SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	1723
Service	Child and Adolescent Mental Health Services Tier 4 (CAMHS T4): General Adolescent Services including specialist eating disorder services
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 adolescent inpatient services including specialist eating disorder services (Appendix 1) 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 including crisis intervention, home treatment, step-down care 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 'step-down' services alongside inpatient provision'.

2.1.2 Tier 4 inpatient CAMHS services in England offer care at four levels to support the effective management of differing nature of risk presented by children and young people who are under 18 years:

- **Medium secure services** accommodate young people with mental and neurodevelopmental disorders (including learning disability and autism) who present with the highest levels of risk of harm to others including those who have committed grave crimes.
- **Low secure services** accommodate young people with mental and neurodevelopmental disorders at lower but significant levels of physical, relational and procedural security. Young people may belong to one of two groups: those with 'forensic' presentations involving significant risk of harm to others and those with 'complex non-forensic' presentations principally associated with behaviour that challenges, self-harm and vulnerability.
- **Psychiatric Intensive Care Units (PICU)** manage short-term behavioural disturbance which cannot be contained within a Tier 4 CAMHS general adolescent service. Behaviour will include serious risk of either suicide, absconding with a significant threat to safety, aggression or vulnerability due to agitation or sexual disinhibition. Levels of physical, relational and procedural security should be similar to those in low security.
- **General adolescent services** provide inpatient care without the need for enhanced physical or procedural security measures

2.1.3 This specification relates to general adolescent services including specialist eating disorder services.

2.1.4 Tier 4 CAMHS General Adolescent Services will be provided across an integrated care pathway which includes crisis/ home treatment services, specialist eating disorder services, inpatient services, step-down

services and Tier 3 CAMHS. 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.

2.1.5 Tier 4 Commissioners will liaise with CCGs and Local Authorities (LA) to ensure that there are no gaps in the pathway. Many 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.

2.1.6 Young people must 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 community Tier 3 CAMHS as soon as it is safe to do so.

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

2.1.8 Acceptance by a Tier 4 CAMHS General Adolescent (Inpatient) Service must 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.

2.1.9 The above services must provide safe and effective 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).

2.1.10 The services should comprise the following elements:

- Crisis/home treatment service
- Planned intensive home-based treatments
- 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
- Step-down provision.

2.1.11 The crisis assessment, crisis management and gatekeeping functions should be provided by a single team that may or may not offer other functions such as step down, intensive outreach and/or home treatment.

2.1.12 The team should be integrated with or closely collaborate with the Tier 4 CAMH 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 Adolescent Service must be from Tier 3 CAMHS or community adult mental health services and must follow the National Referral and Access Process (Forms 1 and Form 2).

2.2.2 Responsibility for the care of the young person remains with the referring agency/service until the point of admission to the Tier 4 service.

2.2.3 The processing of referrals should not be delayed because of issues relating to establishing commissioning responsibility or ordinary residence status.

2.2.4 Response Times:

- **Emergency referrals** must be reviewed and responded to by a senior clinician within 4 hours. Emergency assessment must 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 must be reviewed and responded to within 48 hours
- **Routine referrals** must be reviewed and responded to within 1 week.

2.3 Assessment

2.3.1 An Access Assessment must determine suitability for acceptance by Tier 4 CAMHS Adolescent Service; this should be done in consultation with the Crisis/Home treatment services.

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 must explicitly address the following issues:

- Major treatment/care needs
- The best environment / level of service (day/in-patient or community crisis management/home treatment/intensive outreach) 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.

2.4 Acceptance Criteria

2.4.1 The service accepts referrals meeting the following criteria:

- Primary diagnosis of mental illness including young people with neurodevelopmental disorders including mild learning disability and autism, drug and alcohol problems, physical disabilities, or those with social care problems as secondary needs
- Severe and complex needs that cannot be safely managed within Tier 3 CAMHS
- Aged 13 years until 18th birthday (there may be rare cases of 12 year olds being more appropriately admitted than to a Tier 4 CAMHS Children's Unit)
- May require detention under the Mental Health Act although not a pre-requisite.

2.5 Exclusion criteria

- Over 18 years of age (unless this is for a short time period to complete an episode of care and appropriate safeguards are in place)
- Young people with a moderate or severe learning disability unless considered to be in their best interests and they would be able to benefit from general adolescent Tier 4 service intervention
- Young people with a primary diagnosis of substance misuse
- Young people with a primary diagnosis of conduct disorder and no co-morbid mental disorder
- Young people whose primary need is for accommodation due the breakdown of family or other placement
- Young people who are in need of Tier 4 CAMHS Low Secure or Tier 4 CAMHS Medium Secure care
- Young people who are currently in secure settings (including secure welfare placements) provided by local authorities or Youth Justice, who in the first instance would be referred to the Tier 4 CAMHS Medium Secure or a Low Secure Unit
- Young people who are deaf where care may be more appropriately be

provided by the National Deaf CAMHS service

- Young people with severe autism where it is clinically assessed that care would be more appropriately provided by a specialist unit.

2.6 Admission

2.6.1 Admission can be to any of the general adolescent service elements.

2.6.2 All patients must 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 young people must have an initial assessment (including a risk assessment) and care-plan completed within 24 hours. Where admission is for day/in-patient care this will include a physical examination.

2.6.4 For young people receiving Crisis/Home Treatment from the Tier 4 CAMHS Adolescent Service the physical assessment may be provided by the young person's General Practitioner (GP) or by a clinician from another team e.g. paediatrician.

2.6.5 All young people must 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 young person 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 must address the young person's goals and wishes/feelings as far as possible. The aim of the formulation is to develop a shared understanding of the young person's difficulties and needs, and guide interventions.

2.6.6 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 young person's admission.

2.6.7 Where there has been an emergency admission a multi-agency review must 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 young person, parents/carers, community team and any other agency involved in the young person's care.

2.6.8 Where the young person has a learning disability or autism every effort must be made to hold a Care, Education and Treatment Review (CETR) before admission, including a Blue Light CETR if there is not time to convene a full one.

2.6.9 If a CETR was not carried out prior to admission one must be held within 2 weeks of admission. CETRs must 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

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

2.6.11 The general adolescent service must organise regular Care Programme Approach (CPA) meetings involving the young person, their parents/carers, Tier 3 CAMHS and any other agencies involved in the young person's care.

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

2.6.13 For planned admissions the first CPA must be within the first 3-6 weeks of day/in-patient admission.

2.7 Care and Treatment Programme

2.7.1 The Care Programme Approach must underpin the structure of care in the service. The CPA format and documentation must be appropriate for use with young people.

2.7.2 Care plans should be drawn up with the young person and they should have their own copy. Care plans should also be shared with parents/carers when possible and in accordance with information sharing protocols.

2.7.3 The care plan must reflect the young person's needs in the following domains:

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

2.7.4 The treatment and care plan must be informed by a comprehensive formulation of the young person's needs and difficulties and, where possible, be based upon current NICE guidelines or established evidence-based best practice guidance.

2.7.5 The treatment/care plan must incorporate routine outcomes monitoring such as those set out by QNIC to monitor progress and treatment on a week to week basis.

2.7.6 For patients admitted for treatment of low weight eating disorder the treatment plan must include regular monitoring of weight and other physical indices in accordance with current Junior Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines (Royal College of Psychiatrists).

2.7.7 Following the initial CPA meeting, the service must organise regular CPA reviews at a frequency determined by the 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 must be offered a structured programme of education enabling them to continue their education.

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

2.7.10 Patients receiving step-down care should attend elements of the day/in-patient programme according to need.

2.7.11 Where specific evidence-based individual interventions are indicated these must be offered without delay. Such evidenced-based interventions may include

- Cognitive Behaviour Therapy (CBT)
- Interpersonal Therapy for Adolescents
- Cognitive Analytic Therapy (CAT)
- Dialectical Behaviour Therapy (DBT)
- Eye Movement De-sensitisation Reprocessing (EMDR) and medication
- Creative therapies and psychodynamic psychotherapies.

2.7.12 All families/carers must be offered family/carer meetings to identify family/carer support and psychoeducational needs as well as the potential need for formal family/carer interventions/therapy.

2.7.13 Where a specific form of family therapy is indicated such as Eating

Disorder Focussed Family Therapy (EDFFT) for anorexia nervosa this must be offered.

2.7.14 The referring Tier 3 CAMHS or AMH team should ensure a Care Co-ordinator attends CPA reviews and retains contact with the patient and their parents/carers during the period of Tier 4 care.

2.7.15 Where Crisis-Home Treatment is provided as part of the community Tier 3 CAMHS services must 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 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 Adolescent Service is broad and services must assess the risk and consequences of admission for the young person. 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 patient'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 Adolescent must have a dynamic recognised risk assessment and management model in place to support clinicians in making day-to-day decisions about individual patient's care. This must include hazard identification, risk reduction, risk evaluation and a recognised risk communications process.

2.9 High Dependency Area

2.9.1 There must be a designated high-dependency area within the Tier 4 service where patients requiring a higher level of management can be supported for brief periods. This area must 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 young people by NHS England.

2.9.3 Young people placed in the high dependency area should normally be detained under the Mental Health Act unless they are able to give capacious consent to the placement and are free to leave the area when they wish to do so.

2.9.4 Young people being secluded in a high dependency area must be

detained under the Mental Health Act and must be managed in line with the latest Code of Practice unless there is a cogent reason for not doing so, this decision and rationale must be clearly documented and reviewed regularly over the period of seclusion.

2.9.5 The service must ensure that young people who pose a significant and continued risk to others OR whose risk to themselves cannot be safely managed within a general purpose adolescent unit are transferred to an appropriate environment such as a Psychiatric Intensive care Unit (PICU) or Low Secure Unit.

2.10 Enhanced Observations (Specialing)

2.10.1 Enhanced observations provide a level of supervision above routine observations. The frequency is determined by the needs of the young person, for example regular 5-minute checks or continuous supervision.

2.10.2 Enhanced Observations will in normal circumstances be considered to be part of the contracted level of general care.

2.10.3 All Tier 4 CAMHS General Adolescent Inpatient Services must:

- Develop and implement a policy for enhanced observations in the day/in-patient element
- Deliver enhanced observations in line with good clinical practice (for example but not limited to - when a young person exhibits overt physically aggressive behaviour towards others, or is an active risk to themselves).
- Review enhanced observations at least twice daily and reduced to the minimum at the earliest opportunity
- Undertake enhanced observations using staff members who are familiar with the care needs of the young person.

2.11 Psychiatric Emergencies

2.11.1 The service's management of violence and aggression must 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 must 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).

2.12 Home Leave

2.12.1 Home leave is important in helping young people maintain family and community relationships whilst in an inpatient setting and is 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 of 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 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 must ensure that patients routinely undergo a full assessment of physical health needs.

2.13.2 Care and treatment plans must reflect both mental and physical healthcare needs and all patients must 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 young people with low weight eating disorders must provide monitoring and services which comply with Junior MARSIPAN guidelines

2.13.4 The provider must:

- 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.

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 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 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 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 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 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 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.

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 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 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 must include agreeing what change is required in order for the young person to be able to safely return to the community. This may include a period of intensive step-down outreach provided by Tier 4 CAMHS.

2.15.3 The decision to discharge or transfer a young person should normally be agreed at formal CPA review and should normally be agreed with the patient, their parents/carers and the Tier 3 CAMHS/community care team. If the young person is detained, the service is responsible for ensuring that the organisations responsible for aftercare under s117 are involved in decisions regarding discharge.

2.15.4 All transfers of detained patients between inpatient settings must comply with s19 of the MHA.

2.15.5 Criteria for discharge must be individualised but should be broadly that the patient'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.

2.15.6 The Provider must 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.

2.15.7 Throughout the period of care the Provider must 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 must also support the patient to retain contact with their home-base community as appropriate.

2.15.8 All Tier 4 CAMHS Adolescent Service pathways should include intensive step-down services to help facilitate the earliest appropriate discharge for those that are admitted. This service can include staff from within the

inpatient outreach 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 young person is in hospital and providing intensive support to facilitate discharge.

2.15.9 A discharge summary must be sent to the family, referrer and the GP at the end of each young person's stay. This must include recommendations for future work/treatment. This summary should be sent to other involved agencies with the consent of the child and/or family according to information sharing protocols.

2.15.10 The service must offer liaison with schools to support educational re-integration.

2.16 Delayed discharges

2.16.1 If a patient is delayed from being discharged from the service other than for clinical reasons, the Provider must inform the relevant commissioning body and the referrer as soon as possible to identify how the delay can be overcome. This should involve liaison with other agencies and should also trigger NHS England escalation procedures.

2.17 Discharges Against Medical Advice

2.17.1 The Provider must have agreed protocols for occasions when a patient discharges themselves against medical advice and use of the Mental Health Act is not indicated. This must include immediate notification of the GP, Tier 3 CAMHS and all other relevant agencies and the commissioning body. The Provider must co-ordinate the network to ensure that the young person and family continue to be offered appropriate health and other services.

2.18 Transfer to another Tier 4 CAMHS setting

2.18.1 Where a patient requires transfer to an alternative Tier 4 or other inpatient service, the clinical needs and best interests of the young person should dictate whether they are transferred from one unit to another. If the patient is detained then any transfers must be carried out in line with s19 of the MHA.

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

- Collaborate with the alternative provider to facilitate transfer
- Take all necessary steps to prepare the patient and parents/carers for transfer
- Provide a full handover including assessment reports, care plan, risk, treatment received and response
- Arrange and 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

2.19.1 Family/carer involvement should include if appropriate

- 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 Young people in Tier 4 CAMHS, especially those with a learning disability are often vulnerable, with high levels of dependence, but low levels of trust. This is also particularly true of some Looked After Children (LAC). In addition to the statutory responsibilities of professionals, sensitivity to these young people's potential vulnerabilities is needed.

2.20.2 The service must take all appropriate measures in relation to the safeguarding of 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 guidance contained in the Royal College of Paediatrics and Child Health publication 'Safeguarding Children and Young People: roles and competencies for healthcare staff Intercollegiate Document' (3rd edition) 2014
- Systems are in place to ensure and have regard to the statutory guidance in "Working together to safeguard children" (2015) is followed.

2.21 Post-18 care pathway

2.21.1 In order to ensure good age transition planning it is essential to be aware of young people's age and date of birth prior to admission. There

must be a transition policy in each provider to transfer young people when they reach 18th birthday.

2.21.2 It is the responsibility of the Local Tier 3 CAMHS to have organised a transition plan six months prior to the young person's 18th birthday.

2.21.3 A young person who turns 18 during an admission to a Tier 4 inpatient care and who still requires admission should be transferred to an adult service. The Tier 4 service staff should organise the transfer jointly with the Tier 3 CAMHS service.

2.21.4 In some cases young people may stay in a Tier 4 adolescent service for a short time beyond their 18th birthday if a brief period of illness is anticipated and it is considered that it would be unnecessarily disruptive to organise a transfer to adult services. The view of the responsible commissioner in the young person's CCG and the Tier 4 commissioner Case Manager should be sought prior to the young person's 18th birthday to confirm arrangements.

2.22 Co-located Services

2.22.1 A Tier 4 general adolescent service should not be an isolated or stand-alone facility and must be located with other mental health services so that there is a critical mass of staff to ensure adequate response team resource.

2.22.2 Robust response plans must be in place to deal with any emergency requiring additional staff.

2.23 Interdependence with other Services

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

2.23.2 Interdependent services at national level include:

- Nationally recognised providers of specialist secure adolescent medium and low secure in-patient care for 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 young people.

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

- Local providers of mental health or neurodisability or other inpatient care for 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 in respect of their role to establish local need
- 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 young people (e.g. child abuse investigation units)
- 3rd sector organisations working with 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)
- Adult mental health services including services for people with neurodevelopmental disorders including learning disability and autism.

3 Population Covered and Population Needs

3.1 Population Covered By This Specification

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

3.2 Population Needs

3.2.1 Assessing the incidence and prevalence of severe adolescent 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 quality of "out-of-hours" support will influence use of Tier 4 services (CAMHS Tier 4 Report, 2014).

3.2.2 The best available estimates of the prevalence of mental disorders

amongst children and young people are those from the Office for National Statistics surveys in 1999 and 2004 (Office for National Statistics, published 2000 and 2005 respectively). These found one in ten children aged between 5 and 16 years has a mental disorder. About half of these (5.8%) has a conduct disorder, 3.7% an emotional disorder (anxiety, depression), 1–2% has severe Attention Deficit Hyperactivity Disorder (ADHD) and 1% has neurodevelopmental disorders. The rates of disorder rise steeply in middle to late adolescence and the profile of disorder changes with increasing presentation of the types of mental illness seen in adults. Although as noted in the Chief Medical Officer's report (Dept. of Health 2013) there is reason to believe these estimates of prevalence may be out of date.

3.3 Expected Significant Future Demographic Changes

3.3.1 It is not known what the specific future demographic changes will be however there are significantly larger numbers of high risk 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 with learning disability, autism or both; such developments should feed into future developments in relation to high risk young people.

3.4 Evidence Base.

3.4.1 There are only two randomised controlled trials comparing inpatient care for adolescents (as provided in the UK) with alternative intensive interventions (Gowers et al, 2010, Ougrin, unpublished 2017). Both studies suggest inpatient care is effective, although on some measures the alternatives are better.

3.4.2 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, (Tulloch et al 2008).

3.4.3 The needs of young people in crisis are often different from those with long-standing complex and severe difficulties requiring intensive treatment. For this reason, where possible, inpatient services for these different groups should be provided separately with young people admitted in crisis being cared for in a separate environment from young people requiring longer term treatment and rehabilitation.

3.4.4 The evidence in support of the benefits of planned admissions comes from a range of studies showing that outcomes are better when treatments and discharge are planned, the young person has motivation

to change, and there is a therapeutic alliance/engagement with the young person and/or their family (Cotgrove et al, 2007).

3.4.5 Some Tier 4 CAMHS General Adolescent Services are provided as integrated services including crisis management and intensive outreach (step-down) services allowing safe, high-quality alternatives to in-patient care for young people who would otherwise require admission. Where such services have developed there has been better use of beds in terms of shorter lengths of stay (approximately halved) and a reduced need for admissions (CAMHS Tier 4 Report, 2014, Ougrin, unpublished 2017). Other evidence points to the reduction in the need for admission where effective home treatment services and intensive outpatient services have been developed (Kwok et al, 2016).

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 reduce lengths of stay, variation in service availability and access and improve the experience of young people, their families and carers using mental health services.

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

- Developmentally appropriate care attuned to the complex needs of young people that facilitates emotional, cognitive, educational 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 learning disability and autism
- Reduce the risk of harm to self and others
- Provide an individualised developmentally appropriate framework of care that meets needs and includes the young person and family/carers in decision-making
- Embed the principles of safeguarding children in everyday service practice
- Provide a time-limited intervention that supports recovery and will enable a safe transition to an appropriate alternative mental health setting
- Provide all 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 the return to a non-secure Tier 4 CAMHS setting or effective discharge to a community setting
- Deliver care in line with the principles of Transforming Care including the facilitation and pro-active use of CETR process
- Achieve delivery of efficient and seamless transfers of young people between acute and intensive care settings
- Use the Care Programme Approach 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	Provider	1, 2, 5	safe, effective responsive

		home treatment team is involved in assessment/decision prior to readmission.			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 review within two weeks of admission	Provider	2, 3, 4, 5	safe, effective responsive caring
	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	Provider	1, 2, 3, 5	safe,

	agency staff or bank staff during the previous quarter.			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 psychologist and occupational therapist.	Self-declaration	1, 2, 3, 5	safe, effective responsive 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 must 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

5.1.3 The service must have regard to the provisions of:

- Transforming Care for People with Learning Disabilities – Building the Right Support
- Working Together to Safeguard Children (2010) and relevant subsequent guidance unless there is a cogent reason not to do so
- UN Convention on the rights of the Child

5.2 Other Applicable National Standards to be met by Commissioned Providers

5.2.1 Services must 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 to take place within 24 hours of an appropriate referral with necessary documentation being received
- Providers must be registered with QNIC and participate in the peer review process
- Discharge arrangements:
    - A responsible CAMHS team, including an allocated Responsible Clinician, must be in place before the start of a discharge process for all patients
    - The Tier 4 service must 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, must be provided at the point of discharge
    - A full discharge summary must be provided within 7 days of the discharge date
- Each patient must have their own room and have a Responsible Clinician allocated by the service for the duration of admission
- The nursing model of care must be based on the 'primary nurse' model, each patient must have a named nurse responsible for their day to day nursing needs
- Each patient must 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 must be delivered through a Multi-Disciplinary Team (MDT) approach consisting of psychiatrists, psychologists, 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 must be experienced in the assessment, identification and management of young people with neurodevelopmental disorders including learning disabilities and/or autism
- The service must have expertise in and policies covering the use of psychopharmacology in severe mental illness including the use of rapid tranquilisation and local PRN
- Each patient must be reviewed by the MDT at least weekly and must 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 must be kept updated with any changes to their care plan and have the HONOSCA outcomes and improvements scores shared with them regularly
- Young people with learning disability and/or autism must have their specific needs incorporated in the care plan. This must include practice set out in the Transforming Care national programme particularly the active support, facilitation and delivery of the CETR process
- Each patient must have a named practitioner psychologist who must 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 patient must have a named occupational therapist who must undertake a comprehensive occupational therapy assessment and deliver an appropriate occupational therapy programme based on identified needs
- The service must facilitate access to and/or deliver timely and appropriate speech and language assessment and treatment during the course of the admission
- Each patient must 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 patient must have access to the Independent Mental Health Advocates (IMHA) who will assist by undertaking the direct advocate's role
- Each patient should receive three culturally appropriate meals per day. The food should be prepared in accordance with NHS National guidelines on nutrition and variety
- Have their religious and cultural needs met where practicable
- Have their rights under the Mental Health Act explained
- Have their physical healthcare needs met through a full range of primary healthcare interventions that include health promotion and physical health screens and appropriate support to access secondary care where required.

5.2.2 Services must comply with the following guidance:

- NICE (2004) - Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders CG9
- NICE (2005) - Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder CG31
- NICE (2006) - The management of bipolar disorder in adults, children and adolescents, in primary and secondary care CG38
- NICE (2009) – Borderline Personality Disorder CG78: recognition and management
- NICE (2011)- Psychosis with substance misuse in over 14s: assessment and management CG120
- NICE (2013) – Psychosis and schizophrenia in Children and Young People: recognition and management CG155
- NICE (2015) - Depression in children and young people: identification and management in primary, community and secondary care CG28.

5.3 Service Environment

5.3.1 The provider must meet the following standards:

- The premises and the facilities generally are young person and family friendly, meet appropriate statutory requirements, are fit for purpose as determined by the relevant statutory regulator (e.g. the Care Quality Commission),and have regard 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 young people are adequately met and that comments about food and nutrition are incorporated in menu design
- An environment that ensures that no young person, visitor or staff member is allowed to smoke on the premises
- Facilities which include rooms suitable for contact between young people and their families/carers, including siblings and are available at weekends and evenings. These should be in proximity to, but separate from the ward.
- Bedroom and bathroom areas must 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.

5.4 Gender incongruence

- 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 young person and whether any additional arrangements or supports are needed.
- Risk assessment must be completed to support decisions regarding appropriate placement and consider if additional safeguarding is required for the patient or the other 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 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

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

Appendix 1

C07/S/ CAMHS
Tier 4 CAMHS Specialist Eating Disorder Services

1. National/local context

1.1 National policy (Five Year Forward View) is to increase the delivery of effective community treatments for young people with eating disorders which will reduce the need to treat in an inpatient setting.

1.2 There is no evidence that when a young person is admitted the outcomes are better in a specialist eating disorder unit compared to admission to a paediatric or medical ward, or general purpose child or adolescent unit as long as they receive appropriate evidence based treatment.

1.3 The key recommendations from the NICE Guidelines for Eating Disorder (2017) are as follows:

- Admit people with an eating disorder whose physical health is severely compromised to a medical inpatient or day patient service for medical stabilisation and to initiate refeeding, if these cannot be done in an outpatient setting.
- Do not use an absolute weight or BMI threshold when deciding whether to admit people with an eating disorder to day patient or inpatient care.
- When deciding whether day patient or inpatient care is most appropriate, take the following into account:
    - The person's BMI or weight, and whether these can be safely managed in a day patient service or whether the rate of weight loss (for example more than 1 kg a week) means they need inpatient care.
    - Whether inpatient care is needed to actively monitor medical risk parameters such as blood tests, physical observations and ECG (for example bradycardia below 40 beats per minute or a prolonged QT interval) that have values or rates of change in the concern or alert ranges: refer to Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN), or Guidance 1 and 2 in junior MARSIPAN.
    - The person's current physical health and whether this is significantly declining.
    - Whether the parents or carers of children and young people can support them and keep them from significant harm as a day patient.

- When reviewing the need for inpatient care as part of an integrated treatment programme for a person with an eating disorder:
    - do not use inpatient care solely to provide psychological treatment for eating disorders

- Do not discharge people solely because they have reached a healthy weight.

- For people with an eating disorder and acute mental health risk (such as significant suicide risk), consider psychiatric crisis care or psychiatric inpatient care.

2. Evidence Base

2.1 There is a lack of detailed information on the distribution of eating disorders. An annual incidence of 8 per 100,000 and the average prevalence of 0.1 to 0.3% for adolescents is reported by Hoek (2006). In more focused surveys of anorexia nervosa the disorder most likely to require in-patient admission, approximately 90% of sufferers are girls and about a third of sufferers are expected to be undiagnosed with many sufferers concealing their condition (Hoek HW, 2006).

2.2 A recent UK study based on general practice registers found the age-standardized annual incidence rate of all diagnosed ED for ages 10–49 increased from approx. 32 to approx. 37 per 100, 000 between 2000 and 2009. The incidence of AN and BN was stable; however, the incidence of EDNOS increased. The incidence of the diagnosed ED was highest for girls aged 15–19 and for boys aged 10–14 (Micali et al, 2013).

2.3 Anorexia nervosa is a chronic condition with an average duration of 5-6 years (Strober et al, 1997) and has the highest mortality rate for any mental disorder.

2.4 The National In-patient Child and Adolescent Psychiatric Study (NICAPS) surveyed all Tier 4 CAMHS Units in England and Wales in 1999 and found young people with severe eating disorders to be the largest single diagnostic group accounting for approximately 22% of admissions amongst adolescents and approximately 5% of admissions in the under 12 year olds (under-12s). The Child and Adolescent Mental health services (CAMHS) Tier 4 report (2014) found a similar pattern.

2.5 Gowers et al (2010) carried out a randomized controlled multi-centre trial of treatments for adolescent anorexia nervosa including assessment of cost-effectiveness and patient acceptability - the TOuCAN trial and found that inpatient treatment did not confer any benefit over community based treatment.

2.6 First-step treatment provided by community services specialising in eating disorders assessment and treatment have been found to be associated with a lower subsequent need for inpatient care than either generic CAMHS or initial inpatient treatment (Byford et al, 2007; House et al, 2012).

2.7 Recent research from Germany (Herpetz-Dalmann et al, 2014) suggests that day-patient treatment may be equally effective to inpatient treatment at lower cost.

2.8 Street et al (2016) demonstrated that collaborative working between paediatric wards and CAMH services enabled short lengths of stay and reduced need to refer on to tier 4 CAMHS.

2.9 Several studies have examined effectiveness, costs, satisfaction and outcomes including the COSI-CAPS study (http://www.rcpsych.ac.uk/pdf/COSI%20CAPS.pdf. (RCPsych 2008)) found most young people improved substantially during their inpatient stay and were satisfied with their care. With respect to outcomes Tier 4 CAMHS Eating Disorder Units and Tier 4 CAMHS General Adolescent Units achieved similar outcomes although the specialist eating disorder units tended to admit more severely ill patients.

3. Service Model and Care Pathway

3.1 Children and young people are referred to Tier 4 CAMHS Eating Disorder Services from either Tier 3 CAMHS community eating disorders teams or other Tier 4 CAMHS provision

3.2 The Tier 3 CAMHS CED teams must retain close working links with the Tier 4 CAMHS eating disorders throughout the young person's admission including in-reach and facilitating step-down care.

3.3 The service must have good access to general paediatric and general medical facilities given the physical health risk for this patient group. The service must have medical and nursing staff with expertise in managing the physical complications of anorexia nervosa and related disorders.

3.4 The service must provide:

- Assessment
- Admission
- Bespoke packages of intensive day treatment for young people who would otherwise be admitted as an inpatient or as part of a discharge pathway
- Intensive home-based treatment as an alternative to admission which should be integrated with the Tier 4 service

3.5 The services must also comprise the following elements:

- Day/In-patient education provision
- Second opinion assessments
- Advice and consultation to Tier 3 CAMHS and other Tier 4 CAMHS

3.6 The pathway should include

- urgent and unplanned inpatient or intensive day care admissions within 24 hours of presentation
- non-urgent (within 2 weeks) inpatient or intensive day care,

4. Referrals

4.1 Referral routes:

- Referrals are accepted from Tier 3 CAMHS eating disorder services, Tier 4 CAMHS General Adolescent Units and Tier 4 CAMHS Children's Units.
- Referrals must be reviewed and responded to by a senior clinician within the service.

4.2 Response times:

- Response to urgent and emergency referrals must be within 4 hours.
- Admission for urgent and emergency referrals
    - for high physical risk requiring medical stabilisation (and access to psychological interventions and support), or
    - high psychiatric risk requiring inpatient admission must be within 24 hours
- Response to non-urgent referrals must be within 5 working days, with admission within 2 weeks in instances where there is insufficient progress towards treatment goals on an outpatient basis, or the Community Eating Disorder service believes the child or young person cannot be managed effectively in the community.

5. Assessment

5.1 An Access Assessment must be done by the Tier 4 CAMHS Eating Disorders Service in consultation with the Tier 3 Community Eating Disorders team. There should be flexibility as to the location of the assessment according to need.

5.2 The assessment must explicitly address the following issues:

- Goals of admission
- Major care and treatment needs
- The best environment/level of service (day-inpatient or tier 3 CAMHS community eating disorder service, or paediatric/medical ward)
- Risk identified
- Level of security required
- Comments on the ability of the holding-referring organization to safely care for the patient until admission can occur.

6. Admission

6.1 The inpatient / day patient service must provide:

- a comprehensive assessment of physical health (including Body Mass Index (BMI), physical examination, blood tests, electrocardiogram (ECG)) and
- a comprehensive psychiatric assessment and full risk assessment in accordance with NICE guidance CR69, Junior MARSIPAN Royal College of Psychiatrists (2012) or the most recent update and CPA good practice guidelines.
- Offer of a carer assessment where appropriate.

7. Treatment / interventions

7.1 The service must provide

- A range of interventions aimed at medical stabilisation, weight restoration and the adoption of healthier eating patterns including reduction of the behaviours linked to the eating disorder. The service will also treat any psychiatric co-morbidity
- Safe re-feeding, including access to dietetic advice and paediatric / general medical advice
- NG insertion and feeding
- PEG feeding
- Daily biochemistry, frequent physical observations,
- Management of abnormal weight control behaviours (for example - water loading, excessive exercising, self-induced vomiting and laxative abuse),
- Daily ECG, treatment of pressure sores and immediate cardiac resuscitation with presence of a 'crash' team.
- A range of psychological interventions including Cognitive Behavioural Therapy--Eating Disorders Cognitive Analytic Therapy, Interpersonal psychotherapy, Psychodynamic psychotherapy, Dialectic Behaviour Therapy
- Provide appropriate evidence based family therapy and family interventions including supported family meals, parents groups.
- Provide a multidisciplinary approach in line with current NICE guidance CR69, which includes access to a variety of non -psychological interventions including occupational therapy and dietetics.

8. Discharge

8.1 The Specialist eating disorder service must comply with the discharge processes set out in the Tier 4 general adolescent specification working closely with the community eating disorders teams to plan discharge.

9. Multi-Disciplinary Team (MDT) Membership

9.1.1 The staffing of the unit must be compliant with Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) essential standards and Quality Network for Eating Disorders standards.

10. Population covered

10.1 The population covered by this appendix is set out in paragraph 3 of the main service specification for general adolescent services

10.2 Specifically, this appendix covers services for children and adolescents who require specialised care and treatment for complex eating disorders and are unable to be managed by a Tier 3 community eating disorder service, a paediatric/medical ward or general purpose child or adolescent unit.

11. Acceptance Criteria

11.1 Primary diagnosis of a severe and complex eating disorder which cannot be treated within the local Tier 3 CAMHS Community Eating Disorders team either because of physical or psychiatric risk.

11.2 Where there has already been an admission to or assessment by another Tier 4 CAMHS unit and the severity/complexity of the eating disorder or lack of response to treatment means treatment in a specialist service eating disorder service is required.

12. Exclusions

12.1 Young people who have weight issues in the absence of a recognised eating disorder.

13. Co-located services

13.1 Tier 4 CAMHS and/or paediatric hospital services

14. Outcomes

14.1 The service is required to monitor clinical outcomes. In addition, to the ones recommended in the main general purpose adolescent service specifications, as a minimum the service should also use outcome measures as indicated in the Access and Waiting Time Standard for Children and Young People with an Eating Disorder (2016) including clinical measures

- EDE-Q
- BMI
- Score 15

14.2 Successful treatment is expected to lead to improved outcomes as measured by Outcomes indicators stipulated in the 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder – Commissioning Guide' (July 2015).

Number	Indicator	Detail			Data Source	O.F Domain 1,2,3,4,5	CQC Key question Well led, responsive, effective, caring, safe
		Descriptor	Notes	Evidence documents			
	Clinical Outcomes						
101	% of patients where the crisis intervention service or home treatment team is involved in assessment/decision prior to readmission.	% of patients where the crisis intervention service or home treatment team is involved in assessment/decision prior to readmission.		Annual report	Provider		1, 2, 5
102	Number of emergency referrals reviewed and responded to by a senior clinician within 4 hours.	Number of emergency referrals reviewed and responded to by a senior clinician within 4 hours.		Annual Report	Provider	100%	1, 2, 3, 4, 5
103	Number of emergency referrals admitted within 24 hours of the initial referral.	Number of emergency referrals admitted within 24 hours of the initial referral.		Annual Report	Provider	100%	1, 2, 3, 4, 5
104	Number of urgent referrals admitted within 48 hours	Number of urgent referrals admitted within 48 hours		Annual Report	Provider	100%	1, 2, 3, 4, 5
105	% of people with learning disabilities and/or autism receiving a Care, Education and Treatment Review (CETR) prior to admission or receiving a	% 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		Annual Report	Provider	100%	1, 2, 3, 4, 5

	Care, Education and Treatment review within two weeks of admission	Treatment review within two weeks of admission					
106	% of patients who have a discharged plan agreed before admission or within 24 hours admission	% of patients who have a discharged plan agreed before admission or within 24 hours admission		Annual report	Provider		1, 2, 3, 4, 5
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	% of patients assessed within 7 days of admission using HONOSCA (patient/family/carer/clinician versions) and GBO to determine their health and social functioning		Annual Report	Provider		2, 3, 4, 5
108	Average HONOSCA improvement score for patients discharged during the quarter.	Average HONOSCA improvement score for patients during the quarter. HONSCA should only be undertaken at a maximum of fortnightly, therefore if a discharge takes place within a fortnight there won't be a discharge HONSCA.		Annual Report	Provider	100%	1, 2, 3, 4, 5
109	% of patients who receive their initial care plan within five working days (including CPA)	% of patients who receive their initial care plan within five working days (including CPA)		Annual report	Provider		1, 2, 3, 4, 5
110	% of patients with Improvement in behavioural and emotional problems - SDQ.	% of patients with Improvement in behavioural and emotional problems - SDQ.		Annual Report	Provider		1, 2, 3, 4, 5

111	Percentage of eligible staff who have received clinical supervision as per Trust/organisation policy.	Percentage of eligible staff who have received clinical supervision as per Trust/organisation policy.		Annual report	Provider / SSQD		3, 4, 5
112	Percentage of staff requiring training, who have received level 3 safeguarding children training in specialised services	Percentage of staff requiring training, who have received level 3 safeguarding children training in specialised services		Annual report	Provider / SSQD		3, 4, 5
113	Mean length of stay for patients discharged during the quarter	Mean length of stay for patients discharged during the quarter		Annual report	Provider		1, 2, 3, 5
114	Ratio of substantive staff to agency staff or bank staff during the previous quarter.	Ratio of substantive staff to agency staff or bank staff during the previous quarter.		Annual report	Provider		1, 2, 3, 5
115	Care hours per patient day	Care Hours per patient day		Annual report	Provider		1, 2, 3, 5
	Patient Experience						
201	All patients receive an experience of service questionnaire.	All patients receive an experience of service questionnaire.		Annual report	Self-declaration	N	2, 4
202	All carers receive an experience of service questionnaire.	All carers receive an experience of service questionnaire.		Annual report	Self-declaration	N	2, 4

203	Patient information is provided at the point of assessment.	Patient information is provided at the point of assessment and includes details relating to: treatment; information about the team; information about patient involvement groups and patient self-help groups; out of hours contact details/emergency number		Operational Policy	Self-declaration	N	2, 4
	Structure and Process						
301	There is an MDT in place with membership as per the service specification.	The staffing of the unit is compliant with Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) essential standards. The staff team must include: • Consultant level as well as non-consultant grade medical staff • Clinical Psychology Nursing staff • Occupational therapist • Teaching staff • Social work • Family Therapist • Staff skilled in group work • Creative therapies • Dietetic advice where services provide care		Operational Policy	Self-declaration	N	1, 2, 3, 5

		for young people with eating disorders • Access to psychotherapy as appropriate • Access to Speech and Language assessment and intervention when appropriate • Administrative support • Access to physiotherapy For inpatients with learning disabilities, the following additional staff must be available • Mental health nurses (including learning disability trained nurses) • Psychiatrists (child and adolescent psychiatry or learning disability Certificate of Completion of Training (CCT) or dual CCT • Clinical psychologists (learning disability or child psychology trained or dual trained) • Social workers • Speech and language					

		therapist • Occupational therapist trained in sensory strategies. • There must be input from a dietician.					
302	Each patient has a named psychologist and occupational therapist.	All patients have a named practitioner psychologist who must 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.They will also have a named occupational therapist who must undertake a comprehensive occupational therapy assessment and deliver an appropriate occupational therapy programme based on identified needs.		Operational Policy	Self-declaration	N	1, 2, 3, 5
303	Each patient has access to an Independent Mental Health Advocates (IMHA).	Each patient will have access to an Independent Mental Health Advocate (IMHA) who will assist by undertaking the direct advocate's role.		Operational Policy	Self-declaration	N	3, 4, 5
304	There are agreed clinical protocols/guidelines.	There are clinical guidelines in place as specified by QNIC and		Operational Policy	Self - declaration	N	1, 3, 5

		detailed within the service specification. This will include the QNIC routine outcome measures (ROM)					