NHS England

Model Specification for Transitions from Child and Adolescent Mental Health Services

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Document Status

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Model Specification for Transition from Child and Adolescent Mental Health Services

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Contents

Guidance to Commissioners:

This aim of this sample specification is to support commissioners responsible for funding transitional services for adolescents (hereon referred to as young people) with mental health problems. This sample service specification is non-mandatory.

For those wishing to add in a protocol into existing contracts, there is a specimen **Transfer of and Discharge from Care protocol** that contract managers can insert into the **National Contract** (section K).

Although the specification has been developed using an NHS template, its content can be used by other commissioners as appropriate and it aims at all times to acknowledge the multi-agency nature of commissioning and delivery of mental health services and support. The specification should be appended to the NHS Contract.

Young people may move from Child and Adolescent Mental Health Services (CAMHS) into a specialist Adult Mental Health Service (AMHS) or return to community services in primary health or care systems. It is important to note that only a proportion of young people receiving mental health services from CAMHS need to transfer to secondary care AMHS teams. As a consequence, commissioners may look to other services to support young people with persisting difficulties. This specification is aimed at those who commission and deliver AMHS, CAMHS or other services funded by health or social care commissioners for vulnerable adolescents with mental health and social care needs.

This sample service specification is based on a range of quality standards and best practice. The National Institute for Clinical Excellence (NICE) is considering guidance around transition in 2014-15 but has not yet established specific Quality Standards. Any NICE Quality Standards developed for children and young people with mental health conditions or problems may well include information about what services should be provided through transition into early adulthood, and should also be consulted.

Commissioners should include young people and their parents / carers, as well as providers, in adapting this specification to suit their local circumstances and needs. Young people were however consulted in drawing up this sample specification. Commissioners should be mindful of the needs of inclusion heath groups

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;

- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

The resulting specification should be clear about what each provider is commissioned to provide and also what the provider will not provide, including the responsibilities with respect to inappropriate referrals. These should sit where possible within an integrated approach to delivery focussed on meeting user needs. The commissioned service should work with other services to improve accurate identification of need and swift and flexible access to services to the services an individual needs. This might include specific protocols for vulnerable groups with h the most complex need.

It is critical that commissioners ensure that they work with each provider to agree the level of activity that is included in the final contract and that this level is appropriate to the capacity of the service to deliver the specification as detailed. Information given to young people, parents/carers and referrers about the services should reflect clearly what has and has not been commissioned.

The specification will need to be reviewed regularly (at least annually) and updated to reflect national and local strategic decisions and changes of resource by:

- Commissioners and providers, with active engagement from young people and parents/carers locally
- Local governance structures such as Health and Wellbeing Boards.

Commissioners will need to be aware of the potential impact of cost-improvement programmes implemented by providers on how they meet the specification, and agree any changes to the scope as a result. An agreed change request procedure should be aligned to appropriate governance arrangements within the provider and commissioning organisations.

Commissioners should be clear about what services they wish to commission from a provider as well as what they are not agreeing to fund: both are essential in a specification. This provision should be reflected in activity modelling and made explicit in the contract. This will make it clear – for all parties –the scope and focus of the contract and what deliverables the commissioner can expect.

This specification is being piloted with Clinical Commissioning Groups (CCGs) that volunteered to be part of the pilot. An evaluation will take place to find out how useful CCGs have found the sample specification.

The Template:

1. **Pink headings** indicate mandatory (although, as noted above, this sample specification itself is not mandatory) sections.
2. **Black text** is suitable for inclusion in the NHS Standard Contract but may be varied locally by commissioners.
3. **Blue text** indicates for guidance only and must be deleted or local detail added, before the service specification is included in the NHS Contract.

4. The service specification documents should be read in conjunction with the NHS Standard Contract and the NHS Standard Contract 2014/15 Technical Guidance.

This specification contains hyperlinks (underlined sections) to guidance developed by a group of NHS and Local Authority commissioners, providers and young people who worked on this specification together. For this reason, commissioners may find it helpful to work with this document on a computer rather than with a printed copy for this reason.

The PDF version of this model specification is the original full version published by NHS England. A Word version of the model specification is also available for commissioners to use when developing their own specification for their local area – commissioners may amend and insert detail where appropriate. Once changes have been made, that specification should be attributed to the specific commissioner/local area, not NHS England overall.

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	
Service	Transition Services for young people moving from Child and Adolescent Mental Health Services (CAMHS) to other services (including primary care).
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1 Purpose, introduction and context

The purpose of this document is to specify a transition service for young people moving from Child and Adolescent Mental Health Services (CAMHS) to other services (including primary care).

Commissioners or contract managers wishing to use the content of this specification to create a Transfer of and discharge from protocol for their contracts may find the sample **CAMHS transfer of/discharge from care protocol** useful.

Services for young people should place them and their families / carers at the heart of everything they do.

The content of this specification is based on the consensus document*: Key components of developmentally and age appropriate care to support transition for adolescents and young adults : Service Specification Proposal (2013)* It has been prepared by an expert reference group supported by NHS England, led by the National Clinical Director for Children, Young People and Transition to Adulthood. It is also based on the self-assessment best practice CAMHS Transition Standards developed by CERNIS for the National CAMHS Support Service, the National Mental Health Development Unit and the Social Care Institute of Excellence Transitions Programme, and a wide range of best practice and policy documents. It should sit within an agreed strategic plan developed by multi-agency partnerships to include as a minimum, Health, Social Care, Education and, where appropriate, Third Sector providers. This strategy should be agreed by the Health and Wellbeing Board or other appropriate governance structures, e.g. Children's trusts, Mental Health Trusts.

This specification should be consistent with any Public Health and other Local

Authority contracts or specifications relating to mental health/emotional wellbeing.

The age range for this specification is determined by local decision, but should be explicitly stated, along with any agreements regarding transition of care from the provider to other providers, including arrangements for permeable boundaries. In some areas, transition takes place at 16, in others 18, in still others during the 19th year, and in some areas services are commissioned for 0-25 year olds.

Whatever the age at which a young person leaves one mental health system for another, the transition must be carefully planned with the young person and, where appropriate, their family.

1.2 National/local context and evidence base

The prevalence and recognition of mental health conditions in young people is growing. The number of children and young people in need of support and treatment from mental health services is increasing. A number of disorders are persistent and will continue into adult life unless properly treated. Others show recurrent episodes emerging in childhood and adolescence but continuing into adult life. It is known that 50% of lifetime mental illness (except dementia) begins by the age of 14 and 75% by the age of 25, and that 75% of adults those requiring secondary care mental health services developed problems prior before the age of 18. At the same time, treatments have been developed to improve the life chances of children and young people, and to minimise the impact of mental illness on the long-term health of the population and economic cost to the public purse. [1]

In common with young people with long-term physical health conditions, the transition from adolescence to young adulthood for those with mental health problems, requires individualised health care planning. This should recognise the wider health, social, psychological, educational and vocational impact of a young person's medical condition(s) within a developmental framework and appropriate culture of care.

For some young people, transition health care planning will also require increased engagement with local primary and secondary health services and in some cases with the youth voluntary sector. In addition to health service providers, it will also require integration with social care and educational planning processes as set out by the proposals within the Children and Families Bill 2013 (for example the Birth – 25 Education, Health and Care Plan), Children (Leaving Care) Act 2000 and the Children and Young Person's Act 2008).

This specification should therefore be linked to other specifications within the local area, including:

[1] Department of Health, HM Government, '*No Health without Mental Health. A cross governmental strategy for people of all ages'*, Crown Copyright (2011)
Green et al, *Mental Health of children and young people in Great Britain*, Office of National Statistics (2004)
Kim-Cohen, J. et al, '*MAOA, maltreatment, and gene–environment interaction predicting children's mental health: new evidence and a meta-analysis'*, Molecular Psychiatry (2006) v.11, 903–913
The Prince's Trust Macquarie, *Youth Index 2014*, Prince's Trust (2013)

- Child and Adolescent Mental Health Services (including those prescribed services directly commissioned by NHS England)
- Public Health
- Workforce planning
- Adult Mental Health (including those prescribed services directly commissioned by NHS England)
- Community Child Health
- Acute adult services
- Acute Paediatrics
- Perinatal services
- Adult Learning Disabilities Services.
- Continuing care services

Also consider:

- Local guidance which may have an impact, for example, *Looked After Children* Guidance, work with troubled families and safeguarding.
- Linking with local partnership arrangements and Directors of Children's Services and Adult Services to ensure duty of cooperation (across both commissioners and services including schools as both commissioners, referrers and users).

Commissioning transition arrangements should be framed by the following principles:

1. The mental and physical health of young people in transition should not decline during the process of transition.
2. Young people should be assisted to maximise their health and life opportunities.
3. Young people should be treated as far as possible within their own community and close to home.
4. Commissioners will need to ensure that appropriate plans are in place for young people in crisis.
5. Services should work together in integrated and coordinated ways in the best interests of children and young people
6. It is essential that young people and families are involved in commissioning

and service design (as well as providing feedback to services). Young service users and their families, as well as those who have yet to access services, can help commissioners to prioritise and identify any gaps and blocks to access, and assist providers in improving services and evaluating change.

7. Commissioners should consider the diversity of the populations they are responsible for not only in terms of cultural and ethnic diversity, but all of the factors that may both influence the risk of developing mental health problems, as well as those that need to be taken into account in the design and delivery of services.

Financial cost of failing to implement appropriate transition

There is a growing evidence base documenting the significant mortality and morbidity risks in relation to young people's acute and long- term health and wellbeing if disengagement and non-concordance with their recommended health care plan occurs during adolescence and young adulthood. The point of transfer from child and adolescent or youth to adult or other services and engagement with a new team and culture in adult health care is recognised as a potential risk escalator. In addition to the adverse impact on the health, social and educational outcomes for the young person and their carers if transition is not effected appropriately, there are recognisable impacts on resources in health care and other agencies through repeated non-attendance for planned care, increased use of urgent / out-of-hours care and increased complexity of need through secondary / avoidable complications. Young people with mental health problems who do not transition well are more likely to present in crisis, and struggle to maintain their independence and remain in education or employment. The costs associated with caring for young people in the community with are considerably less than those of inpatient care.

Insert local information about the population of young people according to age range of the specification

The figures should be adjusted for deprivation or other locally agreed benchmarking formats.

Sources of support:

- Ensure Joint Strategic Needs Assessment information includes the needs of young adults.
- The CHIMAT website has a range of tools and advice to support commissioners to plan transition
- The SCIE Website includes guidance, research, case studies and examples of practice.
- Youth Access are providers of young people's advice and counselling

services across the UK

- Right Here guidance on how to commission better mental health and wellbeing services for young people
- Joint Commissioning Panel for Mental Health Guidance for commissioners of mental health services for young people in transition
- The Mental Health Intelligence Network analyses information and data and turns it into timely meaningful health intelligence for commissioners, policy makers, clinicians and health professionals to improve services and outcomes

2. Outcomes

2.1 NHS Outcomes Framework Domains and Indicators

The provision of good transition services will support improved outcomes across all five 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 a safe environment and protecting them from avoidable harm	X

2.2 Public Health Outcomes Framework

Domain 2	Health Improvement	X
Domain 4	Healthcare, public health and preventing premature mortality	X

2.3 Local Area strategic outcomes

Commissioners should ensure that the Local Area strategic outcomes link to National policy and make best use of underpinning evidence.

Local Authorities may wish to consider guidance and support material from the Local Government Association.

NHS England has produced a range of information for CCGs and Local Authorities. Each pack sets out key data to inform the local position on outcomes. Please note that these are focused on high-level comparative information on the NHS, Adult Social Care and Public Health frameworks.

3. Scope

3.1 Aims and objectives of service

Transition is a process undertaken over time. It may include, but is more than, a planned transfer to an adult service. Primary care services must be included to achieve streamlined, efficient and effective transition for all patients. This is, particularly true for those patients needing a range of health and social care services during their transition and beyond.

Transfers from CAMHS, whether to Adult Mental Health Services (AMHS) or to other services, including discharge back to primary care, are single point events in the entire transition process. Young people may be subject to serial and sequential transfers within and across different health care organisations / specialist teams over time. CAMHS should follow Care Programme Approach (CPA) guidance and make a referral 6 months before the transition time so that the young person and their family, and both CAMHS and Adult services, have good time to communicate the needs and provide continuity of care at this vulnerable time.

Where, following such a good practice timely referral, it becomes clear that the commissioned adult services are not equipped or/ appropriate to provide NICE evidence -based care, for example, if Attention Deficit Hyperactivity Disorder (ADHD) or Autistic Spectrum Disorder (ASD) specialists are not available, this should be brought to the attention of the commissioners of services.

Young people who do not meet the threshold for adult mental health services may be best supported by primary care, other agencies such as Youth Counselling services, or may be discharged with a clear plan which tells them and their families what to do if they become unwell. Currently, many receive no such plan and are left to re-contact primary care services if further advice, treatment or care is required.

Transfers require co-ordinated, documented and integrated support plans for young people and their parents/carers from all health services involved in their care and in partnership with any other multi agency providers (e.g. education and social care) that constitute the changing team around the young person at this time.

In order to enable young people (and their parents / carers) to become and remain active partners in their care, to prepare for transfer(s) and to engage with adult mental health or other services, the transition process between services needs to be underpinned by age, sensitive and developmentally appropriate care planning that is:

- Supported by a named professional who can take a co-ordinating support role throughout the transition process. It is recognised that whilst this professional may change over time, young people and their parents/carers should be able to name the professional undertaking this role at any point in the process.

- Supported by access to multi-media information resources that young people want to engage with and have been involved in developing.

- Supported by access to peer support, which may be offered individually or in groups, face to face or through social media.

- Delivered by staff who have have specific training or experience in working with children and young people.

- Delivered by processes, systems and environments that promote safety, quality, effectiveness and are young people friendly. This will be evidenced by clinical outcomes, young people and parent/ carer reported experience measures, and by the involvement of young people and their parent/ carers in service design and evaluation.

- Documented in the young person's medical records and reviewed at each key point in the transition pathway.

The provider shall:

- Work with the commissioner, young people and families, and other relevant services to co design and review the transition pathway

- Work with all relevant agencies to ensure the services for young people with mental health problems are coordinated during transition and address their individual needs, providing a holistic approach.

- Include GPs in the pathway development to ensure GPs have the relevant information to support young people (and their parents/ carers) during and after transition.

- Ensure that young people and their families are treated with compassion, respect and dignity, without stigma or judgment.

- Ensure that young people's physical health needs are considered alongside their mental health needs.

- Ensure that young people who require services during and post after transition are seen in a timely manner.

- Ensure that if appropriate to the provider, services are provided available in an emergency or crisis, including out of hours. If not appropriate to the provider, ensure that the, multi-agency coordinated plan includes information about crisis and out-of-hours care.

- Develop a care plan that is written and shared and agreed with the young person. Where appropriate this should also be agreed and shared with the

parent/ and carer where appropriate.

- Seek and use feedback in a range of settings including the use of routine outcome monitoring of medications, therapy, and social and vocational outcomes, active feedback regarding service delivery, and complaints
- Ensure young people and their families are offered a choice of interventions appropriate to their needs, delivered by trained and appropriate staff.
- Agree the aim and goal of interventions during transition with young person and where appropriate, parent and carer. Monitor the changes to agreed and shared goals and changes in to symptoms, amending therapeutic interactions as a result appropriate to deliver the best possible outcome.
- Co produce and provide information at all stages of the pathway about interventions or treatment options to enable young people and/or families to make informed decisions about their care appropriate to their competence and capacity.
- Co- produce the care plan and provide written information to the young person and if appropriate parent /carer about the care plan, how to access the services routinely and in a crisis.
- Provide written assessments, care plans, etc. that are jargon free (with any technical terms defined
- Ensure that young people leaving the service have a written and agreed discharge plan that supports self-management where possible and explains how to access help if this becomes necessary.
- Where a young person is moving to another service, whether to adult mental health services or to a different service, the sending service will agree with the young person what information will be provided to receiving service to minimise the need for the young person to repeat information
- There will be at least one joint meeting between the provider and the new service that includes the young person and/or family member, a written discharge summary, and the receiving service will provide at least one follow up contact with the young person and if appropriate the parent/carer after 6 months to check that the transition has proceeded smoothly. The outcome of the 6 month contact and transition will be recorded in the service users' clinical records
- Ensure that the service is accessible and provided in an appropriate setting that creates a safe physical environment.
- Ensure that the service provides Continuing Professional Development (CPD) appropriate supervision (including safeguarding supervision) and appraisal, and has a clear workforce plan that takes account of the changing needs of the local population.
- Ensure that appropriate clinical information, structural governance and audit arrangements are in place, including protocols around information sharing

and confidentiality.

- Maintain an accurate data set and provide accurate and timely reporting to commissioners (local, regional and national) and national organisations when requested.
- Have clear reporting processes and standards, for example the Youth Wellbeing Directory and Child Outcomes Research Consortium (CORC)

3.2 Legal and regulatory framework

Consider the following:

The service will operate according to legislation and guidance with particular reference to:

- The Mental Health Act 1983 (amended 2007) and Code of Practice, including protocols for emergency assessment under Section 136
- The Mental Capacity Act 2005
- The Children's and Families Act 2014 including specific duties in relation to children and young people with SEND. Further detail can be found at https://www.gov.uk/government/publications/send-guide-for-health-professionals
- The Equality Act 2010
- The Medicines Act 1968
- Safeguarding procedures (e.g. Working Together to Safeguard Children & Safeguarding policy: vulnerable adults)
- The findings from serious case reviews, in particular the requirements to share information in a timely manner. See Working Together to Safeguard Children 2013 and Safeguarding policy: vulnerable adults for further guidance
- Social Values Act 2012
- Personal Health Budgets may be a good way of arranging services for some patients.
- NHS Choice of Provider initiative
- Care Act 2014
- Promoting the health of looked after children

If appropriate the service will be registered with the Care Quality Commission.

All professionals will remain compliant with their relevant professional standards and bodies and be revalidated as required.

The provider will have an indemnity scheme.

The provider will have a governance system to manage and learn from complaints and incidents and to meets the training and supervision needs of its staff. A service that does not have any (formal or informal) complaints should be of as much interest as one with a high level of complaints. If young people, parents/carers or referrers do not have a mechanism to raise concerns, this could suggest a service is not working in partnership with its clients and referrers.

Providers and commissioners may wish to consider the use of Independent Advocacy Services to young people to gain access to information, to fully explore and understand their options, and to make their views and wishes known.

3.3 Service description/care pathway

Consider and specify care pathway description and examples:

- Discharge from CAMHS inpatient services
- Discharge from CAMHS to primary care
- Admission to CAMHS inpatient units
- Service user moving out of area (including LAC children/young people placed out in out of area placements)
- Service users placed in residential placements – especially where the child/young person is returning home during school holidays
- Young people approaching their 18th birthday – who may be requiring transition to Adult mental health or other services

Northampton have developed care pathways:

- Northamptonshire Transitions Team 14 -18[2]
- Northamptonshire Transitions Team 18 - 24[3]

Examples of service models can be found in :

- SCIE 'Mental Health service transitions for young people' (published November 2011 (reviewed November 2014) contains examples of good practice/service models

[2] Local Example, Northamptonshire County Council, Transitions Team 14-18, Overall 'As is' Process – High Level
[3] Local Example, Northamptonshire County Council, Transitions Team 18-24, Overall 'As is' Process – High Level

- Commissioning Panel for Mental Health, Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services (2012)

- Making integration a reality: Part 1: Joining up the commissioning of young people's services By Youth Access and Young People's Health Partnership, April 2014

For all young people who meet the criteria for the service provided, the following principles apply:

Providers will:

- Be available to all young people without regard to gender, sexuality, religion, ethnicity or social or cultural determinants. However, where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such a services will enhance rather than detract from the existing provision.

- Offer young people and parents/carers age- and developmentally appropriate information about their condition and care.

- Ensure that services have age-appropriate physical settings.

- Ensure initial and continuous care planning that involves all members of the team providing care, the young person and their family where appropriate.

- Develop a risk management plan in collaboration with the young person and their family, where appropriate,

- Provide care/interventions that will prevent crisis presentation and unnecessary admission to inpatient beds and promote safe discharge and recovery.

- Ensure that all service developments and/or redesigns are undertaken using co-production.

- Ensure that any cross charging arrangements for cross -boundary service users are detailed Young people (LAC) should not be denied a service because they originate from another LA/CCG area.

- Ensure that patients' legal rights for patients with regards to choice of mental health provider are implemented, see guidance.

- Contributes to other parts of agreed multiagency care pathways.

The locally agreed transition pathway (s) is/are here: **Link to care pathway diagram or flow chart of local service**

Acceptance criteria

The service will have clear acceptance criteria that are transparent and made clear to referrers, young people, their families and other agencies/services.

- Referrals are accepted from **Insert any locally agreed referral pathways including self-referral, single point of access**
- The provider will accept referrals for young people aged **Insert upper age limit here** where the referrer considers that the young person requires support or treatment from the provider. **Insert locally agreed thresholds including self-referral**

When looking at service upper age limits consider:

- Age limits of other services – are there any gaps?
- What happens to cases that are not eligible?
  - Collection of data regarding cases declined,
  - Sign posting on/ information packs/technology.

- Ensure they provide locally available, age and developmentally appropriate, co-produced information for young people, parents and referrers about the transition process, services provided and how they are accessed.
- Support and ensure interagency working.
- If the service concludes that the needs of children, young people or parents are better met by other agencies it will **Insert protocol here.**

Initial assessment

Insert here local protocol for how professionals refer to another service to Include information sharing protocols with schools/FE/HE colleges

Data recording must include:

- CAMHS Minimum Dataset
- Adult Minimum Dataset

- HES where appropriate
- QOF

Data recording should include whether the individual is currently being seen any other local services including in schools or academies.

Continuing care and assessment

Providers will:

- Ensure that the transition care plans (following Care Programme Approach, or CPA, where applicable) are in place for people receiving support for mental health problems. These plans may include more than one professional or agency group delivering care and should be developed in collaboration with service users and carers A copy should be given to the service user, parent or carer (if appropriate) and GP.
- Ensure that the transition care plan includes risk management and crisis planning.
- Review the transition care plan with the service user, including the goals of treatment, and revise the care plan at agreed intervals of no more than 6 months .
- Select treatment options in consideration of NICE HTAs, NICE guidelines and NICE Quality standards, as follows:
    - Age-appropriate best practice/evidence based psychological intervention
    - Pharmacological and psychosocial interventions.
    - Environmental and occupational/educational interventions or provision
    - Patient choice, Engagement, and flexibility and choice.
- Ensure that clear discharge systems are in place to coordinate effectively with other services when young people are in treatment, when they move between other services both for their physical and mental health, and that there are processes in place to plan the ending of treatment or services.

Groups needing particularly robust transition processes include:

- Young people transferring from child and adolescent to other emotional wellbeing and mental health services

- Vulnerable children and young people's groups, including:
    - Looked after children
    - Care leavers – moving to independent living
    - Young people entering or leaving inpatient care
    - Young people entering or leaving prison
    - Young offenders
    - Children and young people with learning disabilities
    - Children with ADHD, and ASD or Asperger's syndrome
    - Any planning for children and young people with severe educational needs should take account of and be part of the child or young person's statement
    - Unaccompanied asylum-seeking minors
    - Children and young people with caring responsibilities
    - Young people with chronic illnesses and/or lifelong health conditions.
    - Young people who have suffered significant harm such as sexual abuse, neglect, physical and emotional abuse and or who have post traumatic stress disorder

Any planning for children and young people with severe educational needs should take account of and be part of the child or young person's statement or Education Health plan

Staffing arrangements, recruitment and training, supervision/appraisal requirements

Providers will:

- Ensure the workforce have the necessary compassion, values and behaviours to provide person-centred care and enhance the quality of experience through education, training and regular continuing personal and professional development (CPPD) that instils respect for young people and families.

- Anticipate the numbers and capabilities of the workforce needed currently and for the future, ensuring an appropriate skill mix in teams able to deliver a range of recommended evidence-based interventions, with a delivery model that best focuses the capacity of the service to meet the demands of the

population.

- Ensure the workforce is educated to be responsive to changing service models, innovation and new technologies, with knowledge about effective practice and research that promotes adoption and dissemination of better quality service delivery.

- Ensure there are sufficient staff educated and trained with the required knowledge and skills, aligned to service and changing care needs, whilst working effectively in a team.

- Ensure that there is compliance with the recommendations of the Francis Report (2013) and in particular the Code of Candour.

3.4 Population covered

This specification covers the care of young people up to the age of xx in the commissioner's area. See guidance in section 3.2 (acceptance criteria)

3.5 Any acceptance and exclusion criteria and thresholds

Clinical presentation

Insert local clinical presentation here

Young people may not be eligible for the service provided on the basis of:

- Age **insert local threshold**

- The referred problem may be best treated in an alternative service (and the protocol by which the service will refer to the alternative must be explicit)

- Where a more clinically appropriate service has been commissioned from an alternative provider (e.g. in the case of a young person with severe disabilities, ADHD or ASD, substance misuse)

- If the young person is in court proceedings where intervention is not advised under Home Office guidelines

- Court assessments, unless specifically contracted

- Where the service is not commissioned to include the clinical presentation (specify, and provider to record specific instances)

Insert locally agreed protocols for specific services here Consider the needs of young people with multiple problems (for example substance misuse and mental

health, eating disorder and depression) and clarify lead agencies

3.6 Activity

The activity level within the NHS contract sets out the numbers of new cases and levels of activity funded by this contract. Commissioners will need to have in- depth discussions with providers regarding the number of cases and consultation levels commissioned. Commissioners may find the Choice and Partnership Approach (CAPA), the LEAN Improvement Approach and the advice from the Royal College of Psychiatrists regarding staffing levels useful as an aid to agreeing the levels of activity covered by this specification. Commissioners will need to keep this under review, particularly if resource levels change.

See capacity/activity modelling[4] for further guidance.

3.7 Interdependence with other services/providers

Providers should ensure they have excellent links with:

- General Practice
- Schools and academies, FE colleges and other education providers including links to apprenticeship providers , and employment advisers
- CAMHS
- Adult mental health services (adult, specialist, forensic)
- Drug and alcohol services
- Voluntary sector providers
- Independent providers
- Housing services
- Inpatient or other highly specialist services
- Youth services
- Scholl counselling services
- Safe guarding – children and adults (Local Safeguarding Children's Board)
- Local authorities
- Acute sector hospitals
- Emergency departments

[4] Nixon, B. (lead) with CYP IAPT National Service Development Group - Commissioning Subgroup (2014)

- Community child health including specialist practitioners for looked after child and care leavers
- Criminal justice system – including young offenders' services.
- Addiction services
- Local independent providers

Providers should have a formal route to refer service users to highly specialist mental health services, for example, 24/7 intensive case management assertive outreach teams and Early Intervention Teams, or - for example, to cover instances such as if the local age of transition is 16, how the service will link to NHS England to obtain inpatient Tier 4 beds that are age appropriate.

Providers should establish clear communication pathways and information sharing mechanisms are in place to ensure that young people and where appropriate their families experience a smooth journey through the care pathway.

Providers are expected to work together with relevant agencies in health, social services and education to ensure that young people have appropriate advice and support throughout their transition. This includes using whatever locally agreed systems are in place to support joint agency working (e.g. CAF, Team around the Child), meeting safe guarding standards, and provide clear protocols on information sharing. Young people should be asked for consent regarding information sharing with other agencies rather than a blanket decision being taken not to share health information with other agencies. This should include information about nonattendance to mitigate against the risks inherent in the fact that young people are often dependent on others to access care.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

4.2 Standards for young people's and parents' participation.

All services must include their clients when designing and monitoring services. The list below is not exhaustive.

- Department of Health (2011) Quality Criteria for young people friendly health services ('You're Welcome') sets out principles to help commissioners and service providers to improve the suitability of NHS and non-NHS health services for young people.
- National Youth Agency (2006) Hear by Right. Standards for young people's participation (not specifically mental health)

- Health and Social Care Advisory Service (2008) Turning what young people say into what services do. Quality Standards for children and young people's participation in CAMHS, is based on the Hear by Right standards above and adapted specifically for CAMHS.
- CYP IAPT Principles in CAMHS Services: Values and Standards 'Delivering With and Delivering Well"[5] was developed by young people, commissioners and providers, and includes standards regarding participation based on feedback from young people involved in the CYP IAPT Programme.

4.3 Applicable standards set out in guidance and/or issued by a competent body (e.g. Royal Colleges)

- Multiagency peer accreditation standards set out by the Royal College of Psychiatrists Centre for Quality Improvement
- Youth Wellbeing Directory &and ACE- V Quality Standards
- Child Outcome Research Consortium (CORC)
- Choice and Partnership Approach (CAPA)
- SCIE Mental Health service transitions for young people (published November 2011, reviewed November 2014)

Associated policy documents:

- No Health without Mental Health. Department of Health (2011)
- Talking Therapies, a 4-year plan Department of Health (2014)
- Closing the Gap, Department of Health (2014)
- NHS and Social Care Act, (2011)
- Children and Families Act (2013)
- Mandate to Health Education England
- 5 Year Forward view
- Forward View into action: Planning for 2015/16 guidance
- Access and waits policies 2014
- Chief Medical Officer's Annual Report on State of Public Health (2014)

[5] CYP IAPT Values and Standards Subgroup - CYP IAPT National Service Development Group, CAMHS Press (2014)

- Behaviour and Discipline in Schools, Department of Education (2014)
- Personalised Health Budgets Guidance
- Choice of Provider Initiative

4.4 Applicable Service Standards

Specific transition related outcomes and indicators have been identified by the NHS England expert reference group, as follows:

Provider organisation	**Indicator'**
Provision of young people- friendly services	Compliance with You're Welcome Quality Standards for young person appropriate services[Ref Transition Standards self-assessment 3.1 and 3.2]
Provision of transition-focused services	Named executive lead for transition [Ref Transition standard self-assessment 1.6, 2.1 2.2] Transition policy covering services for young people (13-25) developed, implemented and reviewed annually with assurance report to the Board and commissioners [Ref transition standard self-assessment 4.1, 4.7] Transition Steering Group led by named executive lead for transition monitors, reviews and improves compliance with NHS England Generic Transition Specification and any other commissioned outcomes / quality standards relating to transition [Ref transition standard self-assessment 4.1,5 1,5.2]
Population and transition-focused care data sets and performance trackers utilised	Provider data base identifying population of 13 – 25 year olds within commissioned specialist services with transition plans identified and

	accessible via PAS and EPR systems[Ref transition standard self-assessment 5.1,5.3 5.4] DNA rates for 13 – 25 year olds tracked and managed by responsive DNA policy (and involvement of GPs in the DNA policy) Patient safety incidents relating to care of young people , particularly peri-transfer, extracted, collated and reviewed for trend analysis and action plan shared learning
Young people's service experience measured and acted upon	Patient-Led Assessments of the Care Environment (PLACE) assessments undertaken by young people in conjunction with Young People Friendly / You're Welcome assessments [Ref transitions standards self-assessment 4.2 plus 4.3 for parents/carers] Patient survey data for young people (Picker Questionnaire in development)
Staff working with young people have access to training relevant to caring for this population (including safeguarding training	Provider's training directory identifies relevant training available and that core members of the health care team (or an MDT if established) MDT have been trained and receive training updates.[Ref transitions self-assessment whole section on training 6.1 6.2,6.3,6.4,6.5.6.6 – spells out specific conditions often missed eg ADHD ASD Includes requirement for common mental health problems, adolescent mental health development.]

Applicable local standards

Commissioners will need to determine the local standards. Consider local

population needs, demographics, Health Watch, local Health and Wellbeing, CAMHS and Mental Health strategies, and CCG priorities.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable quality requirements (See National Contract Schedule 4 Parts A–D)

Quality Standard 1

The provider (Trust /service) has a documented transition to adulthood and adult health services policy and appropriate protocols that are developed and reviewed with key stakeholders.

Quality Standard 2

All services provided for young people (13 – 25) are routinely evaluated to improve the quality of their service based on annual You're Welcome assessments and Patient Surveys. Service improvement processes include the involvement and participation of young people and parents/carers.

Quality standard 3

CAMHS and receiving services, including adult mental health services. AMHS, will work together with local primary and secondary care and other multi-agency services to enable holistic and integrated person-centred care planning and delivery. Working together processes are built into the transition policy at service and provider level. (toolkit 7.2)

Quality standard 4

All young people identified by targeted, specialist or highly specialist CAMHS who are as likely to need the continuing assessment, review and intervention of AMHS as a result of a severe and enduring long- term condition / and/or complex health needs will have a person- centred plan which covers:

- Developmentally attuned preparation for increased autonomy and self-management.
- Co-ordinated and supported transfer planning in partnership with the young person and their support system led by a named health professional.
- Developmentally attuned integration into adult receiving services with proactive support to maintain engagement with services.

Quality standard 5

All staff working with young people (13 -25) have received training on understanding

the developmental needs and working in partnership with this age group.

Quality standard 6

A range of multimedia information and resources on transition to adulthood, both generic, and condition and service specific will be available and accessible to young people, their parents / carers and clinicians. The detailed evidence on what and how to evidence different conditions and their treatments it is delivered needs to be worked up by specific specialties and perhaps evidenced in their specifications or hyperlinked documents – for example:

The NDCS Quality Standards 'Transition from paediatric to adult audiology services: Guidelines for professionals working with deaf children and young people' (2011) are available to download Quality Standards in Transition

5.2 Feedback and Outcomes Tools

All services providing NHS -funded child and adolescent mental health services must be locally collecting and using the CAMHS and AMHS Minimum Data set, which have been approved by the Information Standards Board for Health and Social Care (ISB) as an information standard for the NHS in England.

Providers should be encouraged to use the tools that best facilitate continuous quality improvement in their clinical practice to ensure quality requirements are meaningful both in tracking progress in and for day-to-day clinical work and collaborative practice.

The CYP IAPT Programme, CORC and the Evidence Based Practice Unit have brought together a set of validated tools for measuring outcomes of clinical treatment and gathering experiential information about treatment. These are described in the Guide to Using Outcomes and Feedback Tools with Children, Young People and Families

5.3 Applicable CQUIN goals (See Standard Contract Schedule 4 Part E)

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Commissioning for Quality and Innovation Guidance (14/15) explains the aims, objectives and financial framework.

Whilst a proportion (0.5%) of the overall proportion (2.5%) of the CQUIN aligned income should be linked with national CQUIN goals where applicable, it is suggested that commissioners may consider creating local CQUINs using qualitative and quantitative measures (

See example local CQUINs below:

- Transition CQUIN Requirements[6]
- Recovery CQUIN[7]
- North West London CQUIN[8]
- Liverpool CQUIN[9]

Further guidance is available in CORC's Position on CQUIN targets.

6. Location of Provider Premises

The provider's premises are located at:

Commissioners may wish to specify the range of locations, for example, voluntary sector drop in centres

7. Individual Service User Placement

[6] Local example for Rotherham, Doncaster and South Humber NHS Foundation Trust
[7] Strachan, C. Example Recovery CQUIN 14-15 document for National Service Leads Meeting (2014)
[8] Local example from North West London Commissioning Support Unit
[9] Local example from Liverpool (Alder Hey & Mersey Care)