National Audit of Adherence to the CAMHS Operational Guidelines Report

January 2024

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Foreword

Foreword

The mental health of Ireland's children and young people is a key priority for the Health Service Executive (HSE). In the development of youth mental health services, it is critical that we **prioritise the promotion of good mental health**, **intervene early when problems develop**, and **ensure clear pathways** to **community-based mental health services** for those who **need extra supports**.

Child and Adolescent Mental Health Services (CAMHS) is a specialist mental health service for approximately 2% of children and young people who have a moderate to severe mental health disorder. For these children and young people, it is particularly important to have access to integrated and person-centered supports provided by a multi-disciplinary team of skilled professionals. Our CAMHS teams receive nearly **20,000 referrals** and deliver approximately **225,000 appointments each year** for children and young people who need support. However, CAMHS is challenged by a growth in demand for services, coupled with the impact of ongoing staff retention and recruitment difficulties.

There has been significant investment in CAMHS over a number of years to meet **this increased demand** and to improve services for children and young people with mental health difficulties. In parallel, the HSE has prioritised the enhancement of upstream youth mental health services for children and young people with mild to moderate **mental health difficulties** who do not need to access specialist mental health services such as CAMHS.

Following the findings of the *'Report on the Look-back review into Child and Adolescent Mental Health Services in Area A (Maskey Report)'* (2022), and to provide assurance to those who use CAMHS, the HSE has commissioned a number of national service reviews. These include an audit of adherence to the *CAMHS Operational Guidelines* (COG), an independently chaired review of prescribing practice and a qualitative study of how those who use, work in and refer young people to CAMHS experience those services.

Published in 2019, the COG sets out **best practice for the pathway and service delivery** for those requiring the support of CAMHS. It builds on the '*CAMHS Standard Operating Procedure'* (2015) and was developed following an extensive review and consultation process that took into consideration the views of service users, family members, front line staff, management and partner organisations.

The **national audit of adherence** to the COG was conducted between December 2022 and May 2023. It involved a self assessment approach across existing CAMHS teams based on a standardised set of survey questions. In excess of **3,000 responses** were received across **75 community teams, 2 specialist teams, 1 day hospital and 4 inpatient units**.

Findings from the COG audit, prescribing practice review and qualitative study will guide our continued efforts to enhance youth mental health services in Ireland. CAMHS Mental Health Intellectual Disability (MHID) services do not operate within the model of service outlined in the COG, and therefore did not participate in this audit. Their own model of service was launched in September 2022.

On behalf of the HSE, we wish to thank our CAMHS staff for contributing to this audit process and for their continued hard work to provide the **best possible care for children** and **young people** who avail of CAMHS services. Throughout the audit process, it was evident that **staff were committed to continuing service improvement** in the best interests of service users.

The HSE acknowledges that there are **deficits in current service provision,** including in relation **to access, capacity and consistency in quality of services provided**, and these challenges are also highlighted within this report. The **increase in referrals** to CAMHS is reflected in reported team caseloads and waiting lists to access services, which in turn impacts the ability of teams to meet clinical and non-clinical demands. There is a need for **continued recruitment** and **enhancement of CAMHS capacity to meet direct and indirect clinical demands**, alongside **investment** in the full continuum of youth mental health services.

The COG audit has also underlined the need to review governance structures and work towards shared governance models in CAMHS, in line with *Sharing the Vision* (StV), our national mental health policy. It is also clear there is an urgent requirement to **ensure all teams have access to adequate ICT systems** to support service provision. Improvements to our auditing practice, as recommended in this report, will support us in reaching appropriate standards of service provision and ensure that those **standards are maintained** going forward.

Building on ongoing initiatives, the HSE is now consolidating and **expanding our overall youth mental health improvement programme**. To deliver on the recommendations within the aforementioned reports and achieve sustainable, lasting improvements to Youth Mental Health Services, a dedicated National Youth Mental Health Office has been established. It will provide for coordinated input across service, legislative and policy developments for all child and youth mental areas. The findings of this report are welcomed and will further inform these **targeted service improvements.** The national child and youth mental health service improvement plan will be published in Q2 2024.

Published in March 2022, the StV 2022 – 2024 implementation plan provides a **three-year roadmap** for the continued development of mental health services, including CAMHS. The HSE is **fully committed** to working in partnership with staff, service users and families, in order to **achieve the goal of a modern and fit for purpose youth mental health service** that meets the needs of those who require support.

Damien McCallion
Chief Operations Officer

David Walsh
National Director of Community Operations

Executive Overview

Executive Overview

Child and Adolescent Mental Health Services (CAMHS)

Child and Adolescent Mental Health Services (CAMHS)
HSE CAMHS provides assessment and treatment for young people and their families who are experiencing mental health difficulties. While a broad range of services support the mental health of children and adolescents, the term CAMHS refers to specialist mental health services for young people up to 18 years of age who have reached the threshold for a diagnosis of moderate to severe mental health disorders.

CAMHS in Ireland consists of teams across **9 Community Health Organisations** (CHOs); 75 community teams, 2 specialist community teams, 1 day hospital and 4 inpatient units, CAMHS Hubs (currently in development), as well as CAMHS Connect and Liaison Psychiatry Teams, which provide enhanced brief mental health interventions in addition to the services provided by community teams.

The development of CAMHS is directed by the national mental health policy, '*A Vision for Change'* (2006), which recommended the number of CAMHS teams and staffing levels required to serve a given population size (one team for every population of 50,000), noting that the composition of each team should ensure that an appropriate mix of skills is available to provide a range of best-practice therapeutic interventions. Its successor policy, '*Sharing the Vision: A Mental Health Policy for Everyone'* (2020), recommends that the composition and skill mix of each team, along with clinical and operational protocols, should take into consideration the needs and social circumstances of its sector population and the availability of staff with relevant skills.

"The demand for CAMHS has been rising steadily nationally and locally for the last 20 years, not least because of a change in the expectations of parents and some reduction in the stigma associated with mental illness."

- Maskey Report (2022)

"Leadership, governance, clinical commitment and clinical effectiveness approaches are required to deliver safe, high quality mental health care at national, regional and local level."

- Sharing the Vision (2020)

HSE Maskey Report

In January 2022, the HSE published the Maskey Report. Conducted in accordance with the '*HSE Incident Management Framework'* (2020), and the '*HSE Look-Back Review Process Guideline'* (2015), the purpose of the review was to consider potential issues relating to the clinical practice of a Non-Consultant Hospital Doctor (NCHD) with regard to prescribing, care planning, diagnostics and clinical supervision between 1 July 2016 and 19 April 2021.

The Maskey Report found that the care received by 240 young people did not meet the necessary standards. It also identified deficits in respect of governance, supervision and oversight, clinical practice and the overall functioning and administrative processes, which contributed to the sub-standard care received by these children and young people.

Thirty-five recommendations have been made stemming from the analysis and findings of the Maskey Report. They cover areas such as re-establishing trust in CAMHS, governance of the service, delivery of clinical services, improved clinical practice and the use of information and communication technology to support service delivery. A significant number of these recommendations have already been delivered, with a comprehensive implementation plan in place for the remaining recommendations and accompanying actions. The realisation of the recommendations put forward by the Maskey Report closely align with the reform envisioned within StV, and will contribute to an overall Child and Youth Mental Health Improvement Programme for CAMHS across Ireland.

Executive Overview

Audit of Adherence to the COG

CAMHS Operational Guidelines (2019)
The implementation of the CAMHS Operational Guidelines (COG) is a key recommendation of the Maskey Report. The purpose of the guidelines is to provide consistency in the service delivery of CAMHS throughout the country.

These operational guidelines apply to all staff engaged in the delivery of CAMHS by, or on behalf of, the HSE in community and inpatient settings. They aim to:

- Build on the existing **good practice** already in place in CAMHS;
- Provide an **operational guideline** that CAMHS teams can adhere to;
- Ensure that **legislative** and **regulatory** requirements are met;
- Ensure that all employees and management are clear on their **roles and responsibilities**;
- Ensure that children, adolescents and their parent(s) are clear on the **service provided** by CAMHS;
- Ensure that **referral agents and other agencies** involved in the provision of care to children and adolescents are **clear on the service provided** by CAMHS; and
- Provide a **framework** for self reported audit and evaluation.

Appropriate clinical governance and service audit systems are necessary to ensure safe and effective structures and operation of services in line with best practice. Assurance is required nationally that these guidelines are being adhered to by every CAMHS team. It is critical that standardisation and consistency in the operation of CAMHS is achieved.

Audit of adherence to the COG
An audit of the implementation of the COG was commissioned in 2022. The aims of the audit were to:

- Assess self reported **levels of adherence** to the COG across all CAMHS teams nationally;
- Identify **barriers to compliance** with the COG so that improvement plans can be implemented to address these challenges;
- Identify **best practice and innovation** in CAMHS teams nationally;
- Inform an update of the COG to ensure **comprehensive updated guidance** is available to each CAMHS team;
- Provide assurance to the HSE on the operation of the COG; and
- Inform relevant service improvement programmes.

COG Audit Framework
A bespoke audit framework was developed, piloted and subsequently rolled out across the 9 HSE CHOs to obtain information from all CAMHS teams nationally, 75 community teams, 2 specialist community teams, 1 day hospital and 4 inpatient units, based on:

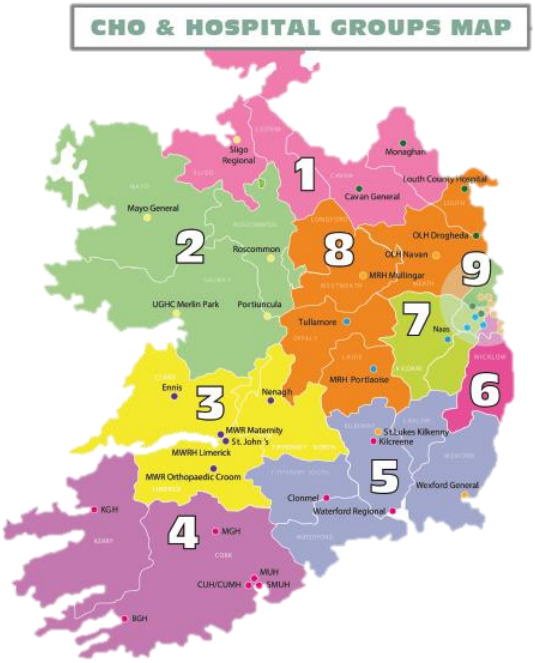
- Service statistics (e.g. caseload, waiting lists, referrals);
- Standard service timeframes (e.g. referrals and assessments);
- Evidence of documentation (treatment, care plans, transition plans and discharge, risk assessments);
- Service pathways; and
- Information on technology used to support operations (e.g. case management systems, record keeping, appointment scheduling).

Due to the nature of the services provided by CAMHS nationally, two audits were created:

- **Community Services Audit**
- **Inpatient Services Audit**

Audit findings
The data presented in this document is based on the self reported responses provided by CAMHS teams nationally. A number of recurring themes emerged from the responses to the audit. The most commonly referenced issues cited by teams and apparent in the data collected include:

- **Lack of a standardised CAMHS governance structure**, leading to ambiguity around reporting lines, roles and responsibilities;
- **Staffing and resourcing issues**, impacting on clinical and non-clinical work of team members, resulting in delays to planned care delivery and discharge in some instances;
- An **increase in case load numbers and referrals,** which leads to added pressure on services; and
- **A lack of digital infrastructure,** with many highlighting an IT infrastructure that is not fit for purpose and can lead to a lack of adherence with COG.



EXECUTIVE OVERVIEW

Key audit findings of adherence to the CAMHS Operational Guidelines in Community Teams Nationally (2019)

COG Compliance

100%
of teams are familiar with COG

4 in every 5 teams
understand their roles and responsibilities relating to the COG

81%
Partial implementation of COG

Barriers to COG Implementation
- Capacity
- Resources
- Lack of Team Coordinator

19%
Full implementation of COG

68%
of teams have **not** completed the self assessment tool available in the COG

Service provision

32% of teams*
offer out of hours service (i.e. services outside of 9 a.m.- 5 p.m., Monday to Friday).

32%

60% of teams
provide services to young people over the age of 18.

60%

34% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG.

34%

94% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

94%

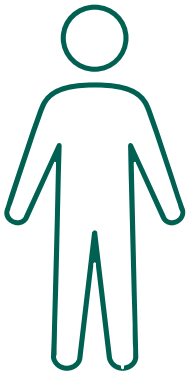
Resourcing

13
Team Coordinators reported nationally across 75 teams

Clinical File:
82% paper based
15% electronic
3% dual form

***Total Whole Time Equivalent (WTE) Staff: 811.9

87% of files reviewed have evidence of an assigned Key Worker



20-50
Average case load of Key Worker

Case Flow

Largest number of referrals are classified as routine

Average waitlist number 59

Average team caseload 246

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

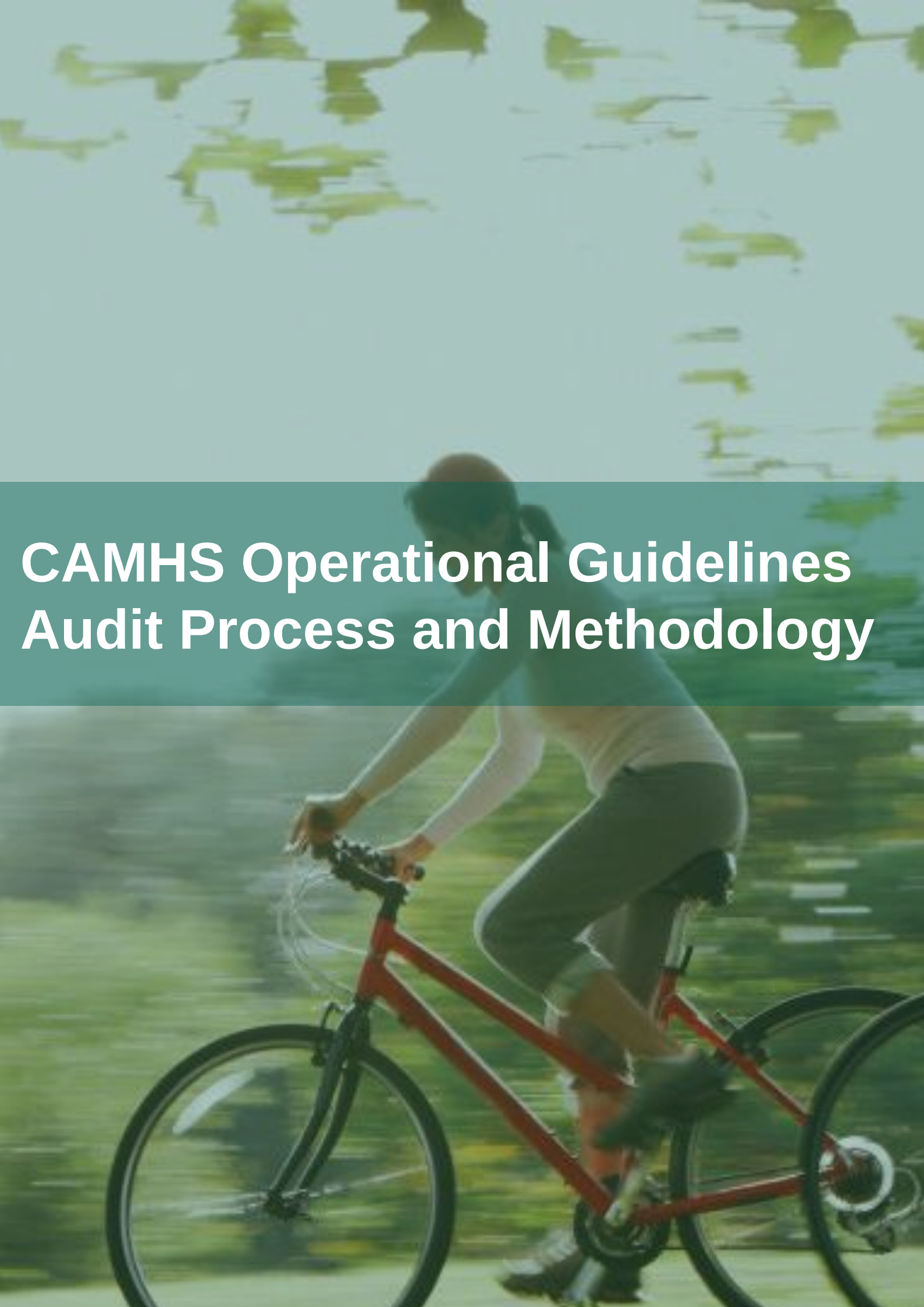
Executive Overview

Themes & Recommendations

In order for the HSE to ensure it is providing an optimal service to young people, their families and carers, a number of targeted improvements are required.

Themes identified from the COG audit and a synopsis of associated recommendations are outlined in the table below. These themes are defined and discussed later in this report. A detailed presentation of recommendations can be found in the 'Recommendations' section of this report. It is important to note that the '*Mental Health Act*' (2001) is currently under review. These recommendations will be reviewed in light of amendments made to the Act.

	Themes				
	Governance	**Staffing/ Resources**	**Case Flow**	**ICT Infrastructure**	**Service Provision**
Recommendation Synopsis	1. Development of a CAMHS stand-alone management structure.	4. Prioritisation of the recruitment of key personnel within CAMHS teams.	5. Review of guidance within the COG regarding the Key Worker role.	6. Ensure appropriate ICT infrastructures have been implemented in each CAMHS team nationally.	7. Update guidance on Individual Care Plan (ICP) within the COG to ensure that every open case would have an agreed documented ICP, which is to be reviewed regularly.
	2. Development of an internal audit framework for CAMHS teams nationally.				8. Development of a policy to standardise out of hours services across CAMHS teams nationally.
	3. Development of Quality Improvement Plans (QIPs).				9. Include clear delineation in the next iteration of COG regarding requirements for risk assessments from clinical and operational perspectives.



CAMHS Operational Guidelines Audit Process and Methodology

COG – Audit Process and Methodology

Overview of the Audit Process and Methodology

Introduction

The audit process and methodology is detailed across the below sections which are outlined in the following pages:

- **Background;**
- **Purpose;**
- **Methodology overview;**
- **Audit development process;**
- **Pilot audit;**
- **National audit;**
- **Methodology;**
- **Audit timeline; and**
- **Tools utilised in audit process.**

Background

On behalf of the HSE Oversight Group for the implementation of the recommendations of the Maskey Report, the HSE commissioned an external agency to support the undertaking of the self-assessed national audit of adherence to the COG, which involved the establishment of an expert audit group to guide this process.

The core objectives of the expert audit group included:

- **Cross-mapping** of the recommendations of the **Maskey Report** and the requirements of the **COG**;
- **Development** of a self reported **audit tool**;
- **Development** of a **methodology**;
- A **pilot** of the self reported audit tool in community and inpatient settings;
- **Distribution** of the audit to **operational teams**;
- **Collation** and **analyses** of the **audit data**;
- Production of a **report** giving an overview of rates and trends in compliance / non-compliance, regional and other factors impacting same and conclusions; and
- Use of information gleaned from this report to conduct a **review** of the **COG.**

Purpose

The overall purpose of the self-assessed audit was to achieve the objectives outlined below:

- To **assess consistency** in the service delivery of CAMHS services around the country;
- **Assess levels of adherence** to the COG;
- **Identify barriers to adherence** to the COG so that improvement plans can be implemented to address these challenges;
- **Identify best practice and innovation** which is occurring in CAMHS teams nationally; and
- **Inform future updates to the COG** so that they better support and guide the work of each CAMHS team.

Audit Development

The audit development process commenced in September 2022 and was divided into 6 steps:

Step 1: **Development** of a **bespoke audit framework**;
Step 2: **Pilot** and agreement of final **audit framework** and approach;
Step 3: **Self assessment** against audit framework;
Step 4: **Analysis** of **self assessments**;
Step 5: **Completion** of **site visits** (as necessary); and
Step 6: **Developmen**t of a national **report**.

This included the creation of a **detailed audit project plan** which outlined key outputs from the audit and timelines for delivery.

A mapping exercise was then conducted of the Maskey recommendations and the COG, which ensured the survey questions encompassed all elements of both. An audit development working group was set up by the expert audit group to inform the development of the audit questions and included clinical and management representatives from CAMHS community and inpatient units across a number of CHO areas.

This audit development working group enabled the facilitation of the below objectives:

- Development of **preliminary audit questions**;
- Multiple audit question **feedback and review** sessions; and
- Development of an online **self reported audit template**.

Pilot Audit

A pilot of the COG audit was rolled out on 11th of November 2022, involving participation from teams in **4 CHO areas.** The pilot audit, its findings and lessons learned are discussed in more detail later in the pilot section of this report.

National Audit

The national COG audit was launched on 05th of December 2022 across all **9 CHO** areas.

The following pages outline the methodology and approach to the pilot and national audit in more detail.

COG – Audit Process and Methodology

Overview of the Audit Process and Methodology

Methodology

The approach utilised to produce this report was specifically tailored to suit the requirements of this audit.

There were two distinct elements in this report:

1. **Audit of adherence to the CAMHS Operational Guidelines**; and
2. **Recommendations and Implementation Plan**.

Each of these two areas required a bespoke approach, with management of stakeholders, communications and on-going risks and issues. Below is the outline of the approach to each of the elements of this audit.

1. Audit of the adherence to the CAMHS Operational Guidelines

The audit of adherence to the COG followed a **6-step process** as detailed below and overleaf, and will culminate in the development of quality improvement plans by teams in each CHO.

Step 1: Development of Bespoke Audit Framework

Following a mapping exercise of the Maskey recommendations and the HSE '*CAMHS Operational Guidelines' (*COG), a bespoke audit framework was developed to review compliance with the HSE COG. The mapping exercise linked sections of the 2019 COG with corresponding recommendations within the Maskey report. This undertaking ensured that the self reported audit framework would be comprehensive, covering all aspects of compliance with the COG in both inpatient and community CAMHS teams.

Stakeholder engagements and consultations were used to inform and develop the audit framework. Regular meetings and presentations of audit questions and tools were provided to ensure feedback was regularly incorporated into the development of the framework.

An audit development working group was set up to inform the development of the audit questions and included clinical management representatives from CAMHS community and inpatient units across the country. In advance of the pilot audit, the working group was divided into inpatient and community groups, which met on a weekly basis to discuss what the audit framework would consist of and how it would be delivered to CAMHS teams nationally. Feedback was regularly sought from each audit development working group and discussions were held at each meeting, with follow up support and discussion facilitated also.

These audit development working groups provided extensive written and verbal feedback on the audit framework. This informed the decision that the audit would be delivered through an online self assessment tool accessible to CAMHS teams nationally and would consist of two separate sections; a set of team questions and a clinical file review.

Overview of Maskey Report and COG 2019

Maskey Report Themed Recommendations	COG Audit
• Trust; • Governance and Team Process; • Clinical Services; • Clinical Practice; • Use of Information and Communications Technology to support healthcare; and • Learning.	• Roles and responsibilities; • Implementation; • Revision; • Self-Assessment; • Recovery; • Involving Children and Adolescents; • Involving Parents; • Clinical Governance; • Children First; • Referral Process; • Individual Care Plan; • MDT Team Reviews; • Attendance/Non-attendance at appointments; • Out of Hours Arrangements; • Transition Planning; and • Discharge Planning.

Step 2: Piloting and Agreement of Final Audit Framework and Approach

A pilot audit was conducted involving a sample of **5** CAMHS teams, 4 community and 1 inpatient unit across **4 CHOs.** These teams were selected as they represented an appropriate mix with both urban and rural populations, with varying caseload levels and both paper and electronically-based records systems. The pilot audit was shared with the pilot participants on the 11th of November 2022 with a completion deadline of the 30th of November 2022.

Feedback was collected from teams participating in the pilot audit via feedback sessions during which participants discussed the structure, content and delivery method of the pilot audit. This feedback was incorporated and the relevant changes were made to the self reported audit process prior to national roll out.

COG – Audit Process and Methodology

Overview of the Audit Process and Methodology

Step 3: Self-Assessment against Audit Framework

The updated self reported audit tool was distributed among the teams not included in the pilot, this was shared with **71 community** teams, **2 specialist**, **1 day hospital** and **3 inpatient** CAMHS teams via an online link on the 5th of December 2022. The following information was requested, in addition to completion of the audit:

- CHO governance structure; and
- Team line management structure.

The audit questions consisted of:

- Anonymised service statistics (e.g. caseload, waiting lists, referrals etc.);
- Standard service timeframes (e.g. referral, assessment);
- Evidence of documentation (treatment, care plans, transition plans and discharge, risk assessments);
- Service Pathways; and
- Information on technology used to support operations (e.g. case management systems, record keeping, service statistics, appointment scheduling).

Step 4: Analysis of Self-Assessments

As responses were collated via the online tool, the expert audit group commenced data analysis of both the self-assessments and any supporting documentation provided. The data analysis was undertaken using a business intelligence platform and was based on the returned audit submissions and supporting documentation. The analysis also informed areas where further examination was required. The findings from the self reported audit were presented regularly to the HSE Implementation Lead, along with daily updates of **completion rates.**

Step 5: Completion of Site Visits

Site visits were offered to each of the **71 community** teams, **2 specialist,1 day hospital** and **3 inpatient** units to facilitate their completion of the audit, however teams did not avail of the service. The expert audit group ensured continuous, close communication with each CAMHS team, through email and phone call, to ensure any additional information required for completion of the audit was received. In addition, this provided further information on factors and root causes impacting compliance and non-compliance of the COG, including barriers and enablers of the specific CAMHS team. Bi-weekly drop in sessions were also facilitated by the expert audit group to offer support to the teams if any queries regarding audit completion or use of the tool arose. These sessions were held on a Monday and Friday afternoon.

Step 6: Development of National Report

Following the conclusion of the COG audit, this report has been produced detailing adherence reported by CAMHS teams to the COG. This report was shared by the expert audit group with the National Oversight Group and Implementation Lead prior to finalisation, providing an opportunity for review and feedback. This report presents the self reported audit findings at both an aggregated level of national compliance and operations as well as a breakdown at CHO and individual CAMHS team levels. The report includes:

- **Standards** and **criteria** measured in relation to the sections and sub-sections of the COG;
- **Issues highlighted** on why teams do not meet the required standard;
- Factors impacting **compliance** and non-compliance;
- **Recommendations** for improvement; and
- **Conclusions**.

2. Recommendations and Implementation Plan

The implementation plan in this document will account for the recommendations provided at team and CHO level as mentioned in the report with actions commencing in quarter 3 2023. These recommendations will inform relevant service improvement plans. These plans should include;

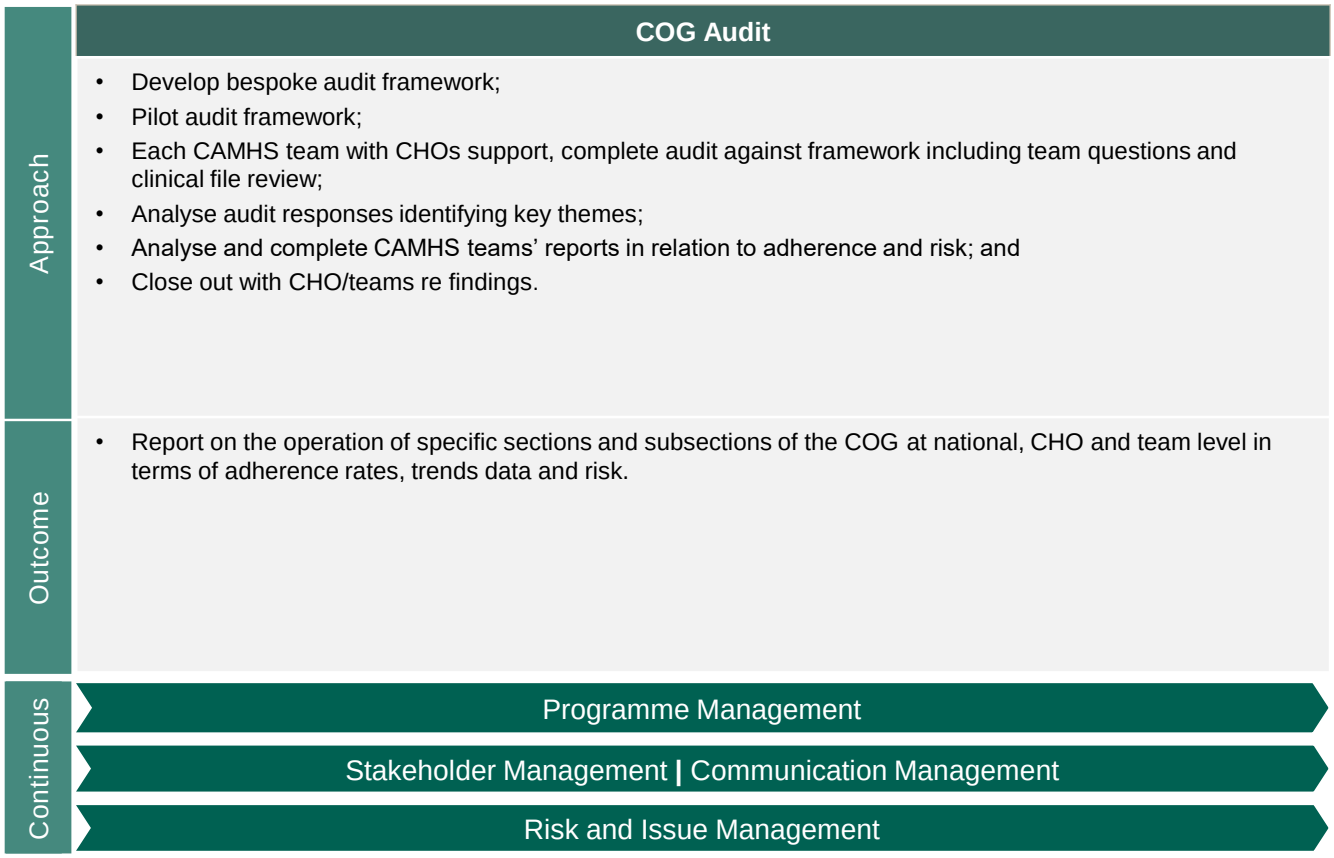
- Areas for improvement and prioritisation;
- Required actions and tasks for improvement; and
- Identification of persons responsible and timeframes for completion of each action.

The table on the next page outlines the approach and outcomes of each component of the audit undertaken.

COG – Audit Process and Methodology

Overview of the Audit Process and Methodology

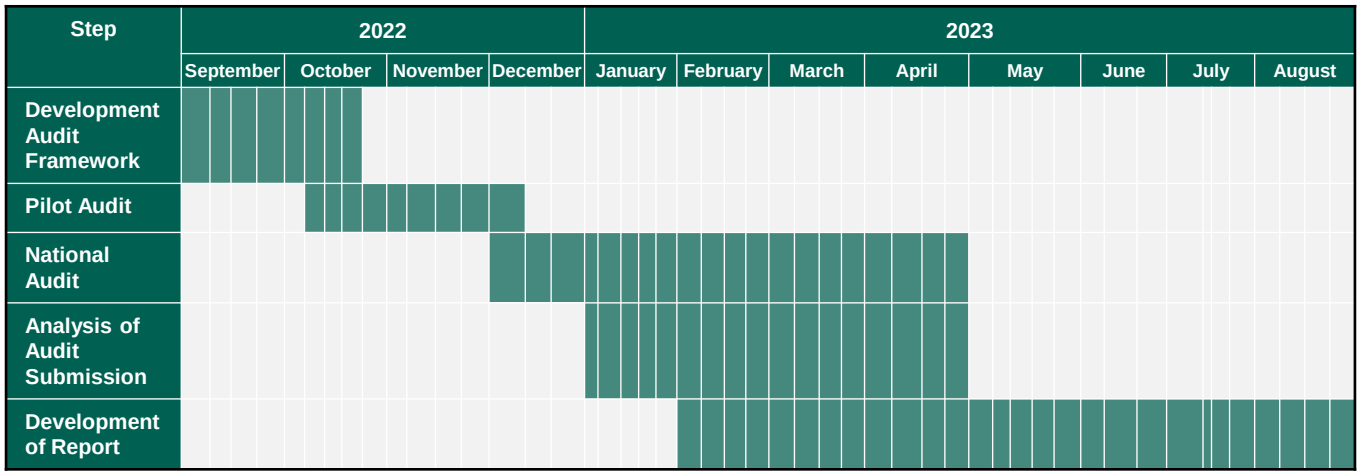
The below diagram gives an overview of the overall audit process and methodology, the approach, outcomes and continuous management process utilised in this audit.



COG – Audit Process and Methodology

Overview of the Audit Process and Methodology

Audit Timeline



The above table presents the consolidated project timeline for the audit (Appendix B: Audit timeline). The first step of the project timeline was the **development of the bespoke audit framework**, which commenced on the week of the 5th of September 2022 and continued until the 24th of October 2022.

Actions included;

- Mapping of the Maskey recommendations and the COG;
- Development and presentation of the draft audit questions; and
- Incorporation of feedback from the draft questions into the final draft for sign off by the audit team.

The **piloting and agreement of the final audit framework and approach** commenced on the 31st of October and ended the week of the 5th of December. This step involved the identification of sample CAMHS teams for the pilot, to examine the feasibility of the self reported audit tool (Appendix C: Audit Tools) in terms of the content and usage. Training was offered to all CAMHS teams involved in the form of webinars and one to one sessions as required.

The above timeline outlines that the Pilot Audit commenced on the 11th of November 2022.

For the duration of the pilot audit, support was offered to teams to ensure completion prior to the 30th of November.

All feedback from the pilot teams were incorporated into the audit prior to national rollout.

On the 5th of December 2022 the National Audit was launched with training webinars offered to all CAMHS teams on the 5th and 6th of December.

Following this, drop-in support sessions were scheduled to offer advice and guidance to teams if they had any queries or issues regarding completion of the audit (Appendix D: Support requests).

These sessions commenced on the 6th of December and continued bi-weekly for the duration of the audit.

Support was offered during the first 2 weeks of January in the form of **site visits** and further support through the dedicated email inbox.

Teams participating in the audit were initially given eight weeks to complete it with a deadline for submission of the 30th of January 2023 at 5pm. Several teams noted difficulty in meeting the audit deadline and this was discussed with the expert audit team and HSE Lead. Each timeline request was reviewed, and extensions were provided as deemed appropriate. Regular support was offered to all teams to ensure the audit was completed.

The collation and **analysis of the self reported audit submissions** commenced on the 3rd of January 2023. Following analysis, additional support including site visits and further follow up was offered to the teams to ensure full completion of the audit. Daily status updates of completion rates were provided to the expert audit group to ensure a 100% completion rate was reached. The data was analysed using a Microsoft Power BI dashboard and the drafting of the audit report commenced on the 30th of January 2023. The ability of teams to complete the audit within the designated timeframe was impacted by significant competing demands including internal and external audits and reviews.

Development of the national report was completed through a detailed data analysis of the audit information gathered. Through collation of the data, graphic representation of responses was presented into a 'Response Summary'. These responses were categorised and themes were subsequently identified. Recommendations in this report were made based on these themes. The report was shared with the National Oversight Group and the HSE Implementation Lead, prior to sign off and completion in Q3 2023, with all feedback being incorporated into the final report.

CAMHS Operational Guidelines Pilot Audit

COG Pilot Audit

Pilot Audit Overview

Introduction

This section of the report outlines the process undertaken in the development of the pilot audit.

The following areas are discussed in more detail below and overleaf:

- **Pilot Sites;**
- **Pilot Audit Structure;**
- **Pilot Timeline;**
- **Feedback Received;**
- **Lessons Learned – Pilot Audit;**
- **Response Summary;**
- **Thematic Analysis; and**
- **Issues Highlighted.**

Pilot Sites

The pilot audit of the COG commenced on the 11th of November 2022, and consisted of **5 CAMHS teams** across 4 CHOS, including both inpatient and community.

These specific sites were chosen as they:

- Represent an **appropriate mix of urban and rural populations**;
- Have **varying caseload levels**;
- Use **a mix of paper based and electronic health records**; and
- Represent both **community and inpatient settings.**

The purpose of the pilot was to evaluate the audit questions, gather feedback and gain perspective on the audit process. Feedback requested from pilot teams related to:

- **Time** taken to complete the audit;
- **Question composition** and **flow;**
- **Resources** required to complete the review; and
- Facilitation of **further development of the audit framework** for the national roll out.

Pilot Audit Structure

The audit development working group met at regular intervals throughout the course of the audit development process. The group discussed the following topics:

- Question **structure**;
- Generation of a **community** and **inpatient** audit form;
- Answer **format**;
- **Number** of **questions**; and
- COG **mapping.**

Due to the nature of the services provided by CAMHS teams in both community and inpatient settings, two audits were created:

- **Community Services Audit**
- **Inpatient Services Audit**

Community Services Audit

- **Community team questions** - relating to policies and procedures followed by the team as outlined in the COG.
- **Community file review** - a review of the young person's clinical file relating to the COG.

Community CAMHS teams were required to select and self review **50 clinical files** which consisted of:

The questions in the clinical file review section of both the community and inpatient audit form relate to one individual case file at a time and the form was completed in full for each clinical file.

Inpatient Services Audit

- **Inpatient team questions** - relating to policies and procedures followed by the team as outlined in the COG.
- **Inpatient file review -** a review of the young person's clinical file relating to the COG.

Teams participating in the pilot were given two weeks to complete the audit with the deadline for submission being the 30th of November 2022 at 5pm.

COG Pilot Audit

Feedback Received

Feedback sessions were held with the pilot teams throughout the audit process. These sessions involved group workshops and one to one meetings with individual teams.

The pilot audit had a **100%** completion rate, with **80%** of teams providing feedback regarding their experience. The feedback gathered from the pilot sites was used to refine the audit questions and the overall methodology.

Following collation of the input received from the pilot teams, the feedback presented several themes.

Five **main themes** were identified:

- **Question clarity**;
- **Rephrasing of questions**;
- Addition of **N/A** answer option for **Yes/No** answer questions;
- Addition of **text box** space to allow teams to comment on answers given; and
- Change in **format of answer** required for a question e.g. from Yes/No to scale of adherence.

Audit Structure

In addition to feedback for each individual question in the audit, the teams were asked to outline any issues faced throughout the course of the pilot, such as the length of time the audit took to complete or the use of the online tool.

The following table illustrates the average time reported by the five participating teams to complete each form on the self reported audit tool.

	Community - Average time to complete	Inpatient - Average time to complete
Team Question	2hours	45mins
Active Case Files	25-45mins	25-45mins
Closed File	25-45mins	25-45mins
Non-Accepted Files	20mins	20mins

There was variation in the time taken to complete the form, with the average cumulative time taken for community teams to finish the audit being on average 29 hours;

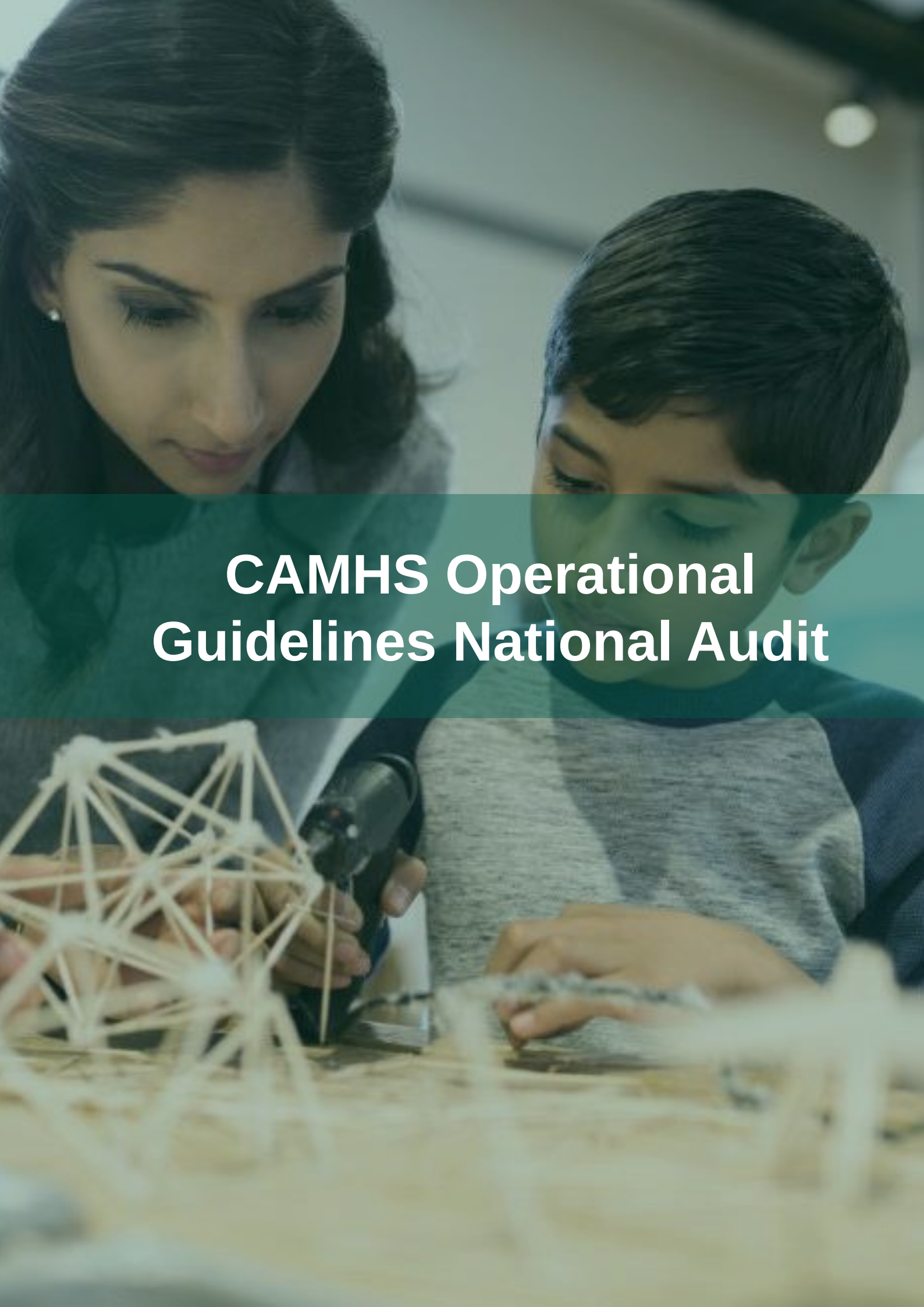
- 2 hours to complete the team questions;
- 22 hours for their 50 Active Case file review;
- 3 hours for their 5 Closed file review; and
- 2 hours for their 5 Non-Accepted file review.

Inpatient units on average took 9.75 hours, to complete the audit;

- 45 minutes to complete the team questions;
- 5 hours for their 10 Active Case file review;
- 2 hours for their 5 Closed file review; and
- 2 hours for their 5 Non-Accepted file review.

The feedback elicited from the clinical file review and the team questions elements of the pilot audit were incorporated in the final iteration of the national audit.

For more detailed analysis of the Pilot Audit results please see Appendix E.



CAMHS Operational Guidelines National Audit

COG National Audit

National Audit Overview

Introduction

The national audit of the 2019 COG commenced on the 5th of December 2022, and consisted of all CAMHS teams across Ireland (Please see Appendix F for a full list of teams participating in the audit).

Excluding the five teams who took part in the pilot audit, a total of 77 teams, **71 community, 2 specialist community-based, 1 day hospital** and **3 inpatient units** completed the national audit across 9 CHOs as outlined below:

- **CHO 1** - 7 teams;
- **CHO 2** - 7 teams (this included 1 inpatient unit);
- **CHO 3** - 6 teams;
- **CHO 4** - 10 teams (this included 1 inpatient unit);
- **CHO 5** - 7 teams;
- **CHO 6** - 6 teams;
- **CHO 7** - 12 teams;
- **CHO 8** - 12 teams; and
- **CHO 9** - 10 teams (this included 1 inpatient unit).

This section of the report discusses in detail:

- The **Audit structure;**
- **Response** Summary **Community teams;**
- **Response** Summary **Inpatient units;**
- **Response** Summary **Non Accepted referrals;**
- **Thematic analyses** CHO1 – CHO9; and
- **Issues highlighted.**

Audit Structure

Following the analysis of the feedback received from the pilot teams, the national audit was developed with the audit divided into both **Community Audit** and **Inpatient Audit** sections.

Feedback received from the pilot audit confirmed that the number of files chosen for each team was suitable, however an inclusion criteria was introduced to the audit to ensure an accurate cross section of young people were represented.

Where teams' current cohort of young people did not meet the inclusion criteria, they were asked to proceed with the audit by first including, where possible, the clinical files of young people who meet the inclusion criteria and then drawing from the other categories listed, to make up the total number of case files required. As this was an operational audit and not a clinical audit the findings of this report were not impacted.

The following section details how the audit for community and inpatient settings were divided into two sections and how the number of files to be reviewed varied.

Community Audit

- **Community team questions** - Each CAMHS team was asked to complete a series of questions relating to the COG including their adherence to them, as well as any issues or challenges they faced in implementing them. This was to be done as a team exercise with as many members of the MDT present as possible.
- **Community file review** – Each CAMHS team was also required to select and audit 50 clinical files to assess their adherence to the COG. These 50 clinical files were to consist of :

Inclusion / Exclusion Criteria

The **inclusion criteria** for the **active file** reviews included:

- **Active attendance** at CAMHS in the **last six months** up to and including the 5th of December 2022;
- Young people **up to and including 17 years of age** on the 5th of December 2022; and
- File must be comprised of the following criteria based on age and gender with a required amount of files required for each category:

No. of Files Reviewed	Age	Gender
10	Less than 12 years on 05.12.22	Male
10	Less than 12 years on 05.12.22	Female
10	12 years or more on 05.12.22	Male
10	12 years or more on 05.12.22	Female

Inclusion criteria for **closed file** reviews stipulated that:

- The young person's case was classified as **closed** in the last **six months** up to and including the 5th of December 2022.

COG National Audit

National Audit Overview

Inclusion criteria for the **non-accepted** file reviews stipulated that:

- The referral was required to be classified as not accepted by CAMHS in the **last six months** up to and including the 5th of December 2022.

Meanwhile, the **exclusion criteria** for the **community CAMHS** file reviews was also reviewed. This was to gain an understanding as to why referrals are not accepted to CAMHS and an understanding of cases that would be deemed not appropriate for CAMHS. The criteria for exclusion included:

- Cases outside of the agreed timeframe i.e. last 6 months;
- Young people outside of the agreed age range i.e. over 18.

The questions in the clinical file for Community and Inpatient files relate to **one individual case file. Therefore, the form was completed in full for each clinical file.**

Inpatient Audit

The Inpatient CAMHS audit is split into two separate sections as follows:

- **Inpatient team questions -** Each CAMHS team was asked to complete a series of questions relating to the COG including their adherence to them, as well as any issues or challenges they faced in implementing them. This was to be done as a team exercise with as many members of the MDT present as possible.
- **Inpatient file review** - Each CAMHS team was also required to select and audit 20 clinical files to assess their adherence to the COG. These 20 clinical files were to consist of :

The questions in the file review section of both the Community and Inpatient audit form related to one individual case file at a time, and the form was completed in full for each clinical file.

The **inclusion criteria** for the **active file** reviews included:

- **Active attendance** at CAMHS in the **last six months** up to and including the 5th of December 2022;
- Young people **up to and including 17 years of age** on the 5th of December 2022; and
- Clinical files of 5 males and 5 females overall.

No. of Files Reviewed	Age	Gender
5	Less than 12 years on 05.12.22	Male/Female
5	12 years or more on 05.12.22	Male/Female

The **inclusion criteria** for the **closed file** reviews included:

- Young person's case was classified as **closed** in the **last six months** up to and including 5th December 2022.

The **inclusion criteria** for the **non-accepted file** reviews included:

- The referral was required to have been classified as not accepted by CAMHS in the **last six months** up to and including the 5th of December 2022. This was to gain an understanding as to why referrals are not accepted to CAMHS.

The **exclusion criteria** for the **inpatient file** reviews included:

- Cases outside of the agreed timeline i.e. last 6 months; and
- Young people outside of the agreed age range i.e. over 18.

COG National Audit

Response Summary

CHO Summary Data

The following section of this report will outline in infographic format the key findings of the qualitative and quantitative analyses conducted on the data submitted for the audit by teams from CHO 1 to CHO 9, excluding teams that participated in the pilot.

Limitations

The interpretation of results presented in the following sections of this report must be considered in the context of a number of limitations. These include;

- **Data collection process -** This audit took the form of a self assessment with teams self reporting data which often included qualitative text based responses;
- **Data sources -** Not all CAMHS teams answered some of the audit question in the appropriate format and
- **Question Interpretation -** Some teams may have misinterpreted what was asked in a particular question and provided incomplete or partial answers

There were **significant challenges** in **validating** and **aligning data** recorded from CAMHS teams during the audit and the HSE data which is routinely collected from CHO areas. This will be improved when appropriate ICT infrastructure is implemented. For a more detailed explanation of the Methodological Limitations of this report please see page 91.

Response Summary

The following infographics (overleaf) provide a summary of the findings of the analyses conducted on responses from community and inpatient units. Results included in these graphics have been broken down into the following sections:

➢ **COG Adherence**

This section of the infographic pertains to:

- Whether teams are familiar with the COG;
- Whether teams are partially/fully implementing the COG;
- Barriers to COG implementation; and
- Use of the self-assessment tool in teams.

➢ **Resourcing**

This section of the infographic displays:

- Whether there is a multidisciplinary key working system in place;
- Average case load per Key Worker;
- Number of team coordinators in place;
- Disciplines engaged in key working; and
- Evidence in the young person's file of there being a Key Worker assigned.

➢ **Case Flow**

This section of the infographic refers to:

- Average waitlist number;
- Average team case load;
- Percentage of referrals classified as urgent; and
- Most common referral classification.

➢ **Service Provision**

This section of the infographic displays:

- Whether teams are offering out of hour services;
- Acceptance rates of young people who do not meet criteria for CAMHS;
- Acceptance rates of over 18s into CAMHS; and
- Use of patient-reported outcome measures.

➢ **Clinical File Review**

This section of the infographic pertains to:

- Whether an Individual Care Plan (ICP) is included in the young person's clinical file;
- Whether an individual risk assessment is included in the young person's file;
- Whether CAMHS teams have a discharge policy in place;
- If there is evidence of development of ICP in collaboration with young person and their parent/guardian;
- If there is evidence of communication and planning for transition to another CAMHS team; and
- Whether the young person received an MDT review every six months.

CHO1 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

86%
Partial implementation of COG

14%
Full implementation of COG

86%
of teams have completed the self assessment tool available in the COG

All 7 Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation
- Increase in referrals
- Joint working
- Lack of Staffing

Resourcing

71%
Of teams have a multidisciplinary Key Worker system in place

1 Team Coordinator in CHO1

***Total Whole Time Equivalent (WTE) Staff: 85.3

80% of files reviewed have evidence of an assigned Key Worker

20-50
Average case load of Key Worker

Service provision

29% of teams *
offer out of hours service (i.e. services outside of 9a.m.- 5p.m., Monday to Friday).

29%

86% of teams
provide services to young people over the age of 18.

86%

86% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

86%

85% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

85%

Case Flow

30.5% of referrals are classified as **urgent** – **70%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 51

Average Team Caseload 219

Clinical File Review

64% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Popular responses outside of this timeframe included-
- Reviewed once
- Reviewed annually

46% of young people's files included an ICP

59%
Of young people files included an individual risk assessment

40% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

100% of CHO1 teams have a **discharge policy** in place.

91% of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

91%

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

CHO2 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

100%
Partial implementation of COG

17%
of teams have completed the self assessment tool available in the COG

4 of 6 Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation
- Key working issues
- Governance
- Lack of Team Coordinator

Service provision

67% of teams *
offer out of hours service (i.e. services outside of 9a.m.-5p.m., Monday to Friday).

67%

67% of teams
provide services to young people over the age of 18.

67%

50% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

50%

87% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

87%

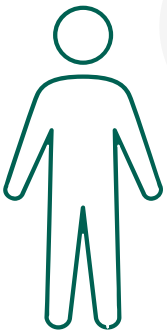
Resourcing

67%
Of teams have a multidisciplinary Key Worker system in place

0
Team Coordinators in CHO2

***Total Whole Time Equivalent (WTE) Staff: 63.6

87% of files reviewed have evidence of an assigned Key Worker



20-50
Average case load of Key Worker

Case Flow

14% of referrals are classified as **urgent** – **63%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 46

Average Team Caseload 374

Clinical File Review

67% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Popular responses outside of this timeframe included-
- Reviewed once
- Reviewed every 9months

57% of young people's files included an ICP

47%
Of young people files included an individual risk assessment

39% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

83% of CHO2 teams have a **discharge policy** in place.

80% of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

80%

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

CHO3 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

83%
Partial implementation of COG

17%
Full implementation of COG

17%
of teams have completed the self assessment tool available in the COG

4 of 6 Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation
- Joint working
- Facilities
- Lack of Team Coordinator

Service provision

17% of teams *
offer out of hours service (i.e. services outside of 9a.m.-5p.m., Monday to Friday).

17%

17% of teams
provide services to young people over the age of 18.

17%

17% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

17%

95% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

95%

Resourcing

100%
Of teams have a multidisciplinary Key Worker system in place

0
Team Coordinators in CHO3

***Total Whole Time Equivalent (WTE) Staff: 66.0

99% of files reviewed have evidence of an assigned Key Worker

20-50
Average case load of Key Worker

Case Flow

26% of referrals are classified as **urgent** – **65%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 73

Average Team Caseload 257

Clinical File Review

69% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Popular responses outside of this timeframe included-
- Reviewed once
- Reviewed annually

78% of young people's files included an ICP

63%
Of young people files included an individual risk assessment

45% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

100% of CHO3 teams have a **discharge policy** in place.

98% of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

98%

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

CHO4 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

78%
Partial implementation of COG

22%
Full implementation of COG

0%
of teams have completed the self assessment tool available in the COG

5 of 9 Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation
- Joint working
- Lack of Team Coordinator

Service provision

67% of teams *
offer out of hours service (i.e. services outside of 9a.m.-5p.m., Monday to Friday).

67%

22% of teams
provide services to young people over the age of 18.

22%

33% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

33%

95% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

95%

Resourcing

100%
Of teams have a multidisciplinary Key Worker system in place

1 Team Coordinator in CHO4

***Total Whole Time Equivalent (WTE) Staff: 144.4

85% of files reviewed have evidence of an assigned Key Worker

20-50
Average case load of Key Worker

Case Flow

31% of referrals are classified as **urgent** – **57%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 97

Average Team Caseload 205

Clinical File Review

81% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Popular responses outside of this timeframe included-
- Reviewed once
- Reviewed twice

62% of young people's files included an ICP

60%
Of young people files included an individual risk assessment

53% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

78% of CHO4 teams have a **discharge policy** in place.

89% of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

89%

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

CHO5 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

100%
Partial implementation of COG

14%
of teams have completed the self assessment tool available in the COG

6 of 7 Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation
- Resources
- Staffing
- Lack of Team Coordinator

Resourcing

57%
Of teams have a multidisciplinary Key Worker system in place

0
Team Coordinators in CHO5

***Total Whole Time Equivalent (WTE) Staff: 72.2

66% of files reviewed have evidence of an assigned Key Worker

20-50
Average case load of Key Worker

Service provision

14% of teams *
offer out of hours service
(i.e. services outside of 9a.m.-5p.m., Monday to Friday).

14%

50% of teams
provide services to young people over the age of 18.

50%

43% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

43%

99% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

99%

Case Flow

18% of referrals are classified as **urgent** – **62%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 55

Average Team Caseload 216

Clinical File Review

77% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Popular responses outside of this timeframe included-
- Case discussed as needed

35%
Of young people files included an individual risk assessment

55% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

67% of CHO5 teams have a **discharge policy** in place.

41% of young people's files included an ICP

94% of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

94%

- Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly
**** 7 of 9 teams from CHO5 participated in this audit. For a list of these teams please see Appendix F

CHO6 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

100%
Partial implementation of COG

17%
of teams have completed the self assessment tool available in the COG

5 of 6 Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation
- Joint working
- Key working
- Lack of Team Coordinator

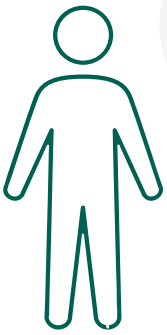
Resourcing

67%
Of teams have a multidisciplinary Key Worker system in place

1 Team Coordinator in CHO6

***Total Whole Time Equivalent (WTE) Staff: 69.2

82% of files reviewed have evidence of an assigned Key Worker



50
Average case load of Key Worker

Service provision

33% of teams *
offer out of hours service
(i.e. services outside of 9a.m.-5p.m., Monday to Friday).

33%

100% of teams
provide services to young people over the age of 18.

100%

33% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

33%

95% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

95%

Case Flow

19.2% of referrals are classified as **urgent** – **72%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 110

Average Team Caseload 436

Clinical File Review

84% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Other responses outside of this timeframe included-
- Due for review

15%
Of young people files included an individual risk assessment

22% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

83% of CHO6 teams have a **discharge policy** in place.

45% of young people's files included an ICP

92% of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

92%

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

CHO7 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

73%
Partial implementation of COG

27%
Full implementation of COG

75%
of teams have completed the self assessment tool available in the COG

8 of 12 of Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation
- Shared Care
- Caseload
- Lack of Team Coordinator

Service provision

8% of teams *
offer out of hours service
(i.e. services outside of 9a.m.-5p.m., Monday to Friday).

8%

91% of teams
provide services to young people over the age of 18.

91%

17% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

17%

95% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

95%

Resourcing

92%
Of teams have a multidisciplinary Key Worker system in place

2 Team Coordinators in CHO7

***Total Whole Time Equivalent (WTE) Staff: 105.6

95% of files reviewed have evidence of an assigned Key Worker

20-50
Average case load of Key Worker

Case Flow

14.5% of referrals are classified as **urgent** – **75%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 30

Average Team Caseload 231

Clinical File Review

74% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Popular responses outside of this timeframe included-
- Annually
- As required

77% of young people's files included an ICP

73%
Of young people files included an individual risk assessment

65% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

83% of CHO7 teams have a **discharge policy** in place.

93%of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

93%

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

CHO8 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

83%
Partial implementation of COG

17%
Full implementation of COG

33%
of teams have completed the self assessment tool available in the COG

10 of 12 Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation
- Staffing
- Transition to AMHS
- Lack of Team Coordinator

Service provision

33% of teams *
offer out of hours service
(i.e. services outside of 9a.m.-5p.m., Monday to Friday).

33%

50% of teams
provide services to young people over the age of 18.

50%

25% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

25%

96% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

96%

Resourcing

92%
Of teams have a multidisciplinary Key Worker system in place

0
Team Coordinators in CHO8

***Total Whole Time Equivalent (WTE) Staff: 104.7

96% of files reviewed have evidence of an assigned Key Worker

20-50
Average case load of Key Worker

Case Flow

19% of referrals are classified as **urgent** – **62%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 53

Average Team Caseload 202

Clinical File Review

75% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Popular responses outside of this timeframe included-
- Reviewed once
- As required

82% of young people's files included an ICP

55%
Of young people files included an individual risk assessment

47% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

92% of CHO8 teams have a **discharge policy** in place.

92% of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

92%

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

CHO9 Community Response Summary

COG Adherence

100%
of teams are familiar with COG

56%
Partial implementation of COG

44%
Full implementation of COG

11%
of teams have completed the self assessment tool available in the COG

9 of 9 Teams
understand the roles and responsibilities relating to the COG

Barriers to COG Implementation

- Staffing

Service provision

22% of teams*
offer out of hours service
(i.e. services outside of 9a.m.-5p.m., Monday to Friday).

22%

56% of teams
provide services to young people over the age of 18.

56%

0% of teams
accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

0%

97% of clinical files
showed evidence of communication with GP/ referral agent regarding young person.

97%

Resourcing

100%
Of teams have a multidisciplinary Key Worker system in place

8 Team Coordinators in CHO9

***Total Whole Time Equivalent (WTE) Staff: 100.9

99% of files reviewed have evidence of an assigned Key Worker

20-50
Average case load of Key Worker

Case Flow

29% of referrals are classified as **urgent** – **80%** of these were responded to **within urgent timeframe** (3 working days)

Largest number of referrals are classified as routine

Average waitlist number 30

Average Team Caseload 174

Clinical File Review

86% of clinical files reviewed have evidence of the young person being reviewed by the MDT at a minimum of every 6 months.
Popular responses outside of this timeframe included-
- ADHD clinic every 3-6months

69%
Of young people files included an individual risk assessment

64% of files reviewed (where applicable) **included** evidence of clear communication & planning 6 months before the young person transitioned to another CAMHS/AMHS team.

100% of CHO9 teams have a **discharge policy** in place.

82% of young people's files included an ICP

95% of ICPs contained evidence that the **ICP was developed in conjunction with the young person** and their parent/guardian.

95%

* Please see limitations regarding Out of Hours data on pg. 91 ** Pilot teams are not included in this data ***This data was collated by the HSE directly

Inpatient Response Summary

COG Adherence

100%
of units are familiar with COG

3 of 3 Units
understand the roles and responsibilities relating to the COG

100%
Full implementation of COG

Barriers to COG Implementation
- Facilities
- Governance

0%
of units have completed the self assessment tool available in the COG

Service provision

100% of units
Do not accept service users who do not meet CAMHS referral criteria; Section 4.3 of the COG

100%

Average lower age limit for admission
(if applicable)

13

Resourcing

67%
Of teams have a multidisciplinary Key Worker system in place

95% of files reviewed have evidence of an assigned Key Worker

1-2
Average case load of Key Worker

Case Flow

Average amount of young people admitted to the Approved Centre at present
9

Average stay of young people in Approved Centre
76.6 days

Clinical File Review

88% of clinical files reviewed have evidence of the young person's admission to the Approved Centre being **Voluntary**

95% of young people's had evidence an ICP was created in the first 7 days of admission

100%
Of young people files included an individual risk assessment

** Pilot teams are not included in this data **This data was collated by the HSE directly

COG National Audit

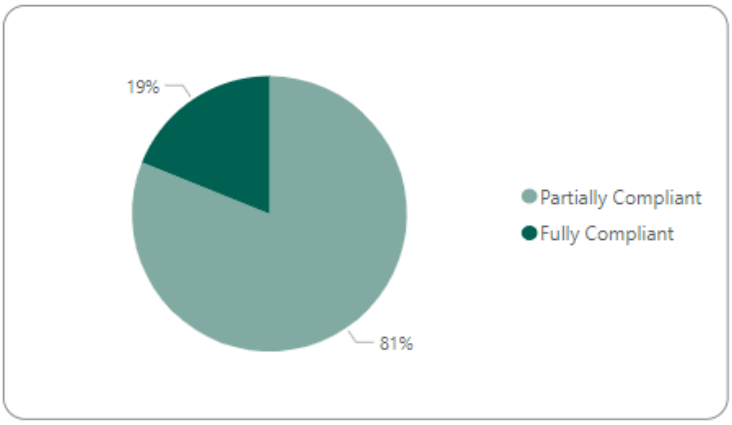
Response Summary – Community

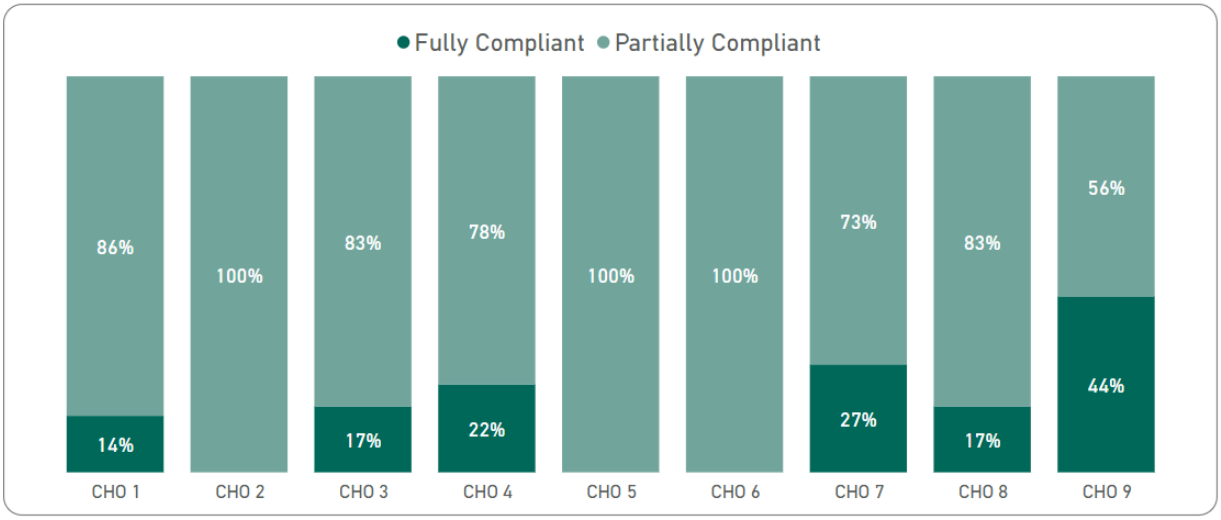
Community Team Question Response Summary

The following is a **graphic representation** of findings from the **community team questions** section of the self reported audit, which seeks to assess the level of adherence to the COG in community teams.
At the outset of this audit, all teams were asked;

Is your team familiar with the CAMHS Operational Guidelines (COG) (2019)?
In previous iterations of the operational guidelines (CAMHS Standard Operating Procedure, 2015), many CAMHS teams reported that they had not read or familiarised themselves with the SOP. This question was asked in this audit to capture teams familiarity with the **current version** of the COG. As is illustrated in the infographics on the preceding pages, **100% of teams reported being familiar with the COG**.

Where teams responded "Yes" to being familiar with the COG, they were then asked;
Are your team implementing the COG?
From a total of 74 responses, 19% (14) of teams responded that they were Fully Compliant, while 81% (60) were Partially Compliant, which is represented in the pie chat below. The column chart displayed on this page shows the percentage of teams in each CHO who are Fully or Partially implementing the COG. Nationally, the majority of teams are partially implementing the COG with **12 teams reporting full implementation**. None of the 74 teams reported no level of compliance.





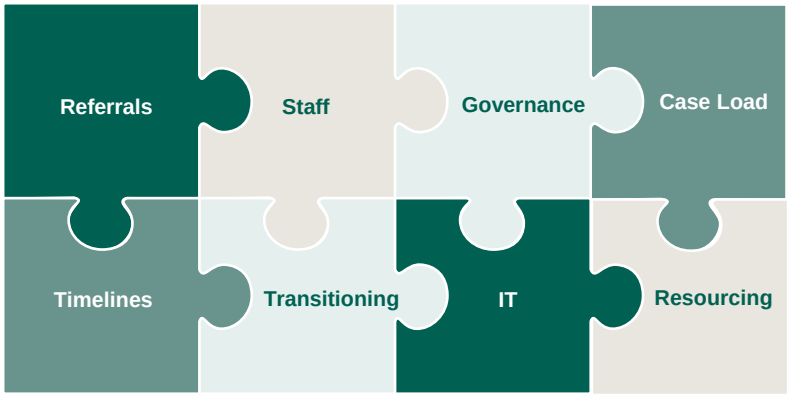
Reasons identified by teams for non adherence to the COG included;

- **resourcing issues**;
- **lack of formal training** on the COG;
- **reservations** about parts of the document;
- **lack of clarity on roles** and **responsibilities** at team level;
- **high caseloads** impeding full implementation even when teams do understand their roles and responsibilities; and
- some specialist teams who adhere to the COG report that **not all parts are relevant to their service.**

COG National Audit

Response Summary – Community

Challenges and Barriers to COG Implementation:
The detailed summary of the reasons highlighted by teams for partially or not implementing sections of the COG are outlined below and can be spread across 8 main themes:-



❖ **Referrals**
- Teams reported referral form was **difficult to complete** due to the level of detailed information required and others reported that it may not include all details necessary.
- **Acceptance of young people** who do not meet the criteria for CAMHS due to **psychosocial and other factors**.
- Reported increase in **inappropriate referrals**.
- Reported **increase in urgent referrals**.
- Referrers do not always have a thorough **understanding of the role of CAMHS** as per the COG.
- Full clinical **information not always provided** by referrers.
- Some referrals accepted **without GP collaboration** which may impact continuity of care and agreed pathways.

❖ **Staff**
- **High turnover of clinical staff** including clinical lead on team impeding progress on full implementation.
- **Funded staffing for team** was reported as **not adequate** to implement the COG in full i.e. one team reported 40% staffing versus VFC recommendations.
- Teams reported that the **demand on the service** and the **inadequate resources available** was a barrier to implementation of Key Worker role.
- No **team coordinator**.
- Teams reported not having a **full skillset** to meet population needs.
- Teams reported **no formal training** has taken place on the COG.
- Teams stated that due to staffing resources across services there are **gaps in all agencies** ability to respond to shared care requests in a **timely manner**.
- Staff numbers in the context of AVFC should be increased further given the **increase in referral** rates to CAMHS.

❖ **Governance**
- Reponses provided by team indicated that poor cohesion and **spread of work load within team** impacts on full implementation of all aspects of the COG.
- **Unclear Clinical Governance** within the service.
- **Confusion regarding reporting lines**.
- Lack of clarity in relation to **clinical responsibility** and **clinical decisions**.
- Not all disciplines have a discipline specific line management structure.
- Lack of clarity of roles and responsibilities between line managers of individual disciplines and the clinical lead that is the consultant
- 'Clinical governance is not **clear within our contracts** or the **service in general**'.
- Clarity required in relation to **roles and responsibilities and level of service.**

❖ **IT**
- Teams reported the inability to **send text reminders** for appointment or follow up for non-attendance.
- Lack of appropriate **IT infrastructure** (paper files, no dedicated fit-for-purpose database etc.).
- **A computerised referral system** would minimise receipt of inconsistent referral information.

COG National Audit

Response Summary – Community

❖ **Case Load**
- Case load numbers.
- Teams reported **poor cohesion** and **spread of work load**, some members have a large workload.
- Volume of cases open to the team has grown over a 3 year period.
- Teams reported that caseloads have to be **distributed** among staff and this **reduced the ability to take on new cases**.
- Teams with large caseloads reported that they do not have the capacity to do **reviews of every file every 6 months**.

❖ **Timelines**
- Challenge in meeting **6 monthly full case reviews** for all cases due to high caseload.
- Waiting list is **longer than 12 weeks** for routine cases in terms of time to assessment.
- Do not have the capacity to see routine patients due to **waitlist within the 12 week period**.
- Teams reported an increase in waitlists for routine appointments due to '**chronic understaffing**' and **'exponential increase in referrals**'.
- ICP is not always completed within the 6 months.
- There can be delays in administration around referrals due to '**chronic administration staff shortages**'.
- Adherence to undertaking 6 monthly MDT reviews for all patients is impaired by a lack of appropriate **IT infrastructure**.
- Team reported the absence of a Team Coordinator adversely impacts referral response times.

❖ **Transitioning/Discharge**
- **Difficulty transitioning** young person into adult mental health services due to **different criteria** for both services e.g. transition in COG begins at 17.5 years however AMHS will not accept referrals until 18.
- Difficulty discussing **discharge planning** by some teams due to impact this could have on young person and family, yet teams work in a 'recovery focused way'.
- Teams reported **no system** for transition to adult services.
- Teams indicated they don't always discuss discharge planning at the Initial Assessment as it is not always '**clinically helpful**'.
- **Collaborative approach** required with adult and other services in regard to best practice.
- Transition to AMHS relies on other **agency policy/protocol** and their capacity to accept referrals.

❖ **Resourcing**
- **Lack of resources** and **key roles** on the team including clinical staff, administration, team coordinator.
- **Inadequate office space** which impacts on availability of rooms for teams meetings and clinics.
- Delayed response times for referrals due to '**pressurised under-resourced teams**'.
- It was reported that the lack of access and availability of intervention in Primary Care and Disability Services can result in children presenting to CAMHS in crisis.
- Shared care protocols can only be utilised if other services engage and are resourced i.e. primary care, CDNTs
- Teams reported a lack of appropriate services in their area including **Autism Support Services, Paediatric Liaison Services, and waiting lists in Children Disability Network Teams**.
- Teams reported difficulty in **sourcing inpatient beds** in some areas.

COG National Audit

Response Summary – Community

National Levels of COG Implementation (by Section of COG):
After focusing on overall compliance, the audit focused on compliance with specific sections of the COG.

Question asked in the Audit: To what extent have you implemented each of the below sections of the COG?
Response options available:

- Fully Implemented
- Partially Implemented
- Not Implemented

The below table shows the extent to which the 74 teams responded to implementing each individual section of the COG. Descriptions of the individual sections are outlined in the pages below this table.

Question in Audit - Section Focus	Full	None	Part	Total
Section 2.2 (COG pg. 10)	33		41	74
Section 2.3 (COG pg. 11)	47		27	74
Section 3.2 (COG pg. 14)	54	1	19	74
Section 4 Community CAMHS - Referral and Access (COG pg. 21)	58		16	74
Section 4.1 Community CAMHS - Referral Criteria (COG pg. 21)	61	1	12	74
Section 4.10 Referral Response Times (COG pg. 26)	35	5	34	74
Section 4.11 Communication, Sharing and Disclosure of Information (COG pg. 29)	29	1	44	74
Section 4.12 CAMHS Community Mental Health Team (COG pg. 29)	32	3	39	74
Section 4.13 The Initial Assessment (COG pg. 30)	66		8	74
Section 4.14 The Key Worker (COG pg. 30)	44	3	27	74
Section 4.15 Individual Care Plan (ICP) (COG pg. 31)	21	8	45	74
Section 4.16 The Team Coordinator (COG pg. 32)	13	59	2	74
Section 4.17 Multi-Disciplinary Team (MDT) Reviews (COG pg. 33)	34	1	39	74
Section 4.18 Promoting Attendance at Appointments (COG pg. 33)	55	2	17	74
Section 4.19 Management of Non-Attendance at Initial Appointments (COG pg. 33)	36	3	35	74
Section 4.20 Management of Non-Attendance at Subsequent Appointments (COG pg. 34)	44	3	27	74
Section 4.21 Out-of-Hours Arrangements (COG pg. 35)	43	8	23	74
Section 4.22 Feedback and Complaints (COG pg. 35)	29	5	40	74
Section 4.23 Transition to Adult Mental Health Services (COG pg. 36)	23	12	39	74
Section 4.24 Transition to other CAMHS (COG pg. 37)	58	3	13	74
Section 4.25 Discharge from Community CAMHS (COG pg. 37)	33	2	39	74
Section 4.4 Types of Referrals Suitable for CAMHS (COG pg. 22)	71		3	74
Section 4.5 Types of Referrals Not Suitable for CAMHS (COG pg. 22)	59	1	14	74
Section 4.6 Joint Working and Shared Care (COG pg. 23)	33	1	40	74
Section 4.7 Referral Agents to CAMHS (COG pg. 24)	61		13	74
Section 4.8 Clinical Information Required for Referrals (COG pg. 25)	33	3	38	74
Section 4.9 Process Following Receipt of Referral by CAMHS (COG pg. 26)	60	1	13	74

COG National Audit

Response Summary – Community

COG Section Summary Description

- **Section 2.2 '*Involving Children and Adolescents*'** this section relates to how children and adolescents should be at the core of a recovery-oriented service, ensuring their involvement in decisions and goals. They should also be encouraged to participate in the design, implementation, delivery and evaluation of mental health services.

  The results of the audit indicate that 33 teams (45%) are fully implementing this section, 41 teams (55%) are partially implementing this section and no team reported that that they were not implementing this section of the COG.

- **Section 2.3 '*Involving Parent(s)*'** this section highlights the importance of collaborative relationships with parent(s) throughout the young person's journey through CAMHS.

  The results of the audit indicate that 47 teams (64%) are fully implementing this section, 27 teams (36%) are partially implementing this section and no team reported that that they were not implementing this section of the COG.

- **Section 3.2 '*Clinical Governance in CAMHS Teams*'** emphasises the needs for clear accountability structures to ensure the delivery of high quality, safe and reliable services.

  The results of the audit indicate that 54 teams (73%) are fully implementing this section, 19 teams (26%) are partially implementing this section and one team (1%) reported that that they were not implementing this section of the COG.

- **Section 4 '*Community Child and Adolescent Mental Health Services*'** gives an overview of the journey through community CAMHS teams for those aged up to 18 years who have moderate to severe mental disorders that require input of a multidisciplinary mental health team.

  The results of the audit indicate that 58 teams (78%) are fully implementing this section, 16 teams (22%) are partially implementing this section and no team reported that that they were not implementing this section of the COG.

- **Section 4.1 '*Community CAMHS Aims*'** this section outlines the main aims of community CAMHS, though clinical assessments, diagnosis and multidisciplinary interventions, providing support to parent(s) and advice to referral agents.

  The results of the audit indicate that 61 teams (82%) are fully implementing this section, 12 teams (16%) are partially implementing this section and one team (1%) reported that that they were not implementing this section of the COG.

- **Section 4.10 *'Referral Response Times'*** details the recommended timeframe of response to routine and emergency referrals, providing an overview of what constitutes as a response.

  The results of the audit indicate that 35 teams (47%) are fully implementing this section, 34 teams (46%) are partially implementing this section and five teams (7%) reported that that they were not implementing this section of the COG.

- **Section 4.11 '*Communication, Sharing and Disclosure of Information*'** indicates the importance of obtaining consent from parent(s), regular communication with the parent(s) and referral agents, and the need for a discharge summary to be provided.

  The results of the audit indicate that 29 teams (39%) are fully implementing this section, 44 teams (59%) are partially implementing this section and one team (1%) reported that that they were not implementing this section of the COG.

- **Section 4.12 '*CAMHS Community Mental Health Team'*** this section explains the multidisciplinary nature of CAMHS team, highlighting the staffing skill mix required**.**

  The results of the audit indicate that 32 teams (43%) are fully implementing this section, 39 teams (53%) are partially implementing this section and three teams (4%) reported that that they were not implementing this section of the COG.

- **Section 4.13 '*The Initial Assessment*'** outlines the aim of the Initial Assessment during the first appointment, where further information is gathered.

  The results of the audit indicate that 66 teams (89%) are fully implementing this section, 8 teams (11%) are partially implementing this section and no team reported that that they were not implementing this section of the COG.

Note: percentages are rounded to the nearest whole percent.

COG National Audit

Response Summary – Community

COG Section Summary Description

- **Section 4.14 '*The Key Worker*'** gives an overview of the role of a Key Worker and the importance of each child or adolescent and their parent(s) having an assigned Key Worker so that they have direct and easy access to a known team member.

  The results of the audit indicate that 44 teams (59%) are fully implementing this section, 27 teams (36%) are partially implementing this section and three teams (4%) reported that that they were not implementing this section of the COG.

- **Section 4.15 '*Individual Care Plan (ICP)*'** provides the overview of the need for a clear plan that describes the levels of care and treatment needed to meet the assessed needs of the child or adolescent while they are attending CAMHS. The section gives instruction on what should be included in the ICP and who should be involved in the development.

  The results of the audit indicate that 21 teams (28%) are fully implementing this section, 45 teams (61%) are partially implementing this section and eight teams (11%) reported that that they were not implementing this section of the COG.

- **Section 4.16 '*The Team Coordinator*'** outlines the role of the team coordinator and the function of the role.

  The results of the audit indicate that 13 teams (18%) are fully implementing this section, two teams (3%) are partially implementing this section and 59 teams (80%) reported that that they were not implementing this section of the COG.

- **Section 4.17 '*Multi-disciplinary Team (MDT) Reviews*'** highlights the importance of formal reviews of all open cases, giving timeframes for regular meetings and indication of what needs to be discussed at each.

  The results of the audit indicate that 34 teams (46%) are fully implementing this section, 39 teams (53%) are partially implementing this section and one team (1%) reported that that they were not implementing this section of the COG.

- **Section 4.18 '*Promoting Attendance at Appointments*'** this section outlines how CAMHS services manage non attendance, and schedule suitable initial appointments for young people.

  The results of the audit indicate that 55 teams (74%) are fully implementing this section, 17 teams (23%) are partially implementing this section and two teams (3%) reported that that they were not implementing this section of the COG.

- **Section 4.19 '*Management of Non-Attendance at Initial Appointments*'** lists guidance on management of attendance to initial appointments.

  The results of the audit indicate that 36 teams (49%) are fully implementing this section, 35 teams (47%) are partially implementing this section and three teams (4%) reported that that they were not implementing this section of the COG.

- **Section 4.20 '*Management of Non-Attendance at Subsequent Appointments*'** lists guidance on management of attendance to subsequent appointments.

  The results of the audit indicate that 44 teams (59%) are fully implementing this section, 27 teams (36%) are partially implementing this section and three teams (4%) reported that that they were not implementing this section of the COG.

- **Section 4.21 '*Out of Hours Arrangements*'** defines the out of hours for CAMHS teams and provides guidance to teams on how to provide details of local out of hours and emergency arrangements. Note: please see page 69 regarding limitations in audit data.

  The results of the audit indicate that 43 teams (58%) are fully implementing this section, 23 teams (31%) are partially implementing this section and eight teams (11%) reported that that they were not implementing this section of the COG.

- **Section 4.22 '*Feedback and Complaints*'** describes how every child and adolescent and their parent(s) should be invited to contribute to feedback and complaints about their experience availing of CAMHS.

  The results of the audit indicate that 29 teams (39%) are fully implementing this section, 40 teams (54%) are partially implementing this section and five teams (7%) reported that that they were not implementing this section of the COG.

Note: percentages are rounded to the nearest whole percent.

COG National Audit

Response Summary – Community

COG Section Summary Description

- **Section 4.23 '*Transition to Adult Mental Health Services*'** this section details the requirements of referrals to adult mental health services, the responsibilities of staff and the information required for transition.

  The results of the audit indicate that 23 teams (31%) are fully implementing this section, 39 teams (53%) are partially implementing this section and 12 teams (16%) reported that that they were not implementing this section of the COG.

- **Section 4.24 '*Transition to Other CAMHS*'** relates to transition of care from one CAMHS team to another, describing the role of the CAMHS teams to ensure continued care.

  The results of the audit indicate that 58 teams (78%) are fully implementing this section, 13 teams (18%) are partially implementing this section and three teams (4%) reported that that they were not implementing this section of the COG.

- **Section 4.25 '*Discharge from Community CAMHS'*** emphasises the planning that must occur when considering discharge, the summary document and discharge meeting that should occur prior to the young person leaving CAMHS.

  The results of the audit indicate that 33 teams (45%) are fully implementing this section, 39 teams (53%) are partially implementing this section and two teams (3%) reported that that they were not implementing this section of the COG.

- **Section 4.4 ' *Types of Referrals Suitable for CAMHS*'** lists the guidance on what constitutes a moderate to severe mental disorder.

  The results of the audit indicate that 71 teams (96%) are fully implementing this section, three teams (4%) are partially implementing this section and no team reported that that they were not implementing this section of the COG.

- **Section 4.5 '*Types of Referrals Not Suitable for CAMHS*'** this section describes the situations where the referral may not be suitable for CAMHS and gives a list of other services available.

  The results of the audit indicate that 59 teams (80%) are fully implementing this section, 14 teams (19%) are partially implementing this section and one team (1%) reported that that they were not implementing this section of the COG.

- **Section 4.6 *'Joint Working and Shared Care*'** explains that where the child or adolescent presents with a moderate to severe mental disorder, it is the role of CAMHS to provide appropriate multidisciplinary mental health assessment and treatment for the mental disorder, this may involve joint working or shared care with other groups.

  The results of the audit indicate that 33 teams (45%) are fully implementing this section, 40 teams (54%) are partially implementing this section and one team (1%) reported that that they were not implementing this section of the COG.

- **Section 4.7 '*Referral Agents to CAMHS*'** provides a list of approved referral agents.

  The results of the audit indicate that 61 teams (82%) are fully implementing this section, 13 teams (18%) are partially implementing this section and no team reported that that they were not implementing this section of the COG.

- **Section 4.8 '*Clinical Information required for Referrals*'** lists the clinical information required regarding the child or adolescent from the referral agent.

  The results of the audit indicate that 33 teams (45%) are fully implementing this section, 38 teams (51%) are partially implementing this section and three teams (4%) reported that that they were not implementing this section of the COG.

- **Section 4.9 '*Process following receipt of Referral by CAMHS*'** outlines the process times and categories to be used following receipt of referral.

  The results of the audit indicate that 60 teams (81%) are fully implementing this section, 13 teams (18%) are partially implementing this section and one team (1%) reported that that they were not implementing this section of the COG.

Note: percentages are rounded to the nearest whole percent.

COG National Audit

Response Summary – Community

Self Assessment Tool

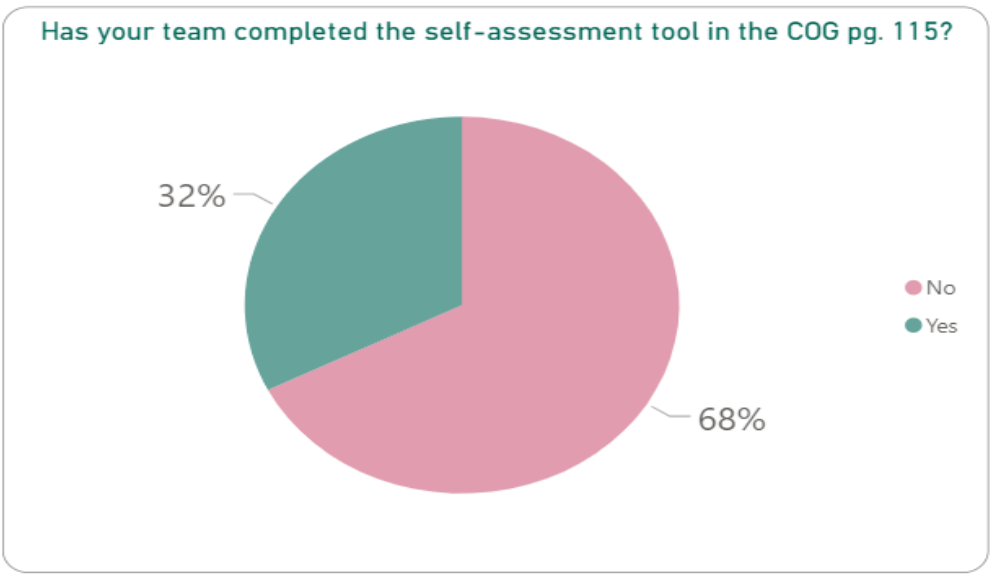
The self-assessment tool has been developed to allow CAMHS teams to assess the service they deliver against the operational guidelines, this contributes to continuous development by providing a structured opportunity to assess performance and identify improvements required for the CAMHS team.

68% of teams reported not using the self assessment tool. CAMHS teams that have reported use of the self assessment tool indicated making several quality improvements to allow greater alignment to the COG guidelines such as:

- Expansion of role of **Key Worker**;
- Increase **compliance** with ICP;
- 6 monthly **MDT review** template;
- Updated **MDT agenda**;
- Monthly **service development** meetings;
- **Honosca Outcome Measures** implemented with service users;
- Training in **AMBIT**, which is to help interagency working especially for complex cases involving multiple agencies;
- Implemented **ADHD Clinic** service user feedback;
- Development of **discharge summary forms**;
- Database of **community resources** created and shared within team;
- **ICP audit**;
- Increased use of **ICPs**;
- Increased collaborative and **timely ICP completion**;
- Increase in **mandatory training** and ensuring all training is up to date;
- Encourage referrers to use **standardised** CAMHS referral form;
- Review of correspondence to families prior to **initial assessment**;
- Regular updates to management about **vacant posts** and inadequate accommodation;
- Posters to highlight advocacy and "**Your Service Your Say**";
- **Copying GPs** on all initial appointment letters; and
- Incorporation of the **risk assessment tool** as part of the initial assessment.

Where teams reported being unable to implement the self assessment tool, the key reasons being reported were:

- **Lack of resourcing and staffing**;
- **Clinical priorities/competing demands**;
- **Lack of time** due to rise in clinical caseloads/ service demands;
- **Time constraints**;
- No instructions to team to **complete self-assessment** at CHO level
- **Poor organisation** of team; and
- **Staff turnover**.



COG National Audit

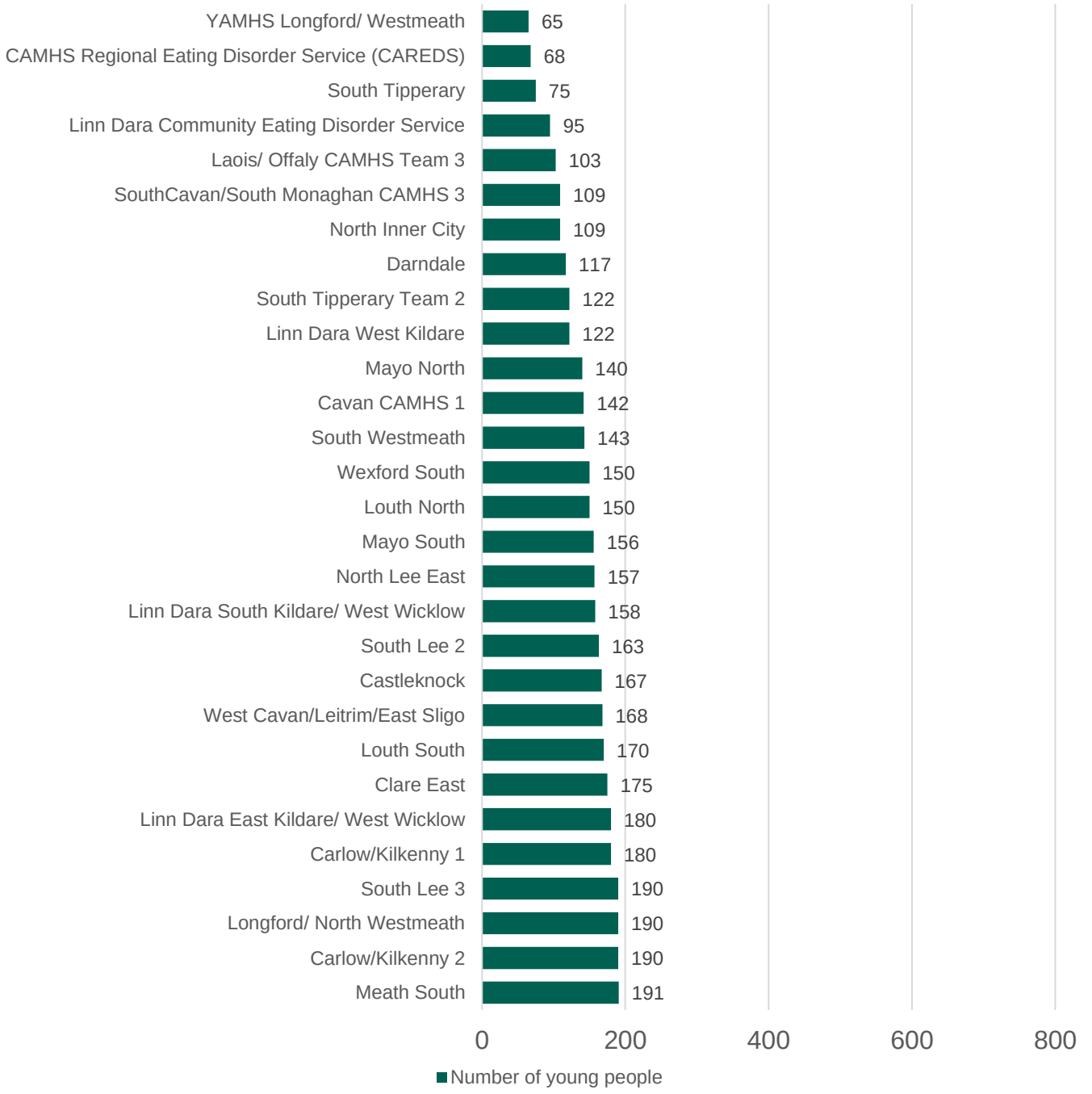
Response Summary – Community

National Team Active Case Loads

This bar chart displays the current active team case load reported within each of the community CAMHS teams at the time of the audit. The case loads vary, with an **average of 246** and **a median of 211** per CAMHS team. The **highest current active case load for a CAMHS team** at the time of the audit was **720** young people in CHO 2, while the **lowest** for a CAMHS team was **65** in CHO 8, representing a **range of 655.**

The term 'case load' pertains to the number of young people currently engaged in a CAMHS service at a particular point in time. A variety of factors can impact case load levels, including the demographics of the catchment area and how recently the CAMHS team was set up and started accepting referrals.

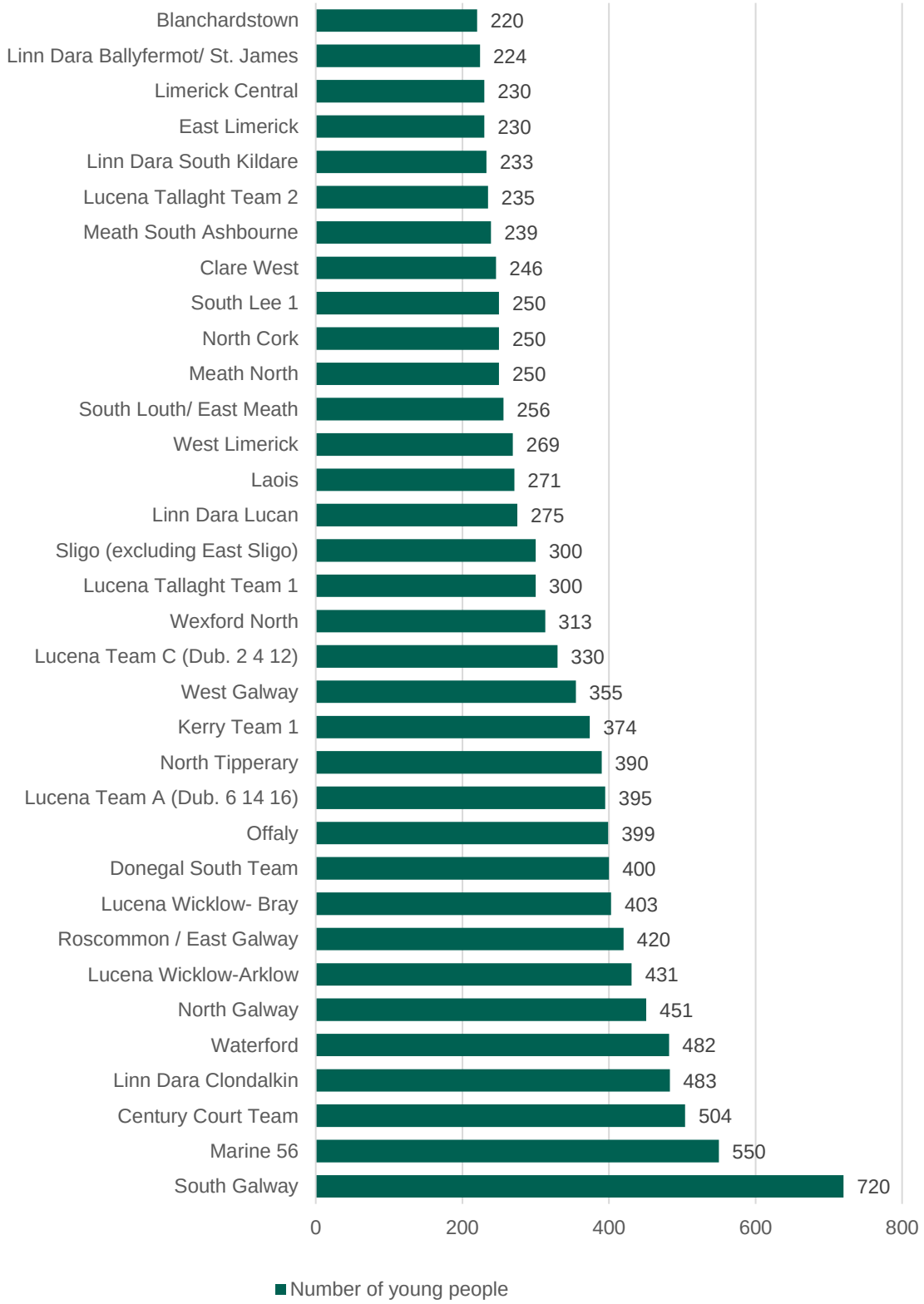
What is your team's current active case load (number of young people)?



COG National Audit

Response Summary – Community

What is your team's current active case load (number of young people)? (cntd.)



COG National Audit

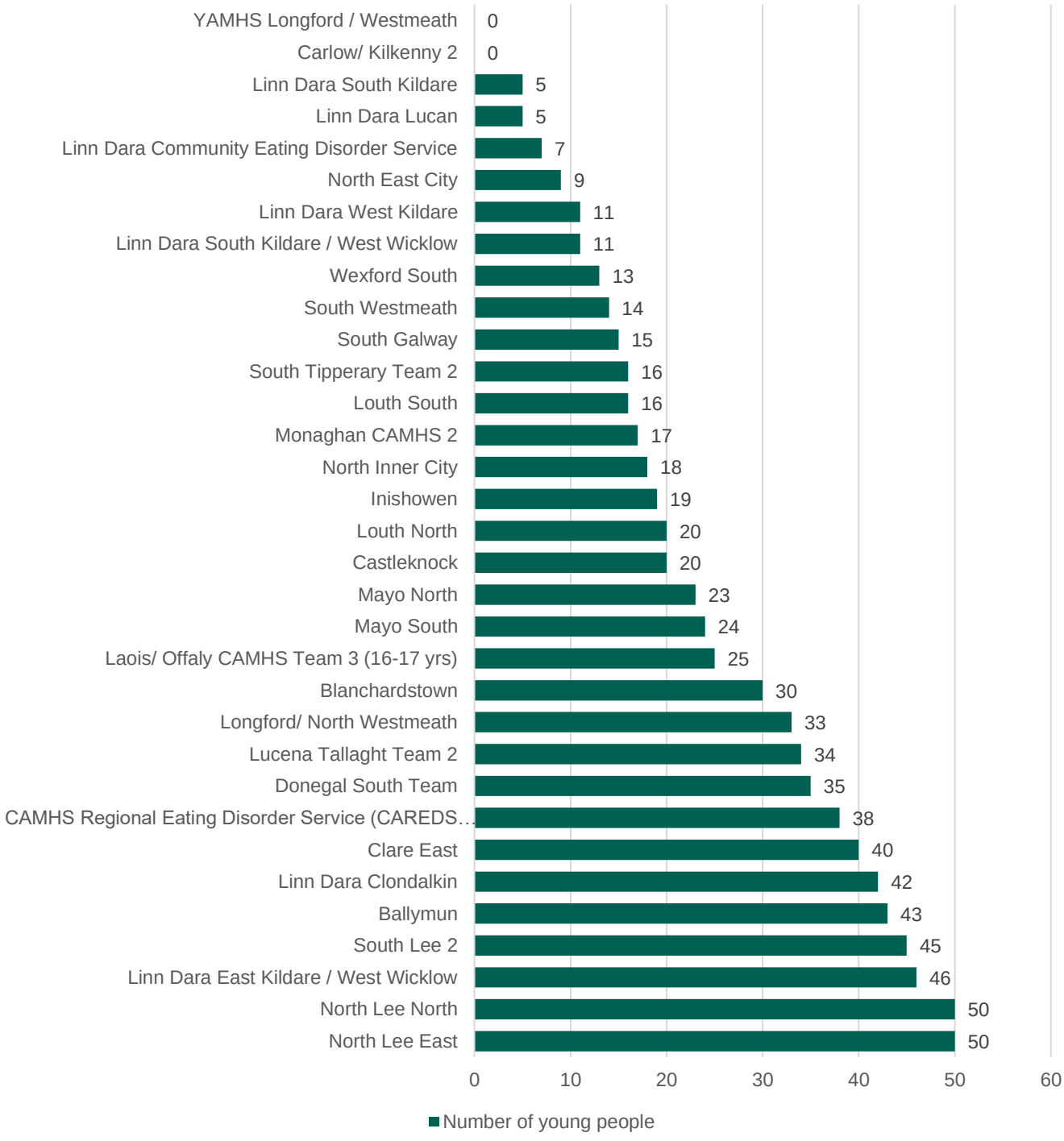
Response Summary – Community

National Waiting List:

The estimated number of young people on the waiting list for each of the community CAMHS teams reported at the time of audit is displayed below. The waiting lists vary significantly with an **average of 59** and a **median of 51**. Two teams reported not having any young people on the waiting list to access their service.

The term 'waiting list' pertains to the number of young people waiting to access services in a CAMHS team at a particular point in time. A variety of factors can impact waiting list levels, including demographics of the catchment area, staffing levels in the CAMHS team and whether they provide a specialty service such as ADHD or Eating Disorder services.

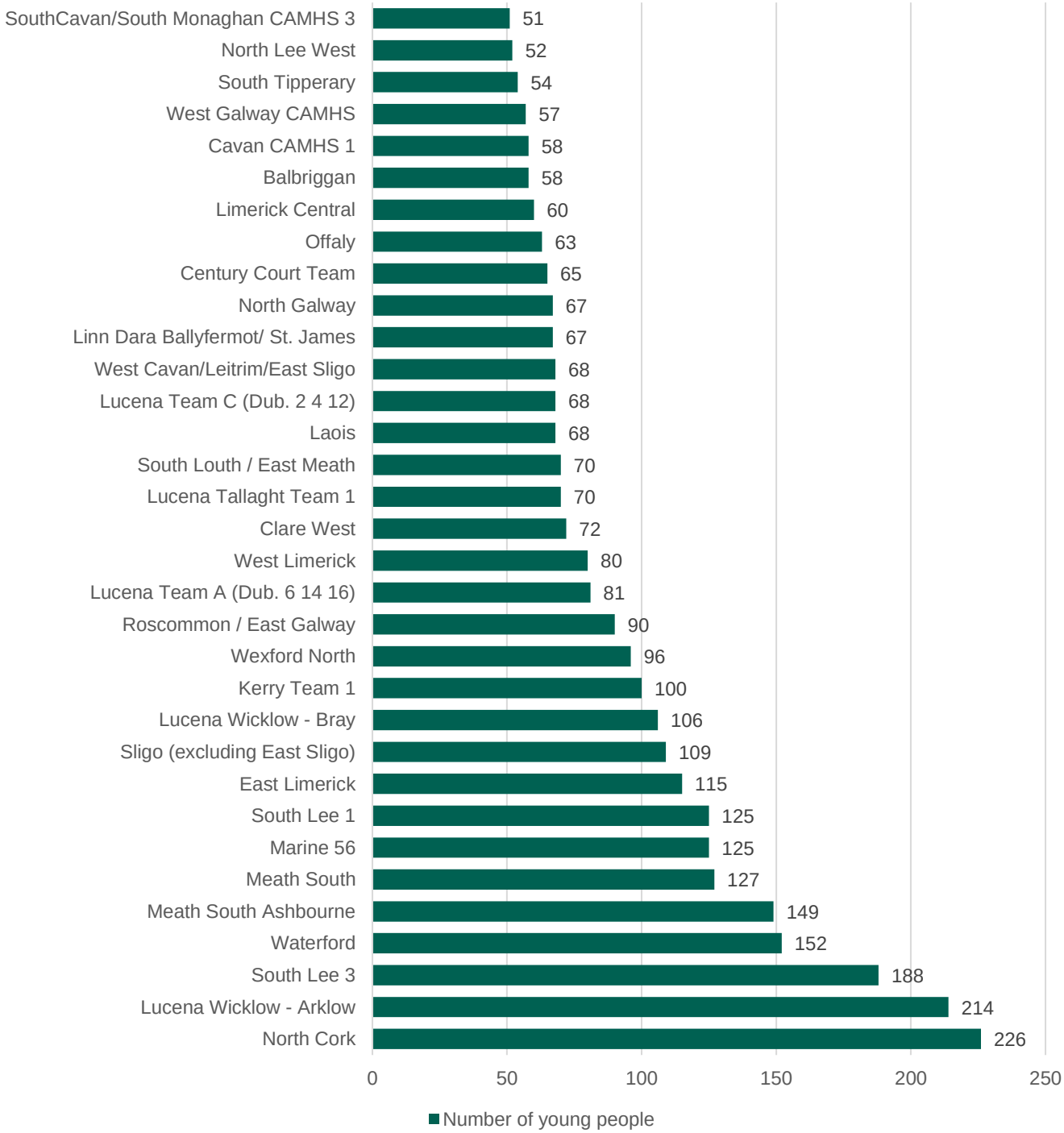
What is your team's current waiting list (number of young people)?



COG National Audit

Response Summary – Community

What is your team's current waiting list (number of young people)? (cntd.)



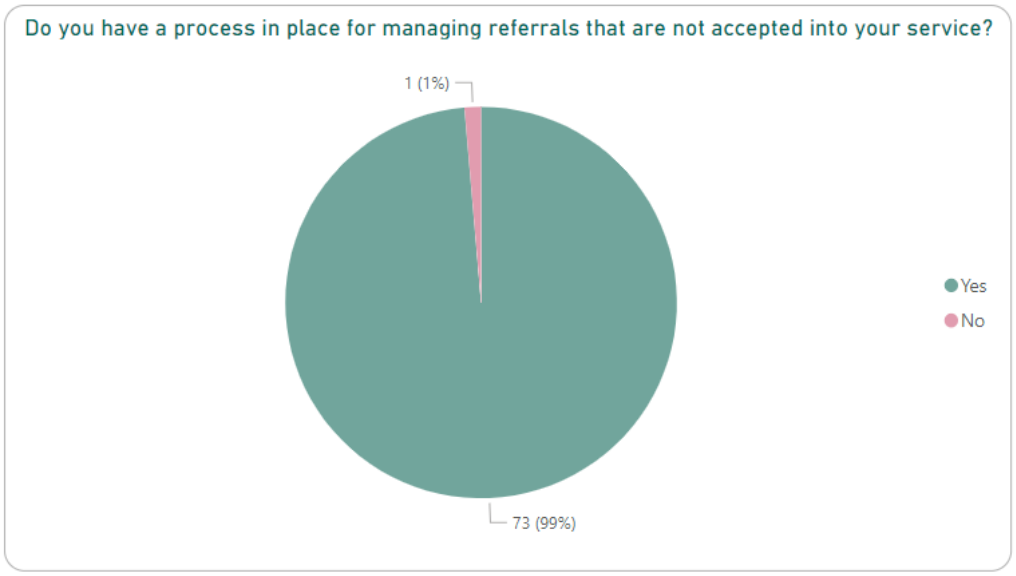
**CAMHS 3 Laois Offaly and YAMHS Longford Westmeath , YAMHS Longford Westmeath (0.5) teams only support young people between the ages of 16 and 18 years old with high level of complex need.

COG National Audit

Response Summary – Community

Do you have a process in place for managing referrals that are not accepted into your service?

This question aims to capture the potential variation in acceptance of referrals. This and subsequent questions in the 'Non-Accepted Referrals' section of the audit sought to gain insight into the processes in place for non accepted referrals. The below chart highlights that 99% (73) of teams responded with 'Yes' when asked if they have a process in place for managing referrals that are not accepted. One out of 74 teams responded 'No' to the same question.



Who was the young person referred by?

Of a total of **3,367 clinical file reviews**, text responses were analysed with the **highest number of referrals** being reported as coming from the following areas:

- **GPs** (74%);
- **Emergency Departments** (13%).
- **Psychiatrists** (5%);
- **Psychologists** and **Senior Psychologists** (5%); and
- **Other CAMHS services** (4%).

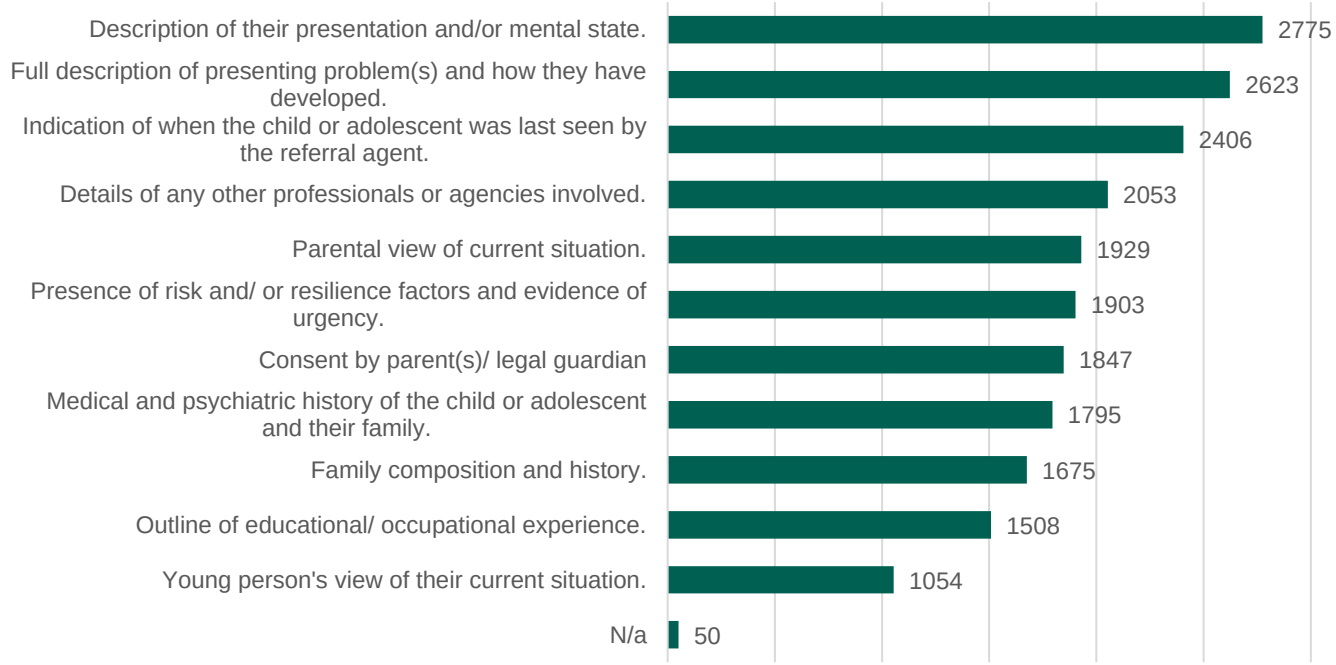
COG National Audit

Response Summary – Community

Managing referrals

Is there evidence that sufficient details were provided by the referral agent to inform a decision to accept the referral?

The COG contains a detailed referral form that is required to be completed for a young person to be referred to CAMHS. The column chart below shows the number of clinical files that showed evidence that teams received sufficient details from the referral agent to inform their decision to accept the referral of the young person. The total number of clinical files reviewed was 3,373.



Is there evidence that remaining referral data was collected by the CAMHS Team outside of the referral letter?

The majority of teams reported having a system in place to collect referral data outside of the referral letter. Teams reported;

- Contacting GP or Referrer by phone or email if more information is required;
- Gathering further information at intake assessment/initial assessment;
- Collecting collateral information from parents;
- MDT requesting further information;
- Phone calls following referral committee meeting;
- Key worker gathering information;
- Using the Referral screen sheet;
- Using the Parent Information Form;
- Referrals Management Meetings; and
- Using the CAMHS Standardised Referral form.

Teams reported collecting additional data from the following sources:

- 58% from the young persons parents;
- 28% from schools;
- 21% from the referral agents; and
- 11% from HSE Primary Care services.

The remaining evidence was collected from services such as Tusla and Paediatrics.

Where teams reported not having a system in place to collect referral data outside of the referral letter this was due to:

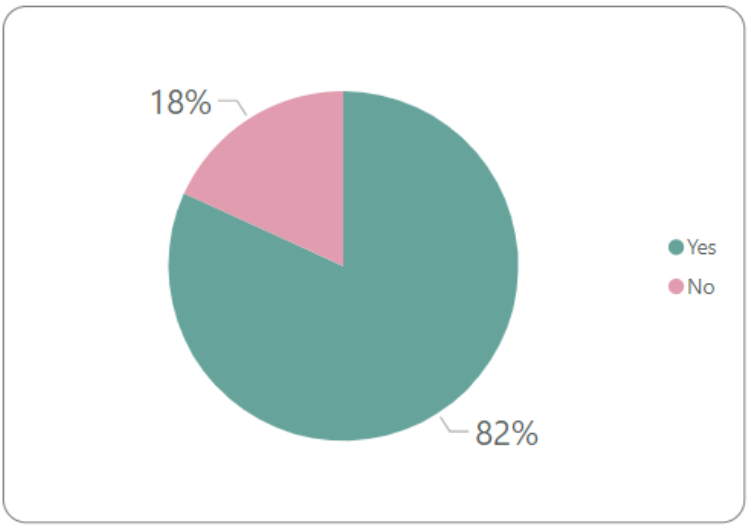
- It not being required;
- Teams having a triage team in place for referrals;
- Teams reporting it can slow down referral processing;
- No additional information was required, as sufficient information was received; and
- Team reporting the families are known to them.

COG National Audit

Response Summary – Community

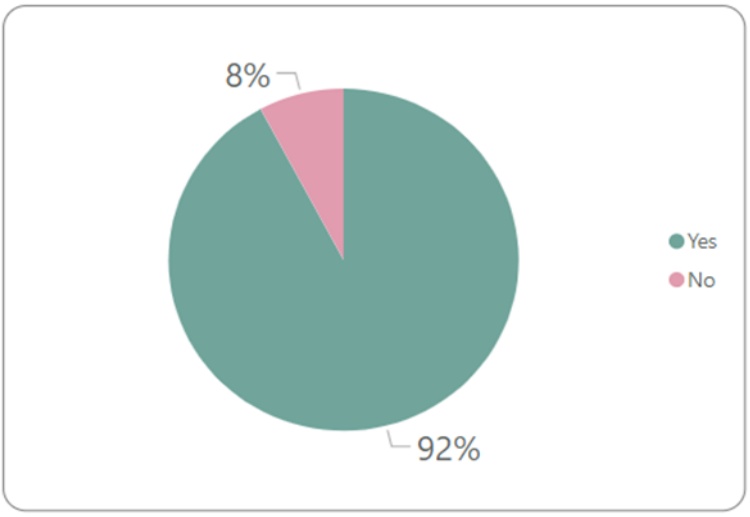
Managing referrals

Is there evidence that remaining referral data was collected by the CAMHS Team outside of the referral letter?
The diagram shows where evidence was reported to have been collected by CAMHS teams outside of receipt of a referral letter. From a total of 3,288 clinical file reviews, 82% (2,690) of files showed evidence remaining referral data was collected, while 18% (598) did not show evidence, which is represented in the pie chart below.



Is there evidence that the referral was discussed at the MDT meetings?
From a total of 3,288 clinical file reviews, 92% (3,030) of files showed evidence that the referral was discussed at the MDT meetings, while 8% (258) did not show evidence. Where teams reported no discussion of the referral at the MDT, this was due to:

- Initial assessment completed;
- 'Not standard practice';
- Ongoing assessment;
- 'No rationale for MDT discussion';
- 'Time constraints';
- 'Lack of resources';
- Urgent referral allocated immediately;
- Case was closed;
- Referral was made directly to relevant disciplines;
- 'Straight forward' ADHD referral;
- No documented evidence on file; and
- Not brought up for discussion 'as parents happy with intervention'.



COG National Audit

Response Summary – Community

Managing referrals

Please explain the process in place for managing referrals that are not accepted to your service?
The following are examples of processes utilised as reported by CAMHS teams for the management of referrals that are not accepted into the service;

- Teams write to referrer to provide advice regarding **alternative management, additional information** or **assessment required to reconsider a future referral**;
- Suggest more **appropriate services** to the referrer;
- Communicate back to referral agent clear **written recommendations** following MDT discussion;
- **Letter** completed informing referrer of lack of acceptance and reasons why;
- **Open to discussion** with referrer or families; and
- If considered that the young person would be better managed, by Tusla, Jigsaw or Primary Care Psychology, then the case is brought (with consent or anonymously) to the **monthly Regional Liaison Meeting**.

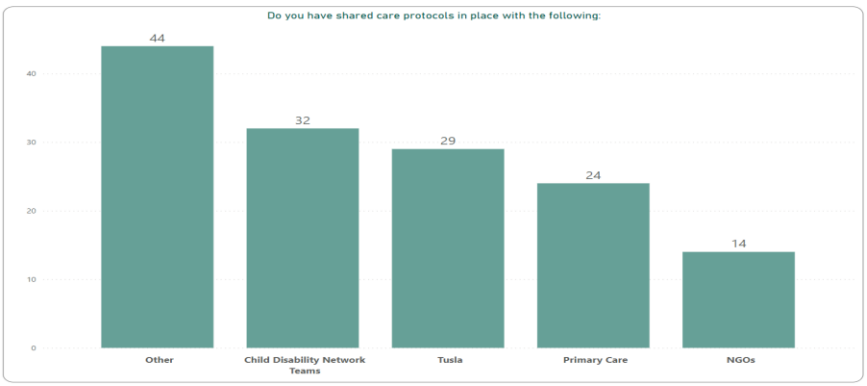
Referral classification
COG referrals are categorised into: **Emergency, Urgent, Routine** or **not appropriate** for CAMHS. It is important we have consistent classification/categorisation for consistency and also for reporting and KPI purposes.

Please provide other classifications if used?
CAMHS teams were asked if they classify referrals according to the COG: Emergency, Urgent and Routine, and if other classification were used a text box was provided. The following list outlines the other classifications reported by teams:

- Priority;
- ADHD;
- Semi-urgent;
- Not appropriate;
- Standard;
- Pending;
- Wait listed;
- Non ADHD;
- P1, P2, P3;
- On Hold;
- Eating Disorders;
- Not taken on;
- High Priority; and
- Medium Priority.

Do you have shared care protocols with the following: NGOs, Primary Care, Tusla, Child Disability Network teams or other?
Where the child or adolescent presents with a moderate to severe mental disorder, it is the role of CAMHS to provide appropriate multidisciplinary mental health assessment and treatment for the mental disorder. This may involve joint working or shared care' – CAMHS Operational Guidelines.

From a total of 74 teams, this column chart displays the number of shared care protocols reported in place amongst CAMHS Teams and other agencies. 143 responses were gathered, with Other representing the 31% of the options selected. This question was a multi-select questions, where teams could select more than one option. When teams were asked to describe their shared care protocols, many reported that they did not have formal shared care protocols in place, but informally have protocols or arrangements in place with other services such as Primary Care, CDNTs, and Tusla (including Meitheal). Teams report attending regular interagency and multiagency meetings, and report that often shared care and joint working agreements are made on a case-by-case basis, with the young person's individual needs in mind.



COG National Audit

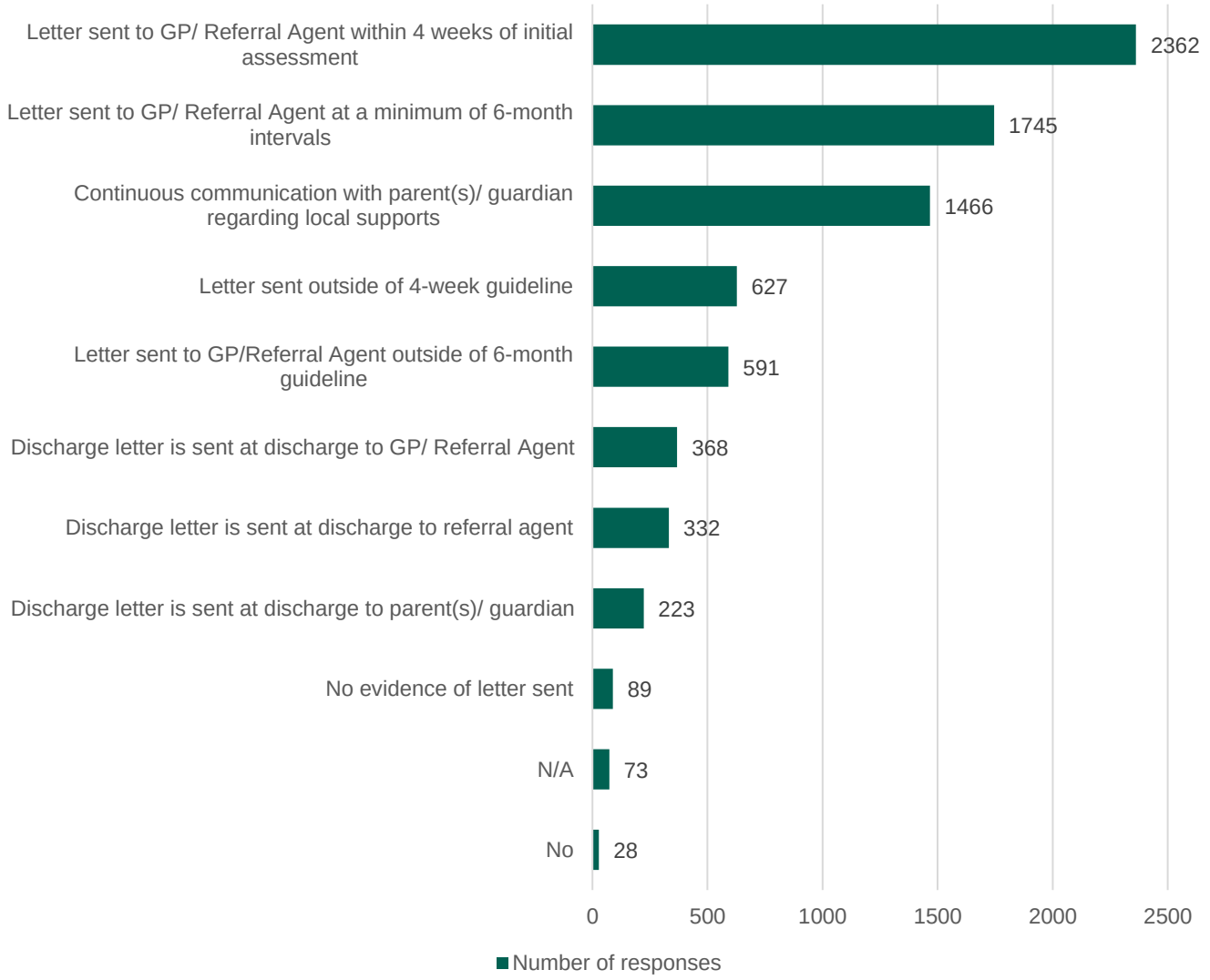
Response Summary – Community

Managing referrals

Is there evidence of regular communication with the GP and referral agent on this young person's file?

The column chart below displays where evidence was reported, on each clinical file review, of regular communication with the GP and referral agent on the young persons file. 94% of the 3,373 files reviewed displayed evidence of communication with the GP and referral agent regarding the young person. Where there is no evidence of regular communication CAMHS teams reported this was due to:

- The clinical file reviewed was new to the team;
- The letter was due to be drafted;
- The young person is currently undergoing assessment;
- The young person is regularly seen by CAMHS;
- Low staff levels;
- The young person did not receive a diagnosis and was discharged from the service;
- Changeover of staff;
- Lack of family engagement with the service;
- Awaiting consultant assessment prior to confirmation of diagnosis and plan; and
- No further information was needed.



COG National Audit

Response Summary – Community

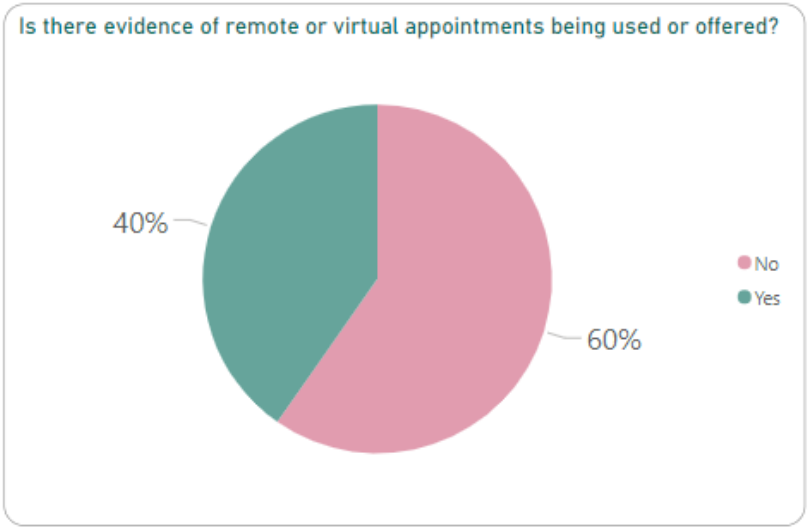
Use of Remote or Virtual Appointments

The pie chart below displays the ratio of teams nationally who have offered or utilised remote or virtual appointments to young service users (in green) versus those who have not (in pink). Reported on a national level, the majority of service users were not offered or did not avail of remote or virtual appointments.

Is there evidence of remote or virtual appointments being used or offered?

There is variation seen across CHOs from the clinical files reviewed, with 40% (1,324) out of a total of 3,288 files containing evidence of virtual appointments being used or offered, and 60% (1,964) not containing evidence of such.

The offering of remote or virtual appointments is not a requirement of the COG, however, due to COVID-19 the utilisation of virtual appointments was encouraged where appropriate. The teams were asked if there was evidence of remote or virtual appointments being offered to capture whether or not this has been maintained post pandemic. As outlined in the pie chart below, 40% of clinical files showed evidence of remote or virtual appointments being used or offered.



Service Improvements/Innovations

Is there any further information, feedback or innovations you would like to share regarding the implementation of COG relating to community?

As part of the audit, CAMHS teams were asked whether they would like to disclose any past or ongoing initiatives or innovations they may have implemented in order to improve their service. 37 teams across all 9 CHOs responded with an innovation or initiative that they had implemented in their team or that had been implemented in their CHO. The below table displays a summary of these initiatives and innovations, categorised by service improvement area.

Service Improvement Area	Innovations/Initiatives
Family Support Initiative	• Parent's support groups • Parent's education groups
Specialist Services	• ADHD clinic • Antipsychotic Medication clinic • CAMHS Connect Services
Case Flow Initiatives	• Waiting list initiatives • Referral triage system • ADHD referral screening pathway • Development and Well Being Assessment (DAWBA) • Diagnostic system for new referrals • Minimum activity levels (min. number of appointments in a week).
Feedback systems	• Use of Patient-Reported Outcome Measures (PROMs) • Patient surveys • Parent surveys

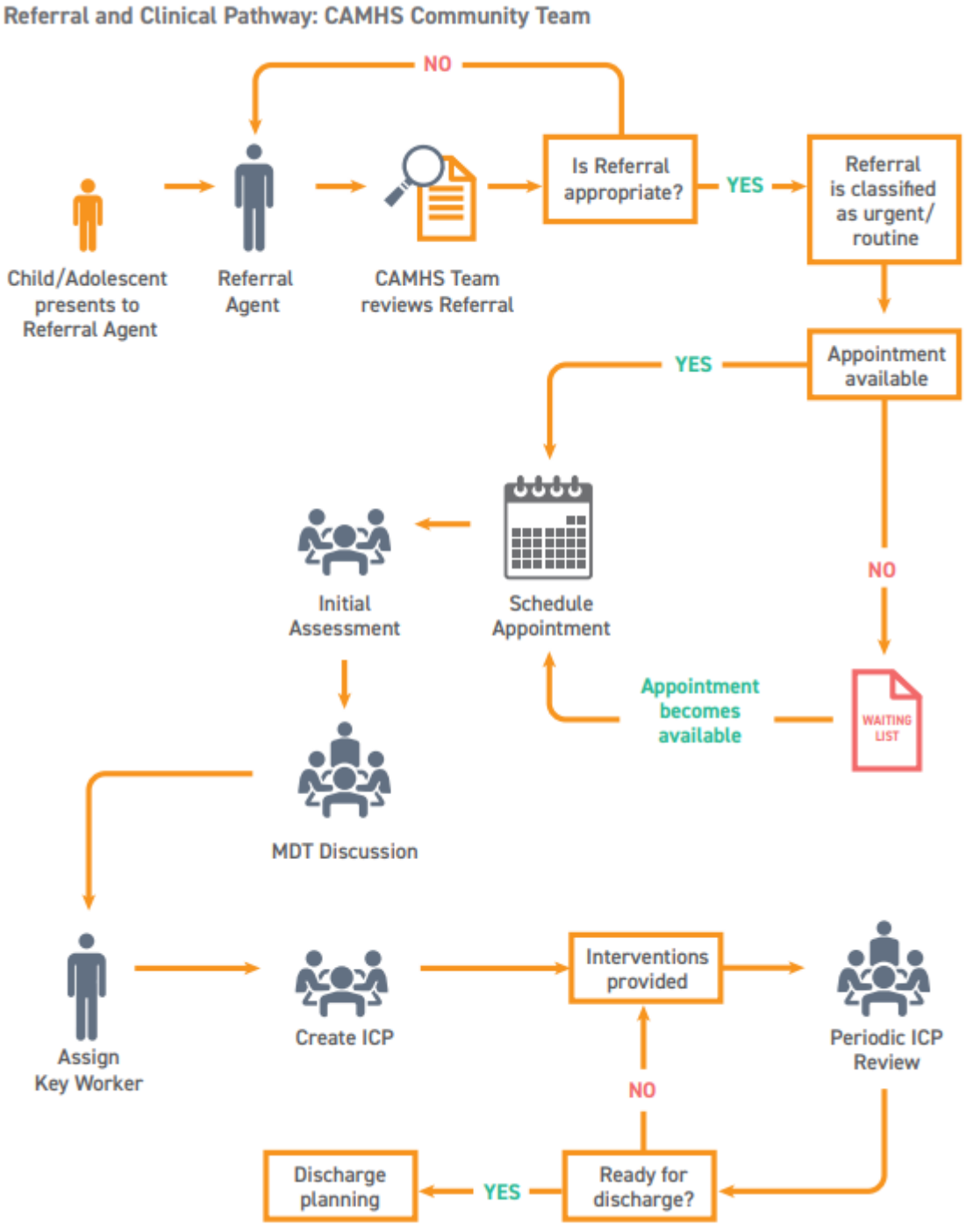
COG National Audit

Response Summary – Community

CAMHS Pathway

Teams were asked to suggest updates that would be beneficial to add to/update the Community CAMHS pathway as referenced in the COG, teams reported:

- "Update to referrals section as referrals are not always reviewed by a consultant";
- "Update to Key Worker section as MDT case load numbers mean that the consultant key works around half of all young people";
- "Update triage of referrals with a description of 'Emergency'. On call triage of referrals often happens prior to MDT meeting";
- "Add the need for signposting to alternative services";
- "There is a need for a monthly case audit review on all open cases";
- "Addition of step wherein discharge is an option following initial assessment"; and
- "Addition of section around referrals to inpatient unit if necessary"



COG National Audit

Response Summary – Community

Key Working:

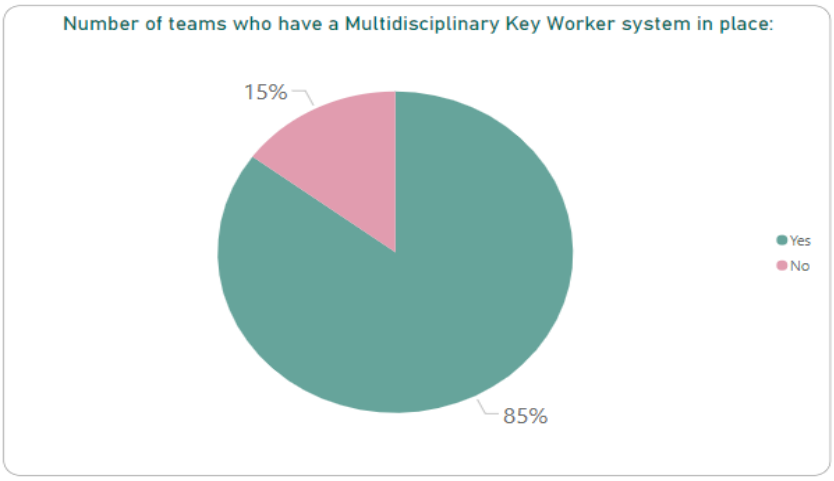
'The role of the Key Worker is to establish a relationship with the child or adolescent, and to take responsibility for actively remaining in contact with them and their parent(s). The Key Worker coordinates the care provided by all other team members, provides feedback to the team on progress and is responsible for making sure that clinicians are following the ICP' – CAMHS Operational Guidelines.

Do you have a Multidisciplinary Key Worker system in place?

Nationally, 85% (63) of teams reported having a multidisciplinary Key Worker system in place. From the 15% (11) of teams who did not have a Key Worker system in place, respondents reported that this was due to;

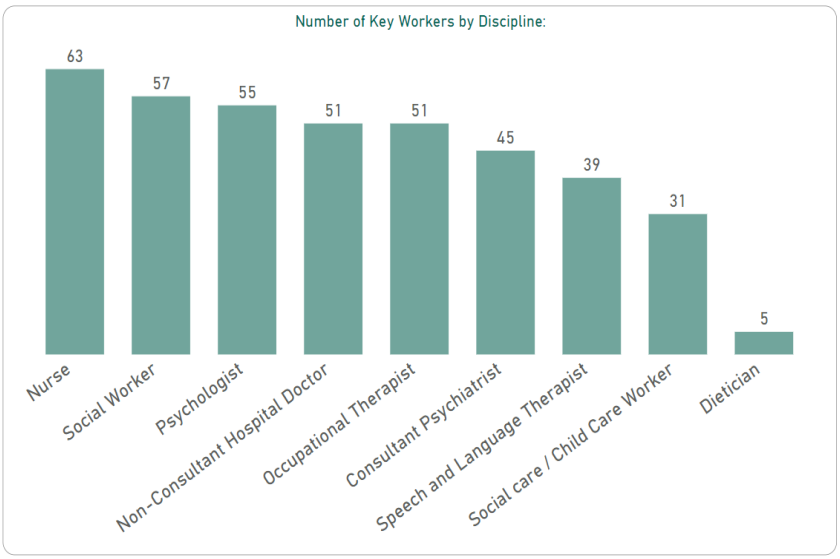
- High caseloads – not enough team members to support a key worker system;
- The Clinician is identified as the key contact; and
- A Key worker is selected based on which team member is the most appropriate to the child's individual needs at that particular time.

However, teams report the majority of families are aware of who they can contact within the service.



Number of Key Workers by Discipline:

A range of disciplines engage in key working with roles varying among teams depending on team composition. Respondents have cited capacity issues as one of the main limitations in taking on key worker responsibilities. Disciplines that are recruited in fewer numbers may have high demand for their services and less capacity to take on key worker responsibilities.



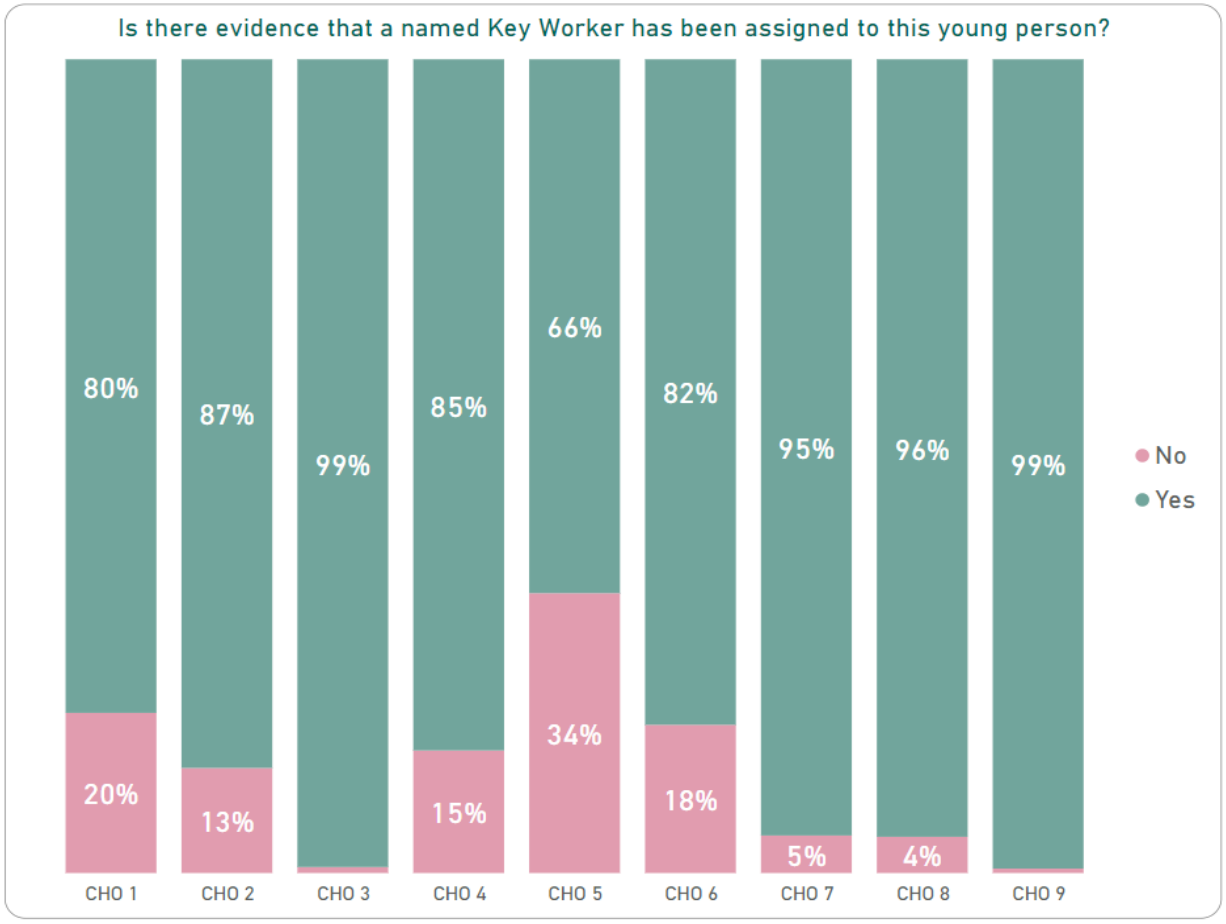
COG National Audit

Response Summary – Community

Key working

Is there a Key Worker assigned to this young person?

A national total of 2,920 (89%) of clinical files reviewed indicated that the young person was assigned a Key Worker, with 368 (11%) of the files reviewed indicating a Key Worker was not assigned. The below graph indicates the percentage of clinical files reviewed that do/do not show evidence that a named Key Worker has been assigned to a young person.



COG National Audit

Response Summary – Community

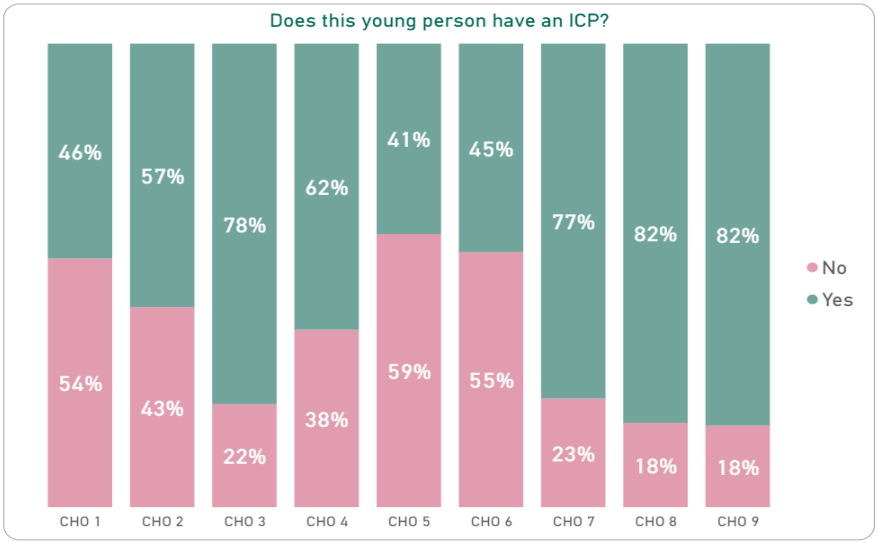
Individual Care Plan

'An ICP is a clear plan, in plain English, that describes the levels of care and treatment needed to meet the assessed needs of the child or adolescent while they are attending CAMHS.' - CAMHS Operational Guidelines.

Does this young person have an ICP on their clinical file?

Out of a total of 3,288 clinical file reviews, 66% (2,166) responded with 'Yes', while 34% responded 'No' (1,122) to the young person having an ICP on their clinical file. The below chart represents the percentage of clinical files where there was evidence of an ICP for the young person in their clinical file. This has then been broken down by CHO. The average time of review for the ICP was reported as **6 months** with a minimum of **1 month** and maximum of **2 years**. 58% clinical files reviewed showed evidence that the young person's ICP has been reviewed by the MDT in the last 6 months. Where teams reported not meeting the criteria for 6-monthly ICP reviews it was due to:

- "Case not open that long";
- "Timeframe is not set to 6 months, e.g. it was every 3 months";
- "Insufficient time"; and
- "No ICP".



Please provide details as to why there is no ICP for this young person

Where teams report the clinical file showed no evidence of an ICP for the young person, reasons provided by CAMHS teams included;

- Young person is at the beginning of assessment;
- ICP is yet to be completed;
- Lack of training in implementation of the ICP;
- 'Inadequate staffing levels to fulfil this aspect of the COG';
- Discharged at initial appointment;
- Changeover of staff;
- Awaiting diagnoses prior to creating an ICP;
- The ICP is outlined in the file notes and correspondence but not recorded on the ICP form;
- Disengaged from the service;
- 'Discussed with mother and child, no ICP requested';
- 'Difficult to engage young person';
- Resourcing issues;
- Reduced collaborative multi-disciplinary team;
- Team 'has only recently started completing ICPs';
- Care plan agreed but no ICP;
- There is a nursing care plan instead of the ICP;
- Not done routinely;
- Team uses own MDT care plan; and
- Offered but declined.

COG National Audit

Response Summary – Community

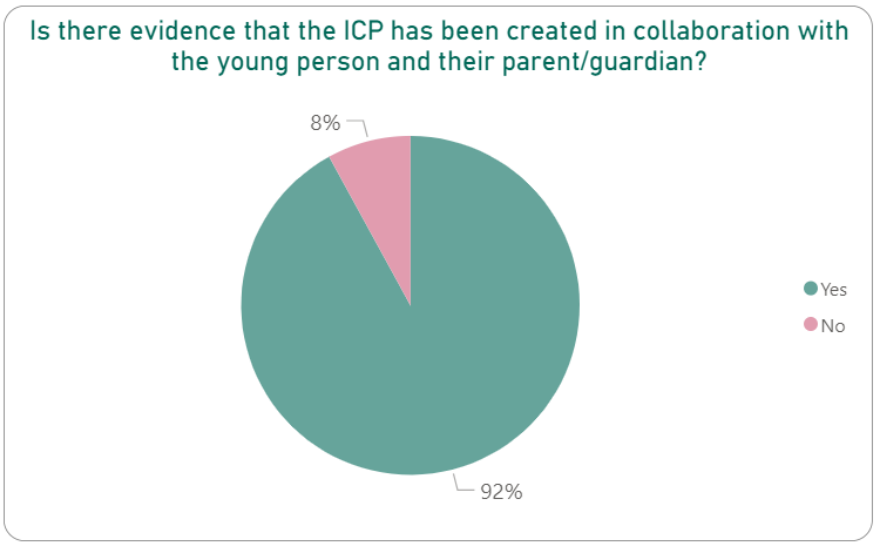
Individual Care Plan

Is there evidence that ICP has been created in collaboration with the young person and their parent?

The chart below shows that 92% (1,998) of ICPs reviewed were created in collaboration with the young person and their parents. This is based on a total of 2,171 clinical file reviews, with 38% (171) of clinical files reported that the young person has a copy of their ICP, 60% do not have a copy and 2% reported it as N/A.

Where it was reported that young people were not given a copy of their ICP, this was due to:

- Unable to engage with the young person;
- Lack of ICP; and
- Young persons age.



8% of clinical files reviewed showed no evidence that the ICP was created in collaboration with the young person and their parent/guardian. Teams reported that this was due to;

- Lack of attendance at follow up appointments;
- Young person unable to engage due to their illness at the time;
- ICP verbally discussed; and
- Not common practice.

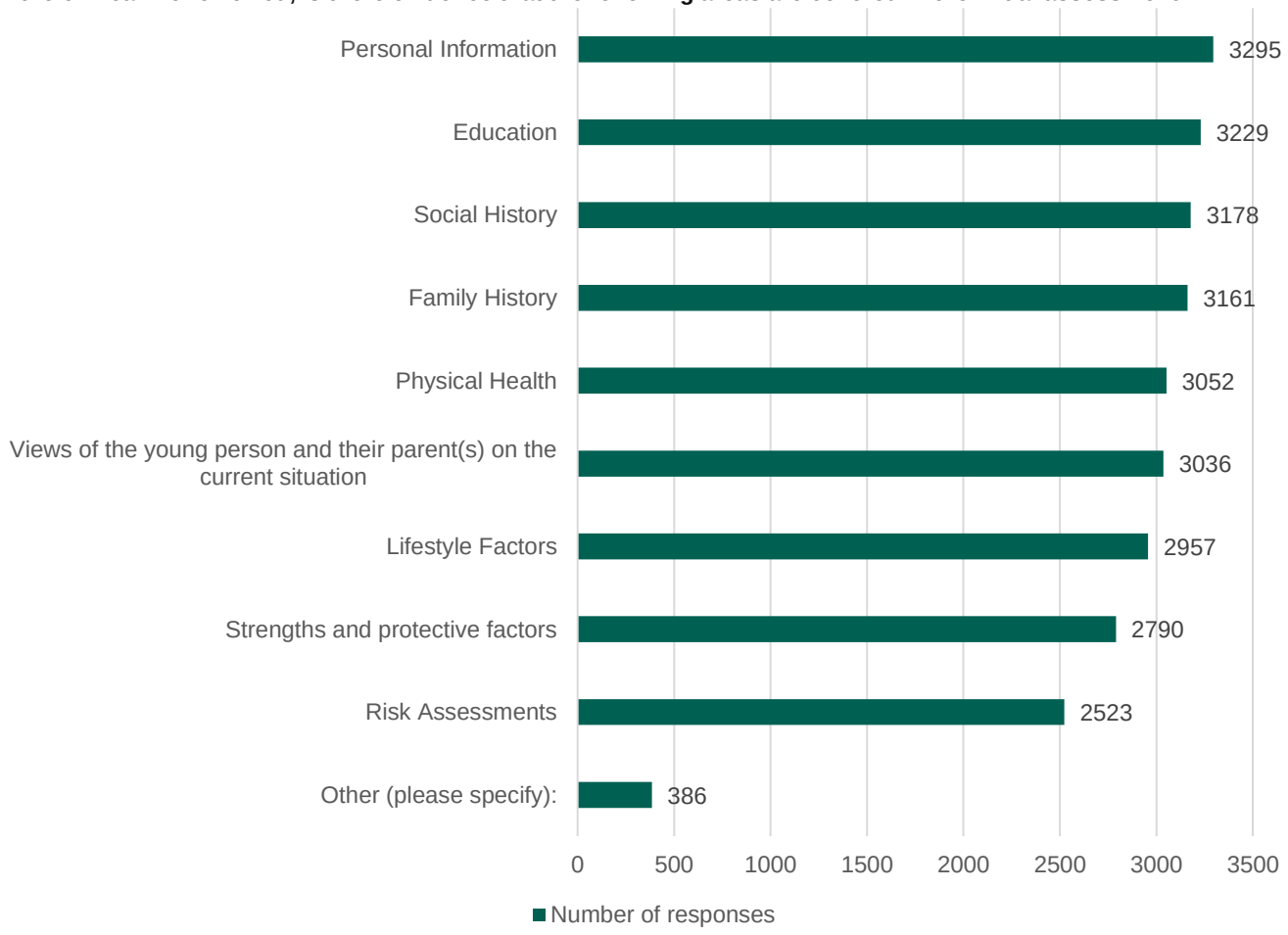
COG National Audit

Response Summary – Community

Initial Assessment

'The initial assessment will cover a range of areas including personal information, social history, family history, education, physical health, lifestyle factors, risk assessments, strengths and protective factors and the views of the child or adolescent and their parent(s) on the current situation' and 'An ICP includes an individual risk and safety management plan' - CAMHS Operational Guidelines.

In the clinical file reviewed, is there evidence that the following areas are covered in the initial assessment?



Of the 3,373 clinical files reviewed, the above graph shows the number of files where the following information was present in the initial assessment:

- Personal information;
- Education;
- Social history;
- Family history;
- Physical health;
- Views of the young person and their parent(s) on the current situation;
- Lifestyle factors;
- Strengths and protective factors;
- Risk assessments; and
- Other e.g. a detailed developmental history, specialist assessments.

This was a multi select question where teams could select more than one answer.

COG National Audit

Response Summary – Community

Risk Management

Risk management planning follows a structured Risk Assessment process and details the clinical processes and actions required to detect, monitor, assess, mitigate, and prevent/minimise any of the identified risks as detailed within the Risk Assessment framework from occurring.

Is there an identified risk management plan?

This pie chart above shows the percentage of clinical files where there is an identified risk management plan for children and young people. Of a total of 3,288 files reviewed, 60% (1,965) of clinical files reported having a risk management plan. For the remaining 40% (1,323) of files, where there was no risk management plan, teams reported that this was due to:

- No evidence of a risk management plan necessary;
- Awaiting formal diagnosis;
- The clinician was unable to contact the family to update the plan;
- Risk reviewed in sessions but not formally documented on a form;
- Referred on to relevant service and discharged;
- Assessments were ongoing; and
- Lack of evidence in the file to confirm if one had been completed.

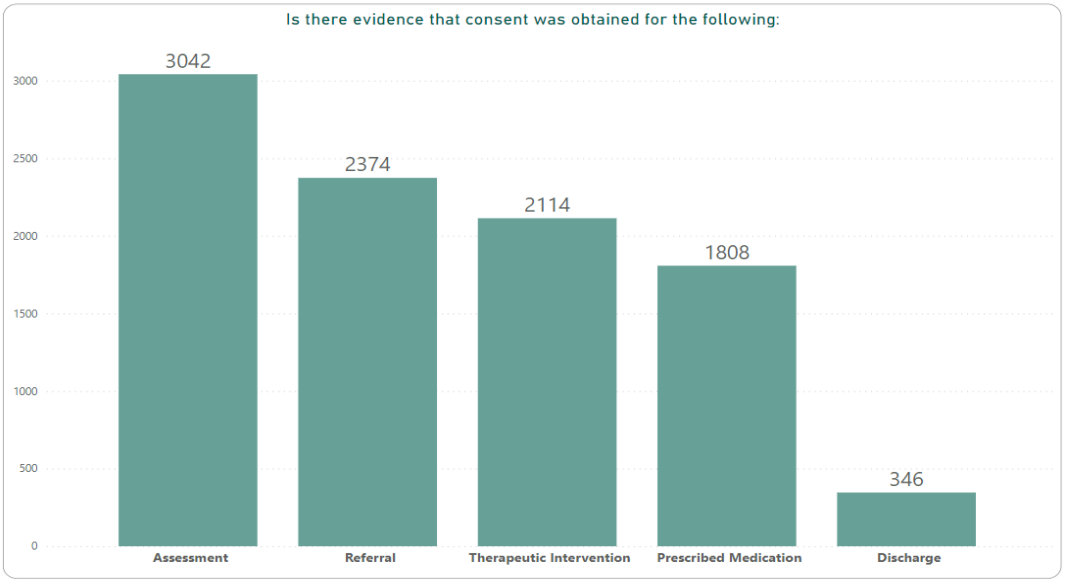
COG National Audit

Response Summary – Community

Consent

'Consent involves a process of communication about the proposed intervention in which the young person and their parents have received sufficient information to enable them to understand the nature, potential risks and benefits of the proposed intervention. Seeking consent should usually occur as an ongoing process rather than a one-off event'.– HSE National Consent Policy. (Please see HSE National Consent Policy for further information).

Is there evidence that consent was obtained for: referral, assessment, prescribed medication and or therapeutic intervention?



'

The chart above shows areas reported by CAMHS teams where consent was obtained for therapeutic interventions, referrals, assessment, and prescribed medication from the 3,373 clinical files reviewed.

Therapeutic Interventions
An intervention that includes for example, clinical inputs, psychiatry, psychology, occupational therapy, social work, speech and language therapy, social work or group interventions

How many therapeutic interventions has this young person received from the MDT in the last 6 months?
94% of the 3,373 clinical files reviewed showed evidence that therapeutic interventions and goals agreed in the ICP have been implemented. The remaining 6% did not provide any detail as to why therapeutic interventions and goals were not agreed. The audit responses highlighted that 76% of clinical files were reviewed by the MDT every 6 months. The majority of young people received 10 or fewer therapeutic interventions in the last 6 months.

COG National Audit

Response Summary – Community

PROMS

Please describe any Patient Reported Outcome Measures or similar for your community team?

'Patient-reported outcomes measures (PROMs) attempt to capture whether the services provided improved patients' health and sense of well-being and are a critical component of assessing whether clinicians are improving the health of patients.' – HSE.

58% of Community teams reported using PROMs or similar tools in their teams. Of a total of 43 team responses, text responses were analysed with the highest number of responses reported as coming from areas such as feedback forms and questionnaires; use of ratings and scales; and pre and post intervention measures. Common measures and tools reported by teams include:

- BECK Youth Inventory;
- Connors rating scale;
- The Swanson, Nolan and Pelham Teacher and Parent Rating Scale (SNAPs);
- Children's Yale-Brown Obsessive Compulsive Scale (CYBOCS);
- Child Behaviour Checklist (CBCL);
- The Session Rating Scale (SRS);
- Qb Test;
- Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA); and
- ICP goals achievement and scaling questionnaires.

Funded Vacant Posts

What are the current funded vacant posts in your service?
As part of the audit, teams were asked to self-report current funded vacant posts in their service. It is important to note that this data is not collected through a centralised database.

Of a total of 74 team responses, text responses were analysed with the highest number of responses for funded vacant posts reported as coming from the following areas:

- Social Worker;
- Nurse;
- Psychology;
- Dietician; and
- Occupational Therapist.

COG National Audit

Response Summary – Community

Current Staffing

What is the current staffing employed in your CAMHS Team (by discipline)?

Teams were asked to report their current staffing; the below table shows a list of the disciplines submitted.

	Discipline
Psychiatry	Non Consultant Hospital Doctor (NCHD)
	Specialist Registrar (SpR)
	Consultant Psychiatrist
	Child Psychiatrist
	Higher Specialist Training (HST) in Psychiatry
	Basic Specialist Training (BST) in Psychiatry
Therapist	Play Therapist
	Art Therapy Student
	Family Therapist
	Trainee Art Psychotherapist
	Trauma Therapist
	Psychotherapist
	Psychoanalytic Psychotherapist
	Cognitive Behavioral Therapy (CBT) Therapist
	Child Art Psychotherapy
Nurse	Assistant Director of Nursing (ADON)
	Advanced Nurse Practitioner (ANP)
	Clinical Nurse Specialist (CNS)
	Candidate ANP (CANP)
	Staff Nurse
	Clinical Nurse Manager (CNM)
Social Worker	Principal Social Worker
	Social Worker
Social Care	Social Care Leader
	Social Care Worker
Administration	Receptionist
	Administrator
	Medical Secretary

	Discipline
Psychology	Clinical Psychologist
	Assistant Psychologist
Occupational Therapy	Occupational Therapist (OT)
Speech and Language Therapy	Speech and Language Therapist (SLT)
Other	Teacher
	Chaplain
	Dietician
	Clinical Coordinator
	Addiction Counsellor
	Team Coordinator

COG National Audit

Response Summary – Community

CHO Governance Structure

Please describe the CHO governance structure?
The following governance structures reported below was submitted by a majority of teams:

Individual disciplines report to their line manager who reports to the Area Management Team, who is overseen by a Chief Officer.

In the organograms provided by teams significant variations in these structures existed. Variations included:

- The existence of a **CAMHS line manager** advisory group;
- A **Mental health management team** in additional to an area management team;
- **Business Manager** role;
- **Operational line management** role;
- Various **Subgroups** e.g. Clinical Governance Group;
- **Community Boards** (Section 38); and
- **Regional Directors** (Section 38).

Additional feedback received from teams included:

- Current **CAMHS governance structures not being** adequately **supported**;
- Current **structure** and **process unfit** for purpose;
- The governance structure is '**confusing and unclear**' as an information session was not provided to the team;
- Recently introduced an **overarching governance group** for CAMHS; and
- No forum for considering strategic CAMHS issues or for **settling operational differences** between disciplines.

What is the structure of your team and reporting relationships (line management structure)?
As above, the structure of the team and reporting relationships (line management structure) varied. The following describes common relationships reported by teams:

- The MDT team is led by the Consultant Psychiatrist as Clinical Team Lead, with **individual disciplines reporting to their own line management**;
- Each professional has a discipline-specific line manager whom they report to, either within or external to CAMHS **depending on discipline** and availability;
- The **Consultant retains clinical responsibility** overall for all young people;
- Health and Social Care Professionals on the team **report** to their **specific line managers**;
- Nurses report to the CAMHS Assistant Director of Nursing; and
- Registrars report to the Consultant Psychiatrist on the team who reports to the CAMHS Clinical Director and the Mental Health Executive Clinical Director.

Additional feedback received from teams included:

- Each member of team **reports** to their **individual line manager**, 'no coherency';
- **No oversight on concerns of the team**, even within the team structure; and
- No forum for agreeing a **joint team direction**.

COG National Audit

Response Summary – Community

Roles reported by teams as part of their CHO Governance structure

	Role
Mental Health Organisation Management	Chief Officer
	Mental Health Head of Service
	General Manager
	Executive Clinical Director
	Clinical Director
	Business Manager
	Operational Line Manager (Grade VIII)
	Area Manager
	Senior Executive Officer
Nursing	Assistant Director of Nursing
	Nurses
	Clinical Nurse Manager 3
	Clinical Nurse Manager 2
	Clinical Nurse Manager
	Area Director of Nursing
	Director of Nursing
	Clinical Nurse Specialist
	Community Mental Health Nurse
	Advanced Nurse Practitioner
	Psychiatric Nurse
Social Work	Principal Social Workers
	Head of Social Work
	Senior Social Workers
	Professionally Qualified Social Workers
Social Care	Social Care Workers
	Social Care Leader
Administration	Grade IV Administrator
	Grade V Administrator
	Grade VI Administrator
	Grade VII Administrator
	Grade VIII Administrator
	Administration
	Administration Manager
	Assistant Staff Officer

	Role
Occupational Therapy	Occupational Therapy Manager
	Occupational Therapist - Senior
	Occupational Therapist
Dietetics	Dietician - Manager
	Dietician - Senior
	Dietician
Speech and Language Therapy	Speech and Language Therapy Manager
	Speech and Language Therapist - Senior
	Speech and Language Therapist
Psychiatry	Consultant Psychiatrist
	Psychiatry Registrar - Senior
	Psychiatry Registrar
	Staff Grade Counselling Psychiatrist
	Consultant
	Day Hospital Consultant
	NCHD
	NCHD Registrar
	Clinical Tutor Consultant
Psychology	Senior Clinical Psychologist
	Psychologist
	Psychology Manager
	Principal Psychologist
	Consultant Team Lead Psychologist
Other	Trainee Clinical Psychologist
	Parent/Carer Rep
	Quality and Patient Safety Advisor
	Personnel Officer
	Play Therapist
	Human Resources
	Finance Officer
	Risk Manager
	Support Staff Manager

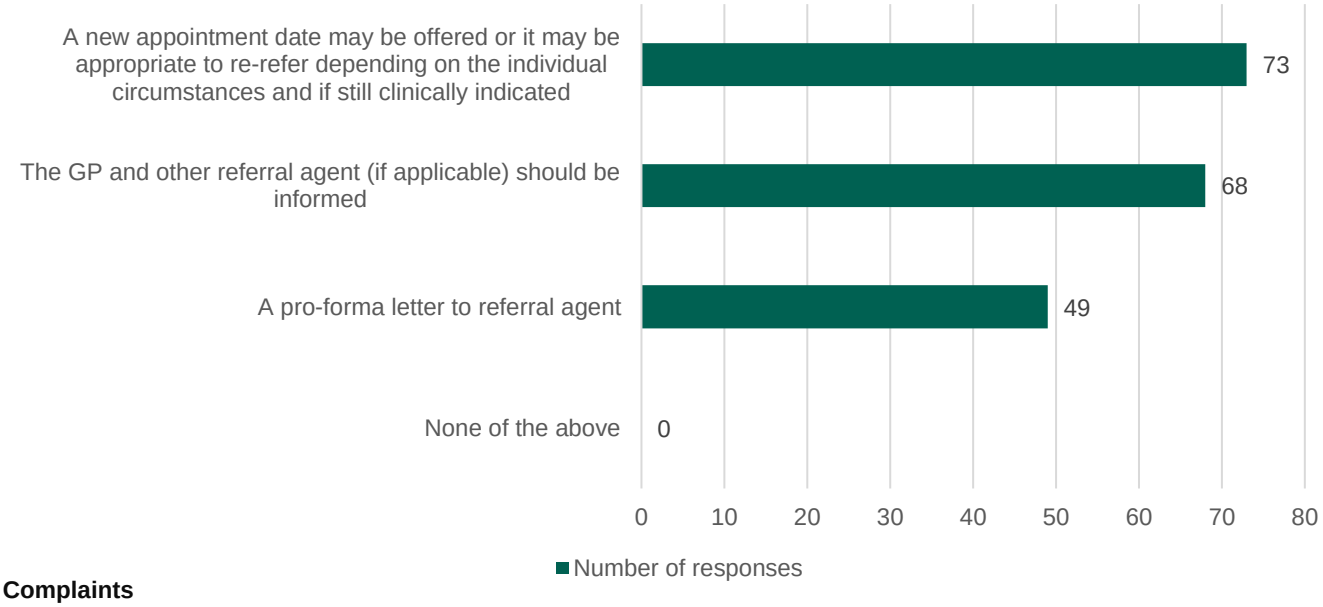
COG National Audit

Response Summary – Community

Non Attendance

Do you follow the COG for management of non-attendance of appointments?
The column chart seen below refers to non attendance of appointments. Where non attendance occurred it was reported that it is often unclear if the appointment was cancelled or the young person did not turn up. **96%** of teams reported evidence of follow up for non attendance in the clinical file. The following chart shows the multi-select question where teams could select the following:

- A new appointment date in the clinical file may be offered or it may be appropriate to re refer depending on the individual circumstances and if still clinically indicated;
- The GP and other referral agent (if applicable) should be informed;
- A pro-forma letter to referral agent; or
- None of the above.



Complaints

Is your team familiar with the HSE's complaints procedure?
The chart below shows that 99% of teams reported that they were familiar with the HSE's complaints procedure.
1% of teams (2 teams) reported they are not familiar with the complaints procedure, one team reported this was due to no training being provided and the other team was a voluntary organization (Section 38) and follow their own complaints procedure.

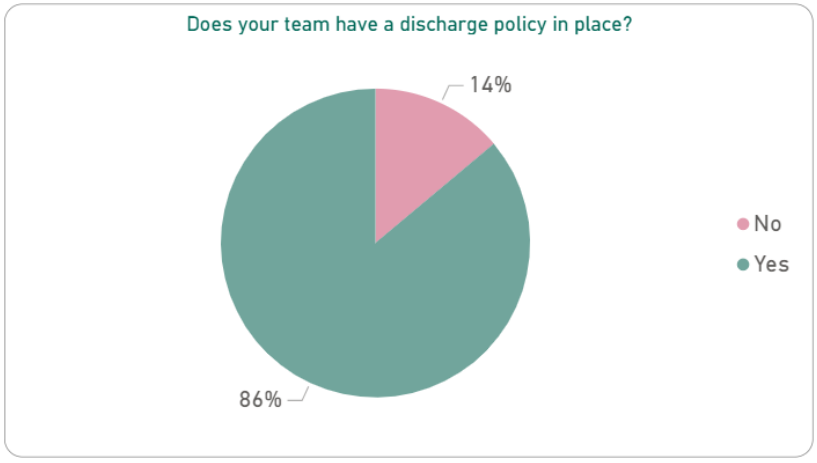
COG National Audit

Response Summary – Community

Discharge

Does your team have a discharge policy in place?
86% of teams reported having a discharge policy in place. Examples of barriers reported by CAMHS teams in implementing the discharge policy included:

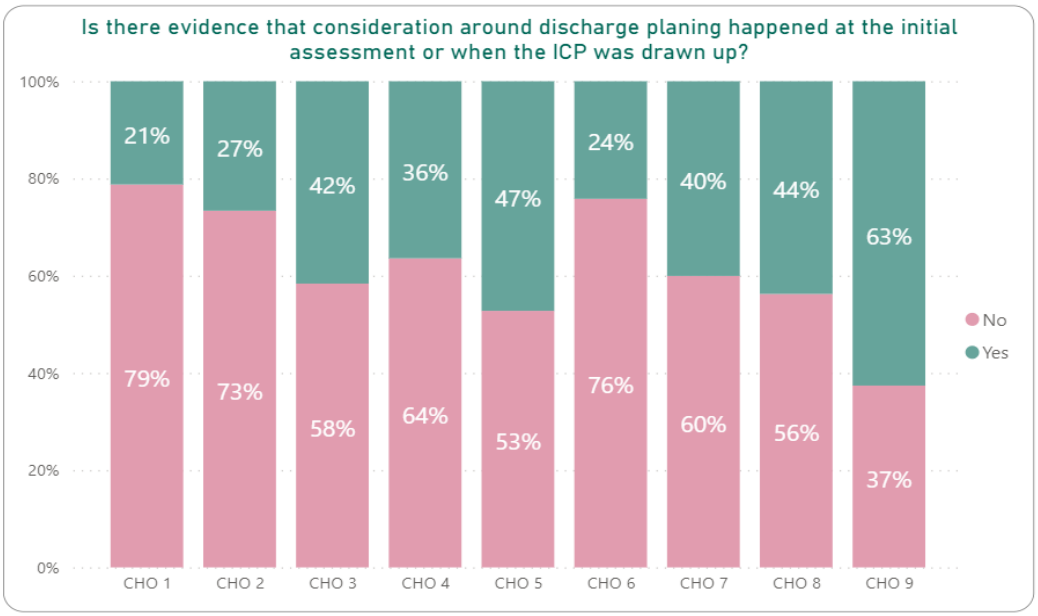
- Insufficient staff;
- Lack of stepdown services to refer on to;
- Lack of appropriate services; and
- Lack of time.



Is there evidence in this clinical file that consideration around discharge planning with the young person happened at the initial assessment or when the ICP was drawn up?
'Discharge for Community CAMHS occurs when a child or adolescent no longer requires the intervention of CAMHS. Discussion about discharge planning should begin at the initial assessment or when the ICP is drawn up in collaboration with the child or adolescent and their parent(s).' - CAMHS Operational Guidelines.

Out of a total of 2,455 clinical trial reviews, 39% (950) of the files showed evidence of consideration around discharge planning, while 61% (1,495) did not show evidence .This bar chart refers to evidence provided by teams that discussions around discharge planning took place with the young person at the initial assessment or when the Individual Care Plan was developed. Reasons submitted for a lack of discharge planning at initial assessment include;

- Disengagement with service;
- Inappropriate to discuss at initial appointment;
- Discussion of discharge caused increased anxiety in the young person; and
- Discharge not indicated.



COG National Audit

Response Summary – Community

Transition

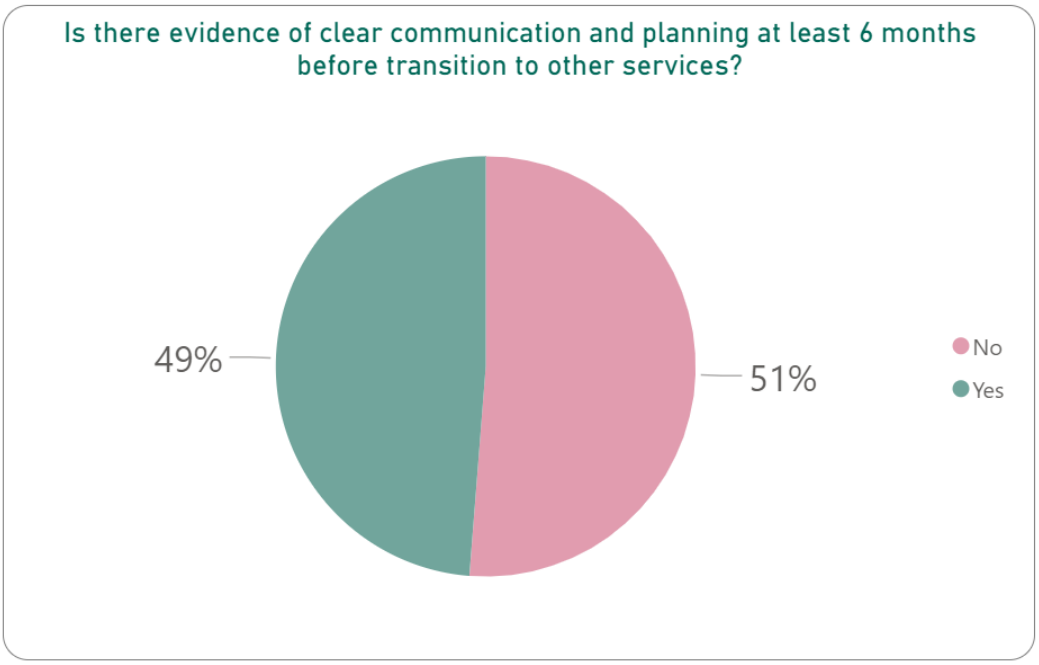
Is there evidence of clear communication and planning at least 6 months before a young person is transitioning to another CAMHS team or adult mental health services?

'There should be a transition plan within the ICP, this should have begun 6 months prior to their 18th birthday. The Consultant Psychiatrist and Key Worker should be responsible for initiating handover to the adult mental health service.' – CAMHS Operational Guidelines.

From a total 802 clinical file reviews where a follow up service was applicable, where teams were presented with Yes/No options, 49% (391) reported evidence of clear communication and planning at least 6 months before a young person is transitioning to another CAMHS team or Adult Mental Health Services (AMHS). 51% (411) reported No to the same question. Reasons identified by CAMHS teams to this occurring included:

- No discharge plan;
- Not indicated on the file; and
- Young person is not at an age to consider referral to AMHS – AMHS minimum age of referral is 18 years of age.

The graph below displays findings for all files reviewed.



COG National Audit

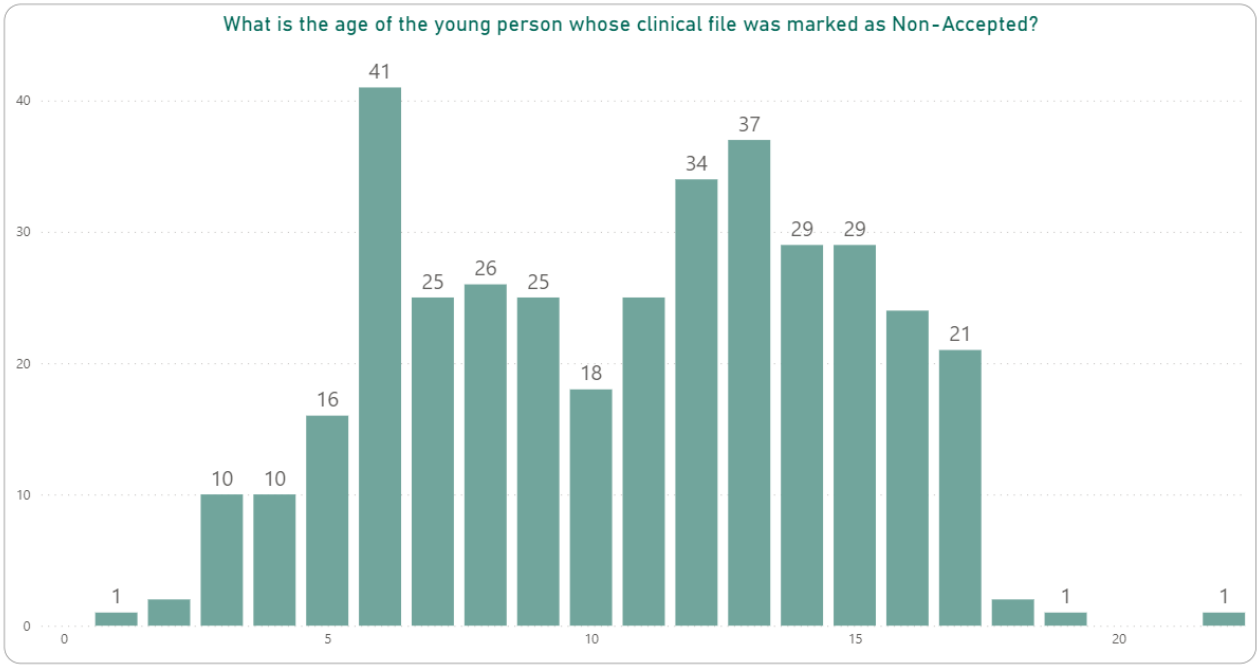
Response Summary – Non-Accepted Referrals

Non-Accepted Referrals

'CAMHS is not suitable for children or adolescents whose difficulties primarily are related to learning problems, social problems, behavioural problems or mild mental health problems. There are many services available to respond to these needs for children and adolescents, e.g. HSE Primary Care Services, HSE Disability Services, Tusla – The Child and Family Agency, Jigsaw, National Educational Psychology Services (NEPS) and local Family Resource Centres' – CAMHS Operational Guidelines.

The following section of the response summary details data captured in this audit regarding non-accepted referrals.

What is the age of the young person whose clinical file was marked as "Non-Accepted"?
The **average** age of young people not accepted to CAMHS services reported was **10.6** years of age, while the **median** is **6** years of age.



When this referral was screened, was it categorised as not appropriate for CAMHS i.e., does not meet the threshold for CAMHS at this time?
7% of clinical files were not categorised as 'non-accepted' at the time of referral screening. The reasons given for why these referrals were not yet categorised as 'non-accepted' for CAMHS were as follows:

- Further information sought from parents;
- No consent received;
- Did not access primary care services initially;
- Parent informed the service it was no longer required;
- Required MDT discussion first;
- On going triage process; and
- Already attending Community CAMHS.

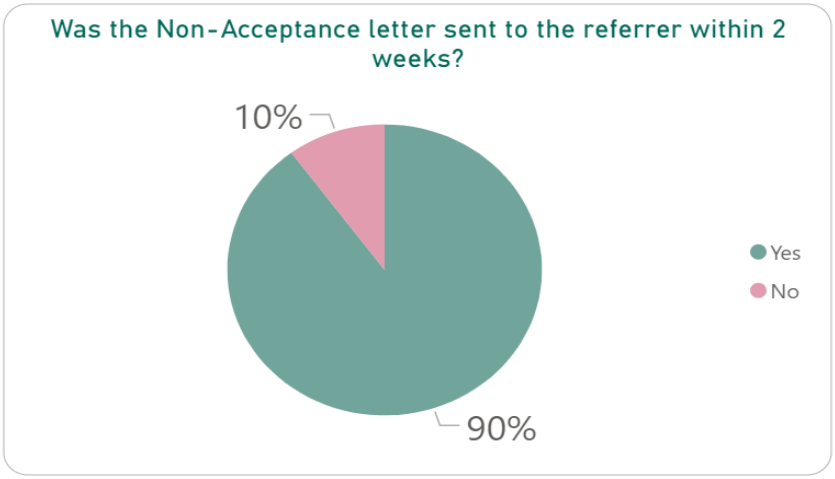
COG National Audit

Response Summary – Non-Accepted Referrals

Non-Acceptance Letter

Was the Non-Acceptance letter sent to the referrer within 2 weeks?
From a total of 366 clinical files where non-acceptance letters were applicable, 90% of non-acceptance letters were sent back to the referrer within the recommended 2-week timeframe. For those which were not sent within 2 weeks, the most common timeframes reported for the letter to be sent were:

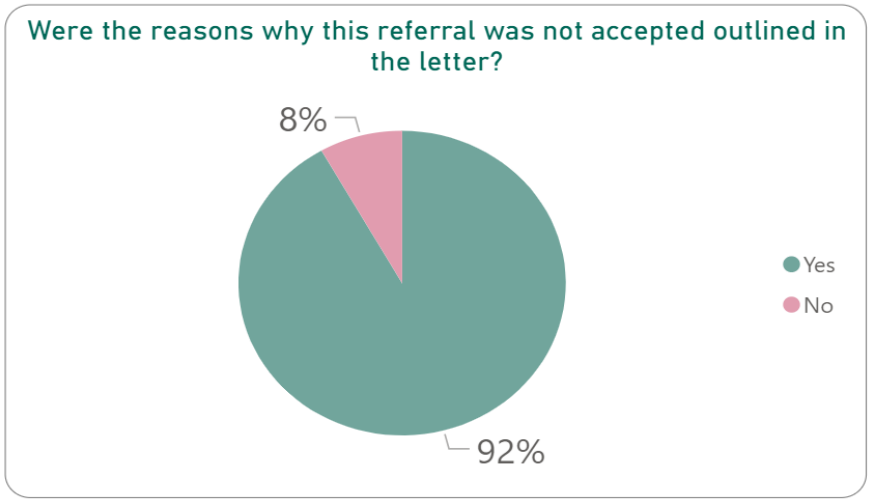
- (Within) 3 weeks; and
- (Within) 4 weeks.



Were the reasons why this referral was not accepted outlined in the letter?
From a total of 366 clinical files where non-acceptance letters were applicable, the below pie chart shows that 92% (336) of CAMHS team reported that the reasons for non acceptance of the referral were outlined in the letter.

For the 8% (30) of clinical files reviewed where it was reported that no evidence of a reason was outlined in the letter, teams reported this was due to:

- Not standard practice;
- No letter on file;
- Insufficient information;
- Accidental omission; and
- Information not received within timeframe and therefore removed from waiting list.



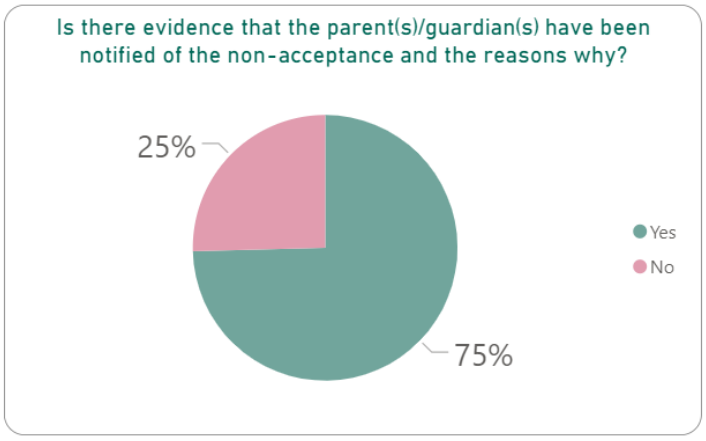
COG National Audit

Response Summary – Non-Accepted Referrals

Parent(s) guardian notification

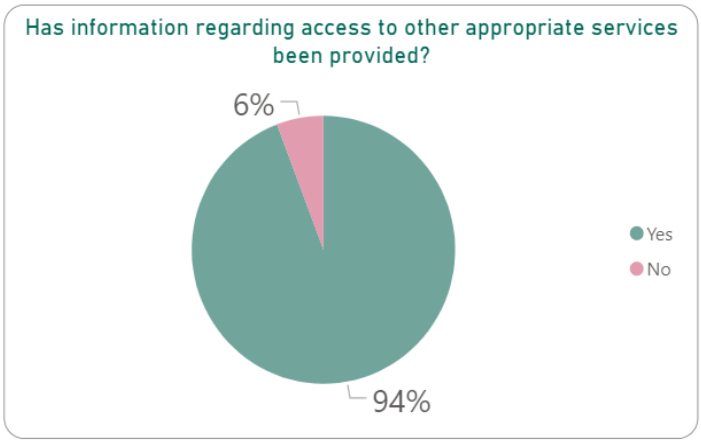
Is there evidence that the parent(s)/ guardian(s) have been notified of the non-acceptance and the reasons why?
From a total of 366 clinical files where non-acceptance notifications were applicable, 75% (273) of non-accepted referrals contained evidence that parents and/or guardians were notified of the non-acceptance and the reasons why the referral was not accepted, while 25% (93) did not show evidence in the file. The most common reasons reported why the parent/guardian was not informed of non-acceptance included:

- CAMHS teams noted it is the responsibility of the referring agent to inform the parents/guardians of the young person in the case of non-acceptance to CAMHS;
- Not standard practice in the CAMHS team; and
- In some instances, it was deemed preferable that the young person's referral be discussed between the parents/guardians and the referring agent such as GP, due to sensitive information in the referral or to determine appropriate pathway for referral.



Other services

Has information regarding other more appropriate services been provided?
From a total of 366 clinical files that were identified as non-accepted referrals, 94% (345) of non-accepted referrals contained evidence that information regarding other, more appropriate services were provided to the referring agent or the parent/guardian, while 6% (21) of non-accepted referrals did not show evidence of more appropriate service information.



6% of files did not show evidence that information regarding other appropriate services was provided. Teams reported this was due to the following factors:

- The young persons family **did not engage** with the service;
- CAMHS is the **appropriate service**;
- **No consent** received to process the referral;
- 'Advising about treatment of adults is **beyond scope** of practice' – Young person was over the age of 18;
- General signposting to primary care services rather than specific service;
- GP listed all services available in **original GP** consultation;
- Already attending **another appropriate service**;
- Referral did **not provide enough information** to allow a decision; and
- **Not enough information** to give recommendations.

COG National Audit

Response Summary – Other Significant Findings (Community)

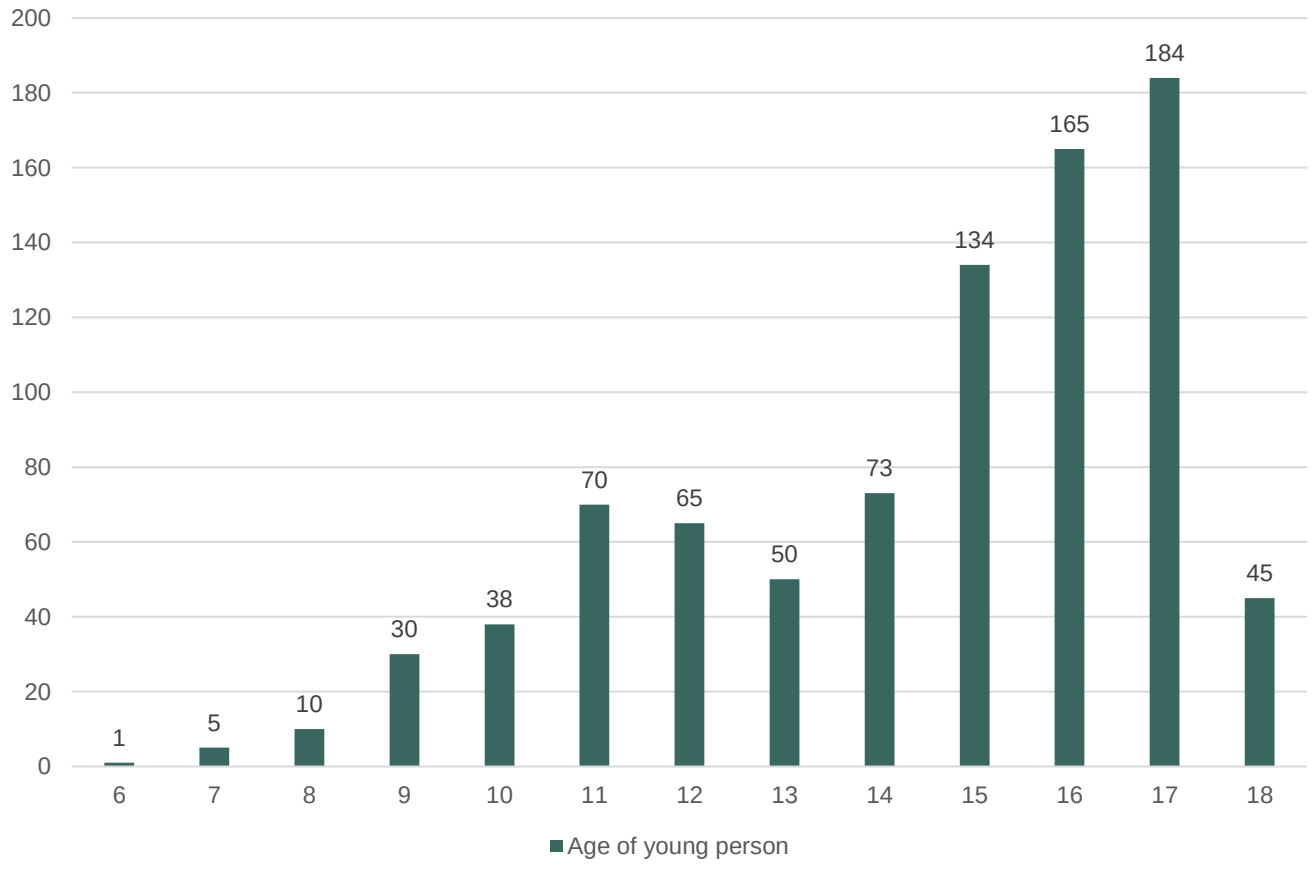
The following section of the report details significant findings extracted from the self reported audit data which do not fall under the scope of adherence to the COG, but are relevant to those reading this report in a clinical context.

National Diagnoses of Young People

Of a total of 3,288 clinical files reviewed, text responses were analysed for this questions with the highest number of responses reported relating to the following diagnoses :

- Anxiety;
- ADHD;
- ASD; and
- Emotional Dysregulation.

Of note, **870 young people were diagnosed with anxiety, 1.512 young people were diagnosed with ADHD, 500 young people were diagnosed with ASD and 144 with Emotional Dysregulation –** the majority of which had dual or multiple diagnosis. In total, 870 files reviewed reported some element of the diagnosis as being related to anxiety. The incidence of an anxiety diagnosis appears to increase with age, peaking at 184 diagnoses at 17 years of age. Outlined below are the number of files, of the 870 where anxiety formed all or part of the diagnosis, per age group.



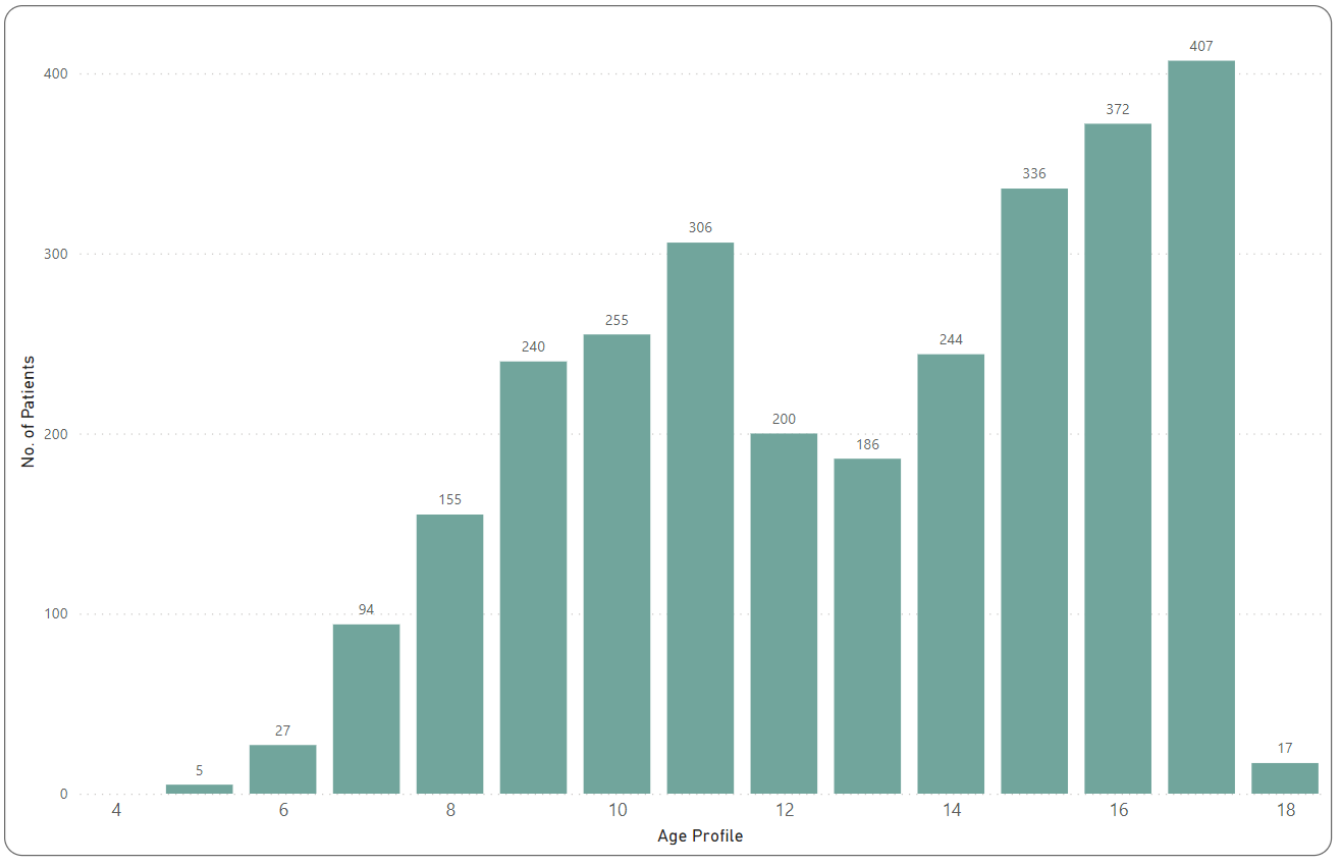
COG National Audit

Response Summary – Other Significant Findings (Community)

The following section of the report details significant findings extracted from the audit data which do not fall under the scope of adherence to the COG, but are relevant to those reading this report in a clinical context.

Ages of Young People in Community File Review

In the column chart below, the ages of young people whose clinical files were reviewed can be seen. The average age of young people whose clinical files were reviewed is 13 years of age, with the range of ages seen in Community teams also being 13 years.



COG National Audit

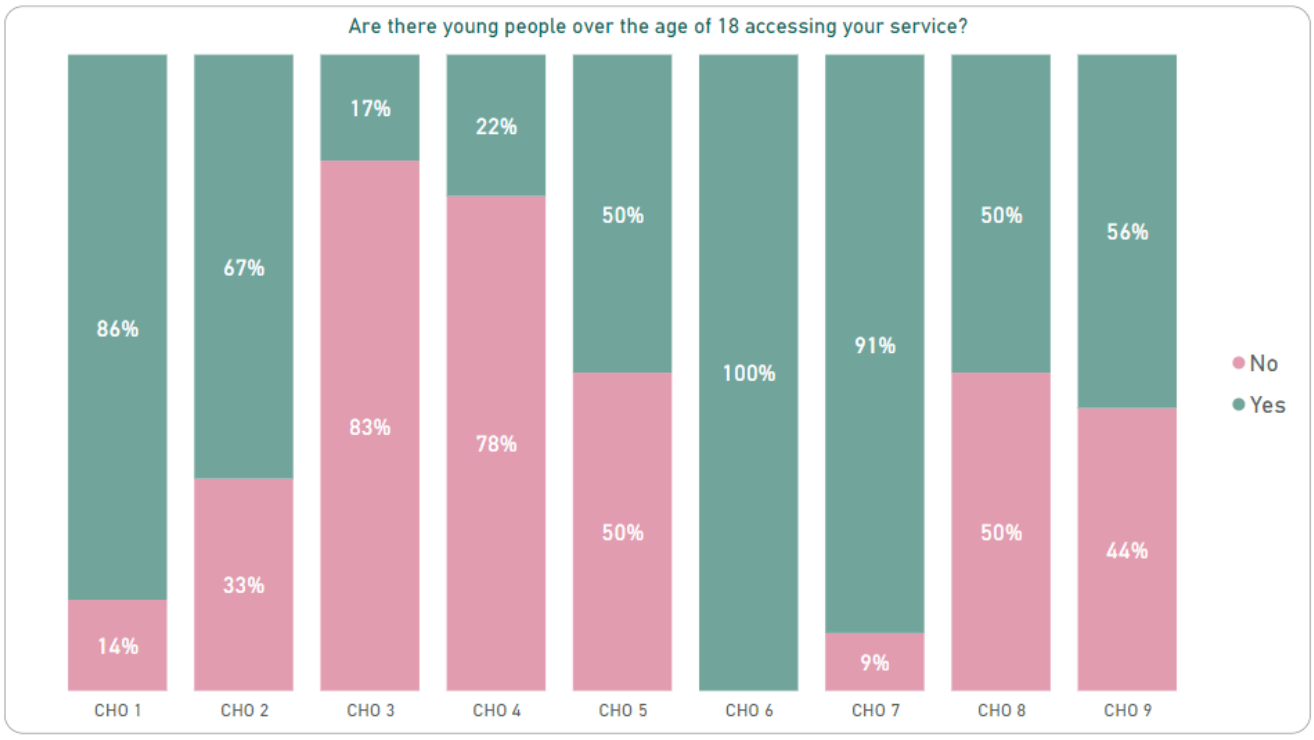
Response Summary – Other Significant Findings (Community)

Service Access & Eligibility

Are there young people over the age of 18 accessing your service?
The presence of over 18s varies both within and across the CHOs, with 100% of teams in CHO 6 supporting young people over 18, and 83% of teams in CHO 3 not supporting young people over 18 in their service. Many teams report supporting young people over the age of 18 in their services due to;

- Lack of alternative services to meet the young persons needs;
- Awaiting Adult Mental Health System (AMHS) appointments;
- Difficulty accessing services due to mental health illness e.g. ADHD, neuro divergent;
- Delays in transition due to workload;
- Failure of transition to AMHS;
- Teams reported that GPs will not continue to prescribe specialist medication if the young person is not under the review of a Psychiatrist;
- Young person may need extra input from CAMHS for a short period of time during significant life events such as sitting the Leaving Certificate, which may avoid the need for onward referral to another service;
- Young people completing state examinations;
- Lack of community resources available;
- Complexity of cases;
- Attending school; and
- Completing time limited clinical interventions.

The below graph illustrates per CHO the percentage of teams who have young people over the age of 18 accessing their service.



COG National Audit

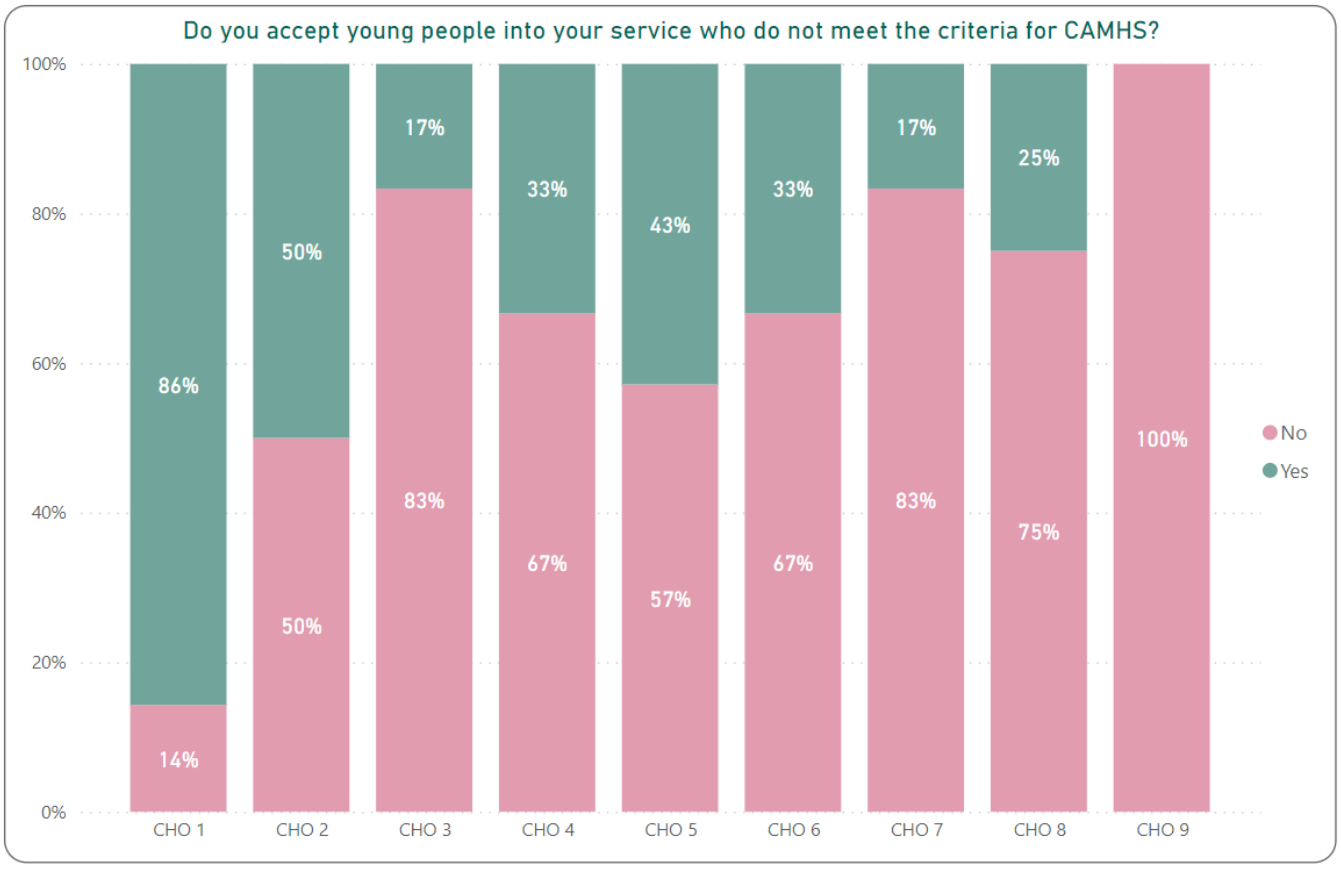
Response Summary – Other Significant Findings (Community)

Service Access & Eligibility

Do you accept young people in your service who do not meet the criteria for CAMHS?
Where CAMHS teams accept young people into their service outside of the criteria outlined in the COG, they report this is due to;

- Inadequate referral information resulting in acceptance of inappropriate referrals;
- CAMHS may be seen as a more responsive service;
- Referrals due to psycho social issues or disability can be difficult to discharge once seen due to lack of availability to more appropriate services;
- Increasing number of children presenting with ASD. Joint care model with CDNT not always effective;
- Lack of services available in the community;
- Referral returned back from other services like Primary Care, CDNT, TUSLA;
- Risk assessment and risk management;
- Lack of input from other agencies; and
- Unable to obtain sufficient information to clarify severity, especially where multiple additional confounders are present.

The below graph illustrates per CHO the percentage of teams who accept young people into their service who do not meet the criteria for CAMHS.



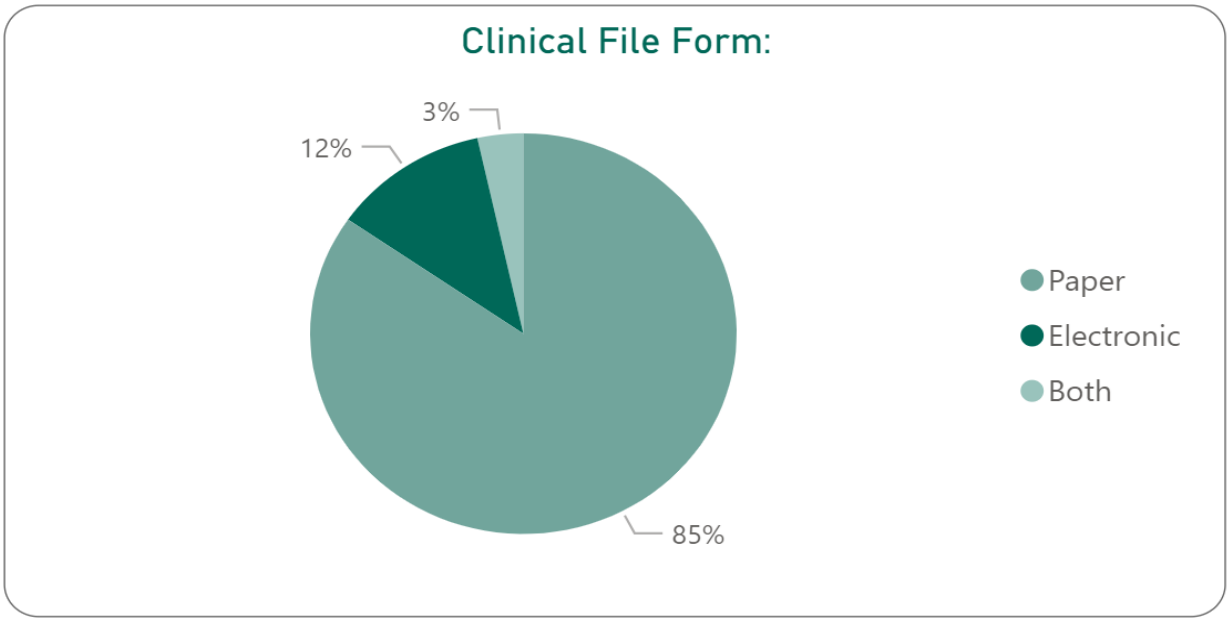
COG National Audit

Response Summary – Other Significant Findings (Community)

Clinical File Storage

The below pie chart displays the reported variation in clinical file storage in CAMHS teams nationally. **85%** of the 3,288 young people's clinical files that were reviewed, were stored in a **paper-based** clinical file storage system. Almost **12%** of clinical files reviewed were stored exclusively on an **electronic** system, while approximately **3%** of young people's files were stored using both **paper & electronic** systems of clinical file storage.

How is this young person's clinical file routinely stored?



Out of Hours services
This question was asked to capture Out of Hours or on call services provided by CAMHS, which were available to children and young people and their families outside of office hours (9am-5pm). However, it is evident that teams interpreted this as any service outside of office hours. Please see a summary of the list of responses Teams were asked to provide details of services provided outside of normal office hours. While there are limitations to the data captured regarding out of hours, see page 91, a number of CHO's have reported that they provide out of hours services through:

- On call work by consultants;
- Emergency/liaison services;
- Family Connection parent support group for 4 week nights;
- Group work/intervention for parents;
- Webinars;
- CAMHS connect weekend service;
- Weekend clinic with visiting Consultants;
- On call system incorporating hospital psychiatric registrar, CAMHS Senior Registrar, and CAMHS Consultant during all out of hours periods;
- ADHD and MHID remote clinics in the evenings; and
- Flexible working (e.g. reviews go beyond 5pm in emergency situations, some staff work 8am-4pm, others work 10am-6pm).

In your area, what are your out of hour arrangements for emergency referrals?
The following is a list of out of hour arrangements for emergency referrals reported by teams:

- Attend local A&E;
- Out of hours GP service;
- If safe to do so, await urgent appointment with CAMHS team;
- 24 hour Consultant Psychiatrist cover;
- Local Liaison Psychiatry at the National Children's Hospital;
- Pieta House;
- Samaritans; and
- An Garda Síochána.

COG National Audit

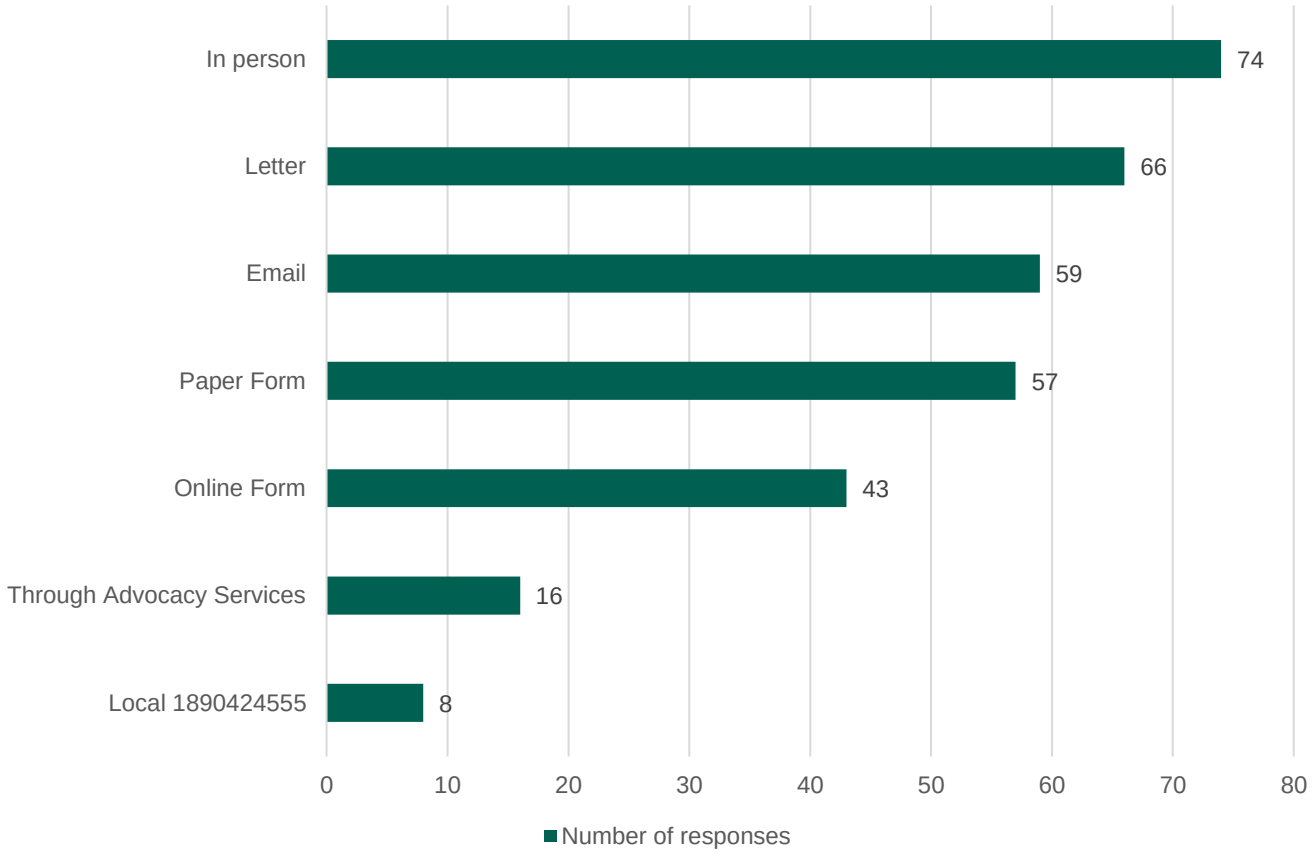
Response Summary – Other Significant Findings (Community)

Shared Clinical Diary

Please explain why there is no shared clinical diary (paper or electronic based) to track appointments and case management?
37% of teams reported not having a shared clinical diary to track appointments and case management. Reasons provided by CAMHS teams for not having this in place included:

- Lack of line management within the team;
- Not all migrated to Health IRL;
- Electronic diary via outlook shared with Administration only;
- No IT infrastructure to allow shared diaries and appointment tracking;
- Clinical staff and line managers 'not keen' on implementation; and
- System incompatible with new computers and new email addresses.

Has your CAMHS team used the following methods for receiving feedback/ complaints?
100% of community CAMHS teams have received feedback/ complaints in person, while only 11% have received feedback or complaints through a local phone line (1890 424555).



COG National Audit

Response Summary – Inpatient

Implementation of the CAMHS Operational Guidelines

The levels of adherence to each section of the COG specifically applicable to inpatient units can be seen in the table below. The majority of sections are reported as being partially implemented among inpatient CAMHS teams.

Question in Audit – Section Focus	Full	None	Part	Total
Section 2.2 (COG pg. 10)	3	-	-	3
Section 2.3 Involving Parent(s) (COG pg. 11)	3	-	-	3
Section 3.2 Clinical Governance in CAMHS Teams (COG pg. 14)	2	1	-	3
Section 5.11 Admission to a CAMHS Inpatient Unit (COG pg. 49)	3	-	-	3
Section 5.11.4 Initial Care Plan (COG pg. 50)	2	1	-	3
Section 5.17 Individual Care Plan (ICP) (COG pg. 52)	2	1	-	3
Section 5.20 Discharge Planning (COG pg. 54)	2	1	-	3

COG Section Summary Description

- **Section 2.2 '*Involving Children and Adolescents*'** this section relates to how children and adolescents should be at the core of a recovery-oriented service, ensuring their involvement in decisions and goals. They should also be encouraged to participate in the design, implementation, delivery and evaluation of mental health services.

  The results of the audit indicate that all three teams (100%) are fully implementing this section, with no team reporting that they were partially implementing or not implementing this section of the COG.

- **Section 2.3 '*Involving Parent(s)*'** this section highlights the importance of collaborative relationships with parent(s) through out the young persons journey through CAMHS.

  The results of the audit indicate that all three teams (100%) are fully implementing this section, with no team reporting that they were partially implementing or not implementing this section of the COG.

- **Section 3.2 '*Clinical Governance in CAMHS Teams*'** emphasises the needs for clear accountability structures to ensure the delivery of high quality, safe and reliable services.

  The results of the audit indicate that two teams (66%) are fully implementing this section, no team are partially implementing this section and one team (33%) reported that they were not implementing this section of the COG.

- **Section 5.11 *'Admission to a CAMHS Inpatient Unit*'** gives an overview of the processes that should occur when a decision is made to admit a young person to a CAMHS inpatient unit.

  The results of the audit indicate that all three teams (100%) are fully implementing this section, with no team reporting that they were partially implementing or not implementing this section of the COG.

- **Section 5.11.4 '*An initial care plan is usually completed by the admitting clinician. It details the immediate treatment and interventions required for the child or adolescent. This may include for example levels of observations required, medication, etc*.'** explains that an ICP is usually completed by the admitting clinician and what it must detail.

  The results of the audit indicate that two teams (66%) are fully implementing this section, no team are partially implementing this section and one team (33%) reported that they were not implementing this section of the COG.

- **Section 5.17 '*Individual Care Plan (ICP)'*** this section outlines the requirements of the ICP, including what the document should included, timeframes for when it must be completed and how often it must be reviewed.

  The results of the audit indicate that two teams (66%) are fully implementing this section, no team are partially implementing this section and one team (33%) reported that they were not implementing this section of the COG.

- **Section 5.20 'Discharge Planning'** emphasises the planning that must occur when considering discharge, the summary document and discharge meeting that should occur prior to the young person leaving the CAMHS inpatient unit.

  The results of the audit indicate that two teams (66%) are fully implementing this section, no team are partially implementing this section and one team (33%) reported that they were not implementing this section of the COG.

COG National Audit

Response Summary – Inpatient

The following section contains graphic representations of the findings of this analysis for the **inpatient team questions** section of the audit. The data displayed in this section was collated from the responses of 3 inpatient CAMHS units.

Implementation of the CAMHS Operational Guidelines

What are the challenges/barriers to implementation of the COG?
Teams reported challenges and barriers to implementation of the COG as;

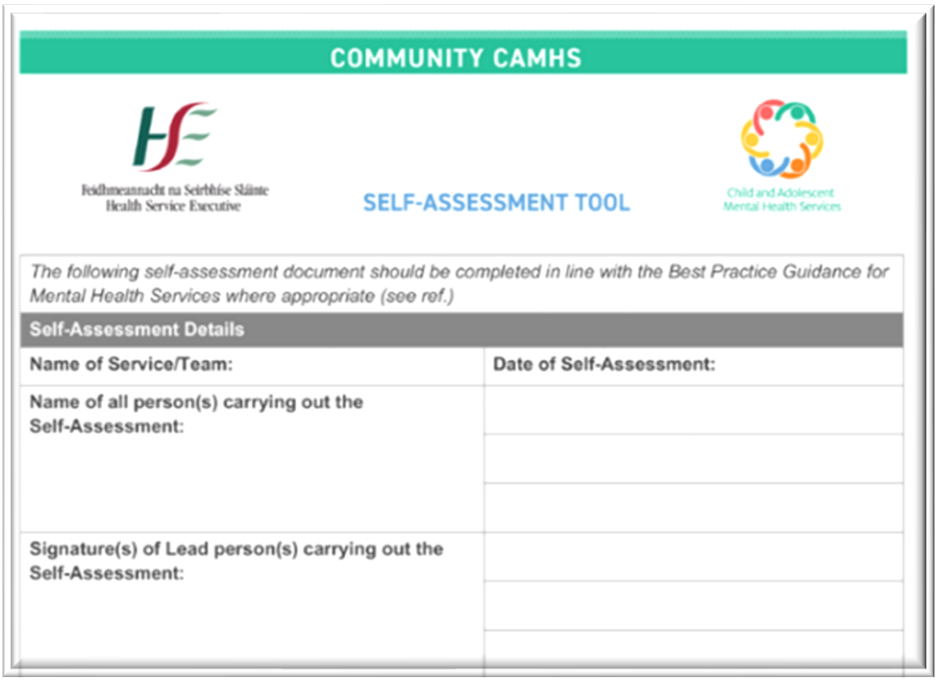
- **Lack of electronic service user records** (digital records) 'which has major impact on efficiency of service and on communication';
- Community teams and inpatient teams hold **separate paper records**, 'comprising several volumes, creating inherent risk of limited access to information in timely enough way to make well informed clinical decisions';
- '**Operational Guideline** of HSE is **not consistent in language with MHC codes** and regulations, creating confusion';
- The **MHC is the statutory regulator for approved centres** and must take precedence; and
- 'The **responsibilities of chief officers, heads of services** and of **area management teams** are **not explicit** in the operational guidelines'.

Self assessment Tool
'A Self-Assessment Tool has been developed to allow CAMHS teams to assess the service they deliver against this Operational Guideline. Self-assessment contributes to continuous improvement by providing a structured opportunity to assess performance and identify improvements required for the CAMHS team.'
O% of units have completed the Self assessment tool.

Please provide details as to what barriers have prevented you from completing the self-assessment tool?
Two inpatient teams provided details of barriers they face completing the self assessment tool. These were;

- 'No clarity regarding added benefit, as inpatient team already completes annual statutory inspection process with MHC, which has higher and more detailed defined standards of quality'; and
- 'Unaware of it being a requirement'.

Referral and Clinical Pathway
Teams were asked if they utilised any additional pathways other than the Inpatient Pathway outlined in the COG, with one team reporting that referral sources include Paediatric Liaison Psychiatry, Adult Emergency Department, and Paediatric Emergency Department via Child & Adolescent Psychiatry.



COMMUNITY CAMHS

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

SELF-ASSESSMENT TOOL

Child and Adolescent Mental Health Services

The following self-assessment document should be completed in line with the Best Practice Guidance for Mental Health Services where appropriate (see ref.)

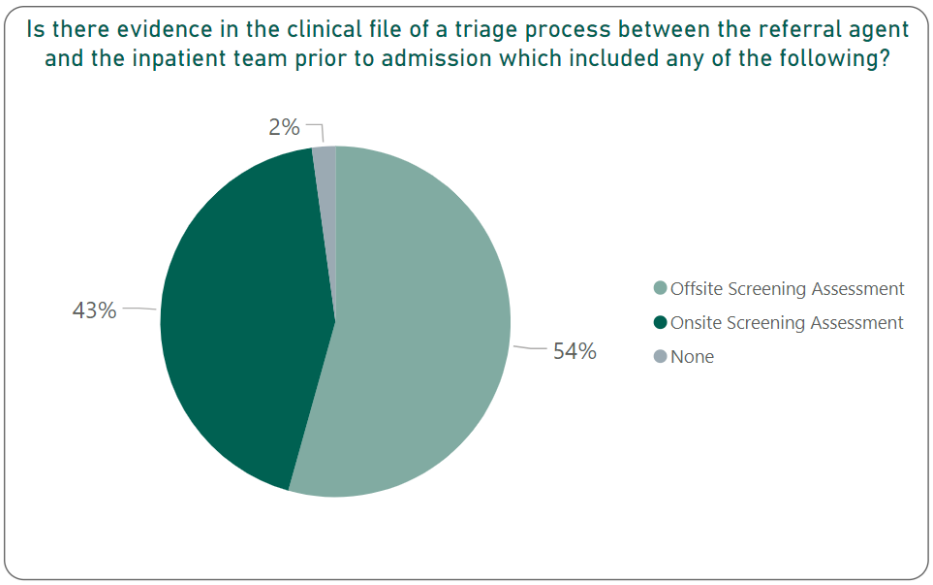
Self-Assessment Details	
Name of Service/Team:	Date of Self-Assessment:
Name of all person(s) carrying out the Self-Assessment:	
Signature(s) of Lead person(s) carrying out the Self-Assessment:	

COG National Audit

Response Summary – Inpatient

Referrals
'It is recommended that there be a triage process prior to admission. This may include telephone consultation with the referral agent, further information gathering from other services, and/or a day visit by the inpatient team to ensure suitability for admission' - CAMHS Operational Guidelines

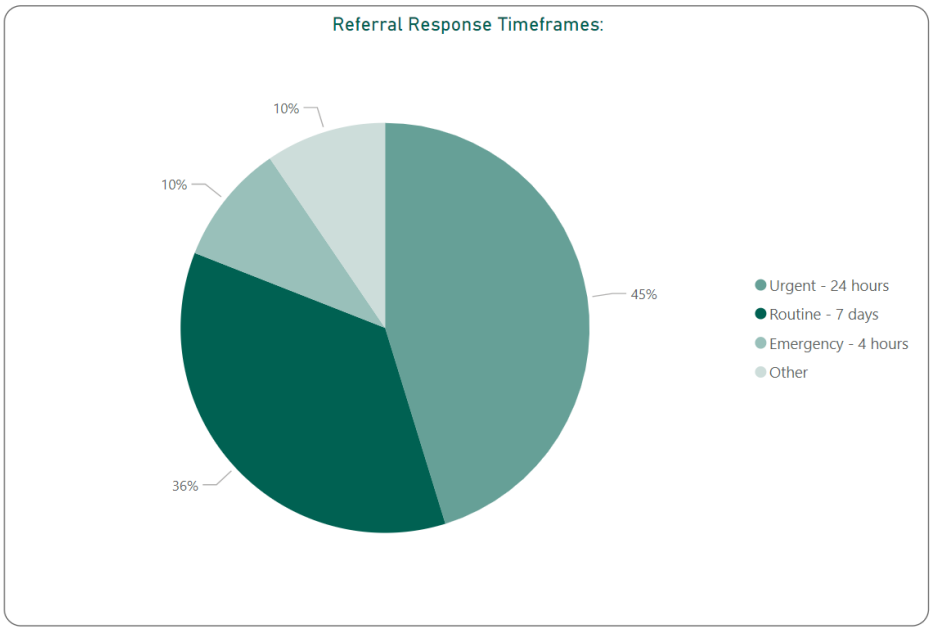
Referral Triage
The below pie chart displays the proportion of the 42 clinical files reviewed which contained evidence of a triage process prior to admission. Of the 42 clinical files reviewed, 98% showed evidence of a triage process prior to admission. 54% of the files reviewed showed that a triage process took place offsite, while 43% showed a triage process occurring onsite.



Referral Response Times
The below pie chart displays the proportion of referrals within the 42 clinical files reviewed which were responded to within

- Urgent (24 hours);
- Routine (7 days); and
- Emergency timeframes (4 hours).

45% of the files reviewed had referrals marked as Urgent, 36% were Routine, 10% were Emergency and 10% did not fit any category. Of these referrals, 1 was responded to within 16 days; 1 was responded to but not screened for a number of weeks for medical reasons and capacity constraints within the service; 1 required medical clearance and 1 was a planned involuntary admission.



COG National Audit

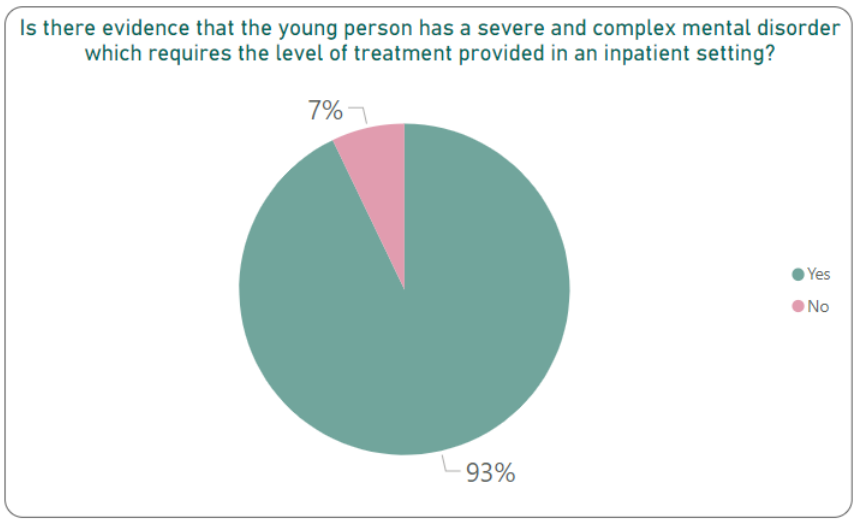
Response Summary – Inpatient

Referrals

Is there evidence that sufficient details were provided by the referral agent to inform a decision to admit?
The below column chart displays the proportion of the 42 clinical files reviewed which contained evidence of sufficient details being provided by the referral agent, informing a decision to admit the young person into inpatient care.

Admissions

Is there evidence that the young person has a severe and complex mental disorder which requires the level of treatment provided in an inpatient setting?
93% (39) of the 42 files reviewed showed evidence of the young person having a severe and complex mental disorder which requires the treatment provided in an inpatient setting. Of note, 3 clinical files reviewed did not contain this evidence.



CAMHS teams reported that 100% of clinical files reviewed have clear goals of admission for the young person.

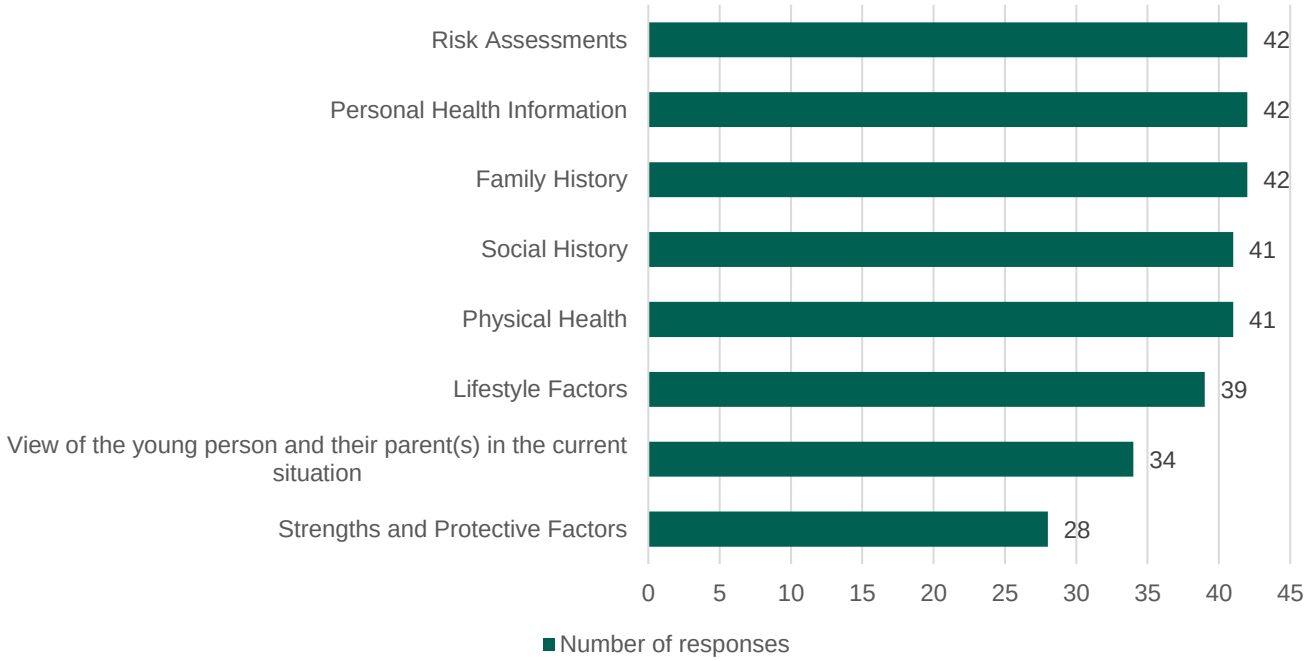
COG National Audit

Response Summary – Inpatient

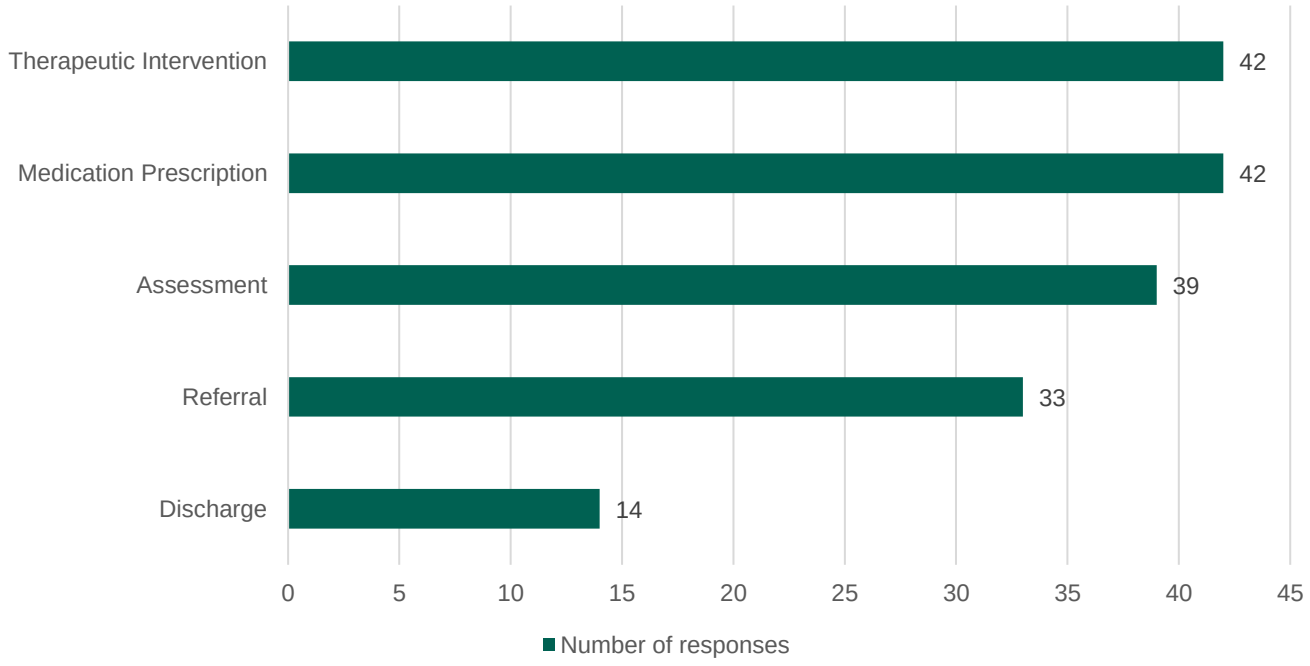
Admissions

Is there evidence that the following areas were covered in the initial biopsychosocial assessment?
The below column chart shows the number of clinical files out of the 42 files reviewed which showed evidence of the following areas covered in the initial biopsychosocial assessment. 100% of clinical files showed evidence of Family History, Personal Health Information, and Risk Assessments being covered in the initial assessment.

This was a multi-select question where teams could select more than one answer.



Is there evidence in the clinical file that consent was obtained in the following areas?
The below column chart displays the number of clinical files out of the 42 files reviewed which contained evidence that consent was obtained for; Medication Prescription, Therapeutic Intervention, Assessment, Referral and Discharge. Of note, all 42 clinical files contained evidence of consent for Medication Prescription and Therapeutic Intervention.

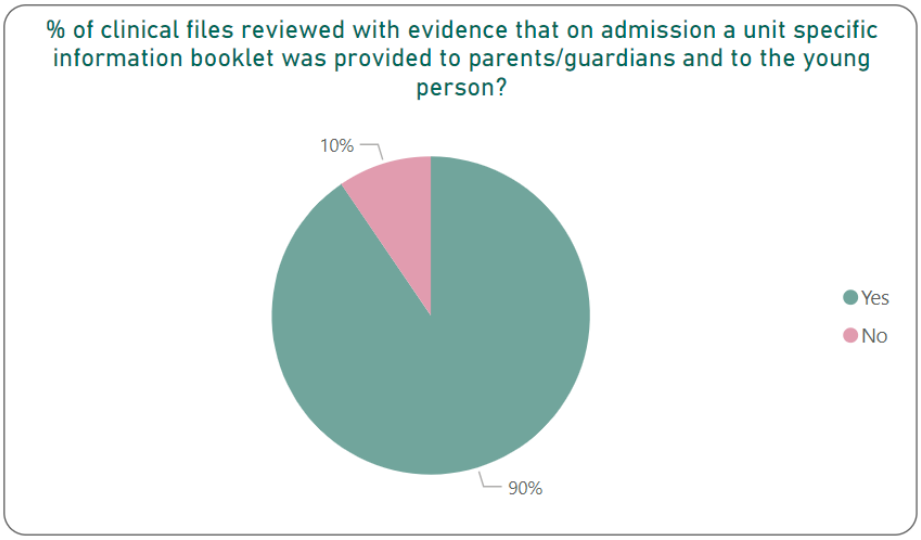


COG National Audit

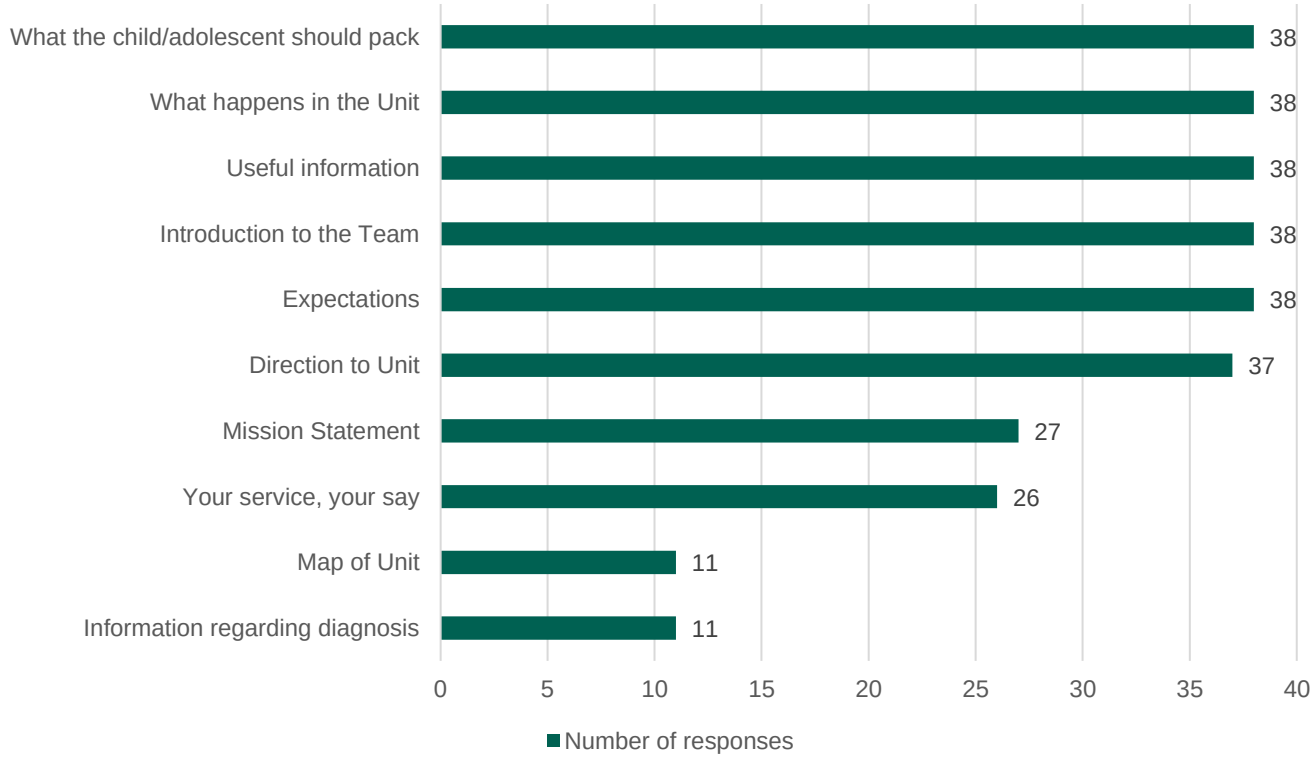
Response Summary – Inpatient

Admissions

Is there evidence in the clinical file reviewed that on admission a unit specific information booklet was provided to parents/guardians and to the young person?
90% (38) of the 42 clinical files reviewed contained evidence of the provision of an information booklet to parent(s)/guardian(s) and the young person on admission to the inpatient approved centre. Where teams reported no information booklet being provided, they explained that it was not documented or mentioned in the clinical file being reviewed.



Information booklet
Does the information booklet include the following:
This was multi-select option where teams could select more than one answer and the below column chart shows the number of the 42 clinical files reviewed which included a variety of information both general and unit-specific.



COG National Audit

Response Summary – Inpatient

Initial Care Plan

'An initial care plan is usually completed by the admitting clinician. It details the immediate treatment and interventions required for the child or adolescent. This may include for example levels of observations required, medication, etc.' – CAMHS Operational Guideline.

100% of the clinical files reviewed contained evidence that an Initial Care Plan was completed within the first 24 hours of admission along with the young person.

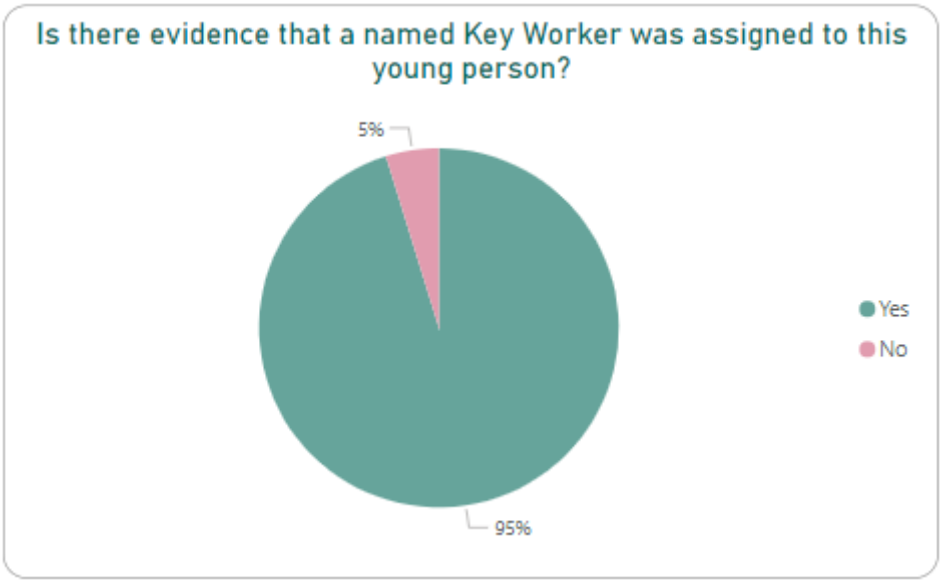
Clinical Interventions
CAMHS teams reported that 100% of clinical files reviewed had an agreed system to manage clinical interventions - a coordinated approach to delivering MDT interventions to children and young people.

Key Working

'A Key Worker is a point of contact on the CAMHS teams who coordinates care, not only within the mental health service but also across systems (e.g. education, social welfare, etc.) for the service user. Key workers do not deliver all of the treatment but they are responsible for making sure that other professionals are keeping to what was agreed in the care plan.' - CAMHS Operational Guidelines.

All inpatient units have a key working system in place. Two units have a multidisciplinary key working system, one is solely nursing. The most common disciplines which engage in key working roles in Inpatient teams are **nurses, psychologists**, **occupational therapists**, **NCHDs** and **social workers**.

Is there evidence that a named Key Worker was assigned to this young person?
The following pie chart displays the proportion of 42 files that were reviewed, which showed evidence of the young person having a Key Worker assigned. The number of young people, 1 or 2, assigned to a key worker depends on the number of admissions. 95% (40) of files showed evidence of a named Key Worker being assigned to the young person, while 5% (2) did not show evidence.



COG National Audit

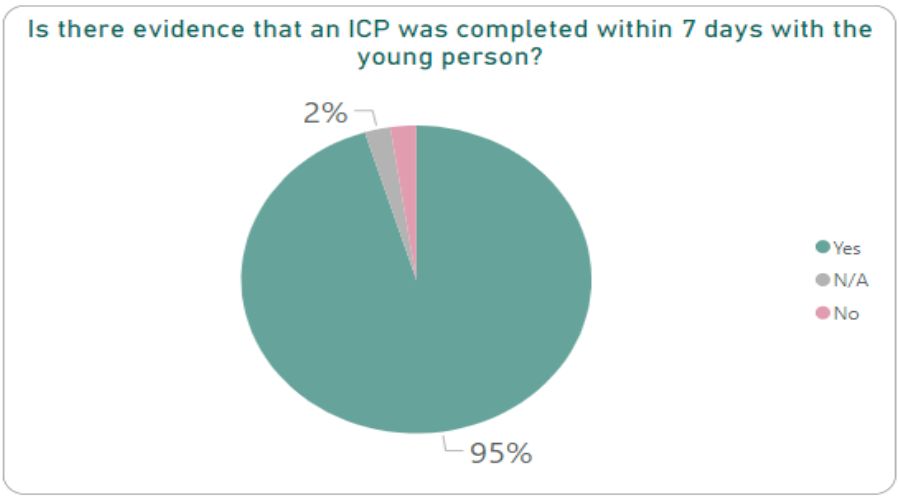
Response Summary – Inpatient

Individual Care Plan

'An ICP is a clear plan, in plain English, that describes the levels of care and treatment needed to meet the assessed needs of the child or adolescent while they are attending CAMHS.' CAMHS Operational Guidelines.

Is there evidence that an ICP was completed within 7 days with the young person?
95% of the 42 clinical files reviewed reported evidence that an ICP was completed within 7 days. Additionally, 90% of clinical files reviewed (38 of 42) contained evidence that the young person's ICP was reviewed weekly at MDT meetings. Of the 4 clinical files which did not contain the evidence, the reason for such was that the duration of their admission to date was less than a week.

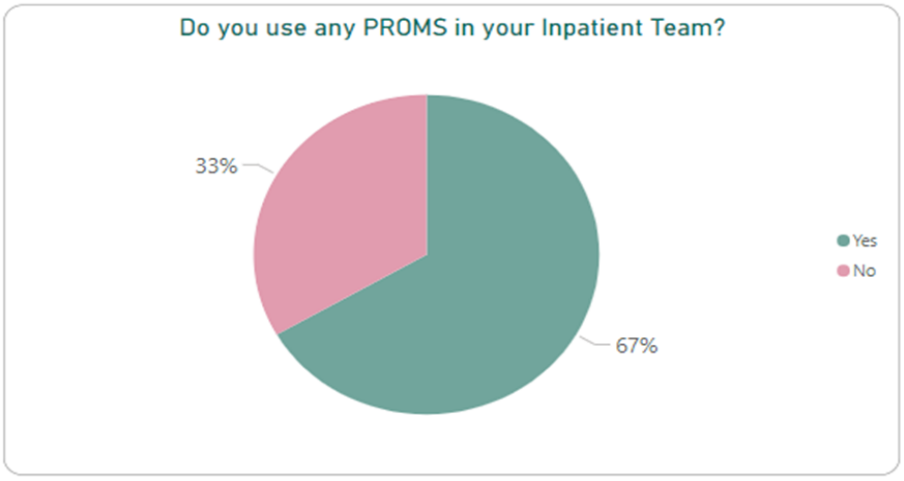
Not applicable (N/A) was selected for one clinical file reviewed but no supporting reason was provided.



Patient Reported Outcome Measures
'Patient-reported outcomes measures (PROMs) attempt to capture whether the services provided improved patients' health and sense of well-being and are a critical component of assessing whether clinicians are improving the health of patients.' – HSE.

Do you use any Patient Reported Outcome Measures or similar for your inpatient team?
Of the 3 inpatient unit responses, 67% (2) of he units report using PROMs. Inpatient teams provided a list of PROMS or similar tools for their team which included:

- Children's Global Assessment Scale (CGAS);
- HoNOSCA; and
- Satisfaction Survey.



COG National Audit

Response Summary – Inpatient

Discharge

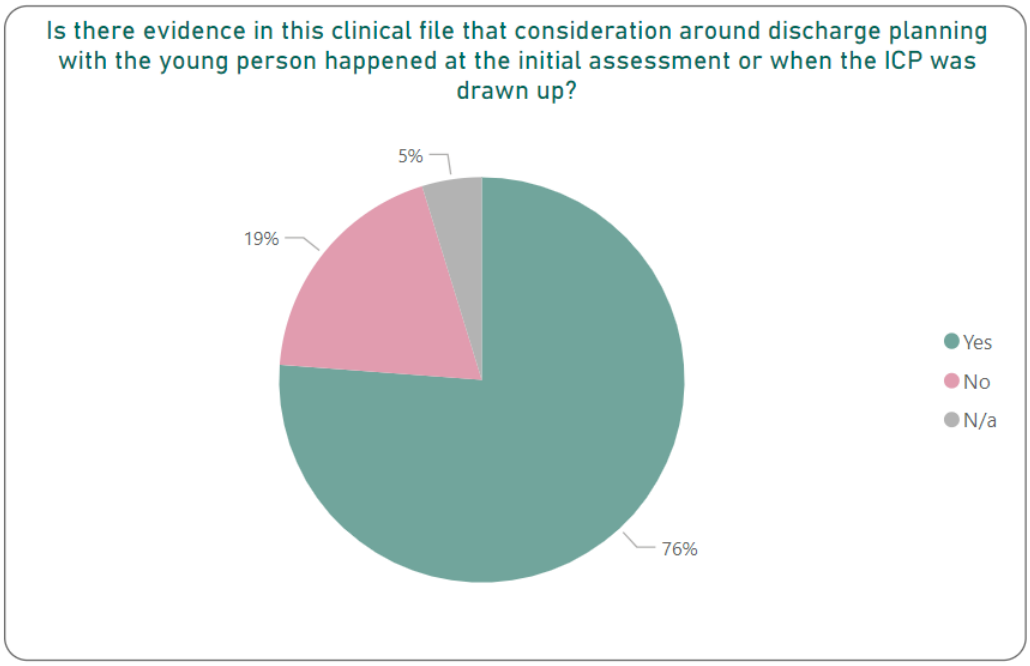
'Discharge from a CAMHS Inpatient Unit occurs when a child or adolescent no longer requires inpatient care. This may mean they have achieved their goals or their care can be managed in a community setting.' CAMHS Operational Guidelines.

Discharge Policy
100% of inpatient units reported barriers in implementing their discharge policy.

Please provide details of any barriers in implementing your discharge policy?
Inpatient units reported barriers to implementing the discharge policy, highlighting it was due to;

- Capacity and/or responsiveness of community CAMHS and/or other community services;
- Limited staffing;
- Logistical reasons, for example 'especially during COVID restrictions as clinicians were less available to attend planning meetings in person';
- 'Relationships with Tusla professionals vary across geographical areas and thresholds for Tusla direct engagement';
- 'Tusla on occasion have no residential placements for patients who are to be discharged';
- Accommodation issues;
- Access to adult mental health services;
- Onward specialist placement; and
- Parent/Guardian did not wish their child to be discharged at this time.

Discharge
Is there evidence in the clinical file that consideration around discharge planning with the young person happened at the initial assessment or when the ICP was drawn up?
Of the 42 clinical files reviewed, 76% (32) of the files contained evidence of consideration around discharge with the young person happening at either the initial assessment or when the ICP was drawn up. 19% (8) of files did not show evidence while 5% (2) were identified as not applicable.



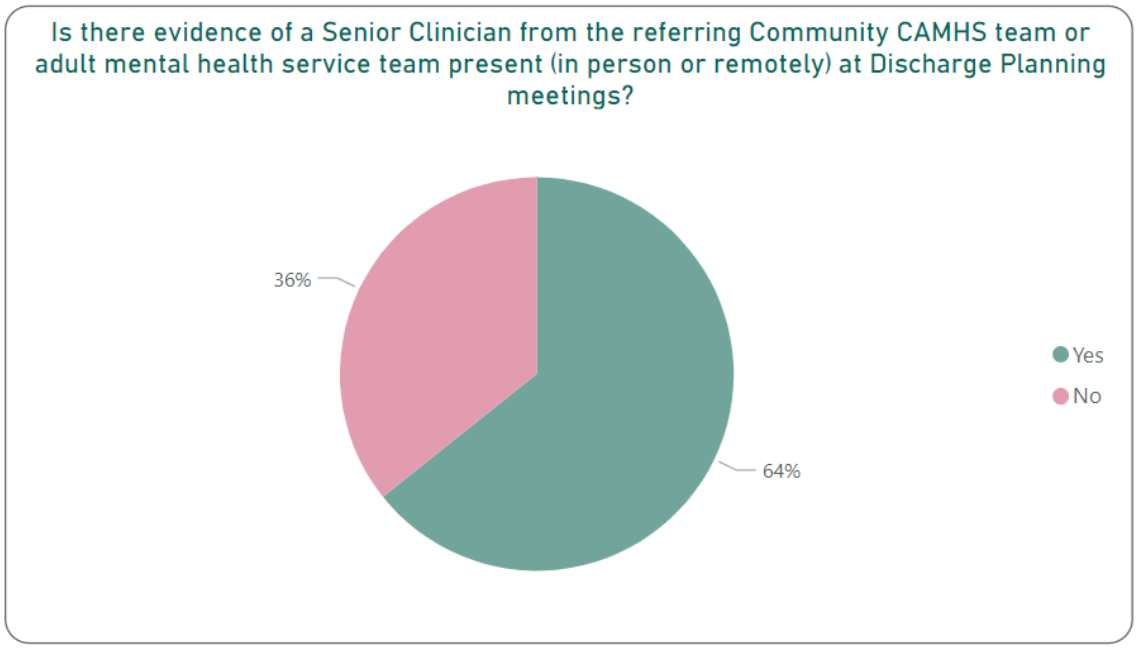
COG National Audit

Response Summary – Inpatient

Discharge

Is there evidence of a senior clinician from the referring Community CAMHS team or adult mental health service team present (in person or remotely) at discharge planning meetings?
Of the 42 clinical files reviewed, 64% (27) of clinical files contained evidence of a senior clinician from the referring Community CAMHS team or AMHS being present at discharge planning meetings regarding the young person. 36% (15) of units selected 'No', where the following reasons were given:

- Discharge meeting had not occurred yet;
- 'Links with Community team only as part of discharge case conference'; and
- Recent admission.



COG National Audit

Response Summary – Non-Accepted Referrals (Inpatient)

Why was this clinical file categorised as Non-Accepted?
The following section of the response summary details data captured in this audit regarding non-accepted referrals in inpatient settings.

Reasons identified for non-accepted referrals were:

- 'No longer required screening for admission';
- 'Managed in the community due to improved mental state';
- 'Outside age range of service';
- 'Out of primary catchment area'; and
- 'Admission offered but declined by parents'.

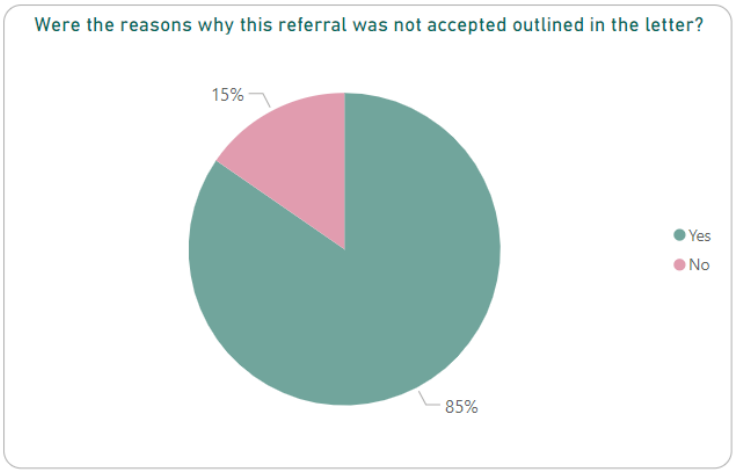
Was the non-acceptance letter sent to the referral agent within 2 weeks?
Of the 16 clinical files where a referral was non-accepted, 94% (15) of files reviewed contained evidence that the non-acceptance letter was sent to the referral agent within a 2-week timeframe.

Where the non-acceptance letter was sent to the referral agent within 2 weeks with no reason mentioned, the reasons reported were was due to;

- 'Referral accepted by team but declined by family'; and
- 'Parents being present at screening/assessment and did not consent for inpatient treatment'.

Were the reasons why this referral was not accepted outlined in the letter?
81% (13) of the 16 non-accepted clinical files reviewed had the reasons for non-acceptance outlined in the letter sent to the referral agent. Of the 19% (3) which did not include the reasons for non-acceptance in the letter, the explanations given for this were:

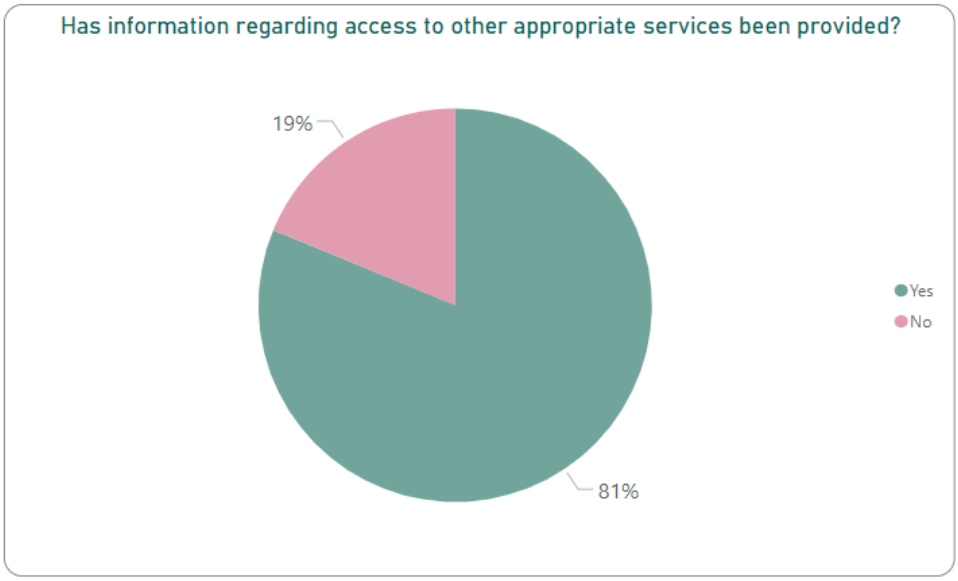
- The referral was initially accepted by the inpatient team but the parents did not consent to admission; and
- The young person was outside of the catchment area and it was advised that the referral agent refers to local inpatient services.



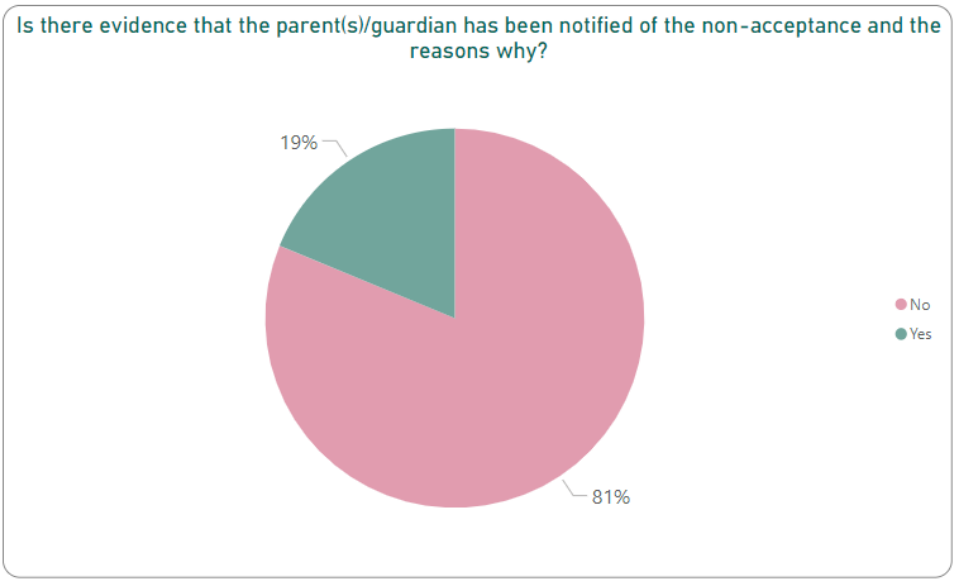
COG National Audit

Response Summary – Non-Accepted Referrals (Inpatient)

Has information regarding access to other appropriate services been provided?
81% (13) of the 16 non-accepted clinical files reviewed contained evidence that information regarding access to other appropriate services was provided. The reason given for why information regarding other appropriate services was not provided was that the young person was already attending Community CAMHS.



Was the parent/guardian notified of the non-acceptance and the reasons why?
81% (13) of the 16 non-accepted clinical files reviewed did not contain evidence that the inpatient team notified the parent(s)/guardian(s) of the non-acceptance and the reasons why.



81% (13) of the 16 non-accepted clinical files reviewed showed no evidence that the parent/guardian was notified of the non-acceptance and the reasons why the young person was not accepted. The reasons reported included:

- 'Inpatient consultant had no direct clinical relationship with young person or family';
- 'Responsibility to communicate outcome of referral remained with referring consultant who has therapeutic relationship';
- 'Contact/assessment by inpatient team not necessary';
- 'Voluntary Care Order placement breakdown';
- 'Declined admission'; and
- 'Letters to outpatient team'.

COG National Audit

Response Summary – Other Significant Findings (Inpatient)

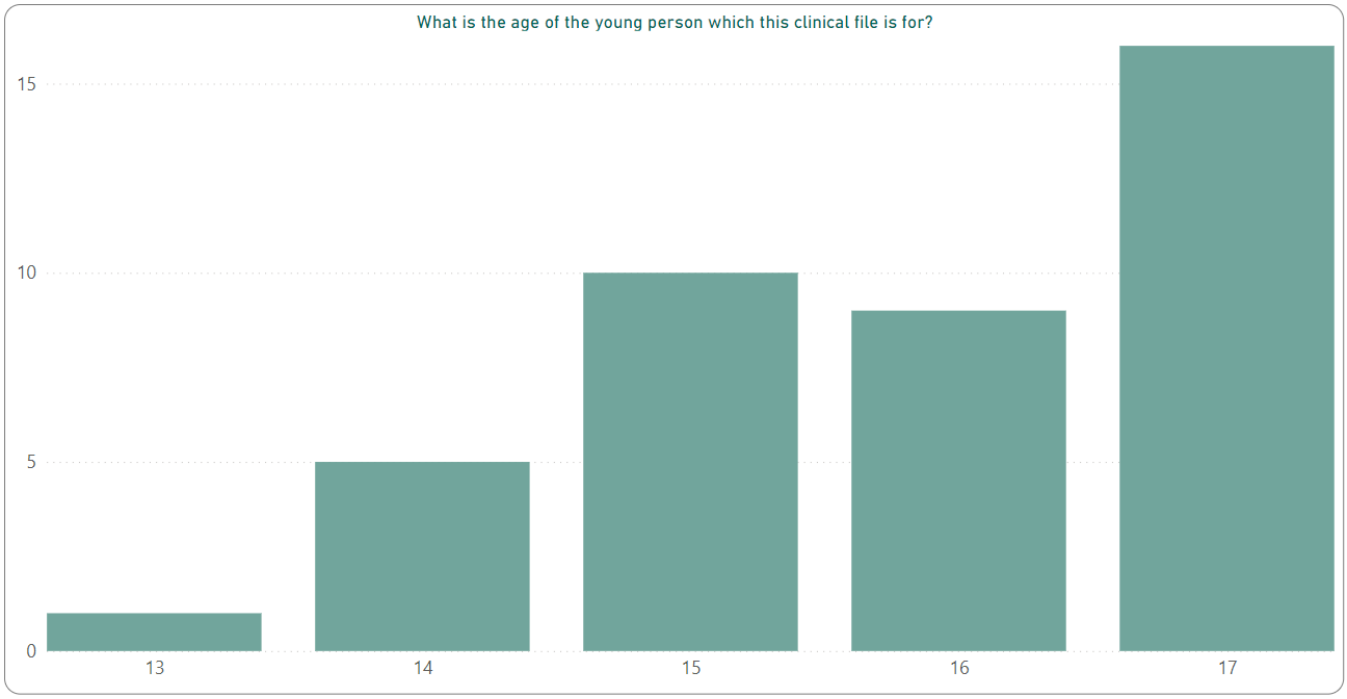
National Diagnoses of Young People in Inpatient Care

Of a total of 42 clinical file reviews, text responses were analysed with the highest number of diagnoses reported as relating to the following areas:

- Disorders, including bipolar, psychotic, schizophrenia and panic disorders;
- Anxiety, including low mood and emotional dysregulation;
- OCD; and
- Suicidal ideation.

The diagnoses which are most prevalent are displayed in larger font size. Of note, 4 young people were diagnosed with **anxiety**, 7 young people were diagnosed with **low mood**, 5 were diagnosed with **OCD** and 5 young people were diagnosed with **psychotic disorder**.

What is the age of this young person?
The average age of young people reported in inpatient care was **15.9** years of age. Of note, 16 years of age was the median response.



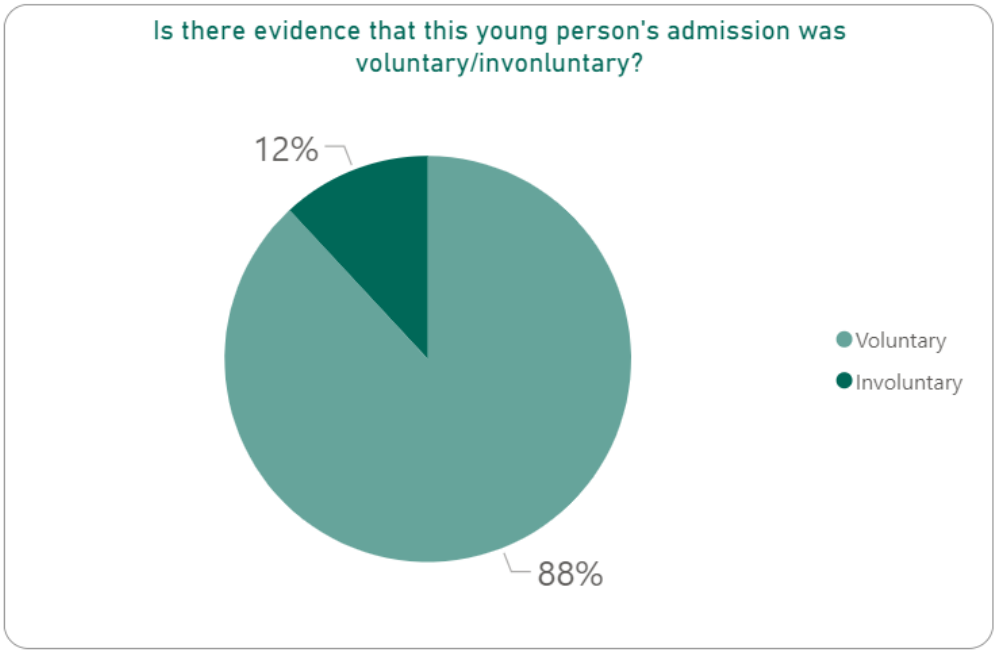
COG National Audit

Response Summary – Other Significant Findings (Inpatient)

Is there evidence that this young person admission was Voluntary/Involuntary?

'Under the Mental Health Act, 2001, as amended, a child is a person under the age of 18 years other than a person who is or has been married. This means that while the child or adolescent's views on a voluntary admission should be sought, consent for admission and treatment can only be given by their parent(s).' and 'Valid consent for admission and treatment must be informed consent. This means that the parent(s) and child have sufficient information to be able to understand the nature of what is proposed and the potential risks and benefits involved.' CAMHS Operational Guidelines.

The following pie chart displays the admission status of young people reviewed. **88% (37)** of clinical files reviewed showed evidence that the young person was **admitted voluntarily**, with **12% (5)** of young people having an **involuntary admission**. The average duration of stay in approved centres for young people whose clinical files were reviewed was **78.7 days**.



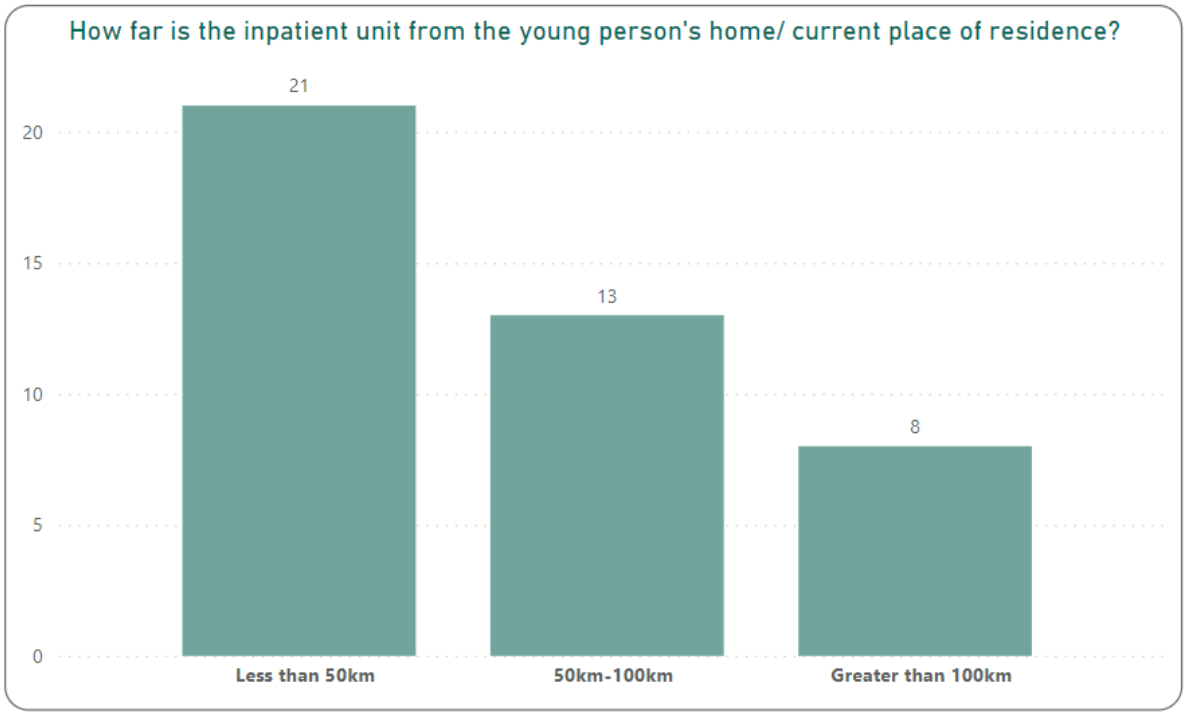
95% Inpatient units reported that the legal status of the young person did not change while admitted.

COG National Audit

Response Summary – Other Significant Findings (Inpatient)

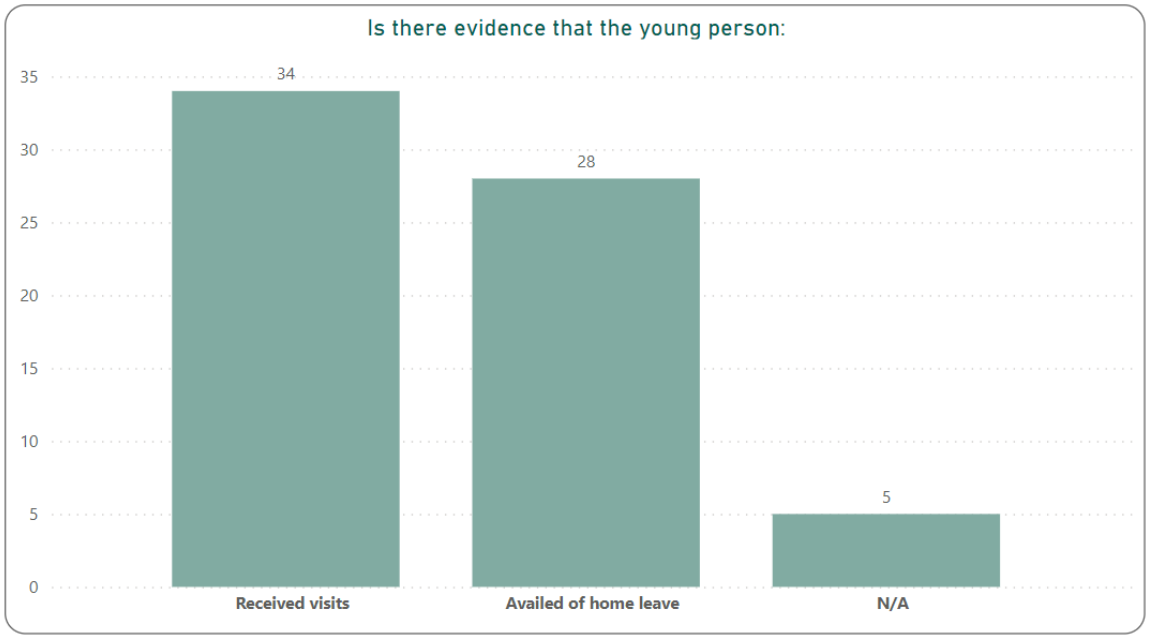
How far is the inpatient unit from the young person's home/ current place of residence?

The below column chart displays the proportion of young people who had to travel less than 50km; 50km-100km; or greater than 100km from their place of residence to reach the inpatient unit. This question was asked to ascertain the number of young people who had to travel a distance for admission to one of the 4 CAMHS regional inpatient units. 60% of the 60 clinical files reviewed showed young people received inpatient care less than 50km from their homes.



Home Leave & Visitation

The below column chart displays the number of clinical files which showed evidence that the young person received visits and/or availed of home leave during their inpatient stay; this was asked as maintaining family relationships is important during an inpatient stay. 87% of young people appear to have received visits while 65% appear to have availed of home leave.

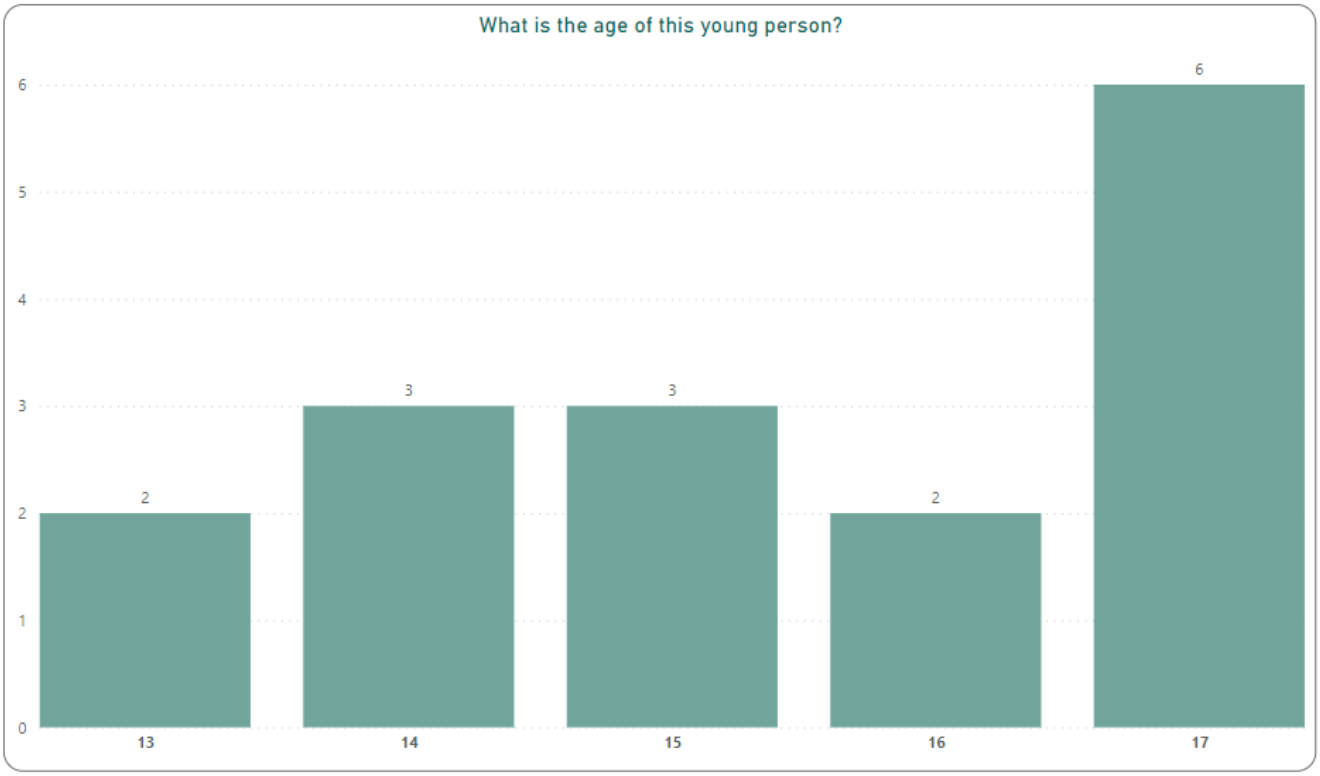


COG National Audit

Response Summary – Other Significant Findings (Inpatient Non-Accepted)

What is the age of the young person whose clinical file was marked as 'Not Accepted'?

The average age of young people whose clinical files were marked as Not Accepted is 15, while the median is 16 years of age.



COG National Audit

Response Summary – Data Limitations

Methodological limitations

The interpretation of the findings and conclusions of this report must be considered in the context of a number of methodological limitations within the national audit on adherence to the COG.

Data collection process
Due to the potential bias in the self-report data collection process applied to this national audit, the approach to responses varied significantly in quality across participating teams, with a number of spoiled responses removed from the dataset. As a result, the reliability and validity of some responses has been impacted, resulting in potentially distorted findings.

Data sources
Some responses submitted were not in the appropriate format relative to the question asked, for example;

- Teams were asked numerically based questions but responded with dates; and
- Invalid responses to questions asked, for example '?' and 'Not Applicable';

Therefore, not all answers provided by teams could be included in the audit data.

Sample Profile
Due to issues relating to the available sample of anonymised service user files across teams, a non-randomised sampling method was applied to the file reviews across all participating teams to facilitate a representative sample of cases.

To overcome this barrier, specific inclusion criteria as outlined previously within this report were designed and applied to all submitted file reviews to facilitate the most representative sample of service users possible across CAMHS nationally.

Some teams were unable to meet the inclusion criteria outlined in the methodology. This resulted in overrepresentation of one or more of the clinical file subgroups relating to age profile and gender. This was not a clinical audit and was designed to assess compliance with operational guidelines and therefore this did not have a significant impact on the findings.

Self-assessment tool
Due to challenges relating to submissions using the online self-assessment tool, a number of paper based responses were submitted. In addition, a number of instances of duplication of files occurred within teams during the audit, requiring a high level of data cleansing.

Out of Hours
Limitations relating to Out of Hours data is discussed on page 73.

COG National Audit

Themes and Issues

Following collation of the data received from all teams involved in the audit, a thematic analysis of responses submitted by teams was conducted. These can be categorised into **5** main themes:

- **Governance;**
- **Staffing/Resources;**
- **Case Flow;**
- **IT Systems;** and
- **Service Provision.**

A combination of these themes can be seen in responses from each CHO, as outlined in the adjacent table.

The most common reoccurring theme across **all** CHOs was that of **staffing/resources** with a lack of staffing reported in **100%** of CHOs. A theme of **service provision** was particularly relevant which was indicated in **100%** of CHOs. Thirdly, **case flow** was documented as an issue across **78%** of CHOs nationally. **Poor IT infrastructure** was reported in **56%** of CHOs**. Governance** was highlighted as a challenge facing CAMHS teams across **44%** of CHOs. These themes will be discussed in detail in this section of the report.

1. Governance

Governance was identified by many teams as a key challenge impacting service delivery. As described in the COG 'Clinical Governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of service users when delivering care'. The following aspects of governance in particular were highlighted by respondents:

- **Lack of clarity around clinical responsibility;**
- **Lack of clarity around clinical decisions;**
- **Developing strategic plans for CAMHS;** and
- **Settling various operational differences that can arise due to the nature of a multi-disciplinary team.**

Some teams reported that the multidisciplinary nature of services provided is conducive to unclear reporting lines (who reports to whom), as each staff member of a specific discipline reports to a manager within their own discipline. It was reported by some CAMHS teams that the discipline specific line manager does not always work within CAMHS and thereby may not have a full understanding of CAMHS operations. Teams reported that these line management structures can lead to ***'confusion regarding reporting lines'*** and may not allow the clinical lead within the CAMHS team to have full oversight of their MDT. In turn, it was reported that disagreements can arise where clinical decisions are needed, potentially leading to difficulty in conflict resolution. As seen previously, teams also submitted organisational structures of their teams which further illustrated a lack of standardisation nationally.

From review of the organograms provided by teams, it is evident that a variety of managerial positions exist within CAMHS teams; for example 'Business Manager' or

Themes Identified per CHO

Governance	CHO 1
	CHO 2
	CHO 3
	CHO 4
	CHO 5
	CHO 7
Staffing/Resources	CHO1
	CHO2
	CHO3
	CHO4
	CHO5
	CHO6
	CHO7
	CHO8
	CHO9
Case Flow	CHO 1
	CHO 2
	CHO 4
	CHO 5
	CHO 6
	CHO 7
	CHO 9
IT Systems	CHO 2
	CHO 3
	CHO 4
	CHO 5
	CHO 8
Service Provision	CHO 1
	CHO 2
	CHO 3
	CHO 4
	CHO 5
	CHO 6
	CHO 7
	CHO 8
	CHO 9

COG National Audit

Themes and Issues

'Administrative Manager' roles are present in some teams but are not present in others. In addition to a lack of clear reporting lines, teams reported that there can be a ***'lack of clarity'*** in relation to the Key Worker role across all disciplines. Respondents reported difficulty in fulfilling key working roles due to the clinical governance structure in their CAMHS team leaving the Key Worker role to one person by default for a high volume of cases. Teams noted that challenges in clarity regarding governance have been ***'mitigated through the good will and cooperation'*** of all involved with individual CAMHS teams.

The lack of a Team Coordinator role was regularly highlighted as a reoccurring issue for many CAMHS teams, with **80%** of teams reporting non-adherence to Section 4.16 in regard to the Team Coordinator role. One responding team reported it was ***'difficult to sustain improvement within the service'*** as they ***'regularly requested a team coordinator'***, but no arrangements for such had been ***'agreed by management'.*** Another team reported that the lack of a team coordinator exacerbated, or delayed solutions to, other issues: ***'The barriers are lack of resources and over stretched clinical services. This kind of initiative would be expected to be organised by a team coordinator or practice manager. We have neither'.***

2. Staffing/Resources

Staff shortages were highlighted by all teams participating in the audit. These staffing issues were reported for clinical and administrative roles, contributing to challenges with waiting lists and appointments. Teams highlighted that this can make following the COG timelines for post-initial assessment follow ups '***difficult to maintain'.*** Several teams made reference to the AVFC model for CAMHS teams with regard to resourcing and how their staff cohort can differ. While AVFC prescribed the composition of CAMHS Teams, StV, in particular Recommendation 32 '*The composition and skill mix of each CMHT, along with clinical and operational protocols, should take into consideration the needs and social circumstances of its sector population and the availability of staff with relevant skills. As long as the core skills are met, there should be flexibility in how the teams are resourced to meet the full range of needs, where there is strong population based needs assessment data*', and the COG, outlined that **CAMHS team composition will vary considering the needs and social circumstances of its sector population.**

AVFC recommended team composition, was previously based on the 2002 census where there was a population of 1,036,752 young people under 18 years of age, which represented 25.9% of the population. There has been a significant growth in population since 2002, with the 2016 census showing a population under 18 of 1,190,502, which is 153,750 more young people under the age of 18 than in 2002. Further growth in population captured in the 2022 census is expected to be 0.93% when census statistics are released in the second quarter of 2023.

Composition of CAMHS Team by Discipline (WTE) as per AVFC (2006) per 50,000 population	
Consultant Psychiatrist	1
NCHD	1
Social Worker	2
Clinical Psychologist	2
Occupational Therapist	1
Speech and Language Therapist	1
Nurse	2
Childcare Worker	1
Administrative Staff	2
Total Staff CAMHS Team	13

To address issues pertaining to resourcing, some CAMHS teams have reported partnering (where possible) with local community and voluntary organisations.

Many teams have found the Key Worker role difficult to fully implement as per the COG, with 36% of teams reporting partial implementation of Section 4.14 'The Key Worker'. A national total of **368 clinical files reviewed** indicated that the young person was not assigned a Key Worker. This was due to ***'chronic staffing issues'*** and ***'the nature of transitioning of inputs within the team'.*** CAMHS teams often found it difficult to implement the COG as clinical staff report not having capacity to do so.

CAMHS teams highlighted that having a Team Coordinator would be hugely beneficial in supporting the team to meet the administrative and organisational requirements of their CAMHS team, with one team adding that the lack of a team coordinator ***'adversely impacts referral responses',*** such as routine response time for patients. This was highlighted to be an issue where teams cannot meet the time frames outlined in the COG due lack of coordination and capacity issues.

A number of CAMHS teams highlighted the ***"inconsistent staffing"*** and ***"high staff turnover"*** as an issue in their teams experience. Teams reported the reasons for turnover as:

- **Burdens placed on staff;**
- **Capacity and lack of time;**
- **Difficulties prioritising clinical work;**
- **Clinical demands;** and
- **Complexity of cases.**

COG National Audit

Themes and Issues

3. Case Flow

The increase in case load numbers and referrals was frequently highlighted as an issue amongst CAMHS teams, with the average waitlist number being **59**. Multiple teams reported a deterioration in service provision due to increased case load numbers. The **average case load reported by CAMHS teams nationally was 246.**

Teams reported that due to a lack of primary care and voluntary mental health services in the community it can be difficult to discharge a young person from CAMHS services in a timely manner, leading to a ***'major problem for CAMHS services and for the patients'*** themselves.

Some teams stated that CAMHS clinicians are sometimes encouraged to undertake assessments through ***'political or complaints-based demands'*** that would ***'more appropriately receive assessment and inputs at primary care level'.***

4. IT Systems

The lack of IT infrastructure is a common issue faced by CAMHS teams, with many teams describing it as '***inadequate***'. Some IT systems in use by CAMHS teams do not allow for shared diaries and appointment tracking, making the sharing of information across an MDT team challenging and time consuming.

Many CAMHS teams are awaiting IT issues to be resolved. Issues reported include ***'some new email addresses do not work with older computers'*** and one team noted that they ***'do not have IT infrastructure at present'.***

Teams highlighted that the use of an IT infrastructure which is not fit for purpose can lead to a lack of adherence with the COG in undertaking reviews, as there is ***'no dedicated fit for purpose database'.***

The response to the audit found that **82%** of files used by CAMHS teams are paper based with **15%** electronic and **3%** were both.

5. Service Provision

Difficulties offering services to young people within the recommended timelines outlined in the COG were highlighted by teams in their responses to the audit questions. Issues around ICP, risk assessments and out of hour arrangements were also emphasised.

Teams reported ***'inadequate staffing levels to fulfil the ICP'*** section of the COG, with **63%** clinical case files audited by community teams having an ICP. '***Reduced MDT work'***, '***lack of training'*** and '***lack of resourcing'*** has made development of ICPs difficult.

40% of clinical files reviewed by community teams did not have a risk management plan in place, with teams reporting difficulty in ***'finding evidence of the plan on file***'. Reasons provided by teams who were not using a formal risk assessment/screening tool included ***'inadequate staff levels and insufficient IT system'.*** Teams also reported no evidence base that formal risk assessment tools are ***'helpful or reduce risk in the adolescent population'***.

32% of community teams offer services out of hours (outside the 9am to 5pm working day), including group facilitation such as '***ADHD and MHID remote clinics in the evenings'*** and ***'Anxiety Management Workshop for Parents was provided out of office hours'.*** However, teams reported signposting emergencies to '***GPs offering out of hours service***' and '***Emergency Departments***'. **60%** of teams providing services to over 18s and **34%** of teams accepting young people who do not meet the criteria for access to CAMHS services. Teams stated that this was due to ***'difficulties accessing external services'*** and ***'delays in accessing community services and their huge waiting lists***'. Teams described that GPs can often be unaware of other more appropriate services available and therefore may direct referrals inappropriately to CAMHS as a result. Limitations regarding the Out of Hours data provided by teams can be reviewed on pg. 94.

The increase in caseload experienced by CAMHS teams, in tandem with the reported lack of sufficient staffing and resourcing, have caused teams to have insufficient capacity to see patients. They report extending their waitlist periods to greater than COG recommended referral response times, with one team reporting their ADHD waiting list as having an ***'average waiting time of 12 months'.***

The COVID-19 pandemic was highlighted as a major contributor to an ***'already stretched'*** service, leading to an ***'exponential increase'*** in referrals and service demands, resulting in teams reporting that they are ***'firefighting to manage the demands on the service'.***

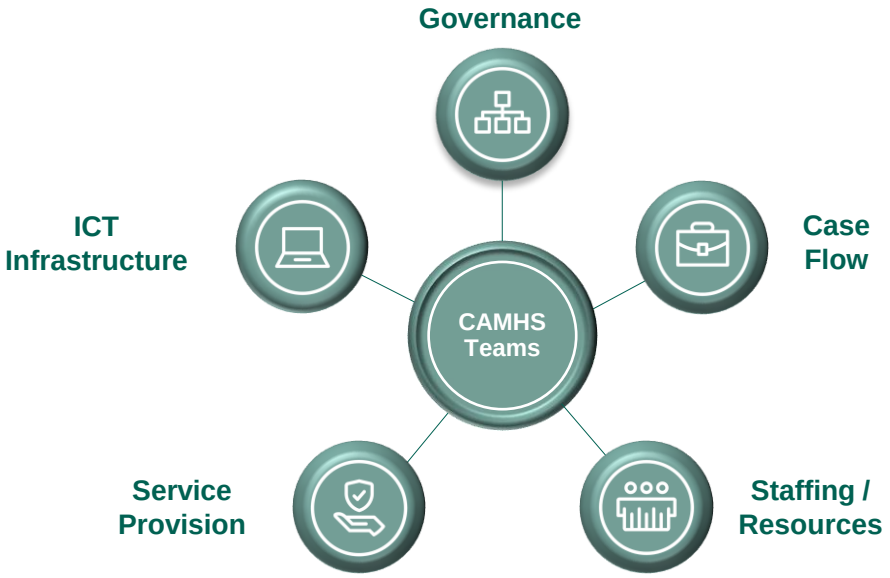
CAMHS Operational Guidelines Recommendations

COG Audit - Recommendations

Recommendation Themes

Recommendations

As discussed, the reported audit of the COG commenced in November 2022 and consisted of a pilot and national audit roll out across **CAMHS teams nationally**, 75 community teams, 2 specialist teams, 1 day hospital and 4 inpatient approved centres. In excess of **3,400 clinical files** were reviewed by community CAMHS teams, and **80 clinical files** were reviewed by inpatient approved centres. Over **80 submissions** were received for the **team question** element of the audit, with many teams participating in group discussions prior to submission. Teams were requested to complete a team questionnaire on a range of service areas such as implementation of the COG, staffing, shared care protocols and case loads. Community teams were asked to complete **50 clinical file reviews** while inpatient units completed **20 clinical file reviews**. These file reviews aimed to measure teams' compliance to the COG in areas such as risk management, key working, ICPs and discharge. A detailed data analysis was conducted of all submissions **including quantitative data mapping and a qualitative thematic analysis** of all text responses received by the expert audit group. As outlined earlier in this report, **5 main themes were identified** in the submissions received from CAMHS teams.



The five themes identified are as follows:

- **Governance** – As per the COG '*Clinical Governance is a framework through which healthcare teams are accountable for the quality, safety and satisfaction of service users when delivering care, it involves having the necessary structures, processes, standards and oversight in place to ensure that safe, person centred and effective services are delivered in CAMHS*';
- **Staffing and Resources** – Appropriate number of skilled persons in post to adequately perform the range of services provided by CAMHS teams to ensure all service user needs are met;
- **Case Flow** – Ensure a dynamic and effective process is in place to optimise the young person's journey through CAMHS;
- **ICT infrastructure** - ICT infrastructure includes hardware, software, networks, facilities, and related equipment, which is used to develop, test, operate, monitor, manage, and support ICT services; and
- **Service Provision** – Ensure services provided to young people and their families are person centered, high quality and timely. Service delivery encompasses effective planning, access to appropriate clinical intervention and robust oversight.

This section of the report will:

- **Outline recommendations for improvement** based on the findings of the audit;
- **Categorise each recommendation** across the 5 themes; and
- **Detail the actions required** to complete the recommendation.

The recommendations outlined in this report have been considered in the context of StV and the Child and Youth Mental Health Service Improvement Programme, and all recommendations and findings will be used to inform the next iteration of the COG. Recommendations provided in this report have been reviewed by the expert audit group, the national oversight group and CHO management. The improvement of mental health supports for children and young people will need a coordinated response involving all aspects of the service, directed by national mental health policy, and supported by multi-annual investment.

COG Audit - Recommendations

Themes and Recommendations

	Themes				
	Governance	Staffing/ Resources	Case Flow	ICT Infrastructure	Service Provision
Recommendation Synopsis	1. Development of a CAMHS stand-alone management structure.	4. Prioritisation of the recruitment of key personnel within CAMHS teams.	5. Review of guidance within the COG regarding the Key Worker role.	6. Ensure appropriate ICT infrastructures have been implemented in each CAMHS team nationally	7. Update guidance on Individual Care Plan within the COG to ensure that every open case would have an agreed documented ICP, which is to be reviewed regularly.
	2. Development of an internal audit framework for CAMHS teams nationally.				8. Development of a policy to standardise out of hours services across CAMHS teams nationally.
	3. Development of Quality Improvement Plans (QIPs) for COG compliance in each CHO.				9. Include clear delineation in the next iteration of COG regarding requirements for risk assessments from clinical and operational perspectives.

COG Audit - Recommendations

Themes and Actions

	Themes				
	Governance	Staffing/ Resources	Case Flow	ICT Infrastructure	Service Provision
Actions	1.1 Standardise governance structures in CAMHS, cognisant of the transition from CHO to Regional Health Areas (RHAs) and all associated structural changes.	4.1 Progress implementation of Team Coordinator function nationally.	5.1 Updated guidance to be included in the next iteration of COG regarding key working allocation.	6.1 Progress implementation of the Integrated Community Case Management System in CAMHS, as part of a comprehensive and integrated ICT solution across community services.	7.1 Incorporate guidance in the next iteration of the COG to improve compliance with agreed documented ICPs for every open case.
	1.2 Develop a shared governance model for implementation by all CAMHS teams.	4.2 Evaluate Practice Manager role in collaboration with CHO areas.		6.2 Identify and support implementation of relevant short-term ICT solutions to support service provision.	8.1 Develop an on-call out of hours policy in conjunction with HR and IR Business Partners to ensure consistent provision of services across CAMHS teams nationally, independent of CHO structures.
	1.3 A standardised template for workforce continuity guidance to ensure effective governance when key members of staff are absent.	4.3 Prioritisation of the recruitment of key personnel in all CAMHS teams, taking into consideration population needs and the availability of staff with relevant skills.			9.1 Develop guidance regarding the content of clinical and operational risk assessments within the next iteration of the COG.
	2.1 Enhancement of self assessment tool and data collection processes to measure compliance and implementation of the requirements of the COG.				
	3.1 Each CHO must develop a Quality Improvement Plan based on the data obtained from the national COG audit.				

COG Audit - Recommendations

1

Theme: Governance
Recommendation 1

Recommendation 1 – Develop a CAMHS stand-alone management structure			
Action 1: Standardise governance structures in CAMHS, cognisant of the transition from CHO to Regional Health Areas (RHAs) and all associated structural changes.			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** Human Resources Department	**Dependencies** Engagement from management at all levels in reorganisation of governance structure Transitioning structure of CHOs to RHAs	**Timeframe** Medium-term
Summary of understanding – our interpretation of what is to be achieved In line with StV Recommendation 25 *'Strengthen the multi-disciplinary CMHT as the cornerstone of service delivery in secondary care through the development and agreed implementation of a shared governance model',* the development of a consistent governance model to CAMHS is required to facilitate appropriate oversight and quality service delivery.			
Inputs / Resources Required. • Assess and review existing governance structures in CAMHS, seeking additional feedback from CAMHS teams as required • Scope and prepare plan for greater standardisation of governance structures, aligned with StV and based on information regarding governance submitted by teams during this audit • Establishment of Governance Planning Group at national level with representatives from CHOs/RHAs • Identify and implement actions to improve governance structure			
Milestones to complete action • Establishment of the Governance Planning Group • Review of the current governance structure • Development of a standardised governance structure			
Outcome indicator • Standardised governance structure across CAMHS teams			

COG Audit - Recommendations

1

Theme: Governance
Recommendation 1

Recommendation 1 – Develop a CAMHS stand-alone management structure			
Action 2: Develop a shared governance model for implementation by all CAMHS teams			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** Governance Planning Group	**Dependencies** Establishment of Governance Planning Group Transitioning structure of CHOs to RHAs	**Timeframe** Long-term
Summary of understanding – our interpretation of what is to be achieved Governance structures will be progressed bringing recommendations of similar themes together under the Mental Health workstream of StV. It is also important to note that the '*Mental Health Act*' (2001) is currently under review. This may have an impact on these recommendations. In line with StV Recommendation 25 *'Strengthen the multi-disciplinary CMHT as the cornerstone of service delivery in secondary care through the development and agreed implementation of a shared governance model',* and Recommendation 33 *'Progress the shared governance arrangements for CMHTs as outlines in AVF 2006-16, including rollout of team coordinators'* a management model that facilitates shared governance should be developed for implementation in CAMHS.			
Inputs / Resources Required • Agreed model regarding intra (within) and inter (between) disciplinary governance			
Milestones to complete action • Draft guidance on standardised governance structures within disciplines outlined in the next iteration of the COG			
Outcome indicator • Guidance is outlined in the next iteration of the COG which indicates required inter disciplinary communication and oversight arrangements			

COG Audit - Recommendations

1

Theme: Governance
Recommendation 1

Recommendation 1 – Develop a CAMHS stand-alone management structure			
Action 3: A standardised template for workforce continuity guidance to ensure effective governance when key members of staff are absent.			
Lead Governance Planning Group	**Supporting partner(s)** Child and Youth Mental Health Office	**Dependencies** Establishment of Governance Planning Group	**Timeframe** Medium-term
Summary of understanding – our interpretation of what is to be achieved Each team will complete a staffing continuity plan to ensure that minimum requirement governance arrangements are maintained in the absence of key personnel required for robust governance.			
Inputs / Resources Required. • Identification of minimum governance requirements to ensure safe and effective service delivery in the absence of key personnel required for robust governance			
Milestones to complete action • Development of a workforce continuity template			
Outcome indicator • Template for workforce continuity available in the next iteration of the COG			

COG Audit - Recommendations

2

Theme: Governance
Recommendation 2

Recommendation 2 – Development of an internal audit framework for CAMHS teams nationally.			
Action 1: Enhancement of self assessment tool and data collection processes to measure compliance and implementation of the requirements of the COG.			
Lead Quality and Patient Safety	**Supporting partner(s)** Governance Planning Group	**Dependencies** Establishment of Governance Oversight Group	**Timeframe** Medium-term
Summary of understanding – our interpretation of what is to be achieved To ensure adherence to the COG is maintained, services should carry out self assessments on aspects of the COG at designated intervals annually. Corrective actions should be identified to address areas of non adherence to the next iteration of the COG. Findings from the self assessment to inform quality improvement plans.			
Inputs / Resources Required • Review of current COG self assessment tool • Draft revised COG self assessment • Resourcing hours required			
Milestones to complete action • Development of a revised COG self assessment tool • Development of a schedule of self assessments			
Outcome indicator • Next iteration of the COG to include enhanced self assessment tool for application in routine practice			

COG Audit - Recommendations

3

Theme: Governance
Recommendation 3

Recommendation 3 – Development of Quality Improvement Plans (QIP)			
Action 1: Each CHO must develop a Quality Improvement Plan based on the data obtained from the National Audit of Adherence to the COG.			
Lead Chief Officers/ Community Health Organisations	**Supporting partner(s)** Child and Youth Mental Health Office	**Dependencies** Availability of resources to develop QIP Transitioning structure of CHOs to RHAs	**Timeframe** Short-term
Summary of understanding – our interpretation of what is to be achieved Data will be provided to each CHO/RHA regarding their performance within the audit by the Community Mental Health Operations team. A quality improvement plan must be developed to address areas of non compliance. Actions must be time bound and plans to be submitted to senior management team to monitor progress at specific intervals.			
Inputs / Resources Required • Data analytics from this self reported audit • Resourcing hours required to develop the QIP • QIP template to be provided to teams following publication of the report			
Milestones to complete action • CHO/RHA completion of their QIP			
Outcome indicator • QIPs are completed and submitted			

COG Audit - Recommendations

4

Theme: Staffing/Resources
Recommendation 4

Recommendation 4 – Prioritisation of the recruitment of Key Personnel within CAMHS teams.			
Action 1: Progress implementation of Team Coordinator function nationally.			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** HSE Human Resources HSE Finances Community Health Organisations	**Dependencies** HSE Recruitment Operating Model HSE Funding availability Engagement with recruitment campaign	**Timeframe** Medium/Long-term
Summary of understanding – our interpretation of what is to be achieved In line with StV Recommendation 33 *'Progress the shared governance arrangements for CMHTs as outlines in AFVC 2006-16, including further rollout of team coordinators*' and the Maskey Report Recommendation 6 '*Recruit a Team Coordinator to support the process of tracking quality standards and performance for the team. The Team Coordinator should also be a member of the CAMHS Governance Group so that there is a direct link from the team into the management structure.*', teams must progress the implementation of the Team Coordinators function nationally to support tracking of quality standards and performance for CAMHS teams.			
Inputs / Resources Required • Incorporate learning from previous service improvement projects in this area • Preparation of a delivery plan for the implementation of the Team Coordinator function nationally, including clear, timed and measurable actions to address any gaps identified • Informed by the National Audit of Adherence to the COG, conduct a review of implementation of the Team Coordinator function • Evaluation of Team Coordinator role in all CHOs • Funding availability			
Milestones to complete action • Consistent access and approach to team coordination across all CAMHS teams			
Outcome indicator • Access to team coordinator in all CAMHS teams			

COG Audit - Recommendations

4

Theme: Staffing/Resources
Recommendation 4

Recommendation 4 – Prioritisation of the recruitment of Key Personnel within CAMHS teams.			
Action 2: Evaluate Practice Manager role in collaboration with CHO areas.			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** HSE Human Resources HSE Finances Community Health Organisations	**Dependencies** HSE Recruitment Operating Model HSE Funding availability Engagement with recruitment campaign	**Timeframe** Long-term
Summary of understanding – our interpretation of what is to be achieved In line with Maskey Report Recommendation 7 *'Recruit a Practice Manager to review and improve current working practices within the team. Lean processes should be implemented to ensure staff are working efficiently in their area of expertise. This is complementary to the Team Coordinator post.'* evaluation of the need for the Practice Manager role nationally.			
Inputs / Resources Required • Prepare and agree evaluation framework, including process for a collection of data • Collaborate with CHO 4 to collate and analyse findings with a view to assessing the impact of the Practice Manager function • Summarise findings, including the relevance for other CHO areas • Funding availability			
Milestones to complete action • Evaluation of Practice Manager role, including recommendations for further national roll-out			
Outcome indicator • Consistent approach to implementation of Practice Manager functions			

COG Audit - Recommendations

4

Theme: Staffing/Resources
Recommendation 4

Recommendation 4 – Prioritisation of the recruitment of Key Personnel within CAMHS teams.			
Action 3: Prioritisation of the recruitment of key personnel in all CAMHS teams taking into consideration population needs and the availability of staff with relevant skills			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** HSE Human Resources HSE Finances Community Health Organisations	**Dependencies** HSE Recruitment Operating Model HSE Funding availability Engagement with recruitment campaign	**Timeframe** Long-term
Summary of understanding – our interpretation of what is to be achieved *'Strategic development and workforce planning will continue with further expansion of national datasets that will support services in developing and expanding workforce and enable an analytic and proactive approach to staffing needs of services*'. – StV, Policy Implementation Status Report Quarter 1. Work will continue to develop, support, retain and expand the Mental Health workforce to ensure the continued provision of quality healthcare. This is in line with StV recommendation 32 *'The composition and skill mix of each CMHT, along with clinical and operational protocols, should take into consideration the needs and social circumstances of its sector population and the availability of staff with relevant skills. As long as the core skills of CMHTs are met, there should be flexibility in how the teams are resourced to meet the full range of needs, where there is strong population based needs assessment data'.*			
Inputs / Resources Required • National and Local workforce planning • Resource allocation • Funding availability			
Milestones to complete action • Successful recruitment of all identified posts. • Review of retention of existing staff			
Outcome indicator • Required posts filled			

COG Audit - Recommendations

5

Theme – Case Flow
Recommendation 5

Recommendation 5 – Review of guidance within the COG regarding the Key Worker role.			
Action 1: Updated guidance to be included in the next iteration of COG regarding key working allocation.			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** Mental Health Engagement and Recovery	**Dependencies**	**Timeframe** Medium-term
Summary of understanding – our interpretation of what is to be achieved In line with StV Recommendation 28 '*All services should have a mutually agreed Key Worker from the CMHT to facilitate coordination and personalisation of services in line with their co-produced recovery plan*', and the Maskey Report Recommendation 11, '*The CAMHS teams should implement the Key Worker role for all cases*', guidance to be outlined in the next iteration of the COG regarding key working allocation to ensure role can be fulfilled to a meaningful extent, cognisant that the complexity of support required will vary from person to person.			
Inputs / Resources Required • Review current practice across CMHTs concerning key working in line with best practice guidance for Mental Health Services			
Milestones 2024 • Findings of review relating to key working to be incorporated in the next iteration of the COG, in line with best practice.			
Outcome indicator • Updated guidance outlined in the next iteration of the COG regarding the assignment of all service users to a Key Worker			

COG Audit - Recommendations

6

Theme: ICT Infrastructure
Recommendation 6

Recommendation 6 – Ensure appropriate ICT infrastructures have been implemented in each CAMHS team nationally.			
Action 1: Progress implementation of the Integrated Community Case Management System (ICCMS) in CAMHS, as part of a comprehensive and integrated ICT solution across community services.			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** EHealth	**Dependencies** ICT system suitability Funding availability	**Timeframe** Medium –term
Summary of understanding – our interpretation of what is to be achieved In line with the Maskey Report Recommendation 86, '*A national mental health information system should be implemented within three years to report on the performance of health and social care services in line with this policy*', all teams should have access to a case management system which will support effective case and resource management.			
Inputs / Resources Required • Detailed ICT review across CAMHS • Continue project group within EHealth • Provide resources to lead on review and development of ICCMS • Ensure Mental Health Operations representation on ICCMS working groups • EHealth to support the implementation of an Interim ICT solution for CAMHS teams nationally.			
Milestones to complete action • Procurement of ICT infrastructure, including training and implementation • Continue to develop and deliver on the vision for an integrated case management system • Explore prioritisation of CAMHS in the roll-out of ICCMS combined with targeted short-term digital enhancements			
Outcome indicator • All services have access to case management system			

COG Audit - Recommendations

6

Theme: ICT Infrastructure
Recommendation 6

Recommendation 6 – Ensure appropriate ICT infrastructures have been implemented in each CAMHS team nationally.			
Action 2: Identify and support implementation of relevant short-term ICT solutions to support service provision			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** EHealth/OoCIO	**Dependencies** ICT system suitability Funding availability	**Timeframe** Medium-term

Summary of understanding – our interpretation of what is to be achieved

In line with the Maskey Report Recommendation 12, '*The members of the CAMHS Governance Group should agree and implement a clinical diary and case management system to track appointments and case allocation*.', all teams should have access to a case management system which will support effective case and resource management. This was also a recommendation from the Mental Health Commission and the Prescribing Practice Audit.

Inputs / Resources Required

- Assessment of current ICT landscape in CAMHS, including existing solutions in place and known ICT developments in progress within CAMHS. Interim ICT solutions to be assessed where there is no solution in place
- Detailed ICT review across CAMHS
- Procurement procedure
- System suitability testing
- Training

Milestones to complete action

- Targeted short-term digital enhancements, including consistent use of electronic shared team diaries, online clinic databases built around episodes of care (e.g. cloud based Excel/Access), electronic transcription software, e-referral, prioritised migration to HealthIRL etc.
- Prepare for roll-out of ICCMS in CAMHS

Outcome indicator

- All services have access to ICT systems

COG Audit - Recommendations

7

Theme: Service Provision
Recommendation 7

Recommendation 7 – Update guidance on Individual Care Plan within the COG to ensure that every open case would have an agreed documented ICP, which is to be reviewed regularly.			
Action 1: Incorporate guidance in the next iteration of the COG to improve compliance with agreed documented ICPs for every open case.			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** Mental Health Engagement and Recovery	**Dependencies**	**Timeframe** Long-term
Summary of understanding – our interpretation of what is to be achieved In line with the Maskey Report Recommendation 30, '*Treatment and care plans for all children should be updated regularly in consultation with the patient and their parents/guardians. All updates should be communicated with the referring clinician.',* guidance on ICPs outlined within the COG, to be updated to ensure that every open case has an agreed documented ICP which is communicated with referring clinician.			
Inputs / Resources Required • Prepare up-dated guidance on ICPs, based on current best practice • Audit tool to be developed • Audit schedule to be developed • Peer auditor training • Incorporation of young person's feedback regarding updates to ICPs			
Milestones to complete action • New Guidance on ICPs based on current best practice • Audit tool developed and implemented • Audit schedule developed and implemented • Peer auditor training delivered			
Outcome indicator • Updated guidance on ICP requirements reflected in next iteration of the COG			

COG Audit - Recommendations

8

Theme – Service Provision
Recommendation 8

Recommendation 8 – Development of a policy to standardise out of hours services across CAMHS teams nationally.			
Action 1: Develop an on-call out of hours policy in conjunction with HR and IR Business Partners to ensure consistent provision of services across CAMHS teams nationally, independent of CHO structures.			
Lead Child and Youth Mental Health Office	**Supporting partner(s)** Human Resources	**Dependencies** CAMHS Hubs pilot outcomes Resource capacity	**Timeframe** Long-term
Summary of understanding – our interpretation of what is to be achieved In line with StV Recommendation 35 *'A comprehensive specialist mental health out of hours response should be provided for children and adolescents in all geographical areas. This should be developed in addition to current ED services.',* an on-call out of hours policy is to be developed and implemented across CAMHS teams nationally. This is to ensure all service users have access to consistent provision of services irrespective of location.			
Inputs / Resources Required • Resource allocation • Assess requirements for a comprehensive out-of-hours response service, in collaboration with the children and young people work stream for StV. This work should be aligned with the ongoing roll-out of CAMHS Hubs			
Milestones to complete action • Development of policy for on-call out of hours service			
Outcome indicator • Policy for out of hours service provision for CAMHS developed and implemented			

COG Audit - Recommendations

9

Theme – Service Provision
Recommendation 9

Recommendation 9 – Include clear delineation in the next iteration of COG regarding requirements for risk assessments from clinical and operational perspectives.			
Action 1: Develop guidance regarding the content of clinical and operational risk assessments within the next iteration of the COG.			
Lead Quality and Patient Safety	**Supporting partner(s)** Office of Youth Mental Health	**Dependencies** Resources	**Timeframe** Medium-term
Summary of understanding – our interpretation of what is to be achieved Clear delineation on risk assessments in the next iteration of the COG based on current best-practice evidence.			
Inputs / Resources Required • Identify best-practice in the clinical risk-assessment • Draft guidance regarding content of clinical and operational risk assessments in COG			
Milestones to complete action • Clear guidance on clinical and operational risk assessments included within the next iteration of the COG			
Outcome indicator • Clear guidance on clinical and operational risk assessments outlined within the next iteration of the COG			

COG Implementation Roadmap

Implementation Roadmap

Implementation Roadmap

Implementation Roadmap Overview

To assist in the implementation of the recommendations and their corresponding actions, a high level roadmap for the next two years has been developed.

The roadmap details a proposed timeline to deliver each of the recommendations and their corresponding actions based on the outcomes of the audit of adherence to the COG between 2023 - 2025.

The roadmap on the following page is divided into fourteen actions and their associated inputs required to realise all of the outlined recommendations within this report.

The recommendations appear as bars depicting the proposed amount of time over the next two years required to deliver these elements of the report recommendations.

Actions, milestones and outcome indicators
The implementation roadmap shows the actions needing to be completed in order to deliver each recommendation. An outcome indicator has been defined for each action. The outputs will be used to evaluate the performance of the implementation plan over the next two years.

Timeline
Each action has been assigned an estimated start and end date, and is represented on an implementation timeline. It should be noted that the timescales provided are based on the understanding of current circumstances and could be subject to change. Therefore, the timescale offers an approximate indication as to how long each action may take, and the order in which they should be implemented.

Lead
To ensure responsibility and accountability, a lead has been assigned to each action. This provides an indication of the department responsible for the delivery of the action, thus ensuring accountability of the delivery of each recommendation.

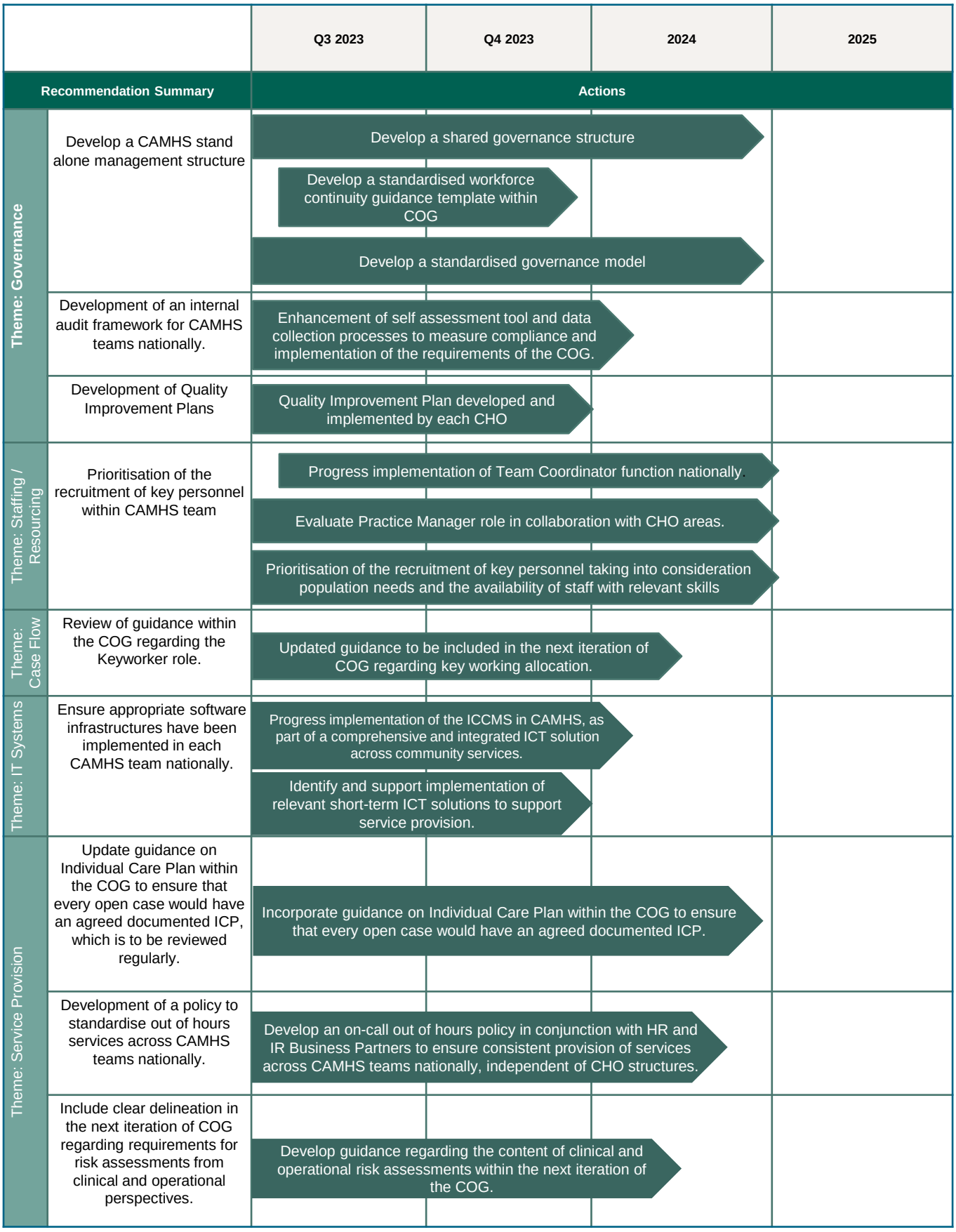
Effort
The suggested 'effort' rating is an estimated level of the effort required to implement each action. In order to have a consistent approach to scoring the recommendations, the definitions outlined have been used to rank the level of effort and impact accordingly, in line with perceived current capacity and capability.

Effort	Definition
○	**Minimal effort** required to implement, and skills or processes to enable are available within the existing capabilities of the organisation. Could be implemented in a short space of time with little or no impact on capacity.
◔	**Minor effort** required to implement internally or with support from an external party with minimal impact on capacity.
◑	**Moderate effort** required with some potential recruitment of additional staff or support from external parties. Could be implemented with some dedicated staff capacity.
◕	**Considerable effort** required with recommended recruitment of additional staff or support from external parties, requiring one or more full-time staff to deliver, using some specialist skills. Likely a discrete project.
●	**Significant effort** required, requiring a team with specialist skills. Long term implementation and likely a discrete project.

Impact	Definition
●	Minor benefits that are not measurable individually, but collectively make a noticeable difference to efficiency, risk/controls, or insight/decision making.
●	Individually recognisable benefits that make noticeable impacts across efficiency, control or insight.
●	Significant, traceable benefits.

Implementation Roadmap

Implementation Roadmap



COG - Implementation Roadmap

Recommendation 1: Develop a CAMHS stand-alone management structure

Action 1.1: Standardise governance structures in CAMHS, cognisant of the transition from CHO to Regional Health Areas (RHAs) and all associated structural changes.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
1.1.1	Assess and review existing governance structures in CAMHS			Medium-term	Q3 2023	Q4 2024	Child and Youth Mental Health Office	Standardised organisational structure across CAMHS teams
1.1.2	Scope and prepare plan for greater standardisation of governance structure, aligned with StV and based on information regarding governance submitted but teams during this audit			Medium-term	Q3 2023	Q4 2024	Child and Youth Mental Health Office	Plan for standardisation of governance structure
1.1.3	Establishment of a Governance Planning Group			Short-term	Q3 2023	Q4 2023	Child and Youth Mental Health Office	Governance Planning Group established
1.1.4	Identify and implement actions to improve governance structure			Medium-term	Q3 2023	Q4 2025	Child and Youth Mental Health Office	Standardised organisational structure across CAMHS teams

Recommendation 1: Develop a CAMHS stand-alone management structure

Action 1.2: Develop a shared governance model for implementation by all CAMHS teams

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
1.2.1	Agreed model regarding intra and inter disciplinary governance			Short-term	Q3 2023	Q4 2023	Child and Youth Mental Health Office	Guidance is outlined in the next iteration of the COG which indicates required inter disciplinary communication and oversight arrangements

COG - Implementation Roadmap

Recommendation 1: Develop a CAMHS stand-alone management structure

Action 1.3: A standardised template for workforce continuity guidance within the COG to ensure effective governance when key members of staff are absent or posts are vacant.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
1.3.1	Identification of minimum governance requirements to ensure safe and effective service delivery in the absence of key personnel	◔	●	Medium-term	Q4 2023	Q4 2024	Youth Mental Health Office	Template for workforce continuity available in the next iteration of the COG

Recommendation 2: Development of an internal audit framework for CAMHS teams nationally.

Action 2.1: Enhancement of self assessment tool and data collection processes to measure compliance and implementation of the requirements of the COG.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
2.1.1	Review of current COG self assessment tool	◔	●	Medium-term	Q3 2023	Q1 2024	Quality and Patient Safety	Current COG self-assessment tool reviewed, with specific elements identified for development in next iteration
2.1.2	Draft revised COG self assessment	◔	●	Medium-term	Q3 2023	Q1 2024	Quality and Patient Safety	Revised COG self-assessment tool and schedule of self-assessment developed

Recommendation 3: Development of Quality Improvement Plans (QIP)

Action 3.1: Each CHO must develop a Quality Improvement Plan based on the data obtained from the National COG Audit.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
3.1.1	Data analytics from the audit of adherence with the COG	◑	●	Short-term	Q3 2023	Q4 2023	Chief Officers/ Community Health Organisations	Findings of audit to inform Quality Improvement Plans for each individual CHO
3.1.2	Resourcing hours required to develop QIP	◑	●	Short-term	Q3 2023	Q4 2023	Chief Officers/ Community Health Organisations	Internal staff capacity assigned to address QIPs in each individual CHO
3.1.3	QIP high-level template to be provided	◑	●	Short-term	Q3 2023	Q4 2023	Chief Officers/ Community Health Organisations	QIP developed

COG - Implementation Roadmap

Recommendation 4: Prioritisation of the recruitment of Key Personnel within CAMHS teams.

Action 4.1: Progress implementation of Team Coordinator function nationally.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
4.1.1	Incorporate learning from previous service improvement projects in this area	◑	🔴	Short-term	Q3 2023	Q4 2023	Child and Youth Mental Health Office	Lessons learned incorporated
4.1.2	Preparation of a delivery plan for the implementation of the Team Coordinator function nationally, including clear, timed and measurable actions to address any gaps identified	◕	🔴	Long-term	Q3 2023	Q4 2024	Child and Youth Mental Health Office	Delivery plan developed
4.1.3	Informed by the national audit of adherence to COG, conduct a review of implementation of Team Coordinator function	◑	🔴	Short-term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Findings relating to the Team Coordinator function published
4.1.4	Evaluation of Team Coordinator role in CHO4 with the intent for national roll out	◑	🟢	Short-term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Team Coordinator evaluation complete
4.1.5	Funding availability	●	🔴	Long-term	Q3 2023	Q4 2024	Child and Youth Mental Health Office	Funding assigned for Team Coordinator roles as required

COG - Implementation Roadmap

Recommendation 4: Prioritisation of the recruitment of Key Personnel within CAMHS teams.

Action 4.2: Evaluate Practice Manager role in collaboration with CHO areas.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
4.2.1	Prepare and agree evaluation framework, including process for a collection of data	◑	🔴	Short-term	Q3 2023	Q4 2023	Child and Youth Mental Health Office	Process in place for collection of data
4.2.2	Collaborate with CHO 4 to collate and analyse findings with a view to assess impact of Practice Manager function	◑	🟢	Short-term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Findings relating to the Practice Manager function published
4.2.3	Summarise findings, including relevance for other CHO areas	◑	🟢	Short-term	Q3 2023	Q4 2023	Child and Youth Mental Health Office	Findings relating to the Practice Manager function published
4.2.4	Funding availability	●	🔴	Long-term	Q3 2023	Q4 2024	Child and Youth Mental Health Office	Funding assigned for currently vacant roles across required teams

Recommendation 4: Prioritisation of the recruitment of Key Personnel within CAMHS teams.

Action 4.3**:** Prioritisation of the recruitment of key personnel taking into consideration population needs and the availability of staff with relevant skills

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
4.3.1	Local workforce planning	◑	🟢	Short-term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Local Workforce plan
4.3.2.	Resource allocation.	●	🔴	Long-term	Q3 2023	Q4 2024	Child and Youth Mental Health Office	Resources identified and allocated
4.3.3	Funding availability	●	🔴	Long-term	Q3 2023	Q4 2024	Child and Youth Mental Health Office	Funding assigned for currently vacant roles across CAMHS nationally

COG - Implementation Roadmap

Recommendation 5: Review of guidance within the COG regarding the Key Worker role.

Action 5.1: Updated guidance to be included in the next iteration of COG regarding key working allocation.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
5.1.1	Review current practice across CMHTs concerning key working in line with best practice guidance for Mental Health Services.	◔	●	Medium-term	Q3 2023	Q2 2024	Child and Youth Mental Health Office	Updated guidance outlined in the next iteration of the COG regarding the assignment of service users to a mutually agreed Key Worker

Recommendation 6: Ensure appropriate software infrastructures have been implemented in each CAMHS team nationally.

Action 6.1: Progress implementation of the Integrated Community Case Management System (ICCMS) in CAMHS, as part of a comprehensive and integrated ICT solution across community services.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
6.1.1	Detailed ICT review across CAMHS	◑	●	Medium - term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Report of current ICT systems in place
6.1.2	Continue project group with OoCIO/ Sláintecare	◑	●	Medium - term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Continued development of an integrated case management system
6.1.3	Provide resource to lead on review and development of ICCMS	◑	●	Medium - term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Resource in post to lead
6.1.4	Ensure Mental Health Operations representation on ICCMS working groups	◑	●	Medium - term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Representation on IICMS working groups

COG - Implementation Roadmap

Recommendation 6: Ensure appropriate software infrastructures have been implemented in each CAMHS team nationally.

Action 6.2: Identify and support implementation of relevant short-term ICT systems to support service provision.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
6.2.1	Assessment of current ICT landscape in CAMHS, including existing solutions in place and known ICT developments in progress within CAMHS	◑	●	Medium-term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	Review of current ICT landscape
6.2.2	ICT review and procurement of ICT infrastructure	◑	●	Medium-term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	New ICT infrastructure procedure for CAMHS at national level
6.2.3	System suitability testing	◑	●	Medium-term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	All services tested for system suitability
6.2.4	Training	◑	●	Medium-term	Q3 2023	Q1 2024	Child and Youth Mental Health Office	All services have training to case management system

Recommendation 7: Update guidance on Individual Care Plan within the COG to ensure that every open case would have an agreed documented ICP to be reviewed regularly.

Action 7.1: Incorporate guidance in the next iteration of the COG to improve compliance with agreed documented ICPs for every open case.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
7.1.1	Prepare up-dated guidance on ICPs, based on current best practice	◑	●	Medium-term	Q3 2023	Q2 2024	Child and Youth Mental Health Office	New guidance on ICPs
7.1.2	Audit tool to be developed	◑	●	Medium-term	Q3 2023	Q2 2024	Child and Youth Mental Health Office	Audit tool developed
7.1.3	Audit schedule to be developed	◔	●	Medium-term	Q3 2023	Q2 2024	Child and Youth Mental Health Office	Audit schedule in place
7.1.4	Peer auditor training	◑	●	Medium-term	Q3 2023	Q2 2024	Child and Youth Mental Health Office	Peer auditing training rolled out

COG - Implementation Roadmap

Recommendation 8: Standardise out of hours service provision across CAMHS teams nationally. .

Action 8.1: Develop an on-call out of hours policy in conjunction with HR and IR Business Partners to ensure consistent provision of services across CAMHS teams nationally, independent of CHO structures.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
8.1.1	Resource allocation			Medium-term	Q3 2023	Q3 2024	Child and Youth Mental Health Office	Resources allocated
8.1.2	Assess requirements for a comprehensive out-of-hours response service, in collaboration with the Children and Young People work stream for StV. This work should be aligned with the ongoing roll-out of CAMHS Hubs			Medium-term	Q3 2023	Q4 2023	Child and Youth Mental Health Office	Collaboration with Children and Young People work stream

Recommendation 9: Include clear delineation in the next iteration of COG regarding requirements for risk assessments from clinical and operational perspectives.

Action 9.1: Develop guidance regarding the content of clinical and operational risk assessments within the next iteration of the COG.

Input		Effort	Impact	Timeframe	Proposed Start Date	Proposed End Date	Lead	Output
9.1.1	Identify best-practice in the clinical risk-assessment			Short-term	Q3 2023	Q4 2023	Child and Youth Mental Health Office	Risk Assessment Working Group established
9.1.2	Draft guidance regarding content of clinical and operational risk assessments in COG			Medium-term	Q3 2023	Q2 2024	Child and Youth Mental Health Office	Guidance regarding content of clinical and operational risk assessments included in COG

Appendices

Appendix A: Acronyms

List of Acronyms used throughout this Document:

Acronym	
ADHD	Attention Deficit Hyperactivity Disorder
AMHS	Adult Mental Health Service
ASD	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Services
CHO	Community Health Organisation
COG	CAMHS Operational Guidelines
ED	Emergency Department
FAQs	Frequently Asked Questions
GP	General Practitioner
HR	Human Resource
HSE	Health Service Executive
ICP	Individual Care Plan
ICT	Information and Communication Technologies
IT	Information Technology
MDT	Multi-Disciplinary Team
MHID	Mental Health Intellectual Disability
NA	Not Applicable
NCHD	Non Consultant Hospital Doctor
OCD	Obsessive Compulsive Disorder
QIP	Quality Improvement Plan
OoCIO	Office of the Chief Information Officer
SOP	Standard Operating Procedure
StV	Sharing the Vision
AVFC	A Vision for Change
WTE	Whole Time Equivalent

Appendix B: Audit Timeline

Step	Action	Action Owner	Status	2022									
				Sept.				Oct.					Nov.
				5th	12th	19th	26th	3rd	10th	17th	24th	31th	7th
Development of Bespoke Audit Framework	Mapping of Maskey Recommendations and the CAMHS Operational Guidelines	Expert Audit Group	Complete										
	Development of Audit Questions	Expert Audit Group	Complete										
	Creation of Audit Dashboard (COB 17th)	Expert Audit Group	Complete										
	Presentation of Draft Audit Question (11th Oct.)	Expert Audit Group	Complete										
	Feedback of Draft Audit Question	Audit Development Working Group	Complete										
	Feedback incorporated into Audit Questions	Expert Audit Group	Complete										
	Sign Off of Audit Questions	Audit Development Working Group	Complete										

Step	Action	Action Owner	Status	2022					
				Oct.	Nov.				Dec.
				31th	7th	14th	21st	28th	5th
Piloting and Agreement of Final Audit Framework and Approach	Identification of sample CAMHS Teams for pilot, to examine the feasibility of the audit tool in terms of the content and usage	Audit Development Working Group	Complete						
	Draft Audit survey link shared	Expert Audit Group	Complete						
	Training of the sample CAMHS Teams for usage of the proposed audit (Webinars, focus groups and 1:1 support)	Expert Audit Group	Complete						
	Pilot Audit issued to sample CAMHS Teams (11th Nov.12pm)	Expert Audit Group	Complete						
	Support offered (Check in calls), reminders issued (frequency x2 times/week)	Expert Audit Group	Complete						
	Return of Pilot Audit from sample CAMHS Teams (COB 30th Nov.)	Expert Audit Group	Complete						
	Webinar with Senior Management Team	Expert Audit Group	Complete						
	Incorporation of feedback from Pilot Audit into Audit Questions	Expert Audit Group	Complete						
	Draft Audit Questions for review	Oversight Group	Complete						
	Incorporation of feedback from Oversight group into Audit Questions	Expert Audit Group	Complete						
	Final sign off of audit questions prior to national roll out	Oversight Group	Complete						
	Training commenced for remaining CAMHS Teams	Expert Audit Group	Complete						
	Training for all CHOs (Webinar)	Expert Audit Group	Complete						
	Additional training if required by CHO (Focus Groups/Webinar)	Expert Audit Group	Complete						

Step	Action	Action Owner	Status	2022					
				Dec.				Jan.	
				5th	12th	19th	26th	2nd	9th
Self Assessment against Audit Framework	Audit issued to CAMHS Teams (5th Dec)	Expert Audit Group	Complete						
	Reminders issued to Teams twice weekly (Mondays and Thursday, commencing 5th Dec.)	Expert Audit Group	Complete						
	Audit returned by CAMHS Team (by COB 16th Jan.)	Expert Audit Group	Complete						

Appendix B: Audit Timeline

Step	Action	Action Owner	Status	2023				
				January				
				2nd	9th	16th	23rd	30th
Analysis of Self-Assessments	Collating data received	Expert Audit Group	Complete					
	Analysis of returned assessments and supporting documents	Expert Audit Group	Complete					
	Follow up with CAMHS Teams where additional information is required	Expert Audit Group	Complete					
	Findings will indicate the need for site visits in priority levels	Expert Audit Group	Complete					

Step	Action	Action Owner	Status	2023	
				January	
				2nd	9th
Completion of site visits	Further examination and information gathering of factors effecting compliance at site visits and stakeholder consultations via phone/email	Expert Audit Group	Complete		

Step	Action	Action Owner	Status	2023			
				Q1	Q2	Q3	Q4
Development of National Report	Development of first draft to include ratings of compliance, risk and impact for each CAMHS team.	Expert Audit Group	Complete				
	Sharing of the report to the Oversight group and Implementation lead	Oversight Group	Complete				
	Incorporation of feedback into final draft	Expert Audit Group	Complete				
	Final Audit Report	Expert Audit Group	Complete				

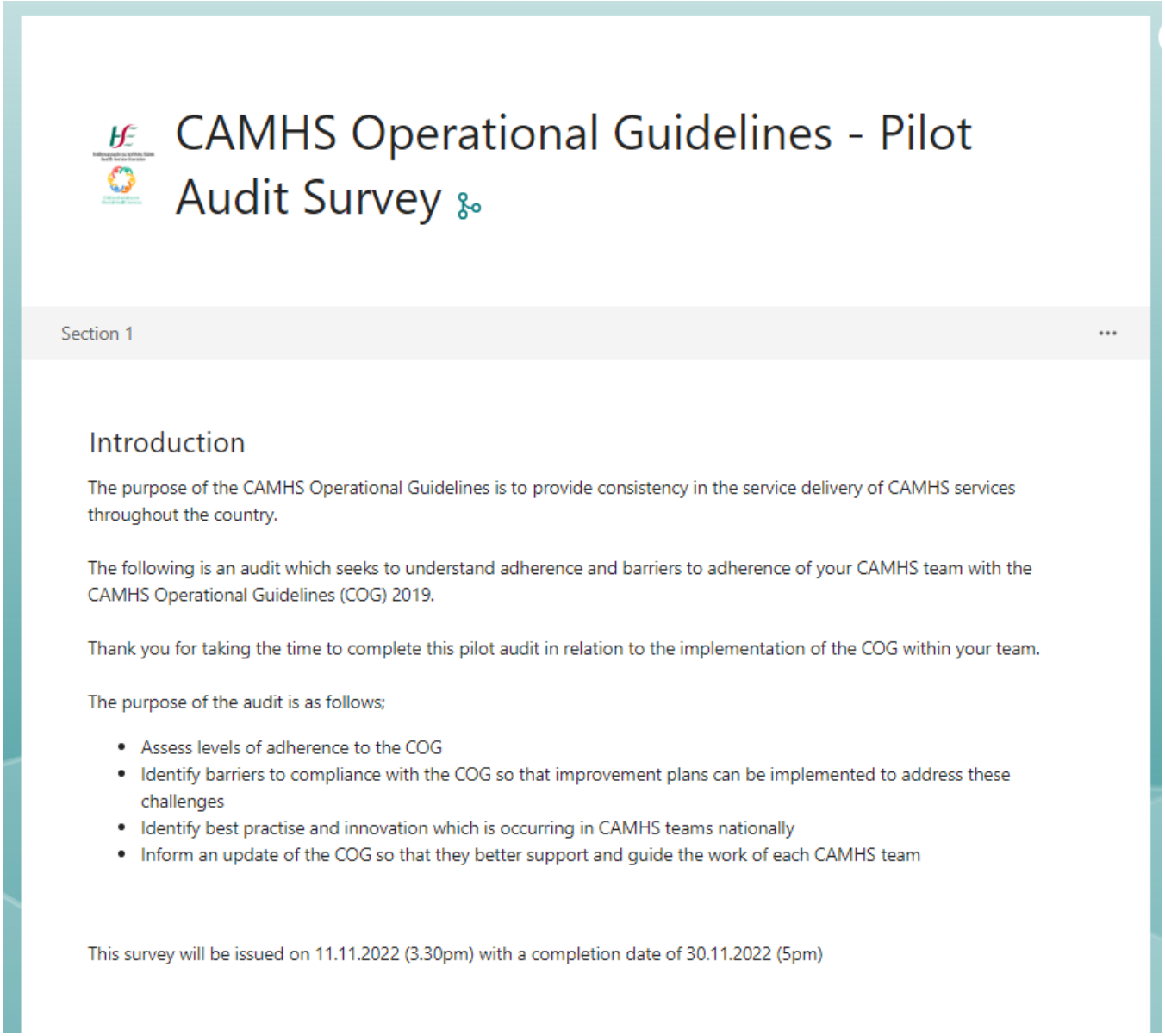
Appendix C: Audit Tools

A variety of tools facilitated the completion of the COG Audit in both the development of the form and completion of the audit:

- **Microsoft Forms;**
- **SmartSurvey;**
- **Centralised Email Address;**
- **Microsoft Power BI; and**
- **Audit Management Trackers**.

Microsoft Forms
The Audit Development Team considered a variety of digital survey platforms which could facilitate the design and completion of the COG audit and opted to use Microsoft Forms for the Pilot Audit.

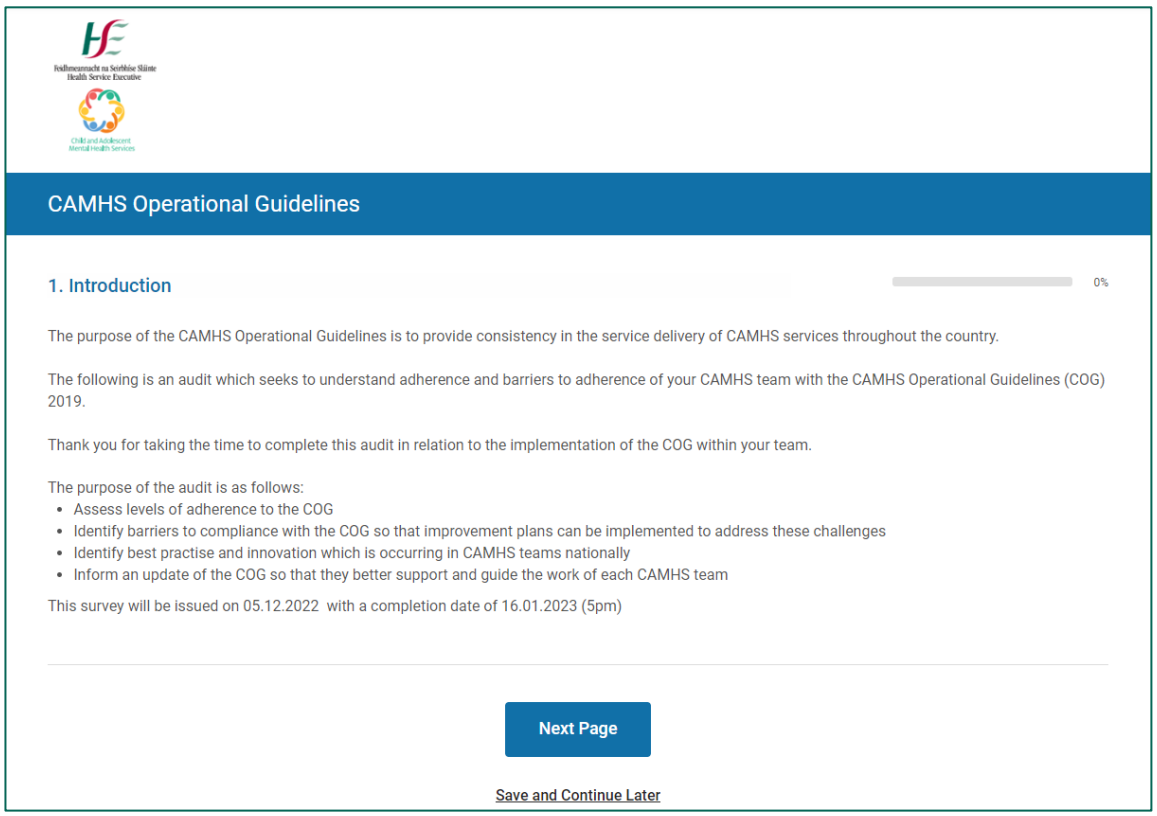
The below figure displays an example of the introductory section of the audit on the Microsoft Forms self reported audit tool.



Appendix C: Audit Tools

SmartSurvey
An online survey creator tool, SmartSurvey, was used to design and deliver the audit as it included a “Save and Continue” function. This online platform was used by the expert audit group to develop the self reported audit tool, and was used by CAMHS teams nationally to submit their audit responses.

The below figure displays an example of the introductory section on the SmartSurvey self reported audit tool.



Centralised Email Address
A centralised email address was established at the outset of the national audit, to accommodate any feedback or support requests submitted by CAMHS teams. This email was accessible to multiple members of the expert audit group thereby mitigating the risk of data loss and support requests going unanswered, while also providing CAMHS teams with a defined point of contact specific to the audit.

The email was monitored multiple times daily with members of the expert audit group assigned to respond to specific support requests.

Audit Management Trackers
The expert audit group employed a number of excel spreadsheets to track and manage aspects of the audit. These included:

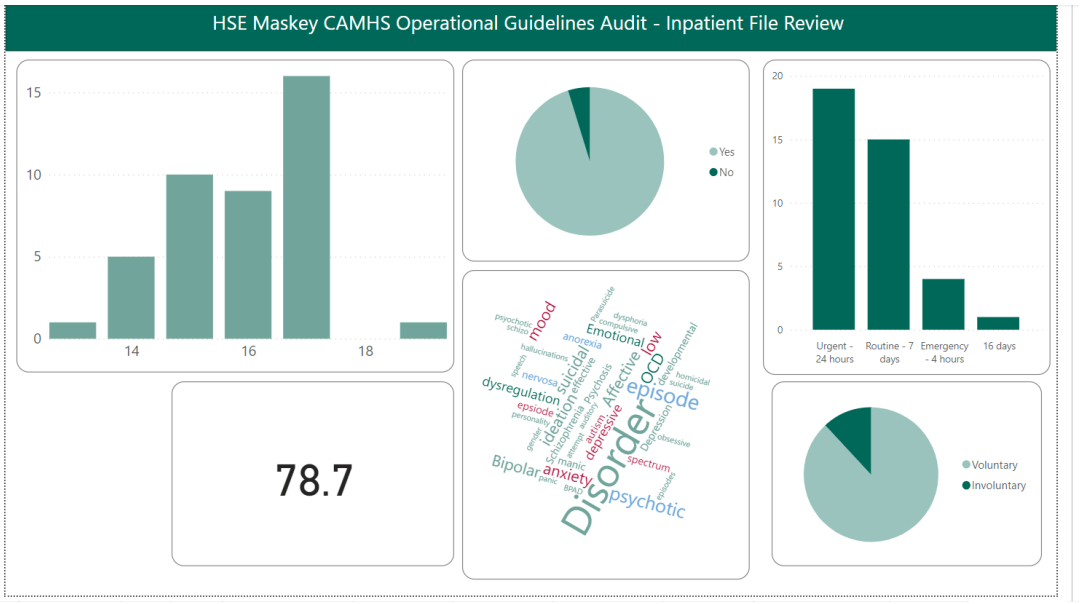
- **Audit Progress Tracker:** This documented completion rates of the audit on a national, CHO, and individual CAMHS team level, and was updated by the expert audit group on a daily basis;
- **Support Request Tracker:** This documented and thematically categorised every support request submitted to the expert audit group. It also indicated which CAMHS team made each request, the submission date of the request and whether the support request had been completed or was in progress;
- **Inclusion/Exclusion Criteria Tracker:** The expert audit group used this document to keep track of the CAMHS teams who could not meet the inclusion/exclusion criteria stipulated in the file review segment of the audit; and
- **Submission Validation Tracker:** A submission tracker was created to validate the number of individual file submissions by each CAMHS team, highlighting any duplicate submissions found by the expert audit group who alerted CAMHS teams regarding these duplicates if required.

Appendix C: Audit Tools

Power BI
The expert audit group utilised Power BI during the data analysis phase of the audit to aid visualisation and interpretation of the data gathered.

Power BI is an interactive data visualisation software developed by Microsoft which is part of the overarching Microsoft Power Platform. It can be used for quick and effective analysis of large amounts of data represented in an easy-to-understand manner. Power BI was used by the expert audit group to develop multiple dashboards graphically displaying responses to both the pilot and national audit; these graphics were then used in provisional analyses and in the audit report itself.

The below images display an example of the Power Bi dashboard.



File Review Tracker
Upon commencement of the national audit, the expert audit group circulated a file review excel tracker to each CAMHS team which would enable each individual team to document which file reviews they had completed and how many they had outstanding at any given point in time. The use of this tracker was optional but encouraged, so as to avoid duplication of efforts in the respective CAMHS teams.

- **Organisational Chart Templates:** The expert audit group circulated sample templates of organisational structures including reporting relationships, and requested each team completed these templates and returned the completed structure to a member of the expert audit group.

Appendix D: Support Requests

A number of supports were offered to CAMHS teams to facilitate completion of the audit as mentioned previously.

Support requests such as extensions to the audit deadline were reviewed on a case-by-case basis by the expert audit group and HSE Implementation Lead, with factors such as team case load, staffing, resourcing and additional ongoing audits being taken into account .

All support requests raised by audit participants were logged and categorised in a **designated tracker.** In total, **130** requests for support were raised by members of CAMHS teams participating in the audit. These pertained to a variety of different themes, ranging from technical concerns about the self reported audit tool to queries about details of the audit itself.

The below table offers an **overview** of all **support requests** logged with the expert audit group during the national audit.

Support Requests	CHO1	CHO2	CHO3	CHO4	CHO5	CHO6	CHO7	CHO8	CHO9
Feedback in relation to question content						2	1		
Meeting Inclusion/Exclusion Criteria	1	1	2	3			3	1	2
Clarification on parameters of question				1		3	2		1
Update Contact details	1						2		
Request for Audit details	1	3	2	5	2		3	1	5
Request for 1:1 sessions		2	1		1		2	1	
Audit Tool Queries		1	4	2	3	2	3	2	3
Team name Queries				1				12	
Duplications			1				1		
Completion Date							1		
Input error		1		3	1		5	3	4
Deadline date			1						
Progress Update		2	1	5			2	7	1
Quality Control							3		
Total	3	10	12	20	7	7	28	27	16

Appendix E: Pilot Audit Response Summary

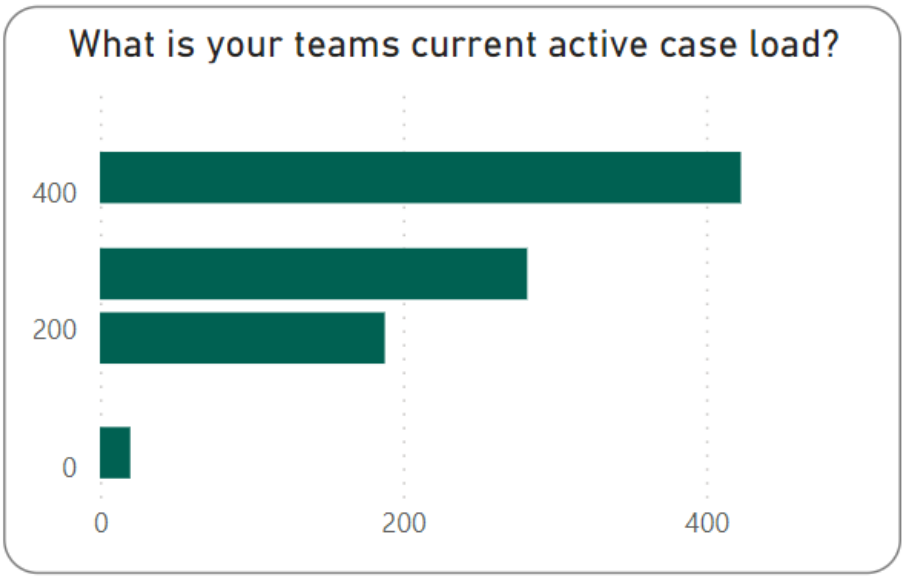
Response Summary - Team Questions

Response Summary

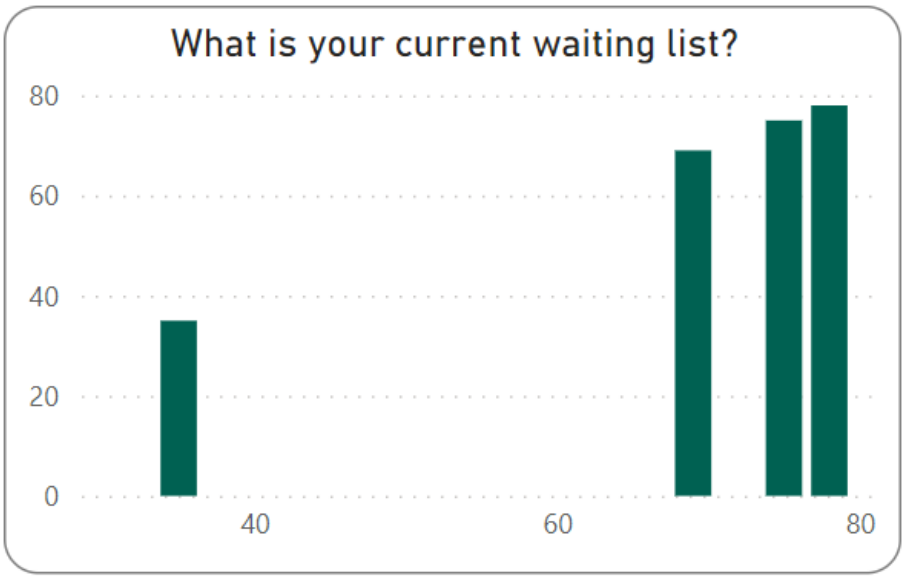
Following collation of data from the pilot teams, the responses were divided into both the team and file review sections of the audit, and key findings are discussed below for both inpatient and community teams.

Team Questions Reponses

Each team participating in the pilot audit was asked whether they were implementing the COG, with notably, **all teams** participating in the pilot audit reporting implementation.



Four of the five participating teams reported their active team caseloads on the audit form and as can be seen from the bar graph above, a large variance is present between teams.

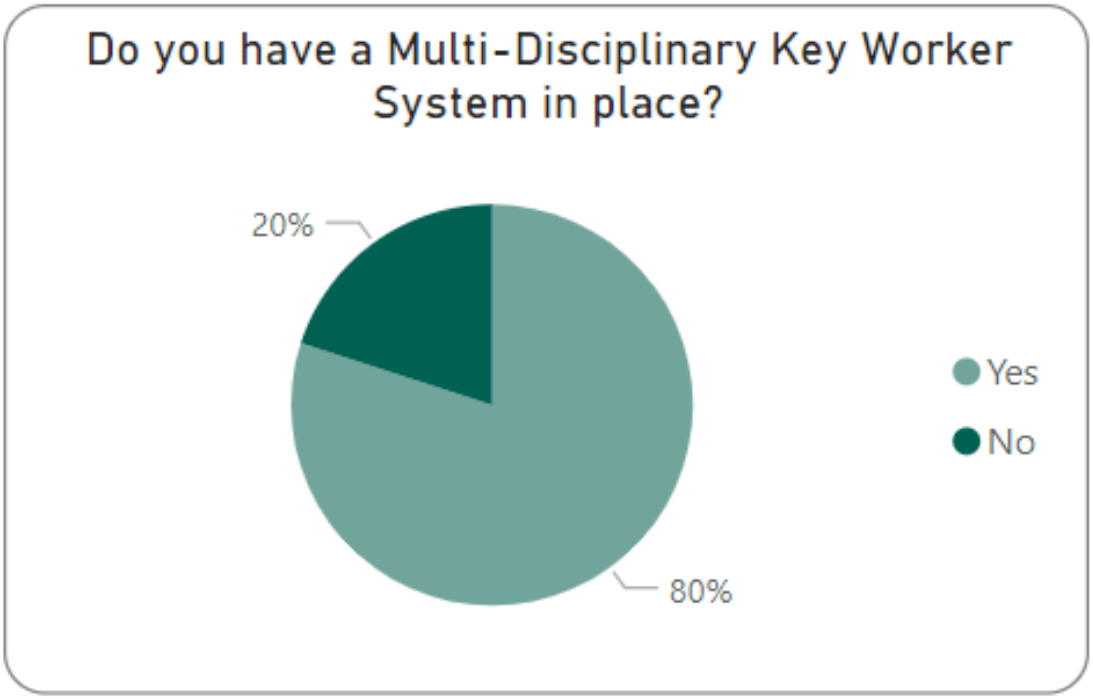


Similar to the data captured regarding team active caseload, four out of five teams submitted data regarding their waiting lists, with **75%** of teams reporting **greater than 70 young people waiting to be seen** by their clinicians**.**

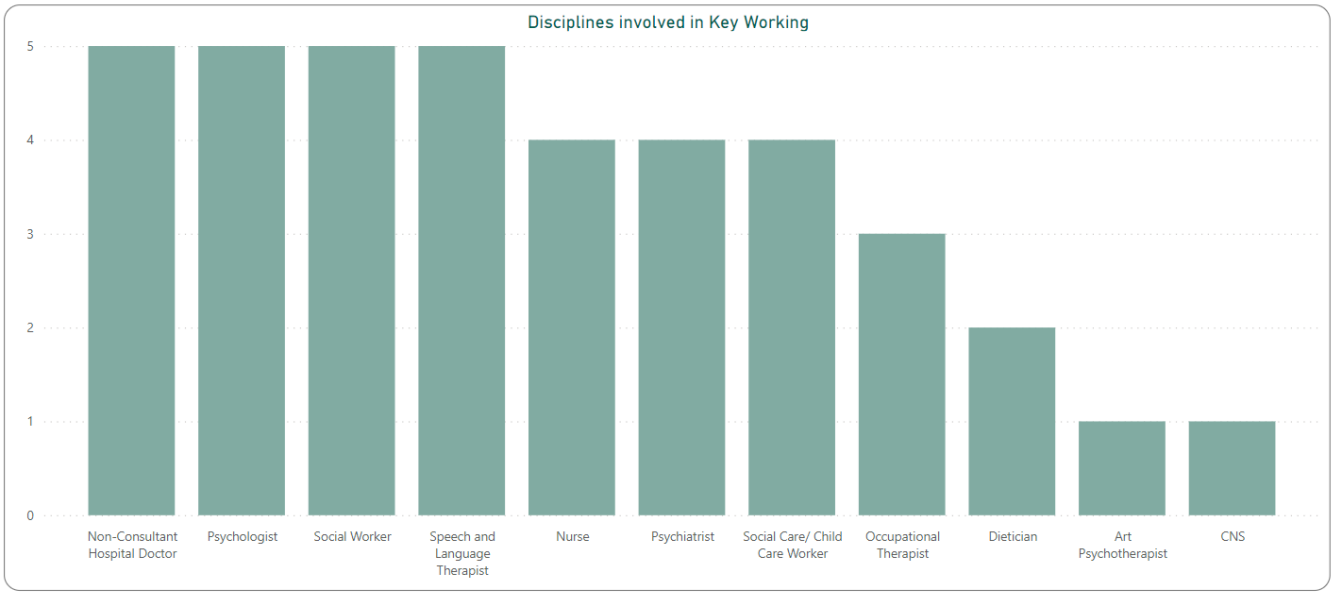
Appendix E: Pilot Audit Response Summary

Response Summary - Team Questions

Questions regarding CAMHS teams having a Key Worker system, also identified **that 80% of pilot teams reported that they had a key working system in place.**



The chart below illustrates that **Social Workers** were among the most common disciplines reported to engage in the key working role, other disciplines referenced in the role were **Speech and Language Therapists**, **Nurses** and **Consultants**. The majority of Key Workers reported supporting 20 young people or less.

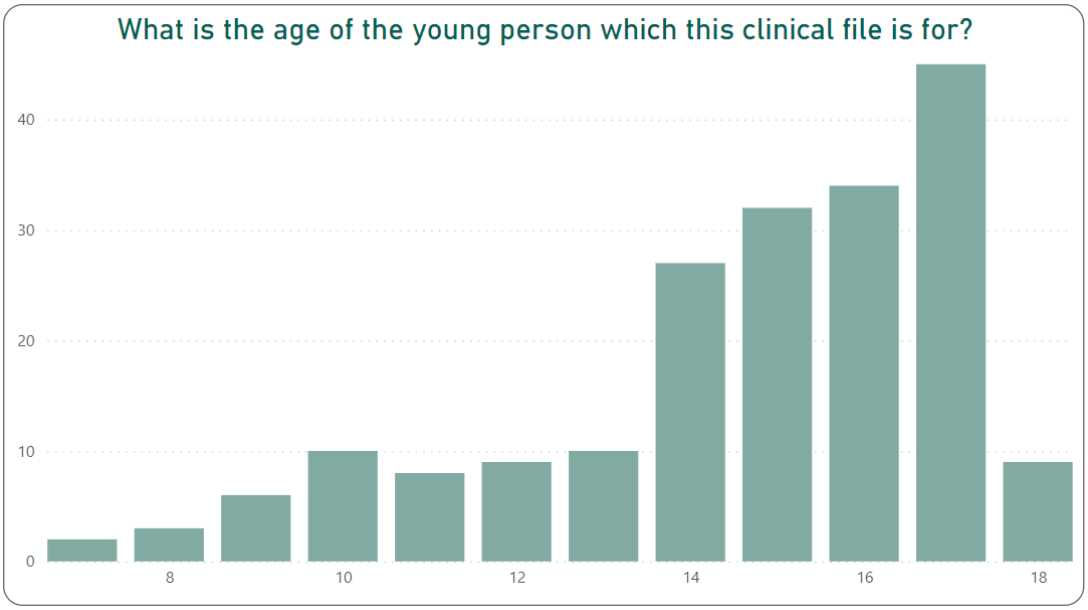


Appendix E: Pilot Audit Response Summary

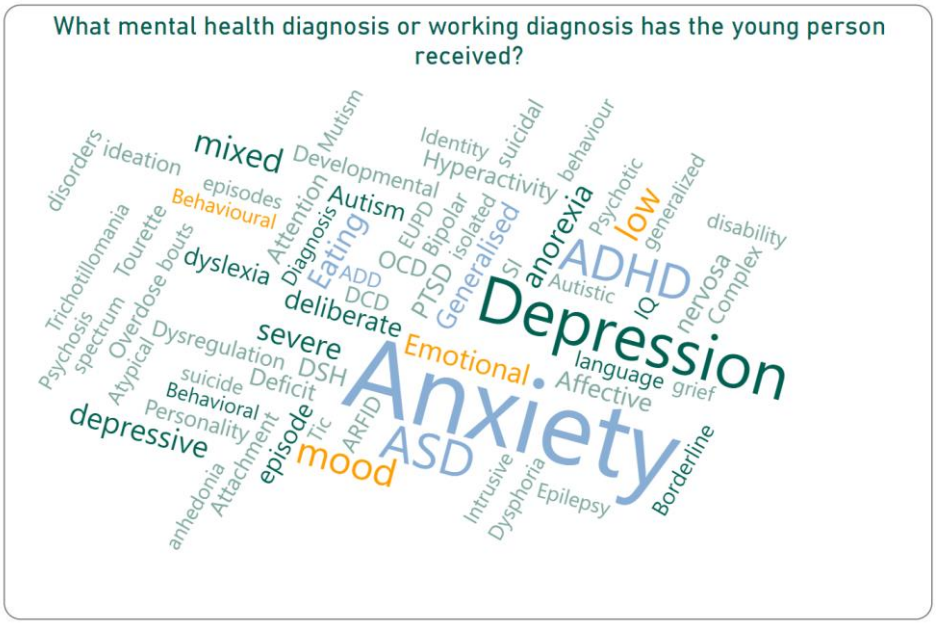
Response Summary – File Review

File Review Reponses

The below is a synopsis of the analysed data relating to the file review questions completed by the pilot teams.



The above graph illustrates that **17 years old** was the most frequently reported age of a young person attending CAMHS teams, with young people aged both 16 and 15 also seen in large numbers.



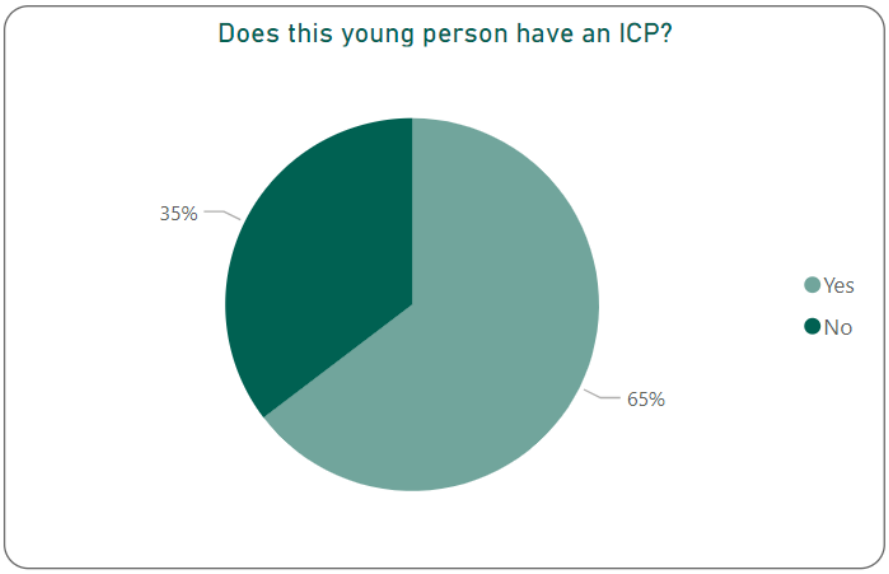
The word cloud above represents diagnoses received by young people whose clinical files were reviewed as part of the pilot audit. The larger the text in the cloud, the more frequently the diagnoses of this mental health condition were reported.

The **most common mental health diagnoses** or working diagnoses received by a young person attending CAMHS services within the pilot cohort were **Depression and Anxiety.**

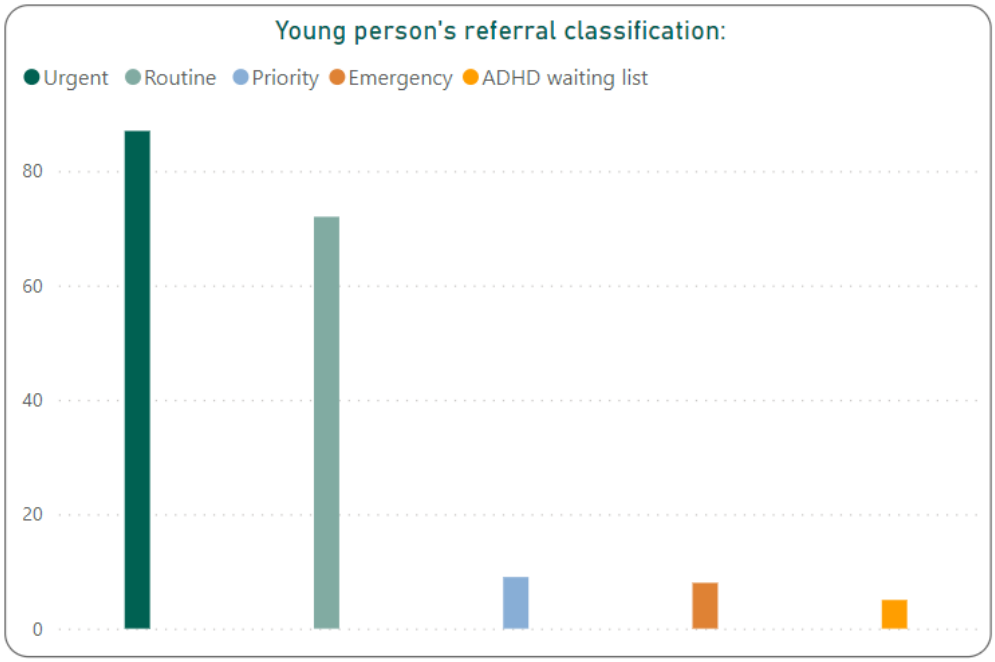
Appendix E: Pilot Audit Response Summary

Response Summary – File Review

CAMHS teams were asked whether the file reviewed had an ICP, as Section 4.15 of the COG emphasised the importance of each young person having one.



Reasons reported as to why a young person may not have an ICP included that they were seen by a clinician and immediately discharged from the service as they no longer required CAMHS services.



The above graph represents the number of classifications used for the young persons' referrals. The most common classifications used were:

- **Urgent;**
- **Routine;** and
- **Emergency.**

Other classifications used by CAMHS teams included Priority or ADHD Waiting List. These classifications do not appear in the COG.

Appendix E: Pilot Audit Response Summary

Thematic Analysis

The below table, highlights a sample of direct responses received from the pilot teams. From the response summary and the feedback received, the expert audit group conducted a qualitative analysis of issues faced by the pilot teams. The three main themes captured in the feedback were:

- **Case Flow;**
- **Governance; and**
- **Staffing.**

The later section in this report 'Issues Highlighted' will discuss the below table in more detail.

Themes	Pilot Participant Responses
Case Flow	'There is no MDT Key Worker for most cases because team active **caseload numbers are excessive,** and MDT members have maximum caseload limits, which include keyworking, as per their Line Managers' 'Case load levels are exacerbated by CAMHS teams having to accept young people who do **not meet criteria** for CAMHS but who require urgent attention, due to a lack of available, alternative more appropriate services for the young person to attend'
Governance	'Ambiguity in both roles and reporting relationships, **impacting negatively** on their ability to **complete both clinical and non-clinical work** in CAMHS' 'Need for a **designated CAMHS Governance Group** stemming from this lack of clarity in reporting structures, in order to standardise reporting relationships and maintain a **clear path of accountability'**
Staffing & Resources	'**Insufficient staffing and time**, combined with high workloads, leads to non-completion of the self-assessment tool found in the COG'. 'Absence of specific MDT members in the service leads to **young people not receiving the designated care** within the planned timeframe'

Appendix E: Pilot Audit Response Summary

Issues Highlighted

Main Themes

Governance

Many teams reported that there was a **lack of a specific CAMHS governance structure**. CAMHS teams highlighted how this often presented a **lack of clarity around responsibilities** in the team, lacking accountability and hindering the ability to fulfil various roles amongst the teams, such as the key working role.

One of the pilot teams consistently noted throughout their audit responses the absence of a defined CAMHS Governance Group. They reported that some line managers in their team are regional managers, not based in their county, and other line managers do not sit in CAMHS but in an Area Mental Health Management team. According to the CAMHS teams, there is ambiguity in roles and a lack of standardised line management.

Case Loads

The most prevalent theme highlighted by the CAMHS teams in the pilot audit, was the team **case loads**. Many CAMHS teams reported high levels of case loads as having negatively impacted their service delivery and ability to complete both clinical and non-clinical work. The average current active case load reported among community CAMHS teams in the pilot audit is 298, and the inpatient unit involved in the pilot reported a case load of 20.

Staffing & Resourcing

Staffing and resourcing was also a reoccurring theme among issues highlighted by the pilot CAMHS teams.
Many teams **stated that staff absences and understaffing of their respective teams interfered with their clinical and non-clinical work**, causing delays to planned care delivery and the discharge of young people from services in some instances. This, in tandem with increasing levels of case loads led to significant pressures on the existing staff who also cited lack of resources as a contributing factor to interference with service delivery.

Appendix F: CAMHS Teams

CHO	Team Name
CHO1	Cavan CAMHS 1
	Donegal North Team
	Donegal South Team
	Inishowen
	Monaghan CAMHS 2
	Sligo (Excl. East Sligo)
	South Cavan/ South Monaghan CAMHS 3
	West Cavan/ Leitrim/ East Sligo
CHO2	Mayo North
	Mayo South
	North Galway
	Roscommon/ East Galway
	South Galway
	West Galway CAMHS
	Merlin Park (Inpatient)
CHO3	Clare East
	Clare West
	East Limerick
	Limerick Central
	North Tipperary
	West Limerick
CHO4	Kerry Team 1
	Kerry Team 2
	North Cork
	North Lee North
	North Lee West
	North Lee East
	South Lee 1
	South Lee 2
	South Lee/West Cork
	South Lee 3
	CAMHS Regional Eating Disorder Service (CAREDS Cork Kerry)
	Eist Linn (Inpatient)
CH05	Carlow/ Kilkenny 1
	Carlow/ Kilkenny 2

Appendix F: CAMHS Teams

CHO	Team Name
CHO5	South Tipperary
	South Tipperary Team 2
	Waterford
	Wexford North
	Wexford South
CHO6	Century Court Team
	Lucena Team A (Dub. 6 14 16)
	Lucena Team C (Dub. 2 4 12)
	Lucena Wicklow- Arklow
	Lucena Wicklow- Bray
	Marine 56
CHO7	Linn Dara Ballyfermot/ St James
	Linn Dara Clondalkin
	Linn Dara Community Eating Disorder Service
	Linn Dara East Kildare/ West Wicklow
	Linn Dara Lucan
	Linn Dara North Kildare (Celbridge)
	Linn Dara South Kildare
	Linn Dara South Kildare/ West Wicklow
	Linn Dara West Kildare
	Lucena Tallaght Team 1
	Lucena Tallaght Team 2
	ADMiRE (Specialist Community Team)
	Linn Dara Inpatient (Inpatient)
CHO8	Laois
	Laois/ Offaly CAMHS Team 3 (16-17 yrs)
	Longford Westmeath YAMHS
	Longford/North Westmeath
	Louth North
	Louth South
	Meath North
	Meath South
	Meath South Ashbourne
	Offaly
	South Louth/ East Meath
	South Westmeath

Appendix F: CAMHS Teams

CHO	Team Name
CHO9	Balbriggan Ballymun Blanchardstown Castleknock Darndale North East City North Inner City Enhanced Neurodevelopmental Team (Specialist Community Team) CAMHS Day Hospital, 44 North Georges St. (Day Hospital) Swords St. Vincent's (Inpatient)

Appendix G: Thematic Analysis

The following tables display an **analysis of responses from both community and inpatient untis in each CHO, categorised into themes**. These themes were identified following the collation and analysis of all text-based responses submitted by CAMHS teams in the National Audit. A thematic analysis was carried out on these submissions and responses have been categorised into the following themes;

- **Governance;**
- **Staffing/Resources;**
- **Case Flow;**
- **IT Systems ; and**
- **Service Provision**

The later section in this report 'Issues Highlighted' will discuss the below table in more detail.

Themes	CHO1 Team Responses
Governance	'There has been **no overarching governance group** for CAMHS until now. CAMHS issues have been discussed at the Area Mental Health Board. One CAMHS team does not have a representative on the Area Mental Health Board. Apart from that, there has been **no forum** for **considering strategic CAMHS issues** or for settling operational differences between disciplines. Fortunately, the Terms of Reference for a new county-wide (covering three teams) CAMHS Governance Group have recently been agreed and the first meeting will take place this month'.
	'The consultant psychiatrist is the clinical lead, however, **only the NCHD reports to the consultant**. All other members of the team report to their own disciple specific line managers, who usually do not work in CAMHS. Other than the Area Mental Health Board, which has **no representation** from one CAMHS team, there has not been a forum for agreeing a joint team direction. This governance and **leadership gap** has only been mitigated through the good will and cooperation of all involved. The situation should be much improved when the new CAMHS governance group meets this month'.
	'**Evolving** governance structures'.
	'There is some **confusion** regarding reporting lines. MDT members each report to their professional line manager, who sits outside of CAMHS. They do not report to the clinical lead, who holds responsibility for the clinical work of the team. There can be **disagreement regarding clinical decisions**, that can be difficult to resolve within the team. This has been exacerbated by the lack of a CAMHS Governance Group. The status quo generally works because of the professionalism of the MDT, however, there is a potential for problems. This will hopefully be mitigated by the establishment of a CAMHS Governance Group, which will have it's first meeting in January 2023'.
Staffing /Resources	'We have regularly **requested a team coordinator**, but this has not been agreed by management. This situation makes it **difficult to sustain improvement** in the service. Many of the team coordinator tasks are undertaken by the consultant'.
	'ADON/ Clinical Coordinator across three CAMHS teams job description differs from team coordinator in the COG'.
	'Currently recruiting'.
	'Staff shortages'.
	'Skill shortages'.
	'Due to **staff shortages** and MDT caseload limits, around half of patients are key worked by the consultant psychiatrist'.

Appendix G: Thematic Analysis

Themes	CHO1 Team Responses
Staffing/ Resources	'We have not had a permanent medical secretary for many months and have experienced a **backlog** in letters, so have not always written to GP's within 4 weeks of the Initial Assessment. Nor do we routinely copy letters to parents, although we fully discuss the contents during appointments and make them available on request'.
	'We are understaffed compared to the Vision for Change model. We do have a consultant psychiatrist, an NCHD, an OT, a clinical psychologist, a social worker and two nurses. We also have **limited access** to a dietitian, an SLT and a trauma therapist. We have also made strives to partner with local community and voluntary organisations to help fill the **gaps** in our staffing, but this depends on **temporary funding**'.
	'We have **regularly requested a team coordinator**, but this has not been agreed by management. This situation makes it difficult to sustain improvement in the service'.
Case Flow	'County-wide CAMHS continues to face significant challenges: **Increasing referrals'.**
	'There is a **significant risk that waiting lists** will increase and that quality will deteriorate if the 2022, Service Improvement Plan is not replaced with a new package. There will be additional pressure in the pandemic aftermath and following a recent tragedy in the area'.
	'ADHD Waiting list current average waiting time (12 months)'.
	'Increase in **inappropriate referrals** to CAMHS'.
	'We sometimes accept patients with moderate to severe ID or ASD without a co-morbid mental health problem. This often happens because the **underlying issue was not outlined** in the referral. Once we have accepted such patients, who often have **significant risks** to themselves or others, we find it difficult to discharge them due to a severe lack of ID and ASD services in the county. Where services exist, they have waiting **lists measured in years**. Professionally and ethically we are **unable to discharge** some of these patients without another team to pick them up. This is a major problem for our service and for these patients'.
Service Provision	'Difficulties accessing external services'.
	'Expectations from external services and referral agents'.
	'We are currently investigating digital platforms to help manage our PROMs and once that is in place, we hope to adopt several standard sets from the International Consortium for Health Outcome Measurement (ICHOM) across our pathways'.
	'In 2022, we introduced the DAWBA online diagnostic assessment for new referrals. In 2023, this will allow us to identify appropriate guided self-help resources for young people, as soon as they are accepted. By the end of 2022, we hope to have established a bibliotherapy library of self-help resources, which can be offered to young people. We also hope to have commissioned our first brief intervention - an online ADHD parent course'.
	'In 2023, we will develop our core care pathways, starting with ADHD (based on the Dundee Pathway). We will adopt outcome measures for these pathways, starting with paper, before going digital, so that we know what is working for each young person. We will bring staff into the team and **train existing members** to deliver brief interventions within our pathways. We will also create a more flexible mechanism for bringing interventions from community providers into our care pathways, building on the relationships developed this year. Ultimately, to scale up these changes, we will need to **adopt digital platforms** for collecting outcomes and delivering interventions. The work will take place in three stages, with Stage 1 already funded out of the 2022 Service improvement plan'.
	'**Lack of standardised doc**'.

Appendix G: Thematic Analysis

Themes	CHO2 Team Responses
Governance	‘**Lack of clarity of roles and responsibilities** between line managers of individual disciplines and the clinical lead that is the consultant (as a different discipline) Lack of clarity in relation to key working role across all disciplines - i.e. balancing KW role with professional disciplines' specific role’.
	‘**Lack of clarity in relation to clinical responsibility, clinical decisions** and their implementation when differences of clinical opinion emerge between individual professions with their line managers' structures and consultant as clinical lead of the CAMHS team’.
Staffing/ Resources	‘Prioritising service provision to young people and families within **constraints** of our current and historical limited resources’.
	‘**Human and time resource limitations**, including lack of team coordinator role which would assist in such’.
	‘**Lack of time and resources**’.
	‘**A lack of resourcing** in primary care psychology results in some patients entering CAMHS in the absence of appropriate primary care level inputs’.
	‘**A lack of resourcing** and availability of disability service supports results in emotional and behavioral difficulties that are directed to CAMHS as concerns of mental health issues are queried’.
	‘There can be delays in administration around referrals due to **chronic administration staff** shortages’.
	‘The Key Worker role is **not fully implementable** as per COG structure due to **chronic staffing issues** and the nature of transitioning of inputs within the team, so the contact person becomes somewhat fluid for some patients’.
	‘There is no capacity to implement a team coordinator due to chronic understaffing’.
Case Flow	‘**Time constraints and Demand on the service**’.
	‘**Lack of time and resources**’.
	‘CAMHS are sometimes **pushed to undertake assessments** through political or complaints-based demands that would more appropriately receive assessment and inputs at primary care level’.
	‘GPs can often be **unaware** of other more appropriate services and direct referrals to CAMHS as a result’.
IT Systems	‘The **current IT infrastructure** does not allow for this as there are **barriers** between those on the original server and those placed on the new server (staff newly added in the past few years or commencing in other locations)’.
	‘Different electronic systems that **do not allow sharing** (i.e. Health IRL vs WHB)’.
	‘Adherence to undertaking 6 monthly MDT reviews for all patients is impaired by chronic understaffing issues and **lack of appropriate IT infrastructure** (paper files, no dedicated fit-for-purpose database etc.)’.

Appendix G: Thematic Analysis

Themes	CHO2 Team Responses
Service provision	'there is a **significant lack** of primary care psychology and **long waiting** lists for primary care interventions in our area'.
	'We have some (<20) routine cases waiting to be seen for **more than 12 weeks**'.
	'Our caseload is **over 700** so we **do not have the capacity'.**
	We sometimes accept referrals in the best interests of the child and family as there is **no other alternative** due to poor staffing in CDNTs and **lack of provision** at Primary Care **due to long waiting lists**'.
	'Significant **lack of clarity around services available** for young people with ASD'.
	'It is not feasible to contact the patient prior to their appointment due to the **sheer volume of appointments** and **demand on the service'.**

Appendix G: Thematic Analysis

Themes	CHO3 Team Responses
Governance	'Highlighted the need for CAMHS specific governance'.
Staffing/ Resources	'We **do not have a Team coordinator** and feel that this would be hugely beneficial in supporting the team to meet the administrative and organization requirements of our CAMHS Team'.
	'**Human resource, clinical space**'.
IT Systems	'**Do not have IT infrastructure** at present'.
	'**Not all migrated** to Health IRL'.
Service provision	'Group work in evenings'.
	'Pre and post intervention measures'.

Appendix G: Thematic Analysis

Themes	CHO4 Team Responses
Governance	'Poor organization of team'.
Staffing/ Resources	'The team **does not have capacity** to see waitlisted ("Routine" in COG terminology) cases within 12 months. The **absence of a Team Coordinator** adversely impacts referral responses'.
	'No team coordinator has been appointed'.
	'We **do not have a team coordinator**. Nobody on team is in a position to take on this extra role'.
	'Some roles and responsibilities defined by the COG **cannot be implemented** in practice due to resourcing and other issues e.g. the team has not been allocated a Team Coordinator, so it is not possible to implement roles and responsibilities in the way this section of the COG recommends'.
	'**staff turnover**, consultant change and radically **increased demand** for service'.
	'**not sufficient staff resourcing**'.
Case Flow	'We **do not have the capacity** to see ROUTINE patients due to our waitlist within the 12 week period. We RESPOND to all referrals appropriately'.
	'**Increased workloads**'.
IT Systems	'**IT issues**, there was a shared electronic diary in the past'.
	'Awaiting **IT issues** to be resolved for all this service where some staff are on South Domain and some on health IRL - calendar has to be all on the same domain'.
	'**Limited communication** with others as mentioned. May be due to lack of structures in place for same, high workloads, no direct or easy means of contact'.
Service provision	'Groups are provided outside of normal hours'.
	'Group programmes have pre- and post-intervention outcome measures'.

Appendix G: Thematic Analysis

Themes	CHO5 Team Responses
Governance	'That is a question to be completed by management. We are bemused by CAMHS governance arrangements and have notified managers for many years that current CAMHS governance is not adequately supported, the current structure and process is unfit for purpose'.
Staffing/ Resources	'**Lack of resource** to implement plan'.
	'The barriers are **lack of resources** and **over stretched clinical services**. This kind of initiative would be expected to be organized by a team coordinator or practice manager. We have neither'.
	'**Staffing deficits**'.
	'Time **constraints** due to lack of resources'.
	'**No time or resources** to use the tool'.
	'Lack of resources and **no team coordinator** or **practice manager**'.
	'Partial compliance due to **lack of resources**, **staff or lack of collaboration** with primary care services and other community services'.
	'Not able to fully implement these areas due to **staff shortages** and reduced whole time equivalents'.
	'**Huge burden placed on admin staff**'.
Case Flow	'**Service demands**'.
	'Pandemic has resulted in an incr**ease in referrals**'.
IT Systems	'Old system that doesn't work with new computers and new email addresses'.
	'The IT systems are reported to be **inadequate**'.
Service Provision	'Urgent triaging, returning phone calls to GPs, groups and outreach support to service users and families and patient care'.

Appendix G: Thematic Analysis

Themes	CHO6 Team Responses
Staffing/Resources	‘**Chronic understaffing**: MDT has less than 50% Vision for Change figures (psychology has 30% Vision for Change figures), we have no team coordinator + no dietitian, wholly inadequate accommodation/office space’.
	‘Progress has been hindered by **lack of team coordinator**’.
	‘We do not have a team coordinator which prevents us being fully compliant with COG. We **do not have capacity with staffing levels** to see routine cases within 12 weeks’.
	‘We have had a **320% increase in referrals** since 2006 with no increase in staffing. To nobody's surprise, that means we **cannot see all new referrals within a 12 week period**. If we could, that would be miraculous. We have also had a 180% increase in urgent referrals, which also means routine referrals having to **wait longer** to be seen. The HSE are aware of this. Interestingly, despite this, our team has not had any increase in resources, even though our team funded staffing is at 40.2% of Vision for Change recommendations (i.e. 11 clinical WTE per 50,000 population)’.
	‘We **do not have funding** to employ a team coordinator. Given how busy we are and how large our open cases are (see huge increases in referrals and urgent referrals), without a TC the risk of cases being lost to follow up, and the COG not being fully implemented will continue’.
	‘Very difficult to implement the COG as current staffing levels are **incompatible** with the guidelines’.
	‘Major barrier in the way of implementing a Key Worker role as per the COG is the **demand on the service and the inadequate resources available**. One team’s catchment size is significantly larger than it is resourced for (as per Vision for Change, based on 2016 census figures, should have 62% more staff than it currently has). Open cases currently stand at approx. 400 on a team with 11 clinical staff. It is not feasible to implement the role of the Key Worker as per the COG as clinical staff simply do not have the time. The practice on the team is that a named person should be allocated to each case as an 'auditor' for 6-monthly file/care plan audits’.
	‘We understand the roles and responsibilities and have **insufficient staffing** to fully comply with guidelines’.
	‘Inadequate staffing, ever **increasing clinical demand** and complexity of cases, absence of team coordinator’.
	‘No team coordinator, **inadequate staffing** level to fulfil this aspect of the COG. Keyworker role is the regular clinician’.
Case Flow	‘Routine referrals are not see within 12 weeks. Our current routine w/l is up to 9 months due to **chronic understaffing** and **exponential increase** in referrals since Covid-19’.
	‘We cannot get adult mental health services to accept any referrals of children ages under 18 so we cannot fulfill this part of the COG, very unfortunately. In addition, the disability services in 2/3 of our catchment area are not functioning and have **horrific waiting lists** of in one area over 5 years. This means that shared care is not happening and children with autism are not receiving the autism supports they desperately need’.
	‘Unfortunately we **don't have time** to self assess or reflect on practice as every day we are firefighting to manage the demands on the service’.
	‘**Urgency of clinical caseload**’.
Service Provision	‘Many staff offer after 5 appointments’.
	‘Inadequate staffing levels to fulfil this aspect of the COG’.

Appendix G: Thematic Analysis

Themes	CHO 7 Team Responses
Governance	'**No effective system** in place for referral to discipline not present on CAMHS team'.
Staffing/ Resources	'**Resource issues** on the team and prioritizing clinical work'.
	'**Turnover of staff**'.
	'**Clinical demands** and **inadequate staffing levels** have limited our ability to complete same'.
	'Team with **high staff turnover**, including of clinical leads'.
	'Under resourced primary care and **large catchment area** and u18 population'.
	'Our team currently does not have an SLT or dietitian and there has not been a team coordinator role within the team ever'.
	'Communication, Sharing and Disclosure of Information (COG pg. 29): Partially Implemented on this team as communication and joint working is **difficult to establish** and maintain with some other HSE services at present. Due to **staffing resources** across services there are gaps in all agencies ability to respond to shared care requests in a timely manner'.
	'**No team coordinator role in service**'.
	'Alternative services not always available for discharge or assessment - **lack of adequately resourced services** in PC and NDT'.
	'Not all posts available to team, resourced including OT, SCL, SW or lack of senior posts for team for staff retention'.
	'Do **not have full skillset** to meet population needs - no creative psychotherapy, very limited clinical psychology'.
Case Flow	'**Caseload - large** - not able to focus on COG more focus on work at hand'.
	'Team under significant and sustained pressure to meet increasing demands of population'.
	'**Very high levels of crisis referrals**'.
	'**Volume of cases** open to the team has grown over a 3 year period'.
	'Referral information is often **very limited** but we have a structured phone screening assessment that we use to gather the information required to determine if the referral is appropriate'.
Service Provision	'**Reviews can go beyond 5pm in emergency situations'.**
	'Due to **lack of resources**, reduced MDT work during COVID, and **lack of training** in the implementation of the ICP the team has not yet started using ICPs. However the team has signed up for training in the implementation of ICPs in the near future and are hoping to start using ICPs shortly'.

Appendix G: Thematic Analysis

Themes	CHO 8 Team Responses
Staffing/ Resources	'**No team coordinator in post**'.
	'We have approximately **60%** of staffing recommended by Vision for Change'.
	'No Social Worker or Speech and Language Therapists in post. As per vision for change we do not have recommended staff compliment (dietitian, staff grade psychologist, staff social worker, assistant psychologist). Vision for change is **outdated** and staff numbers should be increased further given the increase in referral rates to CAMHS'.
	'COG is not fully implemented in our service due to **staff shortages** and inconsistent staffing'.
	'In the past, there were difficulties back filling the original role of the Team Coordinator, when they stepped up to the Team Coordinator position'.
	'**Inconsistent staffing in last 2 years**'.
IT Systems	'**No IT infrastructure** to allow shared diaries and appointment tracking'.
Service Provision	'Late appointments offered to families which may run past the 5pm clinic closing time'.
	'Current ICP out of date'.

Appendix G: Thematic Analysis

Themes	CHO 9 Team Responses
Staffing/ Resources	'**Staff turnover and reduced resourcing**'.
	'**Low staff levels**'.
Case Flow	'Reduced time allocation due to rise of clinical caseloads'.
	'**Time constraints** and clinical demand'.
Service Provision	'Groups offered in evenings at times'.
	'Successful **waiting list initiatives** on a regular basis'.
	'We try to build relationships with other services in the area...'.

Appendix H: Bibliography

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