QED
QUALITY NETWORK FOR EATING DISORDERS

CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS
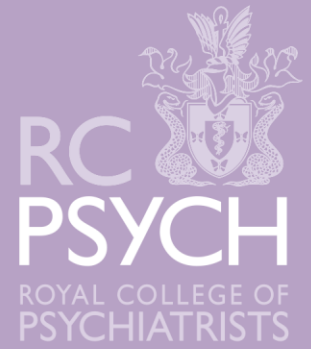
QED Quality Standards for Adult Community Eating Disorder Services

Second Edition

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SECTION 1: ACCESS, REFERRAL AND ASSESSMENT			
Number	**Type**	**Standard**	**CCQI Core**
1.1	**Accessibility**		
1.1.1	**1**	The service reviews data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access that are identified.	1.1
1.1.2	**3**	Everyone can access the service using public transport or transport provided by the service.	1.2
1.1.3	**1**	The service provides information about how to make a referral and waiting times for assessment and treatment.	1.3
1.2	**Referral and waiting times**		
1.2.1	**1**	A clinical member of staff is available to discuss emergency referrals during working hours.	1.4
1.2.2	**2**	Where referrals are made through a single point of access, these are passed on to the community team within one working day, unless it is an emergency referral which should be passed across immediately.	1.5
1.2.3	**1**	The team assess patients, who are referred to the service, within locally-agreed timeframes. *Guidance: Where timeframes are not in place, services should comply with NHS constitution standards.*	1.6
1.2.4	**1**	Outcomes of referrals are fed back to the referrer, patient and carer (where appropriate with the patient's consent) in writing. If a referral is not accepted, the team advises the referrer, patient and carer on alternative options.	
1.2.5	**1**	Referrals for people with diabetes or pregnant women are accepted into the service with a lower threshold of eating disorder severity.	
1.2.6	**1**	When on the waiting list for treatment, there is a care plan in place to ensure risk is monitored, that there is a crisis plan and a named professional within the eating disorder service for the patient, carer (if appropriate) and the GP to contact if they have concerns or questions.	
1.2.7	**2**	There is a protocol to follow for patients who are on the waiting list, including support for carers and frequency of follow ups with a defined timescale and medical monitoring.	
1.3	**The initial assessment**		

1.3.1	1	For non-emergency assessments, the team makes written communication in advance to patients that includes: • The name and title of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them; • How to contact the team if they have any queries or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).	2.1
1.3.2	1	The initial assessment is conducted by a staff member who is trained in a specialist ED assessment and formulation.	
1.3.3	1	Patients have a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development; • Suicide risk; • Eating disorder history (assessment performed in line with NICE guidelines).	3.2
1.3.4	1	A physical health review is conducted by a professional with specialist ED knowledge as part of the initial assessment or as soon as possible. The assessment includes consideration of: • Physical health checks (including blood pressure, skin and mouth condition, and squat (SUSS) test); • Medical complications of an eating disorder; • Details of past medical history; • Current physical health medication, including side effects and compliance with medication regime; • Any co-morbidities which may increase risk (e.g. pregnancy or diabetes); • Lifestyle factors.	3.3
1.3.5	1	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.	3.4
1.3.6	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within one week of the assessment.	3.6
1.4	**Following up patients who do not attend appointments**		

1.4.1	1	The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient.	4.1
1.4.2	1	If a patient does not attend for an assessment / appointment, the assessor contacts the referrer. *Guidance: If the patient 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

	SECTION 2: STAFFING AND TRAINING		
Number	**Type**	**Standard**	**CCQI Core**
2.1	**Staffing levels**		
2.1.1	**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.	19.1
2.1.2	**1**	When a staff member is on annual leave or long-term sick leave, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.	19.2
2.1.3	**1**	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service.	
2.2	**Staff recruitment, induction and supervision**		
2.2.1	**2**	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting staff members.	20.1
2.2.2	**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
2.2.3	**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
2.2.4	**2**	All staff members receive line management supervision at least monthly.	20.4
2.2.5	**2**	Patients and carers who volunteer with the service receive monthly supervision.	
2.3	**Staff well-being**		

2.3.1	**1**	The service actively supports staff health and well-being. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	21.1
2.3.2	**1**	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *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
2.3.3	**1**	Staff members, patients and carers who are affected by a serious incident are offered post incident support.	21.3
2.4	**Staff training and development**		
2.4.1		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:	
2.4.1a	**1**	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	22.1a
2.4.1b	**1**	Physical health assessment. *Guidance: This could include training in understanding physical health problems, understanding physical observations and when to refer the patient for specialist input. The training content should include reference to eating disorders.*	22.1b
2.4.1c	**1**	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	22.1c
2.4.1d	**1**	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.*	22.1d
2.4.1e	**1**	Recognising and communicating with patients with cognitive impairment or learning disabilities.	22.1e
2.4.1f	**1**	Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance, and basic life support.*	22.1f
2.4.1g	**2**	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to	22.1g

		confidentiality.	
2.4.1h	**1**	Managing distorted perceptions of food and body image, managing clients with co-morbidity and understanding the impact of trauma within eating disorders.	
2.4.2	**1**	All staff members who deliver therapies and activities are appropriately trained and supervised.	6.1.9
2.4.3	**2**	Experts by experience are involved in delivering and developing staff training face-to-face.	22.2
2.5	**Leadership, team-working and culture**		
2.5.1	**2**	Staff members can access leadership and management training appropriate to their role and specialty.	
2.5.2	**3**	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.	18.1
2.5.3	**1**	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	18.2

		SECTION 3: CARE AND INTERVENTION	
Number	**Type**	**Standard**	**CCQI Core**
3.1	**Reviews and care planning**		
3.1.1	**1**	Patients know who is co-ordinating their care and how to contact them if they have any questions.	5.1
3.1.2	**2**	The service has an agreed set of care pathways that define frequency of clinical review and define treatment interventions. This ensures that all patients accessing the service get an equal service.	
3.1.3	**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
3.1.4	**1**	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy. *Guidance: 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.*	5.3
3.1.5	**1**	All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	3.5
3.2	**Therapies and activities**		
3.2.1	**1**	Patients begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within a locally-agreed timeframe. Any exceptions to this are documented in the case notes. *Guidance: Where timeframes are not in place, services should comply with NHS constitution standards.*	6.1.1

3.2.2	**1**	There is dedicated sessional time from psychologists to: • Provide assessment and formulation of patients' psychological needs; • Ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway.	6.1.2
3.2.3	**2**	There is dedicated sessional time from psychologists to support a whole team approach for psychological management.	6.1.3
3.2.4	**1**	There is dedicated sessional input from occupational therapists to: • Provide an occupational assessment for those patients who require it; • Ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs.	6.1.4
3.2.5	**3**	There is dedicated sessional input from creative therapists.	6.1.5
3.2.6	**1**	There is dedicated sessional input from dietitians to: • Provide nutritional assessments for all patients; • Ensure the safe and effective provision of evidence-based nutritional interventions adapted to patients' needs.	
3.2.7	**2**	The team supports patients to undertake structured activities such as work, education and volunteering. *Guidance: For patients who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes.*	6.1.6
3.2.8	**1**	The team supports patients to undertake activities to support them to build their social and community networks.	6.1.8
3.2.9	**1**	The service provides one of the NICE-recommended/evidence-based treatments for each of the disorders for which they are commissioned.	
3.2.10	**2**	The service provides two or more of the NICE-recommended/evidence-based treatments for each of the disorders for which they are commissioned.	
3.2.11	**1**	Patients with binge eating disorder are informed that all psychological treatments have a limited effect on body weight and this is recorded.	
3.2.12	**1**	Patients with severe and high-risk illness whose condition has not improved with treatment or who have declined treatment are offered ongoing support and care with a specialist eating disorder clinician, with a focus on a personal recovery model.	
3.3	**Medication**		

3.3.1	**1**	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	6.2.1
3.3.2	**1**	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	6.2.2
3.3.3	**1**	Patients, carers and prescribers can contact a specialist pharmacist to discuss medications.	6.2.3
3.3.4	**1**	Where patients with bulimia nervosa or binge eating disorder are offered a trial of high dose anti-depressant medication, this is done alongside other treatments.	
3.3.5	**1**	For patients 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 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	6.2.4
3.4	**Physical healthcare**		
3.4.1	**1**	Staff members arrange for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan.	7.1
3.4.2	**1**	If initial assessment identifies co-existing physical conditions that increase risk (e.g. diabetes, pregnancy), the assessing practitioner liaises with, or refers to, a doctor and this is recorded.	
3.4.3	**1**	Patients are offered personalised healthy lifestyle interventions appropriate to an eating disorder setting, such as advice on appropriate physical activity and access to smoking cessation services. This is documented in the patient's care plan.	7.2
3.4.4	**1**	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency.	7.3
3.4.5	**1**	The service has a protocol for screening, monitoring, psychoeducation and management of bone health.	
3.4.6	**1**	The service has the capacity to provide at least weekly blood tests and physical health reviews from an eating disorder specialist for patients at high risk, as defined by MARSIPAN.	

3.4.7	1	The service has a protocol for an integrated approach to psychoeducation, monitoring of frequency and physical health risks associated with common compensatory behaviours such as vomiting and laxative misuse, and exercise.	
3.4.8	1	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at six weeks, at three months and then annually unless a physical health abnormality arises.	7.4
3.5	**Carer engagement and support**		
3.5.1	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	13.1
3.5.2	1	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This advice is offered at the time of the patient's initial assessment, or at the first opportunity.*	13.2
3.5.3	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	13.3
3.5.4	3	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.	13.5

SECTION 4: INFORMATION, CONSENT AND CONFIDENTIALITY

Number	Type	Standard	CCQI Core
4.1		**Providing information to patients and carers**	
4.1.1	**1**	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: • Their rights regarding consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments.	2.2
4.1.2	**1**	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites.*	6.1.7
4.1.3	**2**	The team provides each carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes:* *· The names and contact details of key staff members in the team and who to contact in an emergency;* *· Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.*	13.4
4.1.4	**1**	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.	15.1
4.1.5	**2**	Information can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary.	
4.1.6	**2**	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	15.2
4.1.7	**1**	When talking to patients and carers, health professionals communicate clearly, avoiding the use of	

		jargon.	
4.2	**Capacity, consent and confidentiality**		
4.2.1	**1**	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation.	11.1
4.2.2	**1**	Confidentiality and its limits are explained to the patient and carer, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	16.1
4.2.3	**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.*	16.3
4.2.4	**1**	The team knows how to respond to carers when the patient does not consent to their involvement.	16.2

		SECTION 5: RIGHTS AND SAFEGUARDING	15
Number	**Type**	**Standard**	**CCQI Core**
5.1		**Treating patients with compassion, dignity and respect**	
5.1.1	**1**	Staff members treat patients and carers with compassion, dignity and respect.	14.1
5.1.2	**1**	Patients feel listened to and understood by staff members.	14.2
5.1.3	**1**	Staff members are knowledgeable about, and sensitive to, the mental health needs of patients from minority or hard-to-reach groups in relation to eating disorders. This may include: • Men • Black, Asian and minority ethnic groups; • Asylum seekers or refugees; • Lesbian, gay, bisexual or transgender people; • Travellers.	
5.1.4	**2**	The service has a strategy for improving access for male patients to the eating disorder service. This may include but is not limited to: • Ensuring there are male staff; • Male targeted literature; • A gender-neutral clinical environment.	
5.1.5	**1**	Patients feel welcomed by staff members when attending the team base for their appointments. *Guidance: Staff members introduce themselves to patients and address them using the name and title they prefer.*	3.1
5.2		**Risk and safeguarding**	
5.2.1	**1**	The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	8.1

SECTION 6: JOINT WORKING AND TRANSFER OF CARE			
Number	**Type**	**Standard**	**CCQI Core**
6.1		**Intensifying treatment**	
6.1.2	**1**	When outpatient treatment is not effective, the service has a protocol for deciding: • When to discharge; • When to intensify; • When to provide support of clinical management or supportive monitoring; • Alternative intervention from the MDT.	
6.1.3	**1**	The service has a protocol for prioritising patients on the waiting list according to clinical need. Factors to consider include but not limited to: • Severity and risk (including psychosocial risk); • Recent onset/good prognosis; • Transfer from inpatient or day patient or other specialist community services (CAMHS or adult); • Pregnancy or impact on young children.	
6.1.4	**1**	A named worker is provided to inpatient services throughout admission and they are involved in care planning, admission and discharge planning meetings and CPAs.	
6.2		**Discharge planning and transfer of care**	
6.2.1	**2**	A discharge letter is sent to the patient 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 patient as appropriate.	9.1
6.2.2	**1**	The community team makes sure that patients who are discharged from hospital are followed up within three days.	9.2
6.2.3	**1**	When patients 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
6.2.4	**2**	When high-risk patients are transferred from inpatient/day patient to the community service, evidence-based psychological treatment starts within two weeks, even when new to the community team.	

6.2.5	**1**	There is active collaboration between Children and Young People's Eating Disorder Services and Adult Eating Disorder Services for patients who are approaching the age for transfer between services. This starts at least six months before the date of transfer.	9.5
6.2.6	**2**	Teams provide specific transition support to patients when their care is being transferred to another community team, or back to the care of their GP.	9.4
6.2.7	**1**	Where a patient is attending university, the service has a protocol for liaison and collaborative working with the patient's university service.	
6.2.8	**2**	The service offers continued support to families of patients who have moved away to university.	
6.2.9	**1**	Care plans for patients transitioning between university and home are developed in collaboration with both the university and home service, patients and their families (where appropriate). Plans include arrangements for the following: • Physical health monitoring; • Who to contact in case of emergency; • Contingency plans in the event of DNAs; • Plans for follow-up meetings.	
6.3	**Interface with other services**		
6.3.1	**1**	Patients can access help from mental health services 24 hours a day, seven days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams.*	10.1
6.3.2	**1**	The team supports patients to access organisations which offer: • Housing support; • Support with finances, benefits and debt management; • Social services.	10.2
6.3.3	**1**	The service/organisation has a care pathway for the care of women 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
6.3.4	**1**	The service has invited their local district general hospital to collaborate in a MaRSiPAN (Management of Really Sick Patients with Anorexia Nervosa) group, and the team provides specialist ED input into any agreed MaRSiPAN pathway.	
6.3.5	**2**	The service provides risk assessment tools, consultation and advice to all local referrers.	

SECTION 7: ENVIRONMENT AND FACILITIES			18
Number	**Type**	**Standard**	**CCQI Core**
7.1	**Service environment**		
7.1.1	**2**	The service environment is clean, comfortable and welcoming.	17.1
7.1.2	**1**	Clinical rooms are private and conversations cannot be over-heard.	17.2
7.1.3	**1**	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as handrails, are provided to meet individual needs and to maximise independence.*	17.3
7.1.4	**1**	Staff members follow a lone working policy and feel safe when conducting home visits.	17.4
7.1.5	**1**	An audit of environmental risk is conducted annually and a risk management strategy is agreed.	
7.1.6	**1**	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for patients, carers and staff members.	17.5
7.1.7	**2**	Staff members have access to a dedicated staff room.	

		SECTION 8: SERVICE MANAGEMENT	
Number	**Type**	**Standard**	**CCQI Core**
8.1		**Patient and carer involvement**	
8.1.1	**1**	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.	12.1
8.1.2	**2**	Services are developed in partnership with appropriately experienced patients and carers, who have an active role in decision making.	12.2
8.1.3	**1**	Patients are actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.	12.3
8.2		**Clinical outcome measurement**	
8.2.1	**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
8.2.2	**2**	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	23.2
8.2.3	**2**	The service's clinical outcome data are reviewed at least six-monthly. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.	23.3
8.3		**The service learns from feedback, complaints and incidents**	
8.3.1	**1**	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this.	24.1
8.3.2	**1**	When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.	24.2
8.3.3	**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
8.3.4	**2**	The team use quality improvement methods to implement service improvements.	24.4
8.3.5	**2**	The team actively encourages patients and carers to be involved in QI initiatives.	24.5

Glossary of terms

Term	Definition
Advance directive	A set of written instructions that a person gives that specify what actions should be taken for their health if they are no longer able to make decisions due to illness or incapacity.
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.