CAMHS QUALITY NETWORK FOR COMMUNITY CAMHS

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Quality Network for Community CAMHS Standards for Specialist Deaf Services

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Section 1: Access, Referral and Assessment			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
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.	**1.3**
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.	**1.5**
1.1.3	**1**	A clinical member of staff is available to discuss emergency referrals during working hours.	**1.4**
1.1.4	**2**	Young people and families are able to make a self-referral to the service	
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 provides 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.	
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.*	

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.	**1.1**
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.	**4.1**
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.*	**4.2**
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.*	
1.3	**Young people receive timely mental health assessments**		
1.3.1 (Deaf)	**1**	Young people with a routine referral receive a mental health assessment within eighteen weeks.	**1.6**
1.3.2 (Deaf)	**1**	Young people with urgent mental health needs are triaged to the appropriate mental health service within 24 hours.	**1.6**
1.3.3 (Deaf)	**1**	For non-urgent assessments, the team makes 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). *Guidance: Communication must be provided in an appropriate format to meet the needs of the young person and their family (e.g. BSL).*	**2.1**
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.	**3.6**

1.4	**Assessments are collaborative, individual and according to need**		
1.4.1 (Deaf)	**1**	All correspondence and communication with young people and their families is accessible, clear, and free from jargon.	
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*	
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.	**3.2**
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.	**3.4**
1.4.5	**1**	Assessments are based on the wishes and goals of young people, the family and their capacity to support interventions.	
1.4.6	**1**	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	
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.	
1.4.8 (Deaf)	**1**	The language and communication needs of the young person and their family are identified are part of the initial assessment.	
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.	
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.	

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.	**3.3**
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.	**7.1**
1.6.3	**1**	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency.	**7.3**

Section 2: Care and Intervention			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
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.	**12.3**
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.	**5.3**
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.	**3.5**
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. Interpreters and websites such as SignHealth, for example, could be used to access this information.*	
2.1.5	**1**	All young people know who is co-ordinating their care and how to contact them if they have any questions.	**5.1**
2.1.6	**2**	Young people and their parents/carers consistently see the same clinician for intervention, unless their preference or clinical need demands otherwise.	
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.*	

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.	**6.2.1**
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.*	**6.2.2**
2.2.3	**1**	The safe use of medication is audited, at least annually and at a service level.	
2.2.4 (Deaf)	**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. *Guidance: For regional deaf CAMHS services, this responsibility is shared with school nurses or GPs within the area to check the physical health of the young person.*	**6.2.4**
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.	**7.4**
2.2.6	**3**	Young people, parents/carers and prescribers can contact a specialist pharmacist to discuss medications.	**6.2.3**
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.	**7.2**

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.*	
2.3.3 (Deaf)	**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; • Local/national deaf events.	
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.	**13.1**
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.*	**13.2**
2.4.3	**2**	Parents/carers are offered individual time with staff members to discuss concerns, family history and their own needs.	**13.3**
2.4.4 (Deaf)	**2**	The team provides each parent/carer with accessible carer's information. *Guidance: Information is provided in a way the young person and their family will understand. 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.*	**13.4**
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.	**13.5**
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.	**23.1**

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.	**23.2**
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.	**23.3**

Section 3: Information, Consent and Confidentiality			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
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 (Deaf)	**1**	Information, including care plans, is available in a variety of formats to ensure it meets the needs and preferences of the young person and their family as identified in their communication profile.	
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.	**2.2**
3.1.2	**2**	All information materials such as leaflets are regularly updated and include a date for revision.	
3.1.3	**2**	Young people and their parents/carers are able to access information on the service via an up-to-date website.	
3.1.4 (Deaf)	**1**	Young people and parents/carers are offered information about the young person's difficulties in a format that is appropriate for their communication needs.	
3.1.5 (Deaf)	**2**	Staff provide young people and their parents with information about the roles played by key professionals across the CAMHS team. *Guidance: This may be achieved through signposting to national BSL videos about the roles of different professionals.*	
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.	

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.*	
3.1.8 (Deaf)	**2**	Information designed for young people and parents/carers is presented 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*	
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.	**11.1**
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*	
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)*	

3.3	**Young people and their parents are well-informed about confidentiality and their rights to access information held about them**		
3.3.1 (Deaf)	**1**	Confidentiality and its limits are explained to the young person and parent/carer, presented in a way they will understand. The young person's preferences for sharing information with third parties are respected and reviewed regularly.	**16.1**
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.	**15.1**
3.3.3	**1**	The team knows how to respond to parents/carers when the young person does not consent to their involvement.	**16.3**

Section 4: Rights and Safeguarding			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
4.1	**Young people and parents/carers are treated with dignity and respect**		
4.1.1 (Deaf)	**1**	Young people and parents/carers feel welcomed by staff members when attending their appointments. *Guidance: Staff members introduce themselves to young people and address them using the name and title they prefer.*	**3.1**
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.*	**14.1**
4.1.3	**1**	Young people and parents/carers feel listened to and understood by staff members. *Guidance: This can be evidenced through PREMS.*	**14.2**
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.	
4.1.5 (Deaf)	**1**	The service works with 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. The name of the interpreter should be checked with the family to ensure there are no conflicts of interest.*	**15.2**
4.1.6 (Deaf)	**2**	The same interpreter is booked for a series of appointments to ensure continuity for the young person and their family.	
4.1.7 (Deaf)	**2**	Time is allocated before appointments to brief interpreters about the aims of the meeting and any key information, and after the session for them to feed back about language use and any cultural issues which are relevant to the clinical appointment.	
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).	

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*	
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*	
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.	
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.	

Section 5: Transfer of Care			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
5.1	**Leaving the service:**		
5.1.1 (Deaf)	**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; • Requirement for a registered, qualified sign language interpreter.	**9.1**
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.	**9.3**
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.	**9.4**
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.*	**9.2**
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.	
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*	

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*	
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.	
5.2	**Transfer to inpatient care:**		
5.2.1 (Deaf)	**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. *Guidance: Separate procedures are needed for the specialist deaf CAMHS unit and other, non-specialist beds.*	
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.*	
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.	**9.5**
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.	
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 (including learning disability services) will provide liaison to the adult service, if needed and with consent.	
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.	

Section 6: Multi-Agency Working			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
6.1	**The service has identified links within a range of services and agencies, including:**		
6.1.1	**1**	Local GP surgeries.	
6.1.2 (Deaf)	**1**	Paediatrics, development centres and other health services for children and young people, including neurological/audiological services where appropriate.	
6.1.3 (Deaf)	**1**	Education, education support services and school health services, including teachers of the deaf, community paediatricians and school or college nurses.	
6.1.4 (Deaf)	**1**	Organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services; • Sensory teams (focused on services for the deaf).	
6.1.5	**1**	Forensic mental health services.	
6.1.6	**1**	Youth justice service.	
6.1.7	**1**	Young people's drug and alcohol teams/substance misuse services.	
6.1.8	**2**	Dietetics.	
6.1.9	**2**	Community-based services which provide art/creative therapies.	
6.2 (Deaf)	**The service has clear links and pathways with other agencies (in collaboration with the local CAMHS service)**		
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.*	
6.2.2	**1**	There are locally agreed health-based places of safety that are designed for young people.	
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.*	

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.	
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.	**10.3**
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.*	**10.1**
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.	
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*	
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.	

Section 7: Staffing and Training			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
7.1	**There are appropriate numbers of skilled staff**		
7.1.1 (Deaf)	**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. *Guidance: This may be considered on a national, as well as a local level due to shared staffing across teams.*	
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.	**19.1**
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.	**19.2**
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.*	**19.3**
7.1.5	**1**	Administrative support or procedures are in place to enable staff to support the effective running of the service.	
7.1.6	**1**	All staff have clearly defined job descriptions and job plans which are revised at least annually.	
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.*	
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.*	**20.2**
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.	
7.2.3	**2**	Appropriately experienced young person or parent/carer representatives are involved in the interview process for recruiting staff members.	**20.1**
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.*	
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.*	**20.3**
7.3.3	**2**	All staff members receive line management supervision at least monthly.	**20.4**
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.	**18.1**
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.*	

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.*	**17.4**
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.*	**21.1**
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.*	**21.2**
7.4.3 (Deaf)	**2**	Where clinicians are required to travel long distances between appointments, a break is allocated for every two hours of driving undertaken.	
7.4.4	**1**	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	**24.1**
7.4.5	**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.	**24.2**
7.4.6	**1**	Staff members, young people and parents/carers who are affected by a serious incident are offered post incident support.	**21.3**
7.4.7	**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.	**24.3**
7.4.8	**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.	**18.2**

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:**		**22.1**
7.5.1	**1**	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	**22.1a**
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.*	**22.1b**
7.5.3	**1**	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	**22.1c**
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.*	**22.1d**
7.5.5	**1**	Recognising and communicating with young people with cognitive impairment or learning disabilities.	**22.1e**
7.5.6	**1**	Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance and basic life support.*	**22.1f**
7.5.7	**2**	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	**22.1g**
7.5.8 (Deaf)	**1**	British Sign Language (BSL). *Guidance: Level 2 should be attended as a minimum by both hearing and deaf staff.*	
7.5.9 (Deaf)	**1**	Language development, delay, and deprivation, and its impact on mental health.	
7.5.10	**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.	
7.5.11	**2**	Young people, parents/carers and staff members are involved in devising and delivering face-to-face training.	**22.2**
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.	
7.6.2	**1**	Frontline staff are consulted on relevant management decisions such as developing and reviewing operational policies.	
7.6.3 (Deaf)	**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. *Guidance: This includes ensuring policies and guidance are accessible for deaf staff members.*	
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.*	**5.2**
7.6.5	**3**	There is a commitment and financial support to enable staff to contribute to multi-centre clinical audit or research.	

Section 8: Location, Environment and Facilities			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
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.	**1.2**
8.1.2	**2**	There is sufficient car parking space for visitors, including allocated spaces for disabled access.	
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.*	**17.3**
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.	**17.1**
8.2.2	**2**	CAMHS practitioners have access to large and small rooms suitable for individual and family consultations	
8.2.3	**1**	Clinical rooms are private and conversations cannot be easily over-heard.	**17.2**
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.*	
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.*	**16.4**
8.2.6 (Deaf)	**2**	Consultation rooms are window-less or have blinds to ensure that conversations held in BSL remain confidential.	
8.2.7	**1**	Staff members are easily identifiable (for example, by wearing appropriate identification).	
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.	

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*	
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.	
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.*	
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.	**17.5**
8.3.6	**1**	A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least annually.	
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.	
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*	
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.	

Section 9: Commissioning and Service Management			
Standard number	**Standard type**	**Criteria**	**CCQI Core Community Standard**
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.	
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.*	
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.*	
9.1.4 (Deaf)	**2**	There is a mechanism for CAMHS to highlight system-wide commissioning gaps in support for deaf young people.	
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.	
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.	**12.2**
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.*	

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.*	**12.1**
9.2.5	**2**	The team use quality improvement methods to implement service improvements.	**24.4**
9.2.6	**2**	The team actively encourage young people and parents/carers to be involved in QI initiatives.	**24.5**

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Any enquiries relating to this publication should be sent to us at:

Hannah.Lucas@rcpsych.ac.uk

Artwork displayed on the front cover of the report:

Section from 'Recovery Road', M, Stephenson House.

Royal College of Psychiatrists Centre for Quality Improvement
21 Prescot Street • London • E1 8BB

www.rcpsych.ac.uk

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