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ROYAL COLLEGE OF PSYCHIATRISTS

QNCC
QUALITY NETWORK FOR COMMUNITY CAMHS

QNCC 2023-2024 Annual Report

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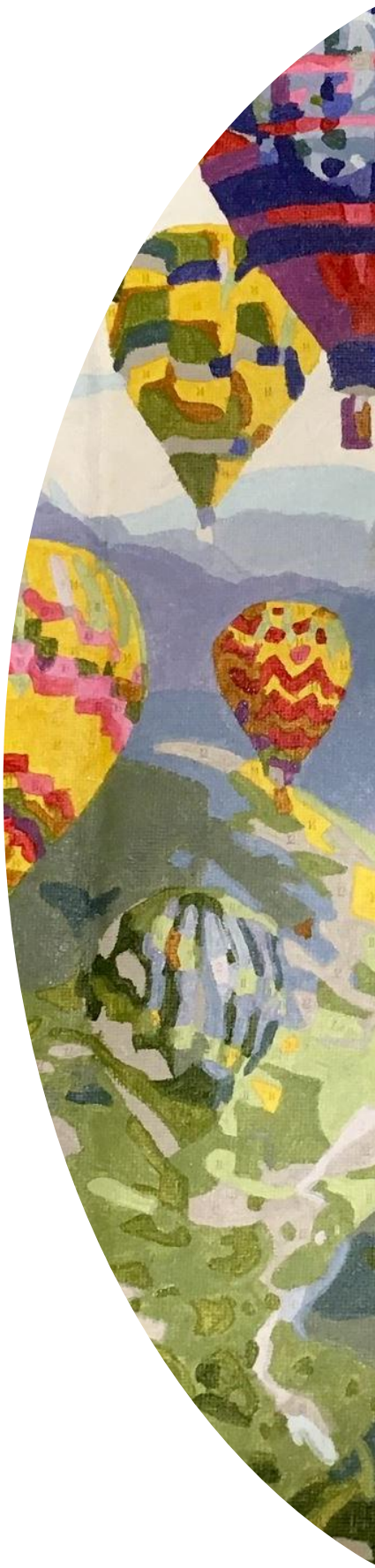
Publication Number: CCQI 500

Date: May 2025

Contents



Foreword

Carol-Anne Murphy

QNCC Advisory Group Chair
Nurse Consultant

I am delighted to introduce this Annual Report to you on behalf of the QNCC. As the Chair of the QNCC Advisory Group, it has been my pleasure to be an integral part of the wider team within the Royal College of Psychiatry. The Advisory Group itself has a full multi-disciplinary membership and, with this, has continued to go from strength to strength. We are as always, grateful to the members of the advisory group but especially to our young people and parent/carer advisors. We have professional representation from across the United Kingdom including Jersey. As you would expect, all members are passionate about quality and how this is delivered within our Menta Health Services for Children and Young People.

Reflecting on the last year has been thought provoking. Quality is what drives us and there is always a worry that when clinical services are facing challenges that quality will be compromised with standards being lowered. However, having attended many reviews across the United Kingdom, it has been refreshing to see that our standards have not been compromised. Our services continue to hold their children, young people and families at the heart of what they are doing. Our reviewers are eager to share ideas from their own practice whilst being keen to learn from others.

It has been a positive year in respect of our accreditation reviews. We have seen an increase in reviewers taking part in the training then participating in the reviews which gives the reviewers an idea of the hard work and effort teams put in to prepare for the accreditation. We have seen too lots of determination and tenacity demonstrated in the teams who are keen to succeed in this process.

We had a successful Special Interest Day back in May focusing on Collaborating between Primary Care and Community Eating Disorder CAMHS Teams which was online with excellent feedback overall, thank you.

In October 2024 we had our Annual Forum which was an in-person event. This was co-chaired by a patient representative and myself which added an excellent dynamic to the day. As always, the day was well attended from our member services and thought provoking throughout.

We appreciate that CYPMHS are currently facing uncertain times but have noticed that there is informal support being offered across the networks, QNCC is no different. The standards across QNCC, QNCC-ED and QNIC have been reviewed and will have taken into consideration some of the anticipated changes. The standards revision also demonstrates that we listened to our members about standards that are no longer applicable. Or standards which are in effect duplicates of other standards. Quality and safety have not been compromised in the standards revision.

The report will therefore demonstrate the commitment improving quality with 11 teams showing this through going through the accreditation process. The use of virtual reviews has meant that the long-distance reviews can be done in a time 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 and/or the Accreditation Committee, you truly are appreciated. Thank you too to the QNCC team at the Royal College of Psychiatrists for their continued enthusiasm and support to our members.

Foreword

Eshan Vadgama

Patient Representative for QNCC

Being a patient representative has never failed to remind me of the responsibility and opportunity I have to represent the unheard voices of young people - those who've struggled, are currently struggling, or unfortunately, may face challenges in the future.

Despite the difficulties of our NHS, the dedication of QNCC members to go above and beyond to meet young people's needs is moving and motivating, to say the least; remarkably demonstrating the collective commitment of members to deliver meaningful QI.

Whilst continuing to use my lived experience of accessing Tier 3 and 4 CAMHS, what's truly been inspiring this cycle, is how open and responsive teams were to patient/carer representative input. It's been encouraging to see suggestions from lived experience being taken seriously, to help foresee and overcome potential barriers before they arise.

In spite of the various challenges posed by COVID-19, it's been excellent to see some positives from the COVID-19 period being maintained. Specifically, flexibility in appointment times and virtual appointments, with a focus on a holistic approach to meet young people's needs, has displayed the recurring theme of empowering young people to access education and achieve future aspirations.

With that being said, communication between CAMHS and third-party services/agencies i.e. GPs, schools, and social care, remains an area for development.

Furthermore, as more young people feel comfortable to begin to open up and identify with neurodivergent experiences, we must prioritise adaptability, accessibility, and clear information, and I have no doubt that QNCC members will continue working towards this.

In this cycle, seeing young people increasingly involved in co-production (something I'm extremely passionate about!) through interview panels and various QI projects, has been fantastic. As someone who has been involved in QI, it's rewarding, validating, and impactful; for young people, families and professionals.

This cycle has especially highlighted my privilege to be involved as a patient representative for QNCC in the quality improvement process of young people's mental health services.

And finally, a huge thank you to the QNCC project team, representatives, and all network members. This cycle's success wouldn't have been possible without your collaboration, compassion, and commitment to improving young people's mental health. I look forward to seeing the endless change and quality improvement of our community CAMHS in the upcoming cycles.

Keep up the good work everyone!

QNCC Team

Harriet Clarke
Head of Quality and Accreditation
CCQI

Arun Das
Programme Manager
QNIC/QNCC/PQN/QED

Leyla Ury
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QNIC/QNCC

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Project Officer
QNCC

Jane Brown (Maternity Leave)
Project Officer
QNCC

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). A full list of member services and their current accreditation status is available to view on our website and on page 103 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 29 reviews undertaken by services who completed their self-review and peer or accreditation review from September 2023 to June 2024, against the 7th Edition Standards for QNCC or the 3rd 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 29 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 2023-2024

This is followed by a full summary detailing the average scores for each QNCC Standard for all 29 reviews who completed a review from 2023 to 2024.

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 7th Edition QNCC Standards and 3rd 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

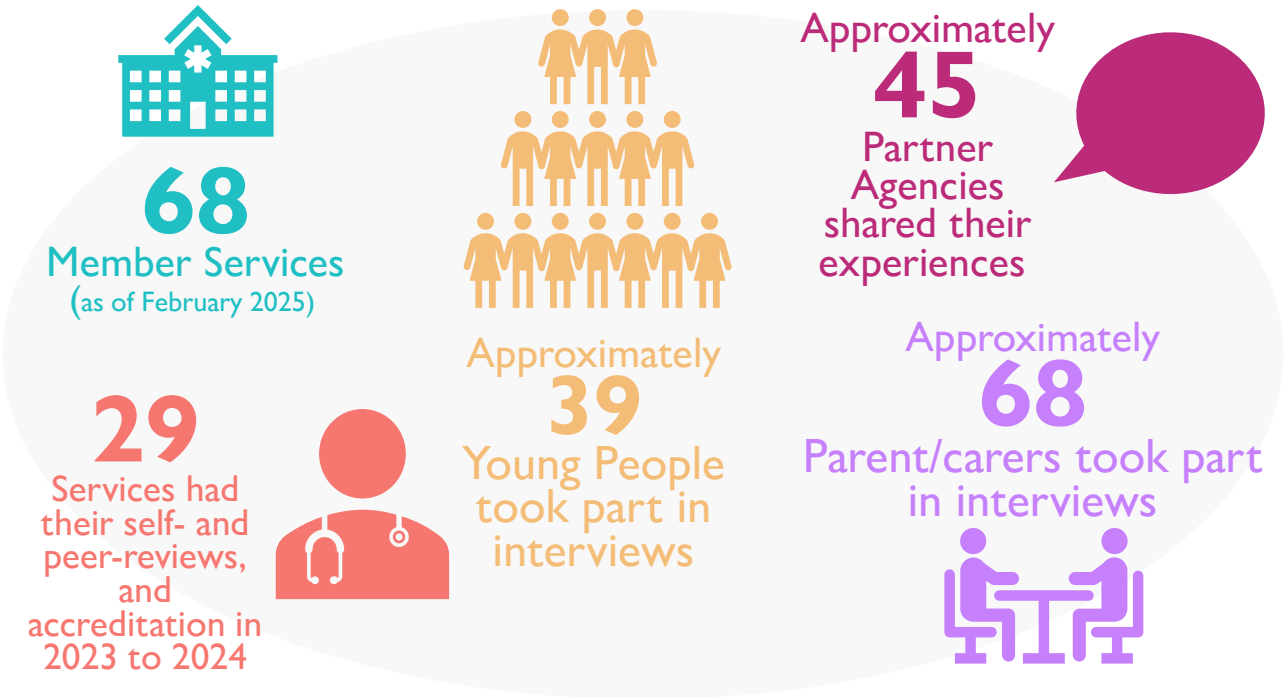
Jargon Buster

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



Where did data come from?

The data in this report comes from **29** reviews undertaken from September 2023 to June 2024 where services have completed their self-review, peer-review or accreditation using the 7th QNCC standards and 3nd QNCC ED standards.

In 2023-2024 17 reviews were undertaken against the QNCC Generic standards, and 12 were 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.

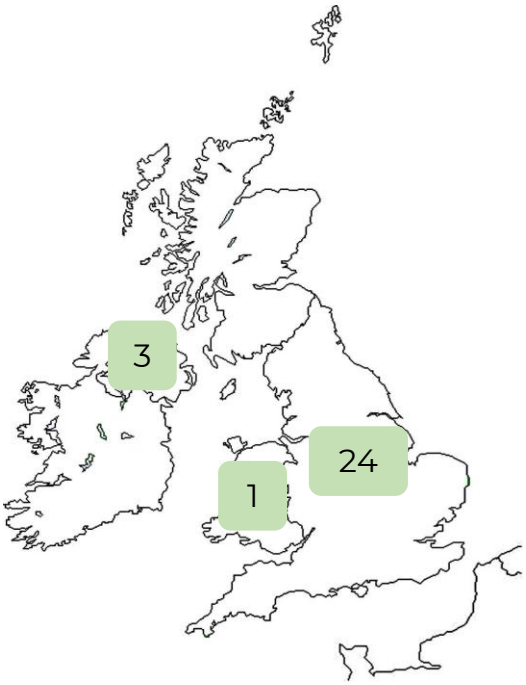
Contextual Data

Location

Of the 29 reviews of services that took part in a self-review and peer-review in 2023 to 2024:

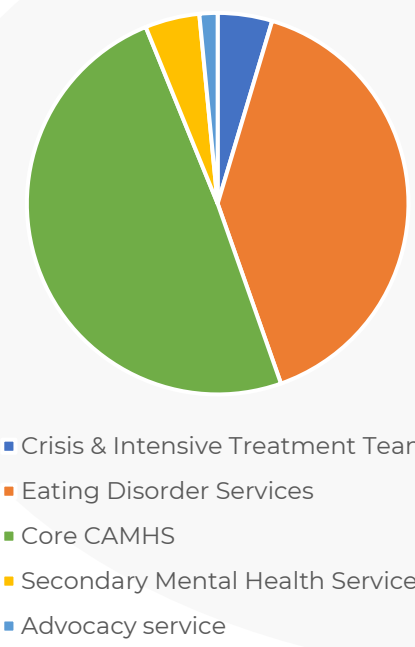
- 24 were based in England
- 3 in Northern Ireland
- 1 in Wales
- 1 in United Arab Emirates

To compare to the current 65 QNCC members (as of February 2025): 58 QNCC members are based in England, 1 in Wales, 3 in Northern Ireland, 1 in Republic of Ireland, 1 in Guernsey.

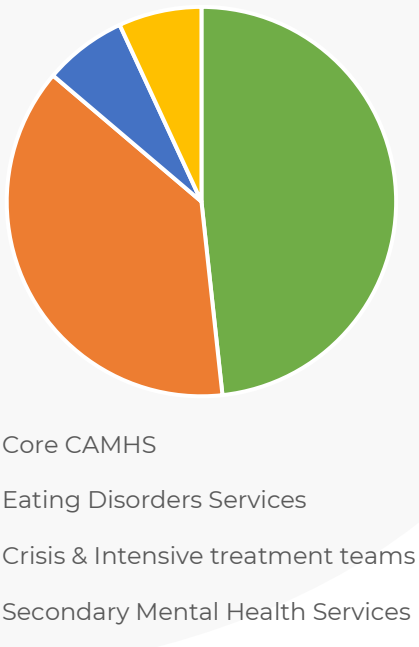


Service Type

All QNCC Members:



The 29 services focused on in this analysis:



Contextual data continued

Accredited Status

As of February 2025:

- 7 of the QNCC members are Accredited (1 in Cycle 2023/24).
- 11 are currently undergoing accreditation or will undertake their accreditation review in Cycle 24/25.

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.

To see all accredited members, please visit our website.

Contextual data continued

The contextual data over the next pages has been provided by each service who completed a self-review from 2023 to 2024 using the QNCC 7th edition standards or the QNCC ED 3rd edition standards. Of the 29 services that completed a review, one service did not complete this section of their workbook and therefore have been excluded from the analysis. Two crisis teams and two secondary mental health services have also been excluded from analysis in order to protect anonymity.

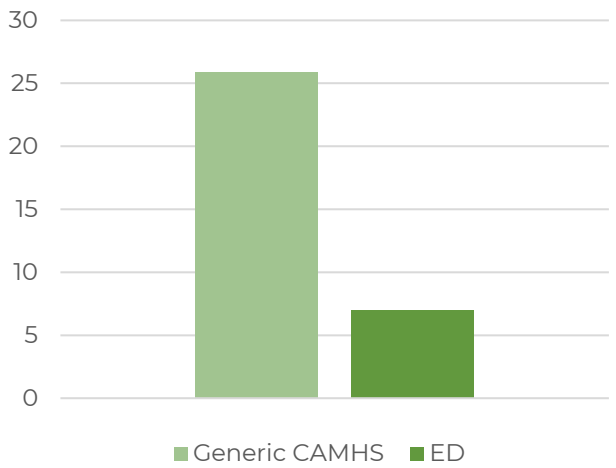
Average total case load per clinical staff member

Generic CAMHS

Across the 12 generic services that took part in reviews in 2023/24, the highest case load per clinical staff member was **57.91** and the lowest was **12.07**. The average caseload per clinical staff member was **25.87.**

Eating Disorder Teams

Across the 12 ED services took part in reviews in 2023/24, the highest caseload per staff member was **13.86** and the lowest was **1**. The average caseload per clinical staff member was **6.94.**



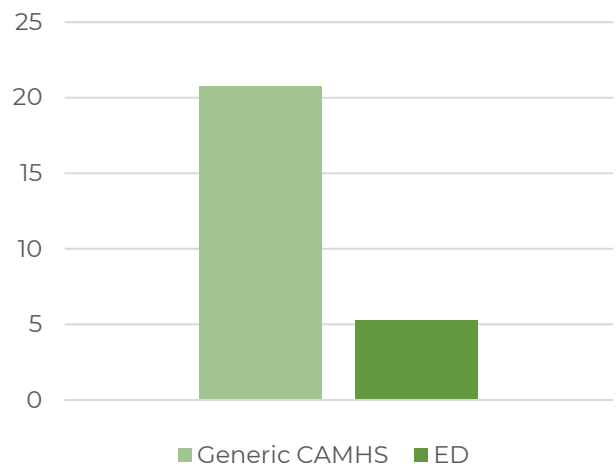
The average number of whole time equivalent clinical staff members per 100,000 total population

Generic CAMHS

Across the 12 generic services that took part in reviews in 2023/24, the largest number of staff per 100,000 total population was **26.11** and the lowest was **9**. The average was **20.73.**

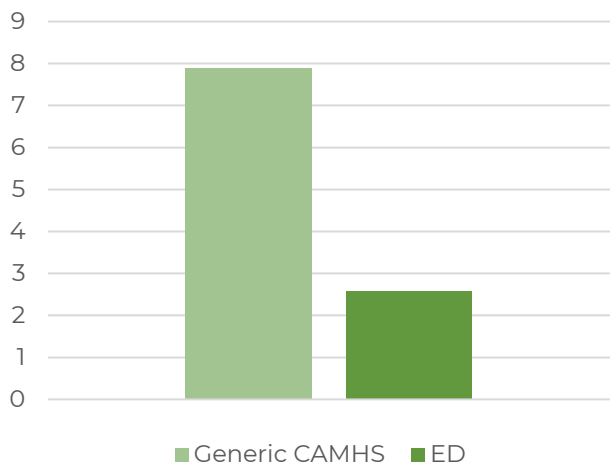
Eating Disorder Teams

Across the 12 ED services that took part in reviews in 2023/24, the largest number of staff per 100,000 total population was **38.57** and the lowest was **0.16**. The average was **5.24.**



Contextual data of 2023/24

The average wait time from referral to assessment



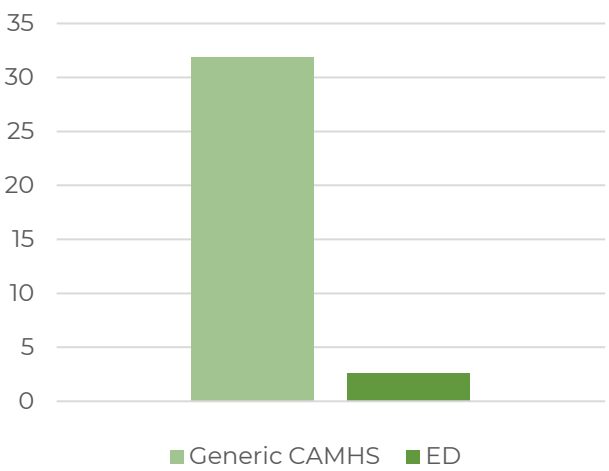
Generic CAMHS

Across the 12 generic services that took part in reviews in 2023/24, the longest wait time for assessment was **20** weeks and the shortest wait time was **1** week. The average wait time was **7.88** weeks.

Eating Disorder Teams

Across the 12 ED services that took part in reviews in 2023/24, the longest wait time for assessment was **4** weeks and the shortest wait time was **1.17** week. The average wait time was **2.59** weeks.

The average wait time from referral to treatment



Generic CAMHS

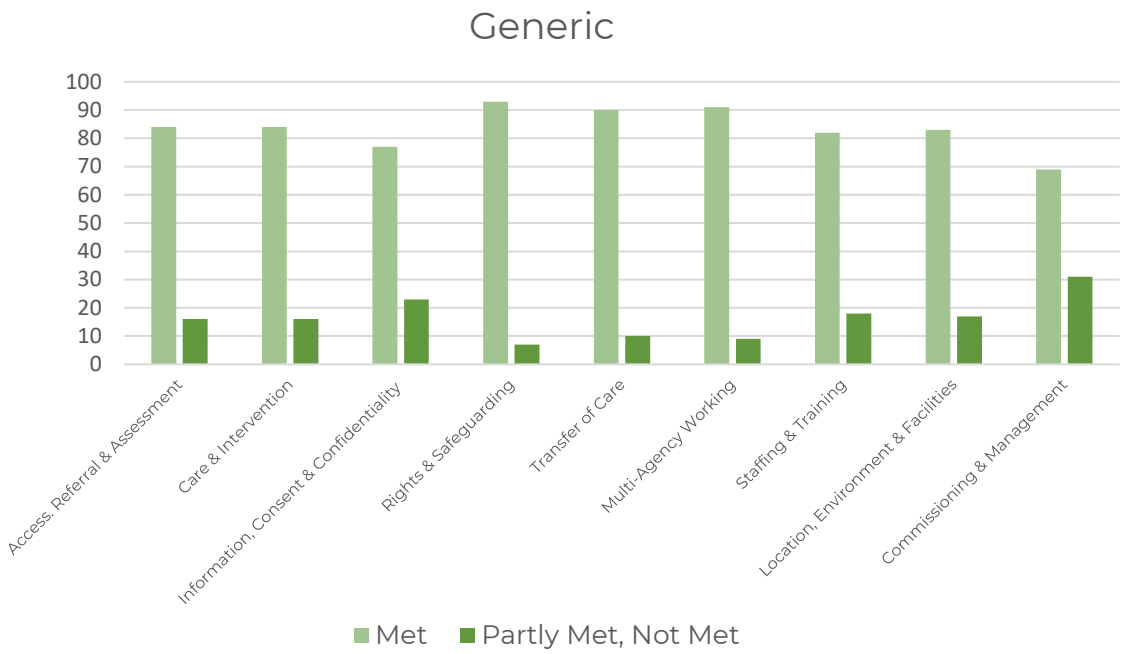
Across the 12 generic services that took part in reviews in 2023/24, the longest wait time for treatment was **100** weeks and the shortest wait time was **1** week. The average wait time was **31.84** weeks.

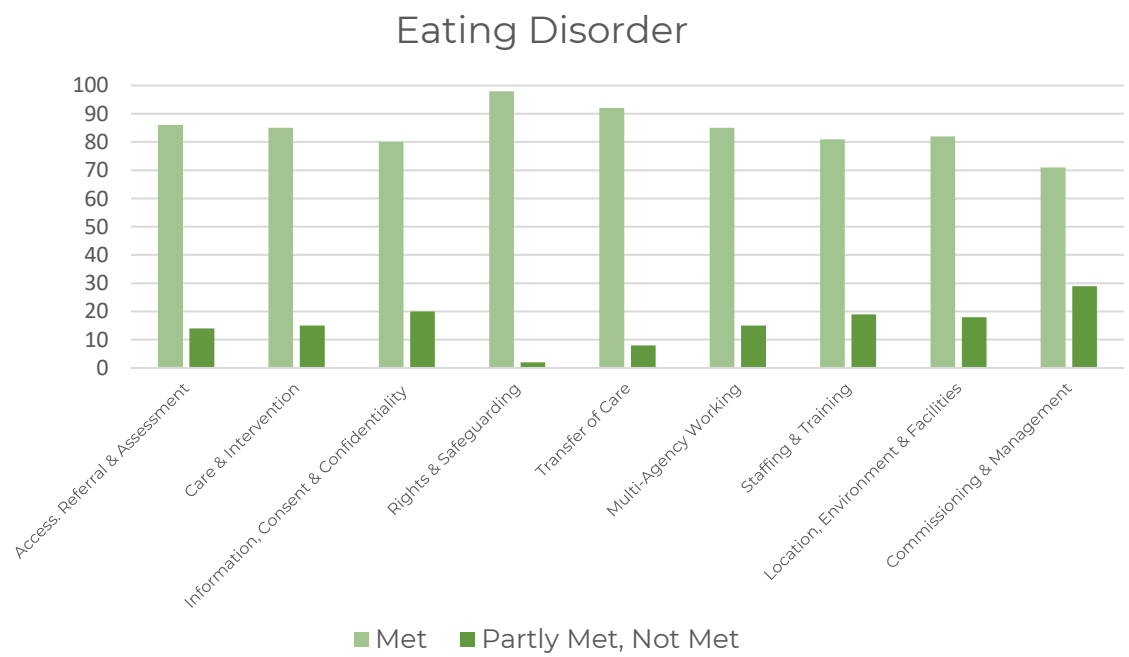
Eating Disorder Teams

Across the 12 ED services that took part in reviews in 2023/24, the longest wait time for treatment was **4** weeks and the shortest wait time was **1** week. The average wait time was **2.62** weeks.

Overall compliance with standards

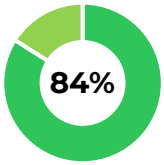
All services were assessed on their compliance with the 6th edition of the QNCC standards, or the 2nd Standards for Eating Disorder services. Below is the average total (percentage) adherence to each of the subsections of these standards (counting "Partly Met", and "Unmet" as not adherent, and "Met" as adherent). Standards marked as N/A or Don't Know have been excluded from analysis.



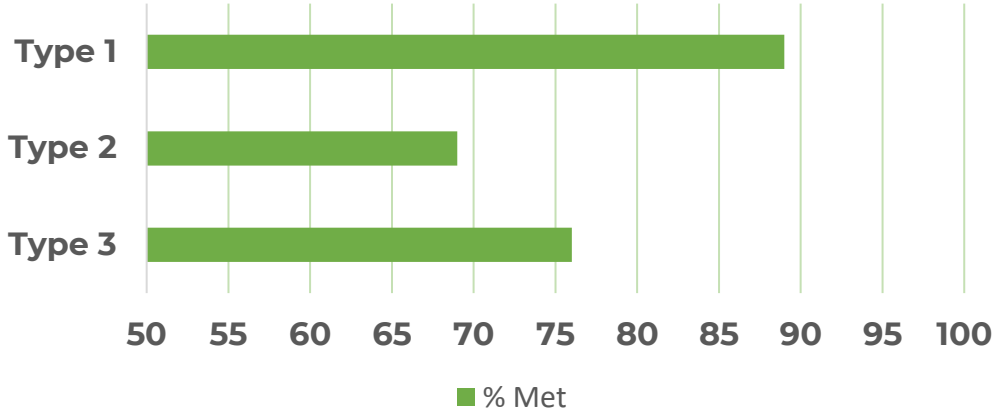


Section 1: Access, Referral and Assessment

Generic **Average total adherence to this subsection:**



Total Met Standards



Achievements

- **100%** of teams were able to provide appointments that are flexible and responsive to the needs of young people and their parents/carers where appropriate.
- **100%** of the teams provided assessments are based on the wishes and goals of young people, the family and their capacity to support interventions.
- **100%** of teams follow up with young people and parents/carers (if appropriate) who were not brought for 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.

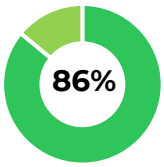
Areas for development

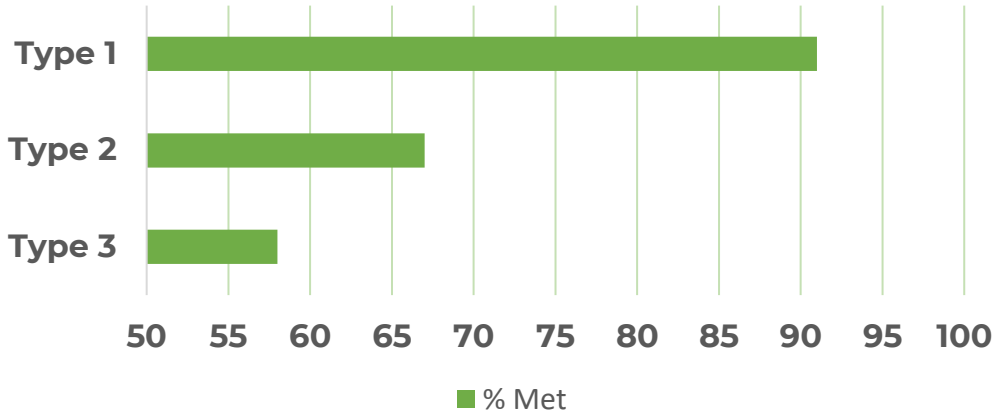
- Just **47%** of services reported that 95% of young people assessed as requiring treatment see an appropriate clinician within access and waiting times guidelines relevant to the practice area and local agreements.
- Only **59%** of the services meet access and waiting times guidelines that 80% of young people assessed as requiring treatment see an appropriate clinician.
- Only **65%** of teams send correspondence detailing the outcomes of the assessment to the referrer, the GP, the young person and other relevant services within a week of the assessment

Section 1: Access, Referral and Assessment

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- **100%** of teams confirmed that 80% of young people with urgent mental health needs for a suspected eating disorder can access a mental health assessment within one week. (In line with the eating disorder RTT standard).
- **100%** of the teams confirmed 80% of young people assessed as requiring urgent treatment for an eating disorder start NICE concordant treatment within 1 week of referral.
- Young people are receiving a comprehensive evidence-based assessment in **100%** of services. This includes: Mental health and medication; Psychosocial and psychological needs; Strengths and areas for development; Risk, including risk of suicide; Educational background Experience of Social Care/Youth Justice

Areas for development

- Self-referral is only available in **42%** of services.
- Assessment thresholds for young people with a routine referral for a suspected eating disorder are being met in **50%** of services.
- Assessment thresholds for young people with a routine referral for a suspected eating disorder are being met in **58%** of services.

Section 1: Access, Referral and Assessment

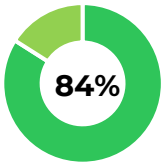
QNCC Team Recommendations

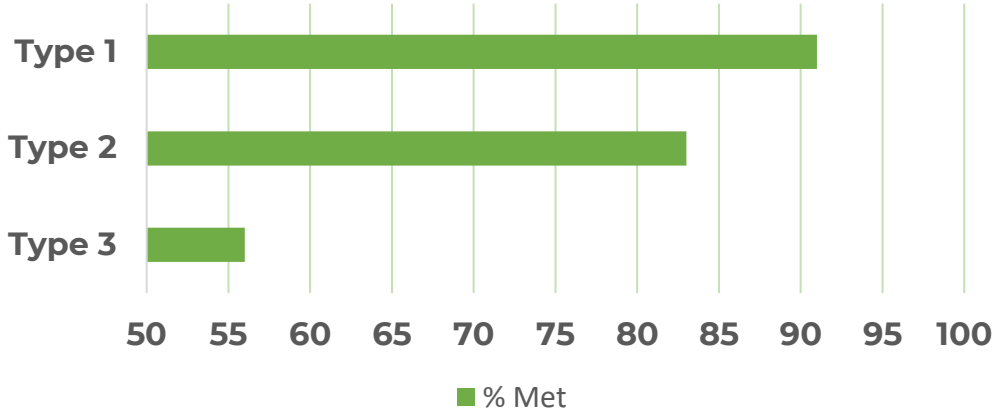
	Standard criteria	Recommendations
Standard 1.1.4	*Young people and families are able to make a self-referral to the service*	Teams that do not offer self-referral should explore the feasibility of this to support young people- particularly with long waiting times for GP appointments. Whilst families may not always know how to make a referral to services, teams should make a self-referral available either through schools or service websites.
Standard 1.3.2	*95% of Young people with a routine referral for a suspected eating disorder 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.*	This standard is for Eating Disorder teams, who follow NHS guidelines of 28 days rather than 15. As a result of this feedback, this standard has been changed, and this will be reflected in next year's report.
Standard 1.4.8	*95% of Young people assessed as requiring treatment see an appropriate clinician within access and waiting times guidelines relevant to the practice area and local agreements.*	Teams who are unable to meet this standard should ensure they have action plans in place to address these challenges. Young people who are waiting particularly long should be provided with interim support, such as regular check-ins and phone calls. This will also help teams to confirm whether the young person's circumstances have changed.

Section 2: Care and Intervention

Total Met Standards

Generic **Average total adherence to this subsection:**





Achievements

- In **100%** of services, 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.
- Parents/carers are involved in discussions and decisions about the young person's care, treatment and discharge planning in **100%** of services. This includes attendance at review meetings where the young person consents.
- Parents/carers are offered individual time with staff members to discuss concerns, family history and their own needs in **100%** of services.

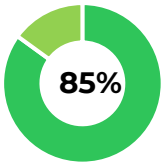
Areas for development

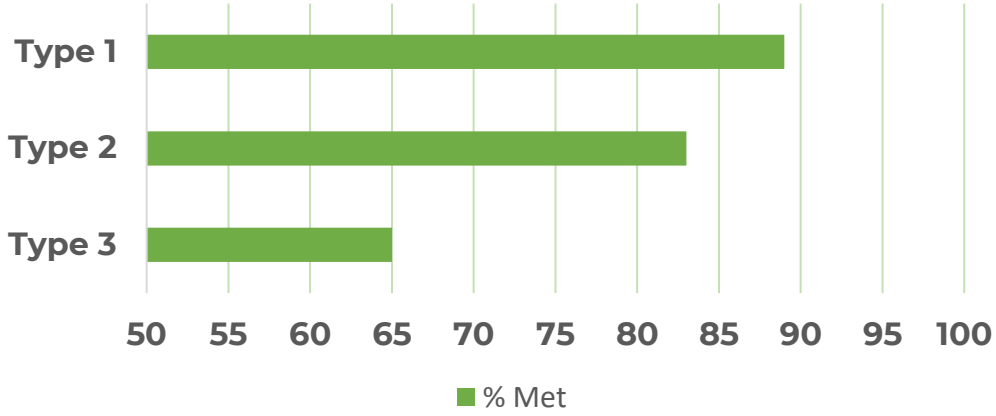
- The opportunity to discuss medications with a specialist pharmacist is available at **36%** of services.
- Only **56%** of service's clinical outcome and experience of care data are reviewed at least every six months, with the data being shared with commissioners, the team, young people and parents/carers, and used to make improvements to the service.
- Only **65%** of services ensure 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.

Section 2: Care and Intervention

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- In **100%** of services, 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.
- Young people are offered treatment for common comorbid problems by the CEDS in **100%** of services.
- Parents/carers are involved in discussions and decisions about the young person's care, treatment and discharge planning in **100%** of services. This includes attendance at review meetings where the young person consents.

Areas for development

- Just **45%** of services reported that young people and parents/carers are able to discuss medications with a specialist pharmacist.
- Only **42%** of the services said clinical outcome measurement and experience of care 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.
- Only **67%** of teams confirmed 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.

Section 2: Care and Intervention

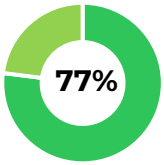
QNCC Team Recommendations

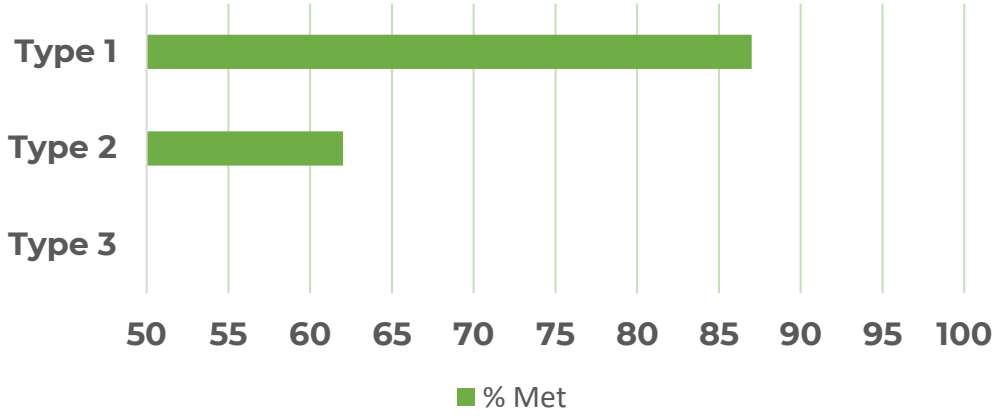
	Standard criteria	Recommendations
Standard 2.2.6	*Young people and parents/carers are able to discuss medications with a specialist pharmacist.*	This was a commonly unmet standard. Teams should have a pharmacist readily available to discuss medications with young people and parents/carers, if applicable. This should be separate to the medical team, to relieve pressures from doctors. Services may want to arrange a shared working agreement.
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 services. 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 were not sure what a care plan was 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 young people's care, including a checkbox that staff must complete.

Section 3: Information, Consent and Confidentiality

Total Met Standards

Generic **Average total adherence to this subsection:**





Achievements

- Young people (and carers, with the young person's consent) are offered written and verbal information about the young person's mental illness and treatment in **100%** of services.
- Young people in **100%** of services are asked if they and their parent/carers wish to have copies of correspondence about their health and treatment.
- **100%** of teams know how to respond to parents/carers when a young person does not consent to their involvement.

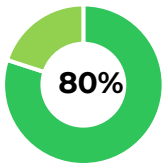
Areas for development

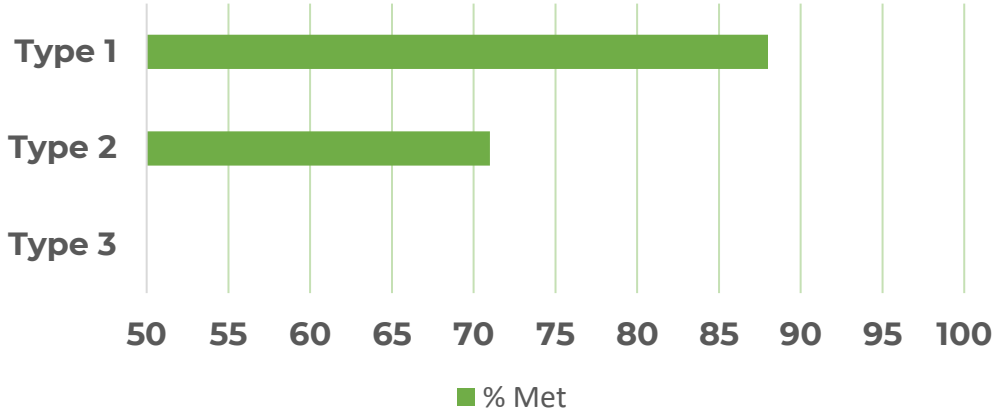
- Young people are given accessible written information which staff members talk through with them as soon as is practically possible, in just **29%** of services.
- Siblings of young people accessing the service are provided with clear information in an appropriate format in only **59%** of services .
- Only **59%** of teams confirmed that information designed for young people and parents/carers is written with the participation of young people and parents/carers.

Section 3: Information, Consent and Confidentiality

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- **100%** of teams know how to respond to parents/carers when a young person does not consent to their involvement.
- **100%** of teams confirmed 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.
- **100%** of teams confirmed that 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.

Areas for development

- Just **58%** of services confirmed siblings of young people with an eating disorder accessing the service are provided with clear information in an appropriate format e.g. Young Minds.
- Only **58%** of the services confirmed the service provides young people and their parents or carers with service information that is culturally relevant and sensitive to protected characteristics.
- Only **67%** of teams confirmed that information designed for young people and parents/carers is written with the participation of young people and parents/carers.

Section 3: Information, Consent and Confidentiality

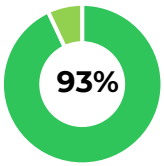
QNCC Team Recommendations

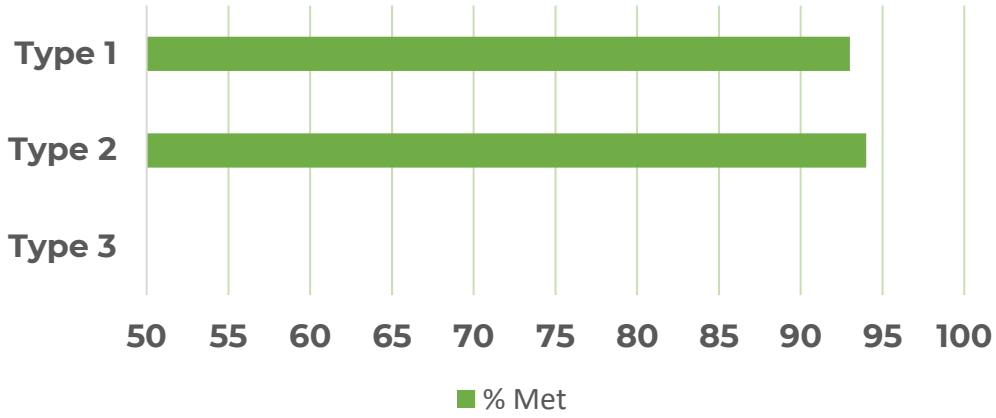
	Standard criteria	Recommendations
Standard 3.1.6	*Siblings of young people accessing the service are provided with clear information in an appropriate format e.g. Young Minds.*	Both ED and generic services were commonly not meeting this standard. Services should be familiar with local services and organisations offering support to siblings. This could be implemented within welcome packs and on service websites.
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 local population's characteristics. They should ensure that images they use reflects the local population. 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 to the same document.

Section 4: Rights and Safeguarding

Total Met Standards

Generic **Average total adherence to this subsection:**





Achievements

- **100%** of young people and parents/carers feel welcomed by staff members when attending the team base for their appointments.
- **100%** of services offer young people the opportunity to see a staff member on their own without other staff or family present. This is recorded in case records.
- **100%** of teams confirmed that staff act in accordance with current child protection protocols (e.g. the procedures of the Local Safeguarding Children Board).

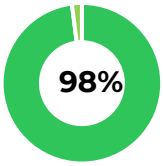
Areas for development

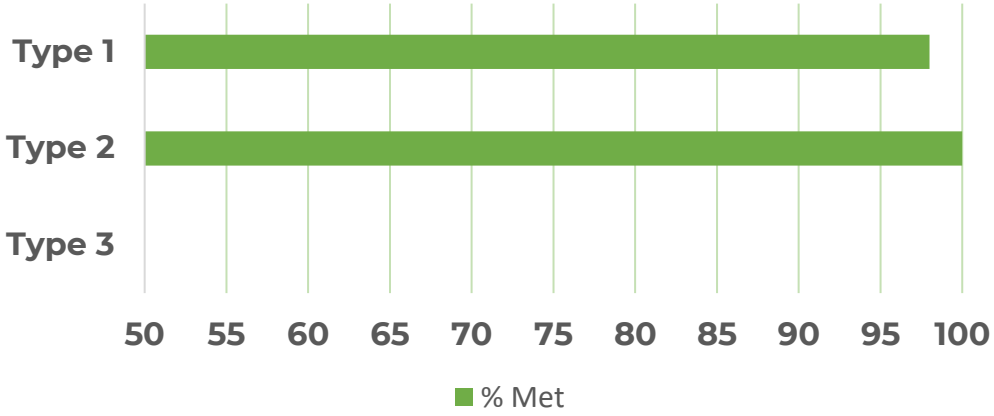
- Staff members treat young people and parents/carers with compassion, dignity and respect in **88%** of services.
- Young people and parents/carers feel listened to and understood by staff members in **88%** of the services.
- **65%** of teams confirmed there are formalised procedures in place for escalating a safeguarding referral via the identified safeguarding lead within 24 hours.

Section 4: Rights and Safeguarding

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- Young people and parents/carers feel welcomed by staff members when attending the team base for their appointments in **100%** of services.
- Young people are offered the opportunity to see a staff member on their own without other staff or family present in **100%** of services.
- Where a young person is identified as a young carer, the service is able to signpost to specific young carer support for the young person. This is true within **100%** of services.

Areas for development

- Young people and parents/carers feel listened to and understood by staff members in **92%** of services.
- **92%** of the services confirmed that a safeguarding referral is made to the Local Authority and no response is received within 24 hours, there are formalised procedures in place for escalation via the identified safeguarding lead.
- **92%** of teams reported that the specific safeguarding needs of young people who are Looked After are responded to through formalised policies, procedures and practice that are designed to protect them.

Section 4: Rights and Safeguarding

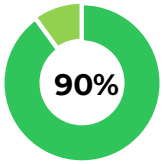
QNCC Team Recommendations

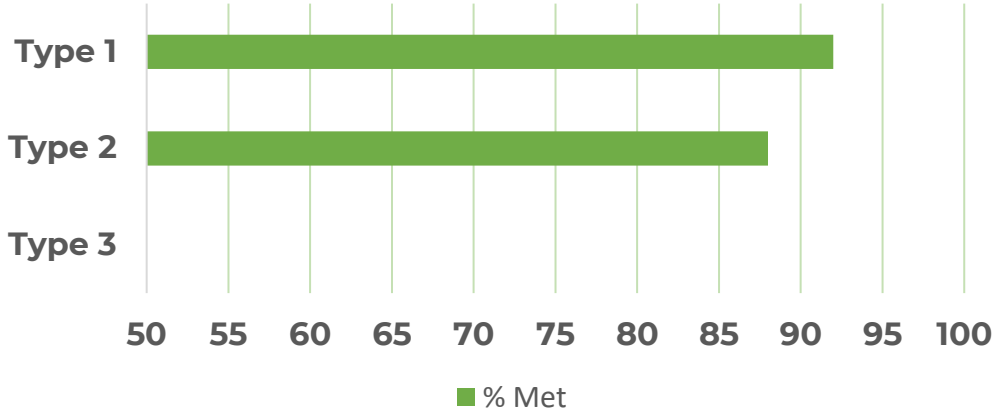
	Standard criteria	Recommendations
Standard 4.1.2 & 4.1.3	*Young people and parents/carers feel listened to and understood by staff members.* *&* *Staff members treat young people and parents/carers with compassion, dignity and respect.*	Although most services had met these standards, they were at a lower percentage across both generic and ED services. When teams receive this feedback, they should ensure that they explore this within team meetings and perhaps use this to form the basis of a QI project, future training, or an Away Day.
Standard 4.2.4	*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.*	Most services have this in place; however, this formalised procedure should be clearly communicated with staff, on notice boards and in policies. If a staff member had a question regarding safeguarding, it would be useful to have a flow chart they can refer to, which should also contain the named safeguarding lead and policy for escalation.
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, formalised procedures in place within safeguarding policies 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

Generic **Average total adherence to this subsection:**





Achievements

- Support is provided to young people in **100%** of services when their care is being transferred to another community team, or back to the care of their GP.
- **100%** of the teams confirmed that for young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant Local Authority Services.

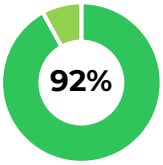
Areas for development

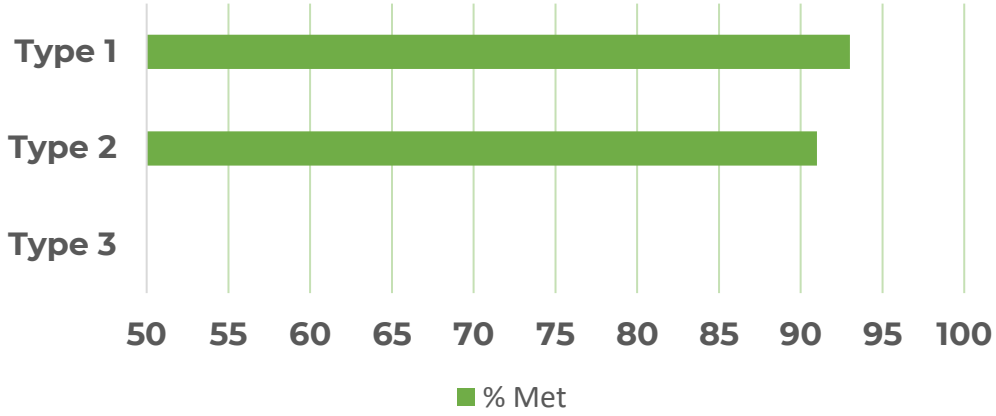
- Just **65%** of services send a discharge letter to the young person and all relevant parties (with the young person's consent) within 10 days of discharge. The letter includes the plan for: On-going care in the community/aftercare arrangements; Crisis and contingency arrangements including details of who to contact; Medication, including monitoring arrangements; Details of when, where and who will follow up with the young person as appropriate.
- When a young person is admitted to inpatient care, **87%** of the services have a community team representative that attends and contributes to ward rounds and discharge planning.
- **82%** of services actively collaborate with 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.

Section 5: Transfer of Care

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- **100%** of teams reported that when young people are referred to adult services, a joint transition meeting is organised between them and the adult team to ensure a comprehensive handover can take place.
- If a young person moves out of area and is being transferred to a new service, **100%** of services ensure that the responsibility is held with their current service until they receive their first assessment.
- When young people are transferred between community services, **100%** services provide a handover which ensures that the new team have an up-to-date care plan and risk assessment.

Areas for development

- A discharge letter is sent to the young person and all relevant parties within 10 days of discharge within **67%** of services.
- In **75%** of the services, young people can re-access the service after they have left, if needed, within agreed timeframes.
- In **82%** of services, there is a named link person who liaises between services around transitions, who is responsible for leadership around transitions and monitors the quality of the transition process.

Section 5: Transfer Of Care

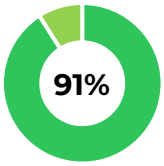
QNCC Team Recommendations

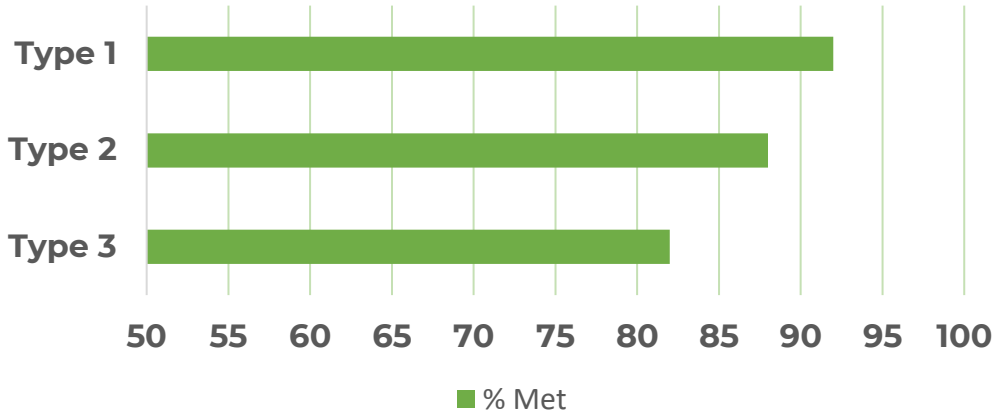
	Standard criteria	Recommendations
Standard 5.2.2	*When a young person is admitted to inpatient care, a community team representative attends and contributes to ward rounds and discharge planning.*	Services have often found that having assigned members of staff to regularly attend ward rounds and support discharge planning, not only improves patient care but also improves professional relationships with local hospitals and inpatient wards.
Standard 5.3.2	*CAMHS 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, it is important to do this to prepare young people for discharge. 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

Generic **Average total adherence to this subsection:**





Achievements

- **100%** of teams have identified links with education, education support services and school health services, including community paediatricians and school or college nurses.
- **100%** of services ensure that young people can access help from mental health services 24 hours a day, seven days a week.
- **100%** of services regularly liaise with representatives from all other agencies involved in young people's care, and this is documented in clinical notes.

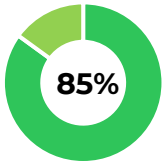
Areas for development

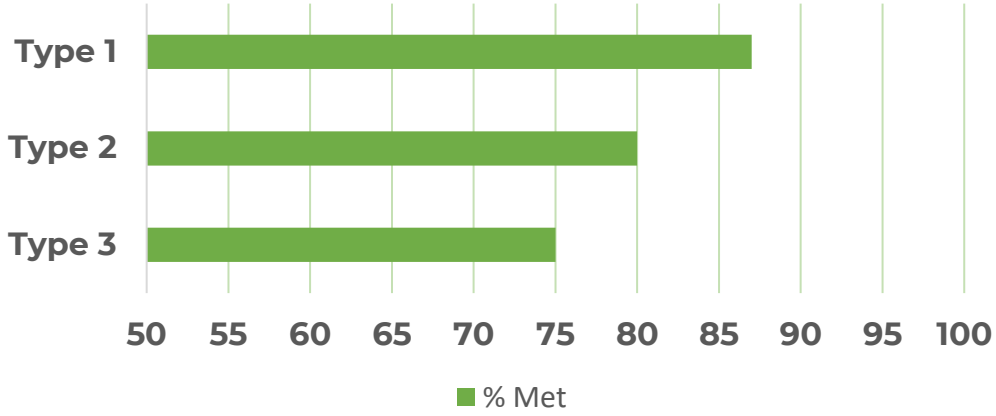
- **69%** of services have documented inter-agency agreements which clearly state the roles and responsibilities allocated to each organisation, and the names of responsible contacts.
- **65%** of services have an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/ harassment/ violence and advice for young people in mental health crisis.
- **75%** of services have 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; and Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.

Section 6: Multi-Agency Working

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- **100%** of teams have identified links with education, education support services and school health services, including community paediatricians and school or college nurses.
- **100%** of services ensure that young people can access help from mental health services 24 hours a day, seven days a week.

Areas for development

- **75%** of teams have identified links with community-based services which provide art/creative therapies
- Just **69%** of services have documented inter-agency agreements which clearly state the roles and responsibilities allocated to each organisation, and the names of responsible contacts.
- **65%** of services have 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.

Section 6: Multi-Agency Working

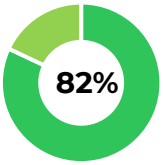
QNCC Team Recommendations

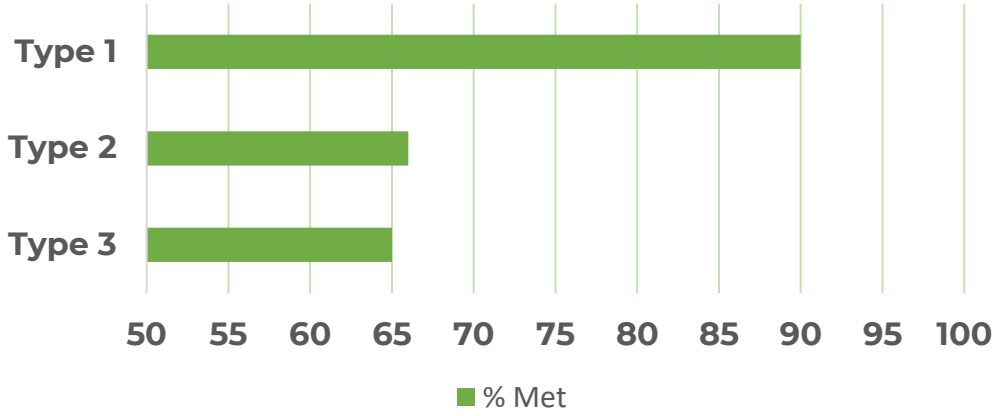
	Standard criteria	Recommendations
Standard 6.1.4	*Documented inter-agency agreements clearly state the roles and responsibilities allocated to each organisation, and the names of responsible contacts.*	QNCC members should ensure they have inter-agency agreements which clearly outline the roles and responsibilities of each organisation. This can ensure clarity and accountability, which will support with effective collaboration. Teams can utilise the QNCC Knowledge Hub or review days to see how other teams achieve this standard.
Standard 6.2.4 **Standard 6.2.5**	*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.*	Teams regularly struggle to meet this standard, and some have noted instances where police were unable to respond to their calls. Strengthening collaboration with the police could enhance response efforts in such situations and provide better support to young people experiencing mental health crises. Teams could begin by providing training sessions and requesting regular liaison meetings with local police to build these working relationships.
	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 standard was also a commonly not met standard in the last QNCC Annual Report which included data from reviews between 2020-2023. 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. Services 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 advice from perinatal services where a referral is not possible.

Section 7: Staffing and Training

Total Met Standards

Generic **Average total adherence to this subsection:**





Achievements

- **100%** of teams have an identified senior clinician available at all times who can attend the team base within an hour (or via video consultation in exceptional circumstances).
- **100%** of services provide new staff members, including bank staff, an induction based on an agreed list of core competencies.
- **100%** of services actively support staff health and well-being.

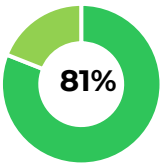
Areas for development

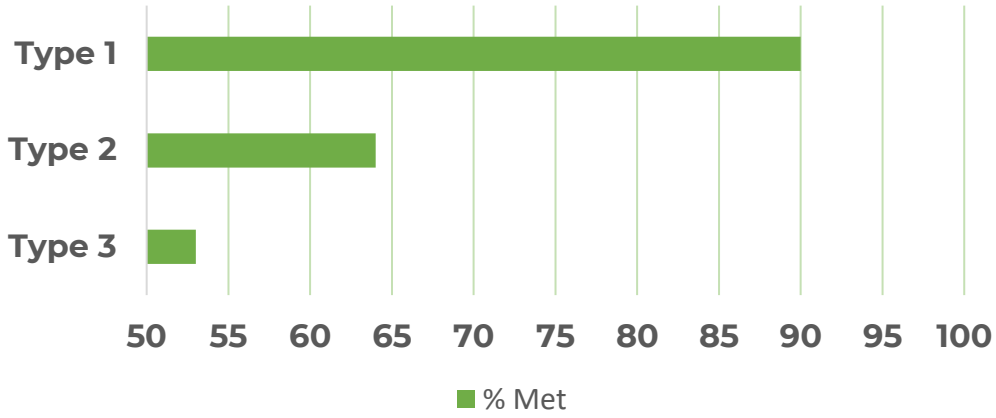
- Only **38%** of teams involve an appropriately experienced young person or parent/carer representative in the interview process for recruiting staff members.
- Additionally, **38%** of teams involve an appropriately experienced young person or parent/carer representative in delivering and developing training.
- Finally, **43%** of services have dedicated sessional input from arts or creative therapists.

Section 7: Staffing and Training

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- **100%** of services have administrative support or procedures in place to enable staff to support the effective running of the service
- **100%** of services actively support staff health and well-being.
- In **100%** of services, staff feel able to challenge decisions and to raise any concerns they may have about standards of care

Areas for development

- Only **8%** of teams include a peer support worker who can share knowledge, experiences and support to those currently accessing the service.
- Additionally, there is only dedicated sessional input from occupational therapists in **17%** of services.
- Only **17%** of teams involve an appropriately experienced young person or parent/carer representative in delivering and developing training.

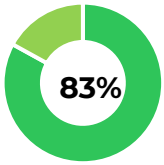
Section 7: Staffing and Training

QNCC Team Recommendations

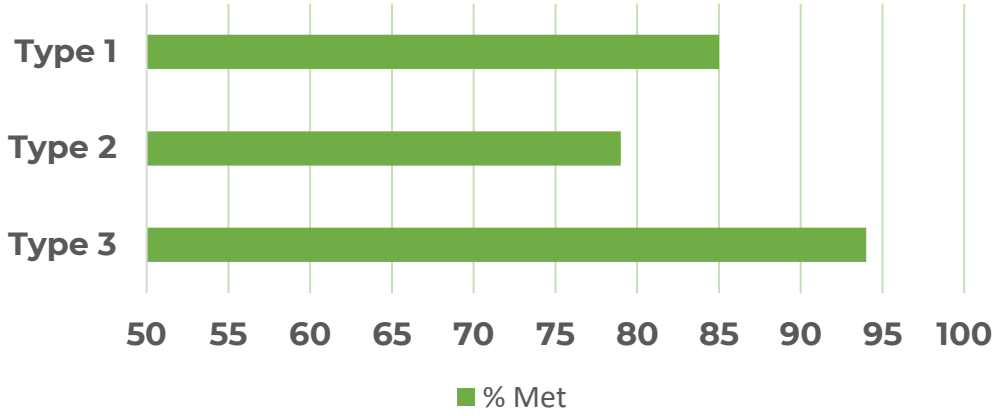
	Standard criteria	Recommendations
Standard 7.1.10 & 7.1.11	*There is dedicated sessional input from occupational therapists in order to: Provide an occupational assessment for those young people who require it; Ensure the safe and effective provision of evidence based occupational interventions adapted to young peoples' needs* *&* *There is dedicated sessional input from arts or creative therapists.*	Occupational therapy and creative therapy can be hugely supportive for young people, particularly for those who are neurodiverse or those with a learning disability. Teams should use the QNCC standards to form the basis of a business case for these staff members. If this is not possible, teams should explore links with voluntary/community-based teams that provide these services.
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.*	Many teams struggle to meaningfully embed participation within their work. Some eating disorder teams have taken on whole families or parents/carers as peer support workers, as this can help to enhance how young people, and their families are supported. Teams could also offer involvement opportunities to young people by adding this on feedback forms, for example by 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?". QNCC recommends that teams attend peer-reviews and accreditations to see how participation is carried out elsewhere.

Section 8: Location, Environment and Facilities

Generic **Average total adherence to this subsection:**



Total Met Standards



Achievements

- **100%** of teams offer appointments both in person and virtually, and patient preference is taken into account.
- **100%** of services keep all patient information in accordance with current legislation.
- **94%** of services are accessible via public transport or transport provided by the service.

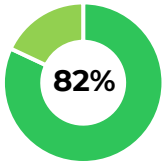
Areas for development

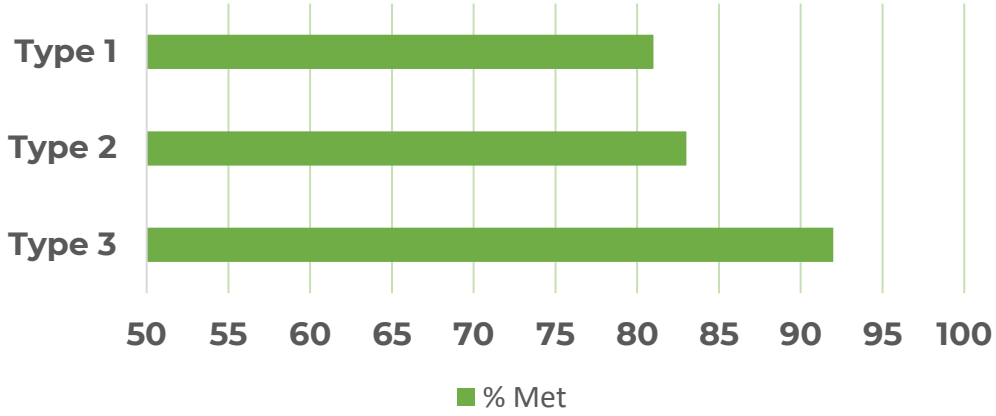
- **64%** of teams have sufficient car parking space for visitors, including allocated spaces for disabled access.
- Just **67%** of services have waiting areas that are sufficiently spacious and young person-friendly.
- **60%** of services have access to low-stimulation environments to meet the needs of young people who require them, including designated quiet areas.

Section 8: Location, Environment and Facilities

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- **100%** of teams offer appointments both in person and virtually, and patient preference is taken into account.
- **100%** of services ensure that staff members are easily identifiable (for example, by wearing appropriate identification).
- **100%** of services keep all patient information in accordance with current legislation.

Areas for development

- Just **67%** of waiting areas are sufficiently spacious and young person-friendly.
- **60%** of services have access to low-stimulation environments to meet the needs of young people who require them, including designated quiet areas.
- Only **50%** of teams have an alarm system in place (e.g. panic buttons or personal alarms) which this is easily accessible for young people, parents/carers and staff members.

Section 8: Location, Environment and Facilities

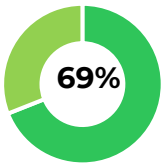
QNCC Team Recommendations

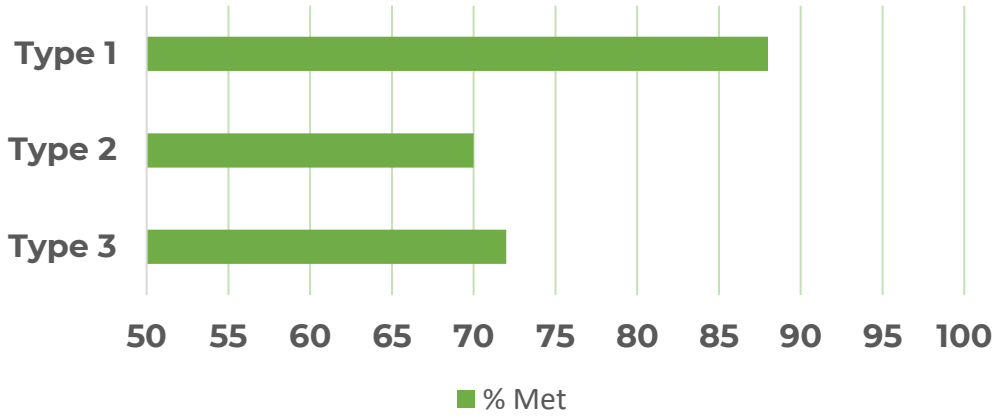
	Standard criteria	Recommendations
Standard 8.3.4	*CAMH services provide low-stimulation environments for young people who require them, including designated quiet areas.*	This was a commonly unmet standard amongst both general and ED CAMHS. Teams could consider making clinic rooms low-stimulation by 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 8.2.4	*Waiting areas are sufficiently spacious and young person-friendly.*	This was also commonly unmet by both types of services. Teams are encouraged to work with young people to make waiting areas more young-person friendly. For example, young people could be consulted on the design and layout of the space. If teams lack space, they should consider staggering appointment times to ensure these spaces do not get too busy.
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 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

Generic **Average total adherence to this subsection:**





Achievements

- Senior managers at **94%** of services 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%** of teams have 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.
- **88%** of services ask young people and parents/carers for their feedback about their experiences of using the service and this is used to improve the service.

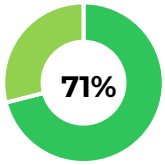
Areas for development

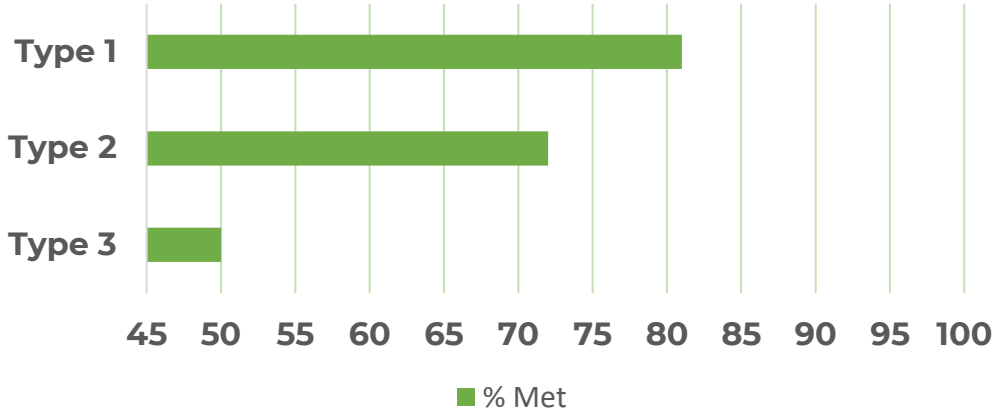
- Only **57%** of services are developed in partnership with appropriately experienced young people and parents/carers who have an active role in decision making.
- **65%** of services actively encourage young people and parents/carers to be involved in QI initiatives.
- **57%** of teams review the environmental and social value of its current practices against their organisation's or NHS green plan

Section 9: Commissioning and Service Management

Total Met Standards

Eating Disorder **Average total adherence to this subsection:**





Achievements

- Senior managers at **92%** of services work collaboratively with the CAMHS commissioning lead for each commissioning agency involved and are aware of their responsibilities as outlined in the service specification.
- In **91%** of teams, there is a mechanism to highlight system-wide commissioning gaps, especially around complex cases e.g. sensory impairments, severe learning disability and complex physical needs.
- **92%** of services use quality improvement methods to implement service improvements.

Areas for development

- Only **58%** of teams have 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
- **65%** of services actively encourage young people and parents/carers to be involved in QI initiatives.
- **57%** of teams review the environmental and social value of its current practices against their organisation's or NHS green plan

Section 9: Commissioning and Service Management

QNCC Team Recommendations

	Standard criteria	Recommendations
Standard 9.2.7	*The team actively encourage young people and parents/carers to be involved in QI initiatives.*	Teams are encouraged to actively seek input from young people and their parents or carers. Opportunities for feedback could be advertised in feedback forms or during parent/carer support groups. Challenges identified through feedback could serve as the foundation for QI initiatives. Once a topic has been selected, families could be invited to contribute further, ensuring their perspectives shape the outcomes.
Standard 9.2.4	*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.*	Interestingly, this was an area of achievement for Generic teams, but a challenge for Eating Disorder teams. Teams should ensure that there is protected time for relevant stakeholders to contribute to service development. Structured opportunities, such as consultation meetings, focus groups, or collaborative workshops, could be organised to gather insights.
Standard 9.2.1	*The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions).*	Teams are encouraged to review their practices to ensure they are providing greener, more sustainable healthcare. For more information on this, teams are encouraged to visit the Royal College of Psychiatrist's Guidance on Net Zero Mental Health Care webpage.

Cycle 23/24 Events

QNCC Annual Forum – Monday 14 October 2024 (in person). Theme: *Participation in Community CAMHS*

100%

of delegates that left feedback rated the event Excellent – Good overall.

51

delegates attended

QNCC Special Interest Day Friday 10 May 2024
Theme: *Collaborating between Primary Care and Community Eating Disorder CAMHS Teams*

72

delegates attended

100%

of delegates that left feedback rated the event Excellent – Good overall.

Planned for Cycle 2024/25

QNCC Special Interest Day
22 May 2025, via Zoom.
Theme: How can systems support individualised care?

QNCC Annual Forum
1 December 2025, In Person at 21 Prescot Street, London, E1 8BB.

For more information visit our event page: QNCC news and events (rcpsych.ac.uk)

CAMHS Accreditation Training (Online) – 02 October 2024, 06 February 2025

78

delegates attended across the two days

and rated the training as

4.3

out of 5

Get involved with QNCC

Join Discussions Using the QNCC Knowledge Hub

Member services can gain instant advise 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 2023/24
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.	**71%**
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.	**92%**
1.1.3	**1**	A clinical member of staff is available to discuss emergency referrals during working hours.	**100%**
1.1.4	**2**	Young people and families are able to make a self-referral to the service.	**73%**
1.1.5	**1**	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. If a referral is accepted the service should provide information on: • 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.	**88%**
1.2	**Measures are taken to ensure equity of access**		
1.2.1	**1**	Appointments are flexible and responsive to the needs of young people and their parents/carers where appropriate. *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.*	100%

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.	**88%**
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%**
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.*	**88%**
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.*	**71%**
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).	**65%**
1.3.2	**1**	Young people with urgent mental health needs can access a mental health assessment within 24 hours.	**65%**
1.3.3	**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 interpreter, how to change the appointment time or have difficulty in getting there).	**88%**
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.	**67%**
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%**
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.*	**94%**
1.4.3	**1**	Young people have a comprehensive assessment which includes: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development; • Risk, including risk of suicide.	**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%**
1.4.5	**1**	Assessments are based on the wishes and goals of young people, the family and their capacity to support interventions.	**100%**
1.4.6	**1**	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	**94%**
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.	**59%**
1.4.8	**2**	95% of Young people assessed as requiring treatment see an appropriate clinician within access and waiting times guidelines relevant to the practice area and local agreements.	**47%**
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%**
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.	**76%**

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.	**82%**
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%**
1.6.3	**1**	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency.	**88%**

Section 2: Care and Intervention

Standard number	Standard type	Criteria	Percentage met 2023/4
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%**
2.1.2	**1**	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. 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.	**65%**
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.	**88%**
2.1.4	**1**	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. *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.*	**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.	**94%**
2.1.6	**2**	Young people and their parents consistently see the same clinician for intervention, unless their preference or clinical need demands otherwise.	**94%**

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. *Guidance: This should be referred to in service information.*	**94%**
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.	**87%**
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.*	**93%**
2.2.3	**1**	The safe use of medication is audited, at least annually and at a service level.	**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.	**93%**
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.	**86%**
2.2.6	**3**	Young people, parents/carers and prescribers can contact a specialist pharmacist to discuss medications.	**36%**
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.	**82%**

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.*	**92%**
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: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	**88%**
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%**
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.*	**88%**
2.4.3	**2**	Parents/carers are offered individual time with staff members to discuss concerns, family history and their own needs.	**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:* *- 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.*	**59%**
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.	**76%**
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%

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.	**82%**
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.	**56%**

Section 3: Information, Consent and Confidentiality

Standard number	Standard type	Criteria	Percentage met 2023/24
3.1		**Young people and their parents/carers are provided with information that is accessible and appropriate for their use** *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.*	
3.1.1	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.	**29%**
3.1.2	2	All information materials such as leaflets are regularly updated and include a date for revision.	**50%**
3.1.3	2	Young people and their parents/carers are able to access information on the service via an up-to-date website.	**65%**
3.1.4	1	Young people and parents/carers are offered written and verbal information about the young person's difficulties.	**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.	**76%**
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.	**59%**
3.1.7	2	The service provides young people and their parents or carers with service information that is culturally relevant and sensitive to protected characteristics. *Guidance: For example, images used in posters and leaflets fully reflect the cultural diversity of the community.*	**65%**

3.1.8	**2**	Information designed for young people and parents/carers is written with the participation of young people and parents/carers. *Guidance: For example, including quotations or narratives reflecting the real experiences of the young people and parents who have used the service.*	**59%**
3.2	**Staff follow clear procedures for gaining valid consent to treatment**		
3.2.1	**1**	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%**
3.2.2	**1**	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. 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: • 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 *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.*	**94%**
3.2.3	**1**	Where parental responsibility is held by a third party, young people and their parents/carers are informed about the procedures for obtaining consent. *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).*	**88%**
3.3	**Young people and their parents are well-informed about confidentiality and their rights to access information held about them**		

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.	**94%**
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%**
3.3.3	**1**	The team knows how to respond to parents/carers when the young person does not consent to their involvement.	**100%**

Section 4: Rights and Safeguarding

Standard number	Standard type	Criteria	Percentage met 2023/4
4.1	**Young people and parents/carers are treated with dignity and respect**		
4.1.1	**1**	Young people and parents/carers feel welcomed by staff members when attending the team base for their appointments. *Guidance: Staff members introduce themselves to young people and address them using the name and title they prefer.*	**100%**
4.1.2	**1**	Staff members treat young people and parents/carers with compassion, dignity and respect. *Guidance: This can be evidenced through the CHI-ESQ.*	**88%**
4.1.3	**1**	Young people and parents/carers feel listened to and understood by staff members. *Guidance: This can be evidenced through PREMS.*	**88%**
4.1.4	**1**	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.	**100%**
4.1.5	**2**	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. *Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.*	**94%**
4.2	**Young people are protected from abuse through clear safeguarding policies and procedures**		
4.2.1	**1**	Staff act in accordance with current child protection protocols (e.g. the procedures of the Local Safeguarding Children Board).	**100%**
4.2.2	**1**	The organisation has a named doctor and a named nurse responsible for child protection. *Guidance: This may include safeguarding lead or the organisation's child protection lead.*	**100%**

4.2.3	**1**	Young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services). *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.*	**100%**
4.2.4	**1**	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.	**65%**
4.2.5	**1**	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.	**94%**
4.2.6	**1**	The team records which young people are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	**94%**
4.2.7	**1**	Where a young person is identified as a young carer, the service is able to signpost to specific young carer support for the young person.	**94%**

Section 5: Transfer of Care

Standard number	Standard type	Criteria	Percentage met 2023/4
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: • 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.	**65%**
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.	**94%**
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.	**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. *Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.*	**93%**
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%**
5.1.6	**2**	Having left the service, young people can re-access the service if needed, within agreed timeframes. *Guidance: There may be exceptions where young people require a generic assessment and where it may be appropriate to follow the initial referral pathway.*	**94%**

5.1.7	**2**	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. *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.*	**81%**
5.1.8	**1**	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.	**94%**
5.2	**Transfer to inpatient care:**		
5.2.1	**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.	**93%**
5.2.2	**1**	When a young person is admitted to inpatient care, a community team representative attends and contributes to ward rounds and discharge planning. *Guidance: This may be in person or via teleconferencing facilities, for example.*	**87%**
5.3	**Transfer to adult mental health services:**		
5.3.1	**1**	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.	**82%**
5.3.2	**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.	**94%**
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.	**94%**
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.	**88%**

Section 6: Multi-Agency Working

Standard number	Standard type	Criteria	Percentage met 2023/4
6.1	**The service has identified links within a range of services and agencies, including:**		
6.1.1	**1**	Local GP surgeries.	**100%**
6.1.2	**1**	Paediatrics, development centres and other health services for children and young people, including neurological services where appropriate.	**100%**
6.1.3	**1**	Education, education support services and school health services, including community paediatricians and school or college nurses.	**100%**
6.1.4	**1**	Organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services.	**100%**
6.1.5	**1**	Forensic mental health services.	**100%**
6.1.6	**1**	Youth justice service.	**100%**
6.1.7	**1**	Young people's drug and alcohol teams/substance misuse services.	**100%**
6.1.8	**2**	Dietetics.	**88%**
6.1.9	**2**	Community-based services which provide art/creative therapies.	**94%**
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. *Guidance: This should follow the service specification.*	**69%**
6.2.2	**1**	There are locally agreed health-based places of safety that are designed for young people.	**88%**
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. *Guidance: This includes joint care reviews and jointly organising admissions to hospital for young people in crisis.*	**80%**

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%
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: • 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.	**75%**
6.2.6	**1**	Young people can access help from mental health services 24 hours a day, seven days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams.*	**100%**
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.	**100%**
6.3.2	**2**	CAMHS offer consultation and training to partner agencies. *Guidance: For example, by appointing link persons to work with education, social services, drug and alcohol teams, and primary healthcare.*	**88%**
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.	**82%**

Section 7: Staffing and Training

Standard number	Standard type	Criteria	Percentage met 2023/4
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%**
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%**
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.	**88%**
7.1.4	**1**	There is an identified senior clinician available at all times who can attend the team base within an hour. *Guidance: Some services may have an agreement with a local GP to provide this medical cover.*	**100%**
7.1.5	**1**	Administrative support or procedures are in place to enable staff to support the effective running of the service.	**100%**
7.1.6	**1**	All staff have clearly defined job descriptions and job plans which are revised at least annually.	**88%**
7.1.7	**3**	The team includes a peer support worker who can share knowledge, experiences and support to those currently accessing the service. *Guidance: This might include providing accounts of their experiences to new young people and parents/carers through a support group or documentation*	**40%**

7.1.8	**1**	There is dedicated sessional time from psychologists in order to: Provide assessment and formulation of young peoples' psychological needs; Ensure the safe and effective provision of evidence based psychological interventions adapted to young peoples' needs through a defined pathway.	**88%**
7.1.9	**2**	There is dedicated sessional time from psychologists to support a whole-team approach for psychological management.	**81%**
7.1.10	**2**	There is dedicated sessional input from occupational therapists in order to: Provide an occupational assessment for those young people who require it; Ensure the safe and effective provision of evidence based occupational interventions adapted to young peoples' needs	**60%**
7.1.11	**3**	There is dedicated sessional input from arts or creative therapists.	**43%**
7.1.12	**3**	All staff members who deliver therapies and activities are appropriately trained and supervised.	**88%**
7.2	**The service takes steps to ensure that staff are sufficiently qualified to fulfil their roles**		
7.2.1	**1**	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. *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.*	**100%**
7.2.2	**1**	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.	**38%**

7.3	**Staff are regularly appraised and supervised and know how to gain additional support when needed**		
7.3.1	**1**	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. *Guidance: This contains clear objectives and identifies development needs.*	**82%**
7.3.2	**1**	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	**82%**
7.3.3	**2**	All staff members receive line management supervision at least monthly.	**65%**
7.3.4	**3**	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.	**76%**
7.3.5	**1**	Legal advice is available to staff on issues such as information sharing, confidentiality, consent, rights and child protection *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.*	**94%**

7.3.6	**1**	Staff members follow a lone working policy and feel safe when conducting home visits. *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.*	**82%**
7.4	**Staff members are supported by management**		
7.4.1	**1**	The service actively supports staff health and well-being. *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.*	**100%**
7.4.2	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive or equivalent. *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.*	**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%**
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%**
7.4.5	**1**	Staff members, young people and parents/carers who are affected by a serious incident are offered post incident support.	**94%**
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.	**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.	**94%**

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).	**75%**
7.5.2	**1**	Physical health assessment. *Guidance: This includes training in understanding physical health problems, understanding physical observations and when to refer the young person for specialist input.*	**71%**
7.5.3	**1**	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	**88%**
7.5.4	**1**	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.*	**88%**
7.5.5	**1**	Recognising and communicating with young people with cognitive impairment or learning disabilities.	**71%**
7.5.6	**1**	Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance and basic life support.*	**76%**
7.5.7	**2**	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	**76%**
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.	**88%**
7.5.9	**2**	Young people, parents/carers and staff members are involved in devising and delivering face-to-face training.	**38%**
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.	**76%**
7.6.2	**1**	Frontline staff are consulted on relevant management decisions such as developing and reviewing operational policies.	**82%**

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%**
7.6.4	**1**	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. *Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.*	**94%**
7.6.5	**3**	There is a commitment and financial support to enable staff to contribute to multi-centre clinical audit or research.	**85%**

Section 8: Location, Environment and Facilities

Standard number	Standard type	Criteria	Percentage met 2023/4
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.	**94%**
8.1.2	**2**	There is sufficient car parking space for visitors, including allocated spaces for disabled access.	**63%**
8.1.3	**1**	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	**88%**
8.1.4	**2**	The team offers appointments both in person and virtually, and patient preference is taken into account.	**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.	
8.2.2	**2**	CAMHS practitioners have access to large and small rooms suitable for individual and family consultations.	**88%**
8.2.3	**1**	Clinical rooms are private and conversations cannot be easily over-heard.	**94%**
8.2.4	**2**	Waiting areas are sufficiently spacious and young person-friendly. *Guidance: Play and reading materials are age- and developmentally-appropriate for the whole age range.*	**75%**
8.2.5	**1**	All information, including audio and visual material, about the young person is kept in accordance with current legislation. *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.*	**67%**
8.2.6	**1**	Staff members are easily identifiable (for example, by wearing appropriate identification).	**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%**
8.3.2	**2**	The team base is securely separated from adult services. *Guidance: There are separate areas and entrances for adult and CYP services, and access to CYP services is restricted*.	**93%**
8.3.3	**1**	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.	**88%**
8.3.4	**2**	CAMH services provide low-stimulation environments for young people who require them, including designated quiet areas. *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.*	**60%**
8.3.5	**1**	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.	**82%**
8.3.6	**1**	A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least annually.	**71%**
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.	**81%**
8.4	**Staff have sufficient office facilities and IT systems**		
8.4.1	**2**	Staff report they have sufficient space to complete administrative work. *Guidance: Staff can access suitable space to make confidential phone calls.*	**71%**
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.	**88%**

Section 9: Commissioning and Service Management

Standard number	Standard type	Criteria	Percentage met 2023/4
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.	**94%**
9.1.2	**1**	The service is explicitly commissioned or contracted against agreed standards. *Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders.*	**81%**
9.1.3	**2**	There is a widely understood CAMHS strategy that the local population can access. *Guidance: For example, for universal, targeted and specialist services.*	**76%**
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.	**82%**
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: • 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.	**67%**
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.	**56%**

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. *Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as young person and carer representatives.*	**67%**
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. *Guidance: For example, this may take the form of a combination of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups.*	**56%**
9.2.5	**2**	The team use quality improvement methods to implement service improvements.	**67%**
9.2.6	**2**	The team actively encourage young people and parents/carers to be involved in QI initiatives.	**56%**
9.2.7	**2**	The team actively encourage young people and parents/carers to be involved in QI initiatives.	**65%**
9.2.8	**3**	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions).	**57%**

QNCC Eating Disorder Standards 2nd Edition

Section 1: Access, Referral and Assessment

Standard number	Standard type	Criteria	Percentage met 2023/4
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.	**75%**
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.	**91%**
1.1.3	**1**	A clinical member of staff is available to discuss emergency referrals during working hours.	**100%**
1.1.4	**2**	Young people and families are able to make a self-referral to the service	**42%**
1.1.5	**1**	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. If a referral is accepted the service should provide information on: - 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.	**92%**
1.2	**Measures are taken to ensure equity of access**		
1.2.1	**1**	Appointments are flexible and responsive to the needs of young people and their parents/carers where appropriate 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	**100%**

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.	**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%**
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%**
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.	**67%**
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.	**58%**
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)	**50%**
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)	**100%**
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).	**75%**
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.	**100%**

1.3.6	**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, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there -Who to contact if the situation worsens significantly, and Crisis lines.	**83%**
1.3.7	**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. The young person receives a copy.	**67%**
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%**
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	**92%**
1.4.3	**1**	Young people have a comprehensive assessment which includes: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development; • Risk, including risk of suicide.	**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.	**92%**
1.4.5	**1**	Assessments are based on the wishes and goals of young people, the family and their capacity to support interventions.	**100%**
1.4.6	**1**	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	**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.	**100%**
1.4.8	**1**	95% of young people assessed as requiring routine or non-urgent treatment for an eating disorder start NICE concordant treatment within 4 weeks of referral.	**75%**
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%**
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.	**58%**

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: • 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	**100%**
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%**
1.6.3 [ED]	**1**	Protocols for collaborative mental health and paediatric/medical care are in place for any young person requiring acute medical stabilisation. 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	**83%**
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.	**92%**
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.	**92%**
1.6.6	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.	**83%**

Section 2: Care and Intervention

Standard number	Standard type	Criteria	Percentage met 2023/4
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%**
2.1.2	**1**	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. 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.	**67%**
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.	**92%**
2.1.4 [ED]	**1**	Young people are offered treatment for common comorbid problems by the CEDS.	**100%**
2.1.5	**1**	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. 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.	**100%**

2.1.6	**1**	All young people know who is co-ordinating their care and how to contact them if they have any questions.	**92%**
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	**92%**
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	**92%**
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.	**92%**
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%**
2.2.3	**1**	The safe use of medication is audited, at least annually and at a service level.	**73%**
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%**
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.	**92%**
2.2.6	**3**	Young people, parents/carers and prescribers can contact a specialist pharmacist to discuss medications.	**45%**

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%**
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	**92%**
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: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	**83%**
2.3.4	**2**	The team provides information, signposting and encouragement to young people to access local organisations for peer support, social engagement and work/education opportunities such as: Voluntary organisations; Community centres; Local religious/cultural groups; Peer support networks; Recovery colleges, pre-vocational training or employment programmes	**83%**
2.3.5	**1**	The team signposts young people to structured activities such as work, education and volunteering.	**75%**
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%**

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.	**75%**
2.4.3	**2**	Parents/carers are offered individual time with staff members to discuss concerns, family history and their own needs.	**92%**
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: - 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.	**83%**
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.	**83%**
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%**
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.	**58%**
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.	**92%**
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.	**42%**
2.5.4	**3**	The team supports young people to access local green space on a regular basis.	**67%**

Section 3: Information, Consent and Confidentiality

Standard number	Standard type	Criteria	Percentage met 2023/4
3.1	**Young people and their parents/carers are provided with information that is accessible and appropriate for their use**		
3.1.1	**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.	**67%**
3.1.2	**2**	All information materials such as leaflets are regularly updated and include a date for revision.	**83%**
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%**
3.1.4	**1**	Young people and parents/carers are offered written and verbal information about the young person's difficulties.	**92%**
3.1.5	**2**	Staff provide young people and their parents with information about the roles played by key professionals across the CAMHS team.	**83%**
3.1.6 [ED]	**3**	Siblings of young people with an eating disorder are provided with clear information in an appropriate format.	**58%**
3.1.7	**2**	The service provides young people and their parents or carers with service information that is culturally relevant and sensitive to protected characteristics. *Guidance: For example, images used in posters and leaflets fully reflect the cultural diversity of the community*	**58%**

3.1.8	**2**	Information designed for young people and parents/carers is written with the participation of young people and parents/carers. *Guidance: For example, including quotations or narratives reflecting the real experiences of the young people and parents who have used the service*	**67%**
3.2	**Staff follow clear procedures for gaining valid consent to treatment**		
3.2.1	**1**	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.	**100%**
3.2.2	**1**	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. 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: • 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 *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*	**100%**
3.2.3	**1**	Where parental responsibility is held by a third party, young people and their parents/carers are informed about the procedures for obtaining consent. *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)*	**83%**
3.3	**Young people and their parents are well-informed about confidentiality and their rights to access information held about them**		

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.	**75%**
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.	**83%**
3.3.3	**1**	The team knows how to respond to parents/carers when the young person does not consent to their involvement.	**100%**

Section 4: Rights and Safeguarding

Standard number	Standard type	Criteria	Percentage met 2023/4
4.1	**Young people and parents/carers are treated with dignity and respect**		
4.1.1	**1**	Young people and parents/carers feel welcomed by staff members when attending the team base for their appointments. *Guidance: Staff members introduce themselves to young people and address them using the name and title they prefer.*	**100%**
4.1.2	**1**	Staff members treat young people and parents/carers with compassion, dignity and respect. *Guidance: This can be evidenced through the CHI-ESQ.*	**100%**
4.1.3	**1**	Young people and parents/carers feel listened to and understood by staff members. *Guidance: This can be evidenced through PREMS.*	**92%**
4.1.4	**1**	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.	**100%**
4.1.5	**2**	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. *Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.*	**100%**
4.2	**Young people are protected from abuse through clear safeguarding policies and procedures**		
4.2.1	**1**	Staff act in accordance with current child protection protocols (e.g. the procedures of the Local Safeguarding Children Board).	**100%**

4.2.2	**1**	The organisation has a named doctor and a named nurse responsible for child protection. *Guidance: This may include safeguarding lead or the organisation's child protection lead*	**100%**
4.2.3	**1**	Young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services). *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*	**100%**
4.2.4	**1**	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.	**92%**
4.2.5	**1**	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.	**92%**
4.2.6	**1**	The team records which young people are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	**100%**
4.2.7	**1**	Where a young person is identified as a young carer, the service is able to signpost to specific young carer support for the young person.	**100%**

Section 5: Transfer of Care

Standard number	Standard type	Criteria	Percentage met 2023/4
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: • 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%**
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%**
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%**
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. *Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.*	**92%**
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%**
5.1.6	**2**	Having left the service, young people can re-access the service if needed, within agreed timeframes. *Guidance: There may be exceptions where young people require a generic assessment and where it may be appropriate to follow the initial referral pathway*	**75%**

5.1.7 [ED]	**2**	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. *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*	**92%**
5.1.8	**1**	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.	**100%**
5.2	**Transfer to inpatient care:**		
5.2.1	**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	**83%**
5.2.2	**1**	When a young person is admitted to inpatient care, a community team representative attends and contributes to ward rounds and discharge planning. *Guidance: This may be in person or via teleconferencing facilities, for example.*	**92%**
5.2.3 [ED]	**1**	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.	**100%**
5.3	**Transfer to adult mental health services:**		
5.3.1	**1**	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.	**100%**
5.3.2	**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.	**82%**

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%**
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%**

Section 6: Multi-Agency Working

Standard number	Standard type	Criteria	Percentage met 2023/4
6.1	**The service has identified links within a range of services and agencies, including:**		
6.1.1	**1**	Local GP surgeries	**92%**
6.1.2	**1**	Paediatrics, development centres and other health services for children and young people, including neurological services where appropriate	**92%**
6.1.3	**1**	Education, education support services and school health services, including community paediatricians and school or college nurses	**100%**
6.1.4	**1**	Organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services.	**83%**
6.1.5	**1**	Forensic mental health services	**82%**
6.1.6	**1**	Youth justice service	**82%**
6.1.7	**1**	Young people's drug and alcohol teams/substance misuse services	**92%**
6.1.8	**2**	Dietetics	**92%**
6.1.9	**2**	Community-based services which provide art/creative therapies	**75%**
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. *Guidance: This should follow the service specification.*	**64%**
6.2.2	**1**	There are locally agreed health-based places of safety that are designed for young people.	**92%**

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. *Guidance: This includes joint care reviews and jointly organising admissions to hospital for young people in crisis.*	**83%**
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.	**58%**
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: · 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.	**75%**
6.2.6	**1**	Young people can access help from mental health services 24 hours a day, seven days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams.*	**100%**
6.2.7 [ED]	**1**	Paediatric care for both acute and chronic aspects of routine eating disorder management includes liaison with paediatric specialities and community services as needed.	**92%**
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.	**92%**
6.3.2	**2**	CAMHS offer consultation and training to partner agencies. *Guidance: For example, by appointing link persons to work with education, social services, drug and alcohol teams, and primary healthcare*	**92%**

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.	**75%**

Section 7: Staffing and Training

Standard number	Standard type	Criteria	Percentage met 2023/4
7.1	**There are appropriate numbers of skilled staff**		
7.1.1 [ED]	**1**	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. *Guidance: Staff are appropriately trained to provide NICE-compliant treatments and appropriate ongoing supervision of such treatments*	**67%**
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.	**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.	**100%**
7.1.4	**1**	There is an identified senior clinician available at all times who can attend the team base within an hour. *Guidance: Some services may have an agreement with a local GP to provide this medical cover.*	**83%**
7.1.5	**1**	Administrative support or procedures are in place to enable staff to support the effective running of the service	**100%**
7.1.6	**1**	All staff have clearly defined job descriptions and job plans which are revised at least annually	**100%**

7.1.7	**3**	The team includes a peer support worker who can share knowledge, experiences and support to those currently accessing the service. *Guidance: This might include providing accounts of their experiences to new young people and parents/carers through a support group or documentation*	**8%**
7.1.8	**1**	There is dedicated sessional time from psychologists in order to: Provide assessment and formulation of young peoples' psychological needs; Ensure the safe and effective provision of evidence based psychological interventions adapted to young peoples' needs through a defined pathway.	**67%**
7.1.9	**2**	There is dedicated sessional time from psychologists to support a whole-team approach for psychological management	**67%**
7.1.10	**3**	There is dedicated sessional input from occupational therapists in order to: Provide an occupational assessment for those young people who require it; Ensure the safe and effective provision of evidence based occupational interventions adapted to young peoples' needs	**17%**
7.1.11	**3**	There is dedicated sessional input from arts or creative therapists	**42%**
7.1.12	**1**	There is dedicated sessional input from a dietitian with responsibility to: Provide dietetic assessment, advice and treatment to patients and to staff Support staff to devise meal plans, manage risk related to refeeding Oversee the nutritional care plan and psychoeducation regarding nutrition, weight and food	**100%**
7.1.13	**3**	All staff members who deliver therapies and activities are appropriately trained and supervised.	**83%**
7.2	**The service takes steps to ensure that staff are sufficiently qualified to fulfil their roles**		

7.2.1	**1**	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. *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.*	**75%**
7.2.2	**1**	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.	**67%**
7.3	**Staff are regularly appraised and supervised and know how to gain additional support when needed**		
7.3.1	**1**	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. *Guidance: This contains clear objectives and identifies development needs*	**100%**
7.3.2	**1**	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	**92%**
7.3.3	**2**	All staff members receive line management supervision at least monthly.	**58%**
7.3.4	**3**	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.	**83%**
7.3.5	**1**	Legal advice is available to staff on issues such as information sharing, confidentiality, consent, rights and child protection *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*	**100%**
7.3.6	**1**	Staff members follow a lone working policy and feel safe when conducting home visits. *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*	**100%**

7.4	**Staff members are supported by management**		
7.4.1	**1**	The service actively supports staff health and well-being. 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.	**100%**
7.4.2	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive or equivalent. *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.*	**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%**
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%**
7.4.5	**1**	Staff members, young people and parents/carers who are affected by a serious incident are offered post incident support.	**82%**
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.	**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.	**100%**
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).	**83%**

7.5.2	**1**	Physical health assessment. *Guidance: This includes training in understanding physical health problems, understanding physical observations and when to refer the young person for specialist input.*	**67%**
7.5.3	**1**	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	**83%**
7.5.4	**1**	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.*	**92%**
7.5.5	**1**	Recognising and communicating with young people with cognitive impairment or learning disabilities.	**83%**
7.5.6	**1**	Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance and basic life support.*	**83%**
7.5.7	**2**	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	**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.	**83%**
7.5.9	**2**	Young people, parents/carers and staff members are involved in devising and delivering face-to-face training.	**17%**
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.	**100%**
7.5.11 [ED]	**1**	Staff receive eating disorder-specific training to be able to support the physical needs of young people. *Guidance: This will include specific training on refeeding and dietary needs*	**75%**
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.	**92%**
7.6.2	**1**	Frontline staff are consulted on relevant management decisions such as developing and reviewing operational policies.	**92%**
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%**
7.6.4	**1**	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. *Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.*	**100%**
7.6.5	**3**	There is a commitment and financial support to enable staff to contribute to multi-centre clinical audit or research	**82%**

Section 8: Location, Environment and Facilities

Standard number	Standard type	Criteria	Percentage met 2023/4
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.	**92%**
8.1.2	**2**	There is sufficient car parking space for visitors, including allocated spaces for disabled access.	**75%**
8.1.3	**1**	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	**83%**
8.1.4	**2**	The team offers appointments both in person and virtually, and patient preference is taken into account	**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.	**83%**
8.2.2	**2**	CAMHS practitioners have access to large and small rooms suitable for individual and family consultations	**83%**
8.2.3	**1**	Clinical rooms are private and conversations cannot be easily over-heard.	**100%**
8.2.4 [ED]	**1**	CED centres have private rooms readily available for physical examinations. *Guidance: Relevant examination equipment, such as a weight stadiometer and a blood pressure machine, are provided.*	**75%**
8.2.5	**2**	Waiting areas are sufficiently spacious and young person-friendly. *Guidance: Play and reading materials are age- and developmentally-appropriate for the whole age range.*	**83%**

8.2.6	**1**	All information, including audio and visual material, about the young person is kept in accordance with current legislation. *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.*	**67%**
8.2.7	**1**	All patient information is kept in accordance with current legislation.	**100%**
8.2.8	**1**	Staff members are easily identifiable (for example, by wearing appropriate identification)..	**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.	**75%**
8.3.2	**2**	The team base is securely separated from adult services. Guidance: There are separate areas and entrances for adult and CYP services, and access to CYP services is restricted	**89%**
8.3.3	**1**	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	**83%**
8.3.4	**2**	CAMH services provide low-stimulation environments for young people who require them, including designated quiet areas *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*	**67%**
8.3.5	**1**	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.	**50%**
8.3.6	**1**	A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least annually.	**83%**

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.	**73%**
8.4	**Staff have sufficient office facilities and IT systems**		
8.4.1	**2**	Staff report they have sufficient space to complete administrative work. *Guidance: Staff can access suitable space to make confidential phone calls*	**83%**
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.	**83%**

Section 9: Commissioning and Service Management

Standard number	Standard type	Criteria	Percentage met 2023/4
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.	**92%**
9.1.2	**1**	The service is explicitly commissioned or contracted against agreed standards. *Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders.*	**67%**
9.1.3	**2**	There is a widely understood CAMHS strategy that the local population can access. Guidance: For example, for universal, targeted and specialist services	**75%**
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.	**91%**
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: • 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	**64%**

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.	**67%**
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. *Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as young person and carer representatives.*	**58%**
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. Guidance: For example, this may take the form of a combination of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups.	**83%**
9.2.5	**2**	The team use quality improvement methods to implement service improvements.	**58%**
9.2.6	**2**	The team actively encourage young people and parents/carers to be involved in QI initiatives.	**92%**
9.2.7	2	The team actively encourage young people and parents/carers to be involved in QI initiatives.	**58%**
9.2.8	3	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions).	**42%**

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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CAMHS Accreditation Committee:

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

Alex Milham, Team Leader & Family Therapist, Solent East ED

Jayne Rolands, School Manager/ Teacher, Cygnet Hospital Bury

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Sebastian Thompson, Clinical Psychologist, Cygnet Hospital Sheffield

Eshan Vadgama, Patient Representative

Acknowledgments continued

QNCC Patient and Carer Representatives

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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

Bradford Mental Health Support Team, Bradford District Care Trust

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

Dublin South Eating Disorder Service, 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 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

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

Leeds Community Eating Disorder Service, Leeds Community NHS Trust

Acknowledgments continued

QNCC Member Services Continued...

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

Lisburn CAMHS Lagan Valley, Belfast Health and Social Care 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

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

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

Acknowledgments continued

QNCC Member Services Continued... **[A]** indicates an accredited service, as of August 2023

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

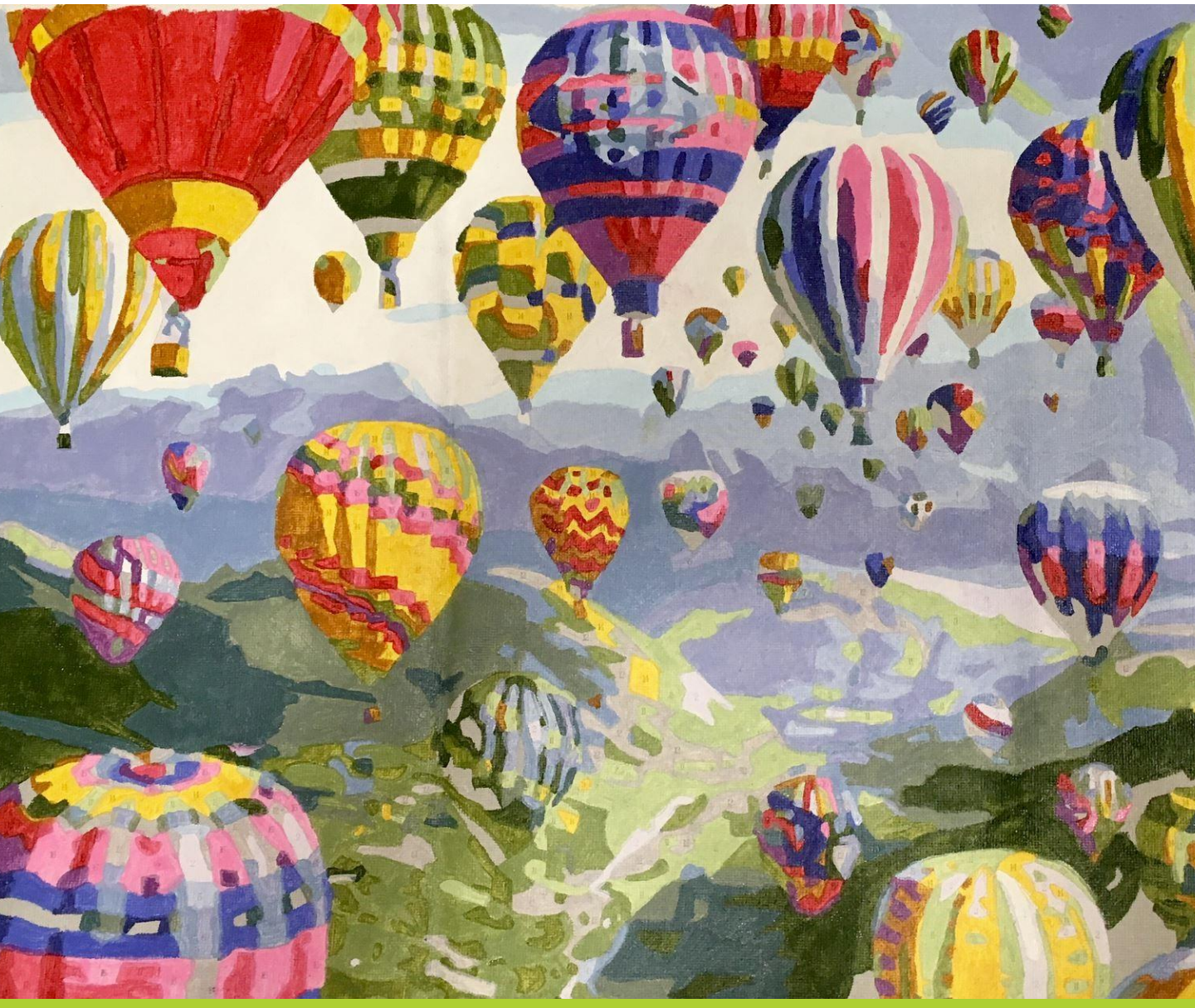
Warrington CAMHS, Mersey Care NHS Foundation Trust (Formally NWBH)

West London CAMHS Eating Disorders, West London NHS Trust

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

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

QNIC
QUALITY NETWORK FOR INPATIENT CAMHS



RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS