SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	
Service	Draft Tier 4 Child and Adolescent Mental Health Services: General Children's Services (Age Up to 13th Birthday)
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 Prescribed Specialised Service

1.1.1 This service specification covers the provision of Child and Adolescent Mental Health (CAMHS) Tier 4 inpatient services.

1.2 Description

1.2.1 This service specification describes Tier 4 general children's inpatient services to be delivered within a clearly defined geographical area at regional and/or sub-regional level with service configuration determined locally based on population needs and existing service provision for Tier 4 CAMHS.

1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners

1.3.1 NHS England commissions Tier 4 Child and Adolescent Mental Health (CAMHS) services provided by Specialist Child and Adolescent Mental Health Centres including associated non-admitted care, crisis intervention, home treatment, supported discharge and other alternatives to admission when delivered as part of a provider network.

1.3.2 Clinical Commissioning Groups (CCGs) commission CAMHS for children and young people requiring care in Tier 1, Tier 2 or Tier 3 services.

2. Care Pathway and Clinical Dependencies

2.1 Care Pathway

2.1.1 Future in Mind (2015) emphasised the need for 'improved care for children and young people in crisis so they are treated in the right place, at the right time and as close to home as possible'. This includes 'implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care 'however, there is recognition that there will always be some children and young people who require more intensive and specialised inpatient care. 'The key to commissioning the right type of care, in the right places is to adopt a whole system commissioning perspective. This should address the role of pre-crisis, crisis and supported discharge services alongside inpatient provision.'

2.1.2 Tier 4 CAMHS General Children Services will be provided across an integrated care pathway which includes crisis/ home treatment services, specialist eating disorder services, inpatient services, supported discharge services and Tier 3 CAMHS. Supported discharge should be individually planned and may be supported where feasible by the tier 4 service for a limited period in collaboration with community services. Effective community services are important in preventing or reducing need for admission, and identifying those most appropriate for referral to Tier 4 CAMHS inpatient services.

2.1.3 Tier 4 CAMHS Commissioners will liaise with CCGs and Local Authorities to ensure that there are no gaps in the pathway. Many children and young people requiring Tier 4 interventions also have significant social care and/or educational needs and these are best met through robust collaboration between agencies.

2.1.4 Children and young people will move through levels of service as clinically appropriate, aiming for treatment as close to home as possible in the least restrictive environment with discharge back to the community as soon as it is safe to do so. Day placement should be offered where feasible allowing for risk, geography and transportation to the service. Day placement avoids dislocation from the home, family/carers and avoids the risk of institutionalisation.

2.1.5 The inpatient service will provide care 24 hours a day, 7 days a week including a capacity for emergency admission.

2.1.6 Acceptance by a Tier 4 CAMHS General Children's (Inpatient) Service will be via an Access Assessment which must consider the goals of admission and any potential risks/benefits including whether the young person's needs could be better met by alternative services such as crisis-home treatment services.

2.1.7 The above services will provide safe and effective age appropriate care across each stage of the following care pathway:

- Referral

- Assessment
- Crisis management in the community
- Admission
- Treatment/CPA process
- Discharge planning and discharge
- Transition to appropriate after care (usually provided by Tier 3 CAMHS)

2.1.8 The services will also comprise the following elements:

- In/day-patient education provision.
- Outpatient attendance as part of second opinion process for patients referred from Tier 3, pre-admission assessments and discharge transition
- Supported discharge provision

2.1.9 The crisis assessment and access assessment functions should be provided by a single team that may or may not offer other functions such as supported discharge care.

2.1.10 The crisis team should be integrated with or closely collaborate with the Tier 4 CAMHS inpatient service and local Tier 3 CAMH services and led by CAMHS staff who have high levels of relevant CAMHS experience, competence and training. There should be consultant level input into the team. The size of the team will be determined by geography, population size and population need.

2.2 Referrals

2.2.1 Referral to a Tier 4 CAMHS General Children's Service will be from Tier 3 CAMHS.

2.2.2 Response Times:

- Emergency referrals will be reviewed and responded to by a senior clinician within 4 hours. Emergency assessment, as appropriate, will be offered within 12 hours, followed by admission within 24 hours if needed. Whilst responding to an emergency referral, assessment and admission should occur as soon as possible, and within the maximum timescales above, it is vital that a thorough biopsychosocial assessment is completed and all alternatives to admission are explored before proceeding to admission.
- Urgent transfer referrals will be reviewed and responded to within 48 hours
- Routine referrals will be reviewed and responded to within 1 week

2.3 Assessment

2.3.1 An Access Assessment will determine suitability for acceptance by Tier 4 CAMHS Children's Service; this should be done in consultation with the Crisis and Home treatment service where available and consider the views

and presentation of the child, the family/carer, or other professional as appropriate.

2.3.2 The assessment should build on assessments and information gathered prior to referral to avoid unnecessary repetition. The Children and Young Person's Mental Health Service Information Passport may be a helpful part of this and can be found at www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/10/cyp-info-passport-yp-example.pdf

2.3.3 There should be flexibility as to the location of the assessment (e.g. provider premises, Tier 3 CAMHS base, patients home or other location) according to need. The assessment will explicitly address the following issues

- Major treatment/care needs
- The best environment / level of service (day/in-patient or community crisis management/intensive home treatment) in which the care should be provided
- Risks identified
- Level of security required
- Comments on the ability of the holding/referring organisation to safely care for the patient until a transfer can be arranged or until crisis assessment team can mobilise.
- Goals for admission to be clearly stated.
- Where it is determined at assessment that the child requires care from a more specialist Tier 4 service (such as a Tier 4 Learning Disability Service, Tier 4 Eating Disorders Service) or another unit Tier 4 Children's Unit with different expertise, the service will provide advice on the type of unit required
- If after assessment it is agreed the child does not require a Tier 4 CAMHS service or the parents decline a service (subject to their being no reason to over-ride this decision) a full assessment report must be provided including where appropriate advice to the Tier 3 service on future care within 7 days.

2.4 Acceptance Criteria

2.4.1 The service will accept referrals meeting the following criteria:

- Aged up to 13th birthday (there may be rare cases of 13+ year olds being more appropriately admitted than to a Tier 4 CAMHS Adolescent Unit).
- Primary diagnosis of mental disorder including children and young people with neurodevelopmental disorders including mild and moderate learning disability and autism, physical disabilities, or those with social care problems as secondary needs.
- Severe and complex needs that cannot be safely managed within Tier 3 CAMHS.
- Severe and complex needs that cannot be adequately assessed within a Tier 3 environment.

- May require detention under the Mental Health Act.

2.5 Exclusion criteria

- 13 years of age (unless this is for a short time period to complete an episode of care and appropriate safeguards are in place or a developmentally appropriate admission of a 13+ year old).
- Children and young people with a severe learning disability unless considered to be in their best interests and they would be able to benefit from a general children's Tier 4 service intervention. A suitable care package could include an adolescent learning disability unit with additional support or an individual package of care co-ordinated across health, education and social care.
- Children and young people with a primary diagnosis of conduct disorder and no co-morbid mental disorder. A suitable care package could include the involvement of social care with support for parenting.
- Children and young people who present with extreme behavioural disturbance that cannot be managed safely by the service and which is likely to have a detrimental effect on the care and treatment of other children in the service. If these children have a mental disorder then transfer to an HDU or local arrangements for PICU adolescent services to offer care should be considered. For children with extreme behavioural disturbance consideration should be given to referral to social care secure services.
- Children and young people with developmental disorders whose needs cannot be met by the service (e.g. severe or profound learning disabilities) – these children should be treated in specialised Tier 4 learning disability services. A suitable care package could include an adolescent learning disability unit with additional support or an individual package of care co-ordinated across health, education and social care.
- Children and young people with a primary diagnosis of Substance Misuse. Referral to substance misuse services. If physical health care required paediatric services.
- Children and young people who are in need of Secure Care in Forensic Services
- Children and young people whose primary need is for accommodation due to breakdown of family or other placement.
- Children and young people who are currently in Secure Placements provided by Local Authorities, who in the first instance should be referred to the Tier 4 CAMHS Low or Medium Secure Services.

2.6 Admission

Discharge planning should be started before admission

2.6.1 Admission can be to any of the general children's service elements.

2.6.2 All patients will have an identified Consultant Child and Adolescent Psychiatrist, although the Responsible Clinician/Approved Clinician may be from another discipline.

2.6.3 On admission all children and young people will have an initial assessment (including a risk assessment) and a physical examination plus care-plan completed within 24 hours.

2.6.4 All children and young people will have a comprehensive multi-disciplinary team biopsychosocial assessment and formulation of their needs and a care/treatment plan, which should as far as possible be drawn up in collaboration with the child and their parents/carers as appropriate and building on any assessment and formulation work which was done prior to referral to Tier 4. The care plan will address the child's goals and wishes/feelings as far as possible. The aim of the formulation will be to develop a shared understanding of the child's difficulties and needs, and guide interventions.

2.6.5 Dietician, speech and language assessments and occupational therapy (e.g. Activities of Daily Living (ADL), sensory and coordination, social skills) assessments and services may be required and where these are not directly provided by the Tier 4 service there should be defined agreements to ensure timely access/provision of during the course of the child's admission.

2.6.6 Where there has been an emergency admission a multi-agency review should be held within 5 working days. This review should address the same questions as the Access Assessment including the goals of admission and involve the child, parents/carers, community team and any other agency involved in the child's care.

2.6.7 Where the young person has a learning disability or autism, it is the responsibility of the CCG commissioner to convene a pre-admission CETR and receiving inpatient units should request this is held prior to admission.

2.6.8 If a CETR was not carried out prior to admission, one must be held within 10 days of admission. CETRs should be repeated every 3 months during an admission in line with the latest national guidance and policy (March 2017). Guidance can be found using the following link www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf Support and guidance for children and young people with autism and learning disability can be sought from the Transforming Care Case Manager and the Regional Strategic Case Manager in NHS England. For any children and young people receiving a diagnosis whilst an in-patient, providers should notify NHS England via their regional case manager, for monitoring and reporting purposes.

2.6.9 Treatment will take place alongside assessments and if appropriate start at the point of admission. The care and treatment plan will be modified and updated regularly as the child's needs change.

2.6.10 The general children's Tier 4 service will organise regular Care Programme Approach (CPA) meetings involving the child (in a developmentally

appropriate way), their parents/carers, Tier 3 CAMHS, education and any other agencies involved in the young person's care eg Social Care.

2.6.11 For emergency admissions, the first CPA will be held within 5 working days of the admission.

2.6.12 For planned admissions the first CPA will be within the first 4-6 weeks of day/in-patient admission

2.7 Care and Treatment Programme

2.7.1 The Care Programme Approach (or equivalent) will underpin the structure of care in the service. The CPA format and documentation used must be appropriate for use with parents/carers with a modified version for children and young people.

2.7.2 Care plans should be drawn up with the child and parent/carer and they should have their own child-friendly copy, appropriate for their development needs. Care plans should also be shared with parents/carers in accordance with information sharing protocols. For children and young people with autism and learning disability, an Education Health Care Plan, Communication Passport and Health Passport should be in place and up to date. Reasonable adjustments must be made to cater to individual needs e.g. environmental stimuli, easy access plans/reports, time allocation for activities (group/individual) and visiting hours.

2.7.3 The care plan will reflect the child's needs in the following domains

- Mental health
- Developmental needs
- Physical Health
- Risk
- Family support / functioning
- Social functioning
- Spiritual and cultural
- Education,
- Where relevant includes a Carer's Assessment
- Where relevant substance misuse
- Where relevant addresses offending behaviour

2.7.4 The treatment and care plan will be informed by a comprehensive formulation of the child's needs and difficulties and, where possible, be based upon current NICE guidelines or established evidence-based best practice guidance. Day placement should be offered where feasible allowing for risk, geography and transportation to the service.

2.7.5 The treatment/care plan will incorporate routine outcomes monitoring used to monitor progress and treatment on a week to week basis, as a minimum those in QNIC ROM.

2.7.6 For children and young people admitted for treatment of low weight eating disorder the treatment plan will include regular monitoring of weight and other physical indices in accordance with current Junior Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines

2.7.7 Following the initial CPA meeting, the service will organise regular CPA reviews at a frequency determined by the child or young person's needs but generally at a frequency of between 4-6 weeks, unless a time scale is specified by NICE guidance, such as for eating disorders where reviews should take place at least monthly.

2.7.8 Day/In-patients will be offered a structured programme of education enabling them to continue their education.

2.7.9 In addition, services will offer a structured programme of recreational as well as therapeutic groups. Children and young people will have an individualised programme which allows attendance at elements of the group programme appropriate to their need.

2.7.10 Children and young people receiving supported discharge because of school integration will attend elements of the day/in-patient programme according to need.

2.7.11 Where specific evidence based individual therapies are indicated these should be offered without delay. Such therapies may include

- Cognitive Behaviour Therapy (CBT),
- Behaviour Therapy ,
- Psychological interventions directly with the child/young person or indirectly via nursing staff/parents/carers
- Psychodynamic psychotherapy
- Creative therapies
- Speech and language therapy
- Occupational therapy
- Family based interventions
- Psychotropic and other medication
- Eye Movement De-sensitisation Reprocessing (EMDR)
- Medication

2.7.12 All families/carers will be offered parent and family work. This may include behaviour modification with parents/carers as co-therapists, parenting skills training; parents support group, social work support, systemic family therapy, and other therapies as appropriate to support positive family relationships.

2.7.13 The referring Tier 3 CAMHS will ensure a Care Co-ordinator attends CPA reviews and retains contact with the child and their parents/carers during the period of Tier 4 care.

2.7.14 Where Crisis and Home Treatment is provided as part of the community, Tier 3 CAMHS services should collaborate closely with the Tier 4 service to reduce the likelihood of unnecessary admissions and provide in-reach to the Tier 4 CAMHS service to aid the transition to community care for those children and young people already admitted.

2.8 Risk Assessment and Management

2.8.1 The range and nature of risk behaviour in a Tier 4 CAMHS General Child Service is broad and services must assess the risk and consequences of admission for the child. Risks can include self-harm, suicidal behaviour, physical consequences of low weight, severe self-neglect, absconding, aggression, sexualised behaviour, fire-setting, and exploitation by others.

2.8.2 Risk assessment and management involves a consideration of the individual child's risk factors and environmental factors which in day/in-patient services include consideration of the group dynamics and impact of other patients.

2.8.3 Tier 4 CAMHS General Children's Services will have a dynamic validated risk assessment and management model in place to support clinicians in making day-to-day decisions about individual children's care. This will include principles of hazard identification, risk reduction, risk evaluation and a recognised risk communications process.

2.9 High Dependency Area

2.9.1 There will be a designated high-dependency area accessible within the Tier 4 Children's network where children and young people requiring a higher level of management can be supported for brief periods. This area should include a bedroom, bathroom and recreational areas.

2.9.2 The term high dependency area is a descriptive term not to be confused with "high dependency units" which are not specified for children and young people by NHS England.

2.9.3 Children and young people being secluded in a high dependency area must be managed in accordance with the appropriate legal framework and in line with the latest Code of Practice.

2.9.4 The service will refer children and young people who pose a significant and continued risk to others OR whose risk to themselves cannot be safely managed within a general purpose children's unit to an appropriate environment such as a PICU.

2.10 Enhanced Observations (Specialing)

All Tier 4 CAMHS General Children's Inpatient Services will:

- Develop and implement a policy for enhanced observations in the

day/in-patient element

- Enhanced observations provide a level of supervision above routine observations.
- The frequency is determined by the needs of the child or young person, for example regular 5-minute checks or continuous supervision.
- Deliver enhanced observations in line with good clinical practice (for example but not limited to - when a child exhibits overt physically aggressive behaviour towards others, or is an active risk to themselves).
- Enhanced observations should be reviewed at least twice daily and reduced to the minimum at the earliest opportunity
- Enhanced Observations will be undertaken by staff members who are familiar with the care needs of the child or young person
- Enhanced Observations will in normal circumstances be considered to be part of the contracted level of general care.

2.11 Psychiatric Emergencies

2.11.1 The service's management of violence and aggression shall be in accordance with NICE Guidance 10 “Violence and aggression; short term management in health, mental health and community settings”.

2.11.2 The service will ensure that all staff involved in administering or prescribing rapid tranquillisation, or monitoring patients to whom parenteral rapid tranquillisation has been administered, receive on-going competency training to a minimum of Intermediate Life Support (ILS) or equivalent standard [e.g. ILS – Resuscitation Council UK covers airway, cardio pulmonary resuscitation (CPR) and use of defibrillators. Medication for Children and young people with Autism and LD should be as a last resort, in line with STOMP (stopping over medication of people with LD/ASD). Regular reviews of prescribed medication and challenges should be made.

2.12 Home Leave

2.12.1 Home leave is important in helping children and young people maintain family and community relationships whilst in an inpatient setting and are an important element of the transition to outpatient care.

2.12.2 The plan for home leave must be included in the overall care plan made prior to any leave being taken and should be agreed with the commissioner/Case Manager. The planning process should consider if transition to another element of the adolescent pathway is included as part of the leave plan.

2.12.3 Home leave for detained patients can only be agreed by the Responsible Clinician under s17 of the MHA.

2.12.4 Leave of up to 2 days should be encouraged.

2.12.5 Any additional leave over 2 days per week or greater than 5 days in total

on one occasion or over several occasions during an admission should be agreed with the commissioner/Case Manager.

2.12.6 Each planned home leave must be risk assessed, include liaison with local services as appropriate and managed with due regard for the service's duty of care to the patient and the commissioning body's statutory duty of care.

2.13 Physical healthcare

2.13.1 Providers will ensure that patients routinely undergo a full assessment of physical health needs.

2.13.2 Care and treatment plans should reflect both mental and physical healthcare needs and all patients will have access to:

- a comprehensive range of primary healthcare services
- regular and comprehensive physical health checks (including medication monitoring) as required
- follow-up investigations and treatment for physical conditions as required.

2.13.3 Providers caring for children and young people with low weight eating disorders should provide monitoring and services which comply with Junior MARSIPAN guidelines

2.13.4 The provider will:

- Implement all appropriate age and gender specific screening and vaccinations in line with Department of Health (DH) guidance where these are required.
- Develop referral pathways to secondary healthcare services within timescales according to DH guidelines or good clinical practice.
- Provide general health promotion activities including screening, dietary advice, sexual health, advice on drug/alcohol use and the opportunity to exercise (with appropriate supervision).
- Provide targeted programmes on smoking cessation as appropriate
- Children and young people with Autism and learning disability require annual health checks, and should have a Health Passport in place. Flags should be made with registered GP, local A&E Departments, Dentists etc. notifying of individuals needs and reasonable adjustments to be made.

2.14 Education

2.14.1 All day/in-patient services must ensure that educational sessions can be provided during the normal academic term. The education provided should be an integral part of the service provision.

2.14.2 The local authority is under a legal duty to make sure that, if a child or young person of compulsory school age is unable to attend their

primary, secondary or special school because of illness, they continue to get a full-time education unless part-time is better for their health needs.

2.14.3 Local authorities are funded to discharge this duty through the dedicated schools grant from the Department for Education. In some cases (e.g. academies) the funding is recouped from local authorities' grant allocations and paid directly by the Education and Skills Funding Agency to the provider. The cost of education provision will not be included in the cost charged to the NHS.

2.14.4 Consequently, the quality and standard of education provided although integrated within the CAMHS provision, is subject to the local authority commissioning arrangements rather than subject to the NHS England's contract with the CAMHS service provider. It is for the relevant local authority to decide what education is delivered, how it is delivered, under a funding agreement or arrangement that depends on the type of education provider.

2.14.5 In all cases the education provided should be in accordance with what is commissioned and funded by the local authority. The type of education provider determines which local authority or authorities are responsible for commissioning and funding the education provision, as follows:

- If a maintained school provides the education, the local authority that maintains the school commissions and funds the education.
- If an academy provides the education, the local authority that previously maintained the school, in whose area the academy is located, commissions and funds the education.
- If a local authority provides the education directly, or enters into a funding agreement with an independent provider to deliver the education, that local authority commissions and funds the education.

    - If an independent provider delivers the education commissioned by a local authority on the basis of an agreement in respect of each individual child or young person, the relevant local authority should be informed of their admission either prior to a planned admission or at the latest within 5 working days after the admission. This will enable the local authority to decide how to commission and fund the child or young person's education, enter into a funding agreement with the independent provider or make alternative arrangements for the young person's education.

    - Independent providers, delivering full time education for five or more pupils of compulsory school age, or one or more such pupils with an education, health and care (EHC) plan or statement of special educational needs, or who are "looked after" by the local authority, must ensure that any provision is registered with the Department for Education as

an independent school, and meets the independent school standards.

2.14.6 The standards which the education arranged by the local authority must meet are set out in statutory guidance for local authorities on alternative provision.

2.14.7 In all cases it must be suitable to the child or young person's age, ability and aptitude and any special educational needs they have, and must include appropriate and challenging teaching in English, maths and science (including IT) on a par with mainstream schools.

2.14.8 The education must be full-time or as close to full-time as in the child or young person's best interests taking account of their health needs. The full guidance can be found here:
https://www.gov.uk/government/publications/alternative-provision and https://www.gov.uk/government/publications/education-for-children-with-health-needs-who-cannot-attend-school

2.14.9 Where a child or young person has an EHC plan or statement of special educational needs, the education provider should contact the local authority responsible for drawing up the plan or statement to establish both the provision required whilst the young person is in the Tier 4 CAMHS and any additional funding available. Providers must check that the EHCP is up to date, and if not ensure that the local SEND team is made aware and takes steps to update.

2.14.10 The education provider must liaise with the virtual school head in the case of all children and young people who are "looked after" by a local authority.

2.14.11 The type of education provider determines how inspections are carried out e.g. by OFSTED, how the results of inspections are reported and how they are followed up to ensure an appropriate standard of education.

2.14.12 The education provider should establish relationships with relevant schools, colleges and other education providers to support the child or young person's transition into Tier 4 CAMHS, their education whilst they are a patient and their aftercare and transition back to their usual place of education.

2.14.13 Expectations for Health Providers and Commissioners

i) The health provider and commissioner must jointly liaise with the LA(s) responsible for commissioning education service regarding the needs of the children and young people in the inpatient service.

ii) The provider should expect the education provision to be operated in accordance with the appropriate regulatory framework, which normally

includes inspection by OFSTED (see above).

2.15 Discharge

2.15.1 Discharge planning should be started before admission, or if not possible, at the point of admission.

2.15.2 Discharge planning will include agreeing what change is required in order for the child to be able to safely return to the community. This may include a period of intensive supported discharge provided by Tier 4 CAMHS.

2.15.3 The decision to discharge or transfer a child will normally be agreed at formal CPA review and should normally be agreed with the child, their parents/carers and the Tier 3 CAMHS/community care team.

2.15.4 Criteria for discharge will be individualised but should be broadly that the child's level of risk can be managed in the community or elsewhere and/or there has been a reduction in impairment and their treatment needs can be met within Tier 3 CAMHS or elsewhere.

2.15.5 The Provider shall use all reasonable endeavours to avoid circumstances whereby discharge is likely to lead to emergency re-admission, including agreeing a crisis plan in a CPA review meeting.

2.15.6 Throughout the period of care the Provider will remain in contact with referring Tier 3 CAMHS and other agencies as appropriate in relation to the patient's progress and prospect and timing of discharge. The Provider will also support the child to retain contact with their home-base community as appropriate.

2.15.7 All Tier 4 CAMHS Children's Service pathways will include supported discharge services to help facilitate the earliest appropriate discharge for those that are admitted. This service can include staff from within the inpatient team liaising with professionals working in the community and offering intensive support to families or carers or services linked to Tier 3 CAMHS in-reaching whilst the child or young person is in hospital and providing intensive support to facilitate discharge.

2.15.8 A discharge summary will be sent to the family/ carer, referrer and the General Practitioner (GP) at the end of each child's stay and within 7 days of discharge. This will include recommendations for future work/treatment. This summary should be sent to other involved agencies eg LA corporate parent with the consent of the child and/or family according to information sharing protocols.

2.15.9 The service will offer liaison with schools to support educational re-integration

2.16 Delayed discharges

If a child's discharge is delayed from the service other than for clinical reasons, the Provider will inform the relevant commissioning body and the referrer as soon as possible to identify how the delay can be overcome. Collaboration with other agencies will be required and will also involve the need to trigger NHS England escalation procedures when all other options have been explored and a local resolution is not possible.

2.17 Discharges Against Medical Advice

Protocols should be in place to ensure that safeguarding issues are considered for all children and young people who are discharged against professional advice. These policies should include notification of all relevant agencies to ensure ongoing support to the child and family/carers.

2.18 Transfer and transition to another Tier 4 CAMHS setting

2.18.1 Where a child or young person requires transfer to an alternative Tier 4 or other inpatient service, their clinical needs and best interests should dictate whether they are transferred from one unit to another. Planning must be done collaboratively and a timely way.

2.18.2 Where transition to another CAMHS service is likely to be required because of age, planning should commence at the very earliest opportunity (where possible 6 months before the 13th birthday) and should involve the child/young person, family and carers. The NHS England Case Manager must be involved in the transition planning and decision making together with other agencies e.g. Community Team, Social Care, Education as appropriate.

2.18.3 The current service has lead responsibility in arranging the transfer including completion of the referral forms. The provider will:

- Collaborate with the alternative provider to facilitate transfer
- Take all necessary steps to prepare the child and parents/carers for transfer
- Provide a full handover including assessment reports, care plan, risk, treatment received and response
- Arrange appropriate transport and any required escort consistent with the Patient's risk assessment
- Liaise effectively with schools to ensure educational re-integration is successful

2.19 Family and Carer involvement (including Local Authority if acting as corporate parent)

Family/carer involvement should include

- Rights to visits and phone calls with family/carers
- Involvement with family/carers in providing a history
- Involvement of family/carers in appropriate treatment and planning for

discharge

2.20 Safeguarding

2.20.1 Children and young people in Tier 4 CAMHS are vulnerable, with high levels of dependence, but low levels of trust. In addition to the statutory responsibilities of professionals, sensitivity to these children and young people's potential vulnerabilities is needed.

2.20.2 The service must take all appropriate measures in relation to the safeguarding of children and young people under their care; in particular ensuring that:

- There is a child protection policy in place that reflects the guidance and recommendations of a 'Competent Authority' and that policy is implemented by all staff
- There is a nominated person within the service who fulfils the role of the competent person for child protection issues.
- There are systems in place to support the Prevent programme and services available aimed at reducing risks of child sexual exploitation.
- There is a robust mechanism in place for the reporting of child protection concerns in accordance with the Children Acts
- All clinical staff complete training in child protection issues to meet their obligations under the Children Acts and to meet the requirements of Safeguarding Children and Young People: Intercollegiate Document for Healthcare Staff 2009.
- Systems are in place to ensure the statutory guidance in "Working together to safeguard children" (2015) is followed.

2.21 Co-located Services

2.21.1 A Tier 4 general children's service, must not be an isolated or stand-alone facility. It must be located with other mental health services or acute paediatric services, to manage complexity and so that there is a critical mass of staff to ensure adequate response team resource.

2.21.2 Robust response plans will be in place to deal with any emergency requiring additional staff.

2.22 Interdependence with other Services

2.22.1 Tier 4 CAMHS general children's services are part of a spectrum of services that meet the needs of children and young people with mental disorders including neurodevelopmental disorders such as learning disability and autism in need of specialist care and treatment.

2.22.2 Interdependent services at national level include:

- Nationally recognised providers of specialist secure medium and low secure in-patient care for children and young people with mental or

neurodevelopmental disorders, including learning disability or autism
- Youth justice custodial settings (Young Offender Institutions (YOIs), Secure Training Centres (STCs) or secure children's homes)
- Secure welfare settings
- Community FCAMHS providers
- Other providers of highly specialist residential or educational care for children and young people.

2.22.3 Interdependent services at regional and sub-regional levels include:

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

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

3.1.1 The service outlined in this specification is for children and young people ordinarily resident in England

3.2 Population Needs

3.2 1 Assessing the incidence and prevalence of severe childhood mental disorders likely to require Tier 4 CAMHS Adolescent Services is challenging. Prevalence is influenced by a variety of factors (social deprivation, family breakdown, learning difficulties, ethnicity etc.) and estimates of prevalence of specific child and adolescent mental health

disorders are often broad and relate to the full range of clinical severity whereas only a minority require Tier 4 care. In addition to epidemiological factors service factors such as gaps in service, capacity of community services or presence of intensive local outreach services will influence use of Tier 4 services. We know that there will always be a small number of the most severely unwell children in each region who will require an inpatient psychiatric admission in order to address their clinical needs adequately.

3.3 Expected Significant Future Demographic Changes

3.3.1 It is not known what the specific future demographic changes will be, however, the rates of children and young people presenting with self-harming behaviours has significantly increased over the last 10 years. There are significantly larger numbers of high risk children and young people with complex needs subject to high levels of supervision in a range of residential and special educational settings as well as in everyday community settings where needs and risk may be difficult to manage and therefore not adequately addressed. 'Transforming Care' proposals set out a requirement for dynamic risk registers and better understanding of local populations of children and young people with learning disability.

3.4 Evidence Base

3.4.1 There are no randomised controlled trials comparing inpatient care for children and adolescents (as provided in the UK) with alternative intensive interventions. However, there are a large number of studies using different designs which generally conclude that inpatient care is effective. Summaries of these studies can be found in The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services -COSI-CAPS report (The Costs, Outcomes and Satisfaction for Inpatient Child and Adolescent Psychiatric Services (COSI-CAPS) study ; Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO)Tulloch et al HMSO 2008).

3.4.2 The best UK research evidence regarding Tier 4 CAMHS In-patient treatment for children is derived from the Children's and Young Person's Inpatient Evaluation (CHYPIE) Department of Health study (Green, Jacobs et al 2007) which examined care pathways, outcomes and health economics for children and adolescents using a selected group of Tier 4 services. For the children aged 12 and under in this large UK study, clinical outcome scores (The Children's Global Assessment Scale (CGAS) and Health of the Nation Outcome Scale Children and Adolescents (HONOSca)) showed clinically and statistically significant improvement in scores between admission and discharge. After discharge the clinical scores for children returned to levels commonly recorded in children attending outpatient clinics. Clinical gains made were maintained a year after discharge.

4 Outcomes and Applicable Quality Standards

4.1 Quality Statement – Aim of Service

4.1.1 The expected outcomes of the service support the national ambition to optimise lengths of stay, variation in service availability and access and improve the experience of children and young people, their families and carers using mental health services

4.1.2 The expected outcomes for this service will be delivered in the context of balancing the following three principles:

- Developmentally appropriate care attuned to the complex needs of children and young people that facilitates emotional, cognitive, educational, physical and social development
- A secure and safe environment that can appropriately manage high risk, high cost behaviours whilst effectively managing high levels of vulnerability
- The provision of comprehensive multi-faceted evidence-based treatments

4.1.3 The core objectives are to:

- Assess, formulate and treat mental disorders including neurodevelopmental disorders such as autism
- Reduce the risk of harm to self and others
- Provide an individualised developmentally appropriate framework of care that meets needs and includes the child and family/carers in decision-making
- Embed the principles of safeguarding children and young people in everyday service practice
- Provide a time-limited intervention that supports recovery and will enable a safe transition to the community.
- Provide all children and young people using the service with a full multi-disciplinary biopsychosocial assessment and formulation of needs resulting in a care plan developed in collaboration with them and reflective of their wishes and aspirations
- Deliver a range of specialist treatment programmes individually or in groups that enable effective discharge to a community setting
- Deliver care in line with the principles of Transforming Care including the facilitation and pro-active use of Care Education and Treatment Review (CETR) process
- Achieve delivery of efficient and seamless transfers of children and young people between acute and intensive care settings
- Use the Care Programme Approach (or equivalent) to underpin service delivery
- Proactively manage violence and aggression
- Provision of a range of activity programmes for periods where education is not provided
- Deliver care within a therapeutic regime that places primary importance on behavioural approaches, de-escalation and psychopharmacological treatment of mental illness and agitated behaviour in the context of mental disorder

4.2 NHS Outcomes Framework Domains

Domain 1	Preventing people from dying prematurely	x
Domain 2	Enhancing quality of life for people with long-term conditions	x
Domain 3	Helping people to recover from episodes of ill-health or following injury	x
Domain 4	Ensuring people have a positive experience of care	x
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	x

4.3 Outcome Indicators

4.3.1 Outcome and activity measures are subject to further development and change. Detailed definitions of indicators setting out how they will be measured, is included in schedule 6.

No.	Indicator	Data source	Domain(s)	CQC Key Question
Clinical Outcomes/Quantitative Indicators				
101	% of patients where the crisis intervention service or home treatment team is involved in assessment/decision prior to readmission.	Provider	1, 2, 5	safe, effective responsive caring
102	Number of emergency referrals reviewed and responded to by a senior clinician within 4 hours.	Provider	1, 3 , 4, 5	safe, effective responsive caring
103	Number of emergency referrals admitted within 24 hours of the initial referral.	Provider	1, 3 , 4, 5	safe, effective responsive caring
104	Number of urgent referrals admitted within 48 hours	Provider	1, 3 , 4, 5	safe, effective responsive caring
105	% of people with learning disabilities and/or autism receiving a Care, Education and Treatment Review (CETR) prior to admission or receiving a Care, Education and Treatment	Provider	2, 3, 4, 5	safe, effective responsive caring

		review within two weeks of admission			
	106	% of patients who have a discharged plan agreed before admission or within 24 hours admission	Provider	2, 3, 4, 5	safe, effective responsive caring
	107	% of patients assessed within 7 days of admission using HONOSCA (patient/family/carer/clinician versions) and GBO to determine their health and social functioning	Provider	2, 3, 4, 5	safe, effective responsive caring
	108	Average HONOSCA improvement score for patients discharged during the quarter.	Provider	1, 3 , 4, 5	safe, effective responsive caring
	109	% of patients who receive their initial care plan within five working days (including CPA)	Provider	1, 2, 3, 4, 5	safe, effective responsive caring
	110	% of patients with Improvement in behavioural and emotional problems - SDQ.	Provider	1, 2, 3, 4, 5	effective, caring
	111	Percentage of eligible staff who have received clinical supervision as per Trust/organisation policy.	Provider / SSQD	3, 4, 5	safe, effective, well-led
	112	Percentage of staff requiring training, who have received level 3 safeguarding children training in specialised services	Provider / SSQD	3, 4, 5	safe, effective, well-led
	113	Mean length of stay for patients discharged during the quarter	Provider	1, 2, 3, 5	safe, effective, caring
	114	Ratio of substantive staff to agency staff or bank staff during the previous quarter.	Provider	1, 2, 3, 5	safe, effective, caring
	115	Care hours per patient day	Provider	1, 2, 3, 5	safe, effective, caring
	Patient Experience				
	201	All patients receive an experience of service questionnaire.	Self-declaration	2, 4	effective, caring, responsive
	202	All carers receive an experience of service questionnaire.	Self-declaration	2, 4	effective, caring, responsive
	203	Patient information is provided at the point of assessment.	Self-declaration	2, 4	effective caring
	Structure & Process				
	301	There is an MDT in place with membership as per the service specification.	Self-declaration	1, 2, 3, 5	safe, effective responsive caring
	302	Each patient has a named clinical psychologist and	Self-declaration	1, 2, 3, 5	safe, effective responsive

	occupational therapist.			caring
303	Each patient has access to an Independent Mental Health Advocates (IMHA).	Self-declaration	3, 4, 5	safe, effective, caring, responsive
304	There are agreed clinical protocols/guidelines.	Self-declaration	1, 3, 5	safe, effective, caring, responsive

4.3.2 Commissioned providers are required to participate in annual quality assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C.

4.3.3 Applicable CQUIN goals are set out in Schedule 4D.

5 Applicable Service Standards

5.1 Applicable Obligatory National Standards

5.1.1 Robust procedures relating to the responsibilities of services and staff under the Mental Health act, the Children Acts and other relevant legislation should be put in place and regularly reviewed.

5.1.2 The service must deliver services, comply to and work within the requirements of

- Mental Health Act 1983
- Mental Health Act Code of Practice 2015
- Human Rights Act 1998
- The Children Act 1989 and 2004
- Criminal Justice Act 1998
- Criminal Justice Act 2003
- Mental Capacity Act 2005
- The Autism Act 2009
- Transforming Care for People with Learning Disabilities – Building the Right Support
- Working Together to Safeguard Children (2010) and relevant subsequent legislation
- UN Convention on the rights of the Child

5.2 Other Applicable National Standards to be met by Commissioned Providers

5.2.1 Services will comply with the following requirements

- Operate 24 hours a day, 365 days per year
- Response to urgent referrals within 4-hours and non-urgent referrals within 1 week
- Admission takes place within 24 hours of an appropriate referral with

necessary documentation being received.

- Providers will be registered with QNIC and participate in the peer review process.
- Discharge arrangements
- A responsible CAMHS team, including an allocated Responsible Clinician will be in place. .
- The Tier 4 service should convene at least one Section 117/CPA pre-discharge meeting before the start of the discharge process for people detained under the Mental Health Act.
- A brief discharge note, including details of diagnosis, medications, allergies and sensitivities, physical health, risk, and recommended discharge care plan, should be provided at the point of discharge
- A full discharge summary should be provided within 7 days of the discharge date.
- Each child will have their own room and will have a Responsible Clinician allocated by the service for the duration of admission
- The nursing model of care will be based on the 'primary nurse' model, each patient will have a named nurse responsible for their day to day nursing needs,
- Each child will have a Care Coordinator/Case Manager allocated within the service to co-ordinate care within the Care Programme Approach (CPA) framework.
- The overall model of care will be delivered through a Multi-Disciplinary Team (MDT) approach consisting of psychiatrists, clinical psychologists, psychotherapists, occupational therapists, social workers, nurses and teachers, in accordance with standards and guidelines outlined by the Quality Network for In-patient Care (QNIC).
- The MDT will be experienced in the assessment, identification and management of children and young people with neurodevelopmental disorders including learning disabilities and/or autism
- The service will have expertise in and policies covering the use of psychopharmacology in severe mental illness including the use of rapid tranquilisation and local PRN
- Each child will be reviewed by the MDT at least weekly and will have a comprehensive up to date MDT care plan and risk assessment developed by the MDT with the young person and, if appropriate, with the young person's family in accordance with best practice guidance. The young person will be kept updated with any changes to their care plan.
- Children and young people with learning disability and/or autism will have their specific needs incorporated in the care plan. This will include practice set out in the Transforming Care national programme particularly the active support, facilitation and delivery of the CETR process.
- Each child will have access to a named clinical psychologist who will undertake a needs based assessment, contribute to a multidisciplinary risk assessment, develop a formulation and use this to identify the appropriate psychological treatment programme on either an individual and/or group basis
- Each child where appropriate will have access to an occupational therapist who will undertake a comprehensive occupational therapy assessment and

will deliver an appropriate occupational therapy programme based on identified needs

- Facilitate access to and/or deliver timely and appropriate speech and language assessment and treatment during the course of their admission.
- Each child will have access to a social worker from the service to liaise with the young person's local Social Care Children's Service to ensure the provision of a full range of appropriate social care services to the patient, their family and carers.
- Each child will have access to the Independent Mental Health Advocates (IMHA) who will assist by undertaking the direct advocate's role.
- Each child will receive three culturally appropriate meals per day. The food will be prepared in accordance with NHS National guidelines on nutrition and variety.
- Have their religious and cultural needs met

5.2.2 Services will comply with the following guidance:

- NICE (2017) – Eating Disorders: Recognition and Treatment. NG69
- NICE (2005) - Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder CG31
- NICE (2018) Bipolar Disorder: Assessment and Management. CG185
- NICE (2009) – Borderline Personality Disorder CG78: recognition and management
- NICE (2011)- Psychosis with substance misuse in over 14s: assessment and management CG120
- NICE (2016) – Psychosis and schizophrenia in Children and Young People: recognition and management CG155
- NICE (2017) - Depression in children and young people: identification and management in primary, community and secondary care CG28
- NICE (2015) NG10 – Violence and aggression: the short term management in mental health; health and community settings .

5.3 Service Environment

5.3.1 The provider will meet the following standards:

- The premises and the facilities are child and young person and family friendly
- and meet appropriate statutory requirements, are fit for purpose as determined by the relevant statutory regulator (e.g. the Care Quality Commission), conform to any other legislation or relevant guidance
- A clean, safe and hygienic environment is maintained for patients, staff and visitors
- A care environment in which patients' privacy and dignity is respected and confidentiality is maintained
- There is appropriate, safe and secure, outdoor space for recreation and therapeutic activities
- A care environment is provided where appropriate measures are taken to reduce the potential for infection and meets the requirements of the

Healthcare Associated Infections (HCAI) code of practice

- The service ensures that the nutritional needs of all children and young people are adequately met and that comments about food and nutrition are incorporated in menu design
- An environment that ensures that no child or young person, visitor or staff member is allowed to smoke on the premises
- Facilities which include rooms which are suitable for contact between children and young people and their families/carers, including siblings and are available at weekends and evenings. These should be in proximity to the ward.
- Bedroom and bathroom areas should be gender-segregated.
- Provide an area that can be used as a multi faith room
- Where possible the service should provide sleep over facilities for parents or carers nearby to the ward or signposting to local alternatives.

5.4 Additional considerations

- Children and young people who are in the process of considering their gender identity and who are dressing and living according to their personal identity should be admitted to beds in male or female areas according to their preferred identity.
- There should always be consideration of privacy and dignity for the child or young person and whether any additional arrangements or supports are needed.
- Risk assessment should consider whether any additional safeguarding is required for this or the other children and young people, this will be a very individual assessment
- Gender identity is separate from orientation and does not necessarily present any risks. The key issue is for the child or young person to feel supported and understood at all points.

5.5 Other Applicable Local Standards

Not applicable

6 Designated Providers (if applicable)

Not applicable

7 Abbreviation and Acronyms Explained

The following abbreviations and acronyms have been used in this document:
CAMHS: Child and Adolescent Mental Health Services
CCG: Clinical Commissioning Group
CETR: Care Education and Treatment Review
CPA: Care Programme Approach
HONOSCA: Health of the Nation Outcomes Scores for Children and Adolescents
IMHA: Independent Mental Health Advocate
MDT: Multi- Disciplinary Team
NICE: National Institute for Health Excellence

QNIC: Quality Network for Inpatient CAMHS
PRN: medication as required