

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	C11/S/c
Service	Community Forensic Child and Adolescent Mental Health Service (including Secure Outreach)
Commissioner Lead	<i>For local completion</i>
Provider Lead	<i>For local completion</i>

1. Scope
<p>1.1 Prescribed Specialised Service</p> <p>This service specification covers the provision of Community Forensic Child and Adolescent Mental Health Service (including Secure Outreach)</p> <p>1.2 Description</p> <p>1.2.1 This service specification describes a Tier 4 community-based forensic Child and Adolescent Mental Health Service model that will be delivered within a clearly defined geographical area at Regional and sub-regional level.</p> <p>1.3 How the Service is Differentiated from Services Falling within the Responsibilities of Other Commissioners</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. The range of Tier 4 services commissioned by NHS England includes inpatient care and associated non-admitted care including forensic outreach when delivered as part of a provider network.</p> <p>1.3.2 CCGs commission CAMHS for children requiring care in Tier 1, Tier 2 or Tier 3 services.</p>

2 Care Pathway and Clinical Dependencies

2.1 Care Pathway

- 2.1.1 Future in Mind (2015) emphasised the need for ‘improved care for children and young people in crisis so they are treated in the right place, at the right time and as close to home as possible’. This includes ‘implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care.
- 2.1.2 This service specification will focus on the functions required of a specialist mental health service to mediate transitions into and out of secure in-patient care. It is recognised that such a function requires a broad remit comprising full understanding of all forms of formal and less formal secure care in which young people from a given geographical catchment may be located. Such a service should support the prevention of admission to all secure settings when a meaningful alternative is feasible.
- 2.1.3 Secure mental health in-patient provision forms only a part of a range of formal secure settings for young people in England; the majority of young people in secure environments are detained either on remand or following sentence in secure youth justice settings (Young Offender Institutions, Secure Training Centres or Secure Children’s Homes) or alternatively under the Children Act (1989 and 2004) on welfare grounds. ‘Less formal’ secure care refers to a range of other settings which are not classified as ‘secure’ but which may support high risk and complex young people by the provision of high levels of continual staff supervision.
- 2.1.4 There are currently two broadly distinguishable clinical groups of young people in secure mental in-patient provision (‘forensic’ and ‘complex non-forensic’); such clinical groups are not necessarily mutually exclusive and there frequently is considerable overlap between them. There are three distinct forms of secure in-patient provision for young people
- **Medium secure** settings 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 (i.e. ‘forensic’ concerns) including those who have committed grave crimes. In such settings there are prescribed stringent levels of physical security and high levels of relational and procedural security. Young people admitted to medium secure settings frequently have longer durations of stay than young people in other inpatient settings.
 - **Low secure** settings accommodate young people with mental and neurodevelopmental disorders (in particular learning disability and autism) at lower, but nevertheless significant levels of physical, relational and procedural security. Young people in such settings 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 challenging behaviour, self-harm and vulnerability. Young people admitted to low secure settings (as is the case for those admitted to medium secure settings) frequently have longer durations of stay than young people in other inpatient settings.

- **Psychiatric intensive care units (PICUs)** for young people allow for containment of short-term behavioural disturbance which cannot be contained within an open adolescent in-patient unit or where such behavioural disturbance is associated with mental health concerns in other non-mental health settings. Young people in such settings may belong to the 'forensic' or 'complex non-forensic' groups. Levels of physical, relational and procedural security in PICUs is similar to those in low security but there would be fewer facilities (e.g. educational and recreational settings) to support a young person over a sustained period of time than is the case within medium and low secure units

2.1.5 A secure outreach service needs to be familiar with the needs and differing care-pathways which exist for young people with 'forensic' and 'complex non-forensic' presentations. It is anticipated that such a service would have direct clinical involvement with the 'forensic' group who currently present particular challenges to generic local CAMHS and other services. Whilst such a service would necessarily need to understand the needs of the 'non-forensic' population and provide advice and consultation where necessary, it is envisaged that direct clinical involvement may not be required routinely as such presentations at entry into, or discharge, from secure care are more likely to fall into the day-to-day remit of existing non-secure ('Tier 4') in-patient units or community CAMHS provision. A secure outreach service needs to be flexible in its approach as many presentations do not divide neatly into 'forensic' and 'non-forensic' groups.

2.2 Service Requirements and Functions

2.2.1 The service is a tertiary referral service for CAMHS teams, CAMHS/Youth Offending Team (YOT) link workers and neurodisability services for young people and other agencies. The team will be accessible to all agencies (e.g. social services, YOTs, prisons, courts, solicitors, education, health commissioners etc.) that may have contact with young people exhibiting risky behaviours or young people in the youth justice system who have mental health difficulties. For this reason, initial contacts about possible referrals will be welcomed from all agencies and responses to initial contact from referrer will be made within 5 working days of receipt

The catchment for each service should be 'regional' in the sense that it covers a population and/or geographical area for a total population of about 2.5 million. It is likely that the catchments of some services working either in densely or sparsely populated areas or in areas with particularly high levels of deprivation will need to be organised accordingly.

2.2.2 Service functions include

- facilitation of smooth transitions for young people between services and agencies working with young people and between children's and adult services
- coordination of, and liaison with, mental health services across community and secure settings, and ensuring that care is provided in line with the welfare principles of the Children Act (1989 and 2004) and Code of Practice 2015 to the Mental Health Act (as amended 2007)
- specialist support for local services to enhance delivery of responsive child-centred care in high risk cases through multiagency care-planning and promotion of user engagement in care and wider service provision
- reduction and management of the potential risks posed by the young person to others and self through individualised treatment plans and clinical risk assessment and management processes; this will frequently be achieved in collaboration with other agencies
- specialist mental health assessment (including forensic assessment where appropriate, and access to timely assessment where undiagnosed learning disability or autism is suspected), Case-formulation and intervention in high risk cases where there is a need for specialist opinion to ensure that young people presenting high risk of harm to others or self are managed in the most appropriate way
- in collaboration with other agencies, where appropriate, provision of evidence-based treatment for complex high risk cases, through a wide range of interventions to address individual's mental health, welfare and educational needs
- development of joint working arrangements with CAMHS and other children's services (including community learning disability and autism services) to support the management of high risk and complex cases
- informing and developing strategic links between local provision and regional and national specialist services
- Facilitation of transition into, and out of, secure settings for young people, providing support, advice and practical input as required, follow-up of cases where young people move out of area, facilitating, where appropriate, return from secure custodial, welfare or mental health placements; the service will take a proactive role around the 'forensic' group of young people; adopting a facilitative role with less direct involvement for the 'complex challenging behaviour' group who are likely to be better known to and followed up by Tier 4 and CAMHS outreach teams
- Community intervention to prevent admission to in-patient settings where appropriate alternatives exist or where in-patient admission is unlikely to prove successful. This should include close adherence to the 'Transforming Care' agenda and engagement with the CETR process in cases of learning disability, autism or both.
- Strong emphasis on liaison with all agencies to promote working arrangements and facilitate access to mental health assessment and intervention
- Liaison and advice to youth offending teams; courts and the legal system as a resource for general advice, liaison, formal consultation and, on occasions, specialist assessment and management advice to

courts and the youth justice process (e.g.: potential for diversion, fitness to appear/plead; risk assessment in cases with clear mental health/neurodisability neurodevelopmental components, recommendations for appropriate disposal and follow-up)

- Formation of strong links with services providing mental health in-reach into youth justice or welfare secure settings within catchment and with agencies such as children's social care and education who may be placing young people with complex needs in highly supervised other settings
- Develop effective strategic partnerships, particularly with children's social care, education and the youth justice system, that successfully influence appropriate multi-agency developments to cater for other needs of complex, high risk young people (e.g. services for young people with sexually harmful behaviours, mental health in-reach to local secure welfare or custodial settings and involvement in criminal justice liaison and diversion teams).
- Identification of existing gaps in local and regional service provision and leadership in identifying remedial action.
- Provision of training to practitioners from all agencies in relation to areas within the service's specialist remit (e.g. principles of working with high risk and complexity, risk assessment and management, understanding the interface between different legislative frameworks in particular The Mental Health Act, The Mental Capacity Act, The Children Act, Education Act and SEND Reforms, and Youth Justice.)

2.3 Referrals

2.3.1 The team will seek to make itself accessible to any professional who wishes to make initial contact or enquiries regarding a young person giving cause for concern and about whom there are questions regarding his/her mental health ('the referrer'). This will reduce risk of referrals not being made, delays in identification of need and potential disengagement by young people from services. The service must be sufficiently accessible at point of referral so that all cases requiring specialist input are identified. Discussion and formal consultation with referrers should be undertaken by experienced members of the team and not delegated elsewhere. There should be very clear expectation of meaningful engagement and joint working with the specialist outreach team from a child's local CAMHS team for any child referred by agencies other than CAMHS.

2.3.2 The service will have broad and inclusive criteria for initial contact with the team; flexibility should apply in some cases to age of young person depending on need and appropriateness of ongoing input beyond their eighteenth birthday. The team does not necessarily expect that a young person at referral will have a previously diagnosed mental health difficulty.

2.3.3 The referral process has been put in place to ensure

- specialist assessments and interventions are only undertaken when

absolutely necessary

- local services are supported to continue their work with identified young people and are encouraged to do this in situations where they might not have felt able to do so
- young people receive input at a level commensurate with their needs and with their potential for risk of harm to others or themselves

2.3.4 Referral Criteria are deliberately broad covering all young under 18 about whom there are questions regarding mental health or neurodevelopmental difficulties including learning disability and autism who:

- present high risk of harm towards others and about whom there is major family or professional concern
- and/or are in contact with the youth justice system
- OR about whom advice about the suitability of an appropriate secure setting is being sought because of complexity of presentation and severe, recurrent self-harm and or challenging behaviour which cannot be managed elsewhere; in such cases, where non-secure in-patient services or locality CAMHS teams are usually extensively involved, the input from the secure outreach service is likely to be advisory or consultative rather than requiring direct clinical involvement

2.3.5 Referral Process

- The referrer will undertake an initial short verbal discussion (either face to face or by phone) with a designated member of the service. The outcome of this initial discussion will result in feedback to the referrer and agreement about further action: a) no further input required (not within referral remit) or mediation of referral to more appropriate service b) referral accepted for further, more detailed formal consultation.
- If the referrer is not from a local CAMHS team and the referral is accepted for further input after an initial discussion, the secure outreach team will usually always discuss the referral with the young person's local CAMHS team. This will facilitate a clear joint approach to the referral from relevant mental health providers and, wherever possible, joint assessment and working can be undertaken.

2.3.6 Possible Referral Outcomes

Once contact has been made with the service there are a number of possible outcomes. These are as follows:

- Referral not accepted
- Referral accepted for either brief advice (including signposting/facilitation of access to more appropriate services) or more detailed formal consultation with referrer/local network regarding young person's presentation
- Formal consultation requires pre-arranged in-depth case discussion and should include prior provision of background documentary information

by the referrer. There is initial agreement that such discussion takes place on the basis that the outreach service has not had direct clinical input with the young person in question and that advice/recommendations are provided in line with general management principles.

- At the end of the formal consultation a course of action will be agreed between referrer and community forensic CAMHS secure outreach clinician. This may result in
 - a. no further current input required
 - b. referrer and outreach service clinician agree initial formulation and local plan of action and that direct input not immediately required; secure outreach team to keep case open and seek progress update before closing or becoming directly involved
 - c. Outreach team agree to become directly clinically involved usually in conjunction with referrer.
- The forensic CAMHS outreach team will always summarise formal consultation and its agreed outcome in writing to the referrer.
- Following formal consultation referral accepted for specialist assessment and clinical input as required. This outcome requires the home team and network to remain involved with the case (e.g. by providing a care/case coordinator) and usually to participate in ongoing risk-management in conjunction with the outreach team. Following the assessment, the secure outreach team will remain involved, as appropriate, to support the local network to manage the case and to provide specific intervention. This will include in some cases facilitation of admission for secure in-patient care with relevant providers (with which the secure outreach service will be well-acquainted) and support for the referrer and local services within the formal NHS England referral process. Written feedback to referrer outlining details of assessment and recommendations will be provided to referrer and relevant others including family/carers and/or those with parental responsibility.

2.3.7 Contact with the case will not automatically end if the young person in question moves out of catchment into specialist residential, custodial, educational or secure mental health in-patient provision. Indeed, the secure outreach team may be the CAMHS team best placed to follow the young person through any out of county placement and ensure that the young person's needs continue to be met and that transition back to the home area can be facilitated.

2.4 Discharge and Care-Planning

2.4.1 Referrers will retain overall clinical responsibility for young people they refer and assume a case coordination role irrespective of level of outreach team involvement. In this way the service local to the child remains linked with the child's progress and can ensure local case management. Referring services must identify a case coordinator who will remain in contact with the case throughout the period of involvement from the specialist secure outreach team.

2.4.2 Any discharge from the service, irrespective of level of input required (whether short or longer term, consultative or involving direct clinical assessment and intervention), should be undertaken in consultation with the referrer and the child/young person and/or their parent/carer or person with parental responsibility, as appropriate.

2.4.3 The service will ensure rigorous care planning from the point of referral to discharge and ensure that meeting of need and risk management is clearly prioritised. This should take into consideration the needs and wishes of child, young person and family, and the involvement of other professionals. A copy of the discharge planning information will be given to referrers, families/carers or those with parental responsibility, general practitioners and, with the permission of the family, to any other involved professionals.

2.4.4 Children and young people may move to other services and other geographical locations. Such transitions will be planned and monitored as appropriate. This may require liaison and ongoing support for the young person from the service.

2.5 Interventions

2.5.1 Treatment of mental health and neurodevelopmental needs in high risk young people and young offenders is the same as that clearly evidenced for other young people with mental health difficulties.

2.5.2 The team is required to be competent in ensuring that such treatments are delivered when required in a wide variety of different settings and that professionals in such settings are adequately supported to do this.

2.5.3 In addition, it is necessary for the team to have wide experience of interventions or support packages which may be specifically of value in young people with offending or challenging behaviours. Whilst the team may not itself deliver such interventions, it will frequently be asked to provide clear opinion with regard to the best course of action in individual cases. Specialist knowledge of different types of residential and educational settings or the applicability of different therapeutic interventions (such as Multi-Systemic Therapy, Dialectical Behaviour Therapy, Treatment Foster Care or treatment of sexually harmful behaviours) in such situations is necessary.

2.5.4 In all situations, reasonable adjustments should be made for children and young people with learning disability, autism or both and adapted treatment programmes should be available.

2.6 Staffing

2.6.1 The secure outreach team will be multidisciplinary and will have specialist mental health and forensic experience in the assessment and treatment

needs of complex high-risk young people. In particular, the service will have specialist understanding of statutory mental health, welfare, youth justice and educational processes and understanding of the interfaces between them. It must be familiar with the needs of young people with neurodevelopmental disorders, including learning disability and autism. The emphasis should be on a small, highly experienced and active team whose members are equipped to provide authoritative specialist support to local generic networks.

2.6.2 Secure outreach Community FCAMHS team members should include combination of some of the following:

- Consultant psychiatrist (s) (wherever possible dual trained Forensic and CAMHS; otherwise clearly demonstrating the required clinical competencies formalised with a dual training)
- Senior grade clinical psychologist(s) with appropriate forensic experience
- Clinical nurse specialist/senior mental health practitioner(s) (at least Band 7)
- Other relevant specialist professionals (e.g. forensic psychologist, social worker) with appropriate experience in this area
- Dedicated team administration

2.6.3 The function of the specialist team combines support for generic child and adolescent services and specialist clinical assessment, formulation and intervention skills. The role of the consultant psychiatrist is essential given the specialist knowledge of the Mental Health Act required in this work. Psychology support is also crucial given the frequent need for structured psychometric cognitive and other psychological assessments as well as consideration of appropriate interventions. The administrator's role is central and requires a wide-range of skills and coordination of a peripatetic team.

2.6.4 Staffing levels per catchment will be determined in line with the team's core functions, catchment population and geographical size and levels of deprivation.

2.7 Co-located Services

2.7.1 Geographical colocation within existing CAMHS provision is highly advisable. This reinforces the fact that such services constitute a part of CAMHS provision and that their primary concern is to be part of an overall care pathway for children and young people with mental health or learning difficulties. Such an arrangement also facilitates access and allows meaningful feedback whilst preventing isolation of a specialist service. Premises should be available to the team to undertake clinical assessments as they are available within other CAMH services. However, it is likely that the team will need to exercise considerable flexibility to ensure that the best assessment outcome is achieved for the child and his/her family; clearly this will involve proximity to residential provision but

will require attention to the need for privacy and confidentiality and putting the young person at ease.

2.7.2 As a result, the team is likely to be peripatetic but should retain a clearly defined team base. It must provide outreach across each region/sub region and ensure that there is appropriate coverage to meet the population needs according to population density, geographical distribution and levels of deprivation. The services are to be:

- Located within providers with existing broad-based CAMHS provision
- Regionally located and provided on a network model to ensure there is consistent and equitable nationwide coverage.

2.8 Interdependence with other Services

2.8.1 Community Forensic CAMHS Secure outreach teams necessarily must be expert in liaising and establishing good working relationships with a wide variety of agencies and institutions. This is essential if they are to ensure the best outcomes for the young people with whom they have contact. The teams must be capable of advising, supporting and challenging such agencies and institutions as appropriate. At times their role in high risk cases will involve the containment of anxiety whilst at others it will involve the injection of concern where risks were hitherto poorly recognised and addressed.

2.8.2 Community FCAMHS Secure outreach teams will also provide education within the NHS and beyond to raise and maintain awareness of the needs of young people with high risk and complex presentations and needs.

2.8.3 All community FCAMHS teams secure outreach services should be adept at working across agencies and institutions operating not only locally but also at regional and national levels

2.8.4 It is expected that all community FCAMHS teams secure outreach services will actively contribute to a national clinical network (yet to be developed) which will ensure parity of provision and determination of uniform clinical standards and monitoring/evaluation. This network should also ensure continuity of provision for young people if they move between placements in different regions although it would be expected that the child's home-based service would maintain contact with the child and his/her family.

2.9 Interdependent Services

2.9.1 At National Level:

- 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
- Other community FCAMHS providers
- Other providers of highly specialist residential or educational care for young people

2.9.2 At Regional and Local Levels:

- Local establishments providing 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
- Public health
- 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 difficulties, including learning disability and autism)

3 Population Covered and Population Needs

3.1 Population Covered By This Specification

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

3.1.2 Specifically, the secure outreach service is commissioned to provide and deliver high quality mental health liaison, assessment and intervention for high risk young people with complex needs living within catchment (or belonging to that catchment but placed elsewhere) who meet the following criteria:

- under 18 years old at the time of referral (no lower age threshold for

access to the service although most referrals will be for 10 to 18 year olds)

- presenting with severe disorders of conduct and emotion, neuropsychological deficits, or serious mental health problems and/or neurodevelopmental disorders (including learning disability or autism) with/without learning difficulties or where there are legitimate concerns about the existence of such disorders
- usually involved in dangerous, high-risk behaviours whether they are in contact with the youth justice system or not. This will include young people who present a high risk to others through such behaviours as fire setting, physical assault and sexual offending.
- in exceptional cases, are not high risk (not primarily dangerous to others) but have highly complex needs (including legal complexities) and are causing major concern across agencies

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 be adequately addressed. 'Transforming Care' proposals sets out a requirement for dynamic 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 The evidence base is derived from an independent evaluation of the regional community FCAMHS service in the Thames Valley (Public Health Resource Unit, 2006) and subsequent re-evaluation of a second service replicating the service model across Hampshire and the Isle of Wight (Solutions in Public health, 2011). Both evaluations were supported by the Department of Health. A further national mapping exercise (Dent, Peto, Griffin and Hindley, 2013) identified significant disparity in provision (with many areas not having access to specialist FCAMHS) and heterogeneity of commissioning arrangements.

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 numbers of inpatient admissions and lengths of stay; reduce variations in service availability and access and improve the experience of patients, families and carers using mental health services.

4.1.2 The expected outcome for this service include

- the provision for a specific geographical catchment of clinical consultation and specialist assessment, case formulation and interventions for young people with very complex needs across a variety of secure, custodial, residential and community settings.
- Flexibility in approach ensuring that all appropriately identified young people from the catchment receive the same quality of input and follow-up irrespective of their geographical location or the nature of their current placement
- The provision of a range of strategic, service development and training functions the maintenance of strong links with and between all agencies and services locally including children's social care, youth justice, education and third sector providers secure or specialist residential settings;
- Assessments delivered in the child's local area/current residential placement or in a setting appropriate to the child and family's needs
- Effective formulation of the needs of high risk young people with decisions on placement based on individual need rather than systemic constraints
- Appropriate access and transition to, and discharge from all forms of secure services for young people with highly complex needs.
- Admission to secure inpatient settings only undertaken when clearly indicated.
- Provision of safe, timely and effective (evidence based / best practice) assessment and intervention across the different stages of the care pathway.
- Admission of children and young people with learning disability and/or autism will be in line with 'Transforming Care' policy and 'Community Care, Education and Treatment Reviews' (CETRs) prior to any admission are actively supported
- Improved mental health and well-being by identifying and addressing the mental health needs of high risk young people in a range of secure, residential and community settings
- Minimisation of risk of harm to self and others
- An individualised, developmentally-appropriate framework of care that includes the young person and family/carers in decision making and provides for their needs.
- Principles of safe guarding children are embedded within the everyday practice of the service.
- Supplementation of local provision across agencies with specific specialist

input and case-formulation relating to the understanding and management of high risk cases

- Service accessible to all young people from an identified geographical catchment regardless of disability, sex, race, gender or current geographical location Promotion and support of young people's development
- Promotion of attachment, achievement of developmental potential, healthy family functioning and continuity of care wherever possible
- Inclusion of young people with neurodevelopmental disorders particularly learning disability and autism.

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

The service will be subject to a formal independent evaluation after 12 months to be commissioned by NHS England; this will inform the on-going development of formal outcome measures. outcome and activity measures are subject to further development

No.	Indicator	Data source	Domain(s)	CQC Key Question
Clinical Outcomes				
101	Number of referrals received by the team.	Provider	1, 2, 3, 4, 5	safe, effective, caring, responsive
102	% of referrals	Provider	1, 2, 3, 5	safe,

	leading to indirect case involvement only.			effective, caring, responsive
103	% of referrals that lead to direct clinical involvement	Provider	1, 2, 3, 5	safe, effective, caring, responsive
104	% of cases with ongoing mental health involvement as part of an integrated care plan	Provider	2, 3, 4, 5	safe, effective, caring
105	% of cases with formal indirect contact accessing feedback from referrer or other professional.	Provider	2, 3, 4	safe, effective, caring
106	% of cases where reduced length of stay has resulted from active involvement in and facilitation of discharge from inpatient care	Provider	2,3,4,5	safe, effective, caring, responsive
Patient Outcomes				
201	% of cases with direct clinical contact receiving feedback	Provider	2, 3, 4	safe, effective, caring
202	Provision of service-related information for young people and families/carers and professionals.	Provider	2, 3, 4	safe, effective, caring
Structure & Process				
301	Forensic MDT membership	Self-declaration	1, 2, 3, 5	safe, effective responsive caring
302	Service infrastructure	Self-declaration	1, 2, 3, 5	safe, effective

				responsive caring
303	Provision of cross agency training	Self-declaration	2, 3, 4, 5	Safe, effective, caring
304	There are agreed patient pathways as per the service specification.	Self-declaration	1, 3, 5	Safe, effective, caring
305	There are agreed clinical protocols/guidelines.	Self-declaration	1, 3, 5	Safe, effective, caring
306	Data collection	Self-declaration	2, 3	Safe, effective, caring

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

4.3.2 Applicable CQUIN goals are set out in Schedule 4D

5 Applicable Service Standards

5.1 Applicable Obligatory National Standards

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

- Mental Health Act 1983, as amended 2007
- 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
- Transforming Care for People with Learning Disabilities – Building the Right Support
- Working Together to Safeguard Children (2010) and relevant subsequent legislation

5.2 Other Applicable National Standards to be met by Commissioned Providers

5.2.1 The service is required to comply with the following national standards, guidance, frameworks and legislation as listed below:

- NICE guidelines for a range of disorders occurring in children and adolescents (e.g. psychosis and conduct disorder)
- National Service Framework for Children, Young People and Maternity Services (2004)
- Code of Practice: See Think Act (Department of Health 2010).
- Every Child Matters in the Health Service (DoH, 2006)
- New Horizons for Mental Health (DoH, 2009)
- DoH/YJB Information Sharing Guidance
- Future in Mind (DoH and DfE, 2014)
- Supporting people with a Learning Disability and/or Autism who Display Behaviour that Challenges, including those with a Mental Health Condition: Service Model for Commissioners of Health and Social Care Services ('Transforming Care')
- The Evidence Base to Guide Development of Tier 4 CAMHS (Department of Health; Kurtz, Z April 2009)
- Promoting mental health for children held in secure settings: a framework for commissioning services. London: DH, 2007
- Procedure for the Transfer from Custody of Children and Young People to and from Hospital under the Mental Health Act 1983 in England (DoH, June 2011)
- Information Sharing - Advice for practitioners providing safeguarding services to children, young people, parents and carers (HM Government, March 2015)
- UN Convention on the Rights of Persons with Disabilities
- Healthcare standards for children and young people in secure settings (2013) Intercollegiate Document (Royal College of Paediatrics and Child Health (RCPCH), Royal College of General Practitioners, Royal College of Nursing; Royal College of Psychiatrists, Royal College of Forensic and Legal Medicine and Faculty of Public Health)
- Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (DFE March 2015)
- Healthy Children Safer Communities (DoH, 2009)

5.3 Other Applicable Local Standards

Not applicable

6 Designated Providers (if applicable)

Not applicable

7 Abbreviation and Acronyms Explained

7.1 The following abbreviations and acronyms have been used in this

document:

- **CAMHS** Child and Adolescent Mental Health Services
- **CCG** Clinical Commissioning Group
- **CETR** Care education and Treatment Review
- **FCAMHS** Forensic Child and Adolescent Mental Health Services
- **PICU** Psychiatric Intensive Care Unit
- **SCT** Secure Training Centre
- **SEND** Special Educational Needs and Disability
- **YOI** Young Offenders Institute
- **YOT** Youth Offending Team

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