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QNCC
QUALITY NETWORK FOR COMMUNITY CAMHS

Quality Network for Community CAMHS

Eating Disorder Service Standards

3rd Edition | 2023-2024

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Contents

Quality Network for Community CAMHS

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Introduction

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation via our standards development group, which includes young people & parents/carers, and email forums with professional groups involved in the provision of community mental health services for children and young people. They incorporate the College Centre for Quality Improvement (CCQI) Core Community Standards, as well as specialist standards relating specifically to community child and adolescent mental health eating disorder services.

Please contact the team at the College Centre for Quality Improvement (CCQI) for further information about the process of review and accreditation.

Who are these standards for?

These standards are designed to be applicable to community child and adolescent mental health eating disorder services and can be used by professionals to assess the quality of the team. The standards may also be of interest to commissioners, young people, carers, researchers and policy makers.

Categorisation of standards

Each standard has been categorised as follows:

To support in their use during the process, each standard has been categorised as follows:

- Type 1: Criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;
- Type 2: Criteria that a service would be expected to meet;
- Type 3: Criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

The full set of standards is aspirational and it is unlikely that any service would meet them all. To achieve accreditation, an organisation must meet 100% of type 1 standards, at least 80% of type 2 standards. The Network facilitates quality improvement and will support teams to achieve accreditation.

Notation

College Centre for Quality Improvement (CCQI) Core Community Standards are marked with the core standard number throughout the document. Those that are not marked with a core number are specialist standards relating to community child and adolescent mental health eating disorder services that are not included in the core set.

Terms used in this document

In this document, the child and adolescent mental health eating disorder service is referred to as 'the team', 'the service' or 'CAMHS'. Children and young people who have been referred to the community service are referred to as 'young people' and their carers are referred to as 'parents/carers'.

Sustainability Principles

The third edition of the QNCC-ED quality standards for community child and adolescent mental health eating disorder services has been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee (**www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx**).

The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core. The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years, the mounting economic, social and environmental constraints have put mental healthcare system under enormous pressure, and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions. A sustainable mental health service is patient-centred, focused on recovery, self-monitoring and independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013). In Principle 6, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources' [20].

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e. the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental and social domains. Adoption of these principles across mental healthcare would lead to a less resource-intensive and more sustainable service.

The five Sustainability Principles are listed below:

1. **Prioritise prevention** – preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

2. **Empower individuals and communities** – this involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision-making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. **Improve value** – this involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. **Consider carbon** – this requires working with providers to reduce the carbon impacts of interventions and models of care (e.g. emails instead of letters, tele-health clinics instead of face-to-face contact). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. **Staff sustainability** – this requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective teamwork facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.

Services that meet 90% or more of the standards relevant to Sustainability Principles (marked with the logo, left) will be awarded a Sustainable Service Accreditation certification in recognition of provision of a sustainable mental health service.

Sustainability will automatically be examined alongside the usual review process and services will not have to submit extra evidence for this. Whether a service is awarded the sustainability certification or not will not affect the accreditation status of the service.

A range of guidance reports and papers has already been developed by the College to help improve the sustainability of mental health care. Please see below for further information:

- Guidance for commissioners of financially, environmentally, and socially sustainable mental health services

  https://www.jcpmh.info/good-services/sustainable-services/

- Choosing Wisely – shared decision making

  http://www.rcpsych.ac.uk/healthadvice/choosingwisely.aspx

- Centre for Sustainable Healthcare

  https://sustainablehealthcare.org.uk/

- Psych Susnet

  https://networks.sustainablehealthcare.org.uk/network/psych-susnet

- Sustainability in Psychiatry

  https://www.rcpsych.ac.uk/improving-care/working-sustainably

Glossary of terms

Term	Definition
Advocacy services	A service which seeks to ensure that patients are able to speak out, to express their views and defend their rights.
Care plan	A systematic way of looking at the potential risks that may be associated with a particular activity or situation.
CPA	A Care Programme Approach is a package of care that is used by secondary mental health service. A CPA includes a care plan and someone to coordinate your care. A CPA aims to support a patient's mental health recovery by helping them to understand their strengths, goals, support needs and difficulties.
Clinical outcome measurement data	Clinical outcomes are measurable changes in health, function or quality of life that result from our care. Clinical outcomes can be measured by activity data such as re-admissions, or by agreed scales and others forms of measurement.
Clinical supervision	A regular meeting between a staff member and their clinical supervisor. A clinical supervisor's key duties are to monitor employees' work with patients and to maintain ethical and professional standards in clinical practice.
Co-produced	Refers to engaging and communicating with the service user and their family members (where appropriate) in the development of their care plan to ensure that support is person-centred.

Crisis plan	A crisis plan outlines key information to be considered during a mental health crisis, such as contact details, history of mental and physical illnesses, previous anti-depressants and psychotherapies, signs predicting relapse, and instructions for care if a future relapse occurs.
European Working Time Directive	Initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety.
Line management supervision	Supervision involving issues relating to the job description or the workplace. A managerial supervisor's key duties are prioritising workloads, monitoring work and work performance, sharing information relevant to work, clarifying task boundaries and identifying training and development needs.
Mental Capacity Act	A law which is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment.
Mental Health Act	A law under which people can be admitted or kept in hospital, or treated against their wishes, if this is in their best interests or for the safety of themselves or others.
Personal development plan	An action plan that helps to identify learning and development needs to help an individual in their job role or progress in their career.
Reflective practice	The ability for people to be able to reflect on their own actions and the actions of others to engage in continuous learning and development.
Risk assessment	An action plan that helps to identify learning and development needs to help an individual in their job role or progress in their career.
Safeguarding	Protecting people's health, well-being and human rights, and enabling them to live free from harm, abuse and neglect.
Statutory carers' assessment	An assessment that looks at how caring affects a carer's life, including for example physical, mental and emotional needs, the support they may need and whether they are able or willing to carry on caring.

Section 1: Access, Referral and Assessment

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
1.1		**CAMHS work with all potential referrers including families and young people to ensure access is appropriate, timely and co-ordinated**	
1.1.1	**1**	The service provides information about how to make a referral and waiting times for assessment and treatment.	**1.3**
1.1.2	**2**	Where referrals are made through a single point of access, these are passed on to the community team within one working day unless it is an urgent referral which should be passed across immediately.	**1.5**
1.1.3	**1**	Referrers are able to discuss urgent referrals with a clinical member of staff during working hours.	**1.4**
1.1.4	**2**	Young people and families are able to make a self-referral to the service	
1.1.5	**1**	Outcomes of referrals are fed back to the referrer, young person and parent/carer (with the young person's consent) in writing. If a referral is not accepted, the team advises the referrer, young person and parent/carer on alternative options. If a referral is accepted the service should provide information on: • How young people can access help while they wait for an appointment (e.g. letter, leaflet or telephone call; points of contact to access help may include the referrer, the school nurse, other local service or online services) • Information about expected waiting times for assessment and treatment • With any updates of any changes to their appointment.	
1.2		**Measures are taken to ensure equity of access**	
1.2.1	**1**	Appointments are flexible and responsive to the needs of young people and their parents/carers where appropriate *Guidance: For example, young people and their parents/carers can choose a suitable appointment time and appointments can be offered out of school or college hours; home-based or school-based treatments; or virtually via tele-appointments are offered where appropriate*	
1.2.2	**1**	The service reviews data at least annually about the young people who use it. Data is compared with local	**1.1**

		population statistics and action is taken to address any inequalities of access where identified.	
1.2.3	**1**	The team follows 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.	**4.1**
1.2.4	**1**	If a young person does not attend an assessment or appointment, the assessor contacts the referrer. *Guidance: If the young person is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.*	**4.2**
1.2.5	**2**	Data on missed appointments are reviewed monthly. This is done at a service level to identify where engagement difficulties may exist. Guidance: This should include monitoring a young person's failure to attend the initial appointment after referral and early disengagement from the service.	
1.3		**Young people receive timely mental health assessments**	
1.3.1	**1**	80% of young people with a routine referral for a suspected eating disorder receive a mental health assessment within 15 days with a view of starting a NICE concordant treatment within four weeks in line with eating disorder referral to treatment. *Guidance: Where services are not able to meet this standard, there must be an action plan in place to demonstrate they are working towards meeting this standard.*	**1.6**
1.3.2	**2**	95% of young people with a routine referral for a suspected eating disorder receive a mental health assessment within 15 days with a view of starting a NICE concordant treatment within four weeks in line with eating disorder referral to treatment. *Guidance: Where services are not able to meet this standard, there must be an action plan in place to demonstrate they are working towards meeting this standard.*	**1.6**

1.3.3	**1**	80% of young people with urgent mental health needs for a suspected eating disorder can access a mental health assessment within one week. (In line with the eating disorder RTT standard) *Guidance: Staff should be aware of the different pathways available and the urgent assessment process should be completed by an appropriately skilled clinician.*	**1.6**
1.3.4	**2**	95% of young people with urgent mental health needs for a suspected eating disorder can access a mental health assessment within one week. (In line with the eating disorder RTT standard) *Guidance: Staff should be aware of the different pathways available and the urgent assessment process should be completed by an appropriately skilled clinician.*	**1.6**
1.3.5	**1**	Young people with emergency mental health needs receive a mental health assessment within 24 hours (in line with the eating disorder RTT standard)	
1.3.6	**1**	For non-urgent assessments, the team makes written communication in advance to young people that includes: • The name and title of the professional they will see; • An explanation of the assessment process • Information on who can accompany them • How to contact the team if they have any queries, require support (e.g. an interpreter), need to change the appointment or have difficulty in getting there • Who to contact if the situation worsens significantly, and Crisis lines	**2.1**
1.3.7	**1**	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment. The young person receives a copy.	**3.6**
1.4		**Assessments are collaborative, individual and according to need**	
1.4.1	**1**	When talking to young people and parents/carers, health professionals communicate clearly, avoiding the use of jargon so that people understand them.	

1.4.2	**1**	Staff check that young people and their parents/carers understand the purpose of the assessment and possible outcomes as fully as possible before it is conducted *Guidance: For example, this is specified on an assessment checklist and audited through service questionnaires for young people and parents/carers*	
1.4.3	**1**	Young people have a comprehensive evidence-based assessment which includes: • Mental health and medication • Psychosocial and psychological needs • Strengths and areas for development • Risk, including risk of suicide • Educational background • Experience of Social Care/Youth Justice	**3.2**
1.4.4	**1**	Young people have a risk assessment and management plan which is co-produced where possible, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality and consent). *Guidance: The assessment considers risk to self, risk to others and risk from others.* <u>Sustainability Principle: Prioritise Prevention</u>	**3.4** 
1.4.5	**1**	Assessments are based on the wishes and goals of young people, the family and their capacity to support interventions.	
1.4.6	**1**	All assessments are documented, signed/validated (electronic records) and dated by the assessing practitioner.	
1.4.7	**1**	80% of young people assessed as requiring urgent treatment for an eating disorder start NICE concordant treatment within 1 week of referral. *Guidance: If a service is unable to meet waiting time guidelines, appropriate steps have been taken to work towards their reduction* .	**6.1.1**
1.4.8	**2**	95% of young people assessed as requiring routine or non-urgent treatment for an eating disorder start NICE concordant treatment within 4 weeks of referral. *Guidance: If a service is unable to meet waiting time guidelines, appropriate steps have been taken to work towards their reduction*.	

1.5		**Assessments are effectively co-ordinated with other agencies so that young people and their parents/carers are not repeatedly asked to give the same information**	
1.5.1	**1**	There are processes in place to identify whether young people or parents/carers are involved with other agencies.	
1.5.2	**3**	The assessing professional can access relevant information (past and current) about the young person from primary and secondary care and other relevant agencies.	
1.6		**The team assess the physical health needs of young people accessing the service**	
1.6.1	**1**	A physical health review takes place as part of the initial assessment, or as soon as possible. This should include: • Details of past medical history • Information about prematurity, and previous growth information, including growth centiles • Details of weight parameters (%median BMI for age, weight change); cardiovascular status (heart rate, blood pressure, hydration, circulation); routine bloods and ECG in the context of medical instability; other (muscle strength, neurological symptoms) • Current physical health medication, including side effects and compliance with medication regime • Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use <u>Sustainability Principle: Prioritise Prevention</u>	**3.3** 
1.6.2	**1**	The CEDS takes responsibility for management of the eating disorder but liaises with or refers to a physician if the initial assessment identifies co-existing physical conditions that increase risk (e.g. diabetes, pregnancy) and this communication is recorded.	**7.1**

1.6.3	**1**	Protocols for collaborative mental health and paediatric/medical care are in place for any young person requiring acute medical stabilisation. *Guidance: The MEED Guidance (Guidance on Recognising and Managing Medical Emergencies in Eating Disorders, formally known as MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa)), outlines suggested parameters for admission and other aspects of acute care and a refeeding protocol to guide initial management of medical risk* <u>Sustainability Principle: Prioritise Prevention</u>	**7.3** 
1.6.4	**1**	Protocols for collaborative mental health and medical care are in place with primary care to support early identification and for any young person requiring medical monitoring.	
1.6.5	**1**	For young people at high risk for refeeding syndrome, there is a suitable environment identified for monitoring and treating complications of refeeding.	
1.6.6	**1**	Growth, pubertal and bone density monitoring is offered to young people and, if action is required, there is a formalised way of following this up.	

Section 2: Care and Intervention

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
2.1		**Young people and parents/carers (with consent) are fully involved and informed in care planning**	
2.1.1	**1**	Young people are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	**12.4**
2.1.2	**1**	Every young person has a written care plan, reflecting their individual needs. Staff members collaborate with young people and their parents/carers when developing the care plan and they are offered a copy. The care plan clearly outlines: • Agreed intervention strategies for physical and mental health • Measurable goals and outcomes • Strategies for self-management • Any advance directives or statements that the patient has made • Crisis and contingency plans • Review dates and discharge framework. *Guidance: Where possible, the young person writes the care plan themselves or with the support of staff*	**5.3**
2.1.3	**1**	All young people have a documented diagnosis and clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	**3.5**
2.1.4	**1**	Young people are offered treatment for common comorbid problems by the CEDS.	
2.1.5	**1**	Young people and their parents/carers (with consent, see guidance below) are supported to understand the benefits, functions, expected outcomes, limitations and side effects of their medications, intervention options and non-intervention options. *Guidance: This is where the child or young person has capability/ competence to consent. HeadMeds, BEAT or YoungMinds websites, for example, could be used to access this information.*	
2.1.6	**1**	All young people know who is co-ordinating their care and how to contact them if they have any questions.	**5.1**
2.1.7	**2**	Young people and their parents/carers consistently see the same clinician for intervention, unless their preference or clinical need demands otherwise	

2.1.8	**2**	There is a mechanism for young people to change their clinician if there are problems without prejudicing their access to treatment *Guidance: This should be referred to in service information*	
2.2		**Decisions around the prescribing of medication are collaborative where possible and monitored appropriately**	
2.2.1	**1**	When medication is prescribed, specific treatment goals are set with the young person, the risks (including interactions) and benefits are discussed, a timescale for response is set and the young person's consent is recorded.	**6.2.1**
2.2.2	**1**	Young people have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.* Sustainability Principle: Consider Carbon	**6.2.2** 
2.2.3	**1**	The safe use of medication is audited, at least annually and at a service level.	
2.2.4	**1**	For young people who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the young person's condition has stabilised. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	**6.2.4**
2.2.5	**1**	Young people who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then six-monthly. If a physical health abnormality is identified, this is acted upon.	**7.4**
2.2.6	**3**	Young people, parents/carers are able to discuss medications with a specialist pharmacist.	**6.2.3**

2.3		**Staff provide support and guidance to enable young people and their parents/carers to help themselves**	
2.3.1	**1**	Where appropriate, young people are offered personalised healthy lifestyle interventions, such as advice on healthy eating and physical activity (taking into account the young person's eating disorder and how it might have developed), and access to smoking cessation services. This is documented in the young person's care plan. Sustainability Principle: Consider Carbon	**7.2** 
2.3.2	**2**	Young people and parents/carers are guided in self-help approaches where appropriate. *Guidance: This may include those waiting between assessment and treatment*	
2.3.3	**2**	Young people and parents/carers are guided in their use of social media and helpful links where appropriate *Guidance: This may include those waiting between assessment and treatment*	
2.3.4	**2**	The team provides information, signposting and encouragement to young people to access local organisations for peer support, social engagement and work/education opportunities such as: • Voluntary organisations • Community centres • Local religious/cultural groups • Peer support networks • Recovery colleges, pre-vocational training or employment programmes	**6.1.6**
2.3.5		The team signposts young people to structured activities such as work, education and volunteering.	
2.4		**Efforts are made actively to support and engage parents/carers**	
2.4.1	**1**	Parents/carers are involved in discussions and decisions about the young person's care, treatment and discharge planning. This includes attendance at review meetings where the young person consents.	**13.1**

2.4.2	**1**	Parents/carers are supported to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This advice is offered at the time of the young person's initial assessment, or at the first opportunity.*	**13.2**
2.4.3	**2**	Parents/carers are offered individual time with staff members to discuss concerns, family history and their own needs. Sustainability Principle: Empowering Individuals	**13.3** 
2.4.4	**2**	The team provides each parent/carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes:* • *The names and contact details of key staff members in the team and who to contact in an emergency (threat to life should be a call to emergency services)* • *Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	**13.4**
2.4.5	**3**	The service actively encourages parents/carers to attend carer support networks or groups. There is a designated staff member to support carers.	**13.5**
2.4.6	**1**	Health care professionals ensure that, in line with a family-based approach, parents/carers are included in any dietary education or meal planning of young people with eating disorders where appropriate and are offered appropriate support. *Guidance: Support for parents/carers may be part of whole family FT-AN sessions, separate sessions for parents, MFT-AN sessions or skills development groups C70*	
2.5		**Outcome measurement is routinely undertaken**	
2.5.1	**1**	Clinical outcome measurement data, including progress against user defined goals, is collected as a minimum at assessment, after six months, 12 months and then annually until discharge. Staff can access this data.	**23.1**
2.5.2	**2**	Staff members review young people's progress against self-defined goals in collaboration with the young person at the start of treatment, during clinical review meetings and at discharge.	**23.2**

2.5.3	**2**	Clinical outcome measurement and experience of care data, including progress against user defined goals, is collected as a minimum at assessment, after six months, 12 months and then annually until discharge. Staff can access this data.	**23.3**
2.5.4	**3**	The team supports young people to access local green space on a regular basis. *Guidance: This could include signposting to local walking groups or arranging regular group activities to visit green spaces. Consideration should be given to how all young people are able to access these sessions including, for example, access to appropriate foot or rainwear.*	**6.1.7**

Section 3: Information, Consent and Confidentiality

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
3.1		**Young people and their parents/carers are provided with information that is accessible and appropriate for their use** ***Guidance: Standard 3.1 is overarching: criteria apply to all information that is provided for young people and parents/carers including service information, intervention information, information on consent, confidentiality and rights***	
3.1.1	**1**	Young people are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: • Their rights regarding consent to treatment • Their rights under the Mental Health Act • Their rights in the instance that they may need to be admitted to an inpatient service • How to access advocacy services • How to access a second opinion • Interpreting services • How to view their records • How to raise concerns, complaints and give compliments	**2.2**
3.1.2	**2**	All information materials such as leaflets are regularly updated and include a date for revision.	
3.1.3	**2**	Young people and their parents/carers are able to access information on the service via an up-to-date website.	
3.1.4	**1**	Young people (and carers, with young person consent) are offered written and verbal information about the young person's mental illness and treatment. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psychoeducation group. Written information could include leaflets or websites.* <u>Sustainability Principle: Staff Empowerment</u>	**6.1.8**
3.1.5	**2**	Staff provide young people and their parents with information about the roles played by key professionals across the CAMHS team.	

3.1.6	**2**	Siblings of young people with an eating disorder accessing the service are provided with clear information in an appropriate format e.g. Young Minds.	
3.1.7	**2**	The service provides young people and their parents or carers with service information that is culturally relevant and sensitive to protected characteristics. *Guidance: For example, images used in posters and leaflets fully reflect the cultural diversity of the community*	
3.1.8	**2**	Information designed for young people and parents/carers is written with the participation of young people and parents/carers. *Guidance: For example, including quotations or narratives reflecting the real experiences of the young people and parents who have used the service*	
3.2		**Staff follow clear procedures for gaining valid consent to treatment**	
3.2.1	**1**	Assessments of young people's capacity (and competency for young people under the age of 16) to consent to care and treatment are performed in accordance with current legislation.	**11.1**
3.2.2	**1**	Where young people are able to give consent, their consent to the proposed treatment or intervention is sought by the practitioner carrying out the treatment and the agreement or refusal is recorded in their notes. This is done each time there is a change in treatment. Where young people are not able to give consent (due to age or capacity), their views are ascertained as far as possible and taken into account, and the legal basis for giving the proposed treatment or intervention is recorded, for example: • Consent from someone with parental responsibility is obtained and recorded; or, • Treatment in the young person's best interest is given in accordance with the MCA 2005 *Guidance: Staff must be clear on who holds parental responsibility – see the Legal Guide paragraph 1.13; for guidance on parental consent where the young person is aged 16-17 see the Legal Guide paragraphs 2.33 - 2.34*	

3.2.3	**1**	Where parental responsibility is held by a third party, young people and their parents/carers are informed about the procedures for obtaining consent. *Guidance: Parental responsibility will be shared with others if the young person is subject to a care order (where the local authority has parental responsibility) or a residence order (in which case the person(s) named in the order will have parental responsibility)*	
3.3		**Young people and their parents are well-informed about confidentiality and their rights to access information held about them**	
3.3.1	**1**	Confidentiality and its limits are explained to the young person and parent/carer on acceptance, both verbally and in writing. The young person's preferences for sharing information with third parties are respected and reviewed regularly.	**16.1**
3.3.2	**1**	Young people are asked if they and their parent/carers wish to have copies of correspondence about their health and treatment.	**15.1**
3.3.3	**1**	The team knows how to respond to parents/carers when the young person does not consent to their involvement.	**16.2**

Section 4: Rights and Safeguarding

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
4.1		**Young people and parents/carers are treated with dignity and respect**	
4.1.1	**1**	Young people and parents/carers feel welcomed by staff members when attending the team base for their appointments. *Guidance: Staff members introduce themselves to young people and address them using their preferred name and correct pronouns.*	3.1
4.1.2	**1**	Staff members treat young people and parents/carers with compassion, dignity and respect. *Guidance: This can be evidenced through the CHI-ESQ.*	14.1
4.1.3	**1**	Young people and parents/carers feel listened to and understood by staff members. *Guidance: This can be evidenced through PREMS.*	14.2
4.1.4	**1**	Young people are offered the opportunity to see a staff member on their own without other staff or family present. This should be recorded in case records.	
4.1.5	**2**	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The young person's relatives are not used in this role unless there are exceptional circumstances. *Guidance: Exceptional circumstances might include crisis situations where it is not possible to get an interpreter at short notice.*	15.2
4.2		**Young people are protected from abuse through clear safeguarding policies and procedures**	
4.2.1	**1**	Staff act in accordance with current child protection protocols (e.g. the procedures of the Local Safeguarding Children Board).	
4.2.2	**1**	The organisation has a named doctor and a named nurse responsible for child protection. *Guidance: This may include safeguarding lead or the organisation's child protection lead*	

4.2.3	**1**	Young people who may be at risk of harm are referred to the appropriate team within the Local Authority (e.g. Social Services). *Guidance: Referrals which are made by telephone should be followed up. Young people are reassured that any disclosure of abuse will be taken seriously and are informed about the next steps*	
4.2.4	**1**	If a safeguarding referral is made to the Local Authority and no response is received within 24 hours, there are procedures in place for escalation via the identified safeguarding lead.	
4.2.5	**1**	The specific safeguarding needs of young people who are Looked After are responded to through policies, procedures and practice that are designed to protect them. *Guidance: This should include those under kindship care or guardians, foster care or under children social services.*	
4.2.6	**1**	The team records which young people are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	8.1
4.2.7	**1**	Where a young person is identified as a young carer, the service is able to signpost to specific young carer support for the young person.	

Section 5: Transfer of Care

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
5.1		**Leaving the service**	
5.1.1	**1**	A discharge letter is sent to the young person and all relevant parties within 10 days of discharge. The letter includes the plan for: • On-going care in the community/aftercare arrangements • Crisis and contingency arrangements including details of who to contact • Medication, including monitoring arrangements • Details of when, where and who will follow up with the young person as appropriate.	**9.1**
5.1.2	**1**	When young people are transferred between community services there is a handover which ensures that the new team have an up-to-date care plan and risk assessment.	**9.3**
5.1.3	**2**	Teams provide support to young people when their care is being transferred to another community team, or back to the care of their GP.	**9.4**
5.1.4	**1**	The community team makes sure that young people who are discharged from an inpatient stay on a mental health unit are followed up within three days. *Guidance: This may be in coordination with the Home Treatment/Crisis Resolution Team.*	**9.2**
5.1.5	**1**	For young people who are Looked After, arrangements for their continuing care are planned in conjunction with the relevant Local Authority Services.	
5.1.6	**2**	Having left the service, young people can re-access the service if needed, within agreed timeframes. *Guidance: There may be exceptions where young people require a generic assessment and where it may be appropriate to follow the initial referral pathway*	

5.1.7	**2**	If young people are placed out-of-area, there are agreements for mental health care to be transferred once they return to the local area. *Guidance: For example, young people placed out of area for educational provision may require mental health support during holidays and should be able to re-access care when they return to the local area without needing to be re-referred*	
5.1.8	**1**	If the young person moves out of area and is being transferred to a new service, the responsibility is held with their current service until they receive their first assessment.	
5.2		**Transfer to inpatient care**	
5.2.1	**1**	There are clear procedures for staff to follow in situations where appropriate inpatient beds are required but not immediately available. *Guidance: The service ought to involve local commissioners.*	
5.2.2	**1**	When a young person is admitted to inpatient care, a community team representative attends and contributes to ward rounds and discharge planning. *Guidance: This may be in person or via teleconferencing facilities, for example.*	
5.2.3	**1**	CEDS continue to be involved with any admission to an inpatient unit, for example to an eating disorder unit or paediatric ward and the young person is made aware of any formal communication between CEDS and the inpatient unit regarding their care.	
5.3		**Transfer to adult mental health services**	
5.3.1	**1**	There is active collaboration between CAMHS/CED and Working Age Adult Services for young people who are approaching the age for transfer between services. This starts at least six months before the date of transfer.	**9.5**
5.3.2	**2**	CAMH/CED services have a named link person who liaises between services around transitions, who is responsible for leadership around transitions and monitors the quality of transition process.	
5.3.3	**2**	Where young people reaching the upper age limit of the service are not referred to adult mental health services, but access adult services at a later date, the CAMHS (including learning disability services) will	

		provide liaison to the adult service, if needed and with consent.	
5.3.4	**2**	When young people are referred to adult services, a joint transition meeting is organised between CED/CAMHS and the adult team to ensure a comprehensive handover can take place.	

Section 6: Multi-Agency Working

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
6.1		**The service has identified links within a range of services and agencies, including:**	
6.1.1	**1**	Local GP surgeries or primary care services	
6.1.2	**1**	Paediatrics, development centres and other health services for children and young people, including neurological services where appropriate	
6.1.3	**1**	Education, education support services and school health services, including community paediatricians and school or college nurses. *Guidance: This should include specialist education provisions such as Special Schools and Pupil Referral Units.*	
6.1.4	**1**	Organisations which offer: • Housing support • Support with finances, benefits and debt management • Social services	**10.2**
6.1.5	**1**	Forensic mental health services	
6.1.6	**1**	Youth justice services	
6.1.7	**1**	Young people's drug and alcohol teams/substance misuse services	
6.1.8	**1**	Dietetics	
6.1.9	**2**	Community-based services which provide art/creative therapies	
6.2		**The service has clear links and pathways with other agencies**	
6.2.1	**2**	Documented inter-agency agreements clearly state the roles and responsibilities allocated to each organisation, and the names of responsible contacts. *Guidance: This should follow the service specification.*	
6.2.2	**1**	There are locally agreed health-based places of safety that are designed for young people with appropriate staffing levels and safeguards.	
6.2.3	**1**	The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution	

		Team in services that have access to one. Guidance: This includes joint care reviews and jointly organising admissions to hospital for young people in crisis.	
6.2.4	**1**	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/ harassment/ violence and advice for young people in mental health crisis.	
6.2.5	**1**	The service/organisation has a care pathway for the care of young people in the perinatal period (pregnancy and 12 months post-partum) that includes: • Assessment • Care and treatment (particularly relating to prescribing psychotropic medication) • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.	**10.3**
6.2.6	**1**	Young people can access help from mental health services 24 hours a day, seven days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams.*	**10.1**
6.2.7	**1**	Paediatric care for both acute and chronic aspects of routine eating disorder management includes liaison with paediatric specialities and community services as needed.	
6.3		**Staff engage in activities and initiatives to improve joint-working and liaison**	
6.3.1	**2**	There is regular liaison between CAMHS/CEDS and representatives from all other agencies involved in the young person's care, and this is documented in the clinical notes.	
6.3.2	**2**	CAMHS offer consultation and training to partner agencies. *Guidance: For example, by appointing link persons to work with education, social services, drug and alcohol teams, and primary healthcare*	
6.3.3	**3**	Joint working is facilitated through flexible initiatives such as secondments, rotational posts, split posts and opportunities for job shadowing across organisations.	

Section 7: Staffing and Training

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
7.1		**There are appropriate numbers of skilled staff**	
7.1.1	**1**	The composition of the MDT is in line with the recommendations of the Eating Disorder RTT standard and is reviewed at least annually with respect to training and skill mix. *Guidance: Staff are appropriately trained to provide NICE-compliant treatments and appropriate ongoing supervision of such treatments* .	
7.1.2	**1**	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels • Access to additional staff members • An agreed contingency plan, such as the minor and temporary reduction of non-essential services. Sustainability Principle: Prioritise Prevention	**19.1**
7.1.3	**1**	When a staff member is on leave, the team puts a plan in place to provide adequate cover for the young people who are allocated to that staff member.	**19.2**
7.1.4	**1**	There is an identified senior clinician available at all times who can attend the team base within an hour. Video consultation may be used in exceptional circumstances. *Guidance: Some services may have an agreement with a local GP to provide this medical cover. Rural services may require more frequent use of video consultation.*	**19.3**
7.1.5	**1**	Administrative support or procedures are in place to enable staff to support the effective running of the service	
7.1.6	**1**	All staff have clearly defined job descriptions and job plans which are revised at least annually	

7.1.7	**3**	The team includes a peer support worker who can share knowledge, experiences and support to those currently accessing the service. *Guidance: This might include providing accounts of their experiences to new young people and parents/carers through a support group or documentation*	
7.1.8	**1**	There is dedicated sessional time from psychologists in order to: • Provide assessment and formulation of young peoples' psychological needs • Ensure the safe and effective provision of evidence based psychological interventions adapted to young peoples' needs through a defined pathway.	**6.1.2**
7.1.9	**2**	There is dedicated sessional time from psychologists to support a whole-team approach for psychological management	**6.1.3**
7.1.10	**3**	There is dedicated sessional input from occupational therapists in order to: • Provide an occupational assessment for those young people who require it • Ensure the safe and effective provision of evidence based occupational interventions adapted to young peoples' needs	**6.1.4**
7.1.11	**3**	There is dedicated sessional input from arts or creative therapists	**6.1.5**
7.1.12	**1**	There is dedicated sessional input from a dietitian with responsibility to: • Provide dietetic assessment, advice and treatment to patients and to staff • Support staff to devise meal plans, manage risk related to refeeding • Oversee the nutritional care plan and psychoeducation regarding nutrition, weight and food	
7.1.13	**3**	All staff members who deliver therapies and activities are appropriately trained and supervised.	**6.1.9**

7.2		**The service takes steps to ensure that staff are sufficiently qualified to fulfil their roles**	
7.2.1	**1**	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. *Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.*	**20.2**
7.2.2	**2**	Appropriately experienced young person or parent/carer representatives are involved in the interview process for recruiting staff members. *Guidance: These representatives should have experience of the relevant service.*	**20.1**
7.3		**Staff are regularly appraised and supervised and know how to gain additional support when needed**	
7.3.1	**1**	All staff members receive an annual appraisal and personal development planning (or equivalent). *Guidance: This contains clear objectives and identifies development needs.*	
7.3.2	**1**	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	**20.3**
7.3.3	**2**	All staff members receive line management supervision at least monthly.	**20.4**
7.3.4	**3**	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice. Sustainability Principle: Staff Empowerment	**18.1** 
7.3.5	**1**	Legal advice is available to staff on issues such as information sharing, confidentiality, consent, rights and child protection *Guidance: For example, staff have access to a solicitor on the children's panel who is familiar with the service and can offer up-to-date legal advice*	

7.3.6	**1**	There are measures in place to ensure staff are as safe as possible when conducting home visits. These include: • Having a lone working policy in place • Conducting a risk assessment • Identifying control measures that prevent or reduce any risks identified	**17.4**
7.4		**Staff members are supported by management**	
7.4.1	**1**	The service actively supports staff health and well-being. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.* Sustainability Principle: Staff Empowerment	**21.1** 
7.4.2	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive or equivalent. *Guidance: Staff have the right to one uninterrupted 20-minute rest break during their working day if they work more than six hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	**21.2**
7.4.3	**1**	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	**24.1**
7.4.4	**1**	When mistakes are made in care this is discussed with the young person themselves and their parent/carer, in line with the Duty of Candour agreement.	**24.2**
7.4.5	**1**	Staff members, young people and parents/carers who are affected by a serious incident are offered post incident support. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection and learning review.* Sustainability Principle: Empowering Individuals	**21.3** 
7.4.6	**1**	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	**24.3**

7.4.7	**1**	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing. Sustainability Principle: Staff Empowerment	**18.2** 
7.5		**Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:**	**22.1**
7.5.1	**1**	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	**22.1a**
7.5.2	**1**	Physical health assessment. *Guidance: This includes training in understanding physical health problems, understanding physical observations and when to refer the young person for specialist input.*	**22.1b**
7.5.3	**1**	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.* Sustainability Principle: Prioritise Prevention	**22.1c** 
7.5.4	**1**	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm*	**22.1d**
7.5.5	**1**	Recognising and communicating with young people with cognitive impairment or learning disabilities.	**22.1e**
7.5.6	**1**	Inequalities in mental health access, experiences, and outcomes for patients that acknowledge, accommodate and respect their protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	**22.1f**
7.5.7	**2**	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	**22.1g**

7.5.8	**2**	The service is able to support the training needs of the team including shared in-house multi-disciplinary team training, education and practice development activities. This should occur in the service at least every three months.	
7.5.9	**2**	Young people and parent/carer representatives are involved in delivering and developing training.	**22.2**
7.5.10	**1**	Staff are trained to deliver a range of effective, NICE-concordant therapeutic interventions specific to the eating disorder and co-morbidities.	
7.5.11	**1**	Staff receive eating disorder-specific training to be able to support the physical needs of young people. *Guidance: This will include specific training on refeeding and dietary needs*	
7.6		**Staff work effectively as a team or network**	
7.6.1	**2**	The team uses monthly business meetings to review progress against its own plan/strategy, which includes objectives and deadlines in line with the broader organisation's strategy.	
7.6.2	**1**	Frontline staff are consulted on relevant management decisions such as developing and reviewing operational policies.	
7.6.3	**1**	Managers ensure that policies, procedures and guidelines are formatted, disseminated and stored in ways that front-line staff members find accessible and easy to use.	
7.6.4	**1**	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. *Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.*	**5.2**
7.6.5	**3**	There is a commitment and financial support to enable staff to contribute to multi-centre clinical audit or research	

Section 8: Location, Environment and Facilities

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
8.1		**CAMH services are accessible**	
8.1.1	**3**	Everyone is able to access the service using public transport or transport provided by the service.	**1.2**
8.1.2	**2**	There is sufficient car parking space for visitors, including allocated spaces for disabled access.	
8.1.3	**1**	The environment complies with current legislation on accessible environments. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	**17.3**
8.1.4	**2**	The team offers appointments both in person and virtually, and patient preference is taken into account	**1.7**
8.2		**Environments in which CAMH/CED services are delivered are managed so that the rights, privacy and dignity of young people and their parents/carers are respected**	
8.2.1	**2**	The service environment is clean, comfortable and welcoming.	**17.1**
8.2.2	**2**	CAMHS practitioners have access to large and small rooms suitable for individual and family consultations	
8.2.3	**2**	If it is and a preference for the individual and for family work/consultations, Practitioners are equipped and supported to offer treatment using digital technology	
8.2.4	**1**	Clinical rooms are private and conversations cannot be easily over-heard.	**17.2**
8.2.5	**1**	CED centres have private rooms readily available for physical examinations. *Guidance: Relevant examination equipment, such as a weight stadiometer and a blood pressure machine, are provided.*	
8.2.6	**2**	Waiting areas are sufficiently spacious and young person-friendly. *Guidance: Play and reading materials are age- and developmentally appropriate for the whole age range.*	

8.2.7	**1**	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	**16.4**
8.2.8	**1**	Staff members are easily identifiable (for example, by wearing appropriate identification).	
8.3		**CAMH services are delivered in safe environments**	
8.3.1	**1**	If teams see young people at their team base, the entrances and exits are visibly monitored and/or access is restricted.	
8.3.2	**2**	The team base is securely separated from adult services. *Guidance: There are separate areas and entrances for adult and CYP services, and access to CYP services is restricted*	
8.3.3	**1**	An audit of environmental risk is conducted annually, and a risk management strategy is agreed. When consultation takes place in a new setting, staff carry out a risk assessment regarding the safety of the environment and its suitability for meeting the needs of the consultation.	
8.3.4	**2**	Low-stimulation environments are available to meet the needs of young people who require them, including designated quiet areas *Guidance: Rooms may be multi-functional if necessary, although young people with additional needs must be able to access quiet spaces.* *For example, waiting areas are kept tidy or materials can be easily put away; there is access to low stimulation areas for 'quiet time' if necessary; this is particularly relevant for services working with learning disabilities.*	
8.3.5	**1**	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for young people, parents/carers and staff members.	**17.5**
8.3.6	**1**	A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least annually.	

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

Section 9: Commissioning and Service Management

Standard Number	Standard Type	Standard Criteria	CCQI Core Standard
9.1		**Commissioner-provider relationships are collaborative and effective**	
9.1.1	**1**	Senior managers work collaboratively with the CAMHS commissioning lead for each commissioning agency involved and are aware of their responsibilities as outlined in the service specification.	
9.1.2	**1**	The service is explicitly commissioned or contracted against agreed standards. *Guidance: This is detailed in the Service Level Agreement, operational policy, or similar and has been agreed by funders* .	
9.1.3	**2**	There is a widely understood CAMHS strategy that the local population can access. *Guidance: For example, for universal, targeted and specialist services*	
9.1.4	**2**	There is a mechanism for CAMHS to highlight system-wide commissioning gaps, especially around complex cases e.g. sensory impairments, severe learning disability and complex physical needs.	
9.2		**Service development is a collaborative, inclusive process**	
9.2.1	**2**	The following groups are involved in and consulted on the development of the commissioning strategy: • Young people who may access the service • Families of young people who may access the service • People from diverse backgrounds, whether or not they are patients of the service • CAMHS staff, including frontline staff • Local community groups and partner agencies	
9.2.2	**2**	Services are developed in partnership with appropriately experienced young people and parents/carers and they have an active role in decision making.	**12.3**

9.2.3	**3**	The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice. *Guidance: Stakeholders could include staff member representatives from inpatient, community, adult, acute/paediatric, social care, voluntary sector partners and primary care teams as well as young person and carer representatives.*	
9.2.4	**1**	The team asks young people and parents/carers for their feedback about their experiences of using the service and this is used to improve the service. *Guidance: For example, this may take the form of a combination of suggestions boxes, discharge questionnaires, follow-up letters, satisfaction surveys, focus groups.* Sustainability Principle: Empowering Individuals	**12.1** 
9.2.5	**2**	Feedback received from young people and parents/carers is analysed and explored to identity any differences of experiences according to protected characteristics.	**12.2**
9.2.6	**2**	The team use quality improvement methods to implement service improvements.	**24.4**
9.2.7	**2**	The team actively encourage young people and parents/carers to be involved in QI initiatives.	**24.5**
9.2.8	**3**	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/ minimising waste and low carbon interventions). *Guidance: Progress against this improvement plan is reviewed at least quarterly with the team.*	**18.3**

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