SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No:	170025/S
Service	Tier 4 CAMHS Adolescent Medium Secure
Commissioner Lead	*For local completion*
Provider Lead	*For local completion*

1. Scope

1.1 Prescribed Specialised Service

1.1.1 This service specification covers the provision of Medium Secure Forensic Services For Young People

1.2 Description

1.2.1 Secure forensic mental health services for young people include services provided by Specialist Secure Forensic Mental Health Service Centres for young people.

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

1.3.1 This service specification describes Tier 4 Medium Secure Child and Adolescent Mental Health Services (CAMHS) 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.

2. Care Pathway and Clinical Dependencies

2.1 Care Pathway

2.1.1 Future in Mind (2015) emphasised the need for 'improved care for children and young people in crisis so they are treated in the right place, at the right time and as close to home as possible'. This includes 'implementing clear evidence-based pathways for community-based care, including intensive

home treatment where appropriate, to avoid unnecessary admissions to inpatient care 'however, there is recognition that there will always be some children and young people who require more intensive and specialised inpatient care. 'The key to commissioning the right type of care, in the right places is to adopt a whole system commissioning perspective…..this should address the role of pre-crisis, crisis and 'step-down' services alongside inpatient provision.'

2.1.2 Tier 4 inpatient CAMHS services in England offer care at four levels to support the effective management of differing nature of risk presented by children and young people 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 medium secure services.

2.2 Service Requirements and Functions

2.2.1 All medium secure adolescent services will be part of the National Secure Forensic Mental Health Service for Young People (NSFMHSfYP) clinical management network. The network supports:

- A single national coordinated referral and admission pathway into individual service settings and across the network
- A coordinated national response that evidences equity of provision

across services in England.

2.2.2 Adolescent medium secure service settings provide care and treatment within a highly prescribed set of physical, relational and procedural security measures to a variety of young people. The predominant need for care and treatment will be related to the young person's assessed risk of harm to self and/or others in the context of their mental disorder.

2.2.3 There are four recognised pathways into adolescent medium secure services:

- Stepping up from low secure adolescent services
- Direct admission through a criminal court process or from youth justice custodial settings
- Admissions from non-criminal justice and welfare settings including welfare secure units and specialist educational settings
- Admission from PICU, from the community or a non-secure adolescent inpatient service.

2.2.4 Multi-disciplinary working and the Care Programme Approach (CPA) process will underpin service delivery; the medium secure service will provide:

- Young person-centred individualised multi-disciplinary evidence-based treatment packages, based upon assessment of need, formulation 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 (minimum of 25 hours per week) 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 Acts and Code of Practice to the Mental Health Act
- Specialist professional and clinical advice to referrers and other agencies.

2.2.5 The competencies that are particularly needed in medium secure services 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 and forensic competencies), social work, occupational therapy, education and nursing professionals. Services should ensure appropriate access to other necessary disciplines (such as speech and language, family therapy etc.)
- Units should work to a therapeutic model based on the principles of child development and attachment that acknowledges the importance of relationships and the key role of primary caregivers as agents of change. The model informs the work of the multidisciplinary team and is an underpinning principle of the nursing workforce in maintaining a safe, therapeutic and developmentally appropriate culture within the unit
- A comprehensive multidisciplinary assessment and formulation of a young person and their wider support network will be undertaken. A structured clinical judgement approach to clinical risk assessment and management will be adopted, and reviewed at regular intervals. The assessment will inform an individual formulation including risks and protective factors which will be clearly recorded and shared by the team, the young person and their wider system
- The therapeutic regime should be able to deliver effectively a variety of psychological interventions at an individual and group level and deliver interventions addressing interpersonal relationships, problem solving, affect regulation, mental health in line with the clinical formulation. The interventions should be flexible and responsive to the needs of the young people. The units will also provide a spectrum of offender-related interventions commensurate with high risk presentations
- The therapeutic milieu should be comfortable with a psychological understanding of formulations. It should have a capacity to effectively deliver interventions for protracted periods of time and should show a level of resilience capable of dealing effectively with chronic challenging young people with past significant adversity. It should also be capable of demonstrating a robust safeguarding approach that is able to balance therapy delivery and safety of staff and patients
- Interventions should draw from the available evidence base, whilst recognising the limits of this evidence for the complex client group. When working outside the evidence base, innovative interventions should be theoretically sound and robustly evaluated and should evidence clinical outcomes and young person and carer satisfaction.

2.3 Referrals

2.3.1 The NSFMHSfYP clinical network will consider all referrals from youth justice settings (courts and custodial units) and determine the level of security required. In general young people from these settings are likely to require medium security however on rare occasions admission to a lower level of security may be more appropriate.

2.3.2 Referrals for medium secure can be made to any unit in the NSFMHSfYP network using the NHS England National Access and Referrals process referral forms (Form 1 and Form 2). Referrals for medium secure should be made in agreement with the CAMHS service from the young person's home area.

2.3.3 All referrals are considered on a weekly basis by the members of the NSFMHSfYP network which then allocates a specific unit to undertake an assessment of the young person. The allocation is based on available treatment, patient gender, presence of learning disability, geography and current capacity to admit.

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

2.3.5 The provider will complete the assessment within 2 weeks of allocation by NSFMHSfYP weekly referral meeting.

2.3.6 The NSFMHSfYP network cannot provide emergency cover but can provide a rapid response to contribute to the assessment and management of imminent harm to others in the context of the young person's mental disorder. The NSFMHSfYP network will provide advice to referring clinicians to ensure that any subsequent referral is appropriately directed to medium or low security.

2.3.7 Referral to the NSFMHSfYP network in the first instance should be made in the following circumstances:

- Where the young person with a mental disorder including neurodevelopmental disorders such as learning disability and autism presents a grave danger to the general public (including those who are high risk without an offending history, those charged with/convicted of specified violent or sexual offences under Schedule 15 of the Criminal Justice Act)
- Where a the young person is subject to a Restriction Order under the Mental Health Act (s49) including those in custody (remand/sentenced) and directed to secure inpatient care by the Ministry of Justice (MoJ) **or** has been sentenced by a Crown Court to a Restriction Order under the Mental Health Act (s41).

2.3.8 On very rare occasions the NSFMHSfYP network will consider referrals for young people with particularly severe presentations which may include prolonged self-harm and particularly challenging behaviour where there is evidence that they cannot be managed in any other setting including PICU or low secure services.

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

2.4 Acceptance Criteria

2.4.1 The young person is under 18 at the point of referral
and
liable to be detained under Part II or Part III of the Mental Health Act
and
presents significant risk to others with one or more of the following

- Direct serious violence liable to result in injury to others
- Sexually aggressive behaviour
- Destructive and potentially life-threatening use of fire

and
there is clear evidence prior to referral that serious consideration of less secure provision has been made and/or tested and discounted as the young person's needs/risk exceed the threshold for and ability of those services to manage.

2.5 Initial Assessment

2.5.1 The need for admission to medium secure services must be considered by the medium secure service in collaboration with the referrer. Repeated assessments for the same young person in relation to the same referral must be avoided.

2.5.2 The initial assessment must be undertaken by members of the medium secure MDT (minimum required psychiatrist and nurse); where possible this should be done in collaboration with the referrer within the timescale set out at 2.4.4 above.

2.5.3 Information about the available treatment and facilities must be shared with the young person, family/carers and others with parental responsibility prior to admission.

2.5.4 The assessing medium secure service must complete the required NHS England CAMHS national referral form (Form 1 and or 2) discuss the assessment with the NSFMHSfYP network at its weekly referral meeting

2.5.5 If the young person does not meet the criteria for admission to medium security the assessing team must feedback to the referrer verbally as soon as possible and provide a written assessment report for the referrer. The assessing team must provide advice on management or risk including alternative options for meeting the needs of the young person.

2.6 Pre-admission

2.6.1 The referring team must ensure that the staff at the medium secure service receive all relevant documents and information about the case including:

(i) The initial assessment and referral (including the referring team's opinion on the reasons for seeking admission to medium secure

which will be completed by Tier 3 CAMHS Consultant Child and Adolescent Psychiatrist or Child and Adolescent Psychiatry Specialty Trainee ST4-6

(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.

2.6.2 The admitting service must inform the young person, parents/those with parental responsibility, carers, the responsible CAMHS service and NHS England Case Managers of the decision to admit.

2.6.3 The medium secure service must agree arrangements for admission with the young person's current placement. This must include written confirmation of admission timescales/date.

2.7 Admission

2.7.1 There is some degree of overlap between admission criteria for adolescent medium secure, low secure and PICU services. This must be borne in mind by clinical teams and at each case review specific consideration must be given to the principle of care in the least restrictive setting and whether the young person is appropriately placed.

2.7.2 On admission the service must provide young people with information about the available treatments and facilities and ensure that the young people 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.

2.8 Treatment Programme

2.8.1 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 'as needed' medication (also known as pro re nata or PRN medication) and Rapid Tranquilizations, which are reviewed regularly by the clinical team and service Pharmacist
- A broad range of psychological interventions (which may be delivered at an individual, group or systems level). These should be sequenced according to need and readiness and delivered within a developmentally sensitive framework in accordance with best available evidence and/or NICE guidelines
- Offence specific therapeutic interventions which may include programmes for sex offending, fire setting aggression reduction if indicated by the risk and needs assessment
- 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).

2.9 Home Leave

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

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

2.9.3 For young people with additional restrictions, the MOJ must be involved in all discussions regarding leave and provide the necessary permissions prior to any leave being taken.

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

2.9.5 Leave of up to 2 days should be encouraged.

2.9.6 Any additional leave over 2 days per week of greater than 5 days in total on one occasion or over several occasions during an admission, must be agreed with the NHS England Case Manager.

2.9.7 Each planned home leave must be risk assessed and managed with due regard for the service's duty of care to the patient and the commissioning body's statutory duty of care.

2.10 Care Planning

2.10.1 Young people must have a comprehensive care plan and risk assessment developed by the MDT collaboratively with the young person and, if appropriate, their family in accordance with best practice guidance.

2.10.2 All care planning must follow a recovery and outcome process, must be embedded in the Care Programme Approach (CPA) and form the cornerstone of delivery of an effective care pathway through secure care.

2.10.3 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.

2.10.4 Medium secure services must support case management from NHS England Case Managers.

2.10.5 All patients must have a community Care Coordinator linked to community CAMHS team local to the patient's home area who must remain updated throughout the admission period and is expected to remain involved with the young person's care.

2.10.6 For restricted patients, adolescent medium secure services must ensure compliance with the Ministry of Justice requirements.

2.10.7 For young people who are subject to input from the Youth Justice Services, reviews of orders including remand reviews must be facilitated and may be undertaken jointly with CPA reviews.

2.10.8 Where the young person has a learning disability or ASD every effort must be made to hold a CETR before admission, including a Blue Light CETR if there is not time to convene a full one.

2.10.9 If a CETR was not carried out prior to admission it must be held within 2 weeks of admission. CETRs must be repeated every 3 months during an admission in line with CETR guidance and policy published in March 2017. This guidance can be found using the following link - www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf

2.10.10 Links must be established proactively with the young person's home local authority at admission and agreement made on the level of social care input required. These links must be maintained until discharge including notifying them of their responsibility at 3 months under section 85 of the Children Acts.

2.10.11 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

2.10.12 Care pathway planning must always involve balancing the relevant needs of the young person, including:

- The immediate risk posed by the young person to themselves and/ or others
- Ministry of Justice or court-ordered restrictions
- Specialist treatment needs which cannot be met in lower security settings
- The Mental Health Act 1983 Code of Practice principle of least restrictiveness
- The young person's vulnerabilities, including potential destabilisation by multiple transitions
- Placement stability and continuity of care the young person's and their family needs including access to and proximity to home and ease of access to family.

2.11 Enhanced Observations

2.11.1 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.

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

2.11.3 All Tier 4 CAMHS medium secure services must:

- Develop and implement a policy for enhanced observations in the day/in-patient element
- Deliver enhanced observations in line with good clinical practice (for example but not limited to - when a young person exhibits overt physically aggressive behaviour towards others, or is an active risk to themselves)
- Review enhanced observations at least twice daily and reduced to

the minimum at the earliest opportunity.

2.12 Seclusion facilities

2.12.1 Medium secure services 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.

2.12.2 All physical seclusion facilities and patient management practices must comply with Quality Network for Inpatient CAMHS (QNIC), Care Quality Commission 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.

2.13 Physical healthcare

2.13.1 Medium secure 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.

2.13.2 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.

2.14 Education

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

2.14.2 The local authority is under a legal duty to make sure that, if a young person of compulsory school age is unable to attend their primary, secondary or special school because of illness, they continue to get a full-time education unless part-time is better for their health needs.

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

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

under a funding agreement or arrangement that depends on the type of education provider.

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

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

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

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

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

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

2.14.8 The education must be full-time or as close to full-time as in the young person's best interests taking account of their health needs. The full guidance can be found here:

https://www.gov.uk/government/publications/alternative-provision and https://www.gov.uk/government/publications/education-for-children-with-health-needs-who-cannot-attend-school

2.14.9 Where a young person has an EHC plan or statement of special educational needs, the education provider should contact the local authority responsible for drawing up the plan or statement to establish both the provision required whilst the young person is in the Tier 4 CAMHS and any additional funding available.

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

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

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

2.14.13 Expectations for Health Providers and Commissioners

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

II. The provider should expect the education provision to be operated in accordance with the appropriate regulatory framework, which normally includes inspection by OFSTED (see above).

2.15 Discharge/transitions

2.15.1 All transitions from secure settings must be carefully planned and must be considered from the point of admission.

2.15.2 The discharge/transfer of a young person from medium secure inpatient care must be dictated by the nature of their mental health difficulties, their risk profile, and their identified needs.

2.15.3 All young people must be supported in taking an active role in their discharge planning.

2.15.4 Recognised discharge routes include discharge/transfer to the following settings:

- Adult secure (high, medium or low) or non-secure inpatient services, including rehabilitation services
- Adolescent Tier 4 CAMHS non-secure inpatient services
- Community mental health services (community CAMHS or adult CMHT)
- Social care residential settings, including secure welfare placements
- Specialist educational settings
- Family home
- Supported living or other community placement
- Custodial placements (Young Offender Institution, Secure Training Centre, Secure Children's Homes, adult prisons).

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

2.15.6 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. This includes input from:

- Mental health services (CAMHS and/or adult mental health as appropriate)
- Social care services (children's social care and/or adult social care)
- Education and training providers.

2.16 Delayed Discharges

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

2.17 Family and carer involvement

2.17.1 Family/carer involvement must 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.

2.18 Post-18 care pathway

2.18.1 When a young person is a minimum of six months from their 18th birthday, the Responsible Clinician in the low secure service must liaise with local services and the Responsible Commissioner to ensure the relevant transition processes for mental health and social services are initiated

including access assessment for adult secure provision if required.

2.18.2 In some cases identification of young people likely to require specialist provision after age 18 can be made at an early stage; good practice requires that transition planning must start at that point.

2.18.3 In some cases young people are required to stay beyond their 18th birthday for completion of adolescent-specific treatments. The maximum extended inpatient period must not exceed the young person's 19th birthday and the view of the responsible commissioner and the Tier 4 commissioner Case Manager in the young person's Clinical Commissioning Group (CCG) must be sought six months prior to the young person's 18th birthday to confirm arrangements.

2.19 Interdependencies

2.19.1 Adolescent medium secure services are part of a spectrum of services that meet the needs of young people with mental disorders including neurodevelopmental disorders such as learning disability and autism in need of specialist care and treatment in an intensive setting. These services also support young people in their recovery and enable transitions into less restrictive environments.

2.19.2 Individual medium secure services must form part of a regionally and nationally coordinated network to ensure parity of practice and flexibility in terms of availability of in-patient beds.

2.19.3 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.

2.19.4 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 difficulties, including learning disability and autism.

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:

- 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 the statutory guidance in "Working together to safeguard children" (2015) is followed.

3. Population Covered and Population Needs

3.1 Population Covered By This Specification

3.1.1 This specification covers children and young people up to age 18 years and who are the direct commissioning responsibility of NHS England.

3.1.2 Specifically adolescent medium secure services are commissioned to provide services for young people who meet the following criteria:

- aged 13 to 18 with mental disorders which cannot safely be contained in Tier 4 low secure, general adolescent inpatient care, PICU, community or other residential or custodial settings
- requires longer-term interventions and specialist risk management procedures and specialist treatment interventions not available in non-secure or PICU settings. This includes young people with needs such as deafness, blindness or other physical disabilities and 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 (approximately100) or youth justice custodial settings (approximately 1000). Young people in all types of secure setting have clearly established significant mental health needs.

3.3 Evidence Base

3.3.1 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 – Aims of Service

4.1.1 The expected outcomes of the service support the national ambition set out in Future In Mind (2015) 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 CETR process
- Achieve delivery of efficient and seamless transfers of young people between acute and intensive care settings
- Use the Care Programme Approach to underpin service delivery
- Proactively manage violence and aggression
- Provision of a range of activity programmes for periods where education is not provided
- Deliver care within a therapeutic regime that places primary importance on behavioural approaches, de-escalation and psychopharmacological treatment of mental illness and agitated behaviour in the context of mental disorder.

4.2 NHS Outcomes Framework Domains

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

4.3 Outcome Indicators

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

No.	Indicator	Data source	Domain(s)	CQC Key Question
Clinical Outcomes				
101	% of assessments completed within two weeks of allocation by the National Secure Forensic Mental Health Service for Young People (NSFMHSfYP) weekly referral meeting.	Provider	2, 3, 4, 5	safe, effective responsive caring
102	% 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
103	% 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
104	Average HONOSCA (see 103 above) improvement score for patients discharged during the	Provider	1, 2, 3, 4, 5	safe, effective responsive caring

	quarter.				
105	% of patients who have a discharged plan agreed before admission or within 48 hours admission	Provider	2, 3, 4, 5	safe, effective responsive caring
106	% of patients who receive their initial care plan (including CPA) before or within 2 weeks of admission	Provider	1, 2, 3, 4, 5	safe, effective responsive caring
107	% of young people prescribed antipsychotics who receive appropriate physical monitoring as per NICE recommendations.	Provider	1, 3, 5	safe, effective, caring
108	Percentage of eligible staff who have received clinical supervision as per Trust/organisation policy.	Provider / SSQD	3, 4, 5	safe, effective, well-led
109	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
110	Mean length of stay for patients discharged during the quarter	Provider	1, 2, 3, 5	safe, effective, caring
111	Ratio of substantive staff to agency staff or bank staff during the previous quarter.	Provider	1, 2, 3, 5	safe, effective, caring
112	Care hours per patient day	Provider	1, 2, 3, 5	safe, effective, caring
Patient Outcomes				
201	All patients receive an experience of service questionnaire.	Self-declaration	2, 4	effective, caring, responsive
202	All carers receive an experience of service questionnaire.	Self-declaration	2, 4	effective, caring, responsive
203	Patient information is provided at the point of assessment.	Self-declaration	2, 4	effective caring
Structure & Process				
301	There is an MDT in place with membership as per the service specification.	Self-declaration	1, 2, 3, 5	safe, effective responsive caring
302	Each patient has a named psychologist and occupational therapist.	Self-declaration	1, 2, 3, 4, 5	safe, effective caring
303	There is access to the Independent Mental Health Advocates (IMHA).	Self-declaration	1, 2, 3, 5	safe, effective responsive caring
304	There are agreed clinical protocols/guidelines.	Self-declaration	1, 3, 5	Safe, effective, caring

4.3.2 Commissioned providers are required to participate in annual quality

assurance and collect and submit data to support the assessment of compliance with the service specification as set out in Schedule 4A-C.

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

5. Applicable Service Standards

5.1 Applicable Obligatory National Standards

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

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

- Mental Health Act 1983
- Mental Health Act Code of Practice 2015
- Human Rights Act 1998
- The Children Act 1989 and 2004
- Criminal Justice Act 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 legislation
- UN Convention on the rights of the Child

5.2 Other Applicable National Standards to be met by Commissioned Providers

5.2.1 Services must comply with the following requirements:

- Operate 24 hours a day, 365 days per year
- An initial planning and welcome meeting with the MDT, including the family should be held within 1 week of admission
- A full multiagency, MDT CPA review meeting should be held before admission to a medium secure unit, where this has not been possible it must be held within the 2 weeks following admission and establish an early estimation of a discharge date and discharge pathway
- Subsequent CPAs must be held at least every 3 months
- 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.

- Discharge arrangements:
    - A responsible CAMHS team, including an allocated Responsible Clinician, must be in place before the start of a discharge process
    - The medium secure 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.
- Each patient must have their own room and must 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 medium secure 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 secure 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 will undertake a needs based assessment, contribute to a multidisciplinary risk assessment, develop a formulation and use this to identify the appropriate psychological treatment programme on either an individual and/or group basis
- Each patient must 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
- Facilitate access to and/or deliver timely and appropriate speech and language assessment and treatment during the course of their admission
- Each patient must have access to a social worker from the medium secure service to liaise with the young person's local Social Care Children's Service to ensure the provision of a full range of appropriate social care services to the patient, their family and carers.
- Each patient must have access to the Independent Mental Health Advocates (IMHA) who will assist by undertaking the direct advocate's role.
- Each patient must:
    - receive three culturally appropriate meals per day 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 Medium secure services must operate within a comprehensive set of physical, procedural and relational security measures, practices and policies that must comply with standards and requirements set by QNIC, CQC 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.

5.4 Service Environment

5.4.1 The provider must meet the following standards:

- The premises and the facilities generally are young person and family friendly and meet appropriate statutory requirements, are fit for purpose as determined by the relevant statutory regulator (e.g. the Care Quality Commission), conform to any other legislation or relevant guidance
- A clean, safe and hygienic environment is maintained for patients, staff and visitors
- A care environment in which patients' privacy and dignity is respected and confidentiality is maintained
- There is appropriate, safe and secure outdoor space for recreation and therapeutic activities
- A care environment is provided where appropriate measures are taken to reduce the potential for infection and meets the requirements of the Healthcare Associated Infections (HCAI) code of practice
- The service ensures that the nutritional needs of all 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 which are 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 should be gender-segregated.
- Provide an area that can be used as a multi faith room
- Where possible the service should provide sleep over facilities for parents or carers nearby to the ward.

5.5 Additional considerations

5.5.1 Young people in the process of considering their gender identity and who are dressing and living according to their personal identify should be admitted to beds in male or female areas according to their preferred identity.

5.5.2 There must 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 consider whether any additional safeguarding is required for this 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 with GID 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 Services
CCG: Clinical Commissioning Group
CETR: Care Education and Treatment Review
CPA: Care Programme Approach
HONOSCA: Health of the Nation Outcomes Scores for Children and Adolescents
IMHA: Independent Mental Health Advocate
NICE: National Institute for Clinical excellence
MDT: Multi-Disciplinary Team
QNIC: Quality Network Inpatient CAMHS

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				
	Clinical Outcomes							
101	% of assessments completed within two weeks of allocation by the National Secure Forensic Mental Health Service for Young People (NSFMHSfYP) weekly referral meeting.	% of assessments completed within two weeks of allocation by the National Secure Forensic Mental Health Service for Young People (NSFMHSfYP) weekly referral meeting.		Annual Report	Provider		2, 3, 4, 5	safe, effective responsive caring
102	% 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	% 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		Annual Report	Provider		2, 3, 4, 5	safe, effective responsive caring

103	% 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 and GBO to determine their health and social functioning		Annual Report	Provider		2, 3, 4, 5	safe, effective responsive caring
104	Average HONOSCA (see 103 above) improvement score for patients discharged during the quarter.	Average HONOSCA improvement score for patients during the quarter. HONSCA should only be undertaken at a maximum of fortnightly, therefore if a discharge takes place within a fortnight there won't be a discharge HONOSCA.		Annual Report	Provider	100%	1, 2, 3, 4, 5	safe, effective responsive caring
105	% of patients who have a discharged plan agreed before admission or within 48 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
106	% of patients who receive their initial care plan (including CPA) before or within 2 weeks of admission	% of patients who receive their initial care plan (including CPA) before or within 2 weeks of admission		Annual report	Provider		1, 2, 3, 4, 5	safe, effective responsive caring
107	% of young people prescribed antipsychotics who receive appropriate physical monitoring as per NICE recommendations.	% of young people prescribed antipsychotics who receive appropriate physical monitoring		Annual report	Provider		1, 3, 5	safe, effective, caring

		as per NICE recommendations.						
108	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
109	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
110	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
111	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
112	Care hours per patient day	Care hours per patient per day		Annual report	Provider		1, 2, 3, 5	safe, effective, caring
	Patient Experience							
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		Operational Policy	Self-declaration		2, 4	effective caring

		relating to: treatment the team patient involvement groups and patient self-help groups out of hours contact details/emergency number						
	Structure and Process							
301	There is an MDT in place with membership as per the service specification.	The staffing of the unit should be compliant with Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC) essential standards. The staff team will include at least: • Consultant level as well as non-consultant grade medical staff • Clinical Psychology • Nursing staff • Occupational therapist • Teaching staff • Social work • Family Therapist Staff skilled in group work • Creative therapies		Operational Policy	Self-declaration		1, 2, 3, 5	safe, effective responsive caring

		• Dietetic advice where services provide care for young people with eating disorders • Access to psychotherapy as appropriate • Administrative support • Access to physiotherapy						
302	Each patient has a named psychologist and occupational therapist.	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 psychological treatment programme on either an individual and/or group basis.-- A named occupational therapist who will undertake a comprehensive occupational therapy assessment and will deliver an		Operational Policy	Self-declaration		1, 2, 3, 4, 5	safe, effective caring

		appropriate occupational therapy programme based on identified needs. A Care Coordinator/Case Manager allocated within the medium secure service to co-ordinate care within the Care Programme Approach (CPA) framework						
303	There is access to the Independent Mental Health Advocates (IMHA).	Each young person has access to the Independent Mental Health Advocates (IMHA) and, where applicable, Independent Mental Capacity Advocates (IMCA), who will assist by undertaking the direct advocate's role.		Operational Policy	Self-declaration		1, 2, 3, 5	safe, effective responsive caring
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		1, 3, 5	Safe, effective, caring