

## SCHEDULE 2 – THE SERVICES

### A. Service Specification

<b>Service Specification No:</b>	1724
<b>Service</b>	Tier 4 CAMHS Psychiatric Intensive Care Unit (PICU)
<b>Commissioner Lead</b>	<i>For local completion</i>
<b>Provider Lead</b>	<i>For local completion</i>

<b>1. Scope</b>
<p><b>1.1 Prescribed Specialised Service</b></p> <p>1.1.1 This service specification covers the provision of Child and Adolescent Mental Health (CAMHS) Tier 4 inpatient services.</p> <p><b>1.2 Description</b></p> <p>1.2.1 This service specification describes Tier 4 PICU inpatient Child and Adolescent Mental Health 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.</p> <p><b>1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners</b></p> <p>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 outreach when delivered as part of a provider network.</p> <p>1.3.2 CCGs commission CAMHS for children and young people requiring care in Tier 1, Tier 2 or Tier 3 services.</p>
<b>2. Care Pathway and Clinical Dependencies</b>
<p><b>2.1 Care Pathway</b></p> <p>2.1.1 Future in Mind (2015) emphasised the need for ‘improved care for</p>

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 under 18.

2.1.3 Medium secure, low secure and Psychiatric Intensive Care Units (PICU) services provide a range of physical, procedural and relational security measures not required in general adolescent services to ensure effective treatment and care whilst providing for the safety of young people, staff and the public.

- **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

2.1.4 This service specification relates to PICU.

## 2.2 Service requirements and Functions

2.2.1 Adolescent PICUs accommodate up to a maximum of 10 young people

at any one time in line with NAPICU standards.

2.2.2 Admissions should not last longer than six weeks with a maximum of eight weeks in exceptional circumstances. Any admission likely to last longer than six weeks must be subject to robust clinical review actively focused on identifying alternative options including, where appropriate, transfer to either low or medium security.

2.2.3 All young people admitted to psychiatric intensive care units must be subject to the Mental Health Act. The predominant need for care and treatment in PICU must be related to the assessed risk of harm to self and/ or others in the context of the young person's mental disorder.

2.2.4 Young people must be treated and managed within a care pathway approach where services work collaboratively to ensure that admission and transfers within general adolescent and PICU are achieved efficiently. The care pathway must be planned early in admission, with changes depending on developing needs and circumstances.

2.2.5 There are three recognised pathways into Tier 4 CAMHS PICU, all admissions must have had an access assessment prior to referral

- Stepping up from a Tier 4 CAMHS general adolescent service
- Direct admission from the community, including other institutional/ residential settings for young people (e.g. educational/ residential social care). Prior to admission an assessment must be completed by a CAMHS Consultant Psychiatrist or Specialist Trainee (ST4-6) in Child and Adolescent Psychiatry (in consultation with a CAMHS Consultant), or a senior experienced nurse or senior psychologist in consultation with a Consultant Psychiatrist. In some areas services for 16 and 17 year olds continue to be provided by adult services; in such circumstances adult psychiatrists (and their specialist trainees under supervision) would be responsible for making referrals.
- Admission from a low secure unit

2.2.6 Responsibility for the care of the young person remains with the referring agency/service until the point of admission to the inpatient service.

2.2.7 Multi-disciplinary working and the Care Programme Approach (CPA) process must underpin service delivery; the PICU must provide:

- Young person-centred individualised multi-disciplinary evidence-based treatment packages, based upon assessment of need and risk
- Proactive management of aggression and violence
- Physical and mental health care that meets the needs of and involves young people and, if appropriate, their families/carers from the beginning of the care pathway
- Care for people with learning disability and/or autism in line with the

expectations and principles set out in Transforming Care and proactive support, facilitation and delivery of the Care Education and Treatment Review (CETR) process

- A secure environment where young people can address their problems in safety and with dignity
- An extensive range of therapeutic, educational and recreational opportunities including activity programmes during periods when education is not provided or young people beyond school age do not wish to continue in education
- On-going assessment that supports effective, safe and timely discharge or transfer to other inpatient or community settings
- Provision of care in line with welfare principles from the Children Act 1989 and Code of Practice to the Mental Health Act 2015
- Specialist professional and clinical advice to referrers and other agencies
- Appropriate educational services from a DfE registered provider which is subject to OFSTED inspection.

2.2.8 The competencies that are particularly needed to meet the needs of young people with a range of complex behaviours are:

- A comprehensive Multi-Disciplinary Team (MDT) with a “core team” of expert psychiatry, psychology (including clinical competencies), social work, occupational therapy, education and nursing professionals. Services should ensure appropriate access to other necessary disciplines (such as speech and language therapy, family therapy etc.)
- A robust process of assessment able to formulate cognitive and behavioural paradigms and flexible enough to allow alternative formulations (psychodynamic, systemic, psychopharmacological etc.)
- Expertise in the use of psychopharmacology in severe mental illness including local PRN and Rapid Tranquilization Policies;
- A therapeutic regime that places primary importance on behavioural approaches, de-escalation and the psychopharmacological treatment of mental illness and agitated behaviour in the context of psychiatric disorder. The therapeutic regime must also be able to deliver effectively a variety of other psychological interventions at an individual and group level and in particular deliver cognitive/behavioural interventions, interventions addressing interpersonal difficulties, family relationships, problem-solving and affect regulation
- Occupational therapy interventions integrated into the care approach.

2.2.9 The suitability of these interventions depends on the likely length of stay. The aim is to discharge young people from PICU when it is safe to do so, which means that lengthier therapeutic interventions will not generally be appropriate, although they should still be available for

example as brief interventions.

2.2.10 The therapeutic milieu must have the capacity and resilience to effectively deliver interventions in the face of acutely challenging behaviour. It must also be capable of demonstrating a robust safeguarding approach that is able to balance therapy delivery and safety of staff and patients.

2.2.11 The service must provide an environment and culture which meets best practice for safety, welfare and security and demonstrates a robust approach to risk assessment and management. Quality improvement methods such as the NHS Institute for Innovation & Improvement Plan, Do Study Act (PDSA) cycles should be used with the objective of reducing violence and use of non-consensual measures such as physical intervention and rapid tranquilisation.

2.2.12 The service is required to complete regular audits throughout an annual cycle demonstrating the degree to which safety, welfare and security within the unit is maintained and reviewed. The audit annual will report to NHS England.

2.2.13 Equally, the individual services are expected to review all serious incidents (SI) and carry out root cause analysis of serious incidents and near misses so that learning can be disseminated through internal security review meetings. (Serious incidents are defined in scheduled 6 of the contract).

2.2.14 Robust governance arrangements must be in place with regard to communication and information governance and all communication should aim to allow the young person access to information about their care in a way that is meaningful for them and enables the provision of feedback about their care.

2.2.15 Information must be given to the young person about the unit they are referred to prior to admission and all information and feedback from service users and their parents or carers should contribute towards future service development.

2.2.16 Services are expected to ensure that robust systems are put in place to gather patient, family and stakeholder organisation feedback. A variety of means should be used to gather information including but not limited to

- social groups in wards such as community meetings
- therapeutic intervention programmes;
- discharge questionnaires;
- patients self-reports on care and treatment;
- advocacy support groups;
- discussion with families
- consultation with referrers, commissioners and other stakeholders

2.2.17 Age-appropriate independent advocacy (including independent mental health advocacy) services must be provided. Advocacy services are required to complete regular activity reports on service provision through service review meetings highlighting young people's feedback and any areas requiring action.

2.2.18 The delivery of services in adolescent PICUs must also include access to child welfare and educational services. The provision of clinical services must be made by a wide variety of professionals with a background in child and adolescent mental health and experience of working with the serious psychiatric disturbance that would necessitate intensive care.

2.2.19 Each unit must have an identified safeguarding lead within the service who will be a senior point of contact in relation to any safeguarding concerns and who can liaise beyond the unit as necessary with regard to such matters.

2.2.20 Where a young person is referred from a general adolescent Tier 4 inpatient service, the unit must remain involved in review meetings and be committed to receiving the young person back into their care when the risk is manageable. In other circumstances the referring clinician/service must continue to be involved until the young person leaves the unit and it is the unit's responsibility to identify the relevant service for the young person's future care.

2.2.21 The involvement throughout the admission and transfer by local/catchment area services is essential and must be maintained through effective communication and involvement in clinical reviews. Particular attention (above and beyond the requirements of inclusion of the nearest relative for the purposes of the Mental Health Act) should be given by the PICU team to the involvement of parents (when appropriate) and social workers responsible for young people who are 'looked after', especially when they have parental responsibility under S31 of the Children Act.

2.2.22 Important local/catchment area services include: health and social care professionals, youth offending teams, educational services, NHS England commissioning case managers (both from host Local Area Team for the PICU and from the NHS England team in the young person's home area) and representatives of the home CCG.

## **2.3 Referrals**

2.3.1 The decision to admit to PICU must be based on a detailed risk assessment, consideration of how risks will be safely managed and identify the measures required to resolve risk in the short term.

2.3.2 Referrals must be made using the National Referral and Access

process (Forms 1 and 2).

- 2.3.3 The processing of referrals must not be delayed because of issues relating to establishing commissioning responsibility or ordinary residence status.
- 2.3.4 To prevent avoidable admissions the assessment must demonstrate that the identified risk(s) cannot be effectively managed in a general T4 CAMHS inpatient setting and will not require longer-term management in low or medium secure settings.

## **2.4 Acceptance Criteria**

2.4.1 All three of the following must apply:

- The young person is under 18 years of age at the time of referral
- The young person will be subject to detention Part II of the Mental Health Act (1983). A PICU setting is not appropriate for young people subject to hospital admission under Part III of the Mental Health Act including for assessment under s35 and s36. Young people may be accepted with pending criminal charges if subject to detention under Part II of the Mental Health Act
- The young person suffers from acute behavioural disturbance that cannot be safely managed in a general in-patient or community setting due to the nature and degree of risk of harm to others or themselves and requires intensive specialist risk management procedures and specialist treatment intervention.

## **2.5 Exclusion Criteria**

- Young people who present with longer term behavioural disturbance, either forensic or non-forensic, and require care in a low secure or residential setting
- Young people who present a grave danger to the general public (which may include some high risk young people who may have no offending history, as well as those who have been charged with or convicted of specified violent or sexual offences under Schedule 15 of the Criminal Justice Act 2003). These young people are more suitable for National Forensic Mental health Service for Young People (NFMHSfYP) and the gate keeping assessment in the first instance should be undertaken by the NFMHSfYP
- Fire Setting not in the context of an acute mental illness.

## **2.6 Referral sources**

2.6.1 Referrals are accepted from the following sources:

- Community CAMHS and Youth Justice diversion schemes following assessment by Tier 3 CAMHS Consultant (or ST4-6 if waiting for a consultant assessment would result in a significant delay).

Community CAMHS includes adolescent outreach services, early intervention in psychosis services, community adolescent forensic service or an adult mental health service if they provide care for 16-18 year olds

- Specialist residential settings including Secure Children's Homes where the referral has been made by a CAMHS Consultant or ST4-6 and only for children on welfare legislation under the Children Act 1989, and who may be liable for detention under the Mental Health Act 1983
- Tier 4 general adolescent and low secure inpatient services

2.6.2 Referrals must be considered by the PICU team in consultation with the referrer. The PICU response must be given within 24 hours of referral (including referrals made out of hours and/or on bank holidays) and in line with local provider pathway arrangements.

2.6.3 All referrals must be supported by the commissioning team Case Manager covering the region from which the young person originates. Notification to the of the decision to admit must be made no later than the next working day

2.6.4 Responsibility for the care of the young person remains with the referring agency/service until the point of admission to the PICU service.

## **2.7 Referral, initial assessment and decision**

2.7.1 The service will frequently take emergency admissions however the appropriateness and suitability of each referral still requires consideration by the PICU and the referrer.

2.7.2 The decision to admit a young person should be made on the basis of clinical need and the availability of a bed on the PICU

- **Emergency Referrals** must be reviewed and responded to by a senior clinician within 2 hours. Emergency assessment must be offered within 12 hours followed by admission within a maximum 24 hours of the decision to accept
- **Urgent referrals** must be reviewed and responded to within 12 hours and assessment offered within 24 hours followed by admission within a maximum of 48 hours of the decision to admit.

2.7.3 There may be occasions when the PICU's clinical lead and team may reject a referral on the basis that it is not appropriate for that specific PICU, because for example the patient mix at the time makes admission unsuitable due to vulnerability or an over-stimulated environment. The referral may also be rejected as individual treatment needs are long term and may be more suited to low or medium secure services.



2.7.4 Following admission, the initial assessment must be carried out by members of the multidisciplinary team (to include a consultant psychiatrist) from the intensive care unit. Following the assessment, the service must give an opinion as to whether the young person requires an ongoing PICU admission.

2.7.5 If it is found that the young person does not require ongoing intensive psychiatric care, then advice on alternative provision must be provided to the referring service where appropriate. In those cases when a young person's care is transferred from PICU to a different hospital site, the PICU must provide a comprehensive assessment report.

## **2.8 Pre-admission**

2.8.1 The referring team must ensure that the staff at PICU receive all relevant documents and information about the case and include:

- (i) The initial assessment and referral (including the referring team's opinion on the reasons for seeking admission to PICU which will be completed by Tier 3 CAMHS Consultant Child and Adolescent Psychiatrist or Child and Adolescent Psychiatry Specialty Trainee ST4-6, or senior nurse or senior psychologist in consultation with the Consultant Psychiatrist
- (ii) A comprehensive risk assessment
- (iii) Any further relevant information for example from the Youth Offending Team, Police or Social Care if available
- (iv) The individuals who hold parental responsibility should be established prior to admission and clarity obtained as to who is the nearest relative for the purpose of Mental Health Act
- (v) Where possible a discharge plan should be agreed before admission.

## **2.9 Admission**

2.9.1 Admission to adolescent PICU must be facilitated in a timely way consistent with the urgency of referral, and it is recognised that admissions will frequently be urgent.

2.9.2 On admission, services must provide young people with information about the available treatments and facilities, and ensure that they are informed of their rights under s132 of the Mental Health Act. Written information about rights under the MHA must be sent to the nearest relative unless the patient objects.

2.9.3 An admission planning meeting must be convened within five working days to plan care pathway in PICU and to consider length of stay and timeline for discharge (if this hasn't been agreed prior to admission).

2.9.4 Services must comply with the requirements under s19 of the MHA where this applies.

2.9.5 Prior to or very early on in the admission of a young person to an adolescent PICU, a named community care coordinator and community consultant child and adolescent psychiatrist in Tier 3 CAMHS must be identified and in place.

## **2.10 Treatment programmes**

2.10.1 Treatment programmes are delivered across 3 domains in structured days:

- (i) **Leisure:** developmentally appropriate and specifically care planned activities provided on and off the ward such as, art, drama, dance, music, gym, sports and group games
- (ii) **Education:** All young people are expected to participate in educational studies to improve their educational attainment. It is expected that when a child or young person has an Education Health and Care Plan (EHCP), or statement of special educational need (where this has not yet been converted) or is receiving SEN support, the provider will ensure that the child or young person continues to access the education and support specified within their plan. This may sometimes require a review or revision of the plan
- (iii) **Therapeutic Interventions:**
  - formal assessment and monitoring of mental state
  - assessment of clinical risks and development of clinical multidisciplinary formulation and management plans
  - management of physical health care
  - prescribing and monitoring of drugs and their side effects in line with NICE guidance
  - Clear guidelines and policies on the use of PRN and Rapid Tranquilizations, which are reviewed regularly by the clinical team and service Pharmacist
  - A broad range of psychological interventions (delivered at an individual, group or systems level) with a view to enhancing social, emotional and behavioural self-monitoring, and self-regulation. These must be in sequence according to need and readiness and delivered within a developmentally sensitive framework in accordance with best available evidence and/or NICE guidelines and may include:
    - Cognitive Behaviour Therapy,
    - Dialectical Behavioural Therapy
    - Family therapy
    - Health promotion (physical and mental health and relapse prevention other therapeutic interventions that may include music therapy and art therapy
  - Occupational Therapy
  - Health Promotion (physical and mental health) and relapse prevention
  - Other therapeutic intervention that may include music therapy

- and art therapy
- Graded programme of s17 leave (where appropriate).

## **2.11 Care Planning**

2.11.1 The Care Plan Approach must follow a recovery and outcome process, be embedded in the Care Programme Approach (CPA) and form the cornerstone of delivery of an effective care pathway through intensive care.

- An initial care planning meeting must be convened within five working days
- Further CPA review meetings must take place at least every three weeks
- CPA review meeting attendance should be encouraged by use of teleconferencing and videoconferencing. Given the short timescales of PICU care pathways, the involvement and responsibility of multiagency colleagues outside the unit is crucial and must be ensured
- For young people in the care of local authorities, Looked After Children (LAC) reviews must be facilitated and should be undertaken jointly with CPA reviews where possible.
- For young people with learning disability and /or autistic spectrum conditions the unit must facilitate Care, Education and Treatment Reviews (CETRs) and ensure that recommendations are acted on.

2.11.2 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.

2.11.3 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.

2.11.4 Considerations in intensive care pathway planning must always balance the relevant needs in an individual young person, including:

- the immediate risk posed by the young person to themselves and/or others
- specialist treatment needs which cannot be met in lower intensity settings
- the principle of least restrictive care
- the young person's vulnerabilities, including potential destabilisation by multiple transitions
- placement stability and continuity of care.

## **2.12 Enhanced observations**

2.12.1 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.

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

2.12.3 All Tier 4 CAMHS PICU 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.

## **2.13 Seclusion facilities**

2.13.1 PICU must have appropriate facilities for the management of young people who require periods of care in seclusion/away from the main patient group in order to appropriately manage the level of risk they pose to others.

2.13.2 All physical seclusion facilities and patient management practices must comply with QNIC, CQC and Mental Health Act Code of Practice standards and requirements unless there is a cogent reason for not doing so, this decision and rationale must be clearly documented and reviewed regularly over the period it applies.

## **2.14 Physical Healthcare**

2.14.1 PICU services must ensure that young people have access to routine and regular physical health needs assessment and treatments for emerging and ongoing physical health issues in a timely and effective

manner.

2.14.2 Routine physical healthcare should be provided by junior medical staff under supervision and there must be access when necessary to paediatric and more specialist medical provision as required.

## **2.15 Education**

2.15.1 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. Whilst educational and recreational facilities should be available to young people in intensive care settings, these should be set up to reflect the shorter period of stay in these services

2.15.2 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.

2.15.3 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.

2.15.4 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.

2.15.5 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.

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

2.15.7 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.

2.15.8 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>

2.15.9 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.

2.15.10 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.

2.15.11 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.

2.15.12 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.

#### 2.15.13 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).

### 2.16 Discharge

2.16.1 All young people must be supported to take an active role in their discharge planning and would normally be discharged into the following settings:

- Tier 4 CAMHS inpatient care or Day Service
- Open residential settings, including family home and residential care
- Secure forensic mental health services for young people.
- Secure non-NHS provision.

2.16.2 Services must actively involve the catchment area services from the patient's home area. If the patient is detained under the MHA the service must ensure that the organisations responsible for aftercare under s117 are involved in discharge planning and decision-making.

### 2.17 Discharge to Tier 4 CAMHS general adolescent units in-patient units, other residential care, and community settings

2.17.1 The discharge of a young person from intensive in-patient care must be dictated by the nature of their presentation and needs. However, the aim should be to keep length of stay as short as possible, in line with the principle of least restrictiveness.

2.17.2 Admissions should not last longer than six weeks. Any admission that is likely to last longer than six weeks must be subject to robust clinical review which focuses actively on alternatives to continuing PICU provision including, where appropriate, transfer to either low or medium security or alternative secure provision including secure children's homes.

2.17.3 Any risk of delayed discharges must also be clearly communicated to responsible commissioners who should become actively involved in facilitation of discharge. NHS England Mental Health Case Managers will work for commissioners to monitor lengths of stay.

2.17.4 A number of different mental health problems may lead young people to require intensive psychiatric care, including psychosis, bipolar disorder, self-harm, neurodevelopmental disorders and learning disabilities. Typically a young person in PICU will be transferred in the first instance to an open adolescent ward although occasionally to either residential care, a low secure setting or directly to the community with either Tier 3 or alternative specialist CAMHS care.

2.17.5 Discharges to the community must comply with s117 of the MHA and transfers to alternative inpatient settings must comply with s19 of the MHA.

## **2.18 Delayed Discharge**

2.18.1 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 must involve liaison with other agencies and should also trigger NHS England escalation procedures.

## **2.19 Family/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 an adolescent PICU and who still requires intensive psychiatric care must be transferred to an adult PICU. The adolescent PICU staff must organise the transfer together with the Tier 3 CAMHS service.

2.21.4 If the young person does not require further PICU admission but needs an adult acute bed this must be organised by adolescent PICU staff with the support of young person's care co-ordinator in the community. The above must be pursued through the CPA process.

2.21.5 In some cases young people may stay in an adolescent PICU 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 must be sought prior to the young person's 18th birthday to confirm arrangements.

## **2.22 Co-location**

2.22.1 A Tier 4 CAMHS PICU must be a separately staffed unit but not an isolated or stand-alone facility. Adolescent PICUs complement Tier 4 CAMHS in-patient provision for young people and must be co-located with such provision.

2.22.2 It is anticipated that a PICU service for young people will serve a wider

geographical area than Tier 4 CAMHS general adolescent unit.

## **2.23 Interdependence with other Services**

2.23.1 Adolescent PICU 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 in an intensive setting. These services also support young people in their recovery and enable transitions into less restrictive environments.

2.23.2 Individual PICU services should form part of a regionally and nationally coordinated network to ensure parity of practice and flexibility in terms of availability of in-patient beds.

2.23.3 PICUs must establish a networking arrangement with local general adolescent units to help facilitate smooth step-up and step-down processes for children and young people referred to or in their services.

2.23.4 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.

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

- Local providers of secure mental health or neurodisability or other inpatient care for young people or those providing other secure care on youth justice or welfare grounds
- Commissioners of CAMHS including Learning Disability and neurodevelopmental services in CCG, Local Authorities and NHS England
- 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 (YOT) services and youth and crown courts
- NHS and independent providers of non-secure in-patient care
- 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 and forensic mental health services including those for people with neurodevelopmental disorder 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 up to age 18 years who are the direct commissioning responsibility of NHS England.

3.1.2 Specifically PICU is commissioned to provide services for young people who meet the following criteria:

- aged 13 to 18 with acute mental health disturbance which cannot be contained in Tier 4 general adolescent inpatient care, community or other residential or custodial settings
- and
- require a shorter-term intervention than that available in low secure settings. This includes young people with special needs such as deafness, blindness or other physical disabilities and it also includes young people with neurodevelopmental disorders including learning disability and autism.

#### **3.2 Population Needs**

3.2.1 In England in 2015 there were over 1450 young people in secure settings at any one time. Over 300 of these were in secure mental health settings; the remaining 1100 were in either welfare secure (approximately 100) or youth justice custodial settings (approximately 1000). Young people in all types of secure setting have clearly established significant mental health needs.

#### **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 no randomised controlled trials comparing inpatient care for 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)

## **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
  - Manage and treat acute mental and behavioural disturbance which is not manageable in a general adolescent inpatient settings or other

- secure settings (such as secure children's homes) for young people
- 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 Care Education and Treatment Review (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
<b>Clinical Outcomes</b>				
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 two 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 48 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	Provider /	3, 4, 5	safe,

	who have received clinical supervision as per Trust/organisation policy.	SSQD		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	% of pts discharged within 6 weeks of admission	Provider	1, 2, 3, 4	effective, caring, responsive
114	% of pts discharged within 8 weeks of admission	Provider	1, 2, 3, 4	effective, caring, responsive
115	Mean length of stay for patients discharged during the quarter	Provider	1, 2, 3, 5	safe, effective, caring
116	Ratio of substantive staff to agency staff or bank staff during the previous quarter.	Provider	1, 2, 3, 5	safe, effective, caring
117	Care hours per patient day	Provider	1, 2, 3, 5	safe, effective, caring
<b>Patient Outcomes</b>				
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
<b>Structure &amp; Process</b>				
301	There is an MDT in place with membership as per the service specification.	Self-declaration	3, 4, 5	safe, effective, caring, responsive
302	Each patient has a named psychologist and occupational therapist.	Self-declaration	3, 4, 5	safe, effective, caring, responsive
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
<p>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.</p> <p>4.3.3 Applicable CQUIN goals are set out in Schedule 4D</p>				
<b>5. Applicable Service Standards</b>				

## **5.1 Applicable Obligatory National Standards and relevant legislation**

5.1.1 Robust procedures relating to the responsibilities of services and staff under the Mental Health Act, The Code of Practice, 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
- DoH Offender Mental Health Pathway 2005
- 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
- An initial internal multidisciplinary care planning meeting must be convened within 48 hours of admission, during which the treatment plan will be refined. The plan must determine:
  - discharge treatment goals
  - discharge destination and discharge care package.
  - whether admission to an acute adolescent ward or the NSFMHSfYP would be more appropriate.
  - estimation of the date a young person can make the transition from PICU to an open setting
- An initial CPA meeting with representation from commissioning, the community CAMHS and other relevant agencies (if involved) must be held within the first 5 working days of admission
- After the initial meeting, CPA meetings must be held at least every three weeks including at the point of transition to an acute service. The



CPA can take place after the transition if there would otherwise be a delay in transfer to a less restrictive setting

- For children and young people with special educational needs including those with an EHCP:
  - Where appropriate (when a child or young person has an Education Health and Care Plan (EHCP) or is receiving SEN support, the provider must ensure that the child or young person continues to access the education and support specified within their plan. This may sometimes require a review or revision of the plan. When appropriate, providers must complete an EHCP application for a young person who requires additional support.
- Discharge arrangements:
  - A responsible CAMHS team, including an allocated Responsible Clinician, must be in place before the start of a discharge process
  - The PICU service must convene at least one Section 117/CPA pre-discharge meeting before the start of the discharge process.
  - 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
- Providers must be registered with QNIC and participate in the peer review process. Whilst QNIC has not published standards for intensive psychiatric care, there are National Minimum Standards for Psychiatric Intensive Care Units for Young People 2015 published by NAPICU which units should comply with
- 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 PICU 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 will 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 PICU 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 must:
  - Receive three culturally appropriate meals per day, 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 1983 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 Security Requirements**

- 5.3.1 PICU services must operate within a comprehensive set of physical, procedural and relational security measures and practices. These must be in line with standards and requirements set by QNIC, CQC, NAPICU and the Mental Health Act Code of Practice.
- 5.3.2 Operational policies and procedures must comply with Mental Health Act Code of Practice requirements unless there are cogent reasons for not following the guidance in the Code. These reasons must be documented and reviewed regularly.

### **5.4 Service Environment**

- 5.4.1 The provider will meet the following standards:
- The premises and the facilities generally are young person and family friendly and facilities 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 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.

## **5.5 Additional Consideration**

- 5.5.1 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.
- 5.5.2 There should always be consideration of privacy and dignity for the young person and whether any additional arrangements or supports are needed.
- 5.5.3 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
- 5.5.4 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.

## **5.6 Other Applicable Local Standards**

Not applicable

## **6. Designated Providers (if applicable)**

Not applicable

## **7. Abbreviation and Acronyms Explained**

CAMHS: Child and Adolescent Mental Health Service  
 CETR: care Education and Treatment Review  
 GID: Gender Identity Disorder  
 IMHA: Independent Mental Health Advocate  
 MDT: Multi-Disciplinary Team  
 NAPICU: National Association of Psychiatric Intensive Care Units  
 NICE: National Institute for Clinical Excellence  
 NSFMHSfYP: National Secure Forensic Mental Health Service for Young People  
 PICU: Psychiatric Intensive Care Unit  
 QNIC: Quality Network for Inpatient Care

## Appendix 1

Number	Indicator	Detail			Data Source	Alert	O.F Domain 1,2,3,4,5	CQC Key question, Well led, responsive, effective, caring, safe
		Descriptor	Notes	Evidence documents				
	<b>Clinical Outcomes</b>							
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	safe, effective responsive caring
102	Number of emergency referrals reviewed and responded to by a senior clinician within two hours.	Number of emergency referrals reviewed and responded to by a senior clinician within two hours.		Annual report	Provider		1, 3, 4, 5	safe, effective responsive caring
103	Number of emergency referrals admitted within 48 hours of the initial referral.	Number of emergency referrals admitted within 24 hours		Annual report	Provider		1, 3, 4, 5	safe, effective responsive caring
104	Number of urgent referrals admitted within 48 hours	Number of urgent referrals admitted within 48 hours		Annual report	Provider		1, 3, 4, 5	safe, effective responsive caring
105	% of people with learning disabilities and/or autism	% of people with learning disabilities and/or autism		Annual Report	Provider		2, 3, 4, 5	safe, effective responsive

	receiving a Care, Education and Treatment Review (CETR) prior to admission or receiving a Care, Education and Treatment review within two weeks of admission	receiving a Care, Education and Treatment Review (CETR) prior to admission or receiving a Care, Education and Treatment review within two weeks of admission						caring
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		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	% 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	safe, effective responsive caring
108	Average HONOSCA (see 108 above) improvement score for patients discharged during the quarter.	Average HONOSCA improvement score for patients during the quarter.  HONOSCA should only be undertaken at a maximum of fortnightly, therefore if a discharge takes place within a fortnight there won't be a discharge HONOSCA.		Annual report	Provider		1, 3, 4, 5	safe, effective responsive caring
109	% of patients who receive their initial	% of patients who receive their initial		Annual report	Provider		1, 2, 3, 4, 5	safe, effective

	care plan within five working days (including CPA)	care plan within five working days (including CPA)						responsive caring
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	effective, caring
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	safe, effective, well-led
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	safe, effective, well-led
113	% of pts discharged within 6 weeks of admission	% of pts discharged within 6 weeks of admission		Annual report	Provider		1, 2, 3, 4	effective, caring, responsive
114	% of pts discharged within 8 weeks of admission	% of pts discharged within 8 weeks of admission		Annual report	Provider		1, 2, 3, 4	effective, caring, responsive
115	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	safe, effective, caring
116	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	safe, effective, caring

117	Care hours per patient day	Care hours per patient per day		Annual report	Provider		1, 2, 3, 5	safe, effective, caring
	<b>Patient Experience</b>							
201	All patients receive an experience of service questionnaire.	All patients receive an experience of service questionnaire.		Annual report	Self-declaration		2, 4	effective, caring, responsive
202	All carers receive an experience of service questionnaire.	All carers receive an experience of service questionnaire.		Annual report	Self-declaration		2, 4	effective, caring, responsive
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 the team patient involvement groups and patient self-help groups out of hours contact details/emergency number		Operational Policy	Self-declaration		2, 4	effective caring



	Structure and Process							
301	There is an MDT in place with membership as per the service specification.	<p>The Multi-Disciplinary Team (MDT) should consist of the following 'core' members:  Consultant psychiatrists,  Trainee Consultant Psychiatrist  Psychologists,  Occupational therapists,  Social Workers,  Mental Health qualified nurses  Healthcare Assistant  Qualified teacher;</p> <p>Services should ensure there is appropriate access as required to other discipline such as speech and language therapy, dietetics (for eating disorders).</p>		Operational Policy	Self-declaration	N	3, 4, 5	safe, effective, caring, responsive
302	Each patient has a named psychologist and occupational therapist.	All patients have a named practitioner psychologist who will undertake a needs-based assessment, contribute to a multidisciplinary risk assessment, develop a formulation and use this to identify the appropriate		Operational Policy	Self-declaration	N	3, 4, 5	safe, effective, caring, responsive

		<p>psychological treatment programme on either an individual and/or group basis.</p> <p>They will also have a named occupational therapist who will undertake a comprehensive occupational therapy assessment and will deliver an appropriate occupational therapy programme based on identified needs.</p>						
303	Each patient has access to an Independent Mental Health Advocates (IMHA).	Each patient will have access to an Independent Mental Health Advocates (IMHA) who will assist by undertaking the direct advocate's role.		Operational Policy	Self-declaration	N	3, 4, 5	safe, effective, caring responsive
304	There are agreed clinical protocols/guidelines.	There are clinical guidelines in place as specified by QNIC and detailed within the service specification.		guidelines /protocols	Self-declaration	N	1, 3, 5	Safe, effective, caring