



**QNCC
2020-2023
Annual Report**

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Foreword

Estelle Wrathall

Parent/Carer Representative for QNCC & Advisory Group Member

When I was asked to contribute a forward for this report, I realised my involvement as a Parent Carer Representative mirrored the timeframe of this report almost exactly.

At the beginning of my role, we were in the thick of the pandemic, so all my reviews took place online. Gradually, as our world has opened again, so have our reviews, and we're able to hold most of our reviews face to face. It strikes me that I began reviewing services at probably their most difficult and challenging time, with high staff sickness and staff under a great deal of stress. Since the pandemic, the challenges have continued, but in different forms: staff recruitment and retention, the high rates of referrals to services, and the complexity of need of our young people. What has amazed me though, is the determination of staff to remain optimistic, to strive for excellence, and to be willing to engage with quality improvement and the review process, despite all the challenges they face. In many ways this report is a testament to and a celebration of community CAMHS' resilience and dedication.

If I had to highlight any areas for improvement, I wouldn't be doing my job if I didn't mention involving and informing young people and their families. There are commonly unmet standards across several standard types with this theme, and a small investment in staff time will bring huge benefits both for staff, and young people and their families. We need to ensure young people and parents/carers are provided with accessible information on their rights, available support, and the community CAMHS service (access/waiting times, etc); and given opportunities to have their voice heard with Peer Support Workers in staff interviews, devising and delivering training and participation groups for QI projects.

The QNCC reports and standards offer powerful commissioning tools. Standards are nationally agreed, aiming at best practice and achieving the best outcomes for young people and their families. The network itself offers staff and their teams the opportunity to share ideas, learn from challenges, and inspire each other. I hope this latest report will help to do all these things.

Carol-Anne Murphy

*QNCC Advisory Group Chair
Nurse Consultant*

As the Chair of the QNCC Advisory Group I have been privileged to be a part of the QNCC team. The Advisory Group has gone from strength to strength with the membership encompassing young people, parents and carers as well as multi-disciplinary professionals from across the UK. All members are passionate about quality and how this is delivered within Child and Adolescent Mental Health Services.

Reflecting on the period of 2020 – 2023, a time where we were caught up in Covid-19 followed by the post Covid-19 years, reminds me of the challenges our young people and their families faced, which then impacted on the teams delivering CAMHS. However, it must be said that the teams have not only risen to the challenges but surpassed some whilst providing high quality care.

Over this period saw more teams become members across, not only, the UK (including the Channel Islands) but also countries such as Dubai. The use of virtual reviews has meant that the long-distance reviews can be done in a time and cost-effective way.

Thank you to all who have contributed to this QNCC report, either by hosting or attending a review, or by being a member of the Advisory Group or the Accreditation Committee, you truly are appreciated.

QNCC Team



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Introduction

Who we are

The Quality Network for Community CAMHS (QNCC) works with community CAMHS services to assure and improve the quality of services treating children and young people with a mental illness. Through a comprehensive system of reviews against specialist standards, we identify and acknowledge high standards of patient care, and support services to achieve this.

QNCC was developed around 2004 following the launch of the Quality Network for Inpatient CAMHS (QNIC) in 2001. The Network is one of around 30 quality networks, accreditation and audit projects organised by the Royal College of Psychiatrists Centre for Quality Improvement (CCQI). QNCC also has international members in the Republic of Ireland and the United Arab Emirates. A full list of member services and their current accreditation status is available to view on our website and page 91 of this report.



What we do

Our purpose is to support and engage services in a process of quality improvement through peer-led reviews against a set of specialist standards for community CAMHS. This process is supportive and promotes sharing of best practice between services.

Involvement in the network is open to all CAMHS services across the UK and abroad and is strongly encouraged as a supportive mechanism for positive change and quality improvement.

The network is governed by an Advisory Group which includes professionals, patients and carers to progress the programme of work. These individuals represent key interests and areas of expertise in the field of community CAMHS, as well as individuals who have experience of using these services or caring for people in services. Similarly, an Accreditation Committee is in place to make key accreditation decisions and uphold the rigour and consistency of the process. Involving service users and carers in QNCC is a priority, and people with first-hand experience of using community CAMHS are encouraged to get involved in all aspects of QNCC's work.

Introduction

Annual Review Cycle



The review process

The review process has 2 phases:

- a) the completion of a self-review questionnaire which is sent out to all member services, and;
- b) an external peer-review which takes place between September and June.
- c) if the service has chosen to seek accreditation, their evidence will be presented at an Accreditation Committee.

Each year, the latest edition of the standards are applied through a process of self-reviews and peer reviews where members visit each other's services. The self-review provides an opportunity for services to rate themselves against each of the QNCC standards.

This is followed by a peer-review visit whereby colleagues from other similar services review their practices using the data provided from the self-review. Before and during the peer review, further data is collected through interviews with partner agencies, young people and parents/carers.

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

Jargon Buster

Self-review

A service will score themselves against the QNCC standards and identify key areas of achievement and improvement

Peer review

A panel of reviewers and a patient/carer representative visits a service and assesses them against the QNCC standards in discussion, interviews and a tour of the premises

Accreditation

These reviews are more thorough than the usual quality improvement reviews in that they require more evidence to validate self-ratings, use more information sources and more methods of data collection.



This report

What to expect in this report:

This edition of the QNCC Annual Report contains the aggregated results of 43 reviews undertaken by services who completed their self-review and peer or accreditation review from 2020 to 2023, against the 6th Edition Standards for QNCC. This report also includes data from the 2nd edition of the Eating Disorder QNCC standards. It is produced to inform staff, senior management, patients and carers, as well as anyone who has an interest in community CAMHS.

The report first presents an overview of the data collection and then examines the contextual data obtained from the self-reviews of the 43 services.

This report then highlights how well member services are performing against the nine sections of the QNCC standards, including some Eating Disorder standards.

Included throughout the report are examples of good practice, derived from service's local reports following their peer or accreditation review, as well as a number of recommendations for standards which were commonly not met by services from 2020 to 2023.

This is followed by a full summary detailing the average scores for each QNCC Standard for all 46 reviews who completed a review from 2020 to 2023.



Purpose

The purpose of the recommendations listed in this report are to support services to review their own areas for improvement and to continuously improve the quality of care that they provide. Average scores for each QNCC Standard are detailed in this report so teams can see how well they are performing against the standards compared with other community CAMHS teams. Teams can also compare their activity, resources and outcomes with the rest of the network.

Therefore, this report aims to highlight areas for improvement, and ultimately improve outcomes for young people who use community CAMHS services.

QNCC Standards

QNCC assess community CAMHS teams in accordance with a set of standards. The 6th Edition QNCC Standards and 2nd Edition Eating Disorder Standards were drawn from a range of authoritative sources and incorporate feedback from patient and carer representatives, as well as experts from relevant professions.

The standards were used to generate a series of data collection tools for use in the self- and peer-review processes. Participating teams rated themselves against the standards during their self-review.

This model aims to facilitate incremental improvements in service quality.

Standard Types

QNCC Standards are divided into three types:

- Type 1 Standards
- Type 2 Standards
- Type 3 Standards

Each standard type is explained in the Jargon Buster section to the right.

Standards domains

Each set of QNCC Standards are grouped into nine sections:

- 1) Access, Referral and Assessment
- 2) Care and Intervention
- 3) Information, Consent and Confidentiality
- 4) Rights and Safeguarding
- 5) Transfer Of Care
- 6) Multi-Agency Working
- 7) Staffing And Training
- 8) Location, Environment And Facilities
- 9) Commissioning And Service Management

Jargon Buster



Type-1 Standards

Standards that encompass criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment.

Type-2 Standards

Criteria that a service would be expected to meet.

Type-3 Standards

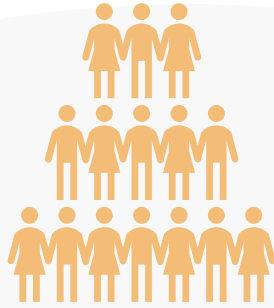
Criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

DATA COLLECTION



67

Member Services
(as of February 2024)



Approximately
50

Young People
took part in
interviews

Approximately

80

Partner
Agencies
shared their
experiences



Approximately

80

Parent/carers took part
in interviews



40

Services had
their self- and
peer-reviews in
2020 to 23



Where did data come from?

The data in this report comes from **44** reviews undertaken from September 2020 to July 2023 where services have completed their self-review, peer-review and accreditation using the 6th QNCC standards and 2nd QNCC ED standards.

In 2020-2021, 22 reviews were undertaken (6 reviewed against the QNCC ED standards).

In 2021-2022 15 reviews were undertaken (5 reviewed against the QNCC ED standards).

In 2022-2023 7 reviews were undertaken (3 reviewed against the QNCC ED standards)

Contextual data was obtained from the QNCC workbook completed by services.

Data showing whether a service was marked as 'Met', 'Not Met', 'Partly Met' or 'N/A' against a given standard was taken from the decisions included in the draft report that is written following each service's peer-review visit.

Decisions as to whether a service had met standards were made by the peer-review teams based on evidence obtained from both a service's self-review and subsequent peer or accreditation review visit.

This evidence included:

- Young people interviews
- Parent/Carer interviews
- Policy and documentation checks
- Environmental checklists from tours of the premises
- Facilitated discussions on the review day with members of the SMT, MDT and any other staff members present.

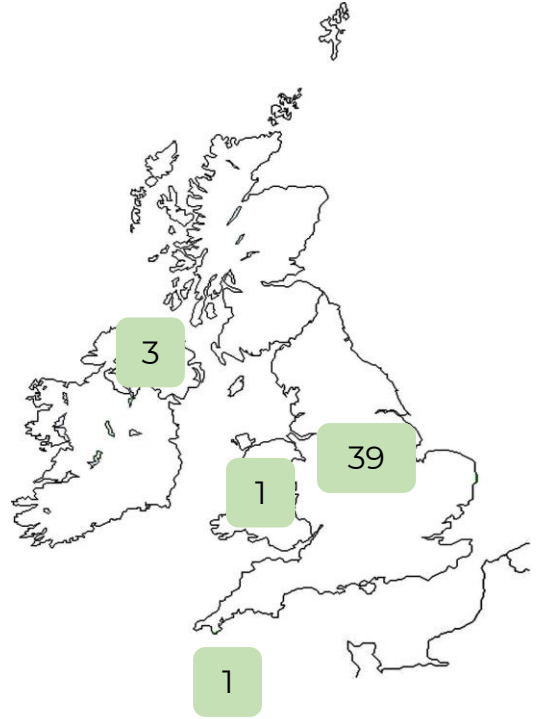
Contextual Data

Location

Of the 44 reviews of services that took part in a self-review and peer-review in 2020 to 2023:

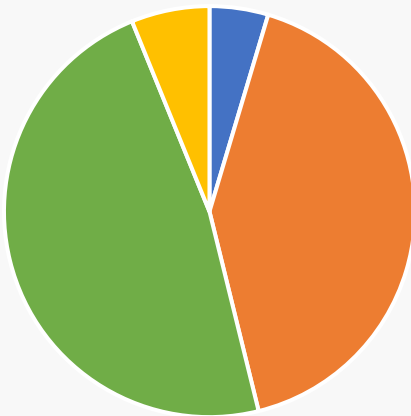
- 39 were based in England
- 3 in Northern Ireland
- 1 in Wales
- 1 in Guernsey

To compare to the current 67 QNCC members (as of February 2024): 58 QNCC members are based in England, 2 in Wales, 3 in Northern Ireland, 1 in Republic of Ireland, 1 in Guernsey, 1 in Jersey and 1 in the United Arab Emirates.



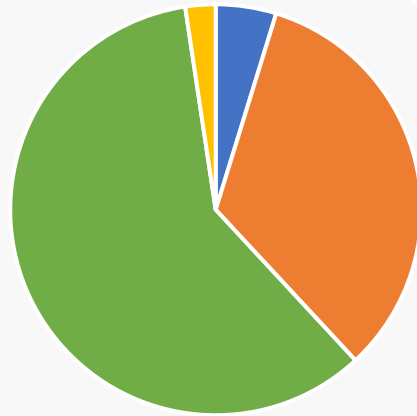
Service Type

All QNCC Members:



- Crisis & Intensive Treatment Teams
- Eating Disorder Services
- Core CAMHS
- Secondary Mental Health Services

The 40 services focused on in this analysis:



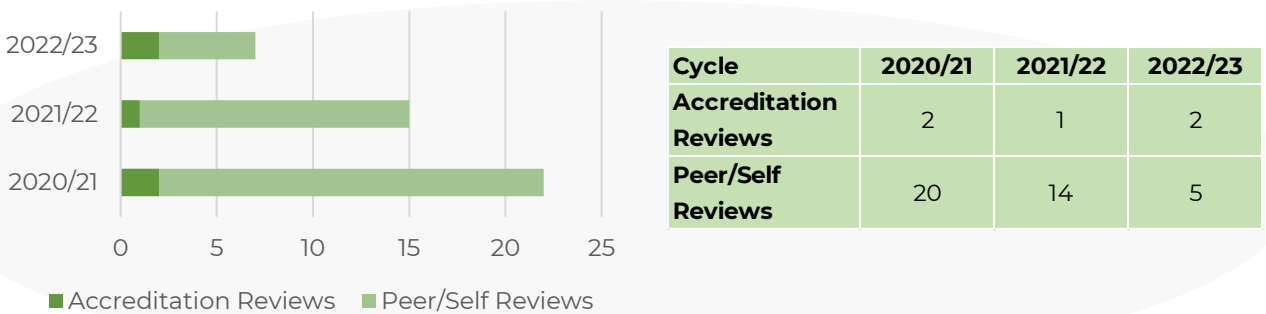
- Crisis & Intensive Treatment Teams
- Eating Disorder Services
- Core CAMHS
- Secondary Mental Health Services

Contextual data continued

Accredited Status

As of February 2024:

- 6 of the QNCC members are Accredited (1 in Cycle 2022/23).
- 10 are currently undergoing accreditation or will undertake their accreditation review in Cycle 23/24.
- 35 services participated in developmental (peer) or self reviews from Cycle 2020/21 to Cycle 2022/23 using the 6th QNCC Standards or 2nd QNCC ED Standards.



Jargon Buster



Accredited

Used to describe a service which has undertaken the accreditation process and has demonstrated that they meet the requirements to be awarded accreditation.

Undergoing Accreditation

Used to describe a service which has completed the self and peer review stages and is now working towards becoming accredited.

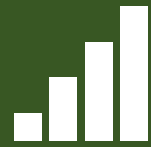
Not accredited

Used to describe a service which has undertaken the accreditation process and has failed to demonstrate that they meet the requirements to be awarded accreditation.

Contextual data continued

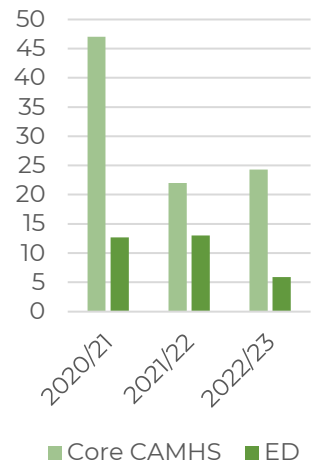
Across the three years, key indicators of CAMHS operations have been identified. The data over the next pages has been provided by each service who completed an online self-review from 2020 to 2023 using the QNCC 6th edition standards and QNCC ED 2nd edition standards. Data from the Secondary Mental Health and Intensive Treatment Teams has not been included as the reviews were too few.

Average total case load per clinical staff member.



Core CAMHS

Across the 15 services that took part in reviews in 2020/21, the highest case load was 90 and the lowest was 16. Nine services took part in 2021/22, and the the highest number of cases per staff member was 53 and the lowest was 10. In 2022/23 the highest case load per staff member was 32 and the lowest was 19 across the three services that took part in reviews.

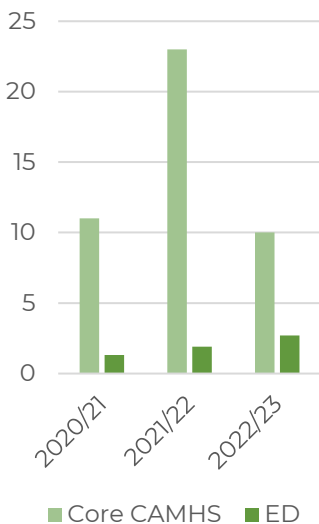


Eating Disorder Teams

Six services took part in reviews in 2020/21, with the highest caseload per staff member being 22 and the lowest being 9. Of the five services that took part in the 2021/22 cycle, the highest case load per staff member was 22 and the lowest was 7. In 2022/23, three services took part and the highest case load per staff member was 7 and the lowest was 5.



The average number of whole time equivalent clinical staff members per 100,000 total population.



Core CAMHS

Across the 15 services that took part in reviews in 2020/21, the largest number of staff per 100,000 total population was 23 and the lowest was 2. Nine services took part in 2021/22, and the largest number of staff per 100,000 was 41 and the lowest was 5. In 2022/23 the largest number of staff per 100,000 was 15 and the smallest was 6 across the three services that took part in reviews.

Eating Disorder Teams

Six services took part in reviews in 2020/21, with the largest number of staff per 100,000 being 22 and the lowest being 9. Of the five services that took part in the 2021/22 cycle, the largest number of staff per 100,000 was 22 and the lowest was 7. In 2022/23, three services took part and the largest number of staff per 100,000 was 7 and the lowest was 5.

Contextual data of 2022/23

The average wait time from referral to assessment.



Core CAMHS

Across the 15 services that took part in reviews in 2020/21, the longest wait time for assessment was 26 weeks and the shortest was 2 weeks.

Nine services took part in 2021/22, and the longest wait time for assessment was 27 weeks and the shortest was 1 week.

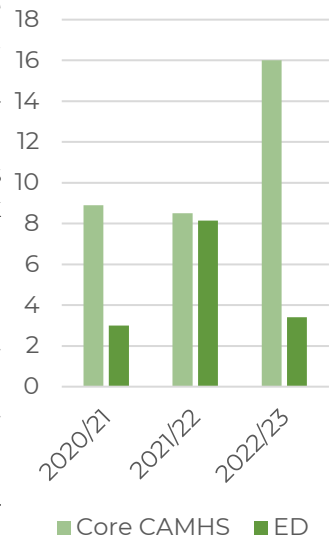
In 2022/23 the longest wait time for assessment was 26 weeks and the shortest was 2 weeks across the three services that took part in reviews.

Eating Disorder Teams

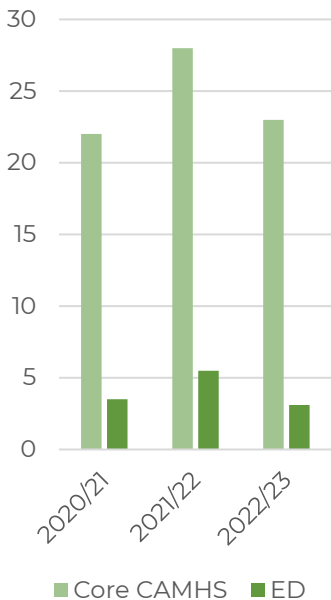
Six services took part in reviews in 2020/21, with the longest wait time for assessment was 5 weeks and the shortest was 2 weeks.

Of the five services that took part in the 2021/22 cycle, the longest wait time for assessment was 20 weeks and the shortest was 1 week.

In 2022/23, three services took part and the longest wait time for assessment was 26 weeks and the shortest was 2 weeks.



The average wait time from referral to treatment.



Core CAMHS

Across the 15 services that took part in reviews in 2020/21, the longest wait time for treatment was 90 weeks and the shortest was 3 weeks.

Nine services took part in 2021/22 the longest wait time for treatment was 27 weeks and the shortest was 1 week.

In 2022/23 the longest wait time for treatment was 44 weeks and the shortest was 2 weeks across the three services that took part in reviews.

Eating Disorder Teams

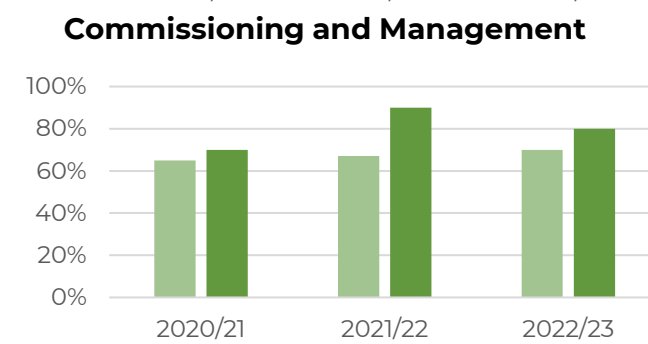
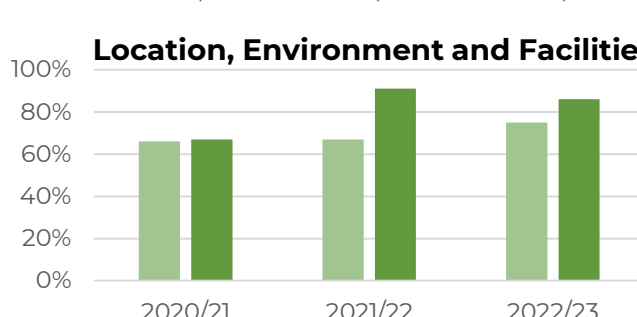
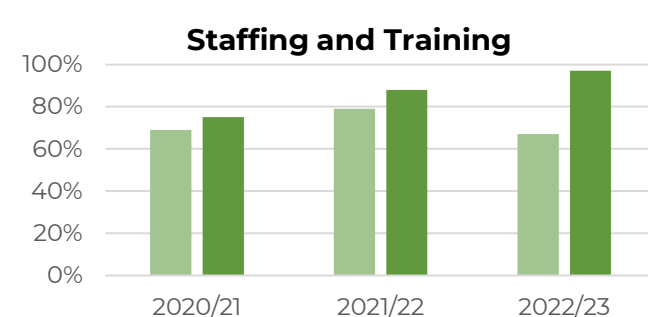
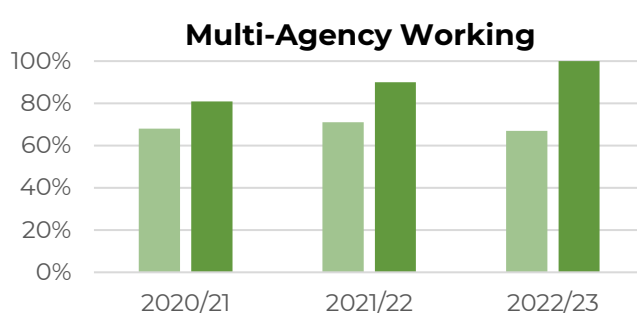
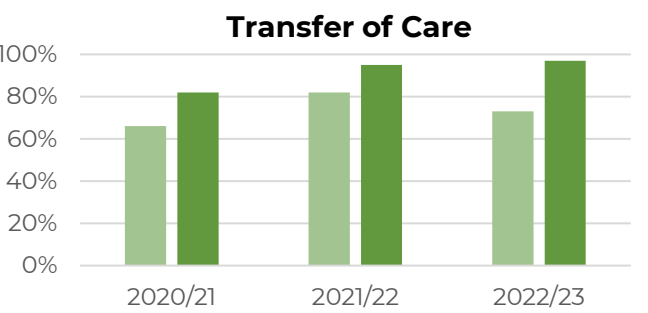
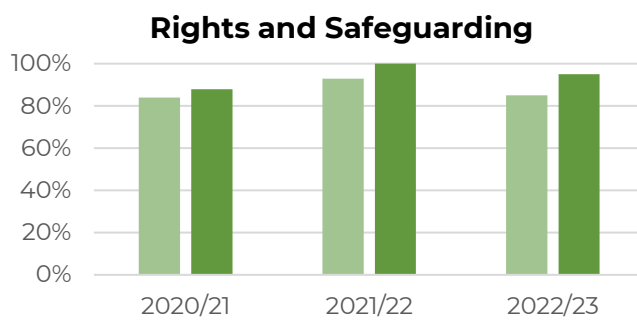
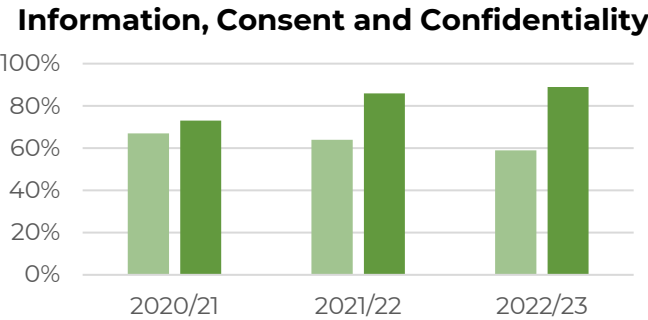
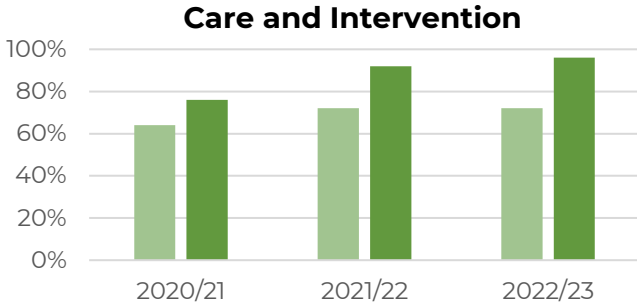
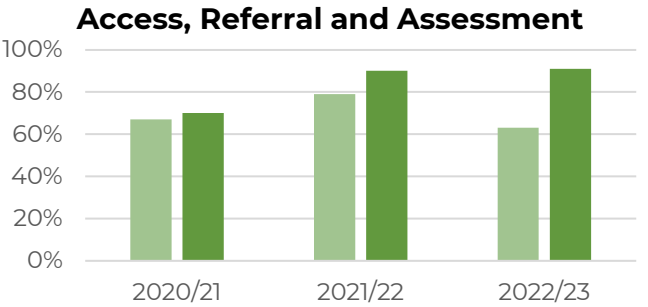
Six services took part in reviews in 2020/21, with the longest wait time for treatment was 5 weeks and the shortest was 2 weeks.

Of the five services that took part in the 2021/22 cycle, the longest wait time for treatment was 20 weeks and the shortest was 1 week.

In 2022/23, three services took part and the longest wait time for treatment was 5 weeks and the shortest was 1 week.

Overall compliance with standards

All services were assessed on their compliance with the 6th edition of the QNCC standards, or the 2nd Standards for Eating Disorder services. Below is the average total adherence to each of the subsections of these standards (counting “Partly Met”, and “Unmet” as not adherent, and “Met” as adherent).



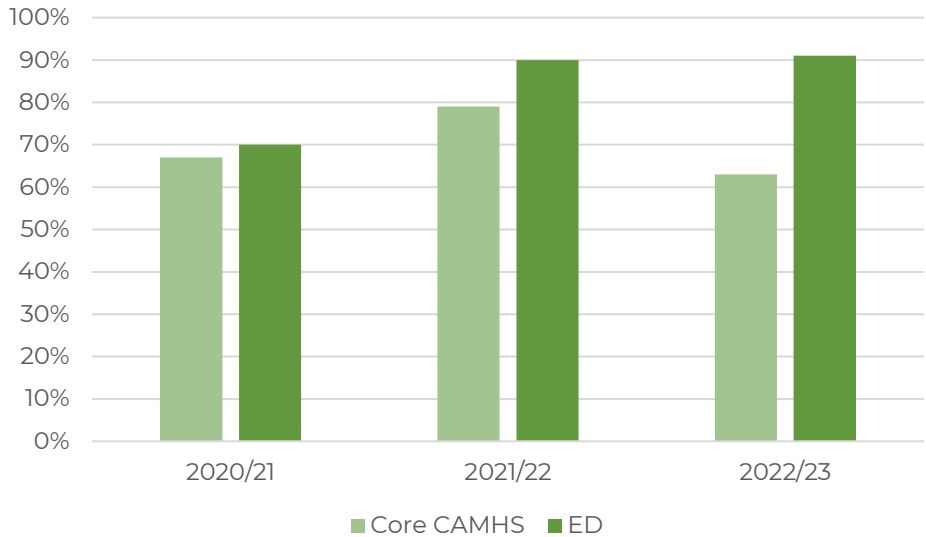
■ Core CAMHS ■ ED

Section 1: Access, Referral and Assessment

Total Met Standards



Average total adherence to this subsection:



Achievements

100% of teams across the three years were able to provide young people with a mental health assessment which includes:

- Mental health and medication;
- Psychosocial and psychological needs;
- Strengths and areas for development;
- Risk, including risk of suicide.

99% of the teams confirmed that they follow up with young people who have not attended an appointment or assessment and, if they are unable to engage with the young person, a decision is made by the assessor/team, based on need and risk, as to how long to continue to follow up with the young person.

Challenges

Just 53% of services said that they review data on missed appointments in order to identify where engagement difficulties may exist.

Standard 1.2.5		
Year	Core CAMHS	ED
2020/21	69%	33%
2021/22	70%	100%
2022/23	25%	50%

49% of the teams over the three years struggled to access relevant information (past and current) about the young person from primary and secondary care and other relevant agencies.

Standard 1.5.2		
Year	Core CAMHS	ED
2020/21	63%	83%
2021/22	50%	60%
2022/23	75%	33%

Section 1: Access, Referral and Assessment

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 1.1.1

The service provides information about how to make a referral and waiting times for assessment and treatment.

This is a commonly not met or partly met standard across the three years as waiting times were not provided. To provide a timeline to assessment and still manage the expectations of families, the service could consider adding a note to their website advising, "We aim to see you for your initial assessment within six weeks."

Standard 1.3.4

The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.

Teams could consider composing a letter template to referrers that could be sent within one week following assessments. The team should consider using language appropriate and sensitive to young people, as they will be included in these emails.

Standard 1.3.3

For non-urgent assessments, the team makes written communication in advance to young people that includes:

- *The name and title of the professional they will see;*
- *An explanation of the assessment process;*
- *Information on who can accompany them;*
- *How to contact the team if they have any queries or require support (e.g. access to an interpreter, how to change the appointment time or if they will have difficulties getting to the appointment).*

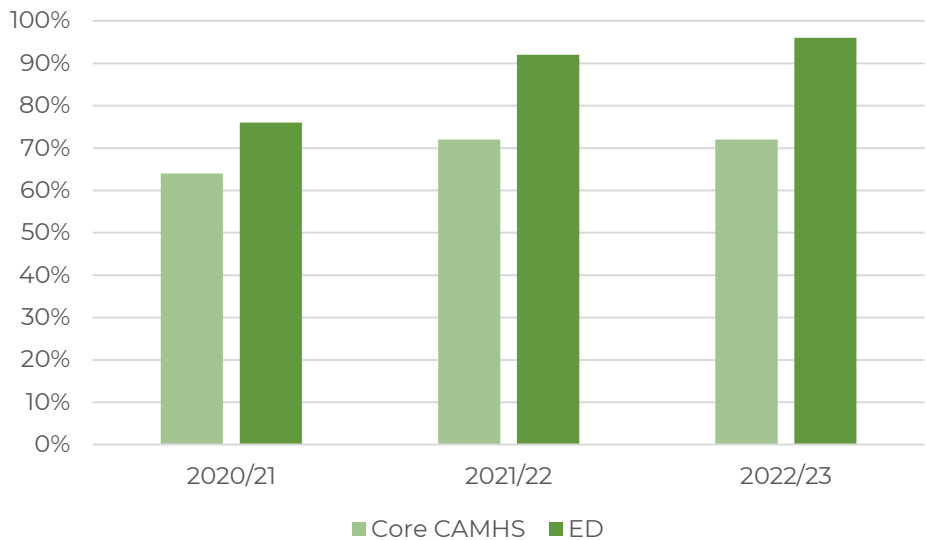
When creating templates or checklists for these letters, the teams could use standard 1.3.3 as a guide. Some teams do not include the name of the clinician, however the QNCC and its patient representatives highly recommend that this is included so that young people are prepared in the best way possible. If teams are concerned of the effect a last-minute change of a clinician may have on young people, QNCC advise to add a caveat that advises that this is subject to change due to extenuating circumstances. Teams may also wish to include their leaflets within their letters.

Section 2: Care and Intervention

Total Met Standards



Average total adherence to this subsection:



Achievements

99% of teams confirmed that young people and their parents/carers (with consent) are supported to understand the benefits, functions, expected outcomes, limitations and side effects of their medications, intervention options and non-intervention options.

99% of teams guide young people and parents/carers in self-help approaches where appropriate.

And 99% of teams across the three years offer parents/carers individual time with staff members to discuss concerns, family history and their own needs.

Challenges

On average only 58% of teams across the three years could say that young people, parents/carers and prescribers can contact a specialist pharmacist to discuss medications.

Standard 2.2.6		
Year	Core CAMHS	ED
2020/21	75%	83%
2021/22	38%	50%
2022/23	33%	67%

62% of teams across the three years could say that they review clinical outcome data at least every six months share and make improvements to the service.

Standard 2.5.3		
Year	Core CAMHS	ED
2020/21	63%	50%
2021/22	38%	80%
2022/23	75%	67%

Section 2: Care and Intervention

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 2.4.2 & 2.4.4

Parents/carers are supported to access a statutory carers' assessment, provided by an appropriate agency & The team provides each parent/carer with accessible carer's information.

These were both commonly unmet standards. Services should produce an information leaflet with similar details as those in standard 3.1.1, as well as carers information and how to access support groups and a carers assessment.

Standard 2.5.3

The service's clinical outcome data are reviewed at least every six months. The data is shared with commissioners, the team, young people and parents/carers, and used to make improvements to the service.

This was a commonly unmet standard across the three years. Staff may add this as an agenda item with commissioners to ensure that it is consistently undertaken. The work could be completed by new staff or trainees.

Standard 2.1.2

Every young person has a written care plan, reflecting their individual needs. Staff members collaborate with young people and their parents/carers when developing the care plan. Young people and parents/carers are offered a copy. The care plan clearly outlines:

- Agreed intervention strategies for physical and mental health;
- Measurable goals and outcomes;
- Strategies for self-management;
- Any advance directives or statements that the young person has made;
- Crisis and contingency plans;
- Review dates and discharge framework.

Teams can consider using this standard as a checklist or create a template to ensure that all staff are working consistently in producing care plans.

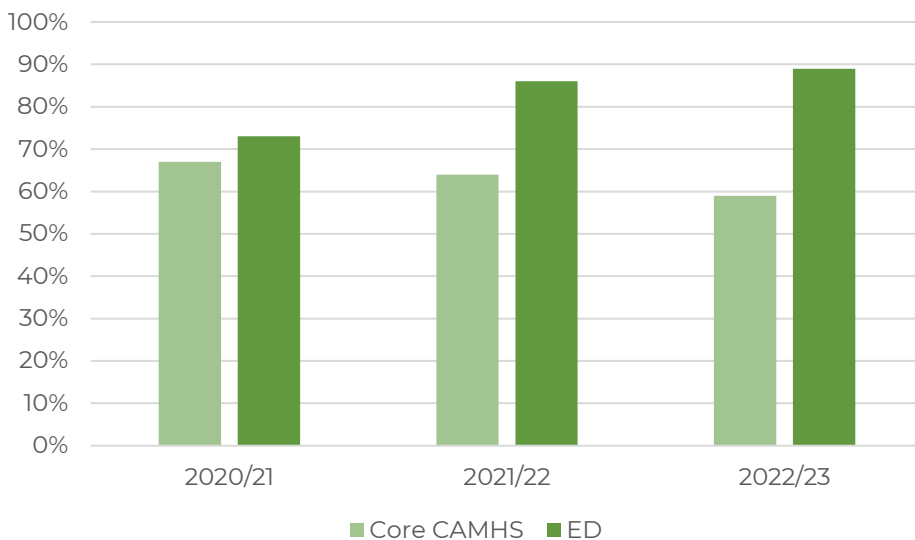
Some young people spoken to during reviews are not sure what a care plan is and advised that this is not shared with them. To ensure that this is consistent, the team should audit these documents regularly for content and quality and discuss improvements during staff supervision. Alongside this, they should ensure that these documents are also routinely shared with families, GPs and others closely involved in their care, including a checkbox that staff must complete.

Section 3: Information, Consent and Confidentiality

Total Met Standards



Average total adherence to this subsection:



Achievements

93% of teams reviewed in the three years confirmed that assessments of young people's capacity (and competency for young people under the age of 16) to consent to care and treatment are performed in accordance with current legislation.

94% of the teams also reported that young people are asked if they and their parent/carers wish to have copies of correspondence about their health and treatment. And 91% of all teams said that their team know how to respond to parents/carers when the young person does not consent to their involvement.

Challenges

Just 55% of services reported that they give and talk through the below information with young people as soon as is practically possible:

- Their rights regarding consent to treatment;
- Their rights under the Mental Health Act;
- How to access advocacy services;

- How to access a second opinion;
- Interpreting services;
- How to view their records;
- How to raise concerns, complaints and give compliments.

Standard 3.1.1		
Year	Core CAMHS	ED
2020/21	63%	67%
2021/22	30%	80%
2022/23	25%	67%

Section 3: Information, Consent and Confidentiality

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 1.1.1

Young people and their parents/carers are able to access information on the service via an up-to-date website.

When teams do not have a website, they should use the Trust website and add a summary of the service and how to make a referral. Having an up-to-date website with detailed information is ideal as young people may wish to do their own research before their first appointment.

Standard 3.1.7

The service provides young people and their parents or carers with service information that is culturally relevant and sensitive to protected characteristics.

Services should be familiar with the local population's characteristics. They should ensure that this is reflected in the imagery they use. It is especially important to consider this as an eating disorder team, when creating meal plans.

Standard 3.1.1

Young people are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes:

- Their rights regarding consent to treatment;*
- Their rights under the Mental Health Act;*
- How to access advocacy services;*
- How to access a second opinion;*
- Interpreting services;*
- How to view their records;*
- How to raise concerns, complaints and give compliments.*

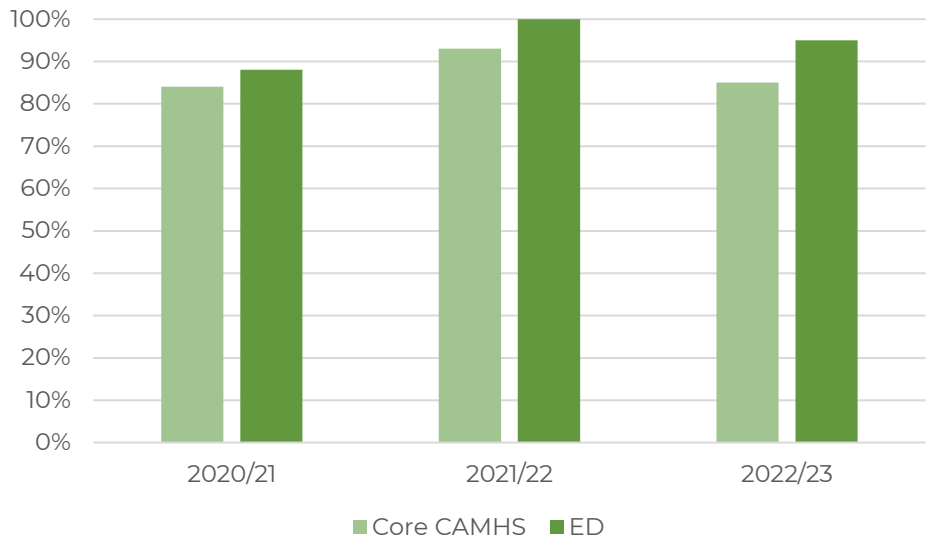
It is common that not all points in this standard are routinely shared with young people. QNCC suggests to compile all this information into one FAQ document or leaflet that can be handed to young people and their families. Teams could also consider using QR codes that link to NHS websites or other resources. When young people have questions about any of these areas they can be referred back to the same document.

Section 4: Rights and Safeguarding

**Total
Met
Standards**



Average total adherence to this subsection:



Achievements

100% of teams say that staff act in accordance with current child protection protocols (e.g. the procedures of the Local Safeguarding Children Board), and also say that young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services).

96% of teams say that young people and parents/carers who use their services feel listened to and understood by staff members.

And 96% of all services say that young people and parents/carers visiting their bases feel welcomed by staff members when attending the team base for their appointments.

Challenges

The standards in the rights and safeguarding section were very well met across the three years. It was interesting to see that only 86% of services said that the specific safeguarding needs of young people who are Looked After are responded to through policies, procedures and practice that are designed to

protect them. However, in 2022/23, 50% of core CAMHS services marked this as met.

Standard 4.2.5		
Year	Core CAMHS	ED
2020/21	88%	100%
2021/22	80%	100%
2022/23	50%	100%

Section 4: Rights and Safeguarding

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 4.2.2

The organisation has a named doctor and a named nurse responsible for child protection.

Most services have this in place, however, it should be clearly communicated with staff, on notice boards and in policies. If a staff member had a question regarding child protection it would be useful to have a flow chart they can refer to, which should also contain the name of the doctor or nurse responsible for child protection.

Standard 4.2.3

Young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services).

Most services meet this standard, however the QNCC team advise to have a simple protocol or flow chart in place to ensure that this process is consistent and clear for staff to understand and follow.

Standard 4.2.5

The specific safeguarding needs of young people who are Looked After are responded to through policies, procedures and practice that are designed to protect them.

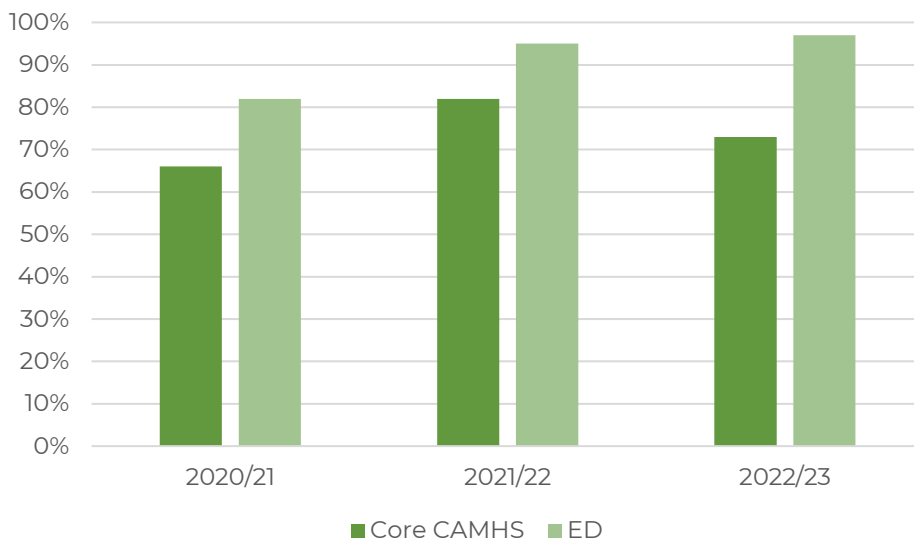
As the needs of young people who are looked after are particularly complex, it is important to have clear procedures in place within Safeguarding policy documentation so that this is easily accessible to staff and clear to follow. The use of flow charts for this type of practice can be particularly helpful.

Section 5: Transfer of Care

Total Met Standards



Average total adherence to this subsection:



Achievements

96% of teams across the three years said that when young people are transferred between community services there is a handover which ensures that the new team have an up-to-date care plan and risk assessment. And 97% of teams said that when a young person is admitted to inpatient care, a community

team representative attends and contributes to ward rounds and discharge planning.

88% of teams said that when young people are referred to adult services, a joint transition meeting is organised between CAMHS and the adult team to ensure a comprehensive handover can take place.

Challenges

Over the three years 68% of teams say that a discharge letter is sent to the young person and all relevant parties within 10 days of discharge, with the letter including the plan for: On-going care in the community/aftercare arrangements; Crisis and contingency arrangements including

details of who to contact; Medication, including monitoring arrangements; Details of when, where and who will follow up with the young person as appropriate. Though this does vary across the years:

Standard 5.1.1		
Year	Core CAMHS	ED
2020/21	56%	67%
2021/22	40%	80%
2022/23	100%	67%

Section 5: Transfer Of Care

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 5.2.1

There are clear procedures for staff to follow in situations when inpatient beds are required but are not immediately available within the relevant service.

This was less commonly met amongst core CAMHS teams. Teams could consider creating an agreed procedure with a closer-to-home team or crisis team so that staff are aware of how to act in these circumstances.

Standard 5.3.2

CAMH services have a named link person who liaises between services around transitions, who is responsible for leadership around transitions and monitors the quality of transition process.

Some teams have assigned one member of staff to work with another assigned member of staff in adult services. These two staff members meet informally monthly to exchange advice and share challenges. Teams could also consider offering secondments to adult services staff to improve relations.

Standard 5.1.1

A discharge letter is sent to the young person and all relevant parties within 10 days of discharge. The letter includes the plan for:

- On-going care in the community/aftercare arrangements;*
- Crisis and contingency arrangements including details of who to contact;*
- Medication, including monitoring arrangements;*
- Details of when, where and who will follow up with the young person as appropriate.*

Some teams struggle to send this letter within 10 days of the young person being discharged. However, This is important to do so that as this can be helpful and relevant for the young person.

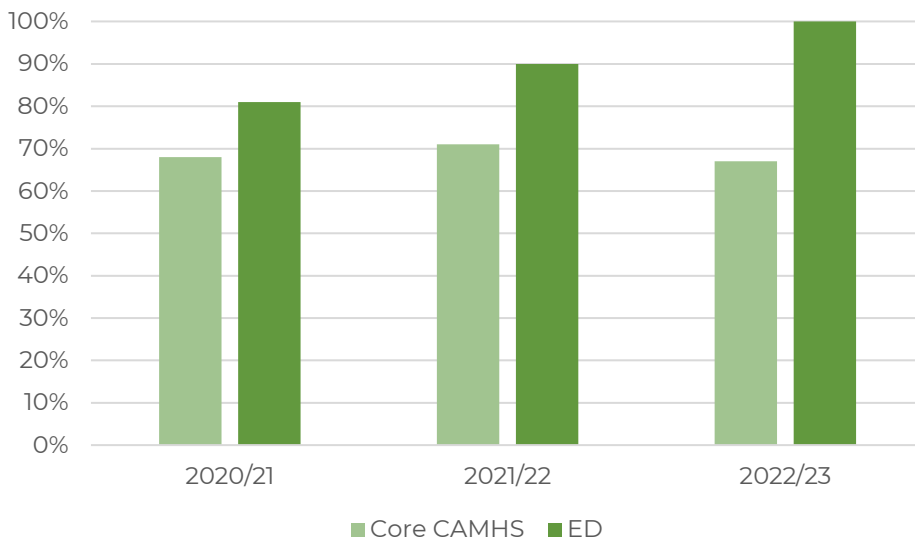
Teams could consider completing this in the final sessions with the young person, ensuring that it is also a collaborative plan. It would be useful to create a template that can be used for GPs, as it is helpful when these letters are not too lengthy. It could be an option to complete a longer discharge letter for young people and their families for them to refer to in the future. Templates should follow the points in this standard.

Section 6: Multi-Agency Working

Total Met Standards



Average total adherence to this subsection:



Achievements

Across the three years, teams have said that young people can access help from mental health services 24 hours a day, seven days a week. The teams also confirmed that 97% of them met the standard explaining that there is regular liaison between CAMHS and representatives from all other agencies involved in the young

person's care, and this is documented in the clinical notes.

And it was great to see that 91% of teams say that CAMHS offer consultation and training to partner agencies.

Challenges

Just 55% of teams have met the following standard:

The service/organisation has a care pathway for the care of young people in the perinatal period (pregnancy and 12 months post-partum) that includes:

- Assessment;
- Care and treatment (particularly relating to

prescribing psychotropic medication);
Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.

Standard 6.2.5		
Year	Core CAMHS	ED
2020/21	53%	50%
2021/22	40%	60%
2022/23	25%	100%

Section 6: Multi-Agency Working

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 6.1.4

The Service Has Identified Links Within A Range Of Services And Agencies, Including organisations which offer:

- Housing support;
- Support with finances, benefits and debt management;
- Social services.

Relationships with social services can be particularly challenging. To improve relations with social care, QNCC advises teams to spend some time working in social care and social care staff could also spend time working in CAMHS to shadow a member of the team. This could be a part of staff inductions.

Standard 6.1.9

The Service Has Identified Links Within A Range Of Services And Agencies, Including:

Community-based services which provide art/creative therapies

In order to meet this standard and provide the service to young people and their families, the team would need to connect with local charities providing creative therapies and link young people to their services by adding their details to leaflets or their website.

Standard 6.2.5

The service/organisation has a care pathway for the care of young people in the perinatal period (pregnancy and 12 months post-partum) that includes:

- Assessment;*
- Care and treatment (particularly relating to prescribing psychotropic medication);*
- Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.*

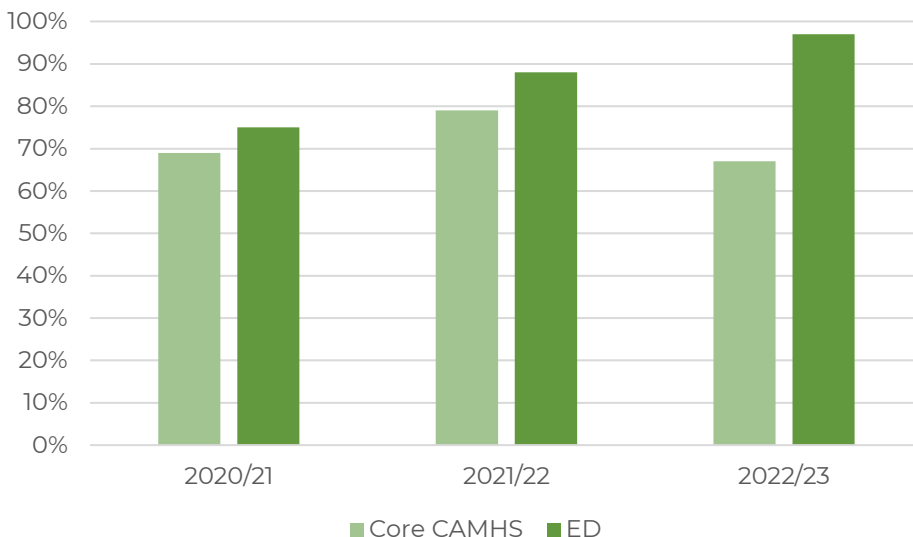
This was a commonly not met standard across the three years. Teams should use the QNCC standard to put together a pathway for treatment for those in the perinatal period. It is also important to have good links with perinatal teams. Teams could identify a link person in their team to visit perinatal services to improve relationships and meet regularly. With this in place the team could access advise from perinatal services where a referral is not possible.

Section 7: Staffing and Training

Total Met Standards



Average total adherence to this subsection:



Achievements

100% of teams say that there are systems in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this. 100% also say that when mistakes are made in care this is discussed with the young person themselves and their parent/carer, in line with the

Duty of Candour agreement. 99% of teams say that staff members, young people and parents/carers who are affected by a serious incident are offered post incident support, and also that the team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews.

Challenges

Just 36% of teams said that they have a peer support worker who can share knowledge, experiences and support to those currently accessing the service. Similarly, 40% of teams had appropriately experienced young person or parent/carer representatives involved in the interview process for recruiting staff members. Also 36% of

teams said that young people, parents/carers and staff members are involved in devising and delivering face-to-face training, with this improving with time:

Standard 7.5.9		
Year	Core CAMHS	ED
2020/21	13%	67%
2021/22	33%	20%
2022/23	50%	33%

Section 7: Staffing and Training

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 7.4.1

The service actively supports staff health and well-being.

QNCC services have been impressive in their work to improve staff wellbeing by providing flexible working hours and hybrid working. Some teams have lunch together daily or take wellbeing walks. Other teams have provided staff with a monthly wellbeing hour, where staff can take an hour each month to do something that helps with their wellbeing.

Standard 7.5.5

Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes: Recognising and communicating with young people with cognitive impairment or learning disabilities.

This is a commonly unmet standard across the three years. Training in this area is incredibly important, especially with delays in ASD and ADHD diagnosis impacting young people's mental health. The QNCC recommend the Oliver McGowan training.

Standard 7.1.7, 7.2.3 & 7.5.9

The team includes a peer support worker who can share knowledge, experiences and support to those currently accessing the service.
&
Appropriately experienced young person or parent/carer representatives are involved in the interview process for recruiting staff members.
&
Young people, parents/carers and staff members are involved in devising and delivering face-to-face training.

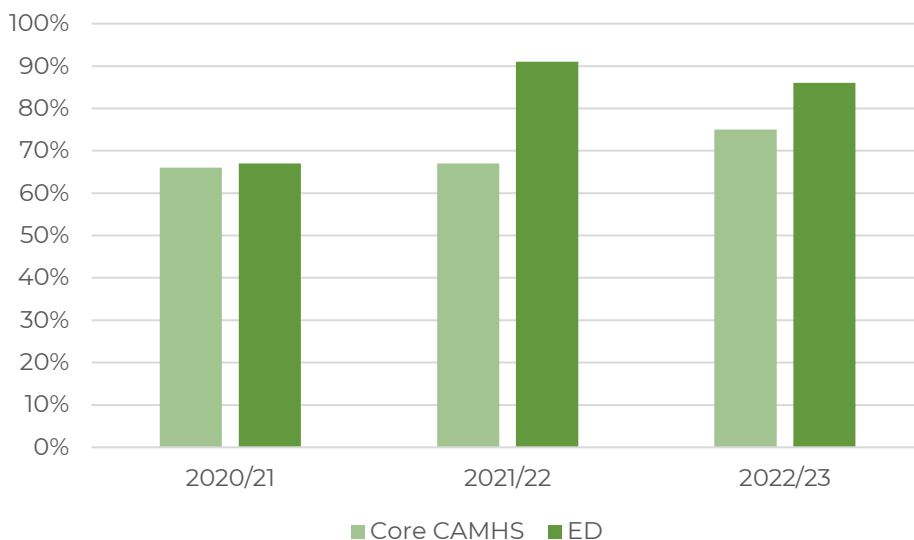
Even when a paid peer support worker is not possible, teams can look at taking on experts by experience and paying for their time with vouchers. Eating disorder teams have taken on whole families as peer support workers, as this can help to enhance how young people and their families are supported. Teams could offer involvement to young people by adding this opportunity into feedback forms, asking "would you be interested in taking part in interviews and training?" or "Would you like to be involved in quality improvement projects at this service?".

Section 8: Location, Environment and Facilities

Total Met Standards



Average total adherence to this subsection:



Achievements

96% of teams over the three years confirmed that everyone is able to access the service using public transport or transport provided by the service. 92% of teams agreed that their service environment was clean, comfortable and welcoming. Whilst 100% of teams over the three years attested that all information, including audio

and visual material, about the young person is kept in accordance with current legislation.

A slightly lower percentage of teams, 86%, said that CAMHS practitioners have access to large and small rooms suitable for individual and family consultations

Challenges

57% of teams felt that their waiting areas were sufficiently spacious and young person-friendly. 59% said that they have an alarm system in place (e.g. panic buttons or personal alarms) which is easily accessible for young people, parents/carers and staff members.

This is split quite evenly over the three years, though eating disorder (ED) teams in 2020 to 2022 presented better:

Standard 8.3.5		
Year	Core CAMHS	ED
2020/21	63%	83%
2021/22	44%	80%
2022/23	50%	33%

Section 8: Location, Environment and Facilities

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 8.3.4

CAMH services provide low-stimulation environments for young people who require them, including designated quiet areas.

This was a commonly unmet standard amongst core CAMHS. Teams could consider making appointment rooms flexible, by including low lighting lamps and space for toys and clutter to be stored. They could also provide a video tour of the base to young people who require it so that they are prepared for their first appointment.

Standard 8.2.6

Staff members are easily identifiable (for example, by wearing appropriate identification).

This standard was commonly met, however QNCC patient representatives felt that it was important for there to be a board in reception with staff pictures. These could include their job roles and fun facts.

Standard 8.3.5

There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for young people, parents/carers and staff members.

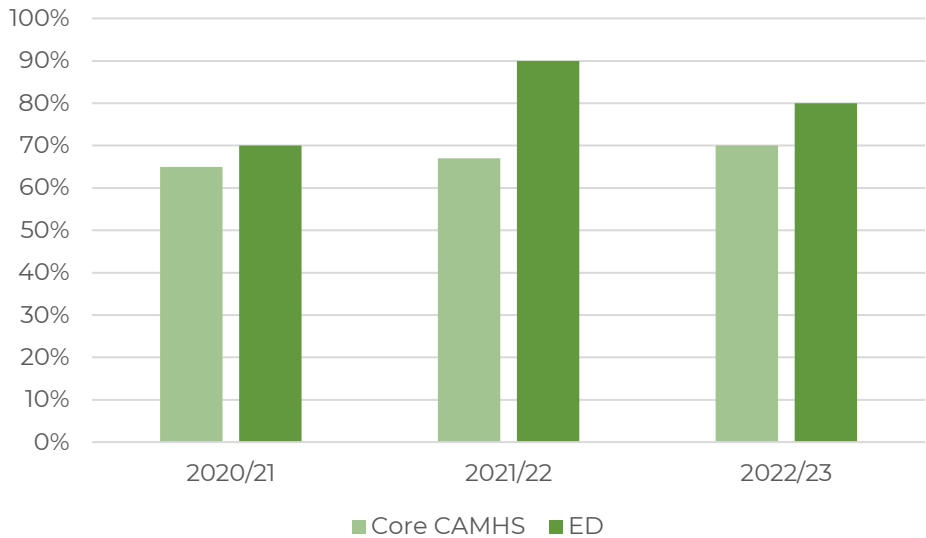
It is important that personal alarms are available to staff and families for staff and patient safety. QNCC advise that personal alarm devices or mobile phone apps are available for staff to consistently check in to and out of an environment, so that their team know where they are. The same device can call the emergency services in an emergency, as the nature of the role could mean that a young person becomes unstable or unwell at any time. Portable alarms that can be charged in reception should also be available. They can be triggered in a clinic room and the reception staff will be notified with a noise like a telephone, so as not to alarm other young people waiting.

Section 9: Commissioning and Service Management

Total Met Standards



Average total adherence to this subsection:



Achievements

Across the three years, 96% of teams said that senior managers within their teams work collaboratively with the CAMHS commissioning lead for each commissioning agency involved and are aware of their responsibilities as outlined in the service specification. Additionally, 90% of teams saying that there is a

mechanism for CAMHS to highlight system-wide commissioning gaps, especially around complex cases e.g. sensory impairments, severe learning disability and complex physical needs. And 97% of teams attest that they use quality improvement methods to implement service improvements.

Challenges

49% of teams said that their services are developed in partnership with appropriately experienced young people and parents/carers and they have an active role in decision making.

Standard 9.2.2		
Year	Core CAMHS	ED
2020/21	69%	50%
2021/22	11%	80%
2022/23	50%	33%

52% of teams said that their service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice.

Standard 9.2.3		
Year	Core CAMHS	ED
2020/21	40%	60%
2021/22	70%	60%
2022/23	50%	33%

Section 9: Commissioning and Service Management

QNCC Team Recommendations

Standard criteria

Recommendations

Standard 1.1.1

Services are developed in partnership with appropriately experienced young people and parents/carers and they have an active role in decision making.

The team could create a participation group of families that they can consult on or work with for quality improvement projects, such as revising assessment and discharge letters. Young people can also help with the clinic environments, providing artwork or advise on waiting area notice boards.

Standard 1.2.7

The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice.

By holding an annual stakeholder meeting, the team will be given a chance to improve challenging relationships with partner agencies and referrers, and will be able to find solutions for common issues.

Standard 9.2.1

The following groups are involved in and consulted on the development of the commissioning strategy:

- Young people who may access the service
- Families of young people who may access the service
- People from different religious, cultural and minority ethnic groups, whether or not they are patients of the service
- CAMHS staff, including frontline staff
- Local community groups and partner agencies

This was a commonly unmet standard across the three years. Teams should consider hosting an annual meeting with stakeholders to consider the commissioning strategy. With this in place the team could liaise with young people and parent/carer participation groups, staff and referrers in preparation, or invite them to the meeting.

Cycle 22/23 Events

QNCC Annual Forum – Tuesday 07 February 2023

(in person). Theme: Transitions
Within; Transitions Beyond.

97%

of delegates that left
feedback rated the event
'excellent', 'very good' or
'good' overall.

37 delegates attended

Planned for Cycle 2023/24

QNCC Special Interest Day

10 May 2024, via Zoom.

QNCC Annual Forum, 14

October 2024, In Person.

Theme: Patient and Carer
Participation

For more information visit our
event page: [QNCC news and
events \(rcpsych.ac.uk\)](https://rcpsych.ac.uk/qncc-news-and-events)

CAMHS Accreditation Training (Online) – 04 October 2022, 05 December 2022 and 10 February 2023



41

clinicians attended
across the three
dates

95% of delegates that left feedback
rated the training session as '4' or '5'
out of 5 overall.

Overlapping Pathways Special Interest Day – Tuesday 16 May 2023 (Online)



59

delegates
attended

94% of delegates that left feedback
rated the event 'excellent', 'very good'
or 'good' overall.



Get involved with QNCC



Join Discussions Using the QNCC Knowledge Hub

Member services can gain instant advice from other QNCC member services via our Knowledge Hub message board. Contact QNCC to be set up with a login.

Become a QNCC Member

Do you feel like your service would benefit from becoming a QNCC member? Contact QNCC to discuss your registration and find out the many benefits to becoming a member!



Become a QNCC Peer Reviewer

Would you like to join review panels for reviews of community CAMHS member services? Get in touch and we'll let you know how you can take part.



Get in touch!

Please email the QNCC with any questions or enquiries on QNCC@rcpsych.ac.uk



Appendix 1: All standards data

QNCC Core CAMHS Standards 6th Edition

Section 1: Access, Referral and Assessment

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
1.1	CAMHS work with all potential referrers including families and young people to ensure access is appropriate, timely and co-ordinated				
1.1.1	1	The service provides information about how to make a referral and waiting times for assessment and treatment.	69%	60%	0%
1.1.2	2	Where referrals are made through a single point of access, these are passed on to the community team within one working day unless it is an emergency referral which should be passed across immediately.	89%	75%	75%
1.1.3	1	A clinical member of staff is available to discuss emergency referrals during working hours.	100%	100%	100%
1.1.4	2	Young people and families are able to make a self-referral to the service.	79%	60%	25%
1.1.5	1	<p>Outcomes of referrals are fed back to the referrer, young person and parent/carer (with the young person's consent). If a referral is not accepted, the team advises the referrer, young person and parent/carer on alternative options.</p> <p>If a referral is accepted the service should provide information on:</p> <ul style="list-style-type: none"> · How young people can access help while they wait for an appointment (e.g. letter, leaflet or telephone call; points of contact to access help may include the referrer, the school nurse, other local service or online services) · Information about expected waiting times for assessment and treatment · With any updates of any changes to their appointment. 	94%	60%	50%
1.2	Measures are taken to ensure equity of access				
1.2.1	1	<p>Appointments are flexible and responsive to the needs of young people and their parents/carers where appropriate.</p> <p><i>Guidance: For example, young people and their parents/carers 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.</i></p>	81%	80%	100%

Appendix 1: All standards data

1.2.2	1	The service reviews data at least annually about the young people who use it. Data are compared with local population statistics and action is taken to address any inequalities of access where identified.	75%	60%	25%
1.2.3	1	The team follows up with young people who have not attended an appointment or assessment. If they are unable to engage with the young person, a decision is made by the assessor/team, based on need and risk, as to how long to continue to follow up the young person.	94%	100%	100%
1.2.4	1	If a young person does not attend an assessment or appointment, the assessor contacts the referrer. <i>Guidance: If the young person is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.</i>	100%	100%	50%
1.2.5	2	Data on missed appointments are reviewed monthly. This is done at a service level to identify where engagement difficulties may exist. <i>Guidance: This should include monitoring a young person's failure to attend the initial appointment after referral and early disengagement from the service.</i>	69%	70%	25%
1.3	Young people receive timely mental health assessments				
1.3.1	1	Young people with a routine referral receive a mental health assessment within six weeks (or four weeks for Trailblazers).	47%	44%	25%
1.3.2	1	Young people with urgent mental health needs can access a mental health assessment within 24 hours.	81%	88%	25%
1.3.3	1	For non-urgent assessments, the team makes written communication in advance to young people that includes: <ul style="list-style-type: none"> • The name and title of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them; • How to contact the team if they have any queries or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there). 	73%	80%	25%
1.3.4	1	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.	44%	50%	75%
1.4	Assessments are collaborative, individual and according to need				

Appendix 1: All standards data

1.4.1	1	When talking to young people and parents/carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them.	94%	100%	75%
1.4.2	1	Staff check that young people and their parents/carers understand the purpose of the assessment and possible outcomes as fully as possible before it is conducted. <i>Guidance: For example, this is specified on an assessment checklist and audited through service questionnaires for young people and parents/carers.</i>	88%	100%	75%
1.4.3	1	Young people have a comprehensive assessment which includes: <ul style="list-style-type: none"> · Mental health and medication; · Psychosocial and psychological needs; · Strengths and areas for development; · Risk, including risk of suicide. 	100%	100%	100%
1.4.4	1	Young people have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality and consent). Assessment considers risk to self, risk to others and risk from others.	94%	80%	50%
1.4.5	1	Assessments are based on the wishes and goals of young people, the family and their capacity to support interventions.	94%	100%	75%
1.4.6	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	94%	100%	100%
1.4.7	1	Young people assessed as requiring treatment see an appropriate clinician within access and waiting times guidelines relevant to the practice area and local agreements.	40%	40%	50%
1.5	Assessments are effectively co-ordinated with other agencies so that young people and their parents/carers are not repeatedly asked to give the same information				
1.5.1	1	There are processes in place to identify whether young people or parents/carers are involved with other agencies.	94%	100%	75%
1.5.2	3	The assessing professional can access relevant information (past and current) about the young person from primary and secondary care and other relevant agencies.	63%	50%	75%
1.6	The team assess the physical health needs of young people accessing the service				
1.6.1	1	A physical health review takes place as part of the initial assessment, or as soon as possible.	81%	50%	50%

Appendix 1: All standards data

1.6.2	1	Where concerns about a young person's physical health are identified, staff members arrange for them to access screening, monitoring and treatment for physical health problems through primary/secondary care services.	94%	100%	100%
1.6.3	1	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency.	100%	100%	100%

Section 2: Care and Intervention

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
2.1	Young people and parents/carers (with consent) are fully involved and informed in care planning				
2.1.1	1	Young people are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	94%	100%	75%
2.1.2	1	<p>Every young person has a written care plan, reflecting their individual needs. Staff members collaborate with young people and their parents/carers when developing the care plan and they are offered a copy.</p> <p>The care plan clearly outlines:</p> <ul style="list-style-type: none"> · Agreed intervention strategies for physical and mental health; · Measurable goals and outcomes; · Strategies for self-management; · Any advance directives or statements that the young person has made; · Crisis and contingency plans; · Review dates and discharge framework. 	69%	50%	25%
2.1.3	1	All young people have a documented diagnosis and clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	81%	67%	67%
2.1.4	1	<p>Young people and their parents/carers (with consent, see guidance below) are supported to understand the benefits, functions, expected outcomes, limitations and side effects of their medications, intervention options and non-intervention options.</p> <p><i>Guidance: This is where the child or young person has capability/competence to consent. HeadMeds or YoungMinds' websites, for example, could be used to access this information.</i></p>	94%	100%	100%
2.1.5	1	All young people know who is co-ordinating their care and how to contact them if they have any questions.	75%	100%	75%
2.1.6	2	Young people and their parents consistently see the same clinician for intervention, unless their preference or clinical need demands otherwise.	88%	90%	75%

Appendix 1: All standards data

2.1.7	2	There is a mechanism for young people to change their clinician if there are problems without prejudicing their access to treatment. <i>Guidance: This should be referred to in service information.</i>	88%	70%	75%
2.2	Decisions around the prescribing of medication are collaborative where possible and monitored appropriately				
2.2.1	1	When medication is prescribed, specific treatment goals are set with the young person, the risks (including interactions) and benefits are reviewed, a timescale for response is set and the young person's consent is recorded.	94%	88%	67%
2.2.2	1	Young people have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. <i>Guidance: Side effect monitoring tools can be used to support reviews.</i>	81%	88%	100%
2.2.3	1	The safe use of medication is audited, at least annually and at a service level.	69%	43%	100%
2.2.4	1	For young people who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the young person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	87%	75%	100%
2.2.5	1	Young people who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at six weeks and then every six months unless a physical health abnormality arises.	71%	75%	100%
2.2.6	3	Young people, parents/carers and prescribers can contact a specialist pharmacist to discuss medications.	75%	38%	33%
2.3	Staff provide support and guidance to enable young people and their parents/carers to help themselves				
2.3.1	1	Where appropriate, young people are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the young person's care plan.	69%	80%	50%

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2.3.2	2	Young people and parents/carers are guided in self-help approaches where appropriate. <i>Guidance: This may include those waiting between assessment and treatment.</i>	94%	100%	100%
2.3.3	2	The team provides information, signposting and encouragement to young people to access local organisations for peer support and social engagement such as: <ul style="list-style-type: none"> • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges. 	88%	90%	100%
2.4	Efforts are made actively to support and engage parents/carers				
2.4.1	1	Parents/carers are involved in discussions and decisions about the young person's care, treatment and discharge planning.	94%	100%	75%
2.4.2	1	Parents/carers are supported to access a statutory carers' assessment, provided by an appropriate agency. <i>Guidance: This advice is offered at the time of the young person's initial assessment, or at the first opportunity.</i>	69%	33%	75%
2.4.3	2	Parents/carers are offered individual time with staff members to discuss concerns, family history and their own needs.	94%	100%	100%
2.4.4	2	The team provides each parent/carer with accessible carer's information. <i>Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes:</i> <ul style="list-style-type: none"> - The names and contact details of key staff members in the team and who to contact in an emergency; - Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities. 	63%	60%	25%
2.4.5	3	The service actively encourages parents/carers to attend carer support networks or groups. There is a designated staff member to support carers.	56%	50%	50%
2.5	Outcome measurement is routinely undertaken				
2.5.1	1	Clinical outcome measurement data, including progress against user-defined goals, is collected as a minimum at assessment, after six months, 12 months and then annually until discharge. Staff can access this data.	56%	40%	50%

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2.5.2	2	Staff members review young people's progress against self-defined goals in collaboration with the young person at the start of treatment, during clinical review meetings and at discharge.	69%	60%	50%
2.5.3	2	The service's clinical outcome data are reviewed at least every six months. The data is shared with commissioners, the team, young people and parents/carers, and used to make improvements to the service.	63%	30%	75%

Section 3: Information, Consent and Confidentiality

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
3.1		<p>Young people and their parents/carers are provided with information that is accessible and appropriate for their use</p> <p><i>Guidance: Standard 3.1 is overarching: criteria apply to all information that is provided for young people and parents/carers including service information, intervention information, information on consent, confidentiality and rights.</i></p>			
3.1.1	1	<p>Young people are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes:</p> <ul style="list-style-type: none"> • Their rights regarding consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments. 	63%	30%	25%
3.1.2	2	All information materials such as leaflets are regularly updated and include a date for revision.	50%	50%	75%
3.1.3	2	Young people and their parents/carers are able to access information on the service via an up-to-date website.	75%	50%	25%
3.1.4	1	Young people and parents/carers are offered written and verbal information about the young person's difficulties.	94%	100%	75%
3.1.5	2	Staff provide young people and their parents with information about the roles played by key professionals across the CAMHS team.	69%	56%	50%
3.1.6	2	Siblings of young people with learning disabilities and/or mental health problems are provided with clear information in an appropriate format e.g. Young Minds.	53%	0%	33%
3.1.7	2	<p>The service provides young people and their parents or carers with service information that is culturally relevant and sensitive to protected characteristics.</p> <p><i>Guidance: For example, images used in posters and leaflets fully reflect the cultural diversity of the community.</i></p>	47%	50%	25%

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3.1.8	2	<p>Information designed for young people and parents/carers is written with the participation of young people and parents/carers.</p> <p><i>Guidance: For example, including quotations or narratives reflecting the real experiences of the young people and parents who have used the service.</i></p>	63%	50%	75%
3.2	Staff follow clear procedures for gaining valid consent to treatment				
3.2.1	1	<p>Assessments of young people's capacity (and competency for young people under the age of 16) to consent to care and treatment are performed in accordance with current legislation.</p>	94%	90%	75%
3.2.2	1	<p>Where young people are able to give consent, their consent to the proposed treatment or intervention is sought by the practitioner carrying out the treatment and the agreement or refusal is recorded in their notes. This is done each time there is a change in treatment.</p> <p>Where young people are not able to give consent (due to age or capacity), their views are ascertained as far as possible and taken into account, and the legal basis for giving the proposed treatment or intervention is recorded, for example:</p> <ul style="list-style-type: none"> • Consent from someone with parental responsibility is obtained and recorded; or, • Treatment in the young person's best interest is given in accordance with the MCA 2005 <p><i>Guidance: Staff must be clear on who holds parental responsibility – see the Legal Guide paragraph 1.13; for guidance on parental consent where the young person is aged 16-17 see the Legal Guide paragraphs 2.33 - 2.34.</i></p>	75%	80%	50%
3.2.3	1	<p>Where parental responsibility is held by a third party, young people and their parents/carers are informed about the procedures for obtaining consent.</p> <p><i>Guidance: Parental responsibility will be shared with others if the young person is subject to a care order (where the local authority has parental responsibility) or a residence order (in which case the person(s) named in the order will have parental responsibility).</i></p>	94%	80%	75%
3.3	Young people and their parents are well-informed about confidentiality and their rights to access information held about them				

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3.3.1	1	Confidentiality and its limits are explained to the young person and parent/carer, both verbally and in writing. The young person's preferences for sharing information with third parties are respected and reviewed regularly.	88%	90%	50%
3.3.2	1	Young people are asked if they and their parents/carers wish to have copies of correspondence about their health and treatment.	100%	90%	75%
3.3.3	1	The team knows how to respond to parents/carers when the young person does not consent to their involvement.	88%	80%	75%

Section 4: Rights and Safeguarding

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
4.1	Young people and parents/carers are treated with dignity and respect				
4.1.1	1	<p>Young people and parents/carers feel welcomed by staff members when attending the team base for their appointments.</p> <p><i>Guidance: Staff members introduce themselves to young people and address them using the name and title they prefer.</i></p>	100%	100%	75%
4.1.2	1	<p>Staff members treat young people and parents/carers with compassion, dignity and respect.</p> <p><i>Guidance: This can be evidenced through the CHI-ESQ.</i></p>	100%	90%	75%
4.1.3	1	<p>Young people and parents/carers feel listened to and understood by staff members.</p> <p><i>Guidance: This can be evidenced through PREMS.</i></p>	88%	90%	100%
4.1.4	1	<p>Young people are offered the opportunity to see a staff member on their own without other staff or family present. This should be recorded in case records.</p>	94%	90%	75%
4.1.5	2	<p>The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The young person's relatives are not used in this role unless there are exceptional circumstances.</p> <p><i>Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.</i></p>	94%	100%	100%
4.2	Young people are protected from abuse through clear safeguarding policies and procedures				
4.2.1	1	<p>Staff act in accordance with current child protection protocols (e.g. the procedures of the Local Safeguarding Children Board).</p>	100%	100%	100%
4.2.2	1	<p>The organisation has a named doctor and a named nurse responsible for child protection.</p> <p><i>Guidance: This may include safeguarding lead or the organisation's child protection lead.</i></p>	100%	90%	100%

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4.2.3	1	<p>Young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services).</p> <p><i>Guidance: Referrals which are made by telephone should be followed up. Young people are reassured that any disclosure of abuse will be taken seriously and are informed about the next steps.</i></p>	100%	100%	100%
4.2.4	1	<p>If a safeguarding referral is made to the Local Authority and no response is received within 24 hours, there are procedures in place for escalation via the identified safeguarding lead.</p>	75%	90%	75%
4.2.5	1	<p>The specific safeguarding needs of young people who are Looked After are responded to through policies, procedures and practice that are designed to protect them.</p>	88%	80%	50%

Section 5: Transfer of Care

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
5.1	Leaving the service:				
5.1.1	1	<p>A discharge letter is sent to the young person and all relevant parties within 10 days of discharge. The letter includes the plan for:</p> <ul style="list-style-type: none"> • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • Details of when, where and who will follow up with the young person as appropriate. 	56%	40%	100%
5.1.2	1	When young people are transferred between community services there is a handover which ensures that the new team have an up to date care plan and risk assessment.	75%	100%	100%
5.1.3	2	Teams provide specific transition support to young people (and parents/carers) when their care is being transferred to another community team, or back to the care of their GP.	81%	80%	75%
5.1.4	1	<p>The community team makes sure that young people who are discharged from an inpatient stay on a mental health unit are followed up within three days.</p> <p><i>Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.</i></p>	79%	75%	67%
5.1.5	1	For young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant Local Authority Services.	94%	89%	75%
5.1.6	2	<p>Having left the service, young people can re-access the service if needed, within agreed timeframes.</p> <p><i>Guidance: There may be exceptions where young people require a generic assessment and where it may be appropriate to follow the initial referral pathway.</i></p>	87%	90%	75%

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5.1.7	2	<p>If young people are placed out-of-area, there are agreements for mental health care to be transferred once they return to the local area.</p> <p><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></p>	69%	80%	100%
5.1.8	1	<p>If the young person moves out of area and is being transferred to a new service, the responsibility is held with their current service until they receive their first assessment.</p>	69%	80%	67%
5.2	Transfer to inpatient care:				
5.2.1	1	<p>There are clear procedures for staff to follow in situations when inpatient beds are required but are not immediately available within the relevant service.</p>	67%	67%	33%
5.2.2	1	<p>When a young person is admitted to inpatient care, a community team representative attends and contributes to ward rounds and discharge planning.</p> <p><i>Guidance: This may be in person or via teleconferencing facilities, for example.</i></p>	81%	100%	100%
5.3	Transfer to adult mental health services:				
5.3.1	1	<p>There is active collaboration between CAMHS and Working Age Adult Services for young people who are approaching the age for transfer between services. This starts at least six months before the date of transfer.</p>	67%	88%	50%
5.3.2	2	<p>CAMH services have a named link person who liaises between services around transitions, who is responsible for leadership around transitions and monitors the quality of transition process.</p>	69%	67%	33%
5.3.3	2	<p>Where young people reaching the upper age limit of the service are not referred to adult mental health services, but access adult services at a later date, the CAMH service will provide liaison to the adult service, if needed and with consent.</p>	88%	100%	67%
5.3.4	2	<p>When young people are referred to adult services, a joint transition meeting is organised between CAMHS and the adult team to ensure a comprehensive handover can take place.</p>	80%	100%	50%

Section 6: Multi-Agency Working

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
6.1	The service has identified links within a range of services and agencies, including:				
6.1.1	1	Local GP surgeries.	81%	60%	100%
6.1.2	1	Paediatrics, development centres and other health services for children and young people, including neurological services where appropriate.	81%	90%	100%
6.1.3	1	Education, education support services and school health services, including community paediatricians and school or college nurses.	81%	80%	100%
6.1.4	1	Organisations which offer: <ul style="list-style-type: none"> · Housing support; · Support with finances, benefits and debt management; · Social services. 	81%	60%	50%
6.1.5	1	Forensic mental health services.	88%	70%	67%
6.1.6	1	Youth justice service.	88%	80%	75%
6.1.7	1	Young people’s drug and alcohol teams/substance misuse services.	88%	90%	100%
6.1.8	2	Dietetics.	81%	60%	50%
6.1.9	2	Community-based services which provide art/creative therapies.	73%	60%	33%
6.2	The service has clear links and pathways with other agencies				
6.2.1	2	Documented inter-agency agreements clearly state the roles and responsibilities allocated to each organisation. <i>Guidance: This should follow the service specification.</i>	53%	33%	0%
6.2.2	1	There are locally agreed health-based places of safety that are designed for young people.	75%	63%	50%
6.2.3	1	The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team in services that have access to one. <i>Guidance: This includes joint care reviews and jointly organising admissions to hospital for young people in crisis.</i>	73%	71%	67%

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6.2.4	1	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/ harassment/ violence and advice for young people in mental health crisis.	63%	67%	67%
6.2.5	1	The service/organisation has a care pathway for the care of young people in the perinatal period (pregnancy and 12 months post-partum) that includes: <ul style="list-style-type: none"> • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so. 	53%	40%	25%
6.2.6	1	Young people can access help from mental health services 24 hours a day, seven days a week. <i>Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams.</i>	88%	100%	75%
6.3	Staff engage in activities and initiatives to improve joint-working and liaison				
6.3.1	2	There is regular liaison between CAMHS and representatives from all other agencies involved in the young person's care, and this is documented in the clinical notes.	94%	90%	100%
6.3.2	2	CAMHS offer consultation and training to partner agencies. <i>Guidance: For example, by appointing link persons to work with education, social services, drug and alcohol teams, and primary healthcare.</i>	88%	100%	75%
6.3.3	3	Joint working is facilitated through flexible initiatives such as secondments, rotational posts, split posts and opportunities for job shadowing across organisations.	63%	60%	75%

Section 7: Staffing and Training

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
7.1	There are appropriate numbers of skilled staff				
7.1.1	1	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service.	94%	80%	75%
7.1.2	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: - A method for the team to report concerns about staffing levels; - Access to additional staff members; - An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	94%	70%	75%
7.1.3	1	When a staff member is on leave, the team puts a plan in place to provide adequate cover for the young people who are allocated to that staff member.	81%	90%	50%
7.1.4	1	There is an identified senior clinician available at all times who can attend the team base within an hour. <i>Guidance: Some services may have an agreement with a local GP to provide this medical cover.</i>	81%	89%	25%
7.1.5	1	Administrative support or procedures are in place to enable staff to support the effective running of the service.	88%	70%	100%
7.1.6	1	All staff have clearly defined job descriptions and job plans which are revised at least annually.	81%	80%	50%
7.1.7	3	The team includes a peer support worker who can share knowledge, experiences and support to those currently accessing the service. <i>Guidance: This might include providing accounts of their experiences to new young people and parents/carers through a support group or documentation</i>	6%	50%	25%
7.2	The service takes steps to ensure that staff are sufficiently qualified to fulfil their roles				

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7.2.1	1	<p>New staff members, including bank staff, receive an induction based on an agreed list of core competencies.</p> <p><i>Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.</i></p>	81%	80%	50%
7.2.2	1	<p>All staff who come into contact with young people or who have access to information about them undergo a Disclosure and Barring Service (DBS) check (or local equivalent) before their appointment is offered. Ongoing monitoring of this is carried out at least once every three years, in line with national guidance.</p>	81%	80%	75%
7.2.3	2	<p>Appropriately experienced young person or parent/carer representatives are involved in the interview process for recruiting staff members.</p>	31%	50%	25%
7.3	Staff are regularly appraised and supervised and know how to gain additional support when needed				
7.3.1	1	<p>All staff members receive an annual appraisal and personal development planning (or equivalent). Clinical staff appraisals include 360-degree feedback including from people who access the service.</p> <p><i>Guidance: This contains clear objectives and identifies development needs.</i></p>	69%	50%	50%
7.3.2	1	<p>All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body.</p> <p><i>Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.</i></p>	94%	90%	75%
7.3.3	2	<p>All staff members receive line management supervision at least monthly.</p>	94%	90%	75%
7.3.4	3	<p>Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.</p>	81%	80%	75%
7.3.5	1	<p>Legal advice is available to staff on issues such as information sharing, confidentiality, consent, rights and child protection</p> <p><i>Guidance: For example, staff have access to a solicitor on the children's panel who is familiar with the service and can offer up-to-date legal advice.</i></p>	100%	90%	100%

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7.3.6	1	<p>Staff members follow a lone working policy and feel safe when conducting home visits.</p> <p><i>Guidance: Procedures may include training on personal safety, conflict resolution and breakaway training, risk assessment procedures, a check in system, equipment such as lone working safety devices and mobile telephones and procedures to share information with the team where there are safety concerns.</i></p>	94%	90%	50%
7.4	Staff members are supported by management				
7.4.1	1	<p>The service actively supports staff health and well-being.</p> <p><i>Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.</i></p>	87%	100%	100%
7.4.2	1	<p>Staff members are able to take breaks during their shift that comply with the European Working Time Directive or equivalent.</p> <p><i>Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.</i></p>	88%	70%	100%
7.4.3	1	<p>Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.</p>	100%	100%	100%
7.4.4	1	<p>When mistakes are made in care this is discussed with the young person themselves and their parent/carer, in line with the Duty of Candour agreement.</p>	100%	100%	100%
7.4.5	1	<p>Staff members, young people and parents/carers who are affected by a serious incident are offered post incident support.</p>	94%	100%	100%
7.4.6	1	<p>Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.</p>	88%	100%	100%
7.4.7	1	<p>Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.</p>	81%	80%	100%

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7.5	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:				
7.5.1	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	100%	100%	50%
7.5.2	1	Physical health assessment. <i>Guidance: This includes training in understanding physical health problems, understanding physical observations and when to refer the young person for specialist input.</i>	69%	56%	0%
7.5.3	1	Safeguarding vulnerable adults and children. <i>Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.</i>	100%	100%	75%
7.5.4	1	Risk assessment and risk management. <i>Guidance: This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.</i>	100%	100%	25%
7.5.5	1	Recognising and communicating with young people with cognitive impairment or learning disabilities.	81%	70%	25%
7.5.6	1	Statutory and mandatory training. <i>Guidance: This includes equality and diversity, information governance and basic life support.</i>	100%	100%	75%
7.5.7	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	56%	60%	67%
7.5.8	2	The service is able to support the training needs of the team including shared in-house multi-disciplinary team training, education and practice development activities. This should occur in the service at least every three months.	94%	60%	100%
7.5.9	2	Young people, parents/carers and staff members are involved in devising and delivering face-to-face training.	13%	33%	50%
7.6	Staff work effectively as a team or network				
7.6.1	2	The team uses monthly business meetings to review progress against its own plan/strategy, which includes objectives and deadlines in line with the broader organisation's strategy.	81%	40%	50%
7.6.2	1	Frontline staff are consulted on relevant management decisions such as developing and reviewing operational policies.	69%	60%	75%

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7.6.3	1	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that front-line staff members find accessible and easy to use.	94%	100%	75%
7.6.4	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. <i>Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.</i>	94%	100%	100%
7.6.5	3	There is a commitment and financial support to enable staff to contribute to multi-centre clinical audit or research.	71%	40%	50%

Section 8: Location, Environment and Facilities

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
8.1	CAMH services are accessible				
8.1.1	3	Everyone is able to access the service using public transport or transport provided by the service.	88%	90%	100%
8.1.2	2	There is sufficient car parking space for visitors, including allocated spaces for disabled access.	53%	50%	50%
8.1.3	1	The environment complies with current legislation on disabled access. <i>Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.</i>	87%	67%	50%
8.2	Environments in which CAMH services are delivered are managed so that the rights, privacy and dignity of young people and their parents/carers are respected				
8.2.1	2	The service environment is clean, comfortable and welcoming.	80%	70%	100%
8.2.2	2	CAMHS practitioners have access to large and small rooms suitable for individual and family consultations.	80%	67%	100%
8.2.3	1	Clinical rooms are private and conversations cannot be easily over-heard.	80%	60%	100%
8.2.4	2	Waiting areas are sufficiently spacious and young person-friendly. <i>Guidance: Play and reading materials are age- and developmentally-appropriate for the whole age range.</i>	73%	40%	50%
8.2.5	1	All information, including audio and visual material, about the young person is kept in accordance with current legislation. <i>Guidance: Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.</i>	100%	90%	100%
8.2.6	1	Staff members are easily identifiable (for example, by wearing appropriate identification).	100%	100%	100%
8.3	CAMH services are delivered in safe environments				
8.3.1	1	If teams see young people at their team base, the entrances and exits are visibly monitored and/or access is restricted.	93%	88%	75%

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8.3.2	2	<p>The team base is securely separated from adult services.</p> <p><i>Guidance: There are separate areas and entrances for adult and CYP services, and access to CYP services is restricted.</i></p>	77%	63%	67%
8.3.3	1	<p>An audit of environmental risk is conducted annually, and a risk management strategy is agreed. 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.</p>	80%	70%	50%
8.3.4	2	<p>CAMH services provide low-stimulation environments for young people who require them, including designated quiet areas.</p> <p><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; this is particularly relevant for services working with learning disabilities.</i></p>	47%	25%	50%
8.3.5	1	<p>There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for young people, parents/carers and staff members.</p>	63%	44%	50%
8.3.6	1	<p>A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least annually.</p>	75%	78%	75%
8.3.7	1	<p>Emergency medical resuscitation equipment (crash bag) is accessible as required by Trust/organisation guidelines, and is maintained and checked weekly, and after each use. The team know the location of the resuscitation equipment.</p>	60%	67%	50%
8.4	Staff have sufficient office facilities and IT systems				
8.4.1	2	<p>Staff report they have sufficient space to complete administrative work.</p> <p><i>Guidance: Staff can access suitable space to make confidential phone calls.</i></p>	75%	40%	75%
8.4.2	1	<p>There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/ treatment, young people's records, clinical outcome and service performance measurements.</p>	100%	90%	100%

Section 9: Commissioning and Service Management

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
9.1	Commissioner-provider relationships are collaborative and effective				
9.1.1	1	Senior managers work collaboratively with the CAMHS commissioning lead for each commissioning agency involved and are aware of their responsibilities as outlined in the service specification.	88%	89%	100%
9.1.2	1	The service is explicitly commissioned or contracted against agreed standards. <i>Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders.</i>	88%	90%	75%
9.1.3	2	There is a widely understood CAMHS strategy that the local population can access. <i>Guidance: For example, for universal, targeted and specialist services.</i>	53%	50%	50%
9.1.4	2	There is a mechanism for CAMHS to highlight system-wide commissioning gaps, especially around complex cases e.g. sensory impairments, severe learning disability and complex physical needs.	88%	70%	100%
9.2	Service development is collaborative and inclusive				
9.2.1	2	The following groups are involved in and consulted on the development of the commissioning strategy: <ul style="list-style-type: none"> • Young people who may access the service • Families of young people who may access the service • People from different religious, cultural and minority ethnic groups, whether or not they are patients of the service • CAMHS staff, including frontline staff • Local community groups and partner agencies. 	77%	50%	25%
9.2.2	2	Services are developed in partnership with appropriately experienced young people and parents/carers and they have an active role in decision making.	69%	11%	50%

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9.2.3	3	<p>The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice.</p> <p><i>Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as young person and carer representatives.</i></p>	40%	70%	50%
9.2.4	1	<p>Young people and their parents/carers are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service.</p> <p><i>Guidance: For example, this may take the form of a combination of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups.</i></p>	94%	80%	75%
9.2.5	2	<p>The team use quality improvement methods to implement service improvements.</p>	81%	100%	100%
9.2.6	2	<p>The team actively encourage young people and parents/carers to be involved in QI initiatives.</p>	63%	60%	75%

QNCC Eating Disorder Standards 2nd Edition

Section 1: Access, Referral and Assessment

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
1.1	CAMHS work with all potential referrers including families and young people to ensure access is appropriate, timely and co-ordinated				
1.1.1	1	The service provides information about how to make a referral and waiting times for assessment and treatment.	83%	80%	100%
1.1.2	2	Where referrals are made through a single point of access, these are passed on to the community team within one working day unless it is an emergency referral which should be passed across immediately.	83%	25%	33%
1.1.3	1	A clinical member of staff is available to discuss emergency referrals during working hours.	100%	100%	100%
1.1.4	2	Young people and families are able to make a self-referral to the service	83%	75%	100%
1.1.5	1	<p>Outcomes of referrals are fed back to the referrer, young person and parent/carer (with the young person's consent). If a referral is not accepted, the team advises the referrer, young person and parent/carer on alternative options.</p> <p>If a referral is accepted the service should provide information on:</p> <ul style="list-style-type: none"> - How young people can access help while they wait for an appointment (e.g. letter, leaflet or telephone call; points of contact to access help may include the referrer, the school nurse, other local service or online services) - Information about expected waiting times for assessment and treatment - With any updates of any changes to their appointment. 	100%	100%	100%
1.2	Measures are taken to ensure equity of access				
1.2.1	1	<p>Appointments are flexible and responsive to the needs of young people and their parents/carers where appropriate</p> <p>Guidance: For example, young people and their parents/carers 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</p>	67%	100%	67%

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1.2.2	1	The service reviews data at least annually about the young people who use it. Data are compared with local population statistics and action is taken to address any inequalities of access where identified.	50%	100%	67%
1.2.3	1	The team follows up with young people who have not attended an appointment or assessment. If they are unable to engage with the young person, a decision is made by the assessor/team, based on need and risk, as to how long to continue to follow up the young person.	100%	100%	100%
1.2.4	1	If a young person does not attend an assessment or appointment, the assessor contacts the referrer. Guidance: If the young person is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.	100%	100%	100%
1.2.5	2	Data on missed appointments are reviewed monthly. This is done at a service level to identify where engagement difficulties may exist. Guidance: This should include monitoring a young person's failure to attend the initial appointment after referral and early disengagement from the service.	33%	100%	50%
1.3	Young people receive timely mental health assessments				
1.3.1 [ED]	1	Young people with a routine referral receive a mental health assessment within 15 days with a view of starting a NICE concordant treatment within four weeks in line with eating disorder referral to treatment.	33%	20%	67%
1.3.2 [ED]	1	Young people with urgent mental health needs receive a mental health assessment within one week (in line with the eating disorder RTT standard)	67%	40%	100%
1.3.3 [ED]	1	Young people with emergency mental health needs receive a mental health assessment within 24 hours (in line with the eating disorder RTT standard)	83%	100%	67%
1.3.4	1	For non-urgent assessments, the team makes written communication in advance to young people that includes: · The name and title of the professional they will see; · An explanation of the assessment process; · Information on who can accompany them; · How to contact the team if they have any queries or require support (e.g. access to an interpret, how to change the appointment time or have difficulty in getting there).	100%	100%	100%
1.3.5	1	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.	67%	100%	33%

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1.4	Assessments are collaborative, individual and according to need				
1.4.1	1	When talking to young people and parents/carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them.	100%	100%	100%
1.4.2	1	Staff check that young people and their parents/carers understand the purpose of the assessment and possible outcomes as fully as possible before it is conducted Guidance: For example, this is specified on an assessment checklist and audited through service questionnaires for young people and parents/carers	100%	100%	100%
1.4.3	1	Young people have a comprehensive assessment which includes: <ul style="list-style-type: none"> • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development; • Risk, including risk of suicide. 	100%	100%	100%
1.4.4	1	Young people have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality and consent). Assessment considers risk to self, risk to others and risk from others.	100%	100%	100%
1.4.5	1	Assessments are based on the wishes and goals of young people, the family and their capacity to support interventions.	100%	100%	100%
1.4.6	1	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	100%	100%	100%
1.4.7	1	Young people assessed as requiring treatment see an appropriate clinician within access and waiting times guidelines relevant to the practice area and local agreements.	67%	100%	100%
1.5	Assessments are effectively co-ordinated with other agencies so that young people and their parents/carers are not repeatedly asked to give the same information				
1.5.1	1	There are processes in place to identify whether young people or parents/carers are involved with other agencies.	100%	100%	67%
1.5.2	3	The assessing professional can access relevant information (past and current) about the young person from primary and secondary care and other relevant agencies.	83%	60%	33%
1.6	The team assess the physical health needs of young people accessing the service				
1.6.1 [ED]	1	A physical health review takes place as part of the initial assessment, or as soon as possible. This should include: <ul style="list-style-type: none"> • Details of past medical history; • Information about prematurity, and previous growth information, including growth centiles • Details of weight parameters (%median BMI for age, weight change); cardiovascular status (heart rate, blood pressure, hydration, circulation); routine bloods and ECG in the context of medical instability; other (muscle strength, neurological symptoms) • Current physical health medication, including side effects and compliance with medication regime; • Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use 	83%	100%	100%

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1.6.2 [ED]	1	The CEDS takes responsibility for management of the eating disorder but liaises with or refers to a physician if the initial assessment identifies co-existing physical conditions that increase risk (e.g. diabetes, pregnancy) and this communication is recorded.	100%	100%	100%
1.6.3 [ED]	1	<p>Protocols for collaborative mental health and paediatric/medical care are in place for any young person requiring acute medical stabilisation.</p> <p>Guidance: Junior MARSIPAN outlines suggested parameters for admission and other aspects of acute care and a refeeding protocol to guide initial management of medical risk</p>	100%	100%	100%
1.6.4	1	For young people at high risk for refeeding syndrome, there is a suitable environment identified for monitoring and treating complications of refeeding.	100%	100%	100%
1.6.5	1	Growth, pubertal and bone density monitoring is offered to young people and, if action is required, there is a formalised way of following this up.	100%	80%	100%

Section 2: Care and Intervention

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
2.1		Young people and parents/carers (with consent) are fully involved and informed in care planning			
2.1.1	1	Young people are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	100%	100%	100%
2.1.2	1	<p>Every young person has a written care plan, reflecting their individual needs. Staff members collaborate with young people and their parents/carers when developing the care plan and they are offered a copy.</p> <p>The care plan clearly outlines:</p> <ul style="list-style-type: none"> • Agreed intervention strategies for physical and mental health; • Measurable goals and outcomes; • Strategies for self-management; • Any advance directives or statements that the young person has made; • Crisis and contingency plans; • Review dates and discharge framework. 	100%	60%	100%
2.1.3	1	All young people have a documented diagnosis and clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	100%	100%	100%
2.1.4 [ED]	1	Young people are offered treatment for common comorbid problems by the CEDS.	100%	80%	100%
2.1.5	1	<p>Young people and their parents/carers (with consent, see guidance below) are supported to understand the benefits, functions, expected outcomes, limitations and side effects of their medications, intervention options and non-intervention options.</p> <p>Guidance: This is where the child or young person has capability/ competence to consent. HeadMeds or YoungMinds' websites, for example, could be used to access this information.</p>	100%	100%	100%

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2.1.6	1	All young people know who is co-ordinating their care and how to contact them if they have any questions.	100%	80%	100%
2.1.7	2	Young people and their parents/carers consistently see the same clinician for intervention, unless their preference or clinical need demands otherwise	100%	100%	100%
2.1.8	2	There is a mechanism for young people to change their clinician if there are problems without prejudicing their access to treatment Guidance: This should be referred to in service information	100%	100%	100%
2.2	Decisions around the prescribing of medication are collaborative where possible and monitored appropriately				
2.2.1	1	When medication is prescribed, specific treatment goals are set with the young person, the risks (including interactions) and benefits are reviewed, a timescale for response is set and the young person's consent is recorded.	100%	100%	100%
2.2.2	1	Young people have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. Guidance: Side effect monitoring tools can be used to support reviews.	100%	100%	100%
2.2.3	1	The safe use of medication is audited, at least annually and at a service level.	25%	100%	67%
2.2.4	1	For young people who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the young person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	100%	100%	100%
2.2.5	1	Young people who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at six weeks and then every six months unless a physical health abnormality arises.	100%	100%	100%
2.2.6	3	Young people, parents/carers and prescribers can contact a specialist pharmacist to discuss medications.	83%	50%	67%

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2.3	Staff provide support and guidance to enable young people and their parents/carers to help themselves				
2.3.1 [ED]	1	Where appropriate, young people are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the young person's care plan.	100%	100%	100%
2.3.2	2	Young people and parents/carers are guided in self-help approaches where appropriate Guidance: This may include those waiting between assessment and treatment	100%	100%	100%
2.3.3	2	The team provides information, signposting and encouragement to young people to access local organisations for peer support and social engagement such as: <ul style="list-style-type: none"> • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges. 	83%	100%	100%
2.4	Efforts are made actively to support and engage parents/carers				
2.4.1	1	Parents/carers are involved in discussions and decisions about the young person's care, treatment and discharge planning.	100%	100%	100%
2.4.2	1	Parents/carers are supported to access a statutory carers' assessment, provided by an appropriate agency. Guidance: This advice is offered at the time of the young person's initial assessment, or at the first opportunity.	83%	100%	100%
2.4.3	2	Parents/carers are offered individual time with staff members to discuss concerns, family history and their own needs.	100%	100%	100%
2.4.4	2	The team provides each parent/carer with accessible carer's information. Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes: <ul style="list-style-type: none"> - The names and contact details of key staff members in the team and who to contact in an emergency; - Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities. 	100%	80%	100%

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2.4.5	3	The service actively encourages parents/carers to attend carer support networks or groups. There is a designated staff member to support carers.	100%	60%	100%
2.4.6 [ED]	1	Health care professionals ensure that, in line with a family based approach, parents/carers are included in any dietary education or meal planning of young people with eating disorders where appropriate and are offered appropriate support. Guidance: Support for parents/carers may be part of whole family FT-AN sessions, separate sessions for parents, MFT-AN sessions or skills development groups C70	100%	100%	100%
2.5	Outcome measurement is routinely undertaken				
2.5.1	1	Clinical outcome measurement data, including progress against user-defined goals, is collected as a minimum at assessment, after six months, 12 months and then annually until discharge. Staff can access this data.	67%	100%	100%
2.5.2	2	Staff members review young people's progress against self-defined goals in collaboration with the young person at the start of treatment, during clinical review meetings and at discharge.	67%	100%	100%
2.5.3	2	The service's clinical outcome data are reviewed at least every six months. The data is shared with commissioners, the team, young people and parents/carers, and used to make improvements to the service.	50%	80%	67%

Section 3: Information, Consent and Confidentiality

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
3.1	Young people and their parents/carers are provided with information that is accessible and appropriate for their use				
3.1.1	1	<p>Young people are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes:</p> <ul style="list-style-type: none"> • Their rights regarding consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments. 	67%	80%	67%
3.1.2	2	All information materials such as leaflets are regularly updated and include a date for revision.	67%	60%	67%
3.1.3	2	Young people and their parents/carers are able to access information on the service via an up-to-date website.	67%	80%	100%
3.1.4	1	Young people and parents/carers are offered written and verbal information about the young person's difficulties.	100%	60%	100%
3.1.5	2	Staff provide young people and their parents with information about the roles played by key professionals across the CAMHS team.	67%	100%	100%
3.1.6 [ED]	3	Siblings of young people with an eating disorder are provided with clear information in an appropriate format.	50%	40%	67%
3.1.7	2	<p>The service provides young people and their parents or carers with service information that is culturally relevant and sensitive to protected characteristics.</p> <p><i>Guidance: For example, images used in posters and leaflets fully reflect the cultural diversity of the community</i></p>	83%	100%	67%

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3.1.8	2	<p>Information designed for young people and parents/carers is written with the participation of young people and parents/carers.</p> <p><i>Guidance: For example, including quotations or narratives reflecting the real experiences of the young people and parents who have used the service</i></p>	83%	100%	67%
3.2	Staff follow clear procedures for gaining valid consent to treatment				
3.2.1	1	<p>Assessments of young people's capacity (and competency for young people under the age of 16) to consent to care and treatment are performed in accordance with current legislation.</p>	100%	100%	100%
3.2.2	1	<p>Where young people are able to give consent, their consent to the proposed treatment or intervention is sought by the practitioner carrying out the treatment and the agreement or refusal is recorded in their notes. This is done each time there is a change in treatment.</p> <p>Where young people are not able to give consent (due to age or capacity), their views are ascertained as far as possible and taken into account, and the legal basis for giving the proposed treatment or intervention is recorded, for example:</p> <ul style="list-style-type: none"> · Consent from someone with parental responsibility is obtained and recorded; or, · Treatment in the young person's best interest is given in accordance with the MCA 2005 <p><i>Guidance: Staff must be clear on who holds parental responsibility – see the Legal Guide paragraph 1.13; for guidance on parental consent where the young person is aged 16-17 see the Legal Guide paragraphs 2.33 - 2.34</i></p>	83%	80%	100%
3.2.3	1	<p>Where parental responsibility is held by a third party, young people and their parents/carers are informed about the procedures for obtaining consent.</p> <p><i>Guidance: Parental responsibility will be shared with others if the young person is subject to a care order (where the local authority has parental responsibility) or a residence order (in which case the person(s) named in the order will have parental responsibility)</i></p>	100%	100%	100%
3.3	Young people and their parents are well-informed about confidentiality and their rights to access information held about them				

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3.3.1	1	Confidentiality and its limits are explained to the young person and parent/carer, both verbally and in writing. The young person's preferences for sharing information with third parties are respected and reviewed regularly.	83%	100%	67%
3.3.2	1	Young people are asked if they and their parent/carers wish to have copies of correspondence about their health and treatment.	100%	100%	100%
3.3.3	1	The team knows how to respond to parents/carers when the young person does not consent to their involvement.	100%	100%	100%

Section 4: Rights and Safeguarding

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
4.1	Young people and parents/carers are treated with dignity and respect				
4.1.1	1	<p>Young people and parents/carers feel welcomed by staff members when attending the team base for their appointments.</p> <p><i>Guidance: Staff members introduce themselves to young people and address them using the name and title they prefer.</i></p>	100%	100%	100%
4.1.2	1	<p>Staff members treat young people and parents/carers with compassion, dignity and respect.</p> <p><i>Guidance: This can be evidenced through the CHI-ESQ.</i></p>	100%	100%	100%
4.1.3	1	<p>Young people and parents/carers feel listened to and understood by staff members.</p> <p><i>Guidance: This can be evidenced through PREMS.</i></p>	100%	100%	100%
4.1.4	1	<p>Young people are offered the opportunity to see a staff member on their own without other staff or family present. This should be recorded in case records.</p>	100%	100%	100%
4.1.5	2	<p>The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The young person's relatives are not used in this role unless there are exceptional circumstances.</p> <p><i>Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.</i></p>	100%	100%	100%
4.2	Young people are protected from abuse through clear safeguarding policies and procedures				
4.2.1	1	<p>Staff act in accordance with current child protection protocols (e.g. the procedures of the Local Safeguarding Children Board).</p>	100%	100%	100%

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4.2.2	1	<p>The organisation has a named doctor and a named nurse responsible for child protection.</p> <p><i>Guidance: This may include safeguarding lead or the organisation's child protection lead</i></p>	100%	100%	100%
4.2.3	1	<p>Young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services).</p> <p><i>Guidance: Referrals which are made by telephone should be followed up. Young people are reassured that any disclosure of abuse will be taken seriously and are informed about the next steps</i></p>	100%	100%	100%
4.2.4	1	<p>If a safeguarding referral is made to the Local Authority and no response is received within 24 hours, there are procedures in place for escalation via the identified safeguarding lead.</p>	83%	100%	67%
4.2.5	1	<p>The specific safeguarding needs of young people who are Looked After are responded to through policies, procedures and practice that are designed to protect them.</p>	100%	100%	100%

Section 5: Transfer of Care

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
5.1	Leaving the service:				
5.1.1	1	A discharge letter is sent to the young person and all relevant parties within 10 days of discharge. The letter includes the plan for: <ul style="list-style-type: none"> • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • Details of when, where and who will follow up with the young person as appropriate. 	67%	80%	67%
5.1.2	1	When young people are transferred between community services there is a handover which ensures that the new team have an up to date care plan and risk assessment.	100%	100%	100%
5.1.3	2	Teams provide specific transition support to young people when their care is being transferred to another community team, or back to the care of their GP.	100%	100%	100%
5.1.4	1	The community team makes sure that young people who are discharged from an inpatient stay on a mental health unit are followed up within three days. <i>Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.</i>	83%	100%	100%
5.1.5	1	For young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant Local Authority Services.	100%	100%	100%
5.1.6	2	Having left the service, young people can re-access the service if needed, within agreed timeframes. <i>Guidance: There may be exceptions where young people require a generic assessment and where it may be appropriate to follow the initial referral pathway</i>	100%	80%	100%

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5.1.7 [ED]	2	<p>If young people are placed out-of-area, there is a clear agreement that CEDS will oversee all eating disorder cases who live in their catchment area, regardless of where they are being treated.</p> <p><i>Guidance: For example, young people placed out of area for educational provision may require mental health support during holidays and will be able to re-access care when they return to the local area without needing to be re-referred</i></p>	100%	100%	100%
5.1.8	1	<p>If the young person moves out of area and is being transferred to a new service, the responsibility is held with their current service until they receive their first assessment.</p>	100%	100%	100%
5.2	Transfer to inpatient care:				
5.2.1	1	<p>There are clear procedures for staff to follow in situations when inpatient beds are required but are not immediately available within the relevant service</p>	67%	80%	100%
5.2.2	1	<p>When a young person is admitted to inpatient care, a community team representative attends and contributes to ward rounds and discharge planning.</p> <p><i>Guidance: This may be in person or via teleconferencing facilities, for example.</i></p>	100%	100%	100%
5.2.3 [ED]	1	<p>CEDS continue to be involved with any admission to an inpatient unit, for example to an eating disorder unit or paediatric ward and the young person is made aware of any formal communication between CEDS and the inpatient unit regarding their care.</p>	100%	100%	100%
5.3	Transfer to adult mental health services:				
5.3.1	1	<p>There is active collaboration between CAMHS and Working Age Adult Services for young people who are approaching the age for transfer between services. This starts at least six months before the date of transfer.</p>	100%	100%	100%
5.3.2	2	<p>CAMH services have a named link person who liaises between services around transitions, who is responsible for leadership around transitions and monitors the quality of transition process.</p>	83%	80%	100%

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5.3.3	2	Where young people reaching the upper age limit of the service are not referred to adult mental health services, but access adult services at a later date, the CAMH service will provide liaison to the adult service, if needed and with consent.	100%	100%	100%
5.3.4	2	When young people are referred to adult services, a joint transition meeting is organised between CAMHS and the adult team to ensure a comprehensive handover can take place.	100%	100%	100%

Section 6: Multi-Agency Working

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2023/22
6.1	The service has identified links within a range of services and agencies, including:				
6.1.1	1	Local GP surgeries	100%	100%	100%
6.1.2	1	Paediatrics, development centres and other health services for children and young people, including neurological services where appropriate	100%	100%	100%
6.1.3	1	Education, education support services and school health services, including community paediatricians and school or college nurses	100%	100%	100%
6.1.4	1	Organisations which offer: <ul style="list-style-type: none"> • Housing support; • Support with finances, benefits and debt management; • Social services. 	100%	100%	100%
6.1.5	1	Forensic mental health services	80%	100%	100%
6.1.6	1	Youth justice service	100%	100%	100%
6.1.7	1	Young people's drug and alcohol teams/substance misuse services	100%	100%	100%
6.1.8	2	Dietetics	100%	100%	100%
6.1.9	2	Community-based services which provide art/creative therapies	83%	60%	100~%
6.2	The service has clear links and pathways with other agencies				
6.2.1	2	Documented inter-agency agreements clearly state the roles and responsibilities allocated to each organisation. <i>Guidance: This should follow the service specification.</i>	83%	80%	100%
6.2.2	1	There are locally agreed health-based places of safety that are designed for young people.	100%	80%	100%

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6.2.3	1	<p>The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team in services that have access to one.</p> <p><i>Guidance: This includes joint care reviews and jointly organising admissions to hospital for young people in crisis.</i></p>	83%	100%	100%
6.2.4	1	<p>The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/ harassment/ violence and advice for young people in mental health crisis.</p>	83%	60%	100%
6.2.5	1	<p>The service/organisation has a care pathway for the care of young people in the perinatal period (pregnancy and 12 months post-partum) that includes:</p> <ul style="list-style-type: none"> • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so. 	50%	60%	100%
6.2.6	1	<p>Young people can access help from mental health services 24 hours a day, seven days a week.</p> <p><i>Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams.</i></p>	100%	100%	100%
6.2.7 [ED]	1	<p>Paediatric care for both acute and chronic aspects of routine eating disorder management includes liaison with paediatric specialities and community services as needed.</p>	100%	100%	100%
6.3	Staff engage in activities and initiatives to improve joint-working and liaison				
6.3.1	2	<p>There is regular liaison between CAMHS and representatives from all other agencies involved in the young person's care, and this is documented in the clinical notes.</p>	100%	100%	100%
6.3.2	2	<p>CAMHS offer consultation and training to partner agencies.</p> <p><i>Guidance: For example, by appointing link persons to work with education, social services, drug and alcohol teams, and primary healthcare</i></p>	83%	100%	100%

6.3.3	3	Joint working is facilitated through flexible initiatives such as secondments, rotational posts, split posts and opportunities for job shadowing across organisations.	100%	80%	100%
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Section 7: Staffing and Training

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
7.1	There are appropriate numbers of skilled staff				
7.1.1 [ED]	1	<p>The composition of the MDT is in line with the recommendations of the Eating Disorder RTT standard and is reviewed at least annually with respect to training and skill mix.</p> <p><i>Guidance: Staff are appropriately trained to provide NICE-compliant treatments and appropriate ongoing supervision of such treatments</i></p>	67%	80%	67%
7.1.2	1	<p>The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including:</p> <ul style="list-style-type: none"> - A method for the team to report concerns about staffing levels; - Access to additional staff members; - An agreed contingency plan, such as the minor and temporary reduction of non-essential services. 	83%	100%	100%
7.1.3	1	<p>When a staff member is on leave, the team puts a plan in place to provide adequate cover for the young people who are allocated to that staff member.</p>	100%	100%	100%
7.1.4	1	<p>There is an identified senior clinician available at all times who can attend the team base within an hour.</p> <p><i>Guidance: Some services may have an agreement with a local GP to provide this medical cover.</i></p>	100%	100%	100%
7.1.5	1	<p>Administrative support or procedures are in place to enable staff to support the effective running of the service</p>	100%	80%	100%
7.1.6	1	<p>All staff have clearly defined job descriptions and job plans which are revised at least annually</p>	83%	100%	100%

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7.1.7	3	<p>The team includes a peer support worker who can share knowledge, experiences and support to those currently accessing the service.</p> <p><i>Guidance: This might include providing accounts of their experiences to new young people and parents/carers through a support group or documentation</i></p>	50%	20%	67%
7.2	The service takes steps to ensure that staff are sufficiently qualified to fulfil their roles				
7.2.1	1	<p>New staff members, including bank staff, receive an induction based on an agreed list of core competencies.</p> <p><i>Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.</i></p>	83%	100%	100%
7.2.2	1	<p>All staff who come into contact with young people or who have access to information about them undergo a Disclosure and Barring Service (DBS) check (or local equivalent) before their appointment is offered. Ongoing monitoring of this is carried out at least once every three years, in line with national guidance.</p>	100%	100%	100%
7.2.3	2	<p>Appropriately experienced young person or parent/carer representatives are involved in the interview process for recruiting staff members.</p>	60%	40%	33%
7.3	Staff are regularly appraised and supervised and know how to gain additional support when needed				
7.3.1	1	<p>All staff members receive an annual appraisal and personal development planning (or equivalent). Clinical staff appraisals include 360 degree feedback including from people who access the service.</p> <p><i>Guidance: This contains clear objectives and identifies development needs</i></p>	83%	100%	100%

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7.3.2	1	<p>All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body.</p> <p><i>Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.</i></p>	83%	100%	100%
7.3.3	2	<p>All staff members receive line management supervision at least monthly.</p>	100%	100%	100%
7.3.4	3	<p>Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.</p>	100%	100%	100%
7.3.5	1	<p>Legal advice is available to staff on issues such as information sharing, confidentiality, consent, rights and child protection</p> <p><i>Guidance: For example, staff have access to a solicitor on the children's panel who is familiar with the service and can offer up-to-date legal advice</i></p>	100%	100%	100%
7.3.6	1	<p>Staff members follow a lone working policy and feel safe when conducting home visits.</p> <p><i>Guidance: Procedures may include training on personal safety, conflict resolution and breakaway training, risk assessment procedures, a check in system, equipment such as lone working safety devices and mobile telephones and procedures to share information with the team where there are safety concerns</i></p>	83%	60%	100%
7.4	Staff members are supported by management				
7.4.1	1	<p>The service actively supports staff health and well-being.</p> <p><i>Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.</i></p>	83%	100%	100%

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7.4.2	1	<p>Staff members are able to take breaks during their shift that comply with the European Working Time Directive or equivalent.</p> <p><i>Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.</i></p>	83%	80%	100%
7.4.3	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	100%	100%	100%
7.4.4	1	When mistakes are made in care this is discussed with the young person themselves and their parent/carer, in line with the Duty of Candour agreement.	100%	100%	100%
7.4.5	1	Staff members, young people and parents/carers who are affected by a serious incident are offered post incident support.	100%	100%	100%
7.4.6	1	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	83%	100%	100%
7.4.7	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	83%	100%	100%
7.5	<p>Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:</p>				
7.5.1	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	83%	100%	100%

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7.5.2	1	Physical health assessment. <i>Guidance: This includes training in understanding physical health problems, understanding physical observations and when to refer the young person for specialist input.</i>	83%	80%	100%
7.5.3	1	Safeguarding vulnerable adults and children. <i>Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.</i>	83%	100%	100%
7.5.4	1	Risk assessment and risk management. <i>Guidance: This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.</i>	83%	100%	100%
7.5.5	1	Recognising and communicating with young people with cognitive impairment or learning disabilities.	83%	80%	67%
7.5.6	1	Statutory and mandatory training. <i>Guidance: This includes equality and diversity, information governance and basic life support.</i>	83%	80%	100%
7.5.7	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	83%	80%	67%
7.5.8	2	The service is able to support the training needs of the team including shared in-house multi-disciplinary team training, education and practice development activities. This should occur in the service at least every three months.	100%	100%	100%
7.5.9	2	Young people, parents/carers and staff members are involved in devising and delivering face-to-face training.	67%	20%	33%
7.5.10 [ED]	1	Staff are trained to deliver a range of effective, NICE-concordant therapeutic interventions specific to the eating disorder and co-morbidities.	83%	80%	100%
7.5.11 [ED]	1	Staff receive eating disorder-specific training to be able to support the physical needs of young people. <i>Guidance: This will include specific training on refeeding and dietary needs</i>	83%	80%	67%
7.6	Staff work effectively as a team or network				

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7.6.1	2	The team uses monthly business meetings to review progress against its own plan/strategy, which includes objectives and deadlines in line with the broader organisation's strategy.	100%	80%	100%
7.6.2	1	Frontline staff are consulted on relevant management decisions such as developing and reviewing operational policies.	100%	100%	100%
7.6.3	1	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that front-line staff members find accessible and easy to use.	100%	100%	100%
7.6.4	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. <i>Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.</i>	100%	100%	100%
7.6.5	3	There is a commitment and financial support to enable staff to contribute to multi-centre clinical audit or research	50%	100%	100%

Section 8: Location, Environment and Facilities

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
8.1	CAMH services are accessible				
8.1.1	3	Everyone is able to access the service using public transport or transport provided by the service.	100%	100%	100%
8.1.2	2	There is sufficient car parking space for visitors, including allocated spaces for disabled access.	83%	80%	33%
8.1.3	1	The environment complies with current legislation on disabled access. <i>Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.</i>	100%	100%	100%
8.2	Environments in which CAMH services are delivered are managed so that the rights, privacy and dignity of young people and their parents/carers are respected				
8.2.1	2	The service environment is clean, comfortable and welcoming.	100%	100%	100%
8.2.2	2	CAMHS practitioners have access to large and small rooms suitable for individual and family consultations	67%	100%	100%
8.2.3	1	Clinical rooms are private and conversations cannot be easily over-heard.	67%	100%	100%
8.2.4 [ED]	1	CED centres have private rooms readily available for physical examinations. <i>Guidance: Relevant examination equipment, such as a weight stadiometer and a blood pressure machine, are provided.</i>	67%	80%	100%
8.2.5	2	Waiting areas are sufficiently spacious and young person-friendly. <i>Guidance: Play and reading materials are age- and developmentally-appropriate for the whole age range.</i>	67%	100%	33%

Appendix 1: All eating disorders standards data

8.2.6	1	<p>All information, including audio and visual material, about the young person is kept in accordance with current legislation.</p> <p><i>Guidance: Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.</i></p>	100%	100%	100%
8.2.7	1	<p>Staff members are easily identifiable (for example, by wearing appropriate identification).</p>	100%	100%	100%
8.3	CAMH services are delivered in safe environments				
8.3.1	1	<p>If teams see young people at their team base, the entrances and exits are visibly monitored and/or access is restricted.</p>	100%	100%	100%
8.3.2	2	<p>The team base is securely separated from adult services.</p> <p><i>Guidance: There are separate areas and entrances for adult and CYP services, and access to CYP services is restricted</i></p>	83%	80%	100%
8.3.3	1	<p>An audit of environmental risk is conducted annually, and a risk management strategy is agreed. 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</p>	100%	100%	100%
8.3.4	2	<p>CAMH services provide low-stimulation environments for young people who require them, including designated quiet areas</p> <p><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; this is particularly relevant for services working with learning disabilities</i></p>	67%	100%	100%
8.3.5	1	<p>There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for young people, parents/carers and staff members.</p>	83%	80%	33%
8.3.6	1	<p>A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least annually.</p>	83%	100%	100%

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8.3.7	1	Emergency medical resuscitation equipment (crash bag) is accessible as required by Trust/organisation guidelines, and is maintained and checked weekly, and after each use. The team know the location of the resuscitation equipment.	67%	80%	100%
8.4	Staff have sufficient office facilities and IT systems				
8.4.1	2	Staff report they have sufficient space to complete administrative work. <i>Guidance: Staff can access suitable space to make confidential phone calls</i>	60%	40%	67%
8.4.2	1	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information, e.g. information about services/conditions/ treatment, young people's records, clinical outcome and service performance measurements.	67%	80%	100%

Section 9: Commissioning and Service Management

Standard number	Standard type	Criteria	Percentage met 2020/21	Percentage met 2021/22	Percentage met 2022/23
9.1	Commissioner-provider relationships are collaborative and effective				
9.1.1	1	Senior managers work collaboratively with the CAMHS commissioning lead for each commissioning agency involved and are aware of their responsibilities as outlined in the service specification.	100%	100%	100%
9.1.2	1	The service is explicitly commissioned or contracted against agreed standards. <i>Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders.</i>	100%	80%	100%
9.1.3	2	There is a widely understood CAMHS strategy that the local population can access. <i>Guidance: For example, for universal, targeted and specialist services</i>	100%	100%	100%
9.1.4	2	There is a mechanism for CAMHS to highlight system-wide commissioning gaps, especially around complex cases e.g. sensory impairments, severe learning disability and complex physical needs.	83%	100%	100%
9.2	Service development is a collaborative, inclusive process				
9.2.1	2	The following groups are involved in and consulted on the development of the commissioning strategy: <ul style="list-style-type: none"> • Young people who may access the service • Families of young people who may access the service • People from different religious, cultural and minority ethnic groups, whether or not they are patients of the service • CAMHS staff, including frontline staff • Local community groups and partner agencies 	33%	100%	33%

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9.2.2	2	Services are developed in partnership with appropriately experienced young people and parents/carers and they have an active role in decision making.	50%	80%	33%
9.2.3	3	The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice. <i>Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as young person and carer representatives.</i>	60%	60%	33%
9.2.4	1	Young people and their parents/carers are given the opportunity to feed back about their experiences of using the service, and their feedback is used to improve the service. <i>Guidance: For example, this may take the form of a combination of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups.</i>	100%	80%	100%
9.2.5	2	The team use quality improvement methods to implement service improvements.	100%	100%	100%
9.2.6	2	The team actively encourage young people and parents/carers to be involved in QI initiatives.	83%	100%	67%

Appendix 2: Acknowledgments

For their time, effort and insight, the QNCC project team sends a warm thank you to:

QNCC Advisory Group:

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Carol-Anne Murphy (Co-Chair), Nurse Consultant, North West Boroughs Healthcare NHS Foundation Trust

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Michelle Whitfield, Social Worker, Pebble Lodge

Dr Paul Millard, Consultant Child and Adolescent Psychiatrist, Clinical Director, Darwin Centre

Dr Sarah Bartlett, Consultant Child and Adolescent Psychiatrist, Riverdale Grange

Sebastian Thompson, Clinical Psychologist, Cygnet Hospital Sheffield

Acknowledgments continued

QNCC Patient and Carer Representatives

Vittoria De Meo, Carer Representative

Hannah Fox, Patient Representative

Emilola Johnson, Patient Representative

Diana Lynch-Bodger, Carer Representative

Kirsten McLoughlin, Carer Representative

Hannah Sharp, Patient Representative

Eshan Vadgama, Patient Representative

Estelle Wrathall, Carer Representative

Jennifer Wilde, Carer Representative

CCQI, Royal College of Psychiatrists:

Peter Thompson, Director of CCQI

Harriet Clarke, Head of Quality and Accreditation

Dasha Nichols, CCQI Clinical and Strategic Director

Mary Doherty, CCQI Clinical and Strategic Director

Michael Henderson, CCQI Systems Manager

QNCC Member Services:

[A] indicates an accredited service, as of February 2024

Adolescent Outreach team (AOT), South West London and St George's Mental Health NHS Trust

Alder Hey Eating Disorder Team, Alder Hey Children's NHS Foundation Trust

Avon & Wiltshire Eating Disorders Team, Avon and Wiltshire NHS Trust

Barnet CAMHS, Barnet, Enfield and Haringey Mental Health NHS Trust

Bedford CAMHS, East London NHS Foundation Trust

Bedfordshire Emotional Wellbeing Service (CHUMS), East London Foundation Trust

Belfast Child and Adolescent Mental Health Outpatients Service, Belfast Trust

Belfast Eating Disorder Youth Service, Belfast Trust

Acknowledgments continued

QNCC Member Services Continued...

[A] indicates an accredited service, as of August 2023

Berkshire CYP and Family Eating Disorder Service (BEDS), Berkshire Healthcare NHS Foundation Trust

Beverley Health Centre CAMHS Eating Disorders Service (Hull & East Riding), Humber NHS Trust

Bradford Mental Health Support Team, Bradford District Care Trust

Camali Clinic, Dubai Healthcare City

Central and North West London Adolescent Community Treatment Service (ACTS), Central and North West London NHS Foundation Trust

Cheshire and Merseyside Adolescent Eating Disorders Service (CHEDS) [A], Cheshire and Wirral Partnership NHS FT

City & Hackney CAMHS, East London NHS Foundation Trust

Cornwall CAMHS, Cornwall Partnership NHS Foundation Trust

Crisis Assessment and Intervention team (Belfast CAIT), Belfast Trust

Derbyshire CAMHS, Derbyshire Healthcare NHS Foundation Trust

Derbyshire CAMHS Eating Disorder Service, Derbyshire Healthcare NHS Foundation Trust

Dorset All Age Eating Disorder Service, Dorset Healthcare University NHS Foundation Trust

Dublin North City & Co. CAMHS, HSE Dublin

East Lancashire CAMHS (ELCAS) [A], East Lancashire Hospitals NHS Trust

Enfield CAMHS, Barnet, Enfield and Haringey Mental Health NHS Trust

Gloucestershire CYPs and Cheltenham CYPs, 2gether Foundation Trust

Guernsey CAMHS, State of Guernsey

Halton CAMHS, Mersey Care NHS Foundation Trust

Hampshire CYP Eating Disorders Team, Sussex Partnership NHS Foundation Trust

Hampshire Early Help (North Team) Service, Sussex Partnership NHS Foundation Trust

Haringey CAMHS, Barnet, Enfield and Haringey Mental Health NHS Trust

Hertfordshire CAMHS Eating Disorders Service, Hertfordshire Partnership University NHS Foundation Trust

Jersey CAMHS, Jersey Care Commission

Kent and Medway All Age Eating Disorder Service, North East London NHS Foundation Trust

Kent Children & Young People's Counselling Service (CYPCS), Kent Community Health NHS Trust

Acknowledgments continued

QNCC Member Services Continued...

[A] indicates an accredited service, as of August 2023

Knowsley CAMHS, Mersey Care NHS Foundation Trust (Formally NWBH)

Lisburn CAMHS Lagan Valley, Belfast Health and Social Care Trust

Leeds Community Eating Disorder Service, Leeds Community NHS Trust

Luton CAMHS, East London NHS Foundation Trust

Mid Mersey CEDS, Mersey Care NHS Foundation Trust (Formally NWBH)

NELFT All Age Eating Disorder Service [A], North East London NHS Foundation Trust

Newcastle & Gateshead CYPS, CNTW Foundation Trust

Newham CAMHS, East London NHS Foundation Trust

Norfolk & Waveney CFYP (Under 14s), Norfolk & Suffolk NHS Foundation Trust

Norfolk & Waveney Youth Team (14-25s), Norfolk & Suffolk NHS Foundation Trust

Norfolk and Waveney Eating Disorders Service, Norfolk & Suffolk NHS Foundation Trust

North Tyneside CAMHS, Northumbria Healthcare NHS Foundation Trust

Northumberland CYPS, Northumberland Tyne and Wear NHS Trust

Nottinghamshire CAMH Eating Disorder Service, Nottinghamshire Healthcare NHS Trust

Portsmouth City CAMHS [A], Solent NHS Trust

Rise - Coventry & Warwickshire Children and Young People's Service (North Warwickshire CAMHS), Coventry and Warwickshire Partnership NHS Trust

Rotherham Doncaster & South Humber CYP Eating Disorder Service (RDASH CEDS), Rotherham Doncaster & South Humber NHS Trust

Royal Free CAMHS Eating Disorders Service, Royal Free London NHS Foundation Trust

Solent East Eating Disorder Service, Solent NHS Trust

South West London & St George's Children and Young Persons CEDS (SWLSTG), South West London and St George's Mental Health NHS Trust

Southampton CAMHS West Team, Solent NHS Trust

SPEED Team, Betsi Cadwaladr University Health Board

St Helen's CYPMHS, Mersey Care NHS Foundation Trust

Stafford CYP CEDS, Midlands Partnership NHS Foundation Trust

Suffolk CFYP, Norfolk & Suffolk NHS Foundation Trust

Suffolk Under 19s Eating Disorder Service, Norfolk & Suffolk NHS Foundation Trust

Acknowledgments continued

QNCC Member Services Continued...

[A] indicates an accredited service, as of August 2023

Surreywide specialist Eating Disorder Service for Children and Young People [A], Surrey and Borders Partnership NHS Foundation Trust

Tavistock and Portman CAMHS, Tavistock and Portman NHS Foundation Trust

TEDS - The Eating Disorder Service Salisbury CAMHS [A], Oxford Health NHS Foundation Trust

Tower Hamlets CAMHS, East London NHS Foundation Trust

Warrington CAMHS, Mersey Care NHS Foundation Trust (Formally NWBH)

West London CAMHS Eating Disorders, West London NHS Trust

Weymouth and Portland Core CAMHS, Dorset Healthcare University NHS Foundation Trust

