NHS
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Delivering inpatient children and young people's mental health care; a multidisciplinary competence framework

Supporting document

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A letter to inpatient staff

Dear inpatient staff,

Thank you for choosing to do this work, we know it must be a tough job at times, but we want you to know how much your care really matters to us. We are writing this letter to you as a collective voice of families who have been through inpatient care. We all have different experiences, so a group of us came together and we shared ideas about what really helped during an inpatient stay. We hope that by knowing what really matters to us, it will help you in your role.

Getting to know us: Please take the time to get to know us as people. Spend time with us (children and young people and their families), find out what our interests are and how we can continue to do these things during our inpatient stay. Find out about what has worked for us in the past, what worries us, help us focus on the positives and allow us to have things in place that bring us comfort and support.

Getting to know you: It really helps us build relationships and trust when the same staff members are on the ward. Please have regular staff who are consistent with their approaches and share the same messages, this helps us feel safe and feel confident in our care.

Listen: Please listen to us. We want to be involved, and we have a lot of information and experience to help make decisions about our care. As children and young people and their families going through a difficult time, it really helps when we are listened to and the things we say are used to inform support.

Information and helping us understand: When you give us information about the difficulties we are experiencing and help us understand what is happening, it really helps. Explain care and treatment options and why you are putting things in place and be patient if we are having difficulty engaging. Leaflets, websites, information sessions and talking through makes a difference.

Family support and involvement: Family involvement is crucial. Please make a commitment to supporting and incorporating us into plans. Provide opportunities and activities (for example, board games) to help us connect with our children at this difficult time. Provide information about support groups, and be honest with what we need to do and even change in order to help.

Communication: Honest and open communication is so important. Ask us what our preferred communication is and work together with all services who are involved with our family, to stop us needing to repeat things over again. Please use language we understand – lots of jargon can be confusing, and sometimes we are scared to ask what you mean.

Sense of purpose: Getting a sense of purpose back in our life is so important. Help us engage with things that will spark conversations, connections and a sense of achievement, for example art, crafts, music, growing plants or spending time in outdoor space. Give us roles or responsibilities on the ward, or include us in planning an event or activity.

Planned discharge: Leaving the unit is scary for young people and families. A good well-planned discharge that involves us will make a huge difference. Help us understand what help and support will continue to be available.

Little things matter: We cannot emphasise enough how important this point is. The staff who do the little things that really matter to families make such a difference. Those kind gestures, really trying to understand someone's needs from their perspective, patience, warmth, empathy and compassion really help. Things like allowing us to have experiences other young people would have, such as takeaway Friday, or even just playing a game with us.

When we all looked back on our inpatient experiences, we realised it was one of the hardest times of our lives. Many of us are now living a meaningful life again, with a sense of purpose which we didn't think was possible. We are really grateful to the kind and compassionate staff, like you, who helped us get here. Thank you for helping families and making a difference.

Children, young people and families focus group

March 2021

Details of feedback from the group can be found in Appendix 2.

Executive summary

The competence framework for inpatient care for children/young people (referred to as 'the Framework') describes a method for identifying competences for staff delivering inpatient care for children/young people. It organises competences into 11 domains, which are represented in a two-part 'map'.

The first domain has competences that should be applied when enacting all other competences, because it describes the '**Attitudes, values and style of interaction embodied by practitioners and the whole team**'.

What is described in that and the next three domains underpins all of the content that follows for practitioners:

- the areas of '**Knowledge**' required of a practitioner
- the '**Professional and legal issues**' that need to be held in mind
- '**Engagement and communication**' skills.

Based on these three areas, the next four domains are grouped together because they all contribute to team building, or building a therapeutic milieu. They draw attention to the importance of a functional team, and a containing and supportive inpatient environment.

These next four domains represent the competences needed to achieve this:

- '**Team working**' – for building an effective team
- '**Working in partnership**' – for achieving a partnership with children/young people and their families/carers
- '**Assessment and formulation**' – a critical area, focused on developing a clear understanding of the child/young person's difficulties
- '**Structured care**' – a range of interventions that a unit could offer, all based on psychological principles, and all contributing to active care in the context of an inpatient unit.

The final domain for practitioners is '**Meta-competences**', which are higher-order competences that involve judgement, decision-making or self-reflection, and which guide the work of all practitioners, at all levels of the system.

The first part of the Framework map also includes '**Organisational competences**', which describe what an organisation needs to do to support the work of its children/young people's inpatient teams.

Building on all of the knowledge and skills set out in the first part, the second part represents competences that rest on a more **specialist training**.

This document then describes how the competences are organised into the map, showing how they fit together and inter-relate. Finally, it addresses issues that are relevant to the implementation of the Framework and considers some of the organisational issues around its application.

How to use this document

This document describes the model underpinning the Framework, and indicates the various areas of activity that, taken together, represent good clinical practice. It describes how the Framework was developed and how it may be used.

The document does not include the detailed descriptions of the competences associated with each of these activities. These are available to download as PDF files from the website of the Centre for Outcomes Research and Effectiveness (CORE) at University College London (UCL) (www.ucl.ac.uk/CORE/competence-frameworks).

Scope of the Framework

The Framework is relevant to all practitioners offering inpatient care to children/young people with mental health problems as part of a multidisciplinary team. While its primary focus is on clinical work, it is not an exhaustive list of all the activities undertaken by clinicians.

Supervision clearly plays a critical role in supporting the development of competences, and the ability to make use of supervision is included in the Framework. Competences associated with the delivery of supervision are detailed in a separate framework, also available at the UCL website.

The context

Criteria for admission to an inpatient CAMHS unit

For some children/young people, an inpatient admission to a child and adolescent mental health service (CAMHS) unit is both appropriate and of benefit. It could give them a break from difficult home or social care circumstances, in a safe environment with an intensity and variety of treatment that they would not be able to receive in the community. Furthermore, an admission allows for an intensive and comprehensive multidisciplinary assessment. But an admission is not suitable for every child/young person who has been referred, and an important task of the admissions team is to screen and assess referrals. It is generally accepted that the criteria for an admission fall into three broad categories:

- When there are high levels of risk to the child/young person, secondary to suicidal thoughts or behaviours, self-neglect or disordered thinking, beyond the capacity of the family and community-based services to manage, and where an admission is expected to reduce this risk.
- When the intensity of treatment needed is not available from community services. This is often the case when a condition is associated with other psychosocial difficulties, and/or coexisting disorders resulting in difficulties pervading all aspects of the child/young person's life.
- When intensive assessment is indicated. An inpatient unit can offer assessment and supervision 24 hours a day by a multidisciplinary team, to gather information to guide formulation and further management. This may involve observing the child/young person's behaviour and their interaction with others, observing the effects of a specific intervention, such as the use of medication, or allowing time for a range of investigations to be carried out, such as cognitive assessments, occupational therapist assessments, speech and language assessments or physical investigations. However, it is important to note that an inpatient assessment should not be considered an alternative to a thorough community-based assessment.

To ensure these criteria are met, a focused assessment needs to be carried out to establish:

- whether admission will address the identified problems
- that there are clear and measurable aims and objectives
- that there are no suitable or preferable alternatives
- that admission is likely to cause more good than harm.

Range of inpatient CAMHS

Most inpatient services are general adolescent units, but there are other specialist inpatient units commissioned in England including:

- children's units, for up to age 13
- psychiatric intensive care units, designed to support children/young people in the short term with behaviour that challenges beyond the capacity of a general unit
- low and medium secure units, which offer a higher level of security for children/young people who present at a very high risk to themselves and/or others
- eating disorder units, designed to only take children/young people with severe eating disorders
- those based within learning disability services.

There is also one inpatient unit for children/young people with hearing impairments.

While these specialist services will have specific criteria for admission, the criteria outlined in the previous section will generally still apply.

Balancing the benefits and risks of an admission

For the right child, an admission can be an important step towards recovery, but one reason for caution is that admission has the potential for harm. Recognising this does not invalidate the benefits of inpatient treatment; rather, it places a focus on the need to ensure that the child/young person receives the treatment that is right for them. By being alert to how an admission can cause harm, staff can mitigate any adverse impacts.

Practitioner's attitudes and values and style of interaction

Attitudes and values when working with children/young people and their families/carers are important because they will strongly influence a practitioner's style of interaction. Helpful attitudes include:

- working from a human rights perspective
- a commitment to understanding children/young people's difficulties and behaviour in relation to their life experiences
- a commitment to developing a 'shared language' and understanding that captures the way children/young people and their carers view themselves.

Respect for the diversity of each person is a primary value, and linked to this is a capacity to recognise how the practitioner's own values influence their interactions with others. A style of interaction that attends to professional boundaries but is open, responsive and receptive should flow from these positions.

Maintaining a therapeutic milieu

An important way of mitigating the potential risks associated with an admission is to try to maintain the inpatient unit as a therapeutic milieu. This is a planned treatment environment in which everyday events and interactions are remedial, and where individual dynamics and the social system are integrated in a meaningful way to manage and change behaviour and relationships. This is a setting which makes a positive contribution to improving wellbeing and functioning – for example, by making the ward a social community with a clear structure and routines, with staff consistently available to children/young people and behaving consistently with each other. This creates a safe space for children/young people to practise new ways of coping through their interactions with others. An atmosphere of mutual respect is created in which responsibilities for many day-to-day decisions can be shared.

Maintaining a coherent sense of the purpose of an admission

In addition to effective team working and a clear organisational structure, the team need to have a coherent sense of the culture, philosophy and purpose of the inpatient unit and the admission itself. Team members need to work closely with the child/young person and their family/carers to ensure that there is a clear and consistent view about the goals of the admission and the possible implications of a child/young person spending time away from home, and away from friends, family and community.

For many children/young people, the unit needs to become a secure base to enable a therapeutic process; however, for some people the unit can become viewed as an alternative to home, which can have significant implications. For example, children/young people may find the containment and predictability of the unit reassuring, and going on leave and working towards discharge may be so anxiety provoking that they prompt behaviours that could be taken to indicate that a longer admission is required, an action that would almost certainly not be in the interest of the child/young person. A capacity to hold in mind the purpose of admission helps guard against what could be seen as the iatrogenic consequences of this sort of 'therapeutic drift' (whereby matters are made worse by the professional intervention).

Importance of generic versus specific therapeutic interventions

There is no doubt that specific interventions (such as psychological therapies) have an important role on a ward, but it is also the case that 'generic' therapeutic activities and relationships on a ward underpin (and create the context for) these treatments. Staff need to be able to form positive, trusting relationships with patients, maintaining professional boundaries but also being 'real', engaging in general conversations and responsive to each person. Without this bedrock, specific interventions are likely to be less effective.

Maintaining effective team working

Effective team working makes for an effective therapeutic culture, but achieving this requires the team to have a clear and supportive organisational structure that helps staff to focus on the children/young people in the unit (as opposed to becoming preoccupied with itself). This means team members working together to a common purpose, communicating clearly with each other, feeling valued in their roles and functions, behaving consistently with each other, having respect for the work of their colleagues and adhering to professional boundaries. They also need to be alert to indications that the team is functioning less than optimally, achieved by maintaining a reflective stance that allows individual team members to voice concerns, and guarding against the development of an unhealthy group culture. Finally, there needs to be a culture that encourages autonomy in decision-making and an openness to innovation.

Membership of the inpatient team

The foregoing assumes that the definition of a team is all the people who are engaged in inputting to the work of the unit, regardless of professional title or status. In some settings a more restrictive definition can emerge, with some staff groups forming a separate team. There may be good reasons for this – for example, recognising professional groupings and their particular training needs and affiliations. But these need to sit alongside (rather than substitute for) meetings that bring together – and so coordinate – the full multidisciplinary practitioner team.

Importance of supervision and reflective practice

A predictable feature of an inpatient ward is that its dynamics will be complex and often stressful, for both the children or young people and the staff. There is a risk that staff can be drawn in to these dynamics and react unhelpfully – for example, responding negatively to a child/young person who expresses their need for care in ways that assumes (and so invites) rejection, which would make the ward an invalidating and potentially harmful environment.

To counter these unhelpful reactions, all staff need time to engage in reflective practice, not only individually (for example, through supervision) but also as a team. Ensuring that time is set aside for this to happen is challenging in the context of a busy ward, but is necessary if staff are to maintain a positive therapeutic milieu.

Working with parents and carers

Extending support to parents and carers should be a standard feature of an inpatient stay, and unless there are clear contraindications, they need to be informed about, and engaged with, the care plan for the child/young person. In many instance, parents and carers can be a valuable resource and support for the work, and their contribution – especially on discharge back to the family – can be critical. This makes their involvement an important feature of care planning.

It is also the case that many parents and carers would benefit from support, often having been exposed to considerable stress as they try to find ways to understand and manage the child or young person's difficulties.

Organisational support

Because working in an inpatient unit is potentially stressful and demanding, good practice can be harder to maintain without organisational support. Staff at all levels of seniority need access to training and supervision, and a work schedule that permits and encourages this. They also need to be supported if serious incidents occur, so that the inquiries that follows such incidents are used as a prompt for learning and improvement rather than for blame.

Organisations and staff need to be supported to train in the appropriate use of debriefs for children and young people and staff following an incident on the unit. The organisation also needs to support the use of audit and service evaluation as a form of quality monitoring, helping staff to identify the strengths of their work (where they make a positive impact) and where changes to practice may be helpful.

The development of the Framework

Oversight and peer review

The work described in this project was overseen by an expert reference group (ERG), comprising experts in delivering inpatient care to children and young people with mental health problems. This included clinicians, researchers and experts by experience, all selected for their expertise in research, training and service delivery.

Adopting an evidence-based approach to framework development[1]

A guiding principle for the development of previous frameworks (Roth and Pilling, 2008) has been a commitment to staying close to the evidence base for the efficacy of therapies, focusing on the competences for which there is either good research evidence or strong expert professional consensus about their probable efficacy.

Extracting competence descriptions

The procedure for extracting competences starts with the identification of manuals associated with trials of effective interventions along with training materials, relevant competence frameworks and published descriptions of professional practice. The process for extracting and collated competences is described in Roth and Pilling (2008). Draft competence lists were discussed by members of the ERG and were subject to iterative peer review by members of the ERG and external experts.

[1] An alternative strategy for identifying competences could be to examine what workers in routine practice do when they carry out a psychological intervention, complementing the observation with a commentary from the workers to identify their intentions as well as their actions. However, the strength of this method – that it is based on what people do when putting their competences into action – is also its weakness. Most psychological interventions are rooted in a theoretical framework that attempts to explain human distress, and this framework usually links to a specific set of actions aimed at alleviating the person's difficulties. It is these more 'rigorous' versions of an intervention that are examined in a research context, forming the basis of any observations about the efficacy of an approach or intervention. In routine practice, these 'pure' forms of an intervention are often modified as workers exercise their judgment in relation to their sense of the person's need. Sometimes this is for good, sometimes for ill, but presumably always in ways that do not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it makes it risky to base conclusions about competence on the work done by practitioners, because this could pick up good, bad and idiosyncratic practice.

The competence model for delivering mental health inpatient care to children and young people

Integrating knowledge, skills and attitudes

A competent team member brings together knowledge, skills and attitudes. It is this combination that defines competence; without the ability to integrate these areas, practice is likely to be poor.

Practitioners need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps them understand the rationale for applying their skills, to think not just about how to implement them skills but also why they are implementing them. Beyond knowledge and skills, their attitude to and stance on an intervention is also critical – not just their attitude to the relationship with the child/young person but also to the inpatient team, and the many cultural contexts in which this is located (including a professional and ethical, as well as societal, context). All of these need to be held in mind because all have a bearing on the capacity to deliver interventions that are ethical, conform to professional standards, and that are appropriately adapted to the child/young person's needs and cultural contexts.

How the competence lists are organised

Competence lists need to be of practical use. To achieve this, they need to be structured in a way that reflects the practice they describe and is both understandable and valid (that is, recognisable to practitioners as something that accurately represents the approach, both as a theoretical model and in its clinical application).

The Framework has been arranged into a two-part map, to create an accessible visual representation of its domains and sub-domains. The first part sets out competences that are associated with every member of a team; the second part identifies competences for which more specialist training is needed. Importantly, all the skills listed in the second part rest and build on the competences from the first part – they are an extension of the map, rather than a separate section.

Both parts of the map are headed by an overarching area of competence which should permeate every area of practice: the '**Attitudes, values and style of interaction embodied by practitioners and the whole team**'. These represent a set of foundation competences shared by all members of the children/young people's inpatient team, and set the scene for all that follows.

Part 1 of the Framework map

The first part of the Framework map is organised into ten domains; taken together, they demonstrate the attitudes, knowledge and skills required of members of the children/young people's inpatient team.

First, there are competences for the 'attitudes, values and styles of interaction' to be embodied by everyone working with children/young people.

The next three domains (2–4) represent a basic underpinning to all that follows:

- the areas of **knowledge** required of a practitioner

- the **professional and legal issues** that need to be held in mind

- **engagement and communication skills.**

The next four domains (5–8) describe the competences needed to build an effective therapeutic milieu – a collaborative environment that facilitates support and care. They draw attention to the importance of a functional team and a containing, supportive inpatient environment. They represent the competences needed to achieve this, though it is important to be clear that different members of the team will use these skills differently. For example, while assessment and formulation skills or leadership are associated with greater levels of training and seniority, more junior members of the team many contribute to these processes if this is appropriately supported and boundaried.

'Team working' and 'Working in partnership' are complementary because, taken together, they describe how a unit operates day-to-day.

- '**Team working**' to build an effective team

- '**Working in partnership**' with children/young people and their families/carers

- **'Assessment and formulation'** – this is a critical area, focused on developing a clear understanding of the child/young person's difficulties, working with them to identify the goals of an admission, and identifying how this will be monitored and reviewed (and revised in the light of experience).

- **'Structured care'** – listed in this domain are a range of interventions that a unit could offer, all based on psychological principles, and all contributing to active care in the context of an inpatient unit.

- The final domain for practitioners is '**Meta-competences' (9)**, the higher-order competences that involve judgement, decision-making or self-reflection, and which guide the work of all practitioners at all levels of the system

- '**Organisational competences**' **(10)** complete the domains on the first part of the map, and describe what an organisation needs to do to support the work of its children/young people's inpatient teams.

1. Attitudes, values and style of interaction embodied by practitioners and the whole team

- Commitment to CYP human rights
- Relational skills and use of self
- Working with the whole person
- Maintaining compassionate understanding

2. Knowledge

- 2.1. Knowledge and understanding of mental health problems in CYP and adults
- 2.2. Knowledge of development in CYP, and of family development and transition
- 2.3. Knowledge of attachment and mentalisation
- 2.4. Knowledge of autism spectrum disorders
- 2.5. Knowledge of learning disability
- 2.6. Knowledge of looked-after CYP
- 2.7. Knowledge of the principles of trauma-informed care
- 2.8. Knowledge of human rights law and principles in CYP
- 2.9. Knowledge of physical health issues in CYP
- 2.10. Knowledge of psychopharmacology in work with CYP
- 2.11. Knowledge of potential risks associated with inpatient admission

3. Professional and legal issues

- 3.1. Knowledge of legal frameworks relating to working with CYP
- 3.2. Knowledge of, and ability to operate within, professional and ethical guidelines
- 3.3. Knowledge of, and ability to work with, issues of confidentiality and consent
- 3.4. Ability to work with difference
- 3.5. Ability to recognise and respond to concerns about child protection
- 3.6. Ability to recognise and respond to concerns about safeguarding
- 3.7. Ability to make use of supervision

4. Engagement and communication

- 4.1. Communication skills
- 4.2. Ability to communicate with CYP of differing ages, developmental level and background
- 4.3. Ability to foster and maintain a good therapeutic relationship
- 4.4. Ability to understand and respond appropriately to high levels of distress
- 4.5. Communicating with CYP with cognitive and/or neurodevelopmental challenges

5. Team working

- 5.1. Ability to contribute to team working
- 5.2. Ability to maintain a therapeutic social environment (therapeutic milieu)
- 5.3. Ability to coordinate with other agencies and/or people
- 5.4. Ability to manage endings
- 5.5. Managing transitions in care within and across services
- 5.6. Leadership

5.1. and 5.2. are closely linked

6. Working in partnership

- 6.1. Working in partnership with parents/carers and families
- 6.2. Shared decision-making
- 6.3. Co-production
- 6.4. Peer support

7. Assessment and treatment planning

- 7.1. Ability to undertake a comprehensive (biopsychosocial) assessment
- 7.2. Collaborative assessment of risk and need (suicide and self-harm)
- 7.3. Undertaking structured behavioural observations
- 7.4. Assessing the CYPs functioning within multiple systems
- 7.5. Ability to conduct a Mental State Examination
- 7.6. Ability to formulate
- 7.7. Communicating outcomes from assessment and formulation
- 7.8. Selecting and using measures and diaries
- 7.9. Fostering participation of the CYP and parents/carers in the admission/intervention plans
- 7.10. Observation of CYP at risk of self-harming

8. Structured care

- 8.1. Psychoeducation
- 8.2. Problem solving
- 8.3. Articulating feelings and managing emotions
- 8.4. Staying well (relapse prevention)
- 8.5. Group-based interventions
- 8.6. Promoting valued activities
- 8.7. Managing interpersonal relationships
- 8.8. Motivational strategies

Domains 5 to 8 contribute to building a therapeutic milieu *(a collaborative environment that facilitates support and care)*

9. Meta-competences

- Meta-competences for CYP inpatient work

***CYP** = children and young people*

10. Organisational competences to support the work of the team

- 10.1. Supervision and training for practitioners
- 10.2. Learning from serious incidents at an organisational level
- 10.3. Support for staff after a serious incident
- 10.4. Audit and quality monitoring

Part 2 of the Framework map

Building on all the areas of knowledge and skills set out in the first part of the Framework map, the second part shows an eleventh domain. For practitioners to implement these competences, they will need further '**Specialist training**'. This domain is organised into three groups, with seven sub-domains.

The first group is 'Working with complexity'. Children/young people admitted to an inpatient unit can have a wide range of difficulties, so it is critical to identify the set of interventions most likely to achieve benefit, and that are right for the child/young person and their circumstances.

The skills required for this are set out in the sub-domain 'Working with complex needs in a CAMHS inpatient setting'. Making decisions about the best way forward relies on an interpretation of evidence of efficacy, and for this reason 'Knowledge of evidence-based interventions for specific conditions and relevant competence frameworks' is an important part of this process.

The next group ('Managing specific challenges in the context of an inpatient setting') identifies three sub-domains of specialist skill:

- behavioural interventions for challenging behaviour
- positive behaviour support
- managing adverse peer influence (contagion).

The final group identifies 'Specialist assessments', carried out by members of the team based on their specialist knowledge or professional expertise, and which contribute to the general process of assessment. It has sub-domains of competences for 'Structured cognitive, functional and neurodevelopmental assessments' and specific 'Specialist assessments'.

Part 2 of the Framework map

Note: The competences on this page take place in the context of the attitudes, knowledge and skills set out in Part 1 of the map, but rely on specialist training for their effective delivery

11. Competences requiring specialist training

Working with complexity	*Managing specific challenges in the context of an inpatient setting*	*Specialist assessments*
11.1. Working with complex needs in a CAMHS inpatient context	11.3. Behavioural interventions for challenging behaviour	11.6. Structured cognitive, functional and neurodevelopmental assessments
11.2. Knowledge of evidence-based interventions for specific conditions and relevant competence frameworks	11.4. Positive behaviour support	11.7. Specific specialist assessments
	11.5. Managing adverse peer influence (contagion)	

Layout of the competence lists

Specific competences are set out in boxes.

Most competence statements start with the phrase, 'An ability to…', indicating that the focus is on the clinician being able to carry out an action.

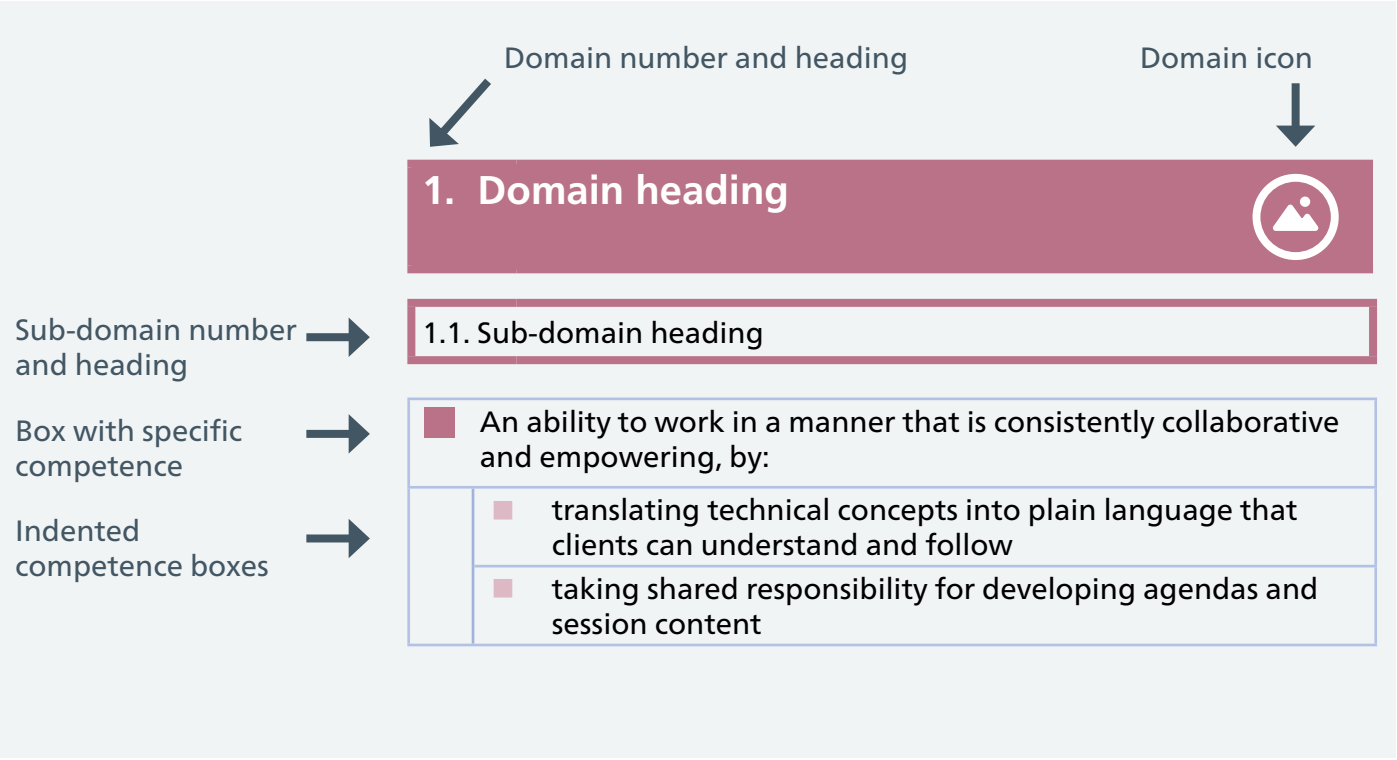
Some competences are concerned with the knowledge that a practitioner needs so that they can carry out an action. In these cases, the wording is usually, 'An ability to draw on knowledge…'. The sense is that clinicians should be able to draw on knowledge, rather than having knowledge for its own sake (hence, the competence lies in the application and use of knowledge in the furtherance of an intervention).

As far as possible, the competence descriptions are behaviourally specific – in other words, they are there to identify what the clinician needs to do to execute the competence.

Some of the boxes are indented, when a high-level skill is introduced and needs to be 'unpacked'. In the example below, the high-level skill is the notion of being 'collaborative and empowering'; the indented boxes that follow are concrete examples of what the clinician needs to do to achieve this.

The competences in indented boxes will make most sense if the practitioner or clinician holds in mind the higher-level skill that precedes them. So, with the above example, although it is always sensible to use plain language, there is a conceptual reason for doing so: it will impact on (and, therefore, contribute to) the patient's sense of collaboration in and engagement with the therapy process. It should be borne in mind that the conceptual idea behind an action should give the clinician a 'road map', and reduce the likelihood that they apply techniques by rote.

Example of competence layout



Applications of the Framework

There are a number of areas in which the Framework can be applied. Some of these are outlined below.

Curricula

The Framework can be used for the development of curricula for people entering professional practice from many different backgrounds, ensuring that professionals will be well versed in the competences required to contribute confidently to team work in an inpatient unit, and to support children/young people and their families/carers.

Commissioning services

The Framework can contribute to the effective use of healthcare resources, by enabling commissioners to specify the appropriate levels and range of competences that need to be demonstrated by workers to meet identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services, by setting out a framework for competences that is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and delivery of services

The Framework represents a set of competences that (wherever possible) are evidence-based, and it aims to describe best practice for the activities that individuals and teams should follow to deliver interventions.

Although further work is required on their utility and on associated methods of measurement, the competences should enable:

- the identification of the key competences required by a practitioner
- the likely training, supervision and leadership competences of people managing and delivering the service.

Because the Framework converts general descriptions of clinical practice into a set of concrete specifications, it can link advice regarding the implementation of services with the interventions that are delivered. Such advice is set out in National Institute for Health and Care Excellence (NICE) or Scottish Intercollegiate Guidelines Network (SIGN) guidance, or National Service Frameworks (NSFs), along with other national and local policy documents. Further, this level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to those of research trials on which claims for the efficacy of specific interventions rest. In this way, it could help to ensure that evidence-based interventions are provided in a competent and effective manner.

Clinical governance

Effective monitoring of the quality of services provided is essential if service users are to be assured of optimum benefit. Monitoring the quality and outcomes of interventions is a key clinical governance activity; the Framework allows providers to ensure that services are provided at the level of competence that is most likely to bring real benefit by allowing for a more objective assessment of clinician's performance.

Supervision

A reasonable expectation is that staff delivering inpatient care to children/young people are supervised by individuals with appropriate training in, and experience of, the same. Used in conjunction with the competence framework for supervision, the Framework is a useful tool to improve the quality of supervision of staff. It does this by focusing the task of supervision on a set of competences that are known to be associated with the delivery of effective treatments. Supervision commonly has two aims – to improve outcomes for clients and to improve the performance of practitioners; the Framework will support both these through:

- providing a structure by which to identify the key components of effective practice
- allowing for the identification and remediation of suboptimal performance.

The Framework can achieve this through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

[1] Elkin (1999) highlighted the fact that when evidence-based therapies are 'transported' into routine settings, there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (2010) examined 27 major research studies of cognitive behavioural therapy for depressed or anxious adults, identifying the training and ongoing supervision associated with each trial. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy – a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems that help to ensure the delivery of competent and effective practice. This means that claims of implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Concluding comments

This document describes a model that identifies the activities that characterise effective delivery of inpatient services for children/young people and locates them in a 'map' of competences.

The work has been guided by two overarching principles. First, the Framework stays close to the evidence-base and to expert professional judgement, meaning that interventions carried out in line with the competences described in the model should be close to best practice, and therefore likely to result in better outcomes for service users. Second, it aims to have utility for those who use it, clustering competences to reflect how interventions are delivered, and hence it facilitates their use in routine practice.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony. Delivering effective interventions involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Clinicians and practitioners need to operate using clinical judgement in combination with their technical and professional skills, interweaving technique with a consistent regard for the relationship between themselves and service users.

Setting out competences in a way that clarifies the activities associated with a skilled and effective practitioner should prove useful for clinicians training in and delivering inpatient services. The more stringent test is whether it results in more effective interventions, and better outcomes for children/young people and their families and carers.

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Appendix 1: Developers

Members of the ERG

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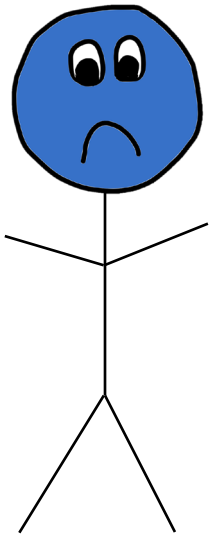
CAMHS Clinical Reference Group

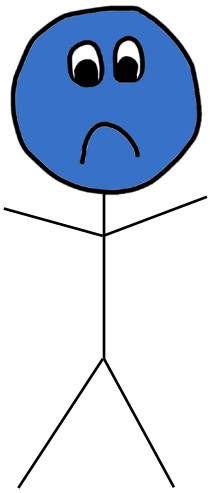
Appendix 2: Feedback from the Focus Group

Focus Group Feedback

- Designed and delivered by six Experts by Experience, with support from members of the Expert Reference Group
- Attended by 27 young people and parents/carers
- After sharing information about the project, discussion focused on the experience of young people and parents/carers:
    - What hasn't helped?
    - What has helped?
    - What would ideal inpatient care look like?

What didn't help?	Negative comments	Medication/ restraint	'Punishment'
	"You would've done it if you really wanted to" "There's other people worse than you, your feelings are nothing (has stuck with me for years)" "You did it, why should we patch it up" "Really bad at trying to kill herself"	"If I was struggling, they'd inject me straightaway" "Staff threatening to use or incorrect use of restraints" "Staff not properly trained in using restraints and restraining techniques/ overuse of restraints" 	"Getting locked out of my room, took my coping things like colouring etc. Felt like a punishment. All I was allowed was a mattress, pillow and a hospital blanket" "They locked my blanket and teddy away" "Every time they asked for games they get told no, it's a hospital not a holiday camp"

What didn't help?



Plans and communication

"Had support and plan, but then the plan was not adhered to"

"Plans not being personalised"

"Patients/parents not informed about their rights"

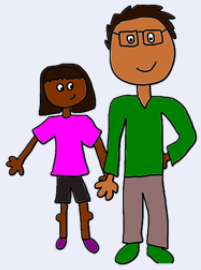
"Lack of communication to parents re: Care ProAs/leave etc."

Eating disorders

"Mock anorexia, being called ridiculous and/or stupid"

"'You're not really underweight yet, so it's nothing to worry about yet'"

"Eating disorders were ignored. 'We're not trained in eating disorders'"



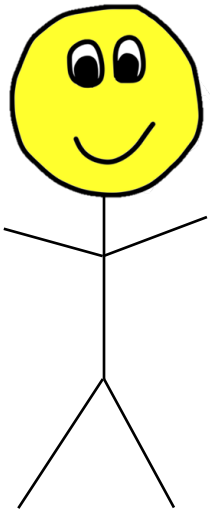
Family involvement

"Not aware of parents' feelings/ not including parents in discussion, causes distress"

"Two main concerns I brought up on my daughters first ever admission were put aside, yet those two things are what were diagnosed and treated. This was three admissions later"

"'I hear your concerns, but what I'm hearing is that you don't want your daughter home this weekend?'"

What did help?



Understanding and explaining

"The person in charge of education regularly updated me on how she was doing"

"The family support worker properly explained psychosis with me and signposted me to great resources"

"The formulation meeting after five days that included parents and explained what would happen and when. 'We are here for you [parents], too'"

"Staff willing to work with parents to develop plans, share possible risks, etc. "

Family involvement

"Things to do in family rooms, e.g. games"

"Parents allowed to come onto ward – hard for parents when you can't even see where your child is sleeping"

"Families allowed to bring own pets during visits"

"We're here for family and patient"

"Parent/carer support groups"

Extra mile

"Allow to have experiences other young people would have, e.g. takeaway Friday"

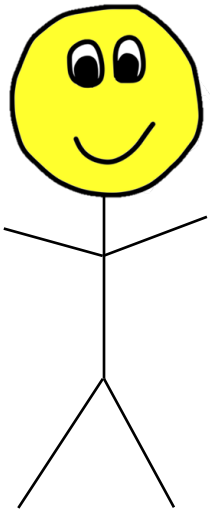
"Nice environment, e.g. outside area, pool table, jukebox"

"Welcome pack and sensory boxes"

"[In] Hospital around Christmas day once, and they let my mum stay all day. Staff did make more of an effort that day"

"'We'll look after him' – compassion and humanity"

What did help?



Getting to know CYP

"Have a laugh/play cards with you"

"Treat you as a person"

"Walks/time away from unit"

"Talking to young people about their interests and getting to know them"

"Listening to individual interest – drawing/ painting, playing an instrument"

"Spending time with us"

Support

"In one hospital, told [I was] getting moved three hours away the next day and wouldn't be allowed phone. They got family to visit and stay over visiting time before the move next day. A [staff] member sat with me until I fell asleep that night"

"I got this worker and I still remember her now, and it was just her going out getting a puzzle book and doing it with me, meant so much at the time. She said I didn't have to talk or anything. I didn't feel pressured to open up"

Little things matter

"Staff member and CYP had the same advent calendar, so they'd swap with the CYP if it was something she didn't like"

"Small things are really important. One staff member brought a laptop to put music on my phone"

"Also, they bought stamps so I could write to my family"

"Being included in planning an event, activity, etc."

Dream inpatient care…

What are the skills and knowledge needed for your dream team or staff member?

A compassionate team who treat the CYP as an individual as well as part of a wider family unit and community

Speaking normally, not jargon

Honesty and communication between education, health and social care services to be working together. All to understand roles and responsibilities

Planned discharge

Consistency with staffing

Warmth

Patience

Give the kids positives, my daughter did Duke of Edinburgh's Bronze Award … sense of achievement

My dream team would be where my son steers his care with the right support at the right time

Listen

Actively listen to young people and their families, and a commitment to supporting and incorporating into plans

More occupational therapists

Good mix of therapy, but positive therapies…. Art, crafts, music, plants and outdoor space

Dream team staff member should love the job they are doing and be compassionate about what they do

Knowledge of autism and learning disabilities

Family inclusion and therapy

Empathy

Compassion

Be fun! Distract – you can have fun

Being listened to, compassionate, see positives not negatives, get to know patient – not just based on notes

Good complaints process – constructive criticism without impact

Thank you to everyone for doing this....it brings a bit of hope

I just want to give a shout-out for staff in units, some of whom are amazing and I marvel at what they need to do in very tough circumstances. There are lots of good people out there and they need to feel appreciated so they do an even better job

Thanks everyone, it's been great and so good to hear there are good things to come

Thank you for letting me take part – it's giving me hope