



# CCQI

## Core Standards for Inpatient Mental Health Services Fifth Edition

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## FOREWORD



I am very pleased to introduce the fifth edition of the Royal College of Psychiatrists' Core Standards for Inpatient Mental Health Services. These standards set out the College's view of what constitutes high quality inpatient care and underpin all specialty standards used in the College Centre for Quality Improvement's (CCQI) quality network and accreditation schemes.

Since the launch of the first quality network in 2001, the CCQI has grown to support more than 1,500 services across 29 networks in the UK and internationally. Its methodology continues to help services evaluate and improve the quality of care they provide.

This fifth edition builds on over two decades of work and comes at a time of challenge and change in mental health services. The standards have been revised through extensive engagement with patients, carers, clinicians, commissioners, academics and representatives from all four UK nations. We are grateful to everyone who contributed through workshops, consultations and the standards revision group.

The updated standards seek to reflect the realities of pressures in inpatient care while continuing to push forward improvements in quality, safety and culture of inpatient care.

They are shaped by a commitment to patient centred, least restrictive, and inclusive practice.

Key updates include:

- Strengthening relevance across all UK nations by removing England centric language and integrating feedback from Scotland, Northern Ireland, and Wales
- Enhancing responsiveness to neurodiverse individuals and promoting personalised, equitable care
- Recognising the role of staff wellbeing and ward culture in delivering safe, compassionate services
- Embedding spirituality, sustainability, and human rights more explicitly
- Improving clarity and usability by refining language and streamlining standards to support practical implementation.

This edition introduces 25 new standards, retires those no longer central to good care, and iterates many reflecting learning from using the standards in practice and evolution of practice. The changes aim to improve clarity, relevance, and usability, while reflecting advances in evidence and understanding of what supports safe and effective inpatient care. Updates focus on purposeful admissions, continuity of care, carer involvement, physical health, therapeutic activity, and ward leadership and productivity. As in previous editions, patient and carer representatives were fully involved, ensuring the standards remain grounded in lived experience.

Together these updates are designed to support services in delivering safe, effective, inclusive, and patient centred care. These standards will be in use as the College's quality and accreditation networks celebrate their 25th anniversary in 2026. Over the past 25 years, they have become of the key ways that the College engages with people working in mental health services and supports improvement in care.

Our thanks go to all who contributed from clinical teams and College experts to patients and carers, whose insights are at the heart of these standards. We hope this edition serves both as a practical tool and as a shared statement of what matters most for quality, safety, and experience in inpatient care.

**Dr Lade Smith CBE**  
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## INTRODUCTION

### Description and scope of the standards

The fifth edition of the core standards for Community mental health services has been revised by the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI). It is based on the first edition which was created by the CCQI and the British Standards Institution (BSI) in 2015. The inpatient standards cover access to the ward/unit and what a good admission looks like (which includes assessment, care, treatment and discharge planning). They also cover ward/unit environment, staffing and governance.

### How the standards were developed

A literature review was undertaken to identify any evidence published since publication of the third edition which could be used to update standards and create new standards. The standards then underwent a consultation process. This was done by a working group of multi-disciplinary mental health professionals, patient and carer representatives and CCQI staff which was representative of a range of specialisms to ensure inclusivity and applicability across our different networks.

The group reviewed all standards considering how critical they were to quality and their proximity to patient experience. Other factors considered included their measurability, if there was any repetition and whether the content was appropriate for core standards and could be applied across a range of mental health services. The final standards, we believe, will enable participating services and reviewers to focus on the issues that are key to quality.

The following principles were used to guide the development of these standards:

- **Access:** Patients have access to the care and treatment that they need, when and where they need it.
- **Compassion:** All services are committed to the compassionate care of patients, carers and staff.
- **Valuing relationships:** The value of relationships between people is of primary importance.
- **Patient and carer involvement:** Patients and carers are involved in all aspects of care.
- **Learning environment:** The environment fosters a continuous learning culture.
- **Leadership, management, effective and efficient care:** Services are well led and effectively managed and resourced.
- **Safety:** Services are safe for patients, carers and staff.

In addition, for this revision, the standards development group focused on ensuring that the standards promote equitable access, experience and outcomes for patients and carers and sustainability in mental health care.

### How the core standards will be used

The core standards will be used by the quality and accreditation networks within the CCQI. Each project will adopt the relevant core standards which will be used alongside their own specialist standards that relate to the service type being reviewed.

### Use of terminology

The core inpatient standards use the terms 'patient' and 'carer'. The decision was made to use these terms during the consultation process for the first edition of the core standards. When projects come to take on these standards, they may change these terms where patient or carer might not be appropriate depending on the specialty.

### Criteria

All criteria are rated as Type 1, 2 or 3.

- **Type 1:** Essential standards. Failure to meet these would result in a significant threat to patient safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.
- **Type 2:** Expected standards that most services should meet.
- **Type 3:** Desirable.





## SUSTAINABILITY PRINCIPLES

This edition of the CCQI core standards been mapped against sustainability principles developed by the Royal College of Psychiatrists' Sustainability and Planetary Health Committee.

[www.rcpsych.ac.uk/workinpsychiatry/sustainability.aspx](http://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 for England (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.'

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, video or telephone appointments instead of face-to-face contacts). 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 team working facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship and supervision.



The green leaf symbol is used throughout this document to indicate core standards that are linked to one of the sustainability principles.

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/>
- Centre for Sustainable Healthcare <https://sustainablehealthcare.org.uk/>
- Psych Susnet <https://networks.sustainablehealthcare.org.uk/network/psych-susnet>

The NHS has committed to be net zero by 2040 for directly controlled emissions, and by 2045 for emissions that the NHS influences. Net zero is achieved when greenhouse gas emissions are equal to their removal from the atmosphere, resulting in no overall emissions. The Royal College of Psychiatrists, in collaboration with NHS England, produced a report entitled 'Delivering greener, more sustainable and net zero mental health care' which includes evidence-based guidance on how to deliver net zero mental health care. Recommendations from this report have been incorporated into these standards. Pursuit of net zero is part of the broader effort to develop mental health services that are climate-resilient and environmentally sustainable.

Number	Type	Standard	Reference
<b>1 Access</b>			
1.1	1	There is easily accessible and up-to-date information about the service in the public domain for patients, carers and referrers to view in advance of admission. This includes contact details for the service, information for referrers about how to make a referral and, where relevant, information on waiting times.	2, 3, 4
1.2	1	<p>People are only admitted when they require assessments, interventions or treatment that can only feasibly be provided in hospital. There is a clearly stated purpose for the admission developed with and taking into account views of the patient and their carer.</p> <p><b>Sustainability Principle: Improving Value</b></p>	66
1.3	1	<p>When a young person under the age of 18 is admitted:</p> <ul style="list-style-type: none"> <li>• There is a named CAMHS clinician who is available for consultation and advice;</li> <li>• The local authority or local equivalent is informed of the admission;</li> <li>• The relevant regulatory authority is informed if the patient is detained;</li> <li>• The admission is discussed with appropriate safeguarding professionals;</li> <li>• A single room is used;</li> <li>• Transfer to an age appropriate environment is facilitated as soon as possible.</li> </ul>	4
1.4	1	<p>The unit reviews demographic data at least annually about people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment.</p> <p><i>Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.</i></p>	4, 71

<b>2 Admission: First 12 hours</b>			
2.1	1	<p>On admission to the ward/unit, patients feel welcomed by staff members who explain why they are in hospital.</p> <p><i>Guidance: Staff members show patients around and introduce themselves and other patients, offer them refreshments and address them using their preferred name and pronouns.</i></p>	4, 11
2.2	1	<p>With patient consent, the patient's carer is contacted as soon as possible by a staff member on the ward to notify them of the admission and to provide them with contact details for the ward and visiting times.</p> <p><i>Guidance: The patient is asked who needs to know they are in hospital.</i></p>	4, 10
2.3	1	<p>Patients are given accessible written information which staff members talk through with them as soon as practically possible. The information includes:</p> <ul style="list-style-type: none"> <li>• Their rights regarding admission and consent to treatment;</li> <li>• Their rights under the relevant mental health legislation;</li> <li>• How to access advocacy services;</li> <li>• How to access a second medical opinion;</li> </ul>	4, 12, 13, 55, 62

Number	Type	Standard	Reference
		<ul style="list-style-type: none"> <li>• How to access interpreting services;</li> <li>• How to view their health records;</li> <li>• How to raise concerns, complaints and give compliments.</li> </ul>	
2.4	1	<p>Patients have a comprehensive mental health assessment which is started within four hours of admission. For patients already receiving care in the community, their existing mental health formulation and care plan is reviewed and updated. The process involves the patient, their carer(s), community care providers and the multidisciplinary team, and includes consideration of the patient's:</p> <ul style="list-style-type: none"> <li>• Mental health and medication;</li> <li>• Psychosocial and psychological needs;</li> <li>• Religious traditions and spiritual beliefs;</li> <li>• Strengths and areas for development;</li> <li>• Advance choices;</li> <li>• Reasonable adjustments.</li> </ul> <p><b>Sustainability Principle: Improving value</b></p>	4, 12, 16, 82
2.5	1	<p>Patients have a comprehensive physical health review. This is started within four hours of admission, or as soon as is practically possible. If all or part of the examination is declined, the reason is recorded and repeated attempts are made. Following the physical health review, the physical health care plan is developed or updated.</p> <p><i>Guidance: The comprehensive physical health review is guided by the principles and components set out in the NCEPOD report 'A Picture of Health' (2022) recommendations 1-3. People carrying out physical health assessments and investigations are mindful of sensory sensitivities to touch and pain.</i></p> <p><b>Sustainability Principle: Prioritise Prevention</b></p>	4, 18, 39, 74
2.6	1	<p>Patients have a risk assessment and safety plan which is co-produced (where the patient is able to participate), involves carers, is updated regularly and is shared, where appropriate, with relevant agencies.</p> <p><i>Guidance: This assessment and plan consider risk to self, risk to others and risk from others, the types of harm that could occur, when they are likely to occur and, relatedly, how they may be mitigated.</i></p> <p><b>Sustainability Principle: Prioritise Prevention</b></p>	4, 19, 20, 73
2.7	1	<p>On admission, any arrangements needed around the following are completed and communicated to the patient:</p> <ul style="list-style-type: none"> <li>• The security of the patient's home;</li> <li>• Arrangements for dependants (children, people they are caring for);</li> <li>• Arrangements for pets.</li> </ul>	4
2.8	1	<p>People admitted to the ward outside the area in which they live have regular reviews of their placement.</p> <p><i>Guidance: The minimum frequency of reviews is determined by the care setting. In acute care settings the review would be at, minimum, weekly.</i></p>	5, 66

Number	Type	Standard	Reference
<b>3 Completing the admission process</b>			
<b>3.1</b>	2	<p>The patient is given an information pack on admission that contains the following:</p> <ul style="list-style-type: none"> <li>• A description of the service;</li> <li>• The therapeutic programme including access to exercise and outdoor space;</li> <li>• Information about the staff team;</li> <li>• The unit mutual expectations of staff and patients;</li> <li>• Key service policies (e.g. permitted items, smoking policy);</li> <li>• Resources to meet spiritual, cultural or gender related needs including signposting to chaplaincy services.</li> </ul>	4, 21, 55, 82

<b>4 Reviews and care planning</b>			
<b>4.1</b>	1	Patients know who the key people are in their team, including their named nurse, and how to contact them if they have any questions.	23
<b>4.2</b>	1	Patients have a formal review of care or ward round within one week of admission which includes time to discuss the patient's questions, concerns and goals. Patients are supported to attend and engage with this process in advance of the review.	4
<b>4.3</b>	1	<p>Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patient and their carer(s) to agree the purpose of admission and admission goals, develop the care plan, and they are offered a copy.</p> <p><i>Guidance: Where possible, the patient writes the care plan themselves or with the support of staff.</i></p>	2, 4, 12
<b>4.4</b>	1	<p>The purpose of admission, care plan, discharge plan and estimated discharge date are reviewed and updated regularly with the patient and their carer.</p> <p><i>Guidance: If the purpose of admission is close to being met, additional focus is given to discharge planning to avoid the discharge being delayed.</i></p>	4, 66
<b>4.5</b>	2	<p>The ward uses a regular structured meeting (e.g. MDT huddle/ management round) to agree, allocate and follow up actions needed to progress the patient's management plan towards planned discharge.</p> <p><i>Guidance: In acute care settings this is a daily meeting.</i></p>	4, 66

<b>5 Leave from the ward/unit</b>			
<b>5.1</b>	1	<p>The team and patient jointly develop a leave plan, which is shared with the patient, that includes:</p> <ul style="list-style-type: none"> <li>• A risk assessment and safety plan that includes an explanation of what to do if problems arise on leave;</li> <li>• Conditions of the leave;</li> <li>• Contact details of the ward/unit and crisis numbers;</li> <li>• Ability to access a bed on return;</li> <li>• How the ward will check in with the patient on their wellbeing when on leave.</li> </ul>	4

Number	Type	Standard	Reference
5.2	1	Staff agree leave plans with the patient's carer allowing them sufficient time to prepare. Carers are given an opportunity to provide feedback after the period of leave to inform ongoing care and leave planning.	4
5.3	1	When patients are absent without leave, the team (in accordance with local policy): <ul style="list-style-type: none"> <li>• Activates a safety management plan;</li> <li>• Makes efforts to locate the patient;</li> <li>• Alerts carers, people at risk and the relevant authorities;</li> <li>• Escalates as appropriate.</li> </ul>	4

6 Care and treatment – therapies, activities & medication			
6.1	1	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to their bio-psychosocial needs and the identified goals for the admission. <i>Guidance: Patients already receiving mental health support in the community have their care plan updated reflecting their change in needs and interventions to be received in an inpatient setting.</i>	4, 13, 27, 28
6.2		There is a core team of professionally qualified MDT staff who work together to deliver assessments and safe and effective evidence-based care. This includes:	4, 64, 66
6.2.1	1	A consultant psychiatrist.	
6.2.2	1	A psychologist.	4, 30, 31
6.2.3	1	An occupational therapist.	4, 5
6.2.4	2	A pharmacist.	4, 29
6.3	3	The ward has access to Allied Health Professionals to meet a range of patient needs as identified in their care plan. There is sufficient sessional time and/or pathway arrangements in place to draw on these staff on an as needed basis. <i>Guidance: This includes dietetics, physiotherapy, speech and language therapy. The ward monitors its demand for and access to these services, the response time when input is needed and any delays in accessing input on patient progression through the inpatient pathway.</i>	4, 79
6.4	2	Patients receive psychoeducation to enhance skills in areas such as activities of daily living, interpersonal communication, relationships, sleep hygiene, coping with stigma, stress and anger management.	4, 5
6.5	2	Every patient has a personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with. <i>Guidance: The timetable covers seven days including unstructured activity time. It may include activities such as physical activity, education, employment, volunteering, faith- or spirituality-related activities, and other occupations such as leisure activities and caring for dependants.</i>	4, 12, 32, 33, 34, 82, 66

Number	Type	Standard	Reference
6.6	2	<p>The ward has a staffing model that ensures activities in therapeutic/ recreational timetables are routinely delivered and that patient leave, exercise, access to the outdoors and faith-based needs can be facilitated in line with the RCPsych core standards.</p> <p><i>Guidance: The ward may draw on a range of roles including therapies staff, peer workers, healthcare assistants, activity co-ordinators and/or they may partner with organisations such as voluntary, community, faith and social enterprise (VCFSE) sector organisations to meet this standard.</i></p>	4, 82, 66
6.7	2	<p>Each patient is offered a one-hour session at least once a week with a nominated member of their care team to discuss progress, care plans and concerns.</p>	4, 34
6.8	1	<p>Patients and carers are offered written and verbal information about the patient's mental illness and treatment.</p>	3, 4, 35, 51
6.9	2	<p>There is a minuted ward community meeting that is attended by patients and multi-disciplinary staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. Actions from the meeting are followed up.</p> <p><i>Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward/unit and to review the quality and provision of activities with staff members. To promote inclusion, the meeting could be chaired by a patient, peer support worker or advocate.</i></p>	4, 5
6.10	1	<p>Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.</p>	4, 82
6.11	1	<p>Patients have access to safe outdoor space every day.</p> <p><b>Sustainability Principle: Consider Carbon</b></p>	4, 32
6.12	2	<p>Patients, according to their care plan, have regular access to longer outdoor activities facilitated by staff.</p> <p><i>Guidance: Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot or rain wear. Staff should be able to facilitate this at least twice a week in a group or individually.</i></p> <p><b>Sustainability Principle: Consider Carbon</b></p>	4, 77
6.13	2	<p>The team provides information and encouragement to patients to access local organisations for peer support and social engagement. This is documented in the patient's care plan and includes access to:</p> <ul style="list-style-type: none"> <li>• Voluntary organisations;</li> <li>• Community centres;</li> <li>• Local religious/cultural groups;</li> <li>• Peer support networks;</li> <li>• Recovery colleges.</li> </ul>	4, 5, 27, 32
6.14	3	<p>Within 24 hours of the patient's admission, pharmacy staff undertake a full medicines reconciliation, including all medications for physical as well as mental health.</p> <p><i>Guidance: For people admitted over a weekend, this may take up to 72 hours.</i></p>	74

Number	Type	Standard	Reference
6.15	1	<p>When medication is prescribed, the risks and benefits are discussed with the patient and carer.</p> <p>The following are discussed and recorded:</p> <ul style="list-style-type: none"> <li>• The intended outcome of the intervention;</li> <li>• Timescale for response;</li> <li>• Monitoring requirements;</li> <li>• Patient consent and capacity to consent.</li> </ul>	4, 74
6.16	1	<p>Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, adherence, safety, and management of side effects, including during medication changes and deprescribing.</p> <p><i>Guidance: Side effect monitoring tools can be used to support reviews.</i></p> <p><b>Sustainability Principle: Consider Carbon</b></p>	4, 74
6.17	1	<p>Every patient's PRN medication is reviewed weekly. This includes frequency, dose and indication.</p>	4, 74
6.18	2	<p>Patients, carers and prescribers are able to meet with a pharmacist to discuss medications.</p>	4

7 Physical healthcare			
7.1	1	<p>Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission.</p> <p><i>Guidance: This is undertaken promptly, and a named individual is responsible for follow-up. Advice may be sought from primary or secondary physical healthcare services.</i></p>	39, 74
7.2	1	<p>Patients are offered personalised healthy lifestyle interventions such as advice on healthy eating and physical activity. They are offered, and can access through the ward, smoking cessation and/or drug and alcohol services. These are documented in the patient's care plan.</p> <p><b>Sustainability Principle: Consider Carbon</b></p>	3, 21, 39, 75, 74
7.3	1	<p>Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people). If a physical health abnormality is identified, this is acted upon.</p>	3, 4, 39, 41, 42, 43, 75, 74

Number	Type	Standard	Reference
<b>8 Risk and safeguarding</b>			
<b>8.1</b>	1	<p>Patients are involved (wherever possible) in decisions about their level of therapeutic observation by staff.</p> <p><i>Guidance: Patients are also supported to understand how the level of observation is decided and the factors that influence it.</i></p>	4, 12, 56
<b>8.2</b>	2	<p>Patients on constant observations receive at least one hour per day of observations and engagement with a member of staff who is familiar to them.</p>	4
<b>8.3</b>	1	<p>Any use of force (e.g. physical, restraint, chemical restraint, seclusion and long term segregation) is recorded and reported in line with hospital policy, relevant legislation and/or regulatory requirements.</p>	71, 78
<b>8.4</b>	1	<p>In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are debriefed and supported to identify triggers and early warning signs, and make advance statements about the use of restrictive interventions.</p>	19, 20, 70
<b>8.5</b>	1	<p>The team uses seclusion only as a last resort and for the shortest period possible until a less restrictive management option can be utilised. All incidences of seclusion are recorded and these are reviewed in team governance meetings.</p>	13, 19, 45, 62, 67, 70
<b>8.6</b>	1	<p>In units where long term segregation is used, the area used conforms to standards prescribed by relevant legislation and/ or regulatory frameworks.</p> <p><i>Guidance: This includes patients having access to meaningful and therapeutic activity and outdoor space.</i></p>	70, 71, 80
<b>8.7</b>	3	<p>Patients in seclusion or long-term segregation have access to independent, specialist-trained advocacy and specialist free legal advice.</p>	14
<b>8.8</b>	1	<p>Patients who are involved in episodes of restraint, or compulsory treatment including tranquilisation, have their vital signs, including respiratory rate, monitored by staff members and any deterioration is immediately responded to in line with unit policy.</p> <p><i>Guidance: If all vital signs cannot be taken because of the patient's presentation, observable signs including respiratory rate and reason for omission of a full set of observations is recorded.</i></p>	13, 19, 45, 74
<b>8.9</b>	1	<p>The multi-disciplinary team collects data on the use of restrictive interventions and actively works to reduce its use year on year through use of audit and/or other quality improvement methodology.</p> <p><i>Guidance: Audit data are used to compare the service to national benchmarks where available.</i></p>	19, 62, 71
<b>8.10</b>	2	<p>The multi-disciplinary team collects patient ethnicity data on the use of restrictive interventions and actively works to reduce inequalities year on year through use of audit and/or other quality improvement methodology.</p> <p><i>Guidance: Audit data are used to compare the service to national benchmarks where available.</i></p>	71

Number	Type	Standard	Reference
<b>9 Discharge planning and transfer of care</b>			
9.1	1	Proactive discharge planning with the patient and their carer takes place from point of admission, focusing on identifying any barriers to discharge and what post-discharge support needs to be in place at point of discharge.	4, 66
9.2	1	Follow-up appointments for the patient post-discharge are arranged with community services prior to the patient being discharged. The details of when, where and with whom this follow-up will take place are given to the patient and their carer in written format.	4, 66
9.3	1	Mental health practitioners carry out a thorough assessment of the patient's personal, social, safety and practical needs to reduce the risk of suicide on discharge. <i>Guidance: Where possible, this should be completed in partnership with carers.</i>	5, 73
9.4	1	The team sends a copy of the patient's care plan or interim discharge summary to everyone identified in the plan as involved in their ongoing care (including carers) within 24 hours of discharge. <i>Guidance: The plan includes details of:</i> <ul style="list-style-type: none"> <li>• Care in the community/aftercare arrangements;</li> <li>• Crisis and contingency arrangements, including details of who to contact;</li> <li>• Medication including prescribing, dispensing and monitoring arrangements;</li> <li>• Details of when, where and with whom the patient's follow-up will take place.</li> </ul>  <b>Sustainability Principle: Prioritise Prevention</b>	4, 5, 47, 69
9.5	2	A discharge summary is sent, within a week, to the patient's GP and others involved in the patient's ongoing care. <i>Guidance: The summary includes a formulation, why the patient was admitted, how their condition has changed, what interventions were used and their impact, their diagnosis, relapse indicators, medication and follow up plan.</i>	4, 5, 61
9.6	3	Patients have all medications (including physical health medications) reviewed prior to discharge to ensure that medication is optimised and evidence-based, and that inappropriate medications are withdrawn. Review or end dates for prescriptions initiated in hospital are included in discharge documentation.  <b>Sustainability Principle: Consider Carbon</b>	4
9.7	1	The team makes sure that patients who are discharged from hospital have arrangements in place before they leave the hospital to be followed up within 72 hours of discharge. <i>Guidance: Face-to-face 72 hour follow-up is arranged where possible.</i>	48, 66

Number	Type	Standard	Reference
9.8	2	The team provides support to patients when their care is being transferred to another unit, to a community mental health team, or back to the care of their GP. <i>Guidance: When the transition is to another organisation or different care pathway, the team provides transition mentors, transition support packs, or education for patients on how to manage transitions.</i>	4, 47
9.9	1	When staff members are concerned about an informal patient self-discharging against medical advice, the staff members undertake a thorough assessment of the patient, taking their wishes into account as far as possible. <i>Guidance: Staff explore with the patient and their carer alternative community options to see if they could be a safe and viable alternative.</i>	4, 5

10 Interface with other services			
10.1	2	The team supports patients to attend appointments with their community GP when needed whilst an inpatient, if they are admitted in their local area.	4
10.2	1	The team supports patients to access support with finances, benefits, debt management and housing needs.	4, 23
10.3	1	The ward/unit/organisation has a care pathway for patients who are pregnant or in the postpartum period. <i>Guidance: Women who are over 32 weeks pregnant or up to 12 months postpartum are not admitted to a general psychiatric ward unless there are exceptional circumstances.</i>	1
10.4	1	Patients are offered access to an advocacy service and supported to work with them.	5

11 Capacity and consent			
11.1	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation.	4, 13, 49,

12 Patient involvement			
12.1	1	The service routinely asks patients and carers for their feedback about their experiences of using the service, and this is used to make improvements.  <b>Sustainability Principle: Empowering Individuals</b>	12, 33



Number	Type	Standard	Reference
12.2	1	Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics. <i>Guidance: Complaints, compliments and other feedback sources include the option to share demographic information.</i>	4
12.3	2	Services are developed in partnership with patient and carers who have relevant lived experience, and who take an active role in informing decision-making.	4, 12

13 Carer engagement and support			
13.1	1	Carers are supported to participate actively in decision-making and care planning for the person they care for. This includes attendance at ward reviews where the patient consents.  <b>Sustainability Principle: Empowering Individuals</b>	3, 4, 51, 56, 76
13.2	1	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency.	4, 52
13.3	2	Carers are offered the opportunity to speak with staff members, within 48 hours of the patient's admission, to discuss concerns, their own needs and to share and receive information.	4, 51, 56
13.4	2	The team provides each carer with accessible carers' information. <i>Guidance: Information is provided verbally and in writing (e.g. in a carers' pack). This includes the names and contact details of key staff members on the unit and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.</i>	3, 4, 59, 55
13.5	2	Carers feel supported by the ward staff members.	4, 51, 53

14 Treatment with dignity and respect			
14.1	1	Staff members treat all patients and carers with compassion, dignity and respect.	12, 33, 54, 56
14.2	1	Patients feel listened to and understood by staff members.	23, 56
14.3	1	Reasonable adjustments are made, if required, for patients with disability, including autistic people and/or people with a learning disability. Any reasonable adjustments are recorded in patients' notes.	4, 72
14.4	1	For patients with a learning disability and/or who are autistic, staff make use of existing information about their care needs and use them in care planning and communication. <i>Guidance: Health passports or similar tools should be used.</i>	4, 72

Number	Type	Standard	Reference
14.5	1	<p>The ward/unit works with 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.</p> <p><i>Guidance: If the patient's first language is not English, an assessment is made as to whether they can accurately describe their symptoms, difficulties and needs. If not, an interpreter is booked for subsequent reviews.</i></p> <p><i>In Wales, services and communication (written and spoken) comply with the Welsh Language Act.</i></p>	4

15 Patient confidentiality			
15.1	1	Confidentiality and its limits are explained to the patient and carer on admission, both verbally and in writing. Patient preferences for sharing information with third parties, including their carers, are respected and reviewed regularly.	4, 56
15.2	1	<p>The team knows what information can be provided to carers when the patient does not consent to their involvement.</p> <p><i>Guidance: The ward may receive information from the carer in confidence.</i></p>	4, 11
15.3	1	<p>All patient information is kept in accordance with current legislation.</p> <p><i>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.</i></p>	56

16 Ward/unit environment			
16.1	1	<p>Accessible key information about the ward is clearly displayed.</p> <p><i>Guidance: This includes clear signage, pictures and names of ward staff members, and the ward activity timetable.</i></p>	4, 72, 83,
16.2	1	<p>Male and female patients have separate bedrooms, toilets and washing facilities. Room allocation is able to accommodate a spectrum of genders.</p> <p><i>Guidance: Where room allocation could present risks to the patient or to vulnerable others, this is risk-assessed and all practical steps taken to accommodate patient preference. If patient preference cannot be safely accommodated, this is discussed between the patient and clinical team and agreement made on the most appropriate environment for care. Care and safety planning is carried out with the patient to address how to best to support them in this context.</i></p>	4, 57
16.3	2	All patients have single bedrooms.	4, 57
16.4	3	Wards are able to designate gender neutral bedrooms and toilet facilities for patients who would prefer a non-gendered care environment.	4, 57

Number	Type	Standard	Reference
16.5	2	Patients are able to personalise their bedroom spaces. <i>Guidance: This may include allowing photos and pictures to be displayed and other personalisations in line with the service's infection control policy.</i>	4
16.6	2	The ward/unit has at least one bathroom/shower room for every three patients.	4
16.7	3	Every patient has an en-suite bathroom.	4
16.8	2	Patients are supported to access materials and facilities that are associated with specific cultural or spiritual practices, e.g. covered copies of faith books, access to a multi-faith room, or access to groups.	4, 82
16.9	3	Patients can access a range of current culturally-specific resources for entertainment, which reflect the ward/unit's population.	4, 58, 59
16.10	1	The environment complies with current legislation on disabled access. <i>Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.</i>	4, 54, 60
16.11	1	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.	4
16.12	1	Patients can use mobile phones, computers (which provide access to the internet and social media), cameras and other electronic equipment on the ward, subject to risk assessment and safety plan. <i>Guidance: Patients can access a charge point for electric devices. Staff members ensure the use of such equipment respects the privacy and dignity of everyone and know how to manage situations when this is breached.</i>	4, 56
16.13	1	A risk assessment of all ligature points on the ward is conducted at least annually. An action plan and mitigations are put in place where risks are identified, and staff are aware of the risk points and their management.	4
16.14	1	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. <i>Guidance: This includes avoiding the use of blanket rules and assessing risk on an individual basis.</i>	4, 35, 62
16.15	1	There is an alarm system on the ward for use by staff, patients and visitors. The ward has an agreed response when the alarm is raised. <i>Guidance: Alarms in patient rooms accord with relevant regulatory guidance.</i>	4
16.16	2	Staff members and patients can control heating, ventilation and light on the ward/unit. <i>Guidance: For example, patients are able to ventilate their rooms through the use of windows, they have access to light switches, and they can request adjustments to control heating. Dimmable lighting is available.</i>	4
16.17	1	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.	61

Number	Type	Standard	Reference
16.18	2	The ward/unit has a designated room for physical examination and minor medical procedures. <i>Guidance: The room has a couch for physical examination.</i>	4
16.19	1	In wards/units where seclusion is used, there is a designated room that meets the following requirements: <ul style="list-style-type: none"> <li>• It allows clear observation;</li> <li>• It is well insulated and ventilated;</li> <li>• It has adequate lighting, including a window(s) that provides natural light;</li> <li>• It has direct access to toilet/washing facilities;</li> <li>• It has limited furnishings (which include a bed, pillow, mattress and blanket or covering);</li> <li>• It is safe and secure, and does not contain anything that could be potentially harmful;</li> <li>• It includes a means of two-way communication with the team;</li> <li>• It has a clock that patients can see.</li> </ul> <i>Guidance: Wards that do not have seclusion facilities ensure that local policies fully describe alternatives to seclusion and how patients' safety, dignity, privacy and health and well-being needs will be met.</i>	13
16.20	2	The ward/unit has at least one quiet room or de-escalation space other than patient bedrooms.	4
16.21	2	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24 hours a day. <i>Guidance: Hot drinks may be available on a risk-assessed basis.</i>	4, 62
16.22	1	Patients are provided with meals which offer choice, address nutritional/balanced diet and specific dietary requirements and which are also sufficient in quantity. Meals are varied and reflect the individual's cultural and religious needs.	62
16.23 	2	Ward/unit-based staff members have access to a dedicated staff room. <b>Sustainability Principle: Empowering Staff</b>	4
16.24	2	Patients are consulted about changes to the ward/unit environment.	4

17 Leadership, team-working and culture			
17.1 	2	There is regular reflective practice available of sufficient frequency to ensure that all staff can access this at least every six weeks. <i>Guidance: Reflective practice should be facilitated by someone with experience in managing a group process.</i> <b>Sustainability Principle: Empowering Staff</b>	4
17.2 	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. <b>Sustainability Principle: Empowering Staff</b>	4, 56, 63, 64

Number	Type	Standard	Reference
17.3	1	<p>Those in ward leadership roles are visible and present on the ward and actively role model and promote an open learning culture. They are confident and competent in both listening and following up in line with Freedom to Speak Up principles.</p> <p><i>Guidance: Staff know that incident reporting, learning from incidents and responsiveness to feedback are leadership priorities. If staff raise concerns, they are confident their leadership will address them.</i></p>	4, 81
17.4	1	<p>When the team meets for handover, adequate time is allocated to discuss patients' needs, safety and care plans.</p> <p><b>Sustainability Principle: Consider Carbon</b></p>	4
17.5	3	<p>The service has a system for reviewing culture in the ward and takes action on findings.</p> <p><i>Guidance: This may include review of incident and restrictive practice data, patient and carer feedback, staffing and employee relations data and/or use of a validated staff survey, culture of care or safety culture tool/survey.</i></p>	4, 81
17.6	2	<p>The ward reviews 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. Progress against the plan is reviewed at regular time points throughout the year and refreshed annually.</p> <p><i>Guidance: Good practice includes adopting practices in line with recommendations in RCPsych Net Zero Guidance. This may include, for example, assigning a Sustainability Champion role and staff undertaking training in sustainable practice.</i></p>	80
17.7	2	<p>The ward has appropriate administrative support and infrastructure in place to release clinical time to care.</p> <p><i>Guidance: The ward has a dedicated administrator.</i></p>	4

18 Staffing levels			
18.1	1	<p>The ward/unit has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including:</p> <ul style="list-style-type: none"> <li>• A method for the team to report concerns about staffing levels;</li> <li>• Access to additional staff members;</li> <li>• An agreed contingency plan, such as the minor and temporary reduction of non-essential services.</li> </ul> <p><b>Sustainability Principle: Empowering Staff</b></p>	4
18.2	2	<p>The ward/unit is primarily staffed by permanent staff members, and unfamiliar bank or agency staff members are used only in exceptional circumstances, e.g. in response to additional clinical need or short-term absence of permanent staff or regular bank/agency staff.</p> <p><i>Guidance: There should be at minimum one permanent qualified nurse on each shift at all times.</i></p>	4

Number	Type	Standard	Reference
18.3	2	If the staff vacancy rate exceeds 15%, there is a workforce recruitment and retention plan in place.	4
18.4	1	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an urgent situation. <i>Guidance: Video consultation for advice/assessment may be used in exceptional circumstances which would include rural settings.</i>	4

19 Staff recruitment, induction and supervision			
19.1	2	Patient or carer representatives are involved in the interview process for recruiting potential staff members. <i>Guidance: The representatives have experience of the relevant service.</i> <b>Sustainability Principle: Empowering Individuals</b>	4
19.2	2	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. This includes arrangements for shadowing colleagues on the team, jointly working with a more experienced colleague, and being observed and receiving enhanced supervision until core competencies have been assessed as met.	13, 17, 66
19.3	1	All clinical staff members receive formal individual clinical supervision at least monthly, or as otherwise specified by their professional body. <i>Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications. Clinical supervision should be in addition to managerial supervision. If the two are provided together, there is a clear differentiation between them.</i>	4,38
19.4	2	All staff members receive individual line management supervision at least monthly. <i>Guidance: Managerial supervision should be in addition to clinical supervision. If the two are provided together, there is a clear differentiation between them.</i>	4, 38

20 Staff wellbeing			
20.1	1	The ward/unit actively supports staff health and wellbeing. <i>Guidance: For example, by providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, promoting sleep hygiene and known health inequalities facing night staff, and reviewing feedback from exit interviews and taking action where needed.</i> <b>Sustainability Principle: Empowering Individuals</b>	37, 67, 68, 69
20.2	1	Patients and staff members feel safe on the ward. <i>Guidance: Staff and patient experience is systematically captured, reviewed and acted on.</i>	4

Number	Type	Standard	Reference
20.3	1	<p>Staff members are able to take breaks during their shift that comply with the European Working Time Directive.</p> <p><i>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.</i></p>	4, 70
20.4	1	 <p>Staff members, patients and carers who are affected by a serious incident including restraint and rapid tranquilisation are offered post-incident support.</p> <p><i>Guidance: This includes attention to the physical and emotional wellbeing of the people involved and post-incident reflection.</i></p> <p><b>Sustainability Principle: Empowering Individuals</b></p>	71, 75, 78, 81

21 Staff training and development			
21.1		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:	
21.1a	1	The use of relevant mental health and capacity legal frameworks.	13, 49, 50
21.1b	1	 <p>Physical health assessment and management, including management of the physically deteriorating patient.</p> <p><i>Guidance: This could include training in understanding physical health problems, undertaking physical observations, using early warning scores (e.g. NEWS2), identification and management of the medically deteriorating patient and basic life support.</i></p> <p><b>Sustainability Principle: Prioritise Prevention</b></p>	3, 4, 74
21.1c	1	 <p>Safeguarding vulnerable adults and children.</p> <p><i>Guidance: This includes recognising and responding to the signs of abuse, exploitation, or neglect.</i></p> <p><b>Sustainability Principle: Prioritise Prevention</b></p>	5, 18, 20, 54, 56, 62
21.1d	1	 <p>Risk assessment and management.</p> <p><i>Guidance: This includes assessing and managing suicide risk and self-harm, risk from others, from self-neglect and the prevention and management of challenging behaviour.</i></p> <p><b>Sustainability Principle: Prioritise Prevention</b></p>	4, 19, 20, 73, 75
21.1e	1	Cognitive impairment, learning disability and autism, including awareness of neurodiversity and how to interact appropriately with autistic people and people who have a learning disability.	57
21.1f	2	<p>Inequalities in mental health access, experiences, and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.</p> <p><i>Guidance: Training should address all nine protected characteristics and their relevance to delivering equitable mental health care.</i></p>	4, 62

Number	Type	Standard	Reference
21.1g	1	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	59
21.1h	1	New members of staff or those changing wards who prescribe or undertake therapeutic engagement and observations receive an induction which includes: <ul style="list-style-type: none"> <li>• Principles around positive engagement with patients;</li> <li>• When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this;</li> <li>• Actions to take if the patient absconds;</li> <li>• Trauma-informed principles.</li> </ul>	7
21.1i	1	Staff are trained in human rights-based approaches to working with people at risk of restrictive practices and in trauma-informed principles.	4, 71
21.2	2	Patient and/or carer representatives are involved in delivering and developing staff training.	12

22 Clinical outcome measurement			
22.1	1	Clinical outcome measurement is collected at two time points (at assessment and discharge). <i>Guidance: This includes patient-reported outcome measurements where possible.</i>	4, 62
22.2	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.	4, 38, 58
22.3	2	The service's clinical outcome data are collated, analysed and reported at least bi-annually. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service. <b>Sustainability Principle: Improving Value</b>	4, 76

23 The ward/unit learns from feedback, complaints and incidents			
23.1	1	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this.	4, 71
23.2	1	When serious mistakes are made in care, this is discussed with the patient and their carer, an apology given and actions taken as appropriate to mitigate the outcome of the mistake and/or prevent its recurrence. Any safeguarding concerns that have arisen through the incident are raised and processed in line with policy.	4, 73

Number	Type	Standard	Reference
<b>23.3</b>	1	Lessons learned from 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.	4, 71
<b>23.4</b>	2	The team is actively involved in QI activity.	4
<b>23.5</b>	2	The team actively encourages patients and carers to be involved in QI initiatives.	4

## REFERENCES

- 1) National Institute for Health and Care Excellence (NICE). *Antenatal and postnatal mental health: clinical management and service guidance (CG192)*. London: NICE; 2014 [updated 2020 Feb]. Available from:  
<https://www.nice.org.uk/guidance/cg192>
- 2) Scottish Intercollegiate Guidelines Network (SIGN). *Management of perinatal mood disorders (SIGN 127)*. Edinburgh: SIGN; 2012 Mar. Available from:  
[https://www.sign.ac.uk/assets/sign127\\_update.pdf](https://www.sign.ac.uk/assets/sign127_update.pdf)
- 3) National Institute for Health and Care Excellence (NICE). *Psychosis and schizophrenia in adults: prevention and management (CG178)*. London: NICE; 2014 Feb. Available from:  
<https://www.nice.org.uk/guidance/CG178>
- 4) Royal College of Psychiatrists, Centre for Quality Improvement (CCQI). *Core standards review group*. London: RCPsych; 2021, 2024.
- 5) National Institute for Health and Care Excellence (NICE). *Transition between inpatient mental health settings and community or care home settings: Quality Standard 159*. London: NICE; 2016 Aug. Available from:  
<https://www.nice.org.uk/guidance/ng53>
- 6) The Point of Care Foundation. *Staff care: how to engage staff in the NHS and why it matters*. London: The Point of Care Foundation; 2014. Available from:  
<https://engageforsuccess.org/wp-content/uploads/2015/10/Staff-Report-2014.pdf>
- 7) NHS Resolution. *Learning from suicide-related claims: a thematic review of NHS Resolution data*. London: NHS Resolution; 2018 Sep. Available from:  
<https://resolution.nhs.uk/resources/learning-from-suicide-related-claims/>
- 8) National Institute for Health and Care Excellence (NICE). *Mental wellbeing at work (PH22)*. London: NICE; 2009. Available from:  
<https://www.nice.org.uk/Guidance/PH22>
- 9) NHS England. *NHS staff health and wellbeing: CQUIN supplementary guidance*. London: NHS England; 2016 Jun. Available from:  
<https://www.england.nhs.uk/wp-content/uploads/2016/03/HWB-CQUIN-Guidance.pdf>
- 10) British Medical Association (BMA). *European Working Time Directive: junior doctors FAQs*. London: BMA; 2018 Dec. Available from:  
<https://www.bma.org.uk/advice/employment/working-hours/ewtd-juniors-faq>
- 11) National Institute for Health and Care Excellence (NICE). *Patient experience in adult NHS services: quality standard (QS15)*. London: NICE; 2012 Feb [updated 2019 Jul]. Available from:  
<https://www.nice.org.uk/guidance/qs15>
- 12) National Institute for Health and Care Excellence (NICE). *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (CG136)*. London: NICE; 2011 Dec.  
<https://www.nice.org.uk/Guidance/CG136>
- 13) Department of Health. *Mental Health Act 1983: code of practice*. London: Department of Health; 2015 Jan [updated 2017 Oct]. Available from:  
<https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>

- 14) NHS England. *Serious incident framework*. London: NHS England; 2015. Available from:  
<https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>
- 15) Care Quality Commission (CQC). *Duty of candour: Regulation 20 guidance*. London: CQC; 2016. Available from:  
<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour#full-regulation>
- 16) Rethink Mental Illness. *100 ways to support recovery: a guide for mental health professionals*. 2nd ed. London: Rethink; 2013. Available from:  
<https://www.rethink.org/resources/a/a-100-ways-to-support-recovery>
- 17) Eales S, Callaghan P, Johnson B. Service users' and other stakeholders' evaluation of a liaison mental health service in an accident and emergency department and general hospital setting. *J Psychiatr Ment Health Nurs*. 2006;13(1):70-7. Available from:  
<https://pubmed.ncbi.nlm.nih.gov/16441396/>
- 18) Royal College of Psychiatrists. *Physical health in mental health (OP67)*. London: RCPsych; 2009. Available from:  
[https://www.rcpsych.ac.uk/docs/default-source/files-for-college-members/occasional-papers/op67.pdf?sfvrsn=8236c66f\\_2](https://www.rcpsych.ac.uk/docs/default-source/files-for-college-members/occasional-papers/op67.pdf?sfvrsn=8236c66f_2)
- 19) National Institute for Health and Care Excellence (NICE). *Violence and aggression: short-term management in mental health, health and community settings (QS154)*. London: NICE; 2015 May. Available from:  
<https://www.nice.org.uk/guidance/ng10/chapter/Introduction>
- 20) National Institute for Health and Care Excellence (NICE). *Self-harm: quality standard (QS34)*. London: NICE; 2013 Jun. Available from:  
<https://www.nice.org.uk/guidance/QS34>
- 21) Public Health England. *Smokefree mental health services in England: implementation document for providers of mental health services*. London: PHE; 2016 Mar. Available from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/779497/SF\\_MH\\_services\\_in\\_England\\_Guidance\\_for\\_Providers.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779497/SF_MH_services_in_England_Guidance_for_Providers.pdf)
- 22) Macneil CA, Hasty MK, Conus P, Berk M. Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BMC Med*. 2012;10:111. Available from:  
<https://bmcmmedicine.biomedcentral.com/articles/10.1186/1741-7015-10-111>
- 23) National Voices. *A narrative for person-centred coordinated care*. London: National Voices; 2013. Available from:  
<https://www.nationalvoices.org.uk/sites/default/files/public/publications/narrative-for-person-centred-coordinated-care.pdf>
- 24) National Institute for Health and Care Excellence (NICE). *Rehabilitation for adults with complex psychosis (NG181)*. London: NICE; 2020 Aug. Available from:  
<https://www.nice.org.uk/guidance/ng181>
- 25) National Institute for Health and Care Excellence (NICE). *Supporting adult carers: quality standard (QS200)*. London: NICE; 2021 Mar. Available from:  
<https://www.nice.org.uk/guidance/qs200/chapter/quality-statement-1-identifying-carers#quality-statement-1-identifying-carers>
- 26) Saraev V, O'Brien L, Valatin G, Bursnell M. *Valuing the mental health benefits of woodlands*. Farnham: Forest Research; 2021. Available from:  
<https://www.forestresearch.gov.uk/documents/8217/FRRP034.pdf>

- 27) National Institute for Health and Care Excellence (NICE). *Common mental health problems: identification and pathways to care (CG123)*. London: NICE; 2011 May. Available from:  
<https://www.nice.org.uk/Guidance/CG123>
- 28) NHS ENGLAND. *Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16*. London: NHS England; 2015 Feb. Available from:  
<https://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf>
- 29) Improving Access to Psychological Therapies (IAPT). *IAPT for adults: minimum quality standards*. London: NHS; 2013. Available from:  
<https://mentalhealthpartnerships.com/wp-content/uploads/sites/3/iapt-for-adults-minimum-quality-standards.pdf>
- 30) Health and Care Professions Council. *Standards of proficiency: practitioner psychologists*. London: HCPC; 2018. Available from:  
<http://www.hpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/>
- 31) British Psychological Society. *Mental health clustering and psychological interventions*. Leicester: BPS; 2013. Available from:  
<https://www.bps.org.uk/sites/www.bps.org.uk/files/Member%20Networks/Divisions/DCP/Mental%20Health%20clustering%20and%20psychological%20intervention.pdf>
- 32) Royal College Of Psychiatrists. *Do the right thing: how to judge a good ward; ten standards for adult in-patient mental healthcare (OP79)*. London: RCPsych; 2011 Jun. Available from:  
[https://www.rcpsych.ac.uk/docs/default-source/files-for-college-members/occasional-papers/occasional-paper-79.pdf?sfvrsn=82f6cd32\\_2](https://www.rcpsych.ac.uk/docs/default-source/files-for-college-members/occasional-papers/occasional-paper-79.pdf?sfvrsn=82f6cd32_2)
- 33) National Institute for Health and Care Excellence (NICE). *Service user experience in adult mental health services (QS14)*. London: NICE; 2011 Dec. Available from:  
<https://www.nice.org.uk/guidance/qs14/resources/service-user-experience-in-adult-mental-health-services-pdf-2098485311173>
- 34) MIND. *Listening to experience: an independent inquiry into acute and crisis mental healthcare*. London: Mind; 2011. Available from:  
[https://www.mind.org.uk/media-a/4377/listening\\_to\\_experience\\_web.pdf](https://www.mind.org.uk/media-a/4377/listening_to_experience_web.pdf)
- 35) National Institute for Health and Care Excellence (NICE). *Dementia: assessment, management and support for people living with dementia and their carers (NG97)*. London: NICE; 2018 Jun. Available from:  
<https://www.nice.org.uk/guidance/ng97>
- 36) UK Parliament. *Mental Health Units (Use of Force) Act 2018*. London: The Stationery Office; 2018. Available from:  
<https://www.legislation.gov.uk/ukpga/2018/27/enacted>
- 37) Care Quality Commission (CQC). *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18: Staffing*. London: CQC; 2014. Available from:  
<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing#full-regulation>
- 38) Royal College of Psychiatrists. *Quality standards for psychological therapies services. 4th ed*. London: RCPsych; 2019. Available from:  
[https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/psychological-therapy-appts/quality-standards-for-psychological-therapies-services-4th-edition.pdf?sfvrsn=b6f4d954\\_2](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/psychological-therapy-appts/quality-standards-for-psychological-therapies-services-4th-edition.pdf?sfvrsn=b6f4d954_2)

- 39) Royal College of Psychiatrists: *Improving the physical healthcare of adults with mental illness: essential actions (OP100)*. London: RCPsych; 2016 Oct. Available from:  
[https://www.rcpsych.ac.uk/docs/default-source/files-for-college-members/occasional-papers/occasional-paper-100.pdf?sfvrsn=af32d84f\\_2](https://www.rcpsych.ac.uk/docs/default-source/files-for-college-members/occasional-papers/occasional-paper-100.pdf?sfvrsn=af32d84f_2)
- 40) NHS England. *Delivering a 'net zero' National Health Service*. London: NHS England; 2020 Oct. Available from:  
<https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf>
- 41) NHS England South Central Cardiovascular Network. *Lester tool: positive cardiometabolic resource (UK adaptation)*. London: NHS; 2014. Available from:  
<http://commissioningguidance.tvscn.nhs.uk/wp-content/uploads/2016/03/Lester-tool-image.jpg>
- 42) National Institute for Health and Care Excellence (NICE). *Psychosis and schizophrenia in children and young people: recognition and management (CG155)*. London: NICE; 2013 Jan [updated 2016 Oct]. Available from:  
<https://www.nice.org.uk/Guidance/CG155>
- 43) National Institute for Health and Care Excellence (NICE). *Bipolar disorder, psychosis and schizophrenia in children and young people (QS102)*. London: NICE; 2015 Oct. Available from:  
<https://www.nice.org.uk/guidance/qs102>
- 44) Nodin N, Peel E, Tyler A, Rivers I. *The RaRE research report: LGBT mental health – risk and resilience explored*. London: PACE/LSBU; 2015. Available from:  
<http://researchopen.lsbu.ac.uk/2652/>
- 45) Department of Health. *Positive and proactive care: reducing the need for restrictive interventions*. London: DoH; 2014 Apr. Available from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300293/JRA\\_DoH\\_Guidance\\_on\\_RP\\_web\\_accessible.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf)
- 46) Care Quality Commission (CQC). *Statement on CQC's roles and responsibilities for safeguarding children and adults*. London: CQC; 2015 Jun. Available from:  
[https://www.cqc.org.uk/sites/default/files/20150710\\_CQC\\_New\\_Safeguarding\\_Statement.pdf](https://www.cqc.org.uk/sites/default/files/20150710_CQC_New_Safeguarding_Statement.pdf)
- 47) National Institute for Health and Care Excellence (NICE). *Transition between inpatient mental health settings and community or care home settings (NG53)*. London: NICE; 2016 Aug. Available from:  
<https://www.nice.org.uk/guidance/ng53/chapter/Recommendations#hospital-discharge>
- 48) National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). *Annual report 2019*. Manchester: University of Manchester; 2019. Available from:  
[https://www.research.manchester.ac.uk/portal/files/162072409/NCISH\\_2019\\_Report.pdf](https://www.research.manchester.ac.uk/portal/files/162072409/NCISH_2019_Report.pdf)
- 49) UK Parliament. *Mental Capacity Act 2005: code of practice*. London: The Stationery Office; 2007. Available from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/497253/Mental-capacity-act-code-of-practice.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf)
- 50) UK Parliament. *Mental Health Act 1983: code of practice*. London: The Stationery Office; 2015. Available from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/435512/MHA\\_Code\\_of\\_Practice.PDF](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF)
- 51) Carers Trust. *The triangle of care: carers included – a guide to best practice in mental health care in England. 2nd ed*. London: Carers Trust; 2013. Available from:  
<https://carers.org/resources/all-resources/53-the-triangle-of-care-carers-included-a-guide-to-best-practice-in-mental-health-care-in-england>

- 52) Carers UK. *Carers assessment*. London: Carers UK; 2014. Available from:  
<https://www.carersuk.org/help-and-advice/practical-support/getting-care-and-support/carers-assessment>
- 53) National Association of Psychiatric Intensive Care and Low Secure Units (NAPICU). *National minimum standards for psychiatric intensive care in general adult services*. London: NAPICU; 2014. Available from:  
<https://napicu.org.uk/wp-content/uploads/2014/12/NMS-2014-final.pdf>
- 54) GOV.UK. *Equality Act 2010: guidance (Discrimination: your rights)*. London: Cabinet Office; 2010. Available from:  
<https://www.gov.uk/guidance/equality-act-2010-guidance>
- 55) NHS England. *Accessible information: implementation guidance (DCB1605)*. London: NHS England; 2017. Available from:  
<https://www.england.nhs.uk/wp-content/uploads/2017/08/implementation-guidance.pdf>
- 56) Department of Health. *The NHS constitution for England*. London: DoH; 2015 Oct. Available from  
<https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>
- 57) NHS Confederation. *Same-sex accommodation: your privacy, our responsibility*. London: NHS Confederation; 2009. Available from:  
[http://www.nhsconfed.org/~/-/media/Confederation/Files/Publications/Documents/Briefing\\_186\\_FINAL.pdf](http://www.nhsconfed.org/~/-/media/Confederation/Files/Publications/Documents/Briefing_186_FINAL.pdf)
- 58) Department of Health. *Health building note 03-01: adult acute mental health units*. London: DoH; 2013. Available from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/147864/HBN\\_03-01\\_Final.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/147864/HBN_03-01_Final.pdf)
- 59) Department of Health. *Environmental design guide: adult medium secure services*. London: DoH; 2011. Available from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215623/dh\\_126177.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215623/dh_126177.pdf)
- 60) United Nations. *Convention on the rights of persons with disabilities and optional protocol*. New York: United Nations; 2006. Available from:  
<http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>
- 61) Resuscitation Council UK. *Quality standards: mental health inpatient care*. London: RCUK; 2014 May [updated 2020 May]. Available from:  
<https://www.resus.org.uk/library/quality-standards-cpr/mental-health-inpatient-care>
- 62) Department Of Health. *The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals*. London: DoH; 2016 May. Available from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/523049/Hospital\\_Food\\_Panel\\_May\\_2016.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/523049/Hospital_Food_Panel_May_2016.pdf)
- 63) Royal College of Psychiatrists, CCQI. *Enabling environments standards*. London: RCPsych; 2019. Available from:  
[https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/enabling-environments-ee/ee-standards-document-2015.pdf?sfvrsn=abdcca36\\_2](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/enabling-environments-ee/ee-standards-document-2015.pdf?sfvrsn=abdcca36_2)
- 64) Francis R. *Report of the Mid Staffordshire NHS Foundation Trust public inquiry*. London: The Stationery Office; 2013. Available from:  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/279124/0947.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf)

- 65) Care Quality Commission (CQC). *Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition*. London: CQC; 2020. Available from:  
<https://www.cqc.org.uk/publications/themed-work/rssreview>
- 66) NHS England. *Commissioning framework for mental health inpatient services*. London: NHS England; 2024 Aug. Available from:  
<https://www.england.nhs.uk/long-read/commissioning-framework-for-mental-health-inpatient-services/>
- 67) Care Quality Commission (CQC). *How CQC identifies and responds to closed cultures*. London: CQC; 2022 May. Available from:  
<https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures>
- 68) NHS England. *Safe and wellbeing reviews: thematic review and lessons learned*. London: NHS England; 2024 Jun. Available from:  
<https://www.england.nhs.uk/long-read/safe-and-wellbeing-reviews-thematic-review-and-lessons-learned/>
- 69) NHS England. *Personalised care and support planning*. London: NHS England; 2024 Dec [cited 2025 Aug 25]. Available from:  
<https://www.england.nhs.uk/personalisedcare/pcsp/>
- 70) Care Quality Commission (CQC). *Restraint, segregation and seclusion review: progress reports*. London: CQC; 2022 Mar. Available from:  
<https://www.cqc.org.uk/publications/themed-work/restraint-segregation-seclusion-review-progress-reports>
- 71) NHS England. *Patient and carer race equality framework*. London: NHS England; 2024 May. Available from:  
<https://www.england.nhs.uk/publication/patient-and-carer-race-equality-framework/>
- 72) Department of Health and Social Care. *The national strategy for autistic children, young people and adults: 2021 to 2026*. London: DHSC; 2021. Available from:  
<https://www.gov.uk/government/publications/national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026/the-national-strategy-for-autistic-children-young-people-and-adults-2021-to-2026>
- 73) NHS England. *Staying safe from suicide*. London: NHS England; 2025 Apr. Available from:  
<https://www.england.nhs.uk/long-read/staying-safe-from-suicide/>
- 74) National Confidential Enquiry into Patient Outcome and Death (NCEPOD). *Physical healthcare in mental health inpatient settings*. London: NCEPOD; 2022 May. Available from:  
<https://www.ncepod.org.uk/2022pnhm.html>
- 75) Royal College of Psychiatrists. *Supporting staff following a patient-perpetrated homicide (PPH): a prevention and postvention framework (CR239)*. London: RCPsych; 2024 Jun. Available from:  
[https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2024-college-reports/supporting-staff-following-a-patient-perpetrated-homicide-\(pph\)-\(cr239\)](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2024-college-reports/supporting-staff-following-a-patient-perpetrated-homicide-(pph)-(cr239))
- 76) Royal College of Psychiatrists. *Outcome measures in psychiatry (CR240)*. London: RCPsych; 2024 Jun. Available from:  
[https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2024-college-reports/outcome-measures-in-psychiatry-\(cr240\)](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2024-college-reports/outcome-measures-in-psychiatry-(cr240))
- 77) Royal College of Psychiatrists. *Co-occurring substance use and mental health disorders (CoSUM) (CR243)*. London: RCPsych; 2025 May. Available from:  
[https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2025-college-reports/co-occurring-substance-use-and-mental-health-disorders-\(cosum\)-\(cr243\)](https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2025-college-reports/co-occurring-substance-use-and-mental-health-disorders-(cosum)-(cr243))

- 78) Royal College of Psychiatrists. *Supporting mental health staff following the death of a patient by suicide: a prevention and postvention framework (CR234)*. London: RCPsych; 2022 Dec. Available from:  
<https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr234>
- 79) Wilson C, et al. Developing the allied health professionals workforce within mental health, learning disability and autism inpatient services: rapid review of learning from quality and safety incidents. *BMJ Open Qual*. 2024;13(1):e002345. Available from:  
<https://pubmed.ncbi.nlm.nih.gov/39740987/>
- 80) Royal College of Psychiatrists. *Delivering greener, more sustainable and net zero mental health care: guidance and recommendations*. London: RCPsych; 2024. Available from:  
[https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/net-zero-mhc/delivering-greener--more-sustainable-and-net-zero-mental-health-care---guidance-and-recommendations.pdf?sfvrsn=c119e9d4\\_6](https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/net-zero-mhc/delivering-greener--more-sustainable-and-net-zero-mental-health-care---guidance-and-recommendations.pdf?sfvrsn=c119e9d4_6)
- 81) NHS England. *The NHS patient safety strategy*. London: NHS England; 2019. Available from:  
<https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/>

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