

Limited access to appropriate office and clinical space was impacting on service capacity, although there was space indicated in future estate projects. The HB aimed to have further demand and capacity data and reporting in place by year end. The service has escalated concerns regarding capacity to the senior HB management.

10.2.3 Palliative Care

The service reported that they were only able to capture activity data, with no data available for demand or closures.

Findings

- The HB has accessed demand and capacity training from the NHS Wales Executive.
- The HB has a PTMG, although it has not met in recent months. Colleagues from the Women and Children's Directorate will attend from the next meeting.
- SCAMHS uses the CAPA model as a process to manage demand and capacity across most teams. A demand and capacity tool to forecast, enabling trends in demand to be tracked. There are monthly meetings in place to monitor performance.
- In SCAMHS, psychological therapists and Psychologists have job plans to identify capacity available in the service. Activity data is captured, with a suggested number of intervention sessions per modality.
- The Women & Children's Directorate reported that undertaking demand and capacity work was challenging, with limited operational capacity in place. The service had recently started to collect limited data relating to demand, activity and waiting lists.

10.3 Waiting Lists

10.3.1 SCAMHS

The only target relating to the delivery of psychological to interventions for CYP is in mental health and relates to Part 1 of the Mental Health Measure. It states that 80% of CYP will commence an intervention within 28 days of assessment. In HD the PMH service data is reported for this target (figure 6). In addition, a trajectory for 2023-24 forecasting the waiting list position against this metric (figure 7), and the monthly numbers of CYP waiting (figure 8), are reported to the NHS Wales Executive. The numbers of CYP waiting for an intervention under Part 1 in PMH have reduced from April to July 2023 and the service expects to meet the target by December 2023. This data is discussed in quarterly performance meetings with the Performance and Assurance Division in the NHS Wales Executive and via the IPQD meetings monthly.

Figure 6

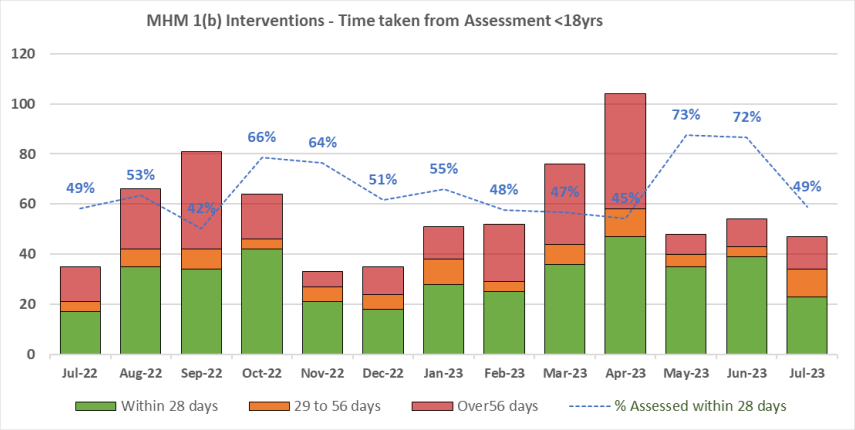


Figure 7

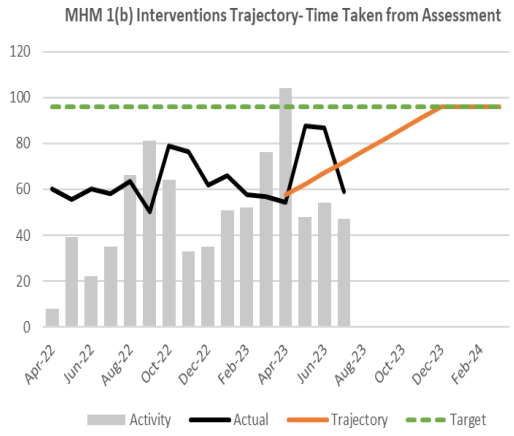
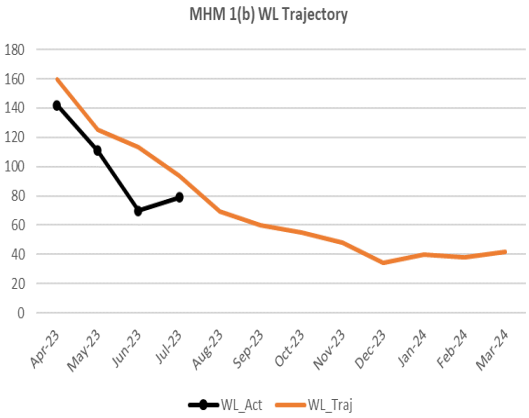


Figure 8



The HB provided snapshot figures for the waiting lists below as of August 2023 for SCAMHS (table 4).

Table 4

SCAMHS			
Waiting List	**Total Waiting**	**Longest Wait in Weeks**	**Average Wait in Weeks**
Part 1b	79	54.7	11.3
Partnership	94	33	13
CBT	0	-	-
Systemic Psychotherapy	0	-	-
Dialectical Behaviour Therapy (DBT)	0	-	-
Cognitive Analytical Therapy (CAT)	2	4	-
Acceptance & Commitment Therapy (ACT)	0	-	-
Eye Movement & Desensitisation Therapy (EMDR)	0	-	-
Solution Focused Therapy (SFT)	0	-	-
Art therapy	5	6	-
Forensic Team	0	-	-

SCAMHS reported that there were 94 CYP waiting for partnership appointments. Within this data, it was reported that the longest waits for partnership were in the Pembrokeshire locality, and this area has higher levels of demand than the other two localities. The numbers waiting for partnership had reduced over recent months. There were either small or no waiting lists reported for specific therapies in SCAMHS.

The HB reported that there were no internal waiting list standards applied to the wider SCAMHS teams, and the service worked to a “timely access” principle and applied the ‘Was Not Brought’ policy to clock starts and stops.

Waiting lists in the service are held within each locality and reviewed on a weekly basis. The Directorate has a clear process for internally reviewing performance data via monthly assurance meeting and Directorate business planning meetings.

10.3.2 Paediatric Psychology

The clinical staff reported that they have managed their own referral and waiting list processes, appointment, and room bookings due to not having administrative support until recently. The service reported keeping a manual spreadsheet updated by the Psychologists which was password protected so only the Psychologists have access as a result of these arrangements. The service does not have targets or

standards relating to waiting times. There is no data currently captured to support performance assurance discussions internally or nationally.

The HB provided snapshot figures for the waiting lists below as of August 2023 for the Women and Children's Directorate (table 5). Paediatric Psychology reported there were 31 CYP waiting for a service, with the longest wait at 89 weeks. The service reported this was due to the limited capacity in the team.

Table 5

Women & Children's Directorate			
Waiting List	**Total Waiting**	**Longest Wait in Weeks**	**Average Wait in Weeks**
Paediatric Psychology	31	89	15
Palliative Care	0	-	-

10.3.3 Palliative Care

The service stated that there was no waiting list, and no detail was provided to the review team regarding waiting list standards or management.

Findings

- There is one target relating to psychological interventions for CYP which relates to SCAMHS only, for Part 1 for the service. There is national data reported and additional assurance metrics which receive scrutiny from the HB, Welsh Government and the NHS Executive.
- There are significant waits for partnership appointments in SCAMHS, with the HB reporting the numbers are reducing.
- All waiting lists in SCAMHS are monitored via HB performance processes.
- Paediatric Psychology holds a waiting list within the team and it is not subject to HB performance processes.

10.4 Waiting list support to patients

10.4.1 SCAMHS

The service reported they send "keep in touch" letters every 3 months to CYP and their families experiencing longer waits. Locality SCAMHS staff will also phone CYP to check in and advise them or their families to contact the service or 111#2 if their mental health deteriorates. There is also a resource pack that can be sent out to CYP and their families.

The HB commissions Kooth, an online mental health service, which is free to access for all CYP living in the HD area as a supportive service to any CYP who requires it. This service is intended to supplement the work undertaken in SCAMHS rather than replace it and is therefore available as waiting list support.

The art boost project is also offered to CYP waiting for support from SCAMHS with mild to moderate mental health needs. This is supplementary to additional work undertaken in SCAMHS.

10.4.2 Paediatric Psychology

The service was unable to offer waiting list support or pre-therapy input to CYP due to limited capacity, however the team reported they would check in with the MDT every few months.

Findings

- In SCAMHS there is a process for contacting patients waiting at 3 month intervals.
- There is online support available to CYP via Kooth to any who are resident across HD.
- Paediatric Psychology was unable to offer waiting list support or pre-therapy input due to limited capacity.

11 Patient outcome measures, feedback & involvement

11.1 SCAMHS

The service reported using outcome measures frequently when delivering psychological interventions and is engaged with the national outcome measures workstream. The service has established that they will be using the short Warwick as a wellbeing and progress measure, the GBOS to enable CYP to set their own goals, and Service Experience Questionnaire (SEQ's). In addition, modality specific outcome measures are used. Data analysis is undertaken by an Assistant Psychologist.

Service evaluation questionnaires are sent out electronically via QR codes on letters to CYP and their families, although the response rate is not as high as the service would like. In addition, every three years the service do a snapshot feedback project over a month for all SCAMHS patients attending clinic. Examples of compliments received by the service from CYP and their families were shared with the review team. Co production and patient engagement is facilitated through the children and young people's forum.

11.2 Paediatric Psychology

The service reported using outcome measures frequently when delivering psychological interventions and that this was a work in progress. Measures used frequently include RCADS and diabetes specific measures. The team reflected that measures could sometimes be used to inappropriately screen or diagnose, so the team are developing a core set of measures. The team reported collecting patient feedback via Microsoft forms. It was not clear to the review team how this feedback was collated or the process for sharing this in the directorate.

Findings

- SCAMHS collect patient feedback, use outcome measures and are engaged with the national outcomes workstream. The service is able to collate and report on these measures.
- SCAMHS has a structure for engaging service user representatives via the CYP Forum.
- Paediatric Psychology collect patient feedback, use outcome measures and are developing a set of core measures. The service does not currently collate or report on these measures.

12 Service Development and Improvement

The HB was asked to consider areas of service that they considered were meeting specific needs of the population, including protected characteristics in the Equality Act, and where there were current gaps and priorities for service development.

12.1 Matrics Plant

SCAMHS reported that Matrics Plant informed evidence-based delivery of psychological interventions and supervision across SCAMHS and was a key element of the SCAMHS training academy. Further guidance influencing the service included involvement in the Traumatic Stress Wales working group and NICE Guidance.

Paediatric Psychology staff reported that the service was committed to Matrics Plant and it strongly influenced practice. In addition, other guidance documents for diabetes were followed and it were used to inform business plans. The Womens and Childrens Directorate Managers were not familiar with Matrics Plant at the time of the review but welcomed the information to support future service planning.

12.2 Service Planning Opportunities

The service reported that there was a HB wide children's planning forum established by the CEO meeting on a six weekly basis which plans joint initiatives and use of funding. Representations from both Managers and Clinicians from Paediatrics and SCAMHS attend. In addition, there is a bi-monthly interface meeting between SCAMHS and Paediatrics to share good practice.

12.3 Service Development Needs

SCAMHS reported undertaking a piece of work via the Regional Planning Board (RPB) to provide care closer to home for CYP in high-cost placements with complex needs. This work, in conjunction with the LA, has capital funding which the LA have secured for a spend to save model to reduce the cost of external placements.

The HB reported that there was currently joint planning underway regarding developing the behaviour support service, with funding combined to establish it following a complaint raised to the Ombudsman. An additional Psychology post (8B) has been proposed to oversee children's continuing care and the new behaviour support service.

It was acknowledged across the HB that the Paediatric Psychology service had insufficient capacity and resource to meet children and young people's needs within the Women and Children's Directorate. The service to CYP with diabetes has been recognised nationally as an excellent standard with the required Psychology input.

There was an acknowledgement that there was a limited understanding within the HB of how patients and services could benefit from greater joint working between directorates, and which areas required development solely within the Women & Children's Directorate. There was a desire expressed from all areas to work together more closely where appropriate. Examples from the services for improved working between directorates included improving prescribing processes, eating disorder services, an SCAMHS LD service and shared training and supervision opportunities.

The HB acknowledged that the Neurodevelopmental Service improvement plan was focused on delivering pre and post diagnostic services, however the fixed term funding model was challenging and inhibited service improvement and recruitment.

As detailed previously in the report, the lack of suitable clinical and office space across directorates was reported to be limiting the service offered to child and young people. Some staff reported they were still reliant on personal mobile devices and did not have sufficient IT equipment to fulfil their roles.

12.4 Welsh Language

SCAMHS reported that the service aimed to facilitate service provision in Welsh where possible, with Welsh speakers available in all teams. In instances where a Welsh speaking therapist wasn't available, the service may offer consultation to a Welsh speaking clinician to support them to do the work. At the time of the review there were no Welsh speaking Psychologists in SCAMHS and the service had delivered cognitive assessments in English in the past.

Paediatric Psychology reported that they were able to provide a service in Welsh, although written materials were not often translated into Welsh. The team reported that access to translators was usually limited to Language Line which had its limitations and at times families had had to translate.

Findings

- The HB uses Matrics Plant and other national guidance to inform service planning and delivery.
- There is a HB wide children's planning forum in place.
- There is a limited understanding within the HB of how patients and services could benefit from greater joint working between directorates, and which areas required development solely within the Women & Children's Directorate. There was a desire to improve joint working expressed.
- The lack of clinical and office space limits the service offered across the HB.
- There are opportunities to deliver a service in Welsh, with some reliance on Language Line.

12. Conclusion

The review sought to understand the consistency and variation in the Psychology and psychological interventions offered to children and young people in Hywel Dda, to clarify the pathways to access and the demand, activity, capacity and waiting lists in the service. The aim was to describe findings and produce recommendations at a local level to improve alignment with statutory duties, reporting guidance, and the delivery of timely access to psychological interventions to children and young people.

The review highlighted the commitment of Hywel Dda UHB to delivering person centred care to children and young people. Whilst service change and development were positively viewed by the service, there remain challenges in creating the capacity to meet the demand for services, particularly with regards to the limited capacity of Paediatric Psychology and the challenges this brings. There are significant opportunities to improve the interface between directorates, share resources and expertise and deliver joint services to improve the services offered.

It was noted that service changes are not fully reflected in the Part 1 scheme and review of this could provide an opportunity to provide greater clarity on how service changes and developments are aligned with the Mental Health Measure. Despite reported improvements in waiting times, there remain challenges and tensions with the role of Care Coordination and the capacity to deliver this and ensure timely access to psychological interventions.

The service demonstrated its commitment to offering patient choice and working collaboratively with children, young people, and their families, including using outcome measures and service user representatives used in planning and recruitment.

The NHS Wales Executive Performance and Assurance Division would like to extend thanks to the staff of Hywel Dda University Health Board for their co-operation and contributions during the review.