Service Specification No.	E05
Service	CAMHS – Eating Disorder
Commissioner Lead	Joanne Marsh, Senior Locality Commissioning Manager, CCG
Provider Lead	Josey Povey, Associate Director North Staffordshire Community Mental Health Services
Period	1st April 2022 – 31st March 2023
Date of Review	**See 22/23 SDIP**

1. Population Needs

1.1. National/local context and evidence base

There has been universal acknowledgment in policy over the past ten years of the challenges faced by children and young people in developing resilience and psychological wellbeing. For those children and young people with diagnosable mental health problems and their parents/carers and the agencies that support them, the challenges are greater. A number of disorders are persistent and will continue into adult life unless properly treated. It is known that 50% of lifetime mental illness (except dementia) begins by the age of 14 and 75% by age 18. Young people who are not in education, employment or training report particularly low levels of happiness and self-esteem. The Macquarie Youth Index 2014 reported that 40% of jobless young people have faced symptoms of mental illness as a result of being out of work, and one-third of long-term unemployed young people have contemplated suicide. At the same time, effective treatments have been identified to improve the life chances of children and young people, and to minimise the impact on the long-term health of the population and economic cost to the public purse.

In the Autumn Statement 2014 the Government released £30m additional recurrent funds to transform Child and Adolescent Mental Health Services (CAMHS), a proportion of these funds have been allocated to deliver evidence-based Community Eating Disorder Services for Children and Young People (CEDS-CYP).

The pan Staffordshire Local Transformation Plan sets out the overarching principles and ambitions (NHS England; Department of Health, 2015). The Access and Waiting Time Standard for Children and Young People (NHS England; National Collaborating Centre for Mental Health, 2015) provides guidance on establishing and maintaining a community eating disorder service for children and young people. The guidance recommends that the service should have a minimum of 50 referrals per year and cover a minimum population of 500,000 (all age).

The service will cover the population of North Staffordshire and Stoke on Trent CCG's.

The agreed service model will address the requirements of the Access and Waiting Time Standard which intends to:

- Improve the quality of eating disorder services
- Provide new enhanced community assessment and treatment service
- Ensure staff are adequately trained and supervised in evidence-based treatment and effective service delivery
- Ensure best use of inpatient beds

As children and young people's emotional wellbeing and mental health affect all aspects of their lives, no one service alone will be able to meet their needs. There is a duty of cooperation placed on commissioners and services to work together to the benefit of children and young people.

The multi-faceted nature of CYPMH will require a whole system multi-agency approach to commissioning based on the needs of the local population. Changes in one agency or one part of the system can affect demand and delivery in another. This interdependency can create risks if not properly considered but also brings with it the possibility of agencies working together to meet the needs of the populations they serve and to achieve wider system efficiencies. Services should work together in integrated ways around needs of the population to ensure good communication and transitions.

This specification should therefore be linked to other specifications within the local area. For example (this is not an exhaustive list):

- Public Health
- Health Education
- CYPMHS inpatient services
- Health and Justice
- Health Visiting
- School Nursing
- Community Child Health
- Acute Paediatrics
- Accident and Emergency Services
- Perinatal Mental Health Services

- Youth Services
- Support services in schools
- Social care including residential care
- Adult Mental Health services
- Workforce planning and education of staff.

It is important that children and young people, wherever they first seek support or present with difficulties, are supported by professionals to receive appropriate help and support as soon as possible. This specification details delivery of local integrated, whole system, multi-agency care to ensure access to effective, holistic evidence-based interventions.

Financial cost of child and adolescent mental health problems

The costs incurred to the public purse of not treating children and young people early in their lives are considerable. For example:

- Mental health problems in children and young people are associated with excess costs estimated at between £11,030 and £59,130 annually per child. These costs fall to a variety of agencies (e.g. education, social services and youth justice) and also include the direct costs to the family of the child's illness. [1]
- There are clinically proven and cost-effective interventions. Taking conduct disorder as an example, potential life-long savings from each case prevented through early intervention have been estimated at £150,000 for severe conduct problems and £75,000 for moderate conduct problems.[2]
- The costs of providing safe and effective interventions associated with supporting children and young people in the community with crisis support or outreach can be considerably less than those associated with inpatient care.

Prevalence Data:

Location	Number Children 13-18	An. Ner. (Swanson Prevalence) (13-18) .3%	Bulimia (Swanson Prevalence) (13-18) .9%	Binge Eating (Swanson Prevalence) (13-18) 1.6%	Number Young People 15-24	An. Ner. (Hoek Study Prevalence) (15-24) .3%	Bulimia (Hoek Study Prevalence) (15-

[1] Department of Health, HM Government, No health without mental health: A cross- Government mental health outcomes strategy or people of all ages. Supporting document - The economic case for improving efficiency and quality in mental health, Crown Copyright (2011)

[2] Friedli, L. & Parsonage, M. 'Mental Health Promotion: Building an Economic Case Northern Ireland Association for Mental Health, NIAMH (2007)

							24) 1.0%
Stoke on Trent	17288.0	51.9	155.6	276.6	34436.0	103.3	344.4
Staffs Moorlands	6796.0	20.4	61.2	108.7	10286.0	30.9	102.9
Newcastle-under-Lyme	8682.0	26.0	78.1	138.9	18572.0	55.7	185.7
Total North Staffs	32766.0	98.3	294.9	524.3	63294.0	189.9	632.9

Prevalence Data North Staffordshire and Stoke on Trent:

Location	**2014/15 Activity ****	**Projected 15/16 full year**	**Estimated Prevalence**	**Projected GAP**	**% met need**
Stoke	14 **	58	484	426	**12**
North Staffs	15 **	66	433	367	**15**
Total	29 **	124	917	793	**13**

**** The Central Referral Hub was only in operation for the last 2 quarters of 2014/15 and therefore collated referrals were not recorded.**

The data indicates that at the present time, between 3% and 9% of children and young people with an eating disorder may be in treatment and/or known to services, of these cases the largest proportion of CYP accessing services had a diagnosis of Anorexia Nervosa. The data does not take into account atypical eating disorders and/or other eating distress, which forms part of the CAMHS caseload. The estimated prevalence of Binge Eating Disorder is 1.6% in 13-18 year olds, the lowest numbers of CYP accessing CAMHS services were those with a diagnosis of binge eating disorder.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

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

2.2 Local defined outcomes

- 90% of CYP referred for assessment or treatment of an eating disorder will access NICE concordant treatment within 1 week for urgent cases and 4 weeks for routine cases (increasing to 95% compliance by 2020).
- Referrals will be screened by the end of the next Operational Day to assess urgency, telephone contact may be made with the CYP or parent / carer to clarify risk
- CYP deemed to be at high risk (and requiring urgent medical assessment) will be seen within 24 hours
- Urgent cases will receive a full clinical assessment (including risk assessment) within 5 Operational Days of referral
- Routine cases will receive a full clinical assessment (including risk assessment) within 4 weeks of referral.
- The service will support early facilitated discharge where clinically indicated to reduce the length of stay for young people admitted to Tier 4 in-patient services. The service will support an overall reduction in the number of Tier 4 in-patient bed nights of 10%.

3. Scope

3.1. Aims and objectives of service

The Children and Young People's Mental Health and Wellbeing Taskforce developed five key themes as part of Future in Mind:

- Promoting resilience, prevention and early intervention

- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

It calls on all those involved in supporting children and young people to work together to:

- Place the emphasis on building resilience, promoting good mental health, prevention and early intervention
- Simplify structures and improve access
- Deliver a clear joined up approach
- Harness the power of information
- Sustain a culture of continuous evidence-based service improvement; and
- Make the right investments

The provider shall:

- Work with children, young people, young adults and families/carers in co-designing and reviewing care pathways.
- Work with all relevant agencies to ensure that services for children and young people with mental health problems are coordinated and address their individual needs, providing a holistic approach.
- Ensure that children, young people and their families/carers are treated with compassion, respect and dignity, without stigma or judgment.
- Ensure that children and young people's physical health, social, educational and cultural needs are considered alongside their mental health needs.
- Ensure that children and young people who access the service receive treatment in a timely manner.
- Provide a range of evidence based (NICE approved) treatment interventions to ensure that children and young people's needs can be met.
- Ensure that children and young people's needs are considered in the whole and access to supplementary therapies and support are available
- Ensure that protocols are in place between the provider and the provider(s) of emergency or out-of-hours care, should support or consultation be required urgently
- Provide initial and follow-up assessments that are written and shared with the child, young person and/or parent/carer.

- Seek and use feedback in a range of settings, including the use of regular outcome monitoring in therapy, feedback regarding service delivery, and complaints.
- Ensure that children, young people and their families/carers are offered a choice of interventions that are evidence based and appropriate to their needs. Provide information at all stages of the pathway about interventions or treatment options to support children, young people and families/carers to make informed decisions about their care. This must be appropriate to their competence and capacity; information needs to be clear, easy to understand and jargon free.
- Ensure the impact of adverse childhood experiences, including trauma, abuse or neglect in the lives of children and young people is properly considered when identifying appropriate interventions
- Ensure that any additional vulnerability or inequality suffered by children and young people (e.g. learning disability, autistic spectrum conditions, victim of child sexual exploitation) is properly considered when identifying appropriate interventions
- Agree the aim and goal of interventions with the child/young person or family/carer, monitor the changes to agreed and shared goals as well as symptoms, and amend therapeutic interactions as a result of these changes, to deliver the best possible outcome
- Provide written information to the child/young person and family/carer about the care plan and how to access services (both routinely and in a crisis); this information needs to be clear, easy to understand and jargon free
- Provide information about how the services commissioned will increase opportunities for social value and social capital in line with the Social Value Act 2012
- Work collaboratively with other agencies in the health and social care and education systems to ensure regular case reviews to ensure effective progress through the care pathway.
- Ensure that best use is made of technology to support, facilitate and improve delivery of evidenced based treatment.
- Ensure that there is a formal route for referring children/young people to highly specialist mental health services (e.g. inpatient services, specialist outpatient services).
- Ensure that good relationships are maintained with relevant agencies in health, social care and education (including statutory, voluntary and third sector organisations) to aid referral into the service and ongoing support and treatment. This includes using whatever locally agreed systems there are to support joint agency working (e.g., Early Help Assessment (EHA) Team Around the Family), meeting statutory safeguarding guidance and providing clear protocols on information sharing, with children and young people being asked for consent regarding information sharing with other agencies (rather than a blanket decision not to share health information with such agencies).
- Ensure that clear communication pathways and information sharing mechanisms are in place so that children, young people and, where appropriate, their families/carers experience a smooth journey through the care pathway.
- Ensure Routine Outcome Measures, Patient Reported Outcome Measures are used to inform individual care plans and wider service improvements.

- Have clear reporting processes and standards, for example, as set out by the MHSDS, Youth Wellbeing Directory, QNCC and CORC .

3.2. Service description/care pathway

The service will provide:

- A multidisciplinary team supporting the individual and family to ensure best outcomes
- therapists with specific training and understanding of Eating Disorders to provide evidence based interventions, working closely with Dieticians and Paediatric Consultants to ensure both physical and mental health needs are addressed
- Access to service will be via the CAMHS Central Referral Hub
- The team will be located with Tier 3 Community CAMHS and will share resources and skill base to provide integrated service provision to this group of patients

3.3. Access and Waiting Time Standards

Access

The service will be compliant with the following access and waiting time standards:

- Provide CEDS for CYP aged 8 to 18 years
- Initially available Monday – Friday 9am-5pm. The Trust's operational policy is to reflect some flexibility where clinically relevant.
- Provide direct access to services through self-referral and/or referral from GPs and other professionals / workers. YP will be encouraged to self-refer
- Accept referrals from GPs, generic CAMHS, paediatric services, other healthcare settings, schools, colleges and non-healthcare workers (e.g., sports coaches, dance teachers)
- CYP under 16 will need a parent / responsible adult present at the initial contact. YP over 16 may be seen alone, although family involvement will be encouraged.

- Professionals / workers will encourage CYP and parents / carers to seek assessment with their GP, to rule out other physical health concerns. Where this is declined, they will be referred directly to the service. However, the CYP and parent / carers must be informed before contact with the service is made.

- Referrals will be via Central Referral Hub.

- The service will provide clear advice and guidance upon how to contact / access the service, including information online.

Waiting Times

The service will be delivered in line with the following waiting times;

- CYP referred for assessment or treatment of an eating disorder will access NICE concordat treatment within 1 week for urgent cases and 4 weeks for routine cases (90% compliance to be achieved, increasing to 95% compliance by 2020).

- Referrals will be screened by the end of the next Operational Day to assess urgency, telephone contact may be made with the CYP or parent / carer to clarify risk (e.g. physical, psychiatric, safeguarding and/or other risks)

- CYP deemed to be at high risk (and requiring urgent medical assessment) will be seen within 24 hours during Operational Days and by the Access Team outside of Monday – Friday, 9am – 5pm. dependent on the presentation location.

- Urgent cases will receive a full clinical assessment (including risk assessment) and commence treatment within 2 weeks of referral. Urgent treatments will be within one week after assessment.

- Routine cases will receive a full clinical assessment (including risk assessment) and commence treatment within 4 weeks of referral. If the child has not been seen by their GP they will be directed to their GP for consultation, to rule out other physical health concerns, with the next 2 Operational Days, if the GP does not see the CYP the referral will be treated as urgent.

3.4. Multi-agency Liaison / Education

The service will provide education, guidance and advice to primary care (GPs, school nurses), education (school and colleges), social care services (local support teams, safeguarding and secondary care services (acute paediatric services). Including:

- Consultation and advice on the appropriateness of referral
- Advice on accessing the services and/or initiating a referral
- 4 sessions per year providing training and education on early identification of eating disorders

The service will provide a Paediatric Liaison service, in accordance with Junior MARSIPAN guidelines (Royal College of Psychiatrists, 2012).

The expectation under the Paediatric Liaison Service is for a lead psychiatrist to be identified and to develop protocols with UHNM. Extracts from MARSIPAN guidance, relevant to this service, have been listed below:

- A lead consultant paediatrician and a lead consultant psychiatrist should be identified to coordinate care for Junior MARSIPAN patients and build working partnerships and develop protocols to support admission, including protocols for transition for young people 16–18 years of age.

- The decision to apply the Mental Health Act 1983 should be considered from the outset in a Junior MARSIPAN patient refusing treatment. If both the child and the parent refuse treatment, local safeguarding procedures should be followed and the Children Act 2004 (for patients up to age 18) used if necessary. An identified CAMHS consultant with a special interest in eating disorders should provide a second opinion in cases where there is a disagreement or uncertainty.

- When the location of SEDBs is identified, commissioners should put together a Junior MARSIPAN group (child and adolescent psychiatrist, paediatrician, paediatric dietician, paediatric and psychiatric/eating disorders nurses) to act as a focus for skill development/dissemination and advice when a child is admitted to a paediatric bed, which is located in a hospital able to admit such patients.

- The Junior MARSIPAN team should have explicit links with tier 4 CAMHS eating disorders services, who will work in conjunction with tier 3 CAMHS. One or two hospitals should be identified within each strategic health authority area (average population in England per area: 5 million) so that patients can be transferred if required.

- Clinicians and managers from paediatric and adult medical wards and CAMHS services likely to see young patients with anorexia nervosa should develop protocols in advance of situations of risk developing.

- Children and young people admitted to a paediatric ward should have the full and ongoing support of a consultant psychiatrist, who should form a partnership with the paediatrician. Input from trainees is welcome but must be backed by involvement of the consultant psychiatrist and regular contact between the two consultants. It is essential that psychiatrists providing support in this way be fully conversant with severe eating disorders and their management through specific training and experience or can be supported to achieve this. This should lead to the development of a shared care approach.

- To facilitate these arrangements, the following practices are recommended:
    - *production of guidelines on medical management of severely unwell young patients with an eating disorder aimed primarily at junior medical staff*
    - *a guide for nursing and medical staff on supporting patients and families*
    - *regular staff meetings to ensure a consistent approach and minimise the risk of splitting (such as playing off some staff against others by the patient).*

- For each individual admission a set of measures are recommended:
    - a regular multidisciplinary team meeting, usually weekly or more frequently if required, until discharge; senior paediatric, psychiatric and nursing staff – or those that can make decisions – should be present, together with someone with dietetic expertise and other individuals as required; input from trainees is welcomed as appropriate, but they must be adequately supported by senior colleagues
    - the role of this meeting should include reviewing progress with parents, the review of future care plans and conveying these to the young person as appropriate
    - a record of the meeting should be prepared and circulated to all, including the young person and the family; discharge planning should be included in the agenda of the multidisciplinary team meeting when appropriate
    - a nursing care plan which addresses the specifics of patient care for children and young people with an eating disorder should be formulated.

3.5. Clinical Pathways - Assessment

The locally agreed care pathway is detailed below. Initial assessment for an eating disorder will incorporate:

- the type and duration of the eating disorder
- an understanding of the mainlining factors of the disorder and any protective factors
- the physical, psychological and social consequences of the disorder
- the presence and severity of coexisting mental and physical health problems
- current medical risk and whether inpatient stabilisation is needed
- current psychiatric risk (to include significant self-harm) and whether inpatient stabilisation is needed
- whether the child or young person has already receive any NICE-concordance treatment for eating disorders
- the strengths, resilience and capacity of the family to manage treatment in the community
- the level of motivation for the child or young person and their family or carers to engage in treatment, including hidden feelings or despair and hopelessness
- the degree of confidence on the part of their child or young person that they will be able to make use of treatment

3.6. Treatment

Evidence based treatments will be concordat with NICE guidance (NICE, 2004) and include:

- CBT and enhanced CBT (CBT-E)
- Family Interventions and formalised family therapy

- Guided self-helps for bulimia nervosa

- Pharmacology interventions (as second-line interventions only, in accordance with NICE guidance)

At all stages patient choice will be embedded in assessment, care and treatment.

The service will maintain oversight of care from the point of referral, through treatment (in all settings), during post-treatment monitoring and is managing risk and relapse. The CEDS-CYP will be the lead service for co-ordinating treatment even if not directly involved in providing all aspects of treatment.

Where eating disorder is confirmed as the primary presenting problem the CEDS-CYP will manage common co-existing mental health problems such as depression and anxiety. Where the eating disorder co-exists with another mental health problems associated with risk, care will be shared between CAMHS and the CEDS-CYP.

The locally agreed care pathways will be developed by the provider. This care pathway should include consultation and liaison with other professionals.

3.7. Population covered

The service will cover the population registered with North Staffordshire or Stoke on Trent CCG GPs.

3.8. Any acceptance and exclusion criteria and thresholds

<u>Acceptance Criteria</u>

Providers will:

Accept referrals for children and young people aged 8-18 where there is a reasonable description that suggests that the child/young person may have an eating disorder from children or young people registered with GP in North Staffordshire / Stoke on Trent.

- Accept referrals from GPs, generic CAMHS workers, paediatric services other healthcare settings, schools, colleges and non-healthcare workers (e.g. sports coaches, dance teachers). CYP under the age of 16 will need a parent / responsible adult to be

present at the initial contact. Young people over the age of 16 may be seen alone, although family involvement will be encouraged,

- In cases where referrals are found to be inappropriate, with consent, refer or signpost the child/young person and their family/carers to other services.
- Provide locally available, age- and developmentally appropriate, co-produced information for children/young people, parents/carers and referrers about the services provided and how they are accessed.
- Support the Early Help Assessment/Common Assessment Framework and local protocols.
- Support and ensure inter-agency working.
- Support and ensure discharge or transition planning.
- If the service concludes that the needs of child/young people or parents are better met by other agencies. It will signpost CYP, families or professionals to that service, referrals will be sent directly where consent is received.
- Ensure that the referrer is clear as to whether the service has accepted the referral and, if not, in line with agreed information-sharing protocols, provide the rationale for this and written suggestions to what the services will do, for example referral onto other appropriate services.
- Provide advice to those thinking about referring can have a discussion prior to the referral.
- Gather the agreed range of information at the point of referral

<u>Exclusion Criteria</u>

Children and young people may *not* be eligible for the service on the basis of:

- Aged below 8 years of age or over 18 years of age
- The referred problem may be best treated in an alternative service e.g. generic CAMHS.
- Where a more clinically appropriate service has been commissioned from an alternative provider
- Children in court proceedings where intervention is not advised under Home Office guidelines
- Court assessments, unless specifically contracted
- Where the service is not commissioned to include the clinical presentation e.g. other mental health problems, eating difficulties

3.9. Initial Assessment

Initial assessment for an eating disorder will incorporate:

- the type and duration of the eating disorder
- an understanding of the mainlining factors of the disorder and any protective factors
- the physical, psychological and social consequences of the disorder
- the presence and severity of coexisting mental and physical health problems
- current medical risk and whether inpatient stabilisation is needed
- current psychiatric risk (to include significant self-harm) and whether inpatient stabilisation is needed
- whether the child or young person has already receive any NIC-concordance treatment for eating disorders
- the strengths, resilience and capacity of the family to manage treatment in the community
- the level of motivation for the child or young person and their family or carers to engage in treatment, including hidden feelings or despair and hopelessness
- the degree of confidence on the part of their child or young person that they will be able to make use of treatment

The outcome of the assessment should be recorded in the service user's note and be passed on to any other service involved in the care of the service user with the informed consent of the young person and/or parent/carer**.**

3.10. Continuing Care and Assessment

Providers will:

- Ensure that care plans (following the Care Programme Approach [CPA], where transitioning to adult services or discharged from Tier 4 inpatient services) are in place for all people receiving support for mental health problems. These plans should be coordinated across agencies, teams and or disciplines, be clearly written, identify the key coordinator and be developed in collaboration with children/young people and parents/carers where possible. A copy should be given to the service user, parent/carer (if appropriate) and other agencies such as the GP.

- Ensure that the care plan includes appropriate risk management and crisis planning.

- Review the care plan with the service user and parent/carer (if appropriate), including the goals of treatment, and revise the care plan at agreed intervals. The dates for review should be set out in writing and depend on the nature of the problem – many problems should be reviewed every three months but others may require a less frequent review. Where a significant change has taken place, or when there is a change in the care management plan, review should be carried out as soon as is practical.

- Select treatment options in consideration of:
    - Age-appropriate best practice/evidence-based psychological intervention
    - Pharmacological and psychosocial interventions
    - Environmental and occupational/educational interventions or provision
    - The availability of a multimedia prevention package whilst on waiting list
    - Engagement, flexibility and choice.

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

3.11. Does Not Attend (DNA) / Re-engagement Policy

When a service user does not attend, a risk assessment should be made and acted upon. A service should not close a case without informing the referrer that the service user has not attended. The service should make explicit re-engagement policies available to referrers, children/young people and parents/carers.

3.12. Care Transition Protocols

The service will have protocols in place to ensure that transitions between services are robust and that, wherever possible, services work together with the service user and parents/carers to plan in advance for transition (this is especially critical in the transfer from between CAMHS and CEDS-CYP and to the adult ED team and primary care or other services, e.g. voluntary/third sector). As a minimum, children/young people leaving CAMHS should have:

- A written and agreed care plan detailing what service they will receive post-transition
- At least one face-to-face meeting with their key worker and the key worker from the service to which they will move for further care
- Follow up after the transition, to ensure appropriate interventions are in place. As per the requirements of CQUIN Indicator 5, 'Transitions out of Children and Young People's Mental

Health Services', Post-Transition Experience component of CQUIN, to be assessed via a User Survey / Questionnaire. Data to be submitted to Commissioners on a quarterly basis, as per the CQUIN requirements.

- A written and agreed plan, if no further interventions or treatment are planned, so that the young person and, where appropriate, parents/carer knows what to do if they become unwell
- A specific protocol for those going to primary care.

Service Transition Protocols should ensure that:

- Children and young people will have continuity of care
- Any risks or safeguarding concerns are clearly considered and documented
- Arrangements for transition planning take place.

Groups needing particularly robust transition processes include:

- Looked after children
- Care leavers moving to independent living
- Young people entering or leaving inpatient care
- Young people entering or leaving prison
- Young offenders
- Children and young people with learning disabilities
- Unaccompanied asylum-seeking minors
- Children and young people with caring responsibilities
- Those not in education, employment or training (NEET).

3.13. Activity

The service will assess and treat a minimum of 50 referrals per year (including existing cases transferring to the new service). Capacity and demand will be kept under review in line with usual contract review arrangements.

3.14. Information Governance and Accountability

The provider will comply with all relevant legislation and guidance to record information, in particular to comply with Data Protection acts, and comply with requirements to keep records for an appropriate period

3.15. Interdependence with other services/providers

Providers should ensure they have excellent links with services regularly used by young people:

- General Practice
- Schools and academies FE colleges and other education providers
- Children centres and early years settings (nurseries)
- Early Help provider
- Health visitors
- Other mental health services (adult, specialist, forensic)
- Voluntary sector providers
- Independent providers
- Inpatient or other highly specialist services
- Youth services
- Safe guarding – children and adults (Local Safeguarding Children's Board)
- Local authorities
- Acute sector hospitals
- Emergency departments
- Community child health
- Criminal justice system – including young offenders services
- Addiction services
- Job centres and careers advice
- Local independent providers

4. Applicable Service Standards

a. Applicable national standards (e.g. NICE)

The Provider shall adhere to NICE Clinical Guidance (CG9), Eating disorders in over 8s: management (2004): https://www.nice.org.uk/guidance/cg9/

This specification links to the following NICE Quality Standards and will be reviewed upon the publication of further guidance.

Please note that the list below is not exhaustive.

NICE quality standards relating to mental health and emotional wellbeing of children and young people:

NICE Quality Standard / Guidelines number	Title and link	Published	Review	Age range
QS31	Health and wellbeing of looked-after children and young people	April 2013	Apr 2018	0–18
QS34	Self-harm	June 2013	June 2018	Children and young people from 8 and adult
QS39	Attention deficit hyperactivity disorder	July 2013	July 2018	Children and young people from 3 and adult
CG28	Depression in children and young people	Sept 2005	Dec 2015	<18
QS48	Depression in children and young people	Sept 2013	Sept 2018	5–18
QS51	Autism	Jan 2014	Jan 2019	Lifespan

CG 128	Autism diagnosis in children and young people	Sept 2011	Nov 2014	<18
QS53	Anxiety disorders	Feb 2014	Feb 2019	Lifespan
PH 4	Interventions to reduce substance misuse among vulnerable young people	March 2007		< 25
QS59	Antisocial behaviour and conduct disorders in children and young people: pathway	April 2014	April 2019	< 18
CG 158	Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management	March 2013		<18
CG78	Borderline personality disorder	January 2009	January 2015	Adults and young people (<18)
CG 155	Psychosis and schizophrenia in children and young people	January 2013		< 18

b. Standards for Children and Young People's and Parents' Participation

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

- Department of Health (2011) Quality Criteria for young people friendly health services ('You're Welcome') sets out principles to help commissioners and service providers to improve the suitability of NHS and non-NHS health services for young people.
- National Youth Agency (2006) Hear by Right. Standards for young people's participation (not specifically mental health) (purchase price).
- Health and Social Care Advisory Service (2008), Turning what young people say into what services do. Quality Standards for children and young people's participation in CAMHS http://www.chimat.org.uk/resource/item.aspx?RID=67265 is based on the Hear by Right standards above and adapted specifically for CAMHS.

- "Delivering With and Delivering Well"[3] was developed by young people, commissioners and providers to integrate the principles of the CYP IAPT programme into existing quality assurance and accreditation frameworks.

c. Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Quality Network for Community CAMHS Standards
- Quality Network for Inpatient CAMHS Standards
- Youth Wellbeing Directory and ACE-V Quality Standards http://www.youngminds.org.uk/training_services/training_and_consultancy/for_commissioners/ace-value
- Child Outcome Research Consortium (CORC)
- Choice and Partnership Approach (CAPA)

Associated policy documents:

- No Health without Mental Health. Department of Health (2011)
- Talking Therapies, a 4-year plan. Department of Health (2011)
- Closing the Gap. Department of Health (2014) https://www.gov.uk/government/publications/mental-health-priorities-for-change
- NHS and Social Care Act (2011)
- Children and Families Bill (2013)
- Mandate to Health Education England
- Chief Medical Officer's Annual Report on State of Public Health (2014)
- Behaviour and Discipline in Schools, Department of Education (2014)
- Public Services (Social Value) Act 2012
- Achieving Better Access to Mental health Services by 2020
- Five Year Forward View

d. Applicable local standards

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

The service will support early facilitated discharge where clinically indicated to reduce the length of stay for young people admitted to Tier 4 in-patient services. The service will support them to be repatriated home, integrate into their local community and to engage with local support networks. A reduction in average length of stay from 82 to 77 days to be supported.

The service will support an overall reduction in the number of Tier 4 in-patient bed nights of 10%.

2. Applicable quality requirements and CQUIN goals

a. Applicable Quality Requirements (See Schedule 4)

The service will be a member of the QNCC-ED.

http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/childandadolescent/communitycamhsqncc/qncc-ed/joiningqncc-ed1.aspx

b. Data recording must include

All services providing NHS-funded CAMHS must be locally collecting and using CAMHS Minimum Dataset which has been approved by the Information Standards Board for Health and Social Care (ISB) as an information standard for the NHS in England.

Data recording should include:

- Agreed assessment measures
- Whether the individual is currently being seen by any other local services, including in schools or academies.

c. Applicable CQUIN goals (See Schedule 3)

6. Location of Provider Premises

The Provider will offer a range of locations that meet the needs of children/young people and their parents/carers and provide a choice of venue, for example, children's centres, clinics, drop-in sessions in other services and CAMHS providers.