



COLLEGE CENTRE FOR QUALITY IMPROVEMENT



**QINMAC**  
**Quality Improvement Network**  
**for Multi-Agency CAMHS**

**Learning Disability Network**

**Annual Report**  
**2008**

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# Contents

<b>Introduction</b>	<b>1</b>
<b>Aggregated Results of Reviews</b>	<b>5</b>
<b>Activity, Resource and Outcomes Indicators</b>	<b>55</b>
<b>Appendix A Team Initiatives and Achievements</b>	<b>57</b>
<b>Appendix B Member Feedback</b>	<b>65</b>
<b>Appendix C List of Member Teams in 2008</b>	<b>67</b>
<b>Appendix D QINMAC Project Team</b>	<b>69</b>
<b>Appendix E QINMAC Learning Disability Advisory Group</b>	<b>71</b>



# Introduction

In 2005, the Royal College of Psychiatrists' Research and Training Unit (CRTU) gained funding from the Department of Health to:

- Develop a set of standards for mental health services for young people with learning disabilities
- Establish a quality network that will support the improvement of these services

This work has been undertaken by the Quality Improvement Network for Multi-Agency CAMHS (QINMAC). QINMAC's Learning Disability Network (QINMAC-LD) supports frontline staff in delivering comprehensive mental health services for children and young people with learning disabilities. QINMAC-LD is a collaboration between the Royal College of Psychiatrists and:

- The Foundation for People with Learning Disabilities (FPLD)
- The Child and Adolescent Learning Disability Psychiatry Network
- The Care Services Improvement Partnership (CSIP)
- The Northumberland, Tyne and Wear NHS Trust
- Do Once and Share (DOAS) – a project set up to develop a national consensus on a care pathway for children with learning disabilities and mental health needs

## What QINMAC does

Mental health services for young people who have learning disabilities ('LD CAMHS') may be provided by generic CAMHS, Learning Disability services, CAMHS Learning Disability teams and by liaison between key professionals. QINMAC-LD is designed to apply to a range of service models that deliver the functions of Tiers 2 and 3.

### The 4 Tiers of Service

**Tier 1** - Primary or direct contact services

**Tier 2** - A level of service provided by uni-professional groups which relate to each other through a network rather than a team

**Tier 3** - A specialised multi-disciplinary service for more severe, complex or persistent disorders

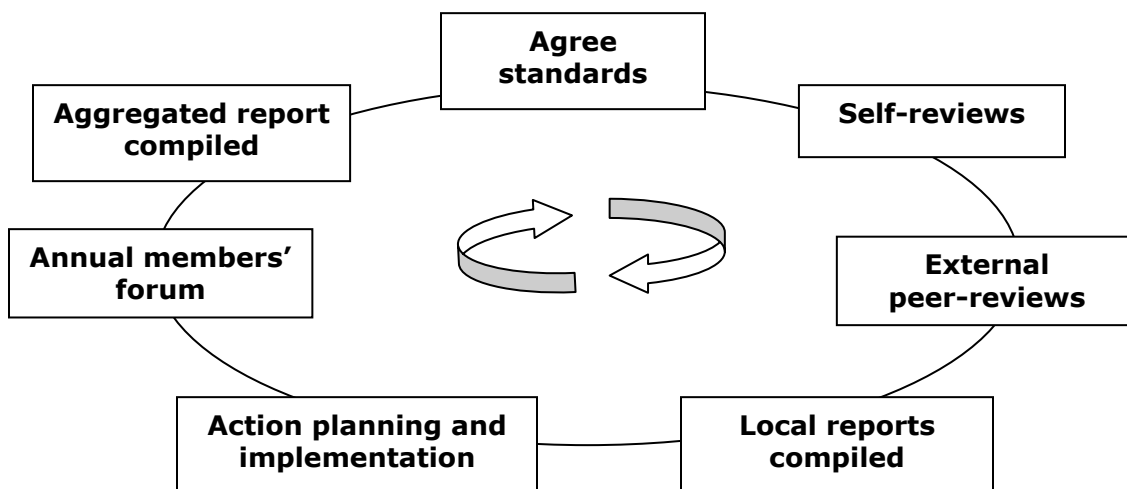
**Tier 4** - Essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units

LD CAMHS are physically dispersed, complex and varied in structure. In 2007, the Department of Health reported that all PCTs had met the CAMHS proxy target to provide a service for young people with learning disabilities. However, most healthcare professionals agree that provision is patchy. Consequently, quality improvement and innovation may often occur in isolation. A central aim of

QINMAC-LD is to provide a communication channel between services. This supportive peer-review network facilitates professionally-led service improvements across LD CAMHS by:

- ▶ Developing and applying standards for LD CAMHS via a system of self- and external peer-review;
- ▶ Supporting local implementation of national policy, as identified in the QINMAC-LD standards;
- ▶ Highlighting areas of achievement and areas for improvement;
- ▶ Developing a national “benchmarking” service to allow services to compare their activity with other services; and
- ▶ Facilitating information-sharing between staff in the network, e.g. regarding best practice.

**Figure 1: The annual cycle of reviews**



Each year, the standards are applied through a process of self-review and external peer-review where members visit each other's services. The self-review questionnaire is a checklist of QINMAC standards against which teams rate themselves, supplemented with more exploratory items to encourage discussion around achievements and ideas for improvement. The self-review process helps staff to prepare for the external peer-review and become familiar with the standards.

During the peer-review, data are collected through interviews with staff and representatives from local agencies (other health services, social services, education and the voluntary sector). The results are fed back in local and national reports. Services then take action to address any development needs that have been identified.

The results are fed back in local and national reports. Services then take action to address any development needs that have been identified. The process is ongoing rather than a single iteration.

### **This report**

Thirteen LD CAMH teams took part in QINMAC-LD's second annual cycle during 2008 (a list of the participating teams can be found in Appendix C). Of these, 1 team undertook an accreditation visit. This report summarises the aggregated results for the 12 teams who undertook the standard QINMAC review process in 2008. The main body of the report is a full summary of the extent to which the 12 teams met the QINMAC-LD standards and criteria. It is structured around the 10 sections of the QINMAC-LD standards. Indicators of teams' activity, resources and outcomes can be found on page 55. Appendix A highlights initiatives undertaken by member teams, organised under the relevant sections of the QINMAC standards. Appendix B is a summary of the feedback received from QINMAC members about the QINMAC review process.

### **How QINMAC members can use this report:**



#### ***How well are we doing overall in comparison with other members?***

Your team's local report provides you with a summary of the number of criteria met, partly met and not met, which then yields an average score for each individual standard. These averages enabled us to obtain a measure of your team's overall performance for each section of the service standards. Average scores for Cycle 2 are detailed in the main body of this report so you can immediately see how well you are doing compared with the other teams in the network. You can also compare your team's activity, resources and outcomes with those of the network as a whole (see page 55). We recommend that you use this report in conjunction with your local report(s) to inform discussions with your commissioners and to demonstrate your team's performance.

#### ***How can we identify other services that could provide advice or support on specific areas of service development?***

A summary of service development initiatives that member services have undertaken is presented in Appendix A to aid information sharing amongst network members.



### **ACKNOWLEDGMENTS:**

The project team gratefully acknowledges:

- The staff in member teams who attended and hosted peer-reviews
- The parents and professionals from partner agencies (including social services, education, health and the voluntary sector) who participated in the multi-agency discussions during peer reviews
- The QINMAC-LD Advisory Group (Appendix D) for their invaluable advice and support



# AGGREGATED RESULTS OF REVIEWS

This table shows the number of member teams that met, partly met and did not meet each criterion. The number of teams responding not applicable (N/A) and 'don't know' (D/K) is also shown.

**Note:** Not every criterion is measured during the reviews. Results presented here relate only to the criteria measured.

<b>Referral and Access</b>					
<b>Standard</b>		<b>Met</b>	<b>Partly Met</b>	<b>Unmet</b>	<b>N/A D/K</b>
<b>1.1</b>	<b>LD CAMHS advise primary services and other relevant services on how to refer young people with learning disabilities and mental health needs</b>				
	<b>Mean Score 2008 = 74%</b> (Min = 38%; Max = 100%) Mean Score 2007 = 70% (Min = 50%; Max = 88%)				
<b>1.1.1</b>	LD CAMHS disseminate clear referral criteria to referrers to help them identify and appropriately refer young people <i>Guidance: Referrers may include GPs, social services, educational psychologists, paediatricians, learning disability teams, CAMHS, relevant voluntary support groups and other referrers</i>	6	4	2	0
<b>1.1.2</b>	Web-based information about the LD CAMHS and its referral criteria is available e.g. on local government websites	1	6	5	0
<b>1.1.3</b>	The staff of LD CAMHS respond promptly to referrers and other relevant agencies, including when a referral has been made inappropriately	11	1	0	0
<b>1.1.4</b>	When inappropriate referrals are made to the LD CAMHS, staff inform the referrer of alternative options if necessary	12	0	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>1.2</b>	<b>There are clear referral pathways for young people with mental health needs and learning disabilities</b>				
	<b>Mean Score 2008 = 69%</b> (Min = 25%; Max = 100%) Mean Score 2007 = 58% (Min = 38%; Max = 75%)				
<b>1.2.1</b>	There are documented, up-to-date referral pathways for young people with learning disabilities which are agreed with other agencies and services	6	4	2	0
<b>1.2.2</b>	There are agreements between relevant services about how to deal with young people who do not fit current criteria or are at risk of being 'bounced' between services <i>Guidance: For example, agreements may involve LD CAMHS, Local Authority Children's Services departments, special schools, and challenging behaviour teams</i>	3	4	5	0
<b>1.2.4</b>	LD CAMHS have documented, up-to-date referral procedures for urgent and emergency referrals, which are agreed with other agencies and services	6	3	2	0
<b>1.2.5</b>	LD CAMHS inform referrers and other relevant professionals when young people and their parents do not attend an initial appointment <i>Guidance: Relevant professionals are likely to include, for example, the young person's GP, and community paediatrician</i>	12	0	0	0
<b>1.3</b>	<b>Young people and their parents are involved and informed during the referral process and know what to expect</b>				
	<b>Mean Score 2008 = 88%</b> (Min = 67%; Max = 100%) Mean Score 2007 = 90% (Min = 83%; Max = 100%)				
<b>1.3.1</b>	LD CAMHS provide referrers with service information (e.g. leaflets) for young people and their families	7	2	3	0
<b>1.3.3</b>	Appointment letters for assessments explain who young people and their parents will be seen by, where they will be seen and what the purpose of the assessment is	10	1	0	1
<b>1.3.4</b>	The staff of the LD CAMHS make themselves available to answer any telephone queries that young people and their parents may have prior to the initial assessment	12	0	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>1.4</b>	<b>All young people with learning disabilities have easy access to appropriate child and adolescent mental health services</b>				
	<b>Mean Score 2008 = 93%</b> (Min = 67%; Max = 100%) Mean Score 2007 = 87% (Min = 67%; Max = 100%)				
<b>1.4.1</b>	Young people with learning disabilities have access to mental health services in their local area <i>Guidance: The journey time for young people attending appointments is usually less than 45 minutes</i>	12	0	0	0
<b>1.4.2</b>	Young people with learning disabilities and mental health needs are offered services in accessible community settings <i>Guidance: For example, services provide sessions at several sites to ensure easy access; services are offered in accessible community settings; home or school visits are offered where this forms a key part of an assessment</i>	12	0	0	0
<b>1.4.3</b>	Failures to attend initial appointments following referral are monitored and reviewed in order to identify where access difficulties may exist	7	3	1	1

<b>Environment and Facilities</b>					
<b>Standard</b>		<b>Met</b>	<b>Partly Met</b>	<b>Unmet</b>	<b>N/A D/K</b>
<b>2.1</b>	<b>Centres used for LD CAMHS work meet the needs of young people with learning disabilities</b>				
	<b>Mean Score 2008 = 76%</b> (Min = 50%; Max = 100%) Mean Score 2007 = 60% (Min = 45%; Max = 70%)				
<b>2.1.1</b>	Assessments and interventions are carried out in settings agreed with the young person and their parents prior to any consultation <i>Guidance: Settings should be agreed with the family and young person and other staff working in the building where appropriate. This is especially important for children and adolescents with moderate and severe learning disabilities</i>	8	2	1	1
<b>2.1.3</b>	Centres used for LD CAMHS work provide low-stimulation environments for young people who require them, including designated quiet areas <i>Guidance: For example, waiting areas are kept tidy or materials can be easily put away; there is access to low stimulation areas for 'quiet time' if necessary</i>	4	5	2	1
<b>2.1.4</b>	The environment meets the needs of people who have physical disabilities, and complies with current legislation on access to buildings for people who have a disability	8	2	0	2
<b>2.1.5</b>	Centres used for LD CAMHS work are comfortable and maintained at high levels of cleanliness	8	3	0	1
<b>2.2.6</b>	Centres used for LD CAMHS work have warm, welcoming atmospheres	7	4	0	1
<b>2.1.7</b>	Centres used for LD CAMHS work are developmentally-appropriate and young person-friendly	7	4	0	1
<b>2.1.8</b>	Centres used for LD CAMHS work are parent-friendly <i>Guidance: For example, refreshments are available, the service provides baby-changing facilities</i>	6	4	0	2
<b>2.1.9</b>	Centres used for LD CAMHS work have spacious waiting areas	4	6	0	2

<b>Standard</b>		<b>Met</b>	<b>Partly Met</b>	<b>Unmet</b>	<b>N/A D/K</b>
<b>2.1.10</b>	Centres used for LD CAMHS work have waiting areas that contain developmentally-appropriate play and reading material	3	7	0	2
<b>2.1.12</b>	Centres used for LD CAMHS work have sufficient car parking space for visitors, including allocated spaces for disabled access	4	7	0	1
<b>2.2</b>	<b>Centres used for LD CAMHS work are designed and managed so that the rights, privacy and dignity of young people and their families are respected</b>				
	<b>Mean Score 2008 = 84%</b> (Min = 50%; Max = 100%) Mean Score 2007 = 90% (Min = 50%; Max = 100%)				
<b>2.2.1</b>	Young people and their families have consultations in private rooms where they cannot be overheard	7	4	0	1
<b>2.2.2</b>	Young people and their families and practitioners have adequate access to large and small rooms suitable for individual and family consultations	8	2	0	2
<b>2.3</b>	<b>Centres used for LD CAMHS work provide safe environments</b>				
	<b>Mean Score 2008 = 77%</b> (Min = 50%; Max = 100%) Mean Score 2007 = 58% (Min = 50%; Max = 67%)				
<b>2.3.1</b>	Entrances and exits are visibly monitored and/or restricted	5	4	1	2
<b>2.3.2</b>	When consultation takes place in a new setting, staff carry out a risk assessment regarding the safety of the environment and its suitability for meeting the needs of the consultation	6	4	1	1
<b>2.3.3</b>	LD CAMH centres are separate from adult services <i>Guidance: For example, there are separate entrances for adults' and children's services</i>	8	1	1	2

Assessment					
Standard		Met	Partly Met	Unmet	N/A D/K
<b>3.1</b>	<b>Young people with learning disabilities receive timely mental health assessments</b>				
	<b>Mean Score 2008 = 80% (Min = 33%; Max = 100%)</b> Mean Score 2007 = 67% (Min = 33%; Max = 100%)				
<b>3.1.1</b>	Young people receive routine mental health assessments within nationally agreed timescales <i>Guidance: England: 13 weeks; Wales: 4 weeks</i>	8	4	0	0
<b>3.1.2</b>	Young people with urgent or emergency mental health needs receive specialist mental health assessments promptly and within nationally agreed timescales <i>Guidance: In emergency cases, specialist mental health assessments are provided within 24 hours or the next working day</i>	9	1	0	2
<b>3.1.3</b>	Protocols regarding criteria for urgent and emergency assessment are negotiated locally with referrers	5	3	3	1
<b>3.2</b>	<b>Young people and their parents are fully involved and informed before the assessment</b>				
	<b>Mean Score 2008 = 78% (Min = 50%; Max = 100%)</b> Mean Score 2007 = 77% (Min = 67%; Max = 100%)				
<b>3.2.1</b>	Staff provide young people and their parents with a welcome pack or introductory booklet about the service prior to or during their first attendance	4	5	3	0
<b>3.2.2</b>	Staff check that young people and their parents understand the purpose of the assessment as fully as possible before it is conducted <i>Guidance: For example, an assessment checklist is followed to ensure this</i>	9	3	0	0
<b>3.2.3</b>	Young people and their parents are involved in a discussion about how long the assessment will last and who will be present	10	2	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>3.3</b>	<b>Assessments are effectively co-ordinated with other agencies so that young people and their parents are not repeatedly asked to give the same information</b>				
	<b>Mean Score 2008 = 69%</b> (Min = 20% ; Max = 100%) Mean Score 2007 = 63% (Min = 30%; Max = 90%)				
<b>3.3.1</b>	The service works within a joined-up approach to assessment so that multiple assessments of young people are minimised <i>Guidance: The assessment process should be co-ordinated across agencies where necessary. This may involve the service contributing towards the development and implementation of the Common Assessment Framework (England only) and/or its principles</i>	3	8	1	0
<b>3.3.2</b>	There is a system in place which enables professionals involved in the care of young people to identify whether they are receiving, or have received, care in any constituent part of the Trust	5	1	3	3
<b>3.3.3</b>	LD CAMHS staff have appropriate levels of access to unified clinical records for young people <i>Guidance: There may be access to one record, or a resume of key factors is available to avoid repetition of information</i>	4	5	3	0
<b>3.3.4</b>	The number of forms that young people are required to complete on assessment are kept to a minimum	9	3	0	0
<b>3.3.5</b>	Prior to any assessment, assessing practitioners familiarise themselves with all referral information that has been made available to them, including past assessments and existing knowledge <i>Guidance: This is likely to include education information such as SEN Assessments; past Annual Educational Reviews; Looked After Children Reviews; other assessments such as completed CAFs, paediatric assessments, speech and language therapy and Child in Need</i>	9	1	1	1

Standard		Met	Partly Met	Unmet	N/A D/K
<b>3.4</b>	<b>Staff have the necessary competencies and resources to conduct assessments and arrange the next steps</b>				
	<b>Mean Score 2008 = 85%</b> (Min = 38% ; Max = 100%) Mean Score 2007 = 80% (Min = 50%; Max = 100%)				
<b>3.4.1</b>	Young people are assessed by staff who have appropriate competencies in learning disability and mental health to conduct the assessment and co-ordinate next steps, or by staff who have appropriate supervision from professionals with these competencies	10	2	0	0
<b>3.4.2</b>	Where assessments are made by a single practitioner, the clinician conducting the assessment is able to gain multi-disciplinary input on the case as needed	10	1	1	0
<b>3.4.3</b>	Staff who are involved in clinical assessments have an agreed pathway to facilitate prompt access to medical investigation <i>Guidance: This should include access to genetic investigations, brain imaging, and electroencephalography, in addition to all routine modern laboratory and investigative facilities</i>	6	3	2	1
<b>3.4.4</b>	Staff follow established protocols and good practice (e.g. NICE guidelines) when assessing young people with learning disabilities and mental health problems	10	2	0	0
<b>3.5</b>	<b>Young people's assessments are individual and comprehensive, according to each young person's needs and those of their family</b>				
	<b>Mean Score 2008 = 92%</b> (Min = 71%; Max = 100%) Mean Score 2007 = 92% (Min = 79%; Max = 100%)				
<b>3.5.1</b>	Case notes show evidence that young people's assessments take into account the young person's specific communication needs	9	2	1	0
<b>3.5.2</b>	Staff take advice from people who know the young person well about how best to modify assessments to meet the young person's needs <i>Guidance: For example, family, school staff, short break carers or other professionals who have worked with the child are asked for their advice</i>	10	1	1	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>3.5.3</b>	Case notes show evidence that young people's assessments include identifying the other agencies involved in their care	11	1	0	0
<b>3.5.4</b>	Case notes show evidence that young people's assessments include consideration of their general level of functioning	11	1	0	0
<b>3.5.5</b>	Case notes show evidence that young people's assessments include consideration of their individual mental health needs, and of their social, physical, emotional, educational, cultural and spiritual needs	9	3	0	0
<b>3.5.6</b>	Case notes show evidence that young people's assessments include consideration of their family and community needs and context <i>Guidance: For example, assessments consider the needs and the impact of disability and mental health problems on parents and siblings</i>	12	0	0	0
<b>3.5.8</b>	Case notes show evidence that young people's assessments include identification and evaluation of relevant risks <i>Guidance: This should include evaluation of both clinical risk and any concerns about child protection</i>	10	2	0	0
<b>3.6</b>	<b>Young people and their parents experience assessment as collaborative and are fully involved in agreeing the next steps</b>				
	<b>Mean Score 2008 = 94%</b> (Min = 63%; Max = 100%) Mean Score 2007 = 94% (Min = 80%; Max = 100%)				
<b>3.6.1</b>	During assessment young people's views, wishes, and feelings are actively sought and recorded by the assessing practitioner	10	2	0	0
<b>3.6.2</b>	Parents are encouraged to participate in the assessment and their views, wishes and feelings are actively sought and recorded by the assessing practitioner	12	0	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>3.6.3</b>	Young people and their parents and/or referrers are provided with feedback on the outcome of their assessment, including explanation of the nature of the young person's problems	11	1	0	0
<b>3.6.5</b>	Where young people or their parents disagree with the professional opinion given on the nature of their problems or their formulation, staff inform them that they are entitled to challenge the opinion and explain the options that are available to them <i>Guidance: For example, young people and their families may discuss the outcome of the LD CAMHS assessment with their referrer before considering whether to proceed and how</i>	9	1	0	2
<b>3.6.6</b>	Staff provide guidance to young people and their parents on what they can do to start helping themselves whilst awaiting the next step <i>Guidance: For example, at a suitable point in the assessment or soon afterwards, staff tell families and individuals what other community resources are available to them, and provide them with leaflets or literature to read</i>	9	3	0	0

## Information, Consent and Confidentiality

Standard		Met	Partly Met	Unmet	N/A D/K
<b>4.1</b>	<b>Young people and their parents are provided with information that is accessible and appropriate for their use</b>				
	<b>Mean Score 2008 = 61%</b> <b>(Min = 33%; Max = 100%)</b> Mean Score 2007 = 43%                      (Min = 33%; Max = 75%)				
<b>4.1.1</b>	Staff provide verbal information to young people and their parents and supplement this with written information	8	4	0	0
<b>4.1.2</b>	All information is provided in an accessible format which is suitable for young people with learning disabilities <i>Guidance: This may involve using audio and video cassettes, accessible documentation (e.g. using symbols, plain English and pictures) communication passports, or signers or interpreters</i>	4	8	0	0
<b>4.1.3</b>	Staff use communication methods that are consistent with young people's usual means of communication	8	3	1	0
<b>4.1.7</b>	Young people and their parents are provided with information that is culturally relevant and sensitive <i>Guidance: For example, images used in posters and leaflets fully reflect the cultural diversity of the community</i>	6	4	2	0
<b>4.1.8</b>	Young people and their parents are consulted and involved in the production of information <i>Guidance: Service information may usefully include quotes or narratives reflecting the real experiences of young people and parents who have used the service</i>	3	3	6	0
<b>4.1.9</b>	LD CAMHS facilitate initiatives in which young people with learning disabilities and/or mental health problems act as information sources for others with similar conditions	1	4	6	1

Standard		Met	Partly Met	Unmet	N/A D/K
<b>4.2</b>	<b>Staff follow clear procedures for gaining consent and ensure that young people and their parents are well-informed of their rights regarding consent</b> <i>Guidance:</i> Staff can refer to the Department of Health publication 'Seeking Consent' for professionals (Ref 70): <a href="http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Consent/ConsentGeneralInformation/fs/en">http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Consent/ConsentGeneralInformation/fs/en</a>				
	<b>Mean Score 2008 = 79%</b> (Min = 31%; Max = 100%) Mean Score 2007 = 65% (Min = 31%; Max = 94%)				
<b>4.2.1</b>	The service has a documented policy relating to consent which includes a list of activities for which specific written consent is required <i>Guidance:</i> The policy should include reference to consent regarding interventions, examinations, video-recording etc	8	3	1	0
<b>4.2.2</b>	Young people and parents are informed by staff of their right to agree to or refuse intervention and the limits of this	8	4	0	0
<b>4.2.3</b>	Consent for interventions is obtained by a practitioner who is competent and capable of performing the intervention, or by a person who has received specialist training on advising young people about the intervention	7	4	1	0
<b>4.2.5</b>	Where young people are assessed as having capacity, consent to interventions is obtained and recorded	4	6	1	1
<b>4.2.6</b>	Careful procedures are used to establish that a young person with learning disabilities has given informed consent <i>Guidance:</i> For example, staff check the young person's understanding of what they are consenting to by asking them to communicate this back to them	6	3	1	2
<b>4.2.7</b>	Staff take steps to facilitate understanding and development of capacity <i>Guidance:</i> For example, staff explore different communication methods to facilitate understanding	8	2	1	1

Standard		Met	Partly Met	Unmet	N/A D/K
4.2.8	Where young people are assessed as not having capacity, consent from someone with parental responsibility is obtained and recorded, and the views of the young person are taken into account and documented in their intervention plan	8	4	0	0
4.2.9	Interventions are only conducted against the will of young people when it is deemed to be in the young person's best interests and all other options have been exhausted	8	1	0	3
4.2.10	When a young person who is assessed as having capacity is treated against their will, this is conducted within the appropriate legal framework and is noted in their health record	6	1	0	4
4.3	<b>Personal information about young people is kept confidential unless this is detrimental to their well-being</b>				
	<b>Mean Score 2008 = 97%</b> Mean Score 2007 = 97%		<b>(Min = 83%; Max = 100%)</b> (Min = 83%; Max = 100%)		
4.3.1	The service has an explicit policy on information-sharing and confidentiality <i>Guidance: This policy should address the requirements of the Caldicott Report on handling Patient Identifiable Information and the requirements of Government about information sharing. For example see the DfES document, "Information sharing: Practitioners' guide" (Ref 68): <a href="http://www.everychildmatters.gov.uk/resources-and-practice/IG00065/">http://www.everychildmatters.gov.uk/resources-and-practice/IG00065/</a></i>	12	0	0	0
4.3.2	Personal information about young people is kept confidential and is only revealed in accordance with explicit protocols for information-sharing <i>Guidance: Confidentiality may be overridden in certain circumstances in order to protect the well-being of the child or young person (See Ref 68 and Appendix E in QINMAC Standards). The reasons for decisions to share or not to share information should always be recorded</i>	11	1	0	0
4.3.3	Letters to referrers and other agencies involved in the young person's care are copied to young people and their parents (not applicable in Wales) <i>Guidance: This may be overridden in certain circumstances, for example where there are child protection concerns</i>	11	1	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>4.4</b>	<b>Young people and their parents are well-informed about confidentiality and their rights to access information held about them</b>				
	<b>Mean Score 2008 = 80%</b> (Min = 33%; Max = 100%) Mean Score 2007 = 63% (Min = 25%; Max = 88%)				
<b>4.4.2</b>	Young people and their parents are informed of their right to confidentiality and the limits of this <i>Guidance: Families should be informed through verbal explanations, supplemented by prominently displayed leaflets or posters</i>	9	3	0	0
<b>4.4.3</b>	Young people and their parents are informed about their rights to see their (child's) health records and the limitations on these rights	6	3	3	0
<b>4.4.4</b>	Young people who are assessed as having capacity are asked to give or withhold consent before case material is disclosed to their parents	5	2	1	4
<b>4.4.5</b>	Young people and their parents are informed (and their consent sought where appropriate) when confidential information about them is to be passed on to other services and agencies <i>Guidance: Staff should also explain the reasons why sharing the information is important to their continuing care. If consent is not given, there should be clear procedures for staff to follow</i>	11	1	0	0

Care & Intervention					
Standard		Met	Partly Met	Unmet	N/A D/K
<b>5.1</b>	<b>Young people are provided with a comprehensive and effective range of care and intervention, co-ordinated across agencies where necessary</b>				
	<b>Mean Score 2008 = 85%</b> (Min = 33%; Max = 100%) Mean Score 2007 = 97% (Min = 83%; Max = 100%)				
<b>5.1.1</b>	LD CAMHS work with primary services and other relevant services to ensure young people with learning disabilities receive the care and intervention they need <i>Guidance: As a minimum, collaboration should involve providing advice or education to other agencies on how to manage young people with learning disabilities and mental health needs. More formalised collaborative arrangements should involve, for example joint care, CAMHS paediatric liaison etc</i>	9	3	0	0
<b>5.1.2</b>	LD CAMHS offer a comprehensive range of interventions according to the needs of young people with learning disabilities	8	2	2	0
<b>5.1.3</b>	Young people with learning disabilities are provided with interventions based on the available evidence base for this group	10	2	0	0
<b>5.2</b>	<b>Young people and their families are provided with timely, flexible and reliable treatment sessions</b>				
	<b>Mean Score 2008 = 92%</b> (Min = 75%; Max = 100%) Mean Score 2007 = 88% (Min = 75%; Max = 100%)				
<b>5.2.1</b>	Young people receive timely treatment within nationally agreed timescales <i>Guidance: England, Scotland and Northern Ireland: Delivering an 18 week patient pathway from referral to the start of treatment by the end of 2008 is a key objective for the NHS (see <a href="http://www.18weeks.nhs.uk">http://www.18weeks.nhs.uk</a>)</i> <i>Wales: Delivering a 26 week patient pathway from referral to the start of treatment by the end of 2009 is a key objective for NHS Wales</i>	7	4	1	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>5.2.2</b>	Treatment sessions are flexible and responsive to the complex needs of young people with learning disabilities and their families <i>Guidance: For example, families can choose a suitable appointment time and appointments can be offered out of school or college hours; home-based or school-based treatments are offered where appropriate; where multiple appointments are required, these can either be staggered or synchronised in one setting on the same day</i>	10	2	0	0
<b>5.2.3</b>	Young people and their parents do not have to wait for longer than 15 minutes beyond their appointment time without an explanation	12	0	0	0
<b>5.2.5</b>	The service has a procedure that staff follow when young people and their families do not keep an appointment <i>Guidance: For example, when an appointment is missed there is a procedure whereby the young person's case manager contacts them to follow this up</i>	12	0	0	0
<b>5.3</b>	<b>Young people and their parents experience consistent contact with a named member of staff</b>				
	<b>Mean Score 2008 = 94% (Min = 75%; Max = 100%)</b> Mean Score 2007 = 90% (Min = 75%; Max = 100%)				
<b>5.3.1</b>	All young people with a learning disability have a named member of staff who co-ordinates their care	9	2	0	1
<b>5.3.2</b>	Young people and their parents see the same clinician consistently, unless their preference or clinical need demands otherwise <i>Guidance: For example this may be their key worker or case manager</i>	11	1	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>5.4</b>	<b>Young people and their parents are helped to make well-informed decisions about the interventions they are offered</b>				
	<b>Mean Score 2008 = 86%</b> (Min = 38%; Max = 100%) Mean Score 2007 = 80% (Min = 50%; Max = 100%)				
<b>5.4.1</b>	Young people and their parents are provided with information about the nature of their problems	9	3	0	0
<b>5.4.2</b>	Young people and their parents are provided with information about the evidence base, risks, benefits and side effects of intervention options and of non-intervention <i>Guidance: For example, staff provide children, young people and their families with NICE/Cochrane guidelines about the treatment for particular conditions</i>	7	5	0	0
<b>5.4.3</b>	Where interventions require a significant degree of parental involvement, staff provide parents with information about the nature and the extent of their proposed role before any decisions are made	11	1	0	0
<b>5.4.6</b>	Young people and their parents know the procedures for getting help in an emergency related to their mental health difficulty	9	0	2	1
<b>5.5</b>	<b>Staff guide children, young people and their parents or carers in how to help themselves</b>				
	<b>Mean Score 2008 = 78%</b> (Min = 57%; Max = 100%) Mean Score 2007 = 86% (Min = 57%; Max = 100%)				
<b>5.5.1</b>	Young people and their parents are actively involved in developing plans for intervention, including agreeing aims, and their views are recorded in their notes	8	4	0	0
<b>5.5.2</b>	Young people and their parents are enabled to be active partners in the decisions made about the medicines prescribed for them	6	4	0	2

Standard		Met	Partly Met	Unmet	N/A D/K
5.5.3	Depending on levels of case complexity young people have a written plan for intervention	7	5	0	0
5.5.4	Risk assessments and plans for intervention are reviewed at regular intervals	11	1	0	0
5.5.5	Young people and their parents are given copies of any written plans for intervention or have ready access to them	7	5	0	0
5.5.7	'Joined-up' care is facilitated by copying plans for intervention to young people's care networks (with appropriate consent – see criterion 4.4.5)	7	4	1	0
5.5.8	Formal care plans are used wherever appropriate (for example, as part of the Care Programme Approach)	4	4	3	1
<b>5.6</b>	<b>Intervention is person-centred, taking into account the individual needs of the young person and their family</b>				
	<b>Mean Score 2008 = 93%</b> (Min = 75%; Max = 100%) Mean Score 2007 = 85% (Min = 75%; Max = 100%)				
5.6.1	Case notes show evidence that plans for intervention take into account individuals' levels of functioning and communication difficulties and are adapted appropriately	10	2	0	0
5.6.3	Case notes show evidence that plans for intervention take into account the needs of the 'whole' family and their capacity to support interventions, particularly where these are home-based <i>Guidance: For example, plans should take into account parents' ability to carry out care and intervention and the possible impact of interventions on other family members</i>	10	2	0	0
5.6.4	Case notes show evidence that plans for intervention include consideration of the capacity and willingness of other agencies to support the intervention <i>Guidance: For example staff may need to talk to schools, voluntary services, social services etc to establish their ability to support the intervention</i>	10	2	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
5.6.5	Intervention is provided to young people with learning disabilities for as long as is required and effective	11	1	0	0
5.7	<b>Interventions are monitored and adapted to meet the needs of young people with learning disabilities</b>				
	<b>Mean Score 2008 = 83%</b> (Min = 50%; Max = 100%) Mean Score 2007 = 83% (Min = 67%; Max = 100%)				
5.7.1	Staff monitor clinical outcomes, risk, and side effects at regular intervals, using validated outcome tools if these are appropriate and relevant <i>Guidance: For example, staff use SDQ, HoNOSCA, the Developmental Behaviour Checklist</i>	6	3	3	0
5.7.2	Young people, parents, teachers and other caregivers are encouraged to play a key role in monitoring, evaluating and reporting the effects of interventions	10	2	0	0
5.7.4	Use of medication is closely monitored by a qualified practitioner	10	0	0	2
5.8	<b>Staff provide support and guidance to enable young people and their parents to help themselves</b>				
	<b>Mean Score 2008 = 89%</b> (Min = 50%; Max = 100%) Mean Score 2007 = 93% (Min = 83%; Max = 100%)				
5.8.1	Where relevant, young people, parents and other caregivers are guided in coping techniques and behaviour management techniques <i>Guidance: This includes helping families and educational staff to understand children's behaviour, facilitating the development of parenting skills, enhancing family coping mechanisms and promoting appropriate play, occupation and communication (Ref 45: pg 14). Challenging behaviour occurs across settings, so guidance needs to be shared with teachers and other caregivers to ensure consistency or compatibility of responses.</i>	10	2	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>5.8.2</b>	LD CAMHS support the mental and emotional needs of parents and siblings <i>Guidance: LD CAMHS should either offer support directly to families or provide contact details of local counselling/support services</i>	8	3	1	0
<b>5.8.3</b>	Young people and their families are informed about local and national services, voluntary organisations, social support networks and self-help groups relevant to their mental health difficulty and learning disability <i>Guidance: These should include culturally specific groups and organisations where relevant and promote opportunities for social integration and independence</i>	11	1	0	0
<b>5.9</b>	<b>Young people with learning disabilities are helped to continue their school or college work throughout their treatment</b>				
	<b>Mean Score 2008 = 94% (Min = 50%; Max = 100%)</b> Mean Score 2007 = 95% (Min = 75%; Max = 100%)				
<b>5.9.1</b>	Appointments are offered out of school or college hours if needed	10	2	0	0
<b>5.9.2</b>	LD CAMHS liaise with education services to co-ordinate responses to young people's mental health and education needs	11	1	0	0

<b>Rights, Safeguards and Child Protection</b>					
<b>Standard</b>		<b>Met</b>	<b>Partly Met</b>	<b>Unmet</b>	<b>N/A D/K</b>
<b>6.1</b>	<b>Young people with learning disabilities are made aware of their rights and are able to express their wishes</b>				
	<b>Mean Score 2008 = 90%</b> Mean Score 2007 = 80%		<b>(Min = 67%; Max = 100%)</b> (Min = 67%; Max = 83%)		
<b>6.1.2</b>	Staff recognise that young people with learning disabilities may be less aware of their rights and less able to express their wishes than others their age <i>Guidance: For example, staff have received specific education and awareness in this area</i>	12	0	0	0
<b>6.1.3</b>	Young people are helped by staff to understand their rights and what they can expect from the service as far as is possible	9	3	0	0
<b>6.1.5</b>	Staff offer families of young people with learning disabilities advice on using alternative methods of communication (e.g. non-verbal communication)	9	2	1	0
<b>6.2</b>	<b>Young people can express their preferences about who they are seen by</b>				
	<b>Mean Score 2008 = 79%</b> Mean Score 2007 = 85%		<b>(Min = 25%; Max = 100%)</b> (Min = 50%; Max = 100%)		
<b>6.2.1</b>	Young people can ask to see a staff member on their own e.g. without other staff or family present	10	2	0	0
<b>6.2.2</b>	Where the option is available, efforts are made to ensure that young people can see a staff member of the gender of their choice	7	2	3	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>6.3</b>	<b>Young people and their parents are treated with dignity and respect</b>				
	<b>Mean Score 2008 = 100%</b> (Min = 100%; Max = 100%) Mean Score 2007 = 100% (Min = 100%; Max = 100%)				
<b>6.3.1</b>	Young people and their parents are treated with dignity and respect	12	0	0	0
<b>6.3.3</b>	Restrictive physical intervention is used only in exceptional circumstances and to the minimum extent necessary <i>Guidance: Exceptional circumstances may include situations in which immediate action is needed to prevent young people from significantly injuring themselves or others.</i>	7	0	0	0
<b>6.4</b>	<b>Young people and their parents are informed about how to raise concerns and to seek independent advice</b>				
	<b>Mean Score 2008 = 63%</b> (Min = 25%; Max = 100%) Mean Score 2007 = 50% (Min = 25%; Max = 75%)				
<b>6.4.1</b>	Complaints procedures are well-publicised and patient-friendly and help is given on how to follow them <i>Guidance: Complaints procedures should include the name of the person to contact in the event of a complaint, including the local Children's Complaints Officer</i>	5	6	1	0
<b>6.4.3</b>	Young people and their parents have access to advocacy services and staff explain the benefits of using these services	4	6	2	0
<b>6.5</b>	<b>The rights and individual needs of young people and their families are recognised and responded to, regardless of their gender, ethnicity, religion, ability, culture, or sexuality</b>				
	<b>Mean Score 2008 = 82%</b> (Min = 33%; Max = 100%) Mean Score 2007 = 79% (Min = 75%; Max = 88%)				
<b>6.5.1</b>	Young people with learning disabilities are accorded the same rights as other young people	10	1	1	0

Standard		Met	Partly Met	Unmet	N/A D/K
6.5.2	The specific needs of young people and parents from different ethnic, cultural or religious backgrounds are respected and responded to <i>Guidance: In particular, LD CAMHS need to demonstrate sensitivity to different cultural attitudes towards mental illness and disability</i>	9	3	0	0
6.5.4	Where needed, young people, parents and practitioners are offered access to professional interpreters, so that relatives are never used as sole interpreters	10	2	0	0
6.5.5	Interpreters used by LD CAMHS have received training or guidance about children, learning disability and mental health matters and recognise the importance of full and accurate translation	1	2	3	6
6.6	<b>Young people are protected from abuse through clear safeguarding policies and procedures that are consistent with the Local Safeguarding Children Board</b>				
	<b>Mean Score 2008 = 93% (Min = 82%; Max = 100%)</b> Mean Score 2007 = 85% (Min = 61%; Max = 100%)				
6.6.1	Staff recognise that young people with learning disabilities are at increased vulnerability to abuse and that greater vigilance is thereby required	12	0	0	0
6.6.2	Staff receive regularly updated training in child protection with specific regard to young people with learning disabilities <i>Guidance: Staff should receive training as part of their induction and have access to in-house training and refresher courses on an annual basis</i>	8	2	2	0
6.6.4	Every member of staff receives written and verbal instruction of whistleblowing procedures and how to operate them	11	1	0	0
6.6.5	Staff act in accordance with the procedures of the Local Safeguarding Children Board	12	0	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>6.6.6</b>	Young people are informed of the procedures that will be followed if a disclosure of abuse is made, and they are reassured that what they say will be taken seriously	10	1	0	1
<b>6.6.8</b>	Young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services)	11	0	0	1
<b>6.6.9</b>	Where the Local Authority does not allocate a social worker, there is a procedure detailing what action should be taken to ensure young people's needs are met <i>Guidance: For example, the staff of the LD CAMHS use the Local Safeguarding Children Board to highlight joint working problems</i>	8	2	0	2
<b>6.6.10</b>	The specific safeguarding needs of young people who are Looked After are responded to through policies, procedures and practices that are designed to protect them	12	0	0	0
<b>6.6.11</b>	The Trust has a named doctor and a named nurse responsible for child protection and their contact details are made available to staff	12	0	0	0
<b>6.6.12</b>	The safeguarding of young people is arranged and monitored across agencies and services <i>Guidance: This will involve clear recording and sharing of safeguarding information for the explicit purpose of child protection – see Standard 4.3</i>	11	1	0	0
<b>6.6.13</b>	All staff who come into contact with young people or who have access to information about them are CRB checked before their appointment is offered and at regular intervals thereafter	6	6	0	0

Pathways On					
Standard		Met	Partly Met	Unmet	N/A D/K
<b>7.1</b>	<b>Young people and their parents are involved in agreeing arrangements for leaving the service and know how to re-access help if they need it</b>				
	<b>Mean Score 2008 = 92% (Min = 67%; Max = 100%)</b> Mean Score 2007 = 83% (Min = 50%; Max = 100%)				
<b>7.1.1</b>	Young people and their parents are involved in agreeing plans for leaving the service	12	0	0	0
<b>7.1.2</b>	On leaving the service, staff tell young people and their parents how they can get back in touch if they need help <i>Guidance: For example, there is a named contact for 'post-discharge' support</i>	9	3	0	0
<b>7.1.3</b>	If young people stop attending appointments before formal arrangements for this are made, there are procedures in place to facilitate their return to the service <i>Guidance: For example, the keyworker or case manager contacts the referrer, family or young person to discuss their options and continuing needs</i>	9	3	0	0
<b>7.2</b>	<b>The service makes arrangements to ensure that young people experience continuity of care when they move on from the service</b>				
	<b>Mean Score 2008 = 86% (Min = 42%; Max = 100%)</b> Mean Score 2007 = 87% (Min = 75%; Max = 100%)				
<b>7.2.1</b>	LD CAMHS retain responsibility for mental health care until it is appropriate to transfer responsibility to another service	10	2	0	0
<b>7.2.2</b>	When young people are to leave the service, their key worker or case manager takes responsibility for planning this	11	0	0	1
<b>7.2.3</b>	When young people are to leave the service, the roles of the agencies involved in any subsequent care are clarified, agreed and documented beforehand	8	4	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
7.2.4	When young people are to leave the service the Care Programme Approach is completed where appropriate	4	2	1	5
7.2.5	When young people leave the service, LD CAMHS provide an outline of the young person's case to their GP, Community Paediatrics and any other agencies involved in their care	9	3	0	0
7.2.6	For young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant Social Services Departments	9	3	0	0
7.2.7	LD CAMHS take active steps to ensure that effective handovers of care take place when young people move to a new area <i>Guidance: For example, LD CAMH staff work closely with other agencies to ensure all relevant information is promptly passed on</i>	9	3	0	0
7.2.9	If young people are placed out-of-area, there are agreements for young people to re-access care once they return to the local area <i>Guidance: For example, young people placed out of area for educational provision may require mental health support during holidays and should be able to re-access care when they return to the local area without needing to be re-referred</i>	7	4	0	1
<b>7.3</b>	<b>Young people who require inpatient care are referred to services that meet their individual needs</b>				
	<b>Mean Score 2008 = 74%</b> (Min = 0%; Max = 100%) Mean Score 2007 = 66% (Min = 50%; Max = 100%)				
7.3.1	If inpatient care is required, primary emphasis is placed upon referring young people to a unit that meets their specific learning disability and mental health needs	8	2	1	1
7.3.2	If inpatient care is required, young people are referred to a unit that is as accessible as possible so that contact with home and family is maintained	5	3	3	1

Standard		Met	Partly Met	Unmet	N/A D/K
<b>7.3.3</b>	If inpatient care is required, young people are referred to a unit that meets their developmental needs	9	1	0	2
<b>7.3.4</b>	There are clear procedures for staff to follow in situations when in-patient beds are required but are not immediately available within the relevant service	4	3	2	3
<b>7.4</b>	<b>LD CAMHS work closely with inpatient services to arrange effective handovers and joined-up provision of continuing care</b>				
	<b>Mean Score 2008 = 85%</b> (Min = 0%; Max = 100%) Mean Score 2007 = 88% (Min = 50%; Max = 100%)				
<b>7.4.1</b>	If young people are admitted to inpatient services, the LD CAMHS Tier 2/3 key worker or case manager works with the inpatient service and other organisations to agree the place of discharge before admission wherever possible	7	0	1	4
<b>7.4.2</b>	The Tier 2 or 3 key worker or case manager attends review meetings (e.g. CPA meetings) of young people following their admission to inpatient settings and engages fully in joint discharge planning with the staff of the inpatient service	8	1	1	2
<b>7.5</b>	<b>LD CAMHS work closely with adult services to arrange effective handovers of care</b>				
	<b>Mean Score 2008 = 76%</b> (Min = 17%; Max = 100%) Mean Score 2007 = 83% (Min = 33%; Max = 100%)				
<b>7.5.1</b>	A local protocol is in force regarding the age for referral to adult services and there are working arrangements for this	7	3	2	0
<b>7.5.2</b>	Young people aged below the locally agreed cut-off for referral to adult services are not referred to adult services unless in exceptional circumstances <i>Guidance: This may be appropriate if there is good clinical cause which outweighs developmental and/or other needs</i>	10	1	1	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>7.5.3</b>	Joint reviews of young people's needs are held with adult services (e.g. using the CPA) to ensure that effective hand-over of care takes place	5	7	0	0
<b>7.6</b>	<b>LD CAMHS evaluate levels of satisfaction amongst those who use or have used the service</b>				
	<b>Mean Score 2008 = 65% (Min = 25%; Max = 100%)</b> Mean Score 2007 = 65% (Min = 50%; Max = 75% )				
<b>7.6.1</b>	On leaving the service, young people and parents are actively encouraged to give feedback on the service they have received, and there are effective means for them to do so <i>Guidance: For example, this may take the form of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups or patient consultation groups</i>	5	4	3	0
<b>7.6.2</b>	If young people stop attending appointments before formal arrangements for this are made, there are procedures in place for monitoring and reviewing this to identify where problems may exist <i>Guidance: For example, the key worker or case manager contacts the family or young person to discuss reasons for leaving and this is used to inform service evaluation and audit</i>	5	7	0	0

Enabling Frontline Staff					
Standard		Met	Partly Met	Unmet	N/A D/K
<b>8.1</b>	<b>There are sufficient numbers of appropriately skilled staff</b>				
	<b>Mean Score 2008 = 33%</b> (Min = 0%; Max = 75%) Mean Score 2007 = 15% (Min = 0%; Max = 29%)				
<b>8.1.1</b>	There are sufficient numbers of skilled staff to effectively meet the mental health needs of young people with learning disabilities in the locality	2	6	4	0
<b>8.1.2</b>	The numbers of qualified personnel and support staff are determined by analyses of demand and capacity, set against the core business agreed between the service and its commissioner(s)	1	6	5	0
<b>8.1.4</b>	The numbers of qualified personnel and support staff are determined by conducting a skill mix review, set against the core business agreed between the service and its commissioner(s)	2	6	4	0
<b>8.1.5</b>	There are 5-6 staff per 100,000 total population who are designated to meet the needs of young people with learning disabilities	1	2	8	1
<b>8.1.6</b>	There are 0.5 WTE psychiatrists per 100,000 total population who are designated to meet the needs of young people with learning disabilities <i>Guidance: Based on Royal College of Psychiatrists recommendations of 0.2 WTE psychiatry time for severe learning disabilities and 0.3 WTE psychiatry time for mild learning disabilities per 100 000 population</i>	1	2	9	0
<b>8.1.7</b>	A review of staffing needs is held at defined intervals and when there are changes in service provision	4	1	3	4

Standard		Met	Partly Met	Unmet	N/A D/K
<b>8.1.9</b>	Staffing levels reflect the commitments of staff who provide training and consultation to other services and who undertake additional duties <i>Guidance: These duties may include work on local or national committees, and teaching, supervising and mentoring commitments</i>	5	0	6	1
<b>8.1.10</b>	When posts are vacant or in the event of long term sickness or maternity leave, prompt arrangements are made for staff cover	0	5	6	1
<b>8.2</b>	<b>There is an up-to-date line management structure and clear and agreed lines of responsibility and accountability</b>				
	<b>Mean Score 2008 = 89%</b> (Min = 63%; Max = 100%) Mean Score 2007 = 75% (Min = 50%; Max = 100%)				
<b>8.2.1</b>	There is a clear, up-to-date line management structure which is made readily available to staff <i>Guidance: For example, all staff are provided with an up-to-date organisational chart for the service</i>	11	1	0	0
<b>8.2.2</b>	All staff have clearly defined, up-to-date and documented job descriptions, role profiles, and job plans	10	2	0	0
<b>8.2.3</b>	There are clear and agreed lines of clinical responsibility for all staff	10	2	0	0
<b>8.2.4</b>	Lines of accountability and responsibility are negotiated and agreed across agencies and disciplines, particularly if staff work in another organisation's facility	7	1	2	2
<b>8.3</b>	<b>Staff are regularly appraised and supervised and know how to gain additional advice and support when they need it</b>				
	<b>Mean Score 2008 = 93%</b> (Min = 78%; Max = 100%) Mean Score 2007 = 84% (Min = 67%; Max = 94%)				
<b>8.3.1</b>	All staff receive annual appraisal and annual review of their job plan	10	2	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>8.3.2</b>	All staff receive regular supervision from a person with appropriate experience and qualifications, according to the guidelines of their respective professional body (where applicable) <i>Guidance: This should include access to specialist LD- trained staff</i>	10	2	0	0
<b>8.3.3</b>	All staff receive regular supervision totalling at least one hour per month	11	1	0	0
<b>8.3.4</b>	Junior staff have regular supervision totalling at least one hour per week and are able to contact a senior colleague as necessary	10	2	0	0
<b>8.3.5</b>	Staff have adequate emotional support <i>Guidance: For example, staff have access to a staff support group, counselling, an occupational health service</i>	9	3	0	0
<b>8.3.6</b>	There is a forum in which staff are able to express their concerns about the management of young people within the service, and such concerns are taken seriously	10	2	0	0
<b>8.3.7</b>	Legal advice is available to staff on issues such as information sharing, confidentiality, consent, rights and child protection <i>Guidance: For example, staff have access to a solicitor on the Children Panel who is familiar with the service and can offer up-to-date legal advice</i>	12	0	0	0
<b>8.3.8</b>	All staff, particularly professionals who work for substantial periods on their own, are well-integrated within multi-disciplinary teams so that they do not become isolated	11	1	0	0
<b>8.3.9</b>	There are procedures in place to promote the safety of staff, including particular guidance or training on personal safety when working in the community and when attending homes of patients	10	2	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>8.4</b>	<b>Staff morale is monitored by the clinical and general manager</b>				
	<b>Mean Score 2008 = 86%</b> (Min = 50%; Max = 100%) Mean Score 2007 = 70% (Min = 50%; Max = 100%)				
<b>8.4.1</b>	Good staff morale is recognised as important and efforts to improve morale are made when necessary <i>Guidance: For example, the levels of vacancies and sick leave are monitored and investigated and action is taken to address low morale</i>	10	1	1	0
<b>8.4.2</b>	There is a clear mechanism for formally recognising good performance e.g. at events, in newsletters or with achievement awards	6	5	1	0
<b>8.4.3</b>	There is a clear grievance procedure for staff to use	12	0	0	0
<b>8.5</b>	<b>Staff have sufficient office facilities and robust administrative and technological support systems, including ITC</b>				
	<b>Mean Score 2008 = 80%</b> (Min = 25%; Max = 100%) Mean Score 2007 = 48% (Min = 25%; Max = 75%)				
<b>8.5.1</b>	Staff have sufficient office space to carry out their roles <i>Guidance: Staff have sufficient space to do administrative work, make confidential phone calls etc</i>	7	2	3	0
<b>8.5.2</b>	The clinical team has sufficient administrative and secretarial support	7	4	1	0
<b>8.5.3</b>	There are sufficient computers available for staff	10	1	1	0
<b>8.5.4</b>	There is an effective I.T. infrastructure which provides reliable e-mail and internet access, including access to electronic journals and papers	10	2	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>8.6</b>	<b>Continuing professional development is facilitated</b>				
	<b>Mean Score 2008 = 65%</b> (Min = 17%; Max = 100%) Mean Score 2007 = 33% (Min = 0%; Max = 67%)				
<b>8.6.1</b>	The service has access to a staff training and development budget	10	1	1	0
<b>8.6.2</b>	Finance is available to meet the training and education needs of staff	5	7	0	0
<b>8.6.3</b>	Mechanisms are in place to advance and support teaching and research <i>Guidance: For example, joint posts are developed with universities</i>	2	5	5	0
<b>8.7</b>	<b>Staff have the necessary competencies and knowledge to work with young people who have learning disabilities and mental health needs</b>				
	<b>Mean Score 2008 = 79%</b> (Min = 53%; Max = 100%) Mean Score 2007 = 60% (Min = 48%; Max = 71%)				
<b>8.7.1</b>	All staff participate in a service induction programme within a specified timescale after appointment and before they have unsupervised access to young people	10	2	0	0
<b>8.7.2</b>	The service undertakes pre-employment checks and ongoing monitoring to ensure that professional staff are registered with the appropriate bodies (for example, the General Medical Council)	11	0	0	1
<b>8.7.3</b>	Staff working with young people with learning disabilities and mental health problems have the necessary competencies in these areas <i>Guidance: i.e. staff have the necessary competencies relevant to practice in 1) learning disability; 2) mental health; 3) working with young people</i>	10	2	0	0
<b>8.7.4</b>	Staff are provided with opportunities to develop their skills and experience in working with young people with learning disabilities and mental health problems <i>Guidance: For example, this is achieved through joint-working, peer consultation, special interest groups and appropriate supervision (see criterion 8.3.2)</i>	11	1	0	0

Standard		Met	Partly Met	Unmet	N/A D/K
	<b>Staff receive regularly updated training and education in:</b>				
<b>8.7.5</b>	Staff receive training and guidance in evidenced-based practices and value-based practices	7	4	1	0
<b>8.7.6</b>	Staff receive training and guidance in a range of therapeutic interventions for use with young people with learning disabilities and their families	8	3	1	0
<b>8.7.7</b>	Staff receive training and guidance in a range of a pharmacological interventions for use with young people with learning disabilities (for those who prescribe, dispense or administer medicines to young people)	4	3	0	5
<b>8.7.8</b>	Staff receive training and guidance in risk assessment and management, including specific guidance relating to young people with learning disabilities	8	3	1	0
<b>8.7.9</b>	Staff receive training and guidance in providing first on-call services to young people presenting with acute psychiatric illness in emergency and out-of-hours services	2	4	3	3
<b>8.7.10</b>	Staff receive training and guidance in communicating with young people with specific communication needs <i>Guidance: Training should include use of specialist communication materials and aids, the importance of listening to young people's views, and how to gain access to and work with signers and interpreters</i>	8	3	1	0
<b>8.7.11</b>	Staff receive training and guidance in gaining informed consent from young people with learning disabilities	4	5	2	1
<b>8.7.12</b>	Staff receive training and guidance in how to facilitate the participation of young people with learning disabilities in decision-making	6	5	1	0
<b>8.7.13</b>	Staff receive training and guidance in policies and procedures on information-sharing and confidentiality	10	1	0	1

Standard		Met	Partly Met	Unmet	N/A D/K
	<b>Staff receive regularly updated training and education in:</b>				
<b>8.7.14</b>	Staff receive training and guidance in the rights of young people with learning disabilities	8	3	1	0
<b>8.7.15</b>	Staff receive training and guidance in legal frameworks and service procedures surrounding use of restrictive physical interventions, including specific guidance relating to young people with learning disabilities	5	4	2	1
<b>8.7.16</b>	Staff receive training and guidance in recognising, and responding appropriately to, indicators of abuse amongst young people with learning disabilities	7	4	1	0
<b>8.7.17</b>	Staff receive training and guidance in culturally sensitive practice, disability awareness, and other diversity and equality issues	9	3	0	0
<b>8.7.18</b>	Staff receive training and guidance in multi-agency working and the availability and scope of local services <i>Guidance: see Appendix D of the standards</i>	7	3	2	0
<b>8.7.19</b>	Staff receive training and guidance in how to engage and work with parents, carers and families	8	3	0	1
<b>8.7.20</b>	Staff receive training and guidance in how to engage young people and their families who have difficulty in gaining access to services, including those from black and minority ethnic groups	6	5	1	0
<b>8.7.21</b>	Staff receive training and guidance in legislation such as the Children Act 2004, Mental Health Act 1983 and its revised Code of Practice, Education Act 2002, and associated regulations	7	5	0	0
<b>8.7.5</b>	Staff receive training and guidance in evidenced-based practices and value-based practices	7	4	1	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>8.8</b>	<b>Staff work effectively as a team or network</b>				
	<b>Mean Score 2008 = 88%</b> (Min = 20%; Max = 100%) Mean Score 2007 = 74% (Min = 20%; Max = 100%)				
<b>8.8.1</b>	There is a team or network of professionals from at least two different disciplines <i>Guidance: The range of disciplines might include representatives from child and adolescent psychiatry; clinical child psychology; child mental health nursing; social work; and possibly other specialisms such as occupational therapy; art therapy; speech and language therapy</i>	12	0	0	0
<b>8.8.2</b>	There are once weekly multi-disciplinary meetings for clinical matters and administration	7	3	2	0
<b>8.8.3</b>	Notes of clinical meetings are kept and made available to all members of the team or network	10	1	1	0
<b>8.8.4</b>	Communication between staff outside meetings is facilitated by administrative staff and communication systems <i>Guidance: Communication systems may include use of bulletin boards, communication books, email, up-to-date lists of contact numbers and times regularly worked at other sites, and formal systems for taking and relaying messages</i>	11	0	1	0
<b>8.8.5</b>	Off-site and informal 'away days' are held to facilitate team building and service development	10	1	1	0
<b>8.9</b>	<b>There are policies and procedures on whistleblowing</b>				
	<b>Mean Score 2008 = 85%</b> (Min = 63%; Max = 100%) Mean Score 2007 = 70% (Min = 55%; Max = 88%)				
<b>8.9.1</b>	There is a written whistleblowing policy that is communicated to all staff on reporting concerns about professional performance, conduct or any aspect of service delivery, both internally and between organisations	12	0	0	0
<b>8.9.3</b>	Staff are able to raise concerns in confidence and without prejudicing their position in accordance with the Public Interest Disclosure Act	12	0	0	0

<b>Multi-Agency Working</b>					
<b>Standard</b>		<b>Met</b>	<b>Partly Met</b>	<b>Unmet</b>	<b>N/A D/K</b>
<b>9.1</b>	<b>LD CAMH staff work closely with, and have good access to, a range of services and agencies to meet the needs of young people. These include the following:</b>				
	<b>Mean Score 2008 = 71% (Min = 31%; Max = 97%)</b> Mean Score 2007 = 60% (Min = 31%; Max = 88%)				
<b>9.1.1</b>	The team works closely with, and has good access to general practitioners and other members of the primary health care team in the area	8	3	0	1
<b>9.1.2</b>	The team works closely with, and has good access to paediatric, child health and other children's services	11	1	0	0
<b>9.1.3</b>	The team works closely with, and has good access to speech and language professionals	8	3	1	0
<b>9.1.4</b>	The team works closely with, and has good access to occupational health professionals	8	1	2	1
<b>9.1.5</b>	The team works closely with, and has good access to school health services including community paediatricians and school or college nurses	11	1	0	0
<b>9.1.6</b>	The team works closely with, and has good access to paediatric neurological services	7	3	1	1
<b>9.1.7</b>	The team works closely with, and has good access to social services	9	2	0	1
<b>9.1.8</b>	The team works closely with, and has good access to education and education support services	10	2	0	0
<b>9.1.9</b>	The team works closely with, and has good access to forensic mental health services	0	1	7	4
<b>9.1.10</b>	The team works closely with, and has good access to youth offending and youth justice services	4	4	3	1

Standard		Met	Partly Met	Unmet	N/A D/K
<b>9.1</b>	<b>LD CAMH staff work closely with, and have good access to, a range of services and agencies to meet the needs of young people. These include the following:</b>				
<b>9.1.11</b>	The team works closely with, and has good access to inpatient and day-patient child and adolescent mental health services	2	6	3	1
<b>9.1.12</b>	The team works closely with, and has good access to adult mental health services	4	4	4	0
<b>9.1.13</b>	The team works closely with, and has good access to learning disability services (for LD CAMHS not provided by a Learning Disability Service, e.g. mainstream Specialist CAMHS)	4	2	1	5
<b>9.1.14</b>	The team works closely with, and has good access to adult learning disability services	9	3	0	0
<b>9.1.15</b>	The team works closely with, and has good access to substance misuse services	3	2	4	3
<b>9.1.16</b>	The team works closely with, and has good access to smoking cessation clinics	1	1	6	4
<b>9.1.17</b>	The team works closely with, and has good access to laboratory and all diagnostic services	2	3	3	4
<b>9.1.18</b>	The team works closely with, and has good access to accident and emergency facilities in emergency departments	4	2	4	2
<b>9.1.19</b>	The team works closely with, and has good access to voluntary sector services	8	4	0	0
<b>9.1.20</b>	The team works closely with, and has good access to employment support agencies <i>Guidance: for example Connexions (England only)</i>	8	2	0	2

Standard		Met	Partly Met	Unmet	N/A D/K
<b>9.2</b>	<b>The service has clear, up-to-date, documented agreements with a range of local services and agencies</b>				
	<b>Mean Score 2008 = 56%</b> (Min = 23%; Max = 83%) Mean Score 2007 = 40% (Min = 17%; Max = 69%)				
<b>9.2.1</b>	There are documented inter-agency or inter-service agreements that clearly state the roles and responsibilities that are allocated to each organisation	1	6	5	0
<b>9.2.2</b>	In particular, there are documented protocols in place for collaboration and/or joint care between specialist learning disability services, paediatric services and specialist mental health services	1	3	7	1
<b>9.2.3</b>	There are documented agreements that state the nature and extent of agreements to provide advice, consultation and training to other services and agencies, in particular Tier 1	1	4	7	0
<b>9.2.4</b>	Protocols for referral and early intervention are agreed between all services and agencies	6	3	3	0
<b>9.2.5</b>	A common understanding of the terms and definitions regarding learning disability are established with relevant agencies and families to ensure that appropriate assessment and intervention takes place	3	6	3	0
<b>9.2.6</b>	Joint protocols for out of hours cover have been agreed between relevant agencies to ensure that there is 24 hour cover for children and adolescents <i>Guidance: These agencies are likely to include commissioners, primary healthcare services, paediatricians, adult psychiatry services, emergency medicine departments, social services and LD CAMHS</i>	2	5	3	2
<b>9.2.7</b>	There is agreement across agencies about the age range covered by each agency which make clear the arrangements for the transfer of care from adolescent to adult mental health services, when young people reach the agreed "cut off" age	7	4	1	0

Standard		Met	Partly Met	Unmet	N/A D/K
9.2.8	There are interagency agreements on the sharing of information	8	3	0	1
9.2.9	Information-sharing arrangements allow for the development and implementation of a locally based multi-agency database containing core data on disabled children	4	3	4	1
9.2.10	There are joint protocols on involving or notifying other services or agencies when there is suspected abuse of young people	12	0	0	0
9.2.11	All documented agreements between organisations have been written or reviewed within the last three years	4	2	1	5
9.3	<b>Staff engage in activities and initiatives to improve joint-working and liaison</b>				
	<b>Mean Score 2008 = 54% (Min = 7%; Max = 86%)</b> Mean Score 2007 = 42% (Min = 29%; Max = 64%)				
9.3.1	There are regular case meetings between local generic workers from all sectors, and specialist mental health and learning disability services	5	4	3	0
9.3.2	There is regular strategic dialogue about the needs of local young people with learning disabilities, between local generic workers from all sectors, and specialist mental health and learning disability services <i>Guidance: For example, LD CAMHS representatives participate in local Children and Young People's Strategic Partnerships (or equivalents), Learning Disability Partnership Boards, CAMHS Partnerships, or Children's Trusts (where established)</i>	5	6	1	0
9.3.3	There is joint training and professional development across the services and agencies involved in caring for young people with learning disabilities	5	3	4	0
9.3.4	There are informal and formal collaborative arrangements in place with adult services <i>Guidance: For example, this may include joint training between adult and children's staff; designated sessions to facilitate liaison between services</i>	3	4	5	0

Standard		Met	Partly Met	Unmet	N/A D/K
<b>9.3.5</b>	There are opportunities for joint training across the agencies with respect to child protection and recognising the young people who may be at risk	6	3	2	1
<b>9.3.6</b>	Joint working is facilitated through flexible recruitment and employment procedures <i>Guidance: For example, there are secondments between organisations, staff move between posts across organisations, joint posts and liaison posts are created</i>	3	3	6	0
<b>9.3.7</b>	The service explores opportunities for co-location with other relevant children's services and agencies, in particular paediatrics	5	2	5	0

## Commissioning

Standard		Met	Partly Met	Unmet	N/A D/K
<b>10.1</b>	<b>Commissioner-provider relationships are collaborative and effective</b>				
	<b>Mean Score 2008 = 81%</b> <b>(Min = 20%; Max = 100%)</b> Mean Score 2007 = 81%                      (Min = 57%; Max = 100%)				
<b>10.1.1</b>	Service providers know who their commissioners are	10	1	0	1
<b>10.1.2</b>	Commissioners work together with providers to achieve a strategic framework that is jointly developed and owned	8	1	2	1
<b>10.1.3</b>	Effective commissioner-provider relationships are evidenced by a long-term approach to service planning and development	7	2	1	2
<b>10.1.4</b>	Effective commissioner-provider relationships are evidenced by sustained relationships between commissioning and provider managers who meet regularly	7	1	0	4
<b>10.1.5</b>	Effective commissioner-provider relationships are evidenced by recognition of the differing organisational cultures of the providers from the various sectors and agencies	7	2	0	3
<b>10.1.6</b>	Effective commissioner-provider relationships are evidenced by joint approaches to service planning and development	7	3	1	1
<b>10.1.7</b>	Effective commissioner-provider relationships are evidenced by clarity about which agency is responsible for which functions, at which of the Tiers	6	4	1	1

Standard		Met	Partly Met	Unmet	N/A D/K
<b>10.2</b>	<b>There are mechanisms for joint commissioning and joint pooling of budgets across the relevant health, education and social services</b>				
	<b>Mean Score 2008 = 82%</b> (Min = 0%; Max = 100%) Mean Score 2007 = 90 % (Min = 75%; Max = 100%)				
<b>10.2.1</b>	There are mechanisms in place for joint commissioning <i>Guidance: For example, CAMH Services are commissioned by Children's Trusts, CAMHS partnerships or Learning Disability Partnership Boards where established or commissioning is otherwise co-ordinated with the commissioning of other children and young people's services</i>	9	1	1	1
<b>10.2.2</b>	Facilities for pooling and creating joint budgets exist across health, education and social services	5	3	1	3
<b>10.3</b>	<b>Each commissioning agency can demonstrate that it has the organisational capacity necessary for effective commissioning</b>				
	<b>Mean Score 2008 = 64%</b> (Min = 0%; Max = 100%) Mean Score 2007 = 77% (Min = 50%; Max = 100%)				
<b>10.3.1</b>	Each commissioning agency has an identified person who is dedicated to commissioning CAMHS and is well-informed about Learning Disability CAMHS, including national policy	5	2	0	5
<b>10.3.2</b>	There is training available to commissioners in understanding Learning Disability CAMHS <i>Guidance: This may usefully include opportunities for commissioners to work within provider services</i>	1	2	3	6
<b>10.3.3</b>	Commissioners and service providers are aware of their responsibilities under the Disability Discrimination Act 1995, the Special Educational Needs and Disability Act 2001 and the Children Act 1989	7	0	0	5

Standard		Met	Partly Met	Unmet	N/A D/K
<b>10.4</b>	<b>There is a clear role for Learning Disability CAMHS that is explicitly set in the context of the four-tier strategic framework for CAMHS</b>				
	<b>Mean Score 2008 = 79%</b> (Min = 50%; Max = 100%) Mean Score 2007 = 68% (Min = 25%; Max = 100%)				
<b>10.4.1</b>	There is a service level agreement or contract with the commissioning agencies which plainly states the core business of LD CAMHS and the functions that they are expected to deliver	4	4	0	4
<b>10.4.2</b>	There is a service level agreement or contract with the commissioning agencies which plainly states how the LD CAMHS relates to Tiers 1 and 4	3	2	2	5
<b>10.4.4</b>	The LD CAMHS has access to a strategy for all CAMHS and specifically for the LD CAMHS, that reflects national policy	7	1	0	4
<b>10.4.5</b>	The values and principles that underpin the strategy and the commissioning plan are identified and clear	6	2	0	4
<b>10.5</b>	<b>A multi-agency commissioning strategy is in place to develop and improve services for young people with learning disabilities and mental disorders. This is based on a comprehensive, multi-agency assessment of need, capacity and effectiveness</b>				
	<b>Mean Score 2008 = 77%</b> (Min = 39%; Max = 94%) Mean Score 2007 = 63% (Min = 17%; Max = 100%)				
<b>10.5.1</b>	There is a written multi-agency commissioning strategy to develop and improve services for young people with learning disabilities and mental disorders <i>Guidance: This should be linked to an overall strategy for children and young people's service. It is recommended that this strategy should incorporate plans for implementing the guidance set out in the National Care Pathway for Learning Disability CAMHS (Ref 65)</i>	4	2	1	5

Standard		Met	Partly Met	Unmet	N/A D/K
<b>10.5.2</b>	The LD CAMHS makes an active and effective contribution to the local CAMHS commissioning strategy	4	4	0	4
<b>10.5.4</b>	The commissioning strategy is informed by analysis of locally adjusted epidemiological information on the prevalence of mental health disorders and learning disabilities	4	3	0	5
<b>10.5.5</b>	The commissioning strategy is informed by analysis of the needs of specific groups of children who are at risk	5	2	0	5
<b>10.5.6</b>	The commissioning strategy is based on analysis of the contributions of current services and awareness of unmet need and service gaps	4	2	0	6
<b>10.5.7</b>	The commissioning strategy includes a service map showing what services are provided and how they are used and by whom	2	3	1	6
<b>10.5.8</b>	The commissioning strategy takes evidence of effectiveness and efficacy of interventions and service models into account <i>Guidance: The strategy should make explicit reference to any evidence used to inform it</i>	2	3	1	6
<b>10.5.9</b>	The commissioning strategy incorporates commitment to current national and local priorities including National Service Frameworks, the National Autism Plan and, in relevant countries, implementation of NICE guidance	6	1	0	5
<b>10.5.11</b>	The commissioning strategy is informed by audit and mapping of workforce capacity, skills and workforce development strategy	4	3	0	5

Standard		Met	Partly Met	Unmet	N/A D/K
<b>10.6</b>	<b>Adequate resources are made available to meet the needs of young people with learning disability and mental health problems</b>				
	<b>Mean Score 2008 = 39%</b> (Min = 0%; Max = 75%) Mean Score 2007 = 35% (Min = 0%; Max = 75%)				
<b>10.6.1</b>	The level of resources available to the LD CAMHS matches the high degree of specialist support required by young people with learning disabilities	2	6	3	1
<b>10.6.2</b>	There is commitment and financial support to conduct research into the effectiveness of interventions for young people with learning disabilities and mental health needs	1	4	5	2
<b>10.7</b>	<b>Commissioners ensure that services are provided for young people with learning disabilities, including those who have particularly complex needs or who belong to specific at-risk or need groups</b>				
	<b>Mean Score 2008 = 70%</b> (Min = 25%; Max = 88%) Mean Score 2007 = 64% (Min = 7%; Max = 96%)				
<b>10.7.1</b>	Commissioners ensure that young people with learning disabilities have access to the general and specialist services available to those without learning disabilities	6	3	1	2
<b>10.7.2</b>	Commissioners of paediatric services and LD CAMHS collaborate to ensure that a Paediatric Liaison service is provided with agreed apportioning of costs to the relevant budgets <i>Guidance: CAMHS paediatric liaison services are required, amongst other needs, to provide for the complex needs of children with learning disabilities, mental health problems and closely linked medical disorders such as epilepsy and life limiting disorders</i>	3	3	2	4
<b>10.7.3</b>	Commissioners ensure that adequate in-patient beds and resources are available to meet the needs of young people with learning disabilities	1	4	3	4

Standard		Met	Partly Met	Unmet	N/A D/K
<b>10.7.4</b>	Commissioners ensure that young people are not placed out of borough as a consequence of inadequate specialist support being provided to schools and colleges	3	3	3	2
<b>10.7.5</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who also have Autistic Spectrum Disorders</b>	9	2	0	1
<b>10.7.6</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who are in transition, i.e. refugees or asylum seekers, homeless and travellers</b>	5	5	0	2
<b>10.7.7</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who also misuse substances</b>	6	2	1	3
<b>10.7.8</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who also are, or have been, involved in criminal offences</b>	6	3	1	2
<b>10.7.9</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who are also Looked After and accommodated</b>	8	3	0	1
<b>10.7.10</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who also have longer-term or complex needs that cannot be met by one agency</b>	7	3	1	1
<b>10.7.11</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who also have particular needs as a consequence of being members of minority ethnic group</b>	3	7	1	1
<b>10.7.12</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who also have physical disabilities or illnesses</b>	8	3	0	1

Standard		Met	Partly Met	Unmet	N/A D/K
<b>10.7.13</b>	Commissioners ensure that services are provided for young people with mental disorders and learning disabilities <b>who are aged 16 or over and are moving between CAMHS and adult services</b> <i>Guidance: Local commissioning agreements should ensure there is adequate specialist mental health provision for those aged 16 or over and there are clear agreements as to who has responsibility for providing these services. There should be overlap to allow flexibility of provision</i>	5	5	1	1
<b>10.7.14</b>	Where a particular service is not available locally, commissioners have identified a clear mechanism by which it can be accessed, for example by contract with a neighbouring trust	3	2	3	4
<b>10.8</b>	<b>Young people and their parents are involved in commissioning the local services and are consulted about service delivery</b>				
	<b>Mean Score 2008 = 66%</b> (Min = 25%; Max = 100%) Mean Score 2007 = 50% (Min = 50%; Max = 50%)				
<b>10.8.1</b>	Children and parents are consulted about the design and delivery of local health, education and social care services, and responses to this are reported back to those consulted	3	5	0	4
<b>10.8.2</b>	The service has means to ascertain the views of people from different religious, cultural and minority ethnic groups, whether or not they are patients of the service	3	3	2	4
<b>10.9</b>	<b>Frontline staff are involved in commissioning the local services and are consulted about service delivery</b>				
	<b>Mean Score 2008 = 50%</b> (Min = 0%; Max = 100%) Mean Score 2007 = 56% (Min = 25%; Max = 100%)				
<b>10.9.1</b>	There are mechanisms in place to communicate key commissioning issues to frontline staff	4	4	3	1
<b>10.9.2</b>	The commissioning strategy incorporates the opinions of service staff	3	3	4	2

Standard		Met	Partly Met	Unmet	N/A D/K
<b>10.10</b>	<b>There is a clear framework for service review and performance management that is agreed between the commissioning and provider agencies</b>				
	<b>Mean Score 2008 = 61%</b> (Min = 0%; Max = 100%) Mean Score 2007 = 58% (Min = 0%; Max = 100%)				
<b>10.10.1</b>	There is a review process involving commissioners and the service that takes place at least annually	3	2	2	5
<b>10.10.2</b>	Standards and/or other performance criteria which are set for the service are agreed by the commissioners and the provider agency	5	1	1	5
<b>10.10.3</b>	Standards and other performance criteria are informed by the aims, objectives and principles agreed for CAMHS in the strategic framework	4	2	1	5
<b>10.10.4</b>	Standards and other performance criteria are informed by professional opinion	4	2	1	5
<b>10.10.5</b>	Standards and other performance criteria are informed by the opinions of patients and their carers	1	2	4	5
<b>10.10.6</b>	Standards and other performance criteria are informed by policy and guidance e.g. The DOAS National Care Pathway	3	0	2	7



# Activity, Resource and Outcome Indicators

Evaluation of a service's quality should take into account indicators of activity, resources and outcome. The following measures were collected as part of QINMAC's annual self review process: aggregated data are presented to allow benchmarking. Additional indicators will be measured in 2009.

**Important:** These data are provided as a guide only. The accuracy of these figures is dependent on the quality of information supplied by member teams. Responses from some members were based on estimates; accuracy is therefore variable.





Indicator	Average (mean)	Minimum	Maximum	Number of teams responding
Proportion of referrals accepted in last 6 months	<b>78</b>	46	94	9
Average waiting time for routine assessments over last 6 months (weeks)	<b>6.6</b>	2	13	9
Average waiting time for treatment, from the point of referral (weeks)	<b>9</b>	2	18	8
Difficulties accessing in-patient CAMHS beds?	<b>Yes= 5 No = 2</b>			7
How many cases were referred to in-patient CAMHS in last 6 months?	<b>0.77</b>	0	2	9
How many of these were accepted (i.e. admitted)?	<b>1</b> <small>(Note: Only 1 team reported a referred case as <u>not</u> being admitted)</small>	0	2	9

<b>Indicator</b>	<b>Average (mean)</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Number of teams responding</b>
<b>Number of WTE clinicians for the team per 100,000 local population</b>	<b>2.38</b>	0.5	5.2	8
<b>Does the team experience particular problems with recruitment?</b>	<b>Yes=1 Partly =4 No=7</b>	n/a	n/a	12
<b>Does the team experience particular problems with staff retention?</b>	<b>Yes = 3 Partly = 3 No = 5</b>	n/a	n/a	11



# Appendix A - Team Initiatives

*Team initiatives are organised under the relevant sections of the QINMAC-LD Standards.*



## Section 2: Environment and Facilities





Team Name	Initiative/Achievement	Contact
 North Staffordshire CAMHS – Disability Team	<ul style="list-style-type: none"> <li>Therapy sessions are offered in a number of locations which facilitates access for young people and their families across a geographically wide catchment area</li> </ul>	Robert Deller T: 01782 427444 E: <a href="mailto:robert.deller@northstaffs.nhs.uk">robert.deller@northstaffs.nhs.uk</a>
 Shropshire /Telford & Wrekin CAMHS-LD	<ul style="list-style-type: none"> <li>The team has moved into new premises and is now co-located with many of its partner agencies. This has helped to strengthen relationships and facilitate communication</li> </ul>	Bill Sample T: 01743 282373 E: <a href="mailto:bill.sample@telfordpct.nhs.uk">bill.sample@telfordpct.nhs.uk</a>
 Butterfly CAMHS	<ul style="list-style-type: none"> <li>The team are based in a special school which facilitates referral and access and informal consultation with school staff</li> </ul>	Sue Fear T: 01945 581822 E: <a href="mailto:Sue.Fear@cpft.nhs.uk">Sue.Fear@cpft.nhs.uk</a>
 South East Hampshire LD CAMHS (Oak Park)	<ul style="list-style-type: none"> <li>The team are able to offer home visits and outreach work, as well as working alongside other agencies in other environments – for example in schools. This improves access and keeps work rooted in the environments with which the young people are already familiar</li> </ul>	Lisa Parker T: 02392 683770 E: <a href="mailto:lisa.parker2@ports.nhs.uk">lisa.parker2@ports.nhs.uk</a>

## Section 4: Information, Consent and Confidentiality




Team Name	Initiative/Achievement	Contact
 Northumberland CALDT	<ul style="list-style-type: none"> <li>The team have produced information/consent booklets suitable for children and young people with learning disabilities, as well as for their parents/carers</li> </ul>	Julie Curtis T: 01670 516131 E: <a href="mailto:julie.curtis@nhs.net">julie.curtis@nhs.net</a>
 Coventry & Warwickshire Children's CLDT	<ul style="list-style-type: none"> <li>The team has excellent information leaflets on aspects of the service. These are accessible and user friendly; service-users were involved in their development</li> </ul>	Thomas McGuire T: 02476 472463/02476 472461 E: <a href="mailto:thomas.mcquire@covwarkpt.nhs.uk">thomas.mcquire@covwarkpt.nhs.uk</a>

## Section 5: Care and Intervention


Team Name	Initiative/Achievement	Contact
 Wolverhampton CALDT	<ul style="list-style-type: none"> <li>The Health Action Plans (HAPS) used by the team are excellent. They are very comprehensive, user-friendly and easy to understand</li> </ul>	Peter Corr 01902 444706 <a href="mailto:peter.corr@wolvespct.nhs.uk">peter.corr@wolvespct.nhs.uk</a>
 Butterfly Team	<ul style="list-style-type: none"> <li>The team use the 'Team Around the Child' model for a number of cases</li> <li>The team use the locally developed 'Sleeping Dragons' model for young people with autism, in which regular reviews are set and achievable goals defined</li> </ul>	Sue Fear T: 01945 581822 E: <a href="mailto:Sue.Fear@cpft.nhs.uk">Sue.Fear@cpft.nhs.uk</a>

 <p>North Staffordshire CAMHS – Disability Team</p>	<ul style="list-style-type: none"> <li>• The team offer regular parenting groups, for example: Skills for Life, Triple-P Parenting and ASD-Wise</li> <li>• The team have strong links with Early Years settings, which allows them to undertake early intervention and prevention work where appropriate</li> <li>• The team regularly use the HoNOSCA as an outcome measure</li> <li>• The team regularly run 'Stop, Think, Do' groups for nominated children in the special schools where they work. Staff running these groups are working on developing outcome measures which are child friendly, and have already begun noting down observations of changes in behaviour and children's peer interactions as means of gauging outcome</li> </ul>	<p>Robert Deller T: 01782 427444 E: <a href="mailto:robert.deller@northstaffs.nhs.uk">robert.deller@northstaffs.nhs.uk</a></p>
 <p>South East Hampshire LD CAMHS (Oak Park)</p>	<ul style="list-style-type: none"> <li>• The team have developed a model of joint-working on cases; instead of holding cases, they offer support, consultation and joint-interventions. This allows them to meet the needs of more service users despite their limited capacity</li> </ul>	<p>Lisa Parker T: 02392 683770 E: <a href="mailto:lisa.parker2@ports.nhs.uk">lisa.parker2@ports.nhs.uk</a></p>
 <p>Newham LD and PDD team</p>	<ul style="list-style-type: none"> <li>• The team run regular post-diagnosis ASD workshops to assist parents to cope with their child's diagnosis of autism</li> </ul>	<p>Ruth Armstrong T: 020 7055 8400 E: <a href="mailto:Ruth.Armstrong@eastlondon.nhs.uk">Ruth.Armstrong@eastlondon.nhs.uk</a></p>
 <p>Bradford CAMHS LD/CCST/BEST</p>	<ul style="list-style-type: none"> <li>• The team are currently piloting the use of CORC as an LD outcome measurement tool</li> </ul>	<p>David Sims T: 01274 723241/ 01535661531 E: <a href="mailto:david.sims@bdct.nhs.uk">david.sims@bdct.nhs.uk</a></p>






## Section 6: Transitions

Team Name	Initiative/Achievement	Contact
 Northumberland CALDT	<ul style="list-style-type: none"> <li>The team has strong links with inpatient CAMHS</li> </ul>	Julie Curtis T: 01670 516131 E: <a href="mailto:julie.curtis@nhs.net">julie.curtis@nhs.net</a>
 Portsmouth CALDS	<ul style="list-style-type: none"> <li>Local negotiation means that there is an overlap between CALDS and adult services for 16-18 year olds, which enables a seamless service for those in transition</li> </ul>	Erica Goddard T: 02392 821912 E: <a href="mailto:erica.goddard@ports.nhs.uk">erica.goddard@ports.nhs.uk</a>
 Coventry & Warwickshire Children's CLDT	<ul style="list-style-type: none"> <li>The team's protocol for referral to adult services has recently been changed so that there is one year of joint working between the services prior to a young person's transition</li> </ul>	Thomas McGuire T: 02476 472463/02476 472461 E: <a href="mailto:thomas.mcquire@covwarkpt.nhs.uk">thomas.mcquire@covwarkpt.nhs.uk</a>



## Section 7: Enabling Frontline Staff

Team Name	Initiative/Achievement	Contact
 South East Hampshire LD CAMHS (Oak Park)	<ul style="list-style-type: none"> <li>The team are creative in using other agencies to support interventions, for example they are currently working towards offering training to respite staff to support them in their work; respite staff are currently available during the day while young people are at school. This is an excellent initiative to increase capacity to deliver care</li> </ul>	Lisa Parker T: 02392 683770 E: <a href="mailto:lisa.parker2@ports.nhs.uk">lisa.parker2@ports.nhs.uk</a>




## Section 8: Multi-agency Working

Team Name	Initiative/Achievement	Contact
 Bradford CAMHS LD/CCST/BEST	<ul style="list-style-type: none"> <li>The service is provided on a multi-agency basis – an integrated service is offered by CAMHS and Social Services. This approach facilitates stable and more comprehensive care for young people</li> </ul>	David Sims T: 01274 723241/ 01535661531 E: <a href="mailto:david.sims@bdct.nhs.uk">david.sims@bdct.nhs.uk</a>
 Portsmouth CALDS	<ul style="list-style-type: none"> <li>The team has established an excellent partnership model with other agencies and has worked closely with them to build a robust managed care network</li> </ul>	Erica Goddard T: 02392 821912 E: <a href="mailto:erica.goddard@ports.nhs.uk">erica.goddard@ports.nhs.uk</a>
 Butterfly Team	<ul style="list-style-type: none"> <li>The team works effectively with outreach workers from the respite team to offer intensive interventions within the home</li> <li>The team are represented on the DCAM panel (Disabled Children's Allocation panel) where they can support requests for additional funding for complex cases</li> <li>A social worker from the Additional Needs team works with the team 2 days a week</li> </ul>	Sue Fear T: 01945 581822 E: <a href="mailto:Sue.Fear@cpft.nhs.uk">Sue.Fear@cpft.nhs.uk</a>
 Shropshire /Telford & Wrekin CAMHS- LD	<ul style="list-style-type: none"> <li>Members of the team have made pro-active attempts to improve partnership working e.g. by initiating work shadowing with the Adult Learning Disability team</li> </ul>	Bill Sample T: 01743 282373 E: <a href="mailto:bill.sample@telfordpct.nhs.uk">bill.sample@telfordpct.nhs.uk</a>
 Newham LD and PDD team	<ul style="list-style-type: none"> <li>The team has participated in a care pathway conference with the aim of pulling together the multi-agency network</li> </ul>	Ruth Armstrong T: 020 7055 8400 E: <a href="mailto:Ruth.Armstrong@eastlondon.nhs.uk">Ruth.Armstrong@eastlondon.nhs.uk</a>

## Section 9: Commissioning

Team Name	Initiative/Achievement	Contact
 Portsmouth CALDS	<ul style="list-style-type: none"> <li>Staff have planned and set up a new learning disability service</li> </ul>	Erica Goddard T: 02392 821912 E: <a href="mailto:erica.goddard@ports.nhs.uk">erica.goddard@ports.nhs.uk</a>
 North Staffordshire CAMHS – Disability Team	<ul style="list-style-type: none"> <li>The team include collated feedback data in their annual report; demographics of referrals and information about main referrers are also included in this report. Producing an annual report is an extremely positive initiative and has been well received by commissioners</li> </ul>	Robert Deller T: 01782 427444 E: <a href="mailto:robert.deller@northstaffs.nhs.uk">robert.deller@northstaffs.nhs.uk</a>

## Service User Involvement

Team Name	Initiative/Achievement	Contact
 Portsmouth CALDS	<ul style="list-style-type: none"> <li>The team is very service-user orientated and has put considerable thought, time and effort into developing meaningful feedback tools for young people and parents</li> </ul>	Erica Goddard T: 02392 821912 E: <a href="mailto:erica.goddard@ports.nhs.uk">erica.goddard@ports.nhs.uk</a>
 Northumberland CALDT	<ul style="list-style-type: none"> <li>The team has implemented excellent initiatives to consult with young people and to facilitate peer support, via focus groups and sibling groups</li> </ul>	Julie Curtis T: 01670 516131 E: <a href="mailto:julie.curtis@nhs.net">julie.curtis@nhs.net</a>
 Newham LD and PDD team	<ul style="list-style-type: none"> <li>The team has carried out excellent work in evaluating ASD post-diagnostic workshops and responding to parent feedback</li> </ul>	Ruth Armstrong T: 020 7055 8400 E: <a href="mailto:Ruth.Armstrong@eastlondon.nhs.uk">Ruth.Armstrong@eastlondon.nhs.uk</a>



North  
Staffordshire  
CAMHS –  
Disability Team

- On discharge the psychology team send a satisfaction questionnaire in the form of a postcard to carers, which is based on an edited version of the CHI questionnaire.
- For parenting groups the team use a feedback questionnaire and also ask for qualitative feedback and suggestions for future groups. Previous group members are invited to give feedback to the next groups.
- The CLDN's are trained in using patient stories in which they can explore the experience of the whole patient journey with service users.
- Parents or young people have been included on interview panels for new posts; recently members of the school council at a special school were involved in the interview process for a new Clinical Psychologist who would be working with the team in their school

Robert Deller  
T: 01782 427444  
E: [robert.deller@northstaffs.nhs.uk](mailto:robert.deller@northstaffs.nhs.uk)



# Appendix B - Members Feedback

Host teams and peer reviewers were asked to fill in a feedback questionnaire in order to review and improve the QINMAC process. The results below represent the data that were returned.

<b>Peer Reviewer Feedback</b>				
Results represented here were compiled from the 71 responses to the QINMAC feedback form that were returned.				
	<b>Yes</b>		<b>No</b>	
Do you think you/the organisation learnt anything new?	97%		3%	
	<b>Very Useful</b>	<b>Mostly Useful</b>	<b>Partly Useful</b>	<b>Not Useful</b>
How useful was it to have the opportunity to meet people from another service?	91%	9%	0%	0%
How useful was the peer review process to go through?	85%	15%	0%	0%
<b>Host Teams Feedback</b>				
Results represented here were compiled from the 20 responses to the QINMAC feedback form that were returned.				
	<b>Yes</b>		<b>No</b>	
Do you think you/your team learnt anything new?	100%		0%	
Did you feel that you had enough support from the QINMAC team? If not, what extra support would you have liked?	100%		0%	
	<b>Very Useful</b>	<b>Mostly Useful</b>	<b>Partly Useful</b>	<b>Not Useful</b>
How useful did you find completing the self-review?	50%	43%	7%	0%
Did you find the peer review useful?	64%	29%	7%	0%
How useful is your QINMAC report?	50%	42%	8%	0%
<b>Report Timescales - QINMAC Project Team</b>				
Results represent data from 37 local peer review reports.				
Percentage of draft reports sent within 4 weeks of Peer Review	90%	Percentage of draft reports sent within 5 weeks of Peer Review	94%	

## Qualitative feedback from members

### Positive comments:

**"[The self review] enabled and encouraged the team to take stock of progress and to focus on our working practices"**

**"As a new service it really helped to focus on areas for development"**

**"[QINMAC] showed us the way forward in a way that we felt was fairly easy and accessible for us"**

**"The people who came up for the peer review on both occasions, have been highly motivated and have been willing to share, I have to say that's been excellent"**

**"The opportunity to share practices and ideas about common difficulties was invaluable"**

**"We felt that it was very useful for our partner agencies hearing what other teams offered as a service"**

### Suggested ideas for improvement:

1. 'More follow-up'
2. 'Ongoing involvement to see if things improve in the services over the years due to QINMAC process'
3. 'Working more to inform commissioners'
4. 'Resources such as pathways, risk assessment tools, assessment tools etc available for downloading'
5. 'Suggest user/carer could be involved in the afternoon'
6. 'Instead of choosing 2 areas to focus on, teams could list 5 main issues because issues facing a team do not always fit simply in one or two areas'

### Action taken by QINMAC in response to feedback:

1. QINMAC is introducing follow-up phonecalls in 2009 to support teams with action-planning and implementation
2. We have conducted a QINMAC Impact Study to identify how QINMAC helps members to improve, and the factors which facilitate and hinder this process. Findings will be published later in 2009
3. QINMAC has developed an Information Sheet for Commissioners which is available from our webpage. We plan to develop further guidance for commissioners on how to use the data from QINMAC reports
4. The QINMAC Online Resource Library was launched in November 2008. The library contains nearly 100 resource documents for members to download, including care pathways, information leaflets, referral criteria and more
5. Parent/young people's interviews have been added to the programme for peer reviews in 2009
6. We are exploring the possibility of introducing 'Developmental Reviews' to allow teams to focus on the key challenges particular to their service

## Appendix C – List of QINMAC-LD Members in 2008

In total, 65 CAMH teams signed up to QINMAC in 2008. Of these, the following teams took part in QINMAC-LD:

- **Bradford CAMHS LD/CCST/BEST** [Bradford District Care Trust and Bradford Social Services]
- **Butterfly Team LD CAMHS** [Cambridgeshire and Peterborough Mental Health NHS Partnership Trust]
- **Children's Community Learning Disability Team** [Coventry and Warwickshire Partnership NHS Trust]
- **New Forest LD CAMHS** [Hampshire Primary Care Trust]
- **Newham CFCS, Learning Disability and Pervasive Developmental Difficulties Team (LD & PDD)** [East London NHS Foundation Trust]
- **North and North East Hampshire Child and Adolescent Learning Disability Team (CALDT)** [Hampshire Primary Care Trust]
- **North Staffordshire CAMHS - Disability Team** [North Staffordshire Combined Healthcare]
- **Northumberland Child and Adolescent Learning Disability Team (CALDT)** [Northumberland Tyne and Wear NHS Trust]
- **Oak Park LD CAMHS** [Hampshire Primary Care Trust]
- **Portsmouth City Child and Adolescent Learning Disability Service (CALDS)** [Portsmouth City Teaching PCT]
- **Shropshire/Telford & Wrekin CAMHS-LD** [Telford and Wrekin PCT]
- **Winchester Children's Learning Disability Team** [Hampshire Primary Care Trust]
- **Wolverhampton Community Learning Disability Team for Child and Adolescents (CLDT-CA)** [Wolverhampton City PCT]



# APPENDIX D: QINMAC PROJECT TEAM

**Otilie Dugmore**

Programme Manager

**Hannah Thorpe**

Quality Improvement Worker

**Mary Elliott**

Quality Improvement Worker

**Meghan Craig** (until April 2008)

Quality Improvement Worker

**Adrian Worrall**

Head of the College Centre for Quality Improvement



# APPENDIX E: QINMAC-LD ADVISORY GROUP

**Pru Allington-Smith**

Consultant Psychiatrist in Learning Disability, Coventry and Warwickshire Partnership NHS Trust

**Frank Besag (Chair)**

Consultant Neuropsychiatrist, Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust

**Julie Curtis**

Team Co-ordinator, Northumberland, Tyne and Wear NHS Trust

**Jill Davies**

CAMHS Lead, Foundation for People with Learning Disabilities

**Ian Gale**

Consultant Child Psychologist, Northumberland, Tyne and Wear NHS Trust

**Chris Jewesbury**

Head of CAMHS Commissioning, Bradford Children and Young People's Services

**Ann Jones**

Regional Development Worker, Care Services Improvement Partnership (CSIP)

**Paul Lelliott**

Director, Royal College of Psychiatrists' Research and Training Unit

***New Advisory Group members for 2009***

**Stella Russell**

Parent Representative, Newham Carers Network

**Jane Williams**

Consultant Paediatrician, Nottingham University Hospitals NHS Trust







**Quality Improvement Network for Multi-Agency CAMHS (QINMAC)**

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