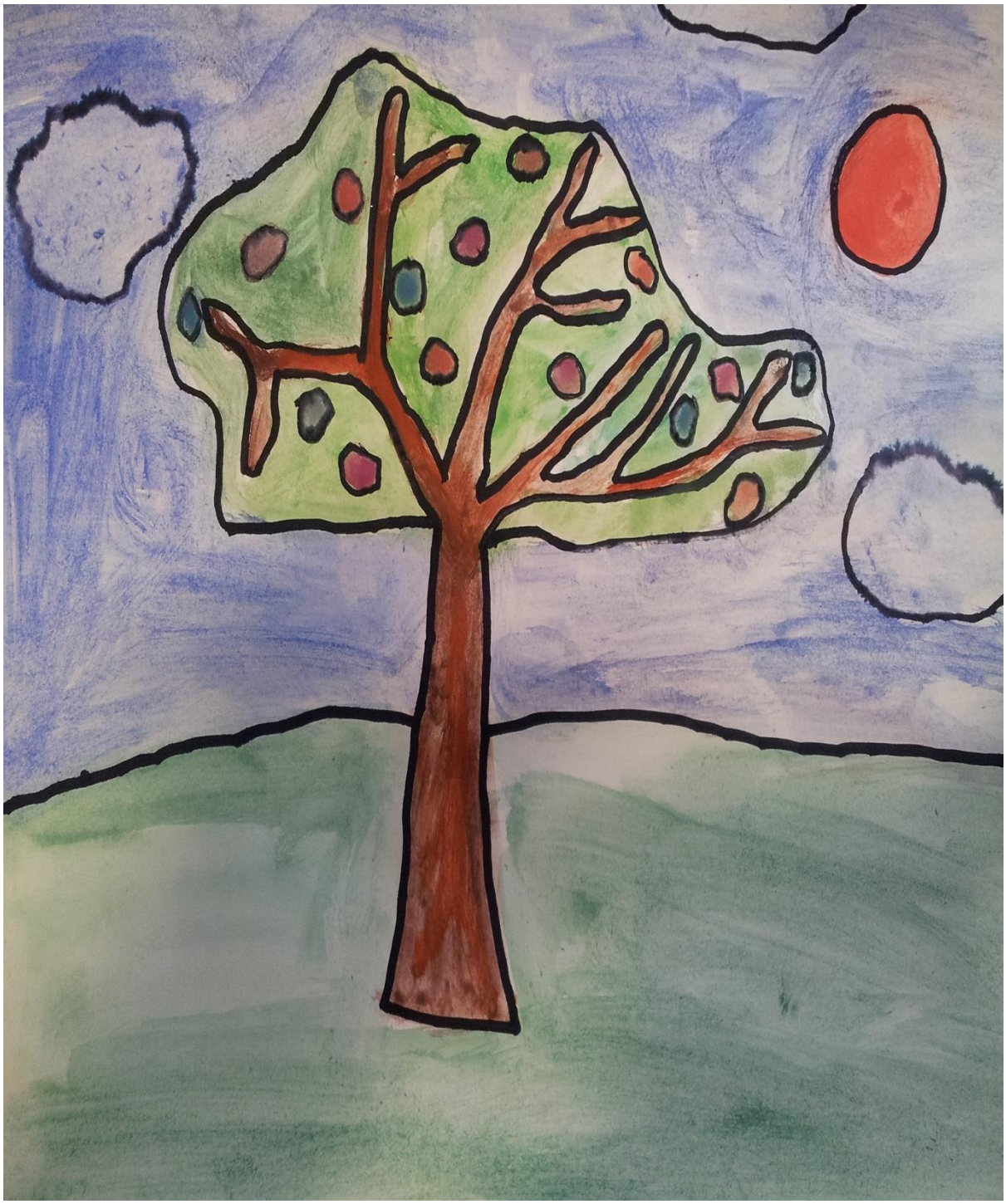

Quality Network for Community CAMHS
Annual Report: Cycle 2016
(January 2016 – December 2016)

Editor: Joseph Lindsay

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Foreword

The Quality Network for Community CAMHS 2016 cycle has seen another very busy year for the QNCC team, review panels and the advisory group, alongside a number of successful special interest days and the annual conference.

One of the key achievements has been the inclusion of young person advisors at the majority of reviews. The involvement of young people on review panels adds a very different dimension to discussions and actions to be taken forward. All our young people advisors come with refreshing ideas and suggestions about how services can 'do it differently' ensuring that children and young people are at the heart of all we do.

The special interest days have been hugely successful with wide and diverse subjects that pose challenges in service delivery and practice. There have been examples of excellent practice shared freely and healthy debate about the more contentious issues.

The annual conference continues to be a forum for sharing good practice as well as an opportunity to develop and extend networks and connections. The presentations from key speakers never fail to provide food for thought and reflection on current practices. The variety of workshops again prove to be stimulating and a springboard for learning for all.

The number of services joining the network have increased and this supports the diverse learning and sharing opportunities nationally. It is often reassuring when a service faces challenges in a particular area to find that a peer service is facing the same or similar issues and that there is the opportunity to share and explore possible solutions.

We have seen changes within the QNCC team and the advisory group over the last year and the departure of key and longstanding personnel. Their contribution over the years has been invaluable and we extend our thanks to them.

I wish, on behalf of the advisory group, to extend our sincerest thanks to the QNCC team, the young person advisors and all reviewers who have continued to support the function of the network and maintain the quality of the delivery of CAMH services.

Julie Curtis
Chair QNCC Advisory Group
March 2017

Introduction

The Quality Network for Community CAMHS (QNCC)

- Develops and applies service standards for community CAMHS through a system of self review and external peer reviews
- Supports local implementation of best practice and national policy, as identified in the QNCC standards
- Produces reports for participating services that highlight areas of achievement and areas for improvement
- Provides a national "benchmarking" service to allow services to compare their activity with other services
- Facilitates information-sharing about best practice between staff in the network

The Review Process

The real benefit for member services is in taking part in the QNCC review process. The reviews aim to improve services incrementally by applying standards, and using the principles of the clinical audit cycle (see Figure 1 below).

Figure 1: The Annual Review Cycle

Each year, the standards are applied through a process of self review and external peer review where members visit each other's services. The self review questionnaire is essentially a checklist of QNCC standards against which teams rate themselves, supplemented with more

exploratory items to encourage discussion around achievements and ideas for improvement. The self review process helps staff to prepare for the external peer review and become familiar with the standards.

During the peer review, data is collected through interviews with CAMHS staff, young people and carers. Representatives from local agencies (other health services, social services, education and the voluntary sector) are also invited to take part in a discussion about multi-agency working.

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.

How QNCC members can use this report:

How well are we doing overall in comparison with other teams in the network?

Your team's local report provides you with a summary of the number of criteria met, partly met and not met, which then yields an average score for each individual standard. These averages enabled us to obtain a measure of your team's overall performance for each section of the service standards. Average scores for teams involved in 2016 are detailed in this report so you can immediately see how well you are doing compared with the other teams in the network. You can also compare your team's activity, resources and outcomes with those of the network as a whole. We recommend that you use this report in conjunction with your local report(s) to inform discussions with your commissioners and to demonstrate your team's performance.

The project team gratefully acknowledges:

- The staff in member teams who organised, attended and hosted peer reviews
- The parents and young people who met with the review team and took part in the QNCC review process
- Professionals from partner agencies who participated in the multi-agency discussions during peer reviews
- The QNCC Advisory Group for their continuing support and advice

Types of Standards:

Throughout the report standards are referred to as type 1, 2 or 3. Please find below a definition of the types of standards

Standard Type	Definition
1	Failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law
2	Standards that an accredited service would be expected to meet
3	Standards that an excellent service should meet or standards that are not the direct responsibility of the team

Cycle 2016

This report explores the data collected throughout the 2016 cycle (January 2016 – December 2016) of the Quality Network for Community CAMHS (QNCC).

37 CAMH services were involved in the QNCC review cycle between January and December 2016. Four services participated in the accreditation process and a further 12 teams undertook a self-review (see Appendix B for teams). A self review involves teams measuring their compliance against the standards without having a peer review. This option is recommended for those teams who are new to the QNCC process and may want to accustom themselves to the process before receiving a peer review or for those who are in the second year of their accreditation.

The peer review process involves interviews with members of the staffing team, young people and parents/carers involved in the service currently or recently discharged. Throughout Cycle 2016 we interviewed:

- 232 staff members
- 52 young people
- 67 parents/carers

Cycle 2016 saw an increase in the number of young people and parents and carers that were interviewed, giving feedback about their experiences of services and helping to identify areas of challenge and ideas for development. The feedback given is always felt to be very valuable for staff and management when thinking about the structure of teams and the way that care is provided. For teams that were unable to involve young people and parents in the review days, the project team would like to remind services that phone interviews are a way to engage with groups in harder to reach areas.

There was also an increase in the number of reviews that were attended by a young person advisor (YPA). In 2016, 78% reviews had a young person advisor attend as part of the peer review team. Almost all reviews that took place in the UK had contributions from YPA's and feedback from teams indicates the value of their involvement in the review process.

While engagement has generally increase in this cycle, 2016 did see a drop in the number of staff that have attended reviews. The project team welcomes the input from staff of all levels and encourages services to invite representatives from the multi-disciplinary team, as well as management.

This Report

This national report contains the aggregated results of the reviews undertaken by the 37 CAMHS teams in Cycle 2016. The main body of the report highlights the most and least met standards in each section across services (type 1 and type 2) and also provides graphs indicating the mean scores met across type of standard.

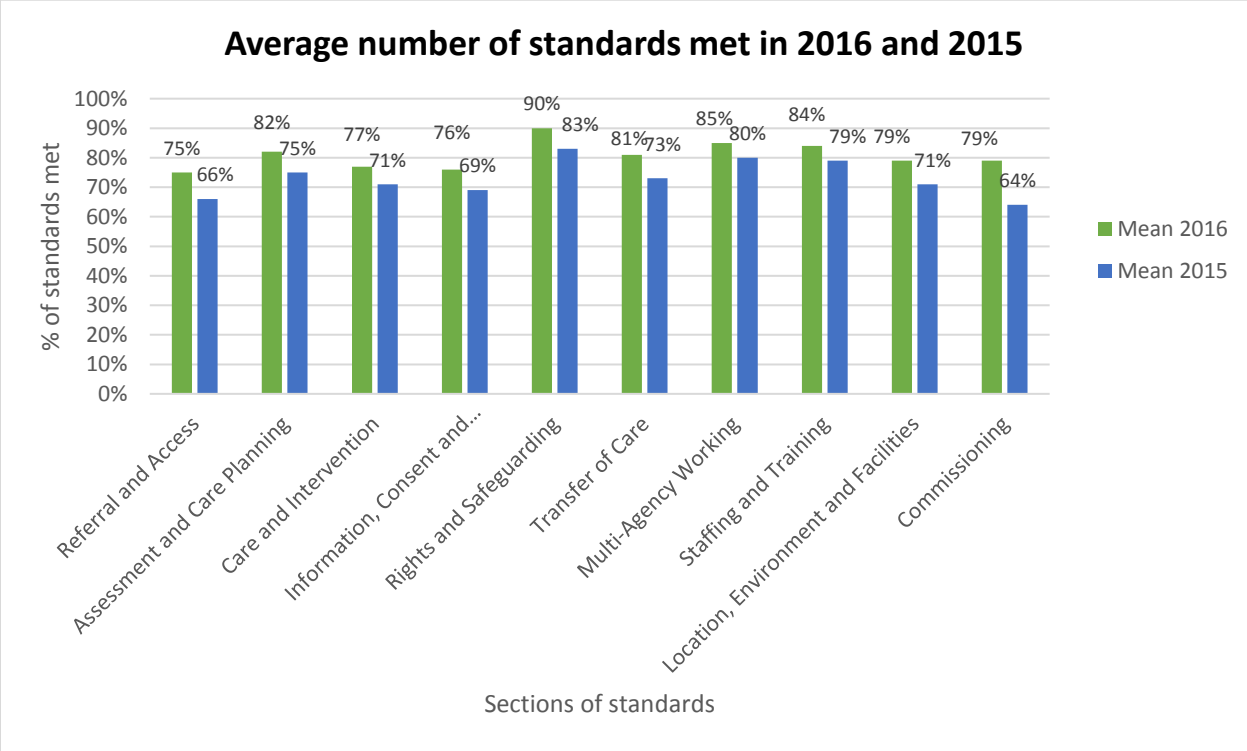
Finally, a full summary detailing the average scores for each criterion for all teams in the 2016 cycle is included (see Appendix A). This enables teams to benchmark themselves against other teams in the network. Indicators of teams' activity, resources and outcomes can be found on page 26

2016 Cycle

The fifth edition of QNCC standards were published in August 2016 and are available online. The standards were revised by a group of clinicians and patient representatives in January 2016. These workshops are open to consultation to the whole network, so that each team is able to contribute to the measures used. The standards revision process takes places every two years and we welcome contributions from across the network. These new standards were implemented towards the end of 2016, and this report will explore the aggregated data for services measured against both the fourth and fifth edition of standards.

2017 will be the first year that all inpatient services use the College's Accreditation and Review System (CARS) to complete their self-review workbook online. The fifth edition of standards are integrated with CARS and this will help to streamline the review process for services and reviewers.

The graph below outlines the overall percentage met for each section of the service standards for all units who took part in Cycle 2016, compared to the same data from Cycle 2015.

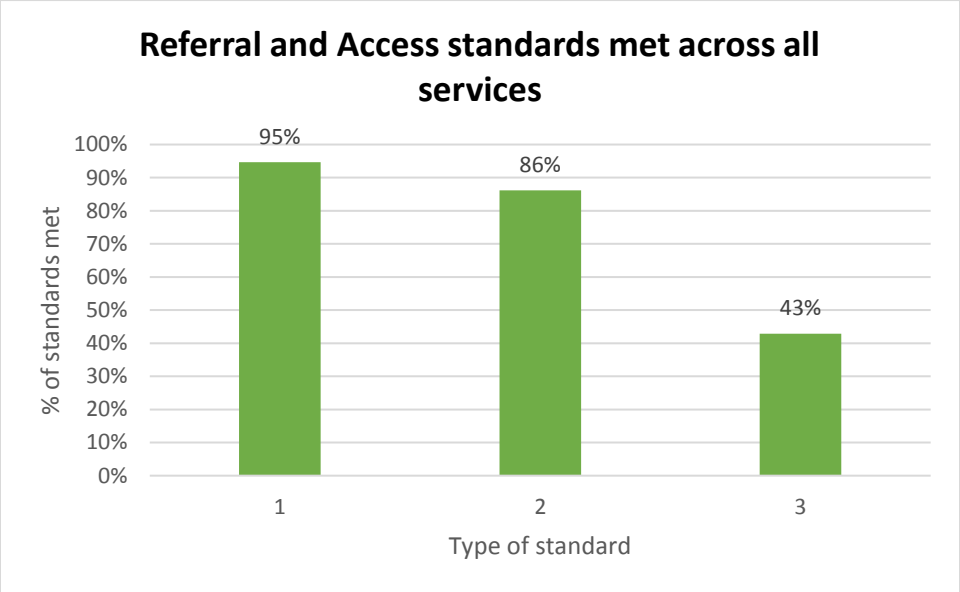


Rights and Safeguarding has the highest percentage of met standards (90%) followed closely by the Multi-Agency working section with 85% of standards met by services. This is an improvement compared to 2015. Referral and Access is the lowest scoring section (75%), but there has still been an increase in the number of standards met in this area in comparison to 2015.

Referral and Access

Key Findings

- Number of criteria in Referral and Access: 19
- Average percentage of criteria met by units: 75%
- Average percentage of criteria met by services in cycle 2015: 66%
- Range of percentages met in Referral and Access: 21% - 100%



Areas of Achievement

- There has generally been an increase in the number of standards met by services around Referral and Access. Key examples include an improvement around managing patients that do not attend. For example, there has been 7% increase in services having policies around risk assessment for young people that do not attend appointments (1.3.3). 92% of teams are now meeting this.
- 81% of teams are able to evidence their flexibility to be responsive to the needs of young people and their parents and carers (1.3.2). There has been an increase of from 66% in 2015 and this is demonstrated in the positive feedback from families about where they can be seen for their appointments
- All services will inform their referrers if they are not able to accept a young person for admission, and will explain the reasons for this (1.1.4)
- 88% of services now record information on waiting times, including internal waiting times for treatment. This is a 14% increase from 2015 (1.4.4)

Areas for Improvement

- Referral and Access is the lowest scoring section of the QNCC standards. While there has been a slight improvement in the number of teams meeting standards in this area, CAMH services are meeting 75% of these standards on average

- Only 30% of services compare data on referrals and missed appointments/early disengagement with local population statistics
- Only 43% of services have structures which allow young people to self-refer to the service and a few teams are able to provide this information on their website

Areas of Achievement Comments from young people and parents/carers

The service has been very flexible with both the time and location of our appointments. We have had appointments at home and at my child's school, which has been very convenient

My child was first seen as a crisis admission. Staff were supportive around this and explained what would happen next and I felt there was a good level of information provided for what we needed to know

Areas for Improvement Comments from young people and parents/carers

I felt quite lost while my child was waiting for their first appointment and bought a book to help support us during this time. Any information and support here would have been greatly valued

I had to see my GP three times before I finally got help. I wish there was better communication between my GP and CAMHS

The waiting time for my child's appointment was seven months and we were told this would only take twelve weeks. We were not given adequate support in the interim

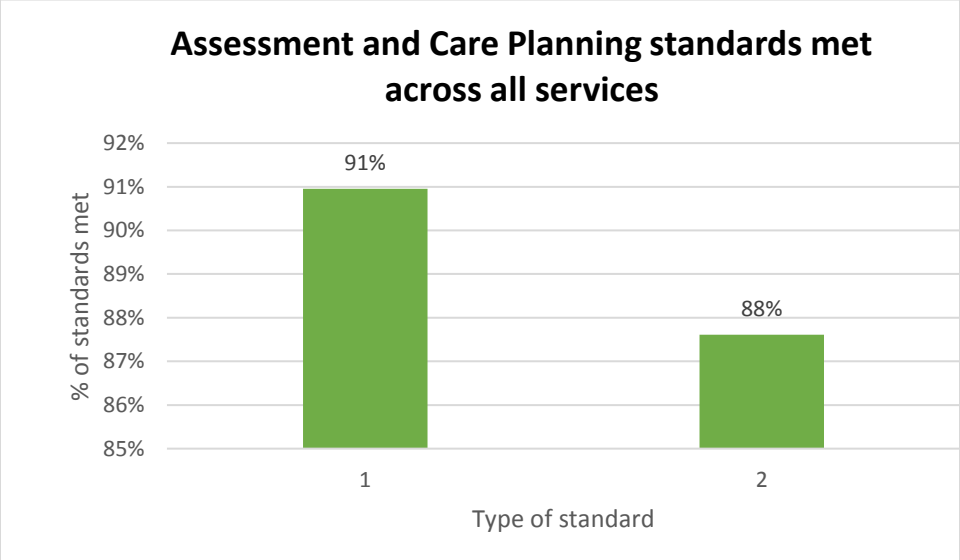
Recommendations

- There has been an increase in the number of teams that are able to monitor DNA's monthly (1.4.2). Moving forward this data could be cross compared nationally, to identify if there any commonalities across the wider QNCC network in terms of difficulties with access
- For services that offer self-referral to young people following discharge, clear policies and information needs to be made available. This should be written both online and also in any information given at discharge. If services do not offer self-referral, clear guidance needs to be written so that young people and staff are aware of the procedures if a discharged patient begins to feel unwell
- Many young people explained that they were unsure how to access support while waiting for their first assessment. Collaborating with GP's, signposting information and helpful websites could be added to appointment letters, so that families are guided around support during this time. This would be particularly valuable for young people in crisis

Assessment and Care Planning

Key Findings

- Number of criteria in Assessment and Care Planning: 30
- Average percentage of criteria met by units: 82%
- Average percentage of criteria met by services in Cycle 2015: 75%
- Range of percentages met in Assessment and Care Planning: 21% - 100%



Areas of Achievement

- All services are now able to provide case notes that show evidence and consideration of young people's mental health needs. This is an improvement over 95% of services in 2015 (2.5.2a)
- There has been a significant improvement in the number of services that are able to provide a mental health assessment for young people with emergency mental health needs, within 24 hours. 94% of services achieved this in 2016, which is an improvement over 76% of services in 2015 (2.1.2)
- Services are continuing to perform well in seeking permission from young people and families, when additional information from other professionals is required. 90% of teams ensure this is a priority (2.2.3)

Areas for Improvement

- Services are still finding it challenging to provide young people and parents/carers with written feedback within 10 days. 44% have
- achieved this within ten days, which is only a slight improvement over 43% in 2015 (2.4.6)
- There is space to improve regarding the information contained in appointment letters for young people and their parents/carers. 59% of services provide assessment

letters that contain the recommended guidance around; who they will see, where the appointment will be, what will happen and who they can have with them (2.4.2)
- Fewer services in 2016 are able to evidence that they consider young people's views and goals for treatment, in their case notes. 80% of teams met this in comparison to 92% in 2015 (2.5.1c)

Areas of Achievement
Comments from young people and parents/carers

CAMHS communicated with my school so they got the relevant information they needed and they asked if this was ok with me

There is good communication between staff and other agencies so I don't have to keep retelling my story

My child has seen the same psychologist every time and she has been brilliant. There's been excellent consistency of care and I believe my child has built a trusting relationship with them

Areas for Improvement
Comments from young people and parents/carers

There seems to be a communication problem with local links such as schools and GP's and the information that's being shared

Throughout my child's care with the service, I feel that I haven't been asked about my child's history. This has all been discussed with them and I've felt quite separate to this discussion

It would have been useful to have had greater involvement in discussions around my child's care and the options available to them. I feel that I was not kept in the loop here and, while the work of the psychologist has been very helpful, as a parent I would have liked more input

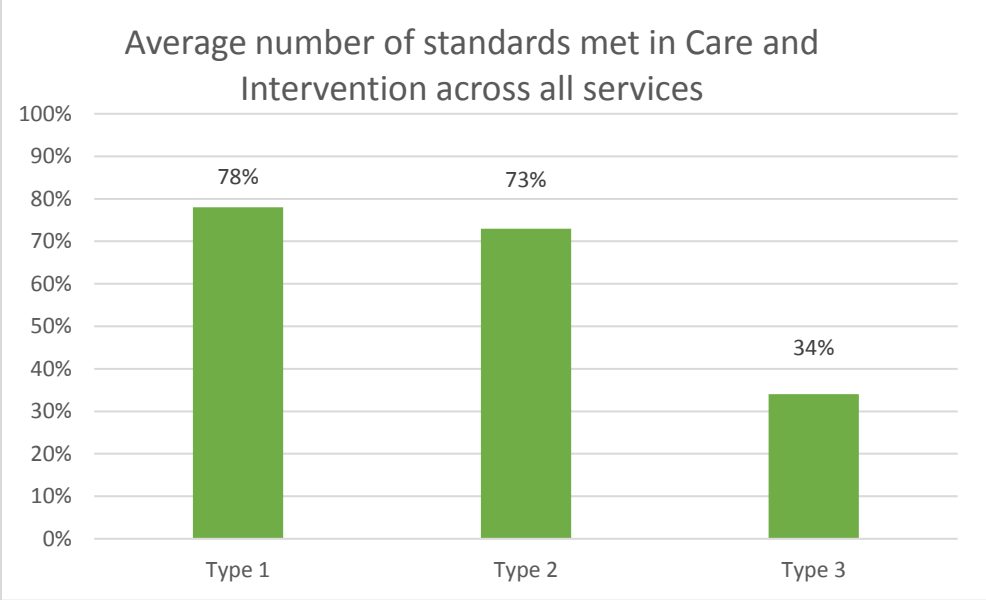
Recommendations

- Families report that having to repeat their child's history to a number of different clinicians within a service can cause increased levels of anxiety for themselves and their child. To combat this, an increased number of services have introduced triage calls and robust duty systems in order to gain greater insight and information around referrals, before the patient is admitted
- Many comments from families in the 2016 cycle, suggested that there were gaps in communication between the GP and the CAMH service. To address this, a focus should be placed on shared training and learning days, encouraging participation from local GP's. This would help to promote a higher quality of information and may help to ensure that pathways in to the service are smoother for families and young people

Care and Intervention

Key Findings

- Number of criteria in Care and Intervention: 23
- Average percentage of criteria met by units: 77%
- Average percentage of criteria met by services in Cycle 2015: 71%
- Range of percentages met in Care and Intervention: 22% - 100%



Areas of Achievement

- All services are now able to gain multi-disciplinary input on cases when needed. This is an increase from 95% in 2015 (3.1.1)
- Data indicates that there has been a considerable increase in the number of young people and parents that have been able to see the same clinician consistently for intervention. 95% teams are now meeting this standard, which is an increase from 73% in 2015 (3.4.4)
- There is a greater number of services providing young people with information around gaining appropriate mental health advice in an emergency. 92% of services now meet this type 1 standard (3.2.2). This is a 10% increase from 2015

Areas for Improvement

- While there has been a slight improvement since 2015 in which 49% of units met this standard, only 68% of services are able to see an appropriate clinician for treatment within six weeks of assessment (3.2.1)
- Cycle 2016 has not seen any growth in the number of services that provide young people and families with information about evidence base, risks benefits and side effects of intervention options and of non-intervention. 73% of teams provide this information (3.4.1)

- Teams are steadily increasing the amount of protected time for staff to collect and collate outcome information, but this still remains relatively low at 48% of services (3.5.1)

Areas of Achievement
Comments from young people and parents/carers

The good communication between the therapist and my family helped to focus on specific goals

The team will always check in with me to see if my treatment is helping me to reach my goals and feel better

The service has helped my child. Having a diagnosis was helpful. I always thought my child's behaviour was related to attachment but now I know it is mediation and mental illness

We have seen the same staff member for appointments and I think this has been one of the most important aspects and it has built up trust. There has been difficulty seeing the same consultant as they are locums but the care within the ED service has been great and consistent

Areas for Improvement
Comments from young people and parents/carers

Nobody approached us about whether we are happy with how things are going. We had an issue with a counsellor a couple of years ago that led to us making a complaint. I would have liked to have been asked instead of having to approach the service myself

It would be beneficial for teams to link with schools to educate them on how to help and understand mental health difficulties, anxiety and self-harm

It would be really useful to have a parent buddy system as the support group wasn't suitable for my needs

The key worker asked my child questions that upset her and weren't tactful so she didn't want to go back. We ended up changing worker. Staff should be more sensitive to individual needs of the person they are working with

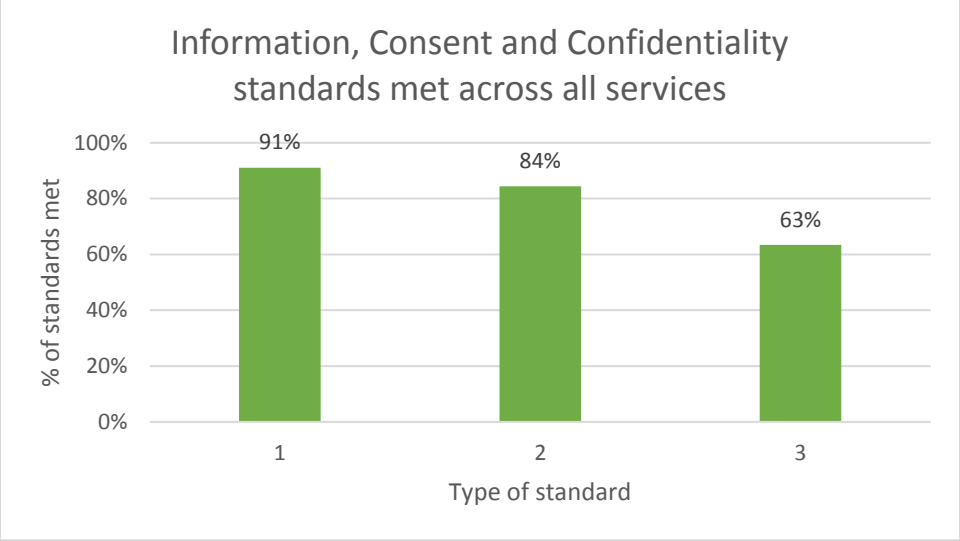
Recommendations

- There were gaps in parent support structures identified through feedback given by families in 2016. Parents commented that they would find support groups/systems to be incredibly valuable. This may include linking parents of newly referred young people with parents that have experience of the service. This may help reassure families and provide answers to common queries that may arise in the anxious time of referral and admission
- Parents commonly suggested that a parent support group would be useful. This could be held at a local community centre or charity, encouraging parents to share their experiences and give feedback about service development

Information, Consent and Confidentiality

Key Findings

- Number of criteria in Information, Consent and Confidentiality: 24
- Average percentage of criteria met by units: 76%
- Average percentage of criteria met by services in Cycle 2015: 69%
- Range of percentages met in Information, Consent and Confidentiality: 22% - 100%



Areas of Achievement

- A consistently high number, 94% of teams, ensure that the practitioner seeks consent to treatment with young people (4.2.4)
- A greater number of teams are able to provide young people with written and verbal information about their service, in a way they can understand (4.1.1). 74% of teams are now meeting this standard, which is an improvement over 58% in 2015
- There has also been an increase in the amount of information provided to families about the CAMH team and other relevant services (4.1.5)

Areas for Improvement

- There has been a decrease in the number of services that are verbally informing young people and their families of their right to confidentiality and its limitations. 68% of teams met this type 1 standard in 2016, down from 82% in 2015 (4.5.1)
- 2016 has seen a drop in the levels of participation of young people and parents/carers in helping to design service information (4.1.). A decrease was seen from 67% to 54% of services in 2016

Areas of Achievement
Comments from young people and parents/carers

I am working together with the team to help re-write some of the written information given out to parents

Some had a lot of information and resources about self-help, including an app to monitor anxiety attacks and which also provides breathing techniques (SAM).

Areas for Improvement
Comments from young people and parents/carers

I did not appreciate the lack of openness with parents about things disclosed to staff by my child about self harm. I would like to be kept in the loop

It would have been useful to receive more information about the service when I was referred by my GP

Some young people were referred to generic websites with basic techniques that did not necessarily apply to their situation

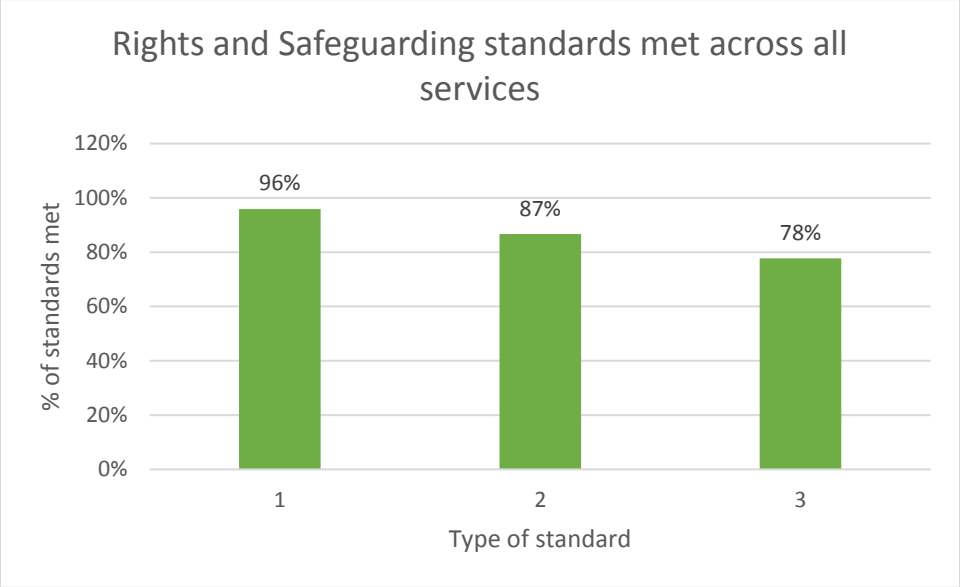
Recommendations

- Service user feedback forums and workshops could be incentivised with gift vouchers and food. This would provide a creative and engaging platform for families and young people to discuss what works well about the service, but also ways in which things could be improved
- Accreditation reviews in 2016 raised an issue around consent being recorded, as well as consent to information being shared. QNCC recommends that services check to see that consent forms also include a section for young people to consent to treatment
- To promote feedback mechanisms, posters could be put up around service bases. Feedback could be gathered through comments boxes and displayed using you said we did boards in waiting rooms. This would help to demonstrate to families that feedback and information is taken seriously and the steps that are made by services to address the ideas put forward

Rights and Safeguarding

Key Findings

- Number of criteria in Rights and Safeguarding: 22
- Average percentage of criteria met by units: 90%
- Average percentage of criteria met by services in Cycle 2015: 83%
- Range of percentages met in Rights and Safeguarding: 67% - 100%



Areas of Achievement

- Rights and Safeguarding is the highest scoring section of the QNCC standards
- Positive feedback from patients and family and an increase in scores since 2015, indicate that 95% of young people and families feel that they are being treated with dignity, respect and that their needs are listened to (5.1.1, 5.1.2)
- Services continue to provide a high level of respect and consideration to the needs of all young people. 97% of teams all take in to account factors such as; gender, ethnicity, sexuality, physical needs, ability and religion (5.4.1)
- All services are now able to efficiently escalate safeguarding concerns, manage safeguarding issues seriously and clearly record and appropriately share information for the purpose of child protection (5.5.4, 5.5.5, 5.5.6, 5.5.7)

Areas for Improvement

- 54% of teams have established links with an advocacy service for use by young people. This is a 12% increase from 2015, but remains one of the consistent challenges for CAMH services (5.3.2)

Areas of Achievement
Comments from young people and parents/carers

It's helpful to be able to talk to someone and not be judged. The service has a really open environment in terms of how comfortable I am in sharing things with the team

We know how to make a complaint (by ringing a certain number or placing it in the suggestion box) and feel that it would be taken seriously and may lead to change in the service

Areas of Improvement
Comments from young people and parents/carers

One incident with a therapist put a black mark and broke the trust with the service. I feel that the child should be listened to first and foremost. This incident had made me lose confidence in the service for a long time although my trust has now returned

I don't know the process for complaining but I have complained to our clinician about therapy and the reasons for stopping it

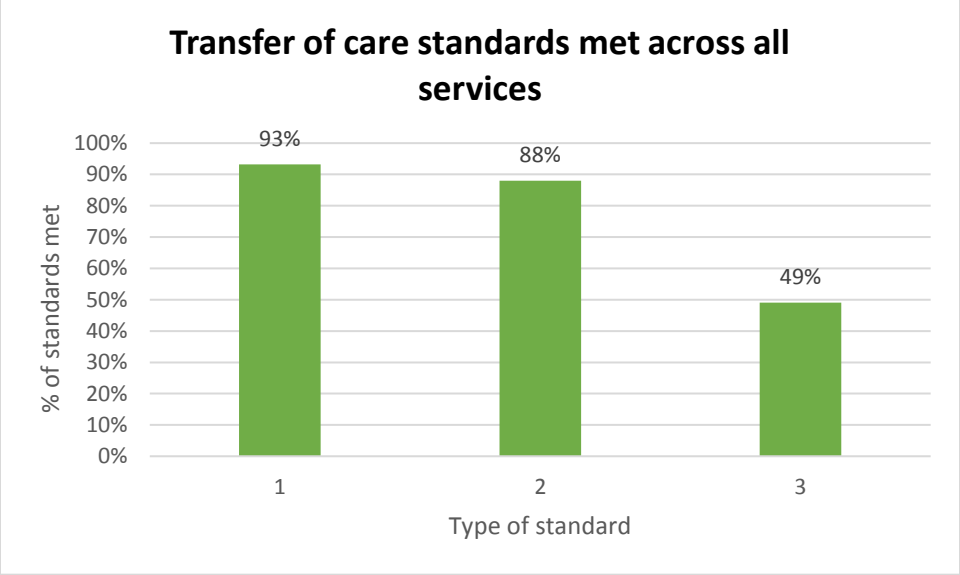
Recommendations

- To encourage all services to have clearly displayed posters in waiting rooms, to encourage and empower young people and families to leave feedback. This includes raising awareness around complaint processes, so that families feel more comfortable addressing any issues around their care

Transfer of Care

Key Findings

- Number of criteria in Transfer of Care: 25
- Average percentage of criteria met by units: 81%
- Average percentage of criteria met by services in Cycle 2015: 73%
- Range of percentages met in Transfer of Care: 59% - 100%



Areas of Achievement

- All teams now ensure that the young person's key worker is taking responsibility for their transition out of the service (6.2.2)
- This cycle has seen a greater emphasis on referring young people to an inpatient unit that meets their specific mental health needs, working with their choices and preferences (6.3.1). 81% of QNCC services are now achieving this, which is an increase from 73% in 2015
- The Care Programme Approach or local equivalent has been completed by a greater number of services in 2016. 86% of teams now complete this when a young person leaves the service, in comparison to 69% in 2015 (6.2.1)

Areas for Improvement

- Very few teams provide young people with a transition pack when they are transferred to adult services. There has been a slight increase in 2016 to 36% of teams over 20% in 2015 (6.4.7)
- Only half of CAMH services have transition protocols in place for young people with neurodevelopmental disorders such as ASD and ADHD. There is opportunity here to improve signposting to other appropriate support where (6.4.4)

Areas of Achievement
Comments from young people and parents/carers

I have had ongoing discussions with staff about when to sign my child off and this has been mutually agreed. We had a meeting recently and it was felt that my child needed longer in the service, so staff were flexible around this and delayed discharge in order to ensure they were ready

My child is due to leave the service shortly but has been told they can still access the support group which I think will be really helpful as there is still a small level of support available to them

Areas for Improvements
Comments from young people and parents/carers

I do not feel that staff have talked to be about my discharge plans and I have some worries about being transferred to adult services

We have been generally informed and prepared for the process but the team seemed to lack specific knowledge about transition

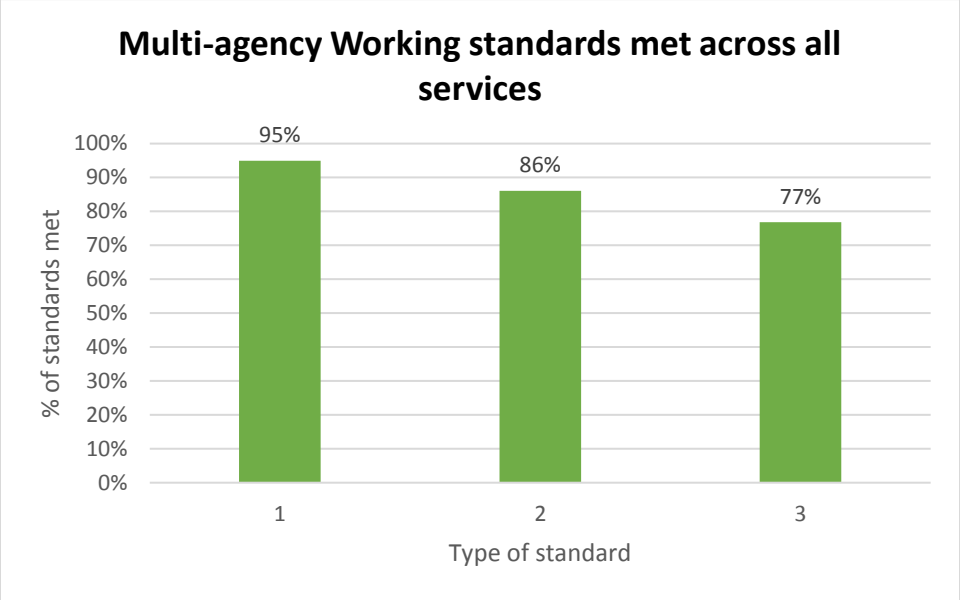
Recommendations

- While it may be challenging to provide each young person with an individually tailored transition pack, it is essential to provide as much support during this transition as possible. Important information about this period of care could be condensed in to an information leaflet and put on each service website
- It is important that teams are able to signpost young people to supportive information post-discharge. This should include information around how to seek support if symptoms return and whether services accept self-referrals

Multi-Agency Working

Key Findings

- Number of criteria in Multi-Agency Working: 23
- Average percentage of criteria met by units: 85%
- Average percentage of criteria met by services in Cycle 2015: 80%
- Range of percentages met in Multi-Agency Working: 50% - 100%



Areas of Achievement

- 100% of services have established close working relationships and have access to paediatric and child development centres, as well as school health services and colleges (7.1.1, 7.1.2). This is an increase from 85% of services in 2015
- All services have now established joint protocols on or involving/notifying other services or agencies when there is a suspected abuse of young people (7.2.4)
- 70% of teams now have documented inter-agency agreements which clearly state the roles and responsibilities allocated to each organisation (7.2.1). This is a marked improvement from 47% of teams in 2015

Areas for Improvement

- Fewer teams are able to demonstrate that joint working is facilitated through flexible initiatives such as secondments, rotational posts, split posts and opportunities for shadowing (7.3.3). This has dropped from 90% of services that were able to achieve this in 2015
- There has been a drop in the links between CAMH services and appropriate voluntary and third sector services (7.1.15). A decrease of 85% to 78% of services in the last year

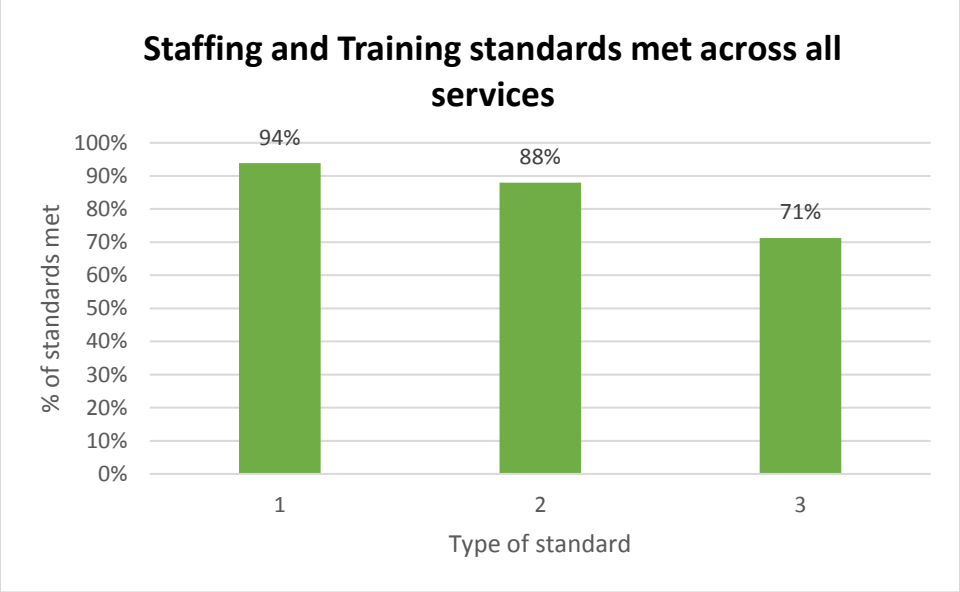
Recommendations

- Feedback from multi-agency professionals working in education suggested that some teachers felt in the dark around ways in which to refer to CAMHS. This could be addressed by encouraging CAMH professionals to deliver mental health workshops at local schools for teachers and pupils, to help raise awareness around common mental health issues and reduce stigma within the classroom
- To ensure that there is relevant, education based resources available on service websites. This would help direct and support teachers around common queries and pathways, enabling them to access useful resources to help manage behaviours and reduce potential difficulties in the classroom

Staffing and Training

Key Findings

- Number of criteria in Multi-Agency Working: 45
- Average percentage of criteria met by units: 84%
- Average percentage of criteria met by services in Cycle 2015: 79%
- Range of percentages met in Multi-Agency Working: 42% - 100%



Areas of Achievement

- 2016 saw a significant increase in the level of staff receiving an annual written appraisal. There has been an 18% increase in annual appraisals for staff across the network in comparison to 2015 (8.4.1). 92% of services are now meeting this
- The levels of regular line management and professional supervision have also increased in 2016. 76% of teams ensure that staff receive supervision totalling at least one hour per month, which is an increase from 69% of teams in 2015 (8.4.4)
- Services have improved access to a budget that can support the training needs of their team. There has been a 27% increase in the services that have met this standard in 2016, so that 81% of services are now accessing this (8.6.1)

Areas for Improvement

- Scores from teams in 2016 has indicated that there could be space to improve the level of engagement when working with young people in influencing the recruitment of new staff (45% of teams met standard 8.2.4) and also in using feedback from young people for staff appraisals (41% of teams met standard 8.4.1a)
- While there has been a slight improvement since 2015 (68% from 60%), the data from this cycle reflects that staffing levels are not always able to support staff commitments to provide training, supervision and consultation both within the service and to other service. 68% of teams were able to meet this type 2 standard (8.2.3)

Areas of Achievement
Comments from young people and parents/carers

We've really built up a rapport with the staff and I feel very relaxed in the fact that my daughter is seeing the right person for her mental health

The team have gone above and beyond. They've always responded to my child's needs, and given him dignity and included him in decisions about his care

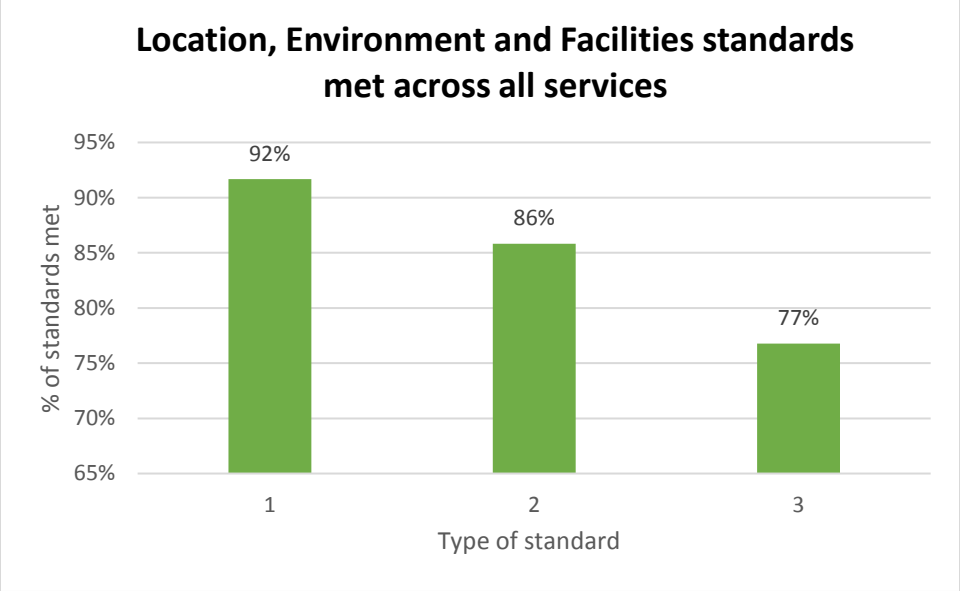
Recommendations

- Ensure protected time is scheduled into the staffing rota to allow staff have time for supervision sessions and reflective practice groups
- Invite young people to attend interview panels of new staff and/or to suggest interview questions.
- Consider ways in which to better capture the informal and formal managerial and clinical supervision meetings.
- Ensure CPD time is included within supervision to encompass staff training needs/ regularly monitor and audit staff training needs.

Location, Environment and Facilities

Key Findings

- Number of criteria in Location, Environment and Facilities: 16
- Average percentage of criteria met by units: 79%
- Average percentage of criteria met by services in Cycle 2015: 71%
- Range of percentages met in Multi-Agency Working: 25% - 100%



Areas of Achievement

- Standards met from 2016 demonstrate a steady improvement across all areas of location, environment and facilities. This suggests that services are finding new ways to be flexible with the space available to them and that there are continued efforts to find ways to improve the space and resources available to staff, young people and families/carers
- 92% of services environments now meet the needs of people that have physical disabilities, and comply with current relevant legislation. There has been a 9% increase in the number of teams meeting this standard (9.2.1)
- There has been a 14% increase, with 89% of teams ensuring that a risk assessment will be carried out when consultations take place in a new setting (9.3.3)

Areas for Improvement

- Just over half of teams report that there is a system in place for staff to summon help in an emergency (9.3.5). This includes the use of personal and wall alarms, or mobile phones for lone working. There has not been a significant improvement here from last year. 58% of services are meeting this in 2016 in comparison to 50% in 2015
- Feedback has shown that 69% of young people and parents/carers feel that waiting rooms are not always sufficiently spacious (9.1.4)

- It is clear that parking is still an ongoing issue for CAMH services. Young people valued services that they were able to walk to and feedback from parents reflected their frustration when unable to park before attending appointments (9.1.5)

Areas of Achievement
Comments from young people and parents/carers

After our input, the building is now more vibrant and colourful. This has been a really positive change and makes the environment more welcoming

There is a graffiti white board in the waiting room which asks for the young people for their input on what they would like to have in a new building when the team relocates

Areas for Improvements
Comments from young people and parents/carers

It can be quite triggering being seen in the same building as inpatient CAMHS as this brings back some uncomfortable memories for me

There are not many resources available for the siblings of young people to do while they wait

Ideally it would be good not to have young children in the same waiting room as older adolescents

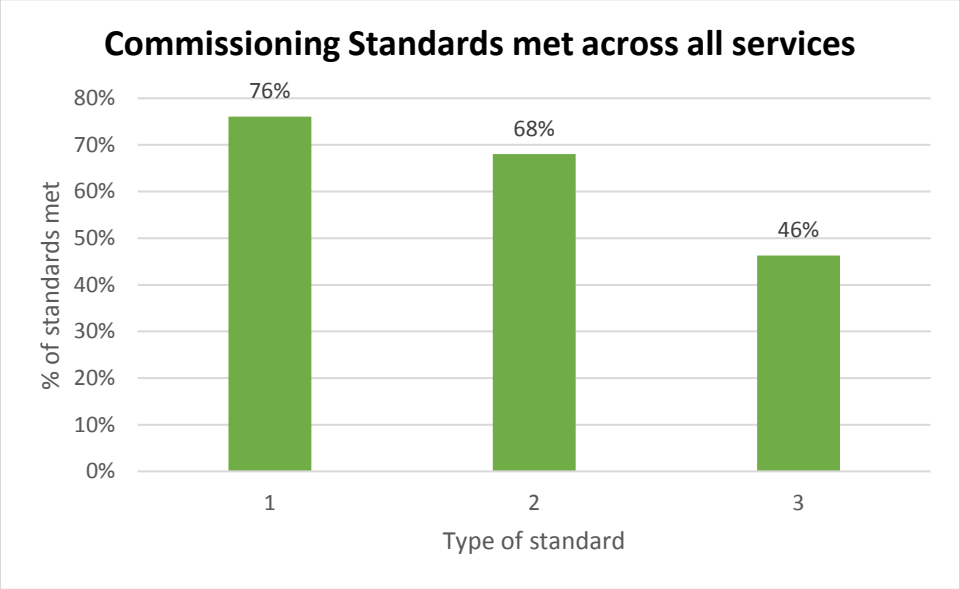
Recommendations

- Feedback from services has shown the value of laptops and mobile phones with outreach work. Access to these devices has helped clinicians access patient information away from the service base, and increase communication capacity with colleagues
- To explore whether workshops can be run with siblings, which may increase understanding around their family's behaviour and the types of support that may be available to them
- Young people valued the opportunity to contribute to large art pieces and murals when leaving the service. It felt that this is useful as an aid in their road to recovery and impact on the environment of the service

Commissioning

Key Findings

- Number of criteria in Commissioning: 13
- Average percentage of criteria met by units: 79%
- Average percentage of criteria met by services in Cycle 2015: 64%
- Range of percentages met in Multi-Agency Working: 38% - 100%



Areas of Achievement

- There has been a significant increase in the number of services that have a comprehensive CAMHS strategy for all levels of service provision, which is accessible and known to all local agencies working with young people. There has been a 35% increase in teams meeting this standard, with 85% of needs now achieving this (10.2.2)
- 97% of commissioners and staff from services regularly review capacity and demand. This is a considerable increase from 66% of teams in 2015 (10.4.1)
- Commissioning has seen the greatest increase in the number of standards met over cycle 2015. An average of 79% of standards are now being met, which is an improvement from 64% in 2015

Areas for Improvement

- There has been little change in the involvement of young people and parents/carers informing performance criteria. 38% of services are able to meet this (10.5.3)
- As commissioning and funding structures vary between England and services in the rest of the UK and Europe, there are a higher number of non-applicable standards in this section. This means that it is harder to accurately compare performance across the network in this area

Activity, Resources and Outcome Indicators

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

Please Note: These data are provided as a guide only. The accuracy of these figures is dependent on the quality of information supplied by member teams. Responses from some members were based on estimates; accuracy is therefore variable. The data below is provided by general as well as specialist community CAMHS, for example outreach teams and eating disorder teams.

Indicator	Number of teams responding	Minimum	Maximum	Average
Total population served	32	6,045	1,200,000	341669.06
Number of whole time equivalent (WTE) clinical staff per 100,000 total population	30	0	62	23.37
What is the number of whole time equivalent (WTE) administrative staff in your team?	31	0	25	6.77
Total caseload (active cases only)	31	12	3,539	876.06
Number of referrals made in last 6 months (includes specialist teams)	26	12	2,231	675.29
Number of accepted referrals in the last 6 months	26	17	1,866	456.67
Average waiting time for routine assessments over last 6 months (weeks)	31	0	86	11.09

Indicator	Number of teams responding	Minimum	Maximum	Average
Average waiting time for treatment, from the point of referral (weeks)	29	0	86	12.36
Number of cases closed/discharged in last 6 months	26	1	1,687	440.23
How many cases were referred to in-patient CAMHS in last 6 months?	24	0	105	13.92
How many of these were accepted (i.e. admitted)?	24	0	100	11.88

Indicator	Number stating Yes/No	Number of teams responding
Difficulties accessing in-patient CAMHS beds?	22 – Yes 6 - No	28

Appendix A: Aggregated Results

This table shows the percentage of member teams that scored themselves as met for each standard.

Note: Percentages are rounded to the nearest integer and consequently do not total 100% for some criteria.

Standard No.	Type	Standard	% Met 2016	% Met 2015
Section 1:		**Referral and access**		
1.1.1	**2**	CAMHS offer consultation and training to frontline referring services *Guidance: For example, by appointing Primary Mental Health Workers or other link persons to work with education, social services, drug and alcohol teams, and primary healthcare*	83%	73%
1.1.2	**2**	CAMHS disseminate clear referral criteria to referrers, including criteria for varying levels of response *Guidance: For example, specifying the criteria to elicit a routine or urgent referral and outlines the exclusion criteria*	76%	68%
1.1.3a	**2**	• Routine referrals	97%	83%
1.1.3b	**2**	• Emergency referrals	96%	85%
1.1.3c	**2**	• Consultation about referrals *Guidance: By telephone; in allocated time slots or within 24 hours*	94%	75%

Standard No.	Type	Standard	% Met 2016	% Met 2015
1.1.4	**2**	When referrals are made which do not meet the service's criteria, staff inform the referrer why the referral has not been accepted and of alternative options	100%	95%
1.2.1	**2**	Staff provide young people and their parents/carers with written information about the service prior to or during their first attendance *Guidance: This might include the distribution of leaflets and web addresses to referrers and linked services*	69%	66%
1.2.2	**2**	CAMHS provide information about how young people on the waiting list can access help while they wait for an appointment *Guidance: Information may be provided in a letter, leaflet or telephone call; points of contact to access help may include the referrer, the school nurse, other local services*	71%	62%
1.2.3	**2**	Young people are kept informed about the progress of their referral and estimated wait for the first appointment	69%	61%

Standard No.	Type	Standard	% Met 2016	% Met 2015
1.3.1	**2**	There are documented, up-to-date referral pathways into CAMHS via a range of local services *Guidance: For example, GPs, emergency departments, schools, social services, paediatric services, youth offending teams, substance misuse services; CAMHS may be commissioned to accept referrals from specified referrers; where there are different points of referral the same criteria for urgent response should apply*	81%	77%
1.3.2	**2**	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*	81%	66%
1.3.3	**1**	The service has a policy or procedure, which may include a risk assessment process, that staff follow when young people and their parents/carers do not attend appointments. *Guidance: For example, missed appointments are followed up with a telephone call in the first instance and referrers are notified if the young person cannot be contacted*	92%	85%

Standard No.	Type	Standard	% Met 2016	% Met 2015
1.3.4	**2**	The service identifies where difficulties exist for particular groups to access the service and implements and monitors strategies to address these difficulties *Guidance: Depending on the locality this may include strategies to address the needs of black and minority ethnic and newly arrived groups; young people on the autistic spectrum and with multiple health conditions; school non-attendees; and young people in transition such as asylum seekers, travellers, and those without secure accommodation*	66%	53%
1.4.1	**2**	The number and characteristics of referrals to the service are monitored, including as a minimum the age, gender, ethnicity and source of referrals *Guidance: 'Protected characteristics' under the Equality Act 2010 are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation*	78%	73%

Standard No.	Type	Standard	% Met 2016	% Met 2015
1.4.2	**2**	Missed appointments (DNAs) are monitored monthly and reviewed in order to identify where access difficulties may exist *Guidance: This should include monitoring of failure to attend the initial appointment after referral and early disengagement from the service*	70%	61%
1.4.4	**2**	The service records information on waiting times *Guidance: The IT system provides accurate and accessible information on waiting times, including any internal waiting times for treatment; information is available on individual referrals and as an average for all referrals*	88%	74%
Section 2:		**Assessment and care planning**		
2.1.1	**2**	Young people with a routine referral receive a mental health assessment within 6 weeks	65%	43%
2.1.2	**1**	Young people with urgent or emergency mental health needs receive a mental health assessment within 24 hours or the next working day	94%	79%

Standard No.	Type	Standard	% Met 2016	% Met 2015
2.2.1	**2**	There is a clear identification of whether the young people or parents/carers are involved with or have access to other agencies	81%	80%
2.2.2	**2**	Prior to assessment, the assessing practitioner accesses relevant previous information to minimise the number of forms and assessments young people and their parents/carers are required to complete *Guidance: The assessment process should be co-ordinated across agencies where necessary, including through CAF or other local systems*	62%	59%
2.2.3	**1**	If additional information or liaison with other professionals is required, the assessing practitioner ensures that permission to access this is first sought from the young person or parent/carer as appropriate *Guidance: See standard 5.2.1 regarding when the young person is able to give consent*	90%	90%
2.3.1	**2**	Clinicians requiring access to medical assessment and investigations have an agreed pathway to access this when necessary *Guidance: This should include access to genetic investigations, brain imaging, and electroencephalography, in addition to all routine modern laboratory and investigative facilities*	87%	72%
2.4.1	**2**	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*	84%	85%

Standard No.	Type	Standard	% Met 2016	% Met 2015
2.4.2	**2**	Appointment letters for young people and their parents/carers about assessments explain: • who they will see • where and when they will be seen • who they can have with them • what will happen during the appointment • the source of the referral	59%	56%
2.4.3	**1**	During assessment young people's views, wishes, and feelings are actively sought and recorded by the assessing practitioner, as far as possible with regards to capacity *Guidance: Wherever possible with regards to age and ability, the assessing practitioner ensures that no decision is made about a young person without their full involvement. This includes initial contact and ongoing assessment appointments*	89%	98%
2.4.4	**1**	During assessment, parents or carers' views, wishes, and feelings are actively sought and recorded by the assessing practitioner (where appropriate) *Guidance: This in essential in cases where the child or young person lacks the capability to assert their own wishes*	97%	98%
2.4.5	**2**	Young people and parents/carers are provided with verbal feedback on the outcome of their assessment at the session	97%	85%
2.4.6	**2**	Written feedback from the assessment is provided to young people and parents/carers within 10 working days	44%	43%

Standard No.	Type	Standard	% Met 2016	% Met 2015
2.5.1		Case notes show evidence that assessments include consideration of:		
2.5.1a	**1**	• The young person's family and community needs and context	100%	93%
2.5.1b	**1**	• The young person's abilities and strengths as well as their difficulties	95%	90%
2.5.1c	**1**	• The young person's views and goals for treatment	84%	92%
2.5.2		Case notes show evidence that plans for intervention involve consideration of:	95%	
2.5.2.a	**1**	• The young person's individual mental health needs	92%	95%
2.5.2.b	**2**	• The young person's level of functioning and communication needs	87%	98%
2.5.2.c	**2**	• The holistic needs of the young person, including social, physical, emotional, educational, cultural and spiritual needs and context	70%	93%
2.5.2.d	**2**	• The wishes and goals of the family and their capacity to support interventions	68%	87%

Standard No.	Type	Standard	% Met 2016	% Met 2015
2.5.2.e	**2**	• The capacity and willingness of other agencies to support the intervention *Guidance: Staff may need to talk to schools, voluntary services and social services to establish their ability to support the intervention*	62%	85%
2.5.4	**2**	Staff ask young people about aspects of their physical health and discuss healthy lifestyles with young people and parents/carers *Guidance: These aspects may include sexual health, pregnancy, drugs and alcohol use, smoking, diet and so on; direction to relevant services may be required*	86%	85%
2.6.1	**1**	Young people have written care plans *Guidance: Clearly outlining agreed intervention strategies, measurable goals, review dates and discharge framework*	62%	66%
2.6.2	**1**	Care plans are reviewed at every session and include discussions with the young person about whether the treatment is helping	78%	60%
2.6.3	**1**	A formal risk assessment review is carried out on referral to the service and reviewed every 3 months and on discharge	86%	53%
2.6.4	**1**	Risk is reviewed session by session *Guidance: This is recorded in the progress notes*	78%	78%
2.6.5	**1**	Young people and their parents are given copies of any written plans for intervention or have ready access to them (with the young person's consent where appropriate) *Guidance: Clinicians should take specific communication needs in to account*	100%	55%
2.6.6	**1**	Plans for intervention are copied to other relevant agencies involved in the young person's care (with consent being sought as appropriate)	95%	78%

Standard No.	Type	Standard	% Met 2016	% Met 2015
2.7.1	**1**	Care plans are developed in partnership with young people and their parents/carers, including agreeing outcomes important to them, and their views are recorded in their note *Guidance: As far as possible with regard to age and ability*	84%	77%
2.7.2	**2**	Wherever an element of intervention detailed in the care plan does not take place, reasons for this are recorded in the case notes and discussed with the young person and their family	95%	71%
Section 3:		**Care and intervention**		
3.1.1	**2**	Clinicians are able to gain multi-disciplinary input on cases when needed *Guidance: This may be in the form of peer group supervision*	100%	95%
3.1.2	**1**	Interventions are provided in accordance with the NICE guidelines and/or the best available evidence	86%	83%
3.1.3	**1**	Where medication is used, prescribing follows protocols and best practice (e.g. NICE guidelines), and is closely monitored and regularly reviewed by an appropriately qualified, experienced practitioner	91%	92%
3.1.4	**1**	Young people and parents/carers can access support that is appropriate to any disabilities or needs additional to their mental health needs. *Guidance: When a young person has a co-occurring disability or long-term condition (such as a learning disability, an autism spectrum disorder or a sensory impairment)*	81%	
3.2.1	**2**	Young people assessed as requiring treatment see an appropriate clinician within 6 weeks of assessment	68%	49%

Standard No.	Type	Standard	% Met 2016	% Met 2015
3.2.2	**1**	Young people and their parents/carers are informed of how to get appropriate mental health advice in an emergency if necessary *Guidance:* *This should also be included in the appointment letter*	92%	82%
3.3.1	**2**	CAMHS liaise with other appropriate clinicians to meet any mental health needs identified within the young person's family *Guidance: Think Family Toolkit*	95%	85%
3.3.2	**2**	Young people and parents/carers are guided in self-help approaches where appropriate *Guidance: This may include those waiting between assessment and treatment*	89%	85%
3.3.3	**2**	Young people and their parents/carers are informed about local voluntary organisations and self-help groups, including culturally specific groups and organisations where relevant *Guidance: This may include those waiting between assessment and treatment*	76%	73%
3.4.1	**2**	Young people and their parents/carers have regular discussions with clinicians about the young person's progress and, where relevant, diagnosis *Add Guidance:* *Session by session*	97%	98%
3.4.2	**1**	Young people and their parents/carers are provided with information about the evidence base, risks, benefits and side effects of intervention options and of non-intervention *Guidance: For example, staff provide children, young people and their parents/carers with NICE/Cochrane guidelines about the treatment for particular conditions*	73%	73%

Standard No.	Type	Standard	% Met 2016	% Met 2015
3.4.3	**1**	All young people have a named member of staff who co-ordinates their care and is named in the young person's notes *Guidance: For example, this may be their key worker or care co-ordinator*	92%	88%
3.4.4	**2**	Young people and their parents consistently see the same clinician for intervention, unless their preference or clinical need demands otherwise	95%	83%
3.4.5	**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*	86%	78%
3.5.1	**2**	Staff have protected time to collect and collate outcome information	48%	45%
3.5.2	**1**	Case records include the results of measurement using at least one validated outcome measure *Guidance: For example, staff use SDQ, HoNOSCA, CGAS; see the CAMHS Outcomes Research Consortium website for guidance (http://www.corc.uk.net/)*	72%	69%
3.5.3	**2**	Outcome measures are evaluated from the perspective of staff, young people and parents/carers at a minimum	68%	60%
3.5.4	**2**	Information from outcome measurement is fed back to staff, service-users and commissioners	51%	43%

Standard No.	Type	Standard	% Met 2016	% Met 2015
3.5.5	**3**	Aggregated outcome data is used to inform individual plans for intervention, service evaluation and development. *Guidance: this should be undertaken at a minimum of every 6 months*	44%	27%
3.6.1	**2**	Young people and parents/carers are actively encouraged to give feedback on the service they receive *Guidance: For example, this may take the form of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups or patient consultation groups such as Patient Advice & Liaison Services (PALS)*	83%	77%
3.6.3	**2**	Feedback from young people and their parents is monitored and used to inform service evaluation and development	77%	70%
3.6.4	**2**	Young people's views on their therapeutic relationship with their key worker/main professional are sought throughout their contact with the service to monitor their engagement and experience of treatment and inform their ongoing care *Guidance: The ChASE is an instrument recently validated for use among 8 to 18 year olds accessing CAMHS to assess the quality of their service experience and therapeutic relationships; for further information please contact Dr Crispin Day, CAMHS Health Services Research Unit, King's College, London, crispin.1.day@kcl.ac.uk*	57%	49%

Standard No.	Type	Standard	% Met 2016	% Met 2015
Section 4:		**Information, consent and confidentiality**		
4.1.1	**2**	Young people are provided with written and verbal information about the service in a way that they can understand *Guidance: This should be provided in young person friendly formats*	74%	58%
4.1.4	**2**	Staff provide young people and their parents with information about the roles played by key professionals involved in their care	69%	68%
4.1.5	**2**	Parents are provided with information about the CAMH team and other services relevant to them *Guidance: This may include information about a parent/carer group, helpful links to websites, contact details*	65%	64%
4.1.6	**3**	Siblings of young people with learning disabilities and/or mental health problems are provided with clear information in an appropriate format	76%	21%
4.1.7	**2**	Staff provide young people and their parents or carers with information that is available in a range of languages where needed, as identified from local population information/analyses on languages spoken	84%	53%

Standard No.	Type	Standard	% Met 2016	% Met 2015
4.1.8	**2**	Staff provide young people and their parents or carers with information that is culturally relevant and sensitive *Guidance: For example, images used in posters and leaflets fully reflect the cultural diversity of the community*	57%	67%
4.2.1	**1**	For all young people, the young person's capacity and/or competency is assessed and recorded when a decision is required about their care *Guidance: In accordance with local legislation. Capacity and/or consent is assessed on admission and for each intervention*	76%	73%
4.2.2	**1**	Where young people are able to give consent, their consent to the proposed treatment or intervention is sought and their agreement or refusal is recorded in their notes	84%	89%
4.2.3	**1**	Where young people are not able to give consent, 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*	81%	85%

Standard No.	Type	Standard	% Met 2016	% Met 2015
4.2.4	**2**	Consent to treatment is sought by the practitioner who will carry out the treatment *Guidance: Where care planning and intervention are conducted by different people, the clinician providing the intervention should ask whether the young person (or parent if relevant) still agrees before starting treatment*	92%	87%
4.3.1	**1**	Staff inform young people of their right to agree to or refuse proposed treatments or interventions and explain the circumstances in which young people can be treated without their consent *Guidance: The right may be limited if the child or young person is not able to give consent; in this case it should be explained that their parents/carers may be asked to give consent on their behalf, but their wishes will be taken into account*	89%	82%
4.3.2	**2**	Staff tell young people that their consent to treatment can be withdrawn at any time and that consent is required again before treatment is reinstated or before further treatment can be given *Guidance: The right to refuse treatment can be raised sensitively in a way that does not discourage the young person, for example by explaining that the proposed treatment will be reviewed regularly and other options can be considered if it isn't helping*	81%	79%

Standard No.	Type	Standard	% Met 2016	% Met 2015
4.3.3	**2**	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); see the Code of Practice to the Mental Health Act paragraph 36.8 in relation to local authorities and parental responsibility*	95%	92%
4.4.1	**1**	Consent is sought prior to the disclosure of case material to parents/carers if the young person is assessed as able to make such a decision. *Guidance: In extreme circumstances this may be overruled if felt in the young person's best interests*	95%	94%
4.4.2	**1**	Audio and visual material is kept confidential and secure and young people and their parents/carers are assured about this and any limitations to this *Guidance: Consent should be obtained for the making of this material and its use thereafter*	97%	84%
4.5.1	**1**	Young people and their parents/carers are informed verbally and in writing of their right to confidentiality and its limitations	68%	82%

Standard No.	Type	Standard	% Met 2016	% Met 2015
4.5.2	**1**	Staff explain clearly to young people at the first appointment what type of information will be shared with whom, and discuss with the young person what should happen in the event the clinician needs to breach confidentiality *Guidance: For example, if information will be discussed with other members of the MDT at case discussion meetings this should be explained*	97%	98%
4.5.3	**1**	Young people and their parents/carers are aware of their rights to see the young person's health records *Guidance: Normally a person with parental responsibility will have the right to see their child's health record; however, staff should consider the young person's wishes and right to confidentiality: see Guidance for Access To Health Records Requests DH 2010 sections 23-24*	87%	73%
4.5.4	**1**	Young people and/or their parents/carers are asked if they wish to be copied into letters about the young person's health and treatment *Guidance: Where the young person is competent/has capacity (see criterion 5.2.1) they may choose to have letters sent to them and not their parents*	76%	70%
4.5.5	**1**	Young people are informed when confidential information about them is to be passed on to other services and agencies, and the reasons why this is important to their continuing care are explained	95%	95%

Standard No.	Type	Standard	% Met 2016	% Met 2015
Section 5:		**Rights and safeguarding**		
5.1		**Young people and parents/carers are treated with dignity and respect**		
5.1.1	**1**	Young people and parents/carers report that staff treat young people with dignity and respect	95%	88%
5.1.2	**2**	Young people and parents/carers report that staff are friendly and approachable	97%	88%
5.2.1	**2**	Young people's rights are explained and information about their rights is accessible and regularly reviewed *Guidance: Young people with learning disabilities may be less aware of their rights and less able to express their wishes than others their age; suitable methods of communication may involve using audio and video materials, accessible documentation (e.g. using symbols, plain English and pictures) communication passports, signers or interpreters*	65%	65%
5.2.2	**2**	Young people are offered the opportunity to see a staff member on their own without other staff or family present	97%	95%

Standard No.	Type	Standard	% Met 2016	% Met 2015
5.2.3	**3**	Young people can meet with a staff member of the gender of their choice	68%	73%
5.3.1	**1**	Complaints procedures are well-publicised and patient-friendly and staff explain to all young people and their parents/carers how to use them *Guidance: Complaints procedures should be explained verbally and in information packs and posters (for clinic-based services)*	86%	90%
5.3.2	**2**	The service has a formal link with an advocacy service for use by young people	54%	38%
5.3.3	**1**	Where young people and parents/carers disagree with a professional opinion, they are able to consult a second opinion and are told how to do this *Guidance: Young people and their parents/carers may discuss the outcome of the CAMHS assessment with their referrer before considering whether, and how, to proceed*	92%	93%
5.4.1	**1**	Staff respect and respond to young people's specific needs, by giving consideration to factors such as: • Gender and gender identity • Ethnicity • Religion • Ability • Culture • Sexuality • Socioeconomic background • Age • Physical needs/ disabilities • If the young person is a refugee or asylum seeker	97%	93%

Standard No.	Type	Standard	% Met 2016	% Met 2015
5.4.2	**2**	The service has access to interpreters and relatives are not used in this role	100%	92%
5.4.3	**3**	Interpreters have received guidance about mental health matters, including the importance of full and accurate translation	74%	69%
5.5.1	**1**	Staff act in accordance with current child protection protocols (e.g. the procedures of the Local Safeguarding Children Board), regardless of the young person's level of ability	100%	98%
5.5.2	**1**	The trust has a named doctor and a named nurse responsible for child protection	95%	97%
5.5.3	**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*	100%	98%
5.5.4	**1**	There are procedures for escalation through the identified safeguarding lead if no response is received when a safeguarding referral is made to the local authority	100%	92%

Standard No.	Type	Standard	% Met 2016	% Met 2015
5.5.5	**1**	Young people are reassured that any disclosure of abuse will be taken seriously and are informed about the next steps	100%	93%
5.5.6	**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	100%	90%
5.5.7	**1**	Safeguarding information is clearly recorded and shared between agencies and services for the explicit purpose of child protection	100%	100%
5.5.8	**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 every two years	94%	88%
5.5.9	**1**	Staff who may see young people with learning disabilities receive regularly updated training in child protection with specific regard to young people with learning disabilities, recognising that young people with learning disabilities are at increased vulnerability to abuse *Guidance: Staff should receive training as part of their induction and have access to in-house training and refresher courses on an annual basis*	80%	60%
5.6.2	**1**	The service has a whistle blowing policy and staff members are able to raise concerns without prejudicing their position	94%	87%

Standard No.	Type	Standard	% Met 2016	% Met 2015
5.6.3	**1**	Staff are made aware that they are able to critically challenge decisions that they feel may not be in the best interests of young people and their parents/carers	97%	92%
Section 6:		**Transfer of care**		
6.1.1	**2**	Young people and parents/carers are involved in agreeing plans for leaving the service, and their views are recorded in the notes	97%	95%
6.1.2	**1**	On leaving the service, staff tell young people, parents/carers and referrers how they can receive further advice if needed	95%	98%
6.1.3	**2**	Where young people reaching the upper age limit of the service are not referred to adult mental health services they are informed how to access adult mental health services if needed later on	100%	95%
6.1.4	**2**	If young people stop attending appointments before formal arrangements for this are made, there are procedures in place to facilitate their return to the service *Guidance: For example, the key worker contacts the young person or parent/carer to discuss reasons for leaving and this is used to inform service evaluation and audit*	89%	78%
6.2.1	**1**	When young people are to leave the service the Care Programme Approach is completed where appropriate *Guidance: See 'Refocusing the Care Programme Approach' for guidance as to when the CPA should apply*	86%	69%

Standard No.	Type	Standard	% Met 2016	% Met 2015
6.2.2	**2**	When young people leave the service, their key worker or equivalent takes responsibility for planning this *Guidance: This would include the care co-ordinator for services which participate in Team Around the Child processes*	100%	95%
6.2.3	**2**	When transfer of care is planned, the roles of the agencies involved in any subsequent care are clarified, agreed and documented beforehand	95%	85%
6.2.4	**1**	For young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant Social Services departments	94%	95%
6.2.5	**1**	When young people leave the service, a summary letter or report outlining recommendations for future care is sent to their GP and any other agencies involved	97%	90%
6.2.6	**2**	On leaving the service, there are agreements with other agencies for young people to re-access the service if needed, without following the initial referral pathway *Guidance: There may be exceptions where young people require a generic assessment and where it may be appropriate to follow the initial referral pathway*	60%	51%
6.2.7	**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*	97%	90%
6.2.8	**2**	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	89%	73%

Standard No.	Type	Standard	% Met 2016	% Met 2015
6.3.1	**2**	Primary emphasis is placed on referring young people to a unit that meets their specific mental health needs, working with their choices and preferences	81%	73%
6.3.2	**2**	Young people are referred to a unit that is as accessible as possible so that contact with home and family is maintained	80%	63%
6.3.3	**2**	Young people are referred to an age-appropriate unit that meets their developmental needs	83%	78%
6.3.4	**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	74%	78%
6.3.5	**1**	If inpatient care is required, the key worker or equivalent contacts the inpatient service soon after admission and attends review meetings (e.g. CPA meetings) during the inpatient stay	90%	87%
6.4.1	**1**	A written transition policy is in force and followed which states the age for referral to adult services *Guidance: The national CAMHS Review recommends that the transition process starts by age 17.5*	86%	71%
6.4.2	**1**	Young people aged below the locally agreed cut-off for referral to adult services are not referred to adult services unless in exceptional circumstances *Guidance: This may occasionally be appropriate if there is good clinical cause which outweighs developmental and/or other needs*	97%	92%
6.4.3	**2**	Joint reviews of young people's needs are held with adult services (e.g. using the CPA) and the young person to ensure that effective handover of care takes place	75%	68%

Standard No.	Type	Standard	% Met 2016	% Met 2015
6.4.4	**2**	Transition protocols are in place for young people with neurodevelopmental disorders (e.g. ASD, ADHD), including signposting to other support where the young person does not meet the criteria for adult mental health services	50%	36%
6.4.5	**3**	CAMH services have a named link person with responsibility for transitions so that staff and young people know who to approach with queries	58%	48%
6.4.6	**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 CAMHS service will provide liaison to the adult service, if needed and with consent	89%	87%
6.4.7	**2**	Young people referred to adult services are provided with a transition pack which contains information on: • The roles of adult mental health staff (for example general adult psychiatrist, CPN) • Who to contact if there is a problem	36%	20%
Section 7:		**Multi-agency working**		
7.1.1	**1**	General practitioners and other members of the primary healthcare team	92%	88%
7.1.2	**1**	Paediatric, child development centres and other children's health services, including neurological services where appropriate	100%	85%
7.1.3	**1**	School health services including community paediatricians and school or college nurses	100%	85%

Standard No.	Type	Standard	% Met 2016	% Met 2015
7.1.4	**1**	All relevant departments in social services including foster care and adoption services	94%	85%
7.1.5	**1**	Education and education support services	97%	90%
7.1.6	**2**	Forensic mental health services	76%	68%
7.1.7	**2**	Youth justice service	92%	85%
7.1.8	**1**	Inpatient and day-patient child and adolescent mental health services	89%	77%
7.1.9	**1**	Adult mental health services	83%	76%
7.1.10	**2**	Occupational Therapy	74%	79%
7.1.11	**1**	Speech and language professionals	78%	83%
7.1.12	**1**	Young people's drug and alcohol teams/substance misuse services	86%	78%
7.1.13	**1**	Laboratory and diagnostic services *Guidance: Psychiatrists should be able to access these for MRI scans, physical investigations and medication reviews*	88%	77%
7.1.14	**1**	Accident and emergency	81%	73%

Standard No.	Type	Standard	% Met 2016	% Met 2015
7.1.15	**2**	Appropriate voluntary and third sector services *Guidance: These include support services for BME groups and LGBT support services*	78%	85%
7.1.16	**2**	Adult learning disability services	77%	72%
7.2.1	**2**	Documented inter-agency agreements clearly state the roles and responsibilities allocated to each organisation *Guidance: This should follow the service specification*	70%	47%
7.2.2	**1**	There are arrangements to ensure that there is 24 hour cover for young people in need of mental health support *Guidance: Joint protocols should be agreed, for example, with commissioners, primary healthcare services, paediatricians, adult psychiatry services, emergency medical departments, social services*	83%	70%
7.2.3	**1**	There are interagency agreements on the sharing of information which balance confidentiality with the need to keep all relevant services informed in the young person's best interests	89%	83%
7.2.4	**1**	There are joint protocols on involving or notifying other services or agencies when there is suspected abuse of young people	100%	90%

Standard No.	Type	Standard	% Met 2016	% Met 2015
7.3.1	**2**	There is regular dialogue, such as case meetings, between CAMHS and representatives from all agencies involved in the young person's care, and this is documented in the clinical notes	92%	88%
7.3.2	**3**	There is joint training and professional development across the services and agencies working with young people *Add Guidance: For example, this may include joint training between adult and children's services; designated sessions to facilitate liaison between services*	69%	81%
7.3.3	**3**	Joint working is facilitated through flexible initiatives such as secondments, rotational posts, split posts and opportunities for job shadowing across organisations	57%	90%
Section 8:		**Staffing and training**		
8.1.1	**1**	All staff participate in a service induction programme before they have unsupervised access to young people	81%	83%

Standard No.	Type	Standard	% Met 2016	% Met 2015
8.1.2	**1**	Young people receive assessments and interventions from appropriately qualified practitioners, who have access to training and supervision in working with the relevant age group and any co-morbid conditions *Guidance: For example, young people with autism spectrum disorders, learning disabilities, or sensory impairments receive support from practitioners who have the necessary skills to work effectively with these young people, including consultation with specialists where necessary*	95%	93%
8.1.3	**1**	The service undertakes pre-employment checks to ensure that professional staff are registered with the appropriate bodies e.g. General Medical Council, Nursing and Midwifery Council, and ongoing monitoring of this is carried out every year	95%	95%
8.2.1	**2**	CAMHS regularly review at defined intervals and when there are changes in service provision: • Their capacity • Their skill mix • Their activity • The demands on the service	76%	73%
8.2.2	**2**	There are administrative and/or secretarial staff to support the effective running of the service	76%	70%
8.2.3	**2**	Staffing levels support staff commitments to provide training, supervision and consultation within the service and to other services	68%	60%

Standard No.	Type	Standard	% Met 2016	% Met 2015
8.3.1	**1**	CAMHS teams have a designated service manager and clinical lead *Guidance: This might be the same person*	92%	93%
8.3.2	**2**	All staff have clearly defined job descriptions and job plans which are revised at least annually	81%	68%
8.3.3	**2**	There are clear and agreed lines of clinical and managerial responsibility for all staff	89%	95%
8.4.1	**2**	All staff receive an annual written appraisal	92%	74%
8.4.2	**1**	All clinical staff receive regular individual clinical supervision totalling at least one hour per month	41%	78%
8.4.3	**3**	All clinical staff receive regular peer group multidisciplinary supervision totalling at least one hour per month	72%	90%
8.4.4	**2**	All staff receive regular line management and professional supervision totalling at least one hour per month	86%	69%
8.4.5	**2**	All supervisors receive training in clinical supervision taking into consideration profession-specific guidelines	76%	71%

Standard No.	Type	Standard	% Met 2016	% Met 2015
8.4.6	**2**	All junior staff (nursing and medical) receive support in line with their professional requirements *Guidance: Through weekly supervision and preceptorship programmes*	92%	83%
8.4.7	**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*	95%	95%
8.4.8	**1**	There is a lone working policy supported by procedures in place to promote the safety of staff *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*	94%	87%
8.5.2	**2**	Levels of staff turnover and sick leave are monitored and investigated	87%	90%
8.5.4	**2**	There is a clear complaints procedure for staff to use	97%	90%
8.6.1	**2**	The service has access to a budget that can support the training needs of the team	81%	54%

Standard No.	Type	Standard	% Met 2016	% Met 2015
8.6.2	**2**	Training needs are informed by individual annual staff appraisal and personal development plan	90%	85%
8.6.3	**2**	Training needs are informed by a 2-yearly review of the skills needed within the service *Guidance: For example SASAT*	53%	38%
8.6.4	**2**	Current reference manuals, electronic journals, statutory guidance, codes of conduct and relevant textbooks are available to staff within the service	89%	88%
8.6.6	**1**	Staff receive clear written guidance laid out in a formal policy on young people's rights to confidentiality and the circumstances in which information can be shared with third parties, including those with parental responsibilities *Guidance: See Information Sharing: Practitioners' Guide DfES 2006 for guidance*	93%	89%
8.6.7	**1**	Staff are trained to deliver a range of therapeutic interventions such as cognitive and behavioural techniques, brief psychotherapy techniques, family interventions, parent counselling	92%	92%
8.7.1	**2**	Specific evidence based practice	86%	80%
8.7.2	**1**	Pharmacological interventions (for staff who prescribe, dispense or administer medicines to young people)	94%	93%
8.7.3	**1**	Policies and procedures around consent	95%	90%
8.7.4	**1**	Policies and procedures around information-governance and confidentiality	95%	93%
8.7.5	**1**	Young people's rights and mental health legislation	93%	83%
8.7.6	**2**	De-escalation and breakaway training	83%	87%

Standard No.	Type	Standard	% Met 2016	% Met 2015
8.7.7	**1**	Safeguarding children, including recognising indicators of abuse and procedures for dealing with abuse *Guidance: This may be delivered through or augmented by joint training between services working with young people*	97%	93%
8.7.8	**1**	Culturally sensitive practice, disability awareness, and other diversity and equality issues, including the Equality Act 2010	89%	90%
8.7.9	**2**	Skills to respond to special needs, including sensory impairments, learning disabilities and developmental disorders	73%	68%
8.7.10	**2**	Use of appropriate clinical outcome measures	81%	83%
8.7.11	**1**	How to respond to an emergency when first on-call to young people presenting with acute psychiatric illness	83%	75%
8.8.1	**2**	All staff attend regular team meetings for clinical matters and administration *Guidance: This is particularly important for staff who spend significant periods of time lone working or work within a different service*	97%	90%
8.8.2	**2**	Notes of clinical meetings are kept and made available to all members of the team	94%	85%

Standard No.	Type	Standard	% Met 2016	% Met 2015
8.8.3	**2**	Staff are consulted on relevant management decisions such as developing and reviewing operational policy	84%	85%
Section 9:		**Location, Environment and Facilities**		
9.1.1	**2**	The entrance and key clinical areas of CAMH centres are clearly signposted	86%	83%
9.1.2	**2**	Staff, young people and parents/carers report that environments used by CAMHS practitioners are comfortable and maintained at high levels of cleanliness	69%	68%
9.1.3	**2**	CAMH centres are age and developmentally appropriate for the whole age range seen by the service and are young person-friendly *Guidance: For example, waiting areas in CAMH centres contain age and developmentally appropriate play and reading material*	74%	63%
9.1.4	**2**	Staff, young people and parents/carers report that waiting areas for CAMH services are sufficiently spacious	69%	55%
9.1.5	**3**	CAMH centres have sufficient car parking space for visitors, including allocated spaces for disabled access	66%	53%
9.2.1	**1**	Environments used by CAMHS practitioners meet the needs of people who have physical disabilities, and comply with current relevant legislation	92%	83%
9.2.3	**2**	CAMHS practitioners have access to large and small rooms suitable for individual and family consultations	86%	83%

Standard No.	Type	Standard	% Met 2016	% Met 2015
9.2.4	**2**	CAMHS practitioners, young people and their parents/carers have consultations in private rooms where they cannot be overheard	89%	76%
9.3.1	**1**	Entrances and exits are visibly monitored and/or access is restricted	89%	83%
9.3.2	**2**	CAMH centres are securely separated from adult services *Guidance: There are separate areas and entrances for adults' and children's services, and access to children's services is restricted*	91%	90%
9.3.3	**1**	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	89%	75%
9.3.4	**3**	CAMH centres 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*	57%	45%
9.3.5	**2**	There is a system in place so that staff can summon help in an emergency *Guidance: For example, wall alarms in clinics, personal alarms, mobile phones for lone worker*	58%	50%
9.4.1	**2**	Staff report they have sufficient space to do administrative work *Guidance: Staff can access suitable space to make confidential phone calls*	70%	76%

Standard No.	Type	Standard	% Met 2016	% Met 2015
9.4.2	**2**	All staff have access to IT facilities to support high quality care and the monitoring and evaluation of the service	81%	80%
Section 10:		**Commissioning**		
10.1.1	**1**	Senior CAMHS managers work collaboratively with the CAMHS commissioning lead for each commissioning agency involved	85%	74%
10.1.2	**2**	Commissioners and CAMHS managers meet quarterly at a minimum	97%	88%
10.1.3	**1**	Commissioners and senior CAMHS managers are aware of their responsibilities as outlined in the service specification *Guidance: For example, the Children Act 1989, Disability Discrimination Act 1995, Equality Act 2010*	82%	87%
10.1.4	**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	57%	39%
10.1.5	**3**	Commissioners produce a feedback report demonstrating how consultation with the above groups has been acted upon to inform the commissioning strategy	61%	41%

Standard No.	Type	Standard	% Met 2016	% Met 2015
10.2.1	**1**	The role of the service is made clear in a service level agreement or contract with the commissioning agencies *Guidance: This should plainly state the core business of the service and the functions that it is expected to deliver*	70%	63%
10.2.2	**2**	There is a comprehensive CAMHS strategy for all levels of service provision which is accessible and known to all local agencies working with young people *Guidance: For example, a four-tier CAMHS strategy or universal, targeted and specialist services*	85%	50%
10.3.1	**2**	Commissioners ensure there is integrated working and agreed referral pathways between CAMHS and other local services working with young people, including: • Youth offending teams • Substance misuse services • Social services • Education services • Other healthcare providers	87%	67%
10.4.1	**1**	Commissioners and staff from the service regularly review capacity and demand	93%	66%
10.4.2	**2**	When posts are vacant or in the case of long term sickness or maternity leave, prompt arrangements are made for temporary staff cover	73%	71%

Standard No.	Type	Standard	% Met 2016	% Met 2015
10.4.5	**2**	CAMHS work in partnership with primary services and other relevant services to ensure young people with particular needs (for example sensory impairments or autistic spectrum disorders) receive the co-ordinated care and intervention they need *Guidance: Collaboration involves providing advice or education to other agencies on how to manage young people with learning disabilities and/or mental health needs; more formalised collaborative arrangements involve, for example, joint care, CAMHS paediatric liaison*	89%	77%
10.5	**2**	There is a review process involving commissioners and the service that takes place at least annually	93%	77%
10.5.1	**1**	Performance criteria which are set for the service are agreed by the commissioners and senior CAMHS managers	93%	87%
10.5.2	**2**	Performance criteria are informed by the opinions of young people and their parents/carers	93%	34%

Appendix B: List of Members in Cycle 2016

Teams with a QNCC peer or self review in 2016

Name of Trust	Team Name
2Gether Foundation Trust	Gloucestershire CYPS
5 Boroughs Partnership NHS Trust	Warrington & Halton
5 Boroughs Partnership NHS Trust	Wigan CAMHS
5 Boroughs Partnership NHS Trust	Wellcroft CAMHS
Belfast Trust	Eating Disorder Youth Team
Belfast Trust	CAMHS Ards Team
Belfast Trust	CAMHS Lagan Valley Hospital
Belfast Trust	Crisis Assessment and Intervention Team
Belfast Trust	Young people's centre
Belfast Trust	Child and Family Clinic
Betsi Cadwaladr University Health Board	North West Wales CAMHS
Betsi Cadwaladr University Health Board	Wrexham Child Development Unit
Betsi Cadwaladr University Health Board	Conwy CAMHS
Betsi Cadwaladr University Health Board	Denbighshire CAMHS
Betsi Cadwaladr University Health Board	Kite Team
Betsi Cadwaladr University Health Board	Flintshire CAMHS
Cambridgeshire & Peterborough NHS	North Team CAMHS
Coventry and Warwickshire Partnership NHS Trust	North Warwickshire CAMHS
Cwn Taf University Health Board	Cwm Taf CAMHS
Dubai Healthcare City	Camali Clinic
West London Mental Health Trust	Ealing CAMHS
East London NHS Foundation Trust	City and Hackney CAMHS
HSE Dublin	Dublin North City & Co CAMHS
East London NHS Foundation Trust	Tower Hamlets CAMHS
Kent Community Health NHS Trust	CHATTS
Lincolnshire Partnership FT	South Lincolnshire Team
Lincolnshire Partnership FT	North Lincolnshire Team
National University Hospital of Iceland	Iceland CAMHS
Northumberland Tyne and Wear NHS Trust	Northumberland CYPS
Northumberland, Tyne and Wear	Newcastle CYPS
Northumberland, Tyne and Wear	South of Tyne and Wear CYPS

Northumbria Healthcare NHS Foundation Trust	North Tyneside CAMHS
Outpatient service in the Parnu Region	
Oxford Health	OSCA Bucks CAMHS
Powys Local Health Board	Powys CAMHS
Solent Healthcare	Portsmouth City CAMHS
South West London and St George's Mental Health NHS Trust	Adolescent Assertive Outreach Team (AAOT)
South West London and St George's Mental Health NHS Trust	Deaf Children Young People and Family Service (NDCAMHS) London
South West London and St George's Mental Health NHS Trust	Deaf Children, YP and Family Service SE Coast
South West London and St George's Mental Health NHS Trust	Deaf Children, Young People and Family Service (NDCAMHS) Cambridge
States of Guernsey	Guernsey CAMHS
Surrey and Borders Partnership NHS Foundation Trust	North Surrey CAMHS
Sussex Partnership NHS Foundation Trust	Canterbury CAMHS
Sussex Partnership NHS Foundation Trust	Chichester CAMHS
Sussex Partnership NHS Foundation Trust	Eastleigh CAMHS
West London Mental Health Trust	Ealing CAMHS
West London Mental Health Trust	Hammersmith CAMHS
West London Mental Health Trust	Hounslow CAMHS

QNCC Advisory Group 2016

- **Peter Thompson** Senior Programme Manager, CCQI
- **Harriet Clarke** Programme Manager, CCQI
- **Emily Lesnik** Deputy Programme Manager, CCQI
- **Joe Lindsay** Project Worker, CCQI
- **Hannah Moore** Project Worker, CCQI
- **Julie Curtis** Senior Clinical Nurse / Community Clinical Manager, Northumberland Tyne and Wear NHS Trust
- **Melanie Dix** Consultant Psychiatrist, Cumbria Partnership NHS Foundation Trust
- **Liz Fellow-Smith** Consultant Psychiatrist, West London Mental Health NHS Trust
- **Briege Gates** Clinical Nurse Specialist, SEPT
- **Andrew Gordon** Young Person Advisor
- **Carol-Anne Murphy** Nurse Consultant for Transitions, 5 Boroughs Partnership Trust
- **Caroline Thompson** Clinical Psychologist, Belfast Trust
- **Charlotte Williams** CAMHS Rights and Participation Coordinator, Surrey CAMHS
- **Caroline Winstone** North Wales Regional Specialist CAMHS Commissioning Manager
- **Ann York** Consultant Psychiatrist, formerly Richmond CAMHS