



The Quality Network for Community CAMHS

Annual Report

2024-2025

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Foreword

Dr Phil Ferreira-Lay

QNCC Advisory Group Member

Associate Medical Director, Consultant Child & Adult Psychiatrist

Surrey and Borders Partnership NHS Foundation Trust

Welcome to our annual report and I hope that you find it interesting and informative reading. It is my pleasure to write a few words by means of a foreword to this document.

The Quality Network for Community CAMHS (QNCC) is one of the many ways in which the Royal College of Psychiatrists helps ensure that the quality and delivery of services is maintained at a high standard.

QNCC is one of several networks within the College that help oversee the amazing, dedicated, and high-quality work that our inpatient and community teams deliver to our populations of young people, families and adults. Wherever possible, all networks provide support and constructive challenge to those services that seek peer reviews and accreditation through us. This demands a high level of work from the services themselves and those who participate as review team members. That membership comprises RCPsych College officers, clinicians and operational staff from a broad range of professional backgrounds and those with lived experience.

In the period between September 2024 – June 2025, there have been 31 self-reviews, peer reviews and accreditation reviews held with teams across the length and breadth of the UK and Ireland. There have also been two accreditation training events, one online special interest day, and an in-person conference which has helped embed and maintain a learning culture across the network.

A special mention must also go to our Chair of the Specialist Advisory Group and Deputy Chair of the Accreditation Committee- Carol-Anne Murphy. She has continued to provide strong leadership and often with good humour.

I hope that what you read in the coming pages reflects the range and detail of all the work that the Quality Network for Community CAMHS is involved in. I also hope that many of you will see reflected the amazing work that your services have continued to deliver.

I encourage you all to keep up the high levels of motivation and passion which underpins all the good work done in the services you are part of.

I wish you all the best in the coming 12 months.

Foreword

Estelle Wrathall

Carer Representative for QNCC

It's been another very busy QNCC cycle! The QNCC network continues, through its Project Team, Advisory Group, Reviews (Self, Peer and Accreditation), Special Interest Days, Annual Forums, and the Accreditation Committee, to share good practice, and to drive up standards in children and Young People's Mental Health Services.

There are some great achievements to highlight in this report, particularly the levels of young people who are actively involved in shared decision making about their health care and treatment, and the level of teams providing assessments based on the wishes and goals of the young person and their families. As ever, there are still some areas where improvements can be made. Nationally, there are huge disparities in waiting and treatment times. Improvement in the provision of written information (e.g. Care Plans, Information Packs) is still required. Support and information for siblings, ensuring our waiting spaces provide low stimulation environments, and more extensive use of creative therapies, are also all areas for development.

Lastly, I'd like to say that I feel very privileged to be part of the team that visit services as part of the review process. As a parent carer representative, it is so heartening that our lived experience can help guide service development and improvements. I always feel a valued member of the team, and what strikes me is that, despite sometimes very challenging conditions, staff and services are so open and willing to share and learn from each other. They continue to strive for improvement and excellence and inspire each other! I hope this report offers an opportunity to recognise and celebrate all this hard work by individuals and teams, and everyone involved in QNCC to improve the care they provide, and to hold children and young people and their families at the heart of everything they do.

Introduction

Who we are

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

QNCC was developed around 2004 following the launch of the Quality Network for Inpatient CAMHS (QNIC) in 2001. The Network is one of around 29 quality networks, accreditation and audit projects organised by the Royal College of Psychiatrists Centre for Quality Improvement (CCQI). A full list of member services and their current accreditation status is available to [view on our website](#).



What we do

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

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

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

Introduction

Annual Review Cycle



The review process

The review process has 2 phases:

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

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

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

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

Jargon Buster

Self-review

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

Peer review

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

Accreditation

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



This report

What to expect in this report:

This edition of the QNCC Annual Report contains the aggregated results of 31 reviews undertaken by services who completed their self-review and peer or accreditation review from September 2024 to June 2025, against the 7th Edition Standards for QNCC or the 3rd edition of the Eating Disorder QNCC standards. It is produced to inform staff, senior management, patients and carers, as well as anyone who has an interest in community CAMHS.

The report first presents an overview of the data collection and then examines the contextual data obtained from the self-reviews of the 31 services.

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

This is then followed by some recommendations for standards which were commonly not met by services during this period.



Purpose

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

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

QNCC Standards

QNCC assess community CAMHS teams in accordance with a set of standards. The 7th Edition QNCC Standards and 3rd Edition Eating Disorder Standards were drawn from a range of authoritative sources and incorporate feedback from patient and carer representatives, as well as experts from relevant professions.

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

This model aims to facilitate incremental improvements in service quality.

Standard Types

QNCC Standards are divided into three types:

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

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

Standards domains

Each set of QNCC Standards are grouped into nine sections:

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

Jargon Buster

Type-1 Standards

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

Type-2 Standards

Criteria that a service would be expected to meet.

Type-3 Standards

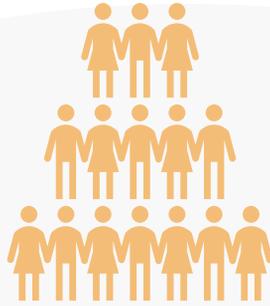
Criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

Data Collection



62

Member Services
(as of June 2025)



Approximately
32

Young people
took part in
interviews

Approximately

38

Partner
agencies
shared their
experiences



Approximately

70

Parent/carers took part
in interviews



31

Services had
their self-
review, peer
review, or
accreditation in
2024 to 2025



Where did data come from?

The data in this report comes from **31** reviews undertaken from September 2024 to June 2025 where services have completed their self-review, peer-review or accreditation using the 7th QNCC standards and 3rd QNCC ED standards.

In 2024-2025 **14** reviews were undertaken against the QNCC Generic standards, and **17** were reviewed against the QNCC ED standards.

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

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

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

This evidence included:

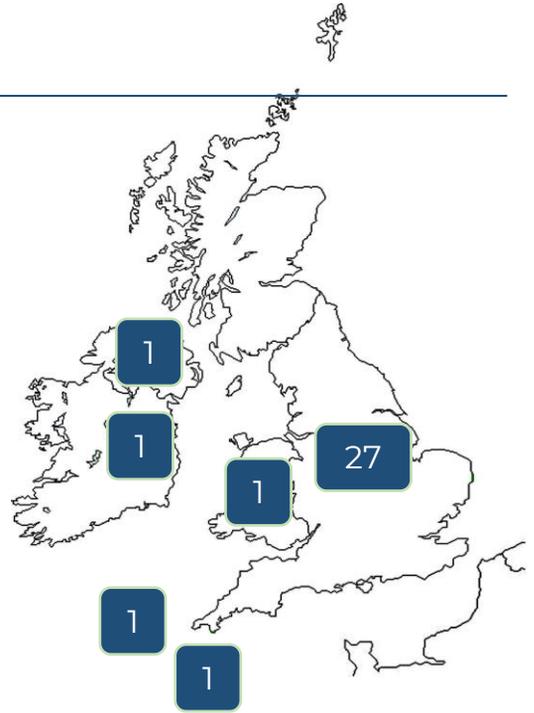
- Young people interviews
- Parent/Carer interviews
- Policy and documentation checks
- Environmental checklists from tours of the premises
- Facilitated discussions on the review day with members of the SMT, MDT and any other staff members present.

Contextual Data

Location

Of the 31 reviews of services that took part in a self-review and peer-review in 2024 to 2025:

- 26 were based in England
- 1 in Northern Ireland
- 2 in Republic of Ireland
- 1 in Wales
- 1 in Jersey
- 1 in Guernsey



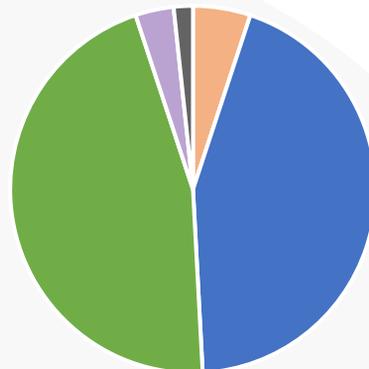
Service Type

All 31 QNCC Members in analysis

59 Current QNCC Members



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



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

The above graphs show the breakdown of member services part of QNCC, both used in the analysis of 2024-25 and those who currently hold membership as of September 2025

Contextual Data

The contextual data included below has been provided by each service who completed a self-review from 2024 to 2025 using the QNCC 7th edition standards or the QNCC ED 3rd edition standards. Of the 31 services that completed a review, two secondary mental health services and one intensive community treatment team have been excluded from analysis in order to protect anonymity. Additionally, some services did not provide data for these areas, and therefore they are also excluded from this analysis.

Average total case load per clinical staff member



General CAMHS

Across the 11 general services that are included in this analysis, the highest case load per clinical staff member was **41.82** and the lowest was **10**. The average caseload per clinical staff member was **24.83**

Eating Disorder Teams

Across the 16 ED services that are included in this analysis, the highest caseload per staff member was **13.22** and the lowest was **2.2**. The average caseload per clinical staff member was **6.79**.



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

General CAMHS

Across the 9 general services that are included in this analysis, the largest number of staff per 100,000 total population was **27** and the lowest was **4.3**. The average was **19.04**.

Eating Disorder Teams

Across the 16 ED services that are included in this analysis, the largest number of staff per 100,000 total population was **27.64** and the lowest was **1**. The average was **8.07**.

The average wait time from referral to assessment



General CAMHS

Across the 8 general services that are included in this analysis, the longest wait time for assessment was **202** days and the shortest wait time was **10.5** days. The average wait time was **61.44** days or **8.78** weeks.

Eating Disorder Teams

Across the 16 ED services that are included in this analysis, the longest wait time for assessment was **57.19** days and the shortest wait time was **5** days. The average wait time was **19.48** days or **2.7** weeks.



The average wait time from referral to treatment

General CAMHS

Across the 8 generic services that are included in this analysis, the longest wait time for treatment was **417** days and the shortest wait time was **14** days. The average wait time was **158.01** days, or **22.57** weeks.

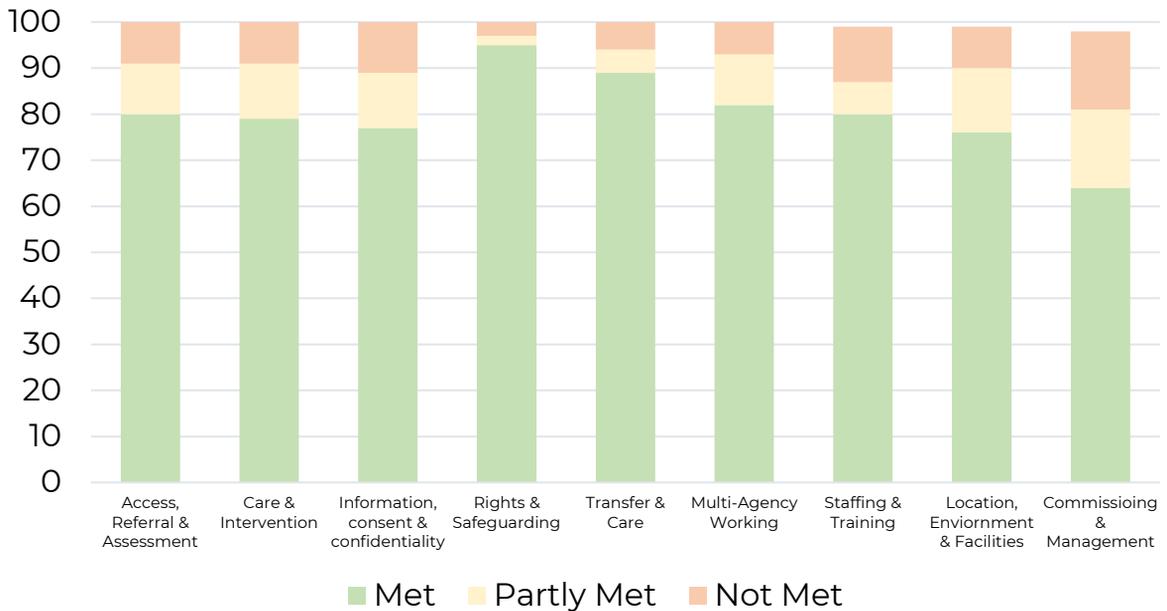
Eating Disorder Teams

Across the 16 ED services that are included in this analysis, the longest wait time for treatment was **206** days and the shortest wait time was **5** days. The average wait time was **31.06** days or **4.5** weeks.

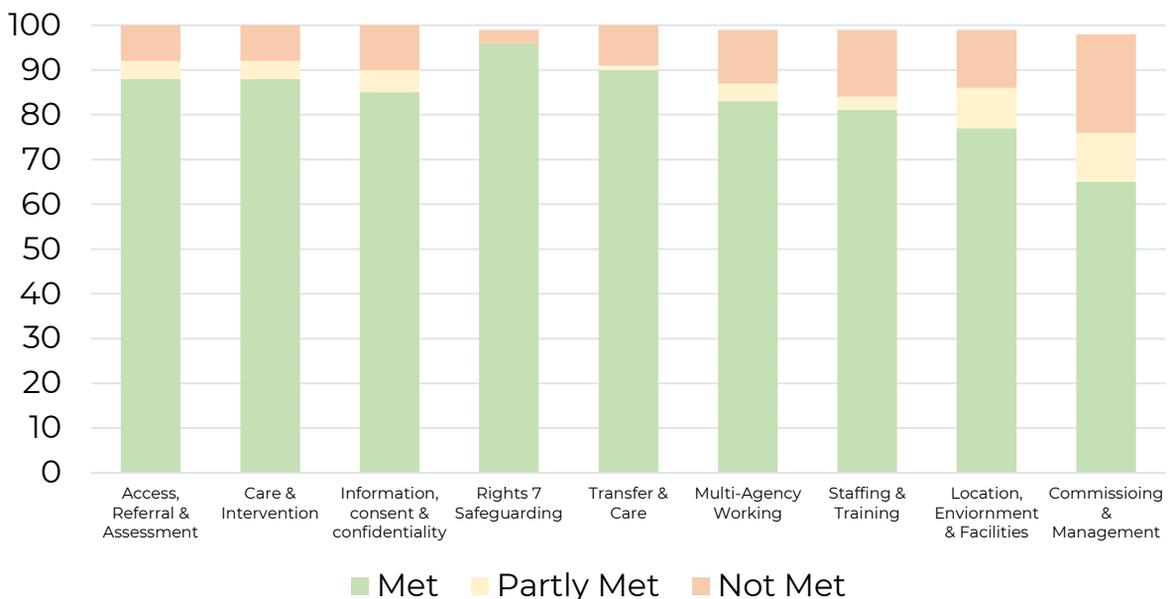
Overall Compliance with the Standards

All services were assessed on their compliance with the 7th edition of the QNCC standards, or the 3rd Standards for Eating Disorder services. Below is the average total (percentage) adherence to each of the subsections of these standards (counting “Partly Met”, and “Unmet” as not adherent, and “Met” as adherent). Standards marked as N/A or Don’t Know have been excluded from analysis.

General CAMHS



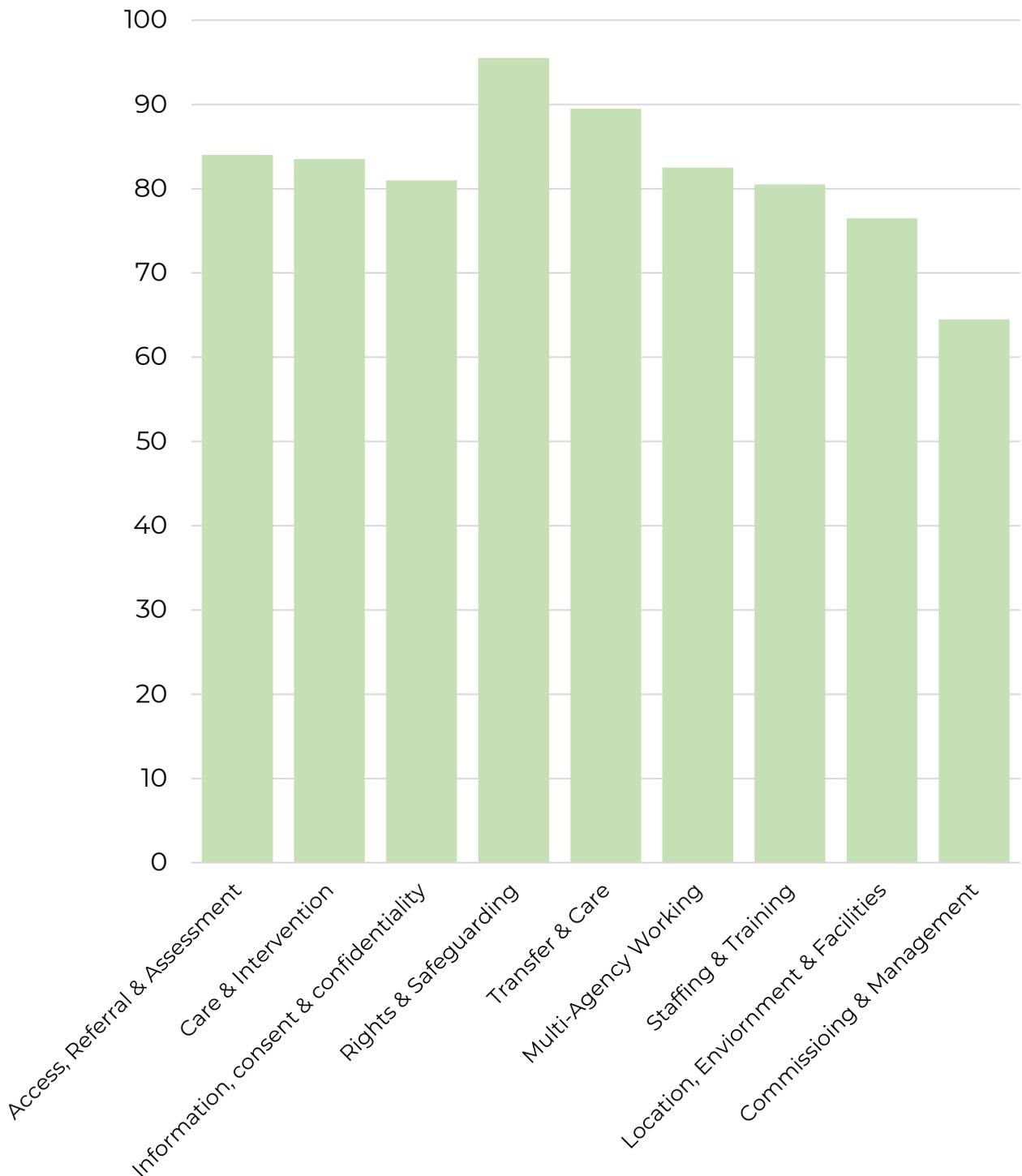
Eating disorder



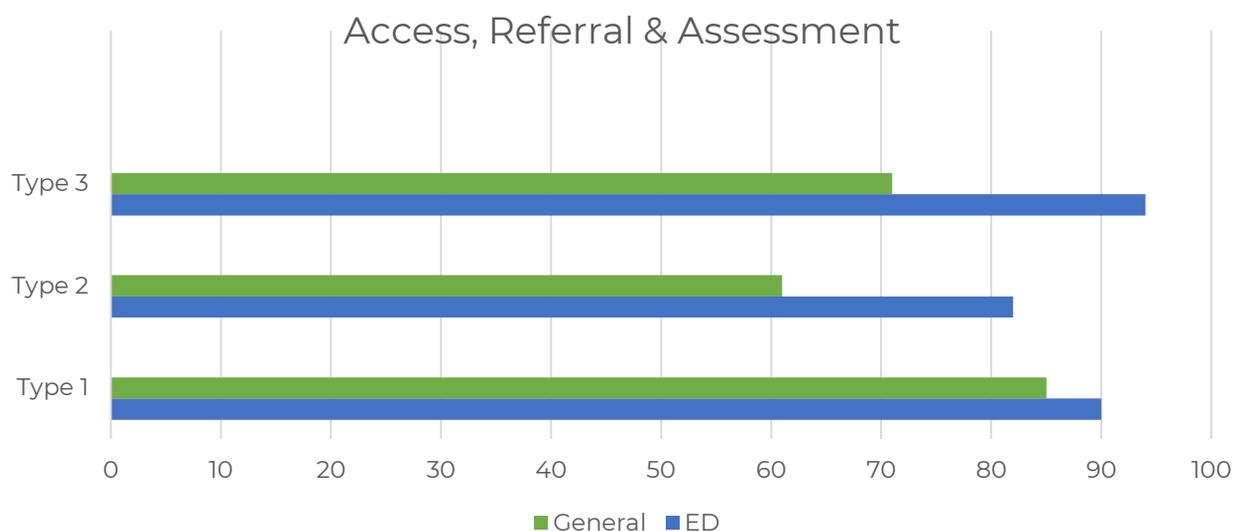
Overall Compliance with the Standards

The following graph shows the **average** total (percentage) adherence for both ED and General services combined, against each of the subsections of the standards, counting only the “Met” standards. The services were assessed on their compliance with the 7th edition of the QNCC standards, or the 3rd Standards for Eating Disorder services.

Average number of Met standards: ED & General



Section 1: Access, Referral and Assessment



Achievements

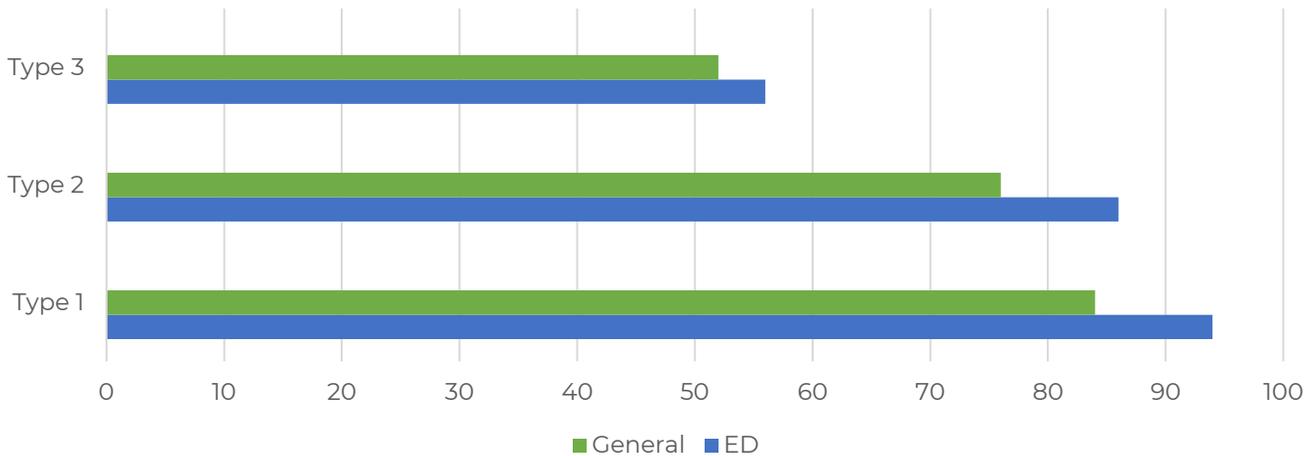
- **100%** of **general** and **ED** services follow up with young people and parents/carers (if appropriate) who were not brought for an appointment or assessment.
- **100%** of **general** and **ED** teams provided assessments are based on the wishes and goals of young people, the family and their capacity to support interventions.
- **100%** of **general** and **ED** teams follow up with young people and parents/carers (if appropriate) who were not brought for an appointment or assessment. If they are unable to engage with the young person, a decision is made by the assessor/team, based on need and risk, as to how long to continue to follow up the young person.

Areas for development

- Just **29%** of **general** services reported that 95% of young people assessed as requiring treatment see an appropriate clinician within access and waiting times guidelines relevant to the practice area and local agreements.
- Only **43%** of **general** services meet access and waiting times guidelines that 80% of young people assessed as requiring treatment see an appropriate clinician.
- Only **65%** of **ED** teams review data at least annually about the young people who use it and compared this data with local population statistics with action taken to address any inequalities of access where identified.

Section 2: Care and Intervention

Care & Intervention



Achievements

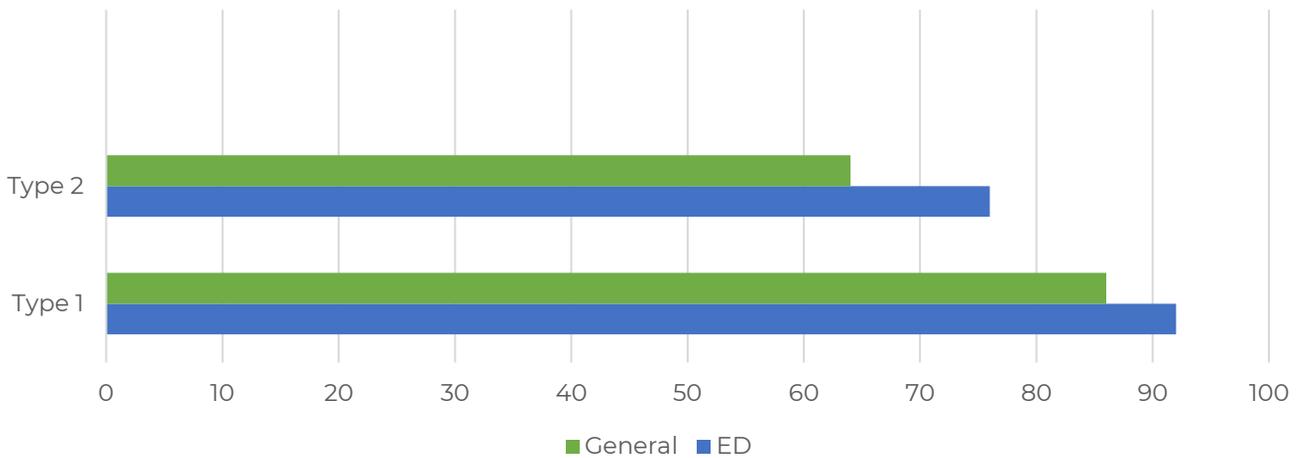
- In **100%** of **ED** and **general** services, young people are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.
- Parents/carers are involved in discussions and decisions about the young person's care, treatment and discharge planning in **100%** of **ED** and **general** services. This includes attendance at review meetings where the young person consents.
- All young people know who is coordinating their care and how to contact them if they have any questions in **100%** of **ED** and **general** services.

Areas for development

- The opportunity to discuss medications with a specialist pharmacist is available at **35%** of **ED** services and 33% of **general** services.
- Only **43%** of **general** service's clinical outcome and experience of care data are reviewed at least every six months, with the data being shared with commissioners, the team, young people and parents/carers, and used to make improvements to the service.
- Only **59%** of **ED** services ensure a young person has a written care plan, reflecting their individual needs or collaborate with young people and their parents/carers when developing their care plan and offer them a copy.

Section 3: Information, Consent and Confidentiality

Information, Consent & Confidentiality



Achievements

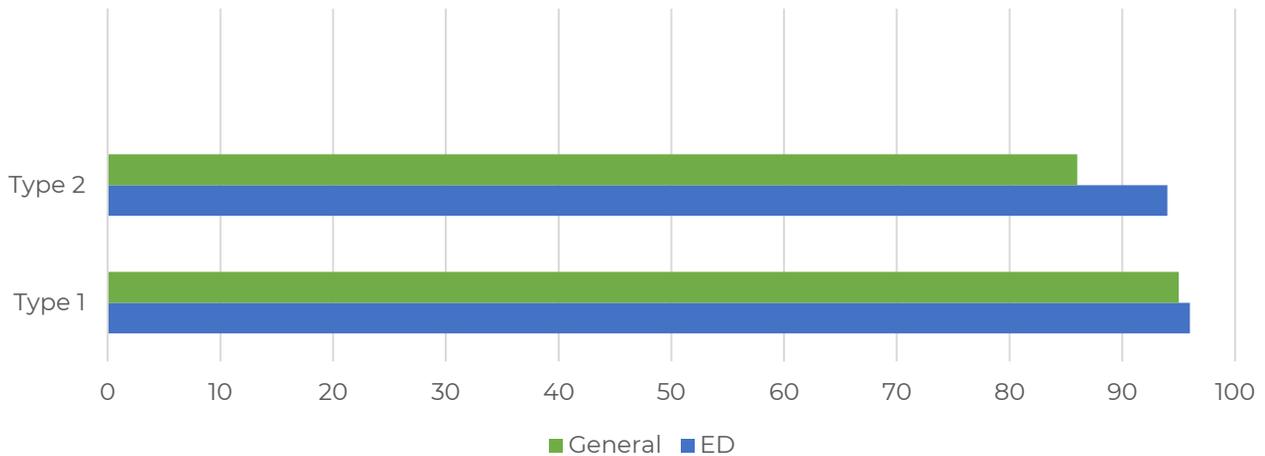
- Young people (and carers, with the young person's consent) are offered written and verbal information about the young person's mental illness and treatment in **100%** of **ED** services.
- **94%** of **ED** teams and 100% of **general** teams know how to respond to parents/carers when a young person does not consent to their involvement.

Areas for development

- Young people are given accessible written information which staff members talk through with them as soon as is practically possible, in just **43%** of **general** services.
- Siblings of young people accessing the service are provided with clear information in an appropriate format in only **38%** of **general** services.
- Only **59%** of **ED** teams confirmed that information designed for young people and parents/carers is written with the participation of young people and parents/carers.

Section 4: Rights and Safeguarding

Rights & Safeguarding



Achievements

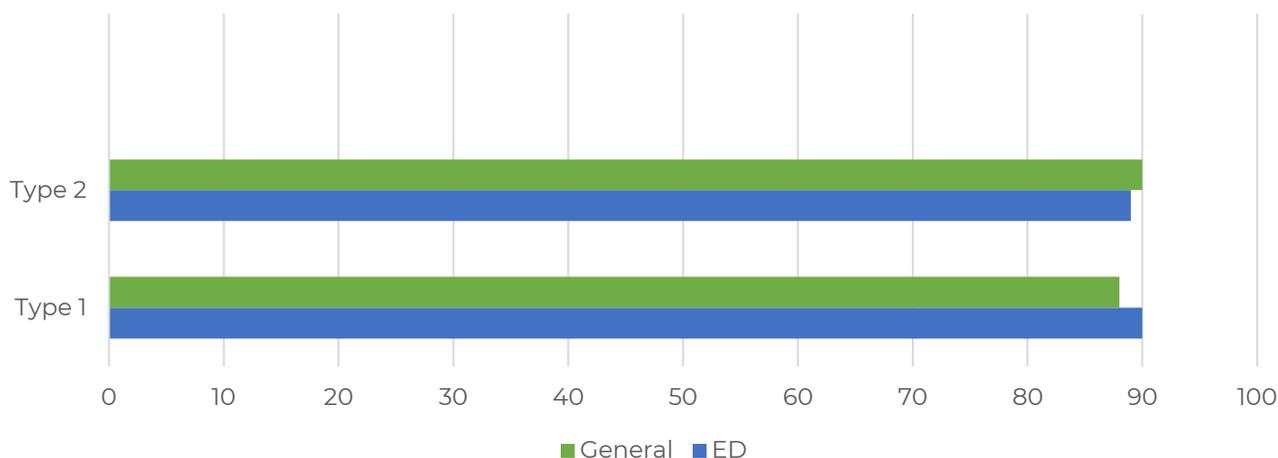
- **100%** of young people and parents/carers feel welcomed by staff members when attending the **ED** team bases for their appointments.
- **100%** of **general** and **ED** services offer young people the opportunity to see a staff member on their own without other staff or family present. This is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

Areas for development

- Staff members treat young people and parents/carers with compassion, dignity and respect in **93%** of **general** services.
- Young people and parents/carers feel listened to and understood by staff members in **86%** of the **general** services.
- **76%** of **ED** teams and **93%** of **general** teams confirmed there are formalised procedures in place for escalating a safeguarding referral via the identified safeguarding lead within 24 hours.

Section 5: Transfer of Care

Transfer & Care



Achievements

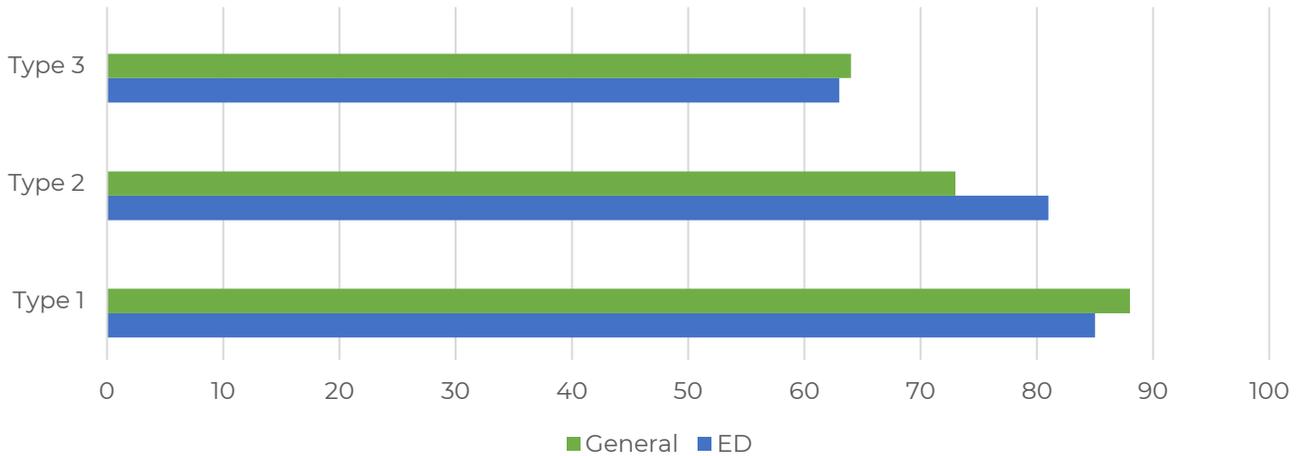
- Support is provided to young people in **100%** of **ED** services when their care is being transferred to another community team, or back to the care of their GP.
- **100%** of the **general** teams confirmed if young people are placed out-of-area, there are agreements for mental health care to be transferred once they return to the local area.

Areas for development

- Just **79%** of **general** services and **76%** of **ED** services send a discharge letter to the young person and all relevant parties (with the young person's consent) within 10 days of discharge. The letter includes the plan for: On-going care in the community/aftercare arrangements; Crisis and contingency arrangements including details of who to contact; Medication, including monitoring arrangements; Details of when, where and who will follow up with the young person as appropriate.
- **82%** of **ED** services confirm that young people that have left the service can re-access the service if needed, within agreed timeframes.
- **75%** of **general** services actively collaborate with Working Age Adult Services for young people who are approaching the age for transfer between services. This starts at least six months before the date of transfer.

Section 6: Multi-Agency Working

Multi-Agency Working



Achievements

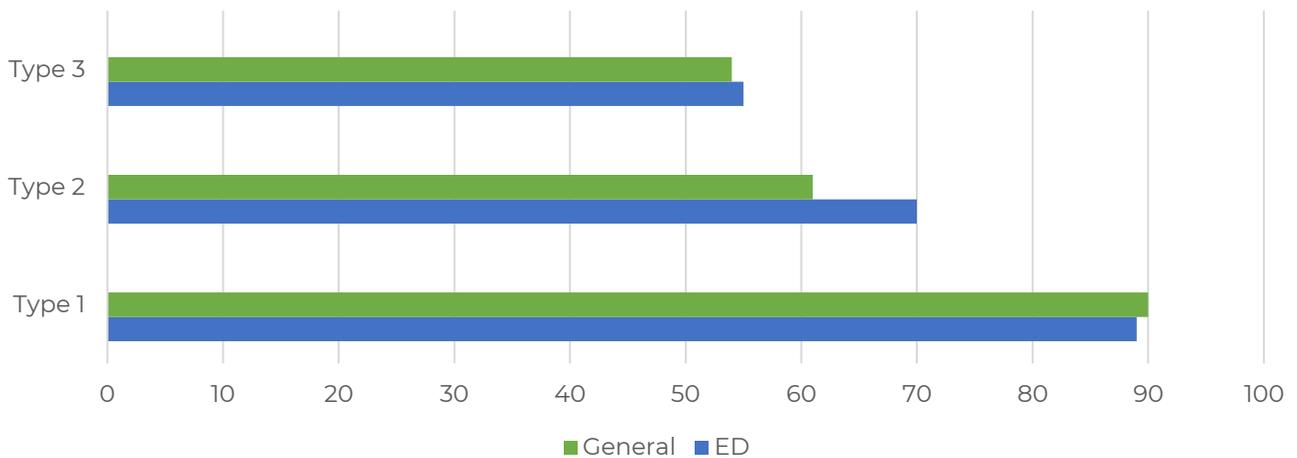
- **100%** of **general** teams have identified links with local GP surgeries or primary care services
- **100%** of **general** services ensure that young people can access help from mental health services 24 hours a day, seven days a week.
- **100%** of **ED** services regularly liaise between CAMHS/CEDS and representatives from all other agencies involved in the young person's care, and this is documented in the clinical notes.

Areas for development

- **59%** of **ED** services and **43%** of **general** have documented inter-agency agreements which clearly state the roles and responsibilities allocated to each organisation, and the names of responsible contacts.
- **63%** of **ED** services follow a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team in services that have access to one.
- **43%** of **general** services have documented inter-agency agreements clearly stating the roles and responsibilities allocated to each organisation, and the names of responsible contacts.

Section 7: Staffing and Training

Staffing & Training



Achievements

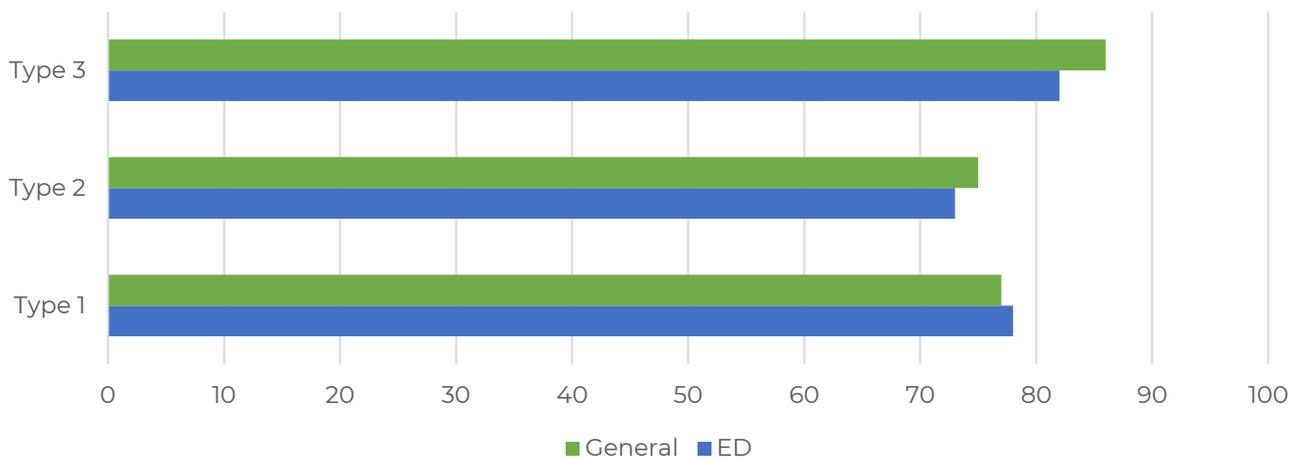
- **100%** of both **ED** and **general** staff teams are able to take breaks during their shift
- **100%** of **general** and **ED** services have systems in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.
- **100%** of **ED** services actively support staff health and well-being.

Areas for development

- Only **47%** of **ED** teams and **29%** of **general** teams involve an appropriately experienced young person or parent/carer representative in the interview process for recruiting staff members.
- Additionally, **41%** of **ED** teams and **50%** of **general** teams involve an appropriately experienced young person or parent/carer representative in delivering and developing training.
- Finally, **54%** of **general** services and **31%** of **ED** services have dedicated sessional input from arts or creative therapists.

Section 8: Location, Environment and Facilities

Location, Environment & Facilities



Achievements

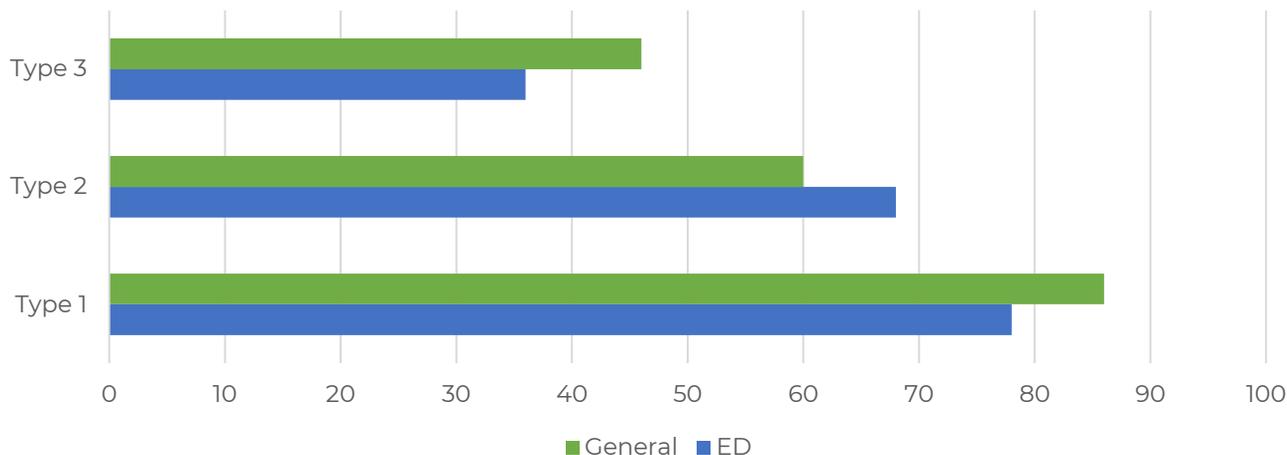
- **100%** of **ED** teams and **93%** of **general** teams offer appointments both in person and virtually, and patient preference is taken into account.
- **100%** of **ED** teams and **93%** of **general** teams reported staff members are easily identifiable (for example, by wearing appropriate identification).

Areas for development

- Only **47%** of **ED** teams have an alarm system in place (e.g. panic buttons or personal alarms) which is easily accessible for young people, parents/carers and staff members.
- Just **50%** of **general** services have waiting areas that are sufficiently spacious and young person-friendly.
- **50%** of **general** services have access to low-stimulation environments to meet the needs of young people who require them, including designated quiet areas.

Section 9: Commissioning and Service Management

Commissioning & Management



Achievements

- Senior managers at **100%** of **general** services work collaboratively with the CAMHS commissioning lead for each commissioning agency involved and are aware of their responsibilities as outlined in the service specification.
- **88%** of **ED** teams use quality improvement methods to implement service improvements.
- **93%** of **general** services have a mechanism for CAMHS to highlight system-wide commissioning gaps, especially around complex cases e.g. sensory impairments, severe learning disability and complex physical needs.

Areas for development

- Only **29%** of **general** services analyse feedback received from young people and parents/carers to identify any differences of experiences according to protected characteristics.
- **53%** of **ED** services actively encourage young people and parents/carers to be involved in QI initiatives.
- Only **19%** of **ED** teams and **21%** of **general** teams review the environmental and social value of its current practices against their organisation's or NHS green plan

Overall QNCC Recommendations

Standard	Standard criteria	Recommendations
<p>Standard 2.1.2</p>	<p><i>Every young person has a written care plan, reflecting their individual needs. Staff members collaborate with young people and their parents/carers when developing the care plan and they are offered a copy.</i></p>	<p>Young people should be involved in the development of their care plan and regularly offered age-appropriate copies in an accessible format, such as online via email/text or through hard copies. They should be offered new copies every time the care plan is updated.</p> <p>It is also important to ensure that parents/carers (with the young person's consent) are meaningfully involved in developing the care plan. Services could include a specific section of the care plan for parent/carer feedback. If parents/carers are not able to attend meetings, they should still be able to contribute to the care plan and provide feedback to staff.</p> <p>It is also important to ensure that parents/carers are offered a copy of the care plan. Instead of relying on young people to share this with their parents/carers, staff should take a proactive approach to involving families, and staff members should be responsible for ensuring that parents/carers are offered updated copies of the care plan.</p>
<p>Standard 2.2.6</p>	<p><i>Young people and parents/carers are able to discuss medications with a specialist pharmacist.</i></p>	<p>This was a commonly unmet standard. Teams should have a pharmacist available to discuss medications with young people and parents/carers, if applicable. This should be separate to the medical team, to relieve pressures from doctors. Services may want to arrange a shared working agreement.</p>
<p>Standard 7.1.10</p>	<p><i>There is dedicated sessional input from arts or creative therapists.</i></p>	<p>Creative therapy can be hugely supportive for young people, particularly for those with communication difficulties. Teams should use the QNCC standards to form the basis of a business case for these staff members. If this is not possible, teams should explore links with voluntary/community-based teams that provide these services</p>

Overall QNCC Recommendations

Standard	Standard criteria	Recommendations
Standard 8.3.4	<i>CAMH services provide low-stimulation environments for young people who require them, including designated quiet areas.</i>	This was a commonly unmet standard amongst both general and ED CAMHS. Teams could consider making clinic rooms low-stimulation by including low lighting lamps and space for toys and clutter to be stored. They could also provide a video tour of the base to young people who require it, so that they are prepared for their first appointment.
Standard 9.2.7	<i>The team actively encourage young people and parents/carers to be involved in QI initiatives.</i>	Teams are encouraged to actively seek input from young people and their parents or carers. Opportunities for feedback could be advertised in feedback forms or during parent/carer support groups. Challenges identified through feedback could serve as the foundation for QI initiatives. Once a topic has been selected, families could be invited to contribute further, ensuring their perspectives shape the outcomes.

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A full list of standards and raw data used within this report is available upon request.