QNLD
QUALITY NETWORK FOR COMMUNITY LEARNING DISABILITY SERVICES
CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Standards for Adult Community Learning Disability Services

First edition

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Contents

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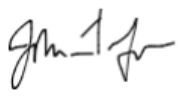
Foreword

People with learning disability who come into contact with specialist learning disability services often have a complex mix of learning disability, other developmental disorders, mental illnesses, personality disorders, substance misuse, and physical disorders including epilepsy. Over the last 5 decades government policy and the process of the deinstitutionalisation resulted in the closure of long stay hospitals and the development of a range of community services. Over the years community services have evolved in different ways in different regions due to variation in commissioning intents. A survey conducted in 2015 by the faculty of intellectual disability at the Royal College of Psychiatrists showed that there is geographical variation in the integration of health and social services, variation in the types of interventions provided and differences in professional composition within teams. This therefore leads to difficulties for services to benchmark themselves against other services. There is therefore a necessity to define and standardise some elements of specialist community learning disability services.

The quality network for learning disabilities has been running a successful scheme for inpatient services for people with learning disability for some years now. The standards for community learning disability teams is a much welcome development. This has been developed with relevant stakeholders including professionals and experts by experience. Providers should aspire to meet these standards and Commissioners and Regulators should use this as a benchmark of quality of services.



Dr John Devapriam

Chair, QNLD Advisory Group and Accreditation Committee

Introduction

Quality Network for Learning Disability Services (QNLD) has a long history of working with inpatient learning disability services and these standards have been developed for the purposes of the review of community learning disability services. They can also be used as a guide for new or developing services.

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation via our standards development group and email forums with professional groups involved in the provision of community learning disability services. They incorporate the College Centre for Quality Improvement (CCQI) Core Community Standards, as well as specialist standards relating specifically to community learning disability teams.

The standards cover the follow topics:

- Access and assessment
- Care planning and treatment
- Working with other services and discharge
- Service user and carer experience
- Environment and facilities
- Governance

Who are these standards for?

These standards are designed to be applicable to community learning disability services for working age adults and can be used by professionals to assess the quality of the team. The standards may also be of interest to commissioners, service users, carers, researchers and policy makers.

Since community learning disability services differ widely in their configuration and the models used, these standards focus on the function of a team in order to make them as widely accessible as possible.

Categorisation of standards

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

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

Notation

C	Standard is included in the College's Core Community Standard set
S	Standard is a specialist standard relating to community learning disabilities services and not included in the College's Core Community Standards set

Terms used in this document

In this document, the community learning disabilities service is referred to as *'the team'* or *'the service'*. People who have assessed by community learning disability services are referred to as *'service users'* and their loved ones are referred to as *'carers'*.

References

Please see the list at the end of this document for full references. These are referred to by the number in square brackets in the 'ref.' column throughout the document.

The standards are also available to download on our website www.rcpsych.ac.uk/QNLD

Standards for Adult Community Learning Disability Services

1. Access & assessment

No.	Type	Standard	Ref.
Access, referral and waiting times			
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]
2	1	The service provides information about how to make a referral and waiting times for assessment and treatment. *Guidance: This may be included in a service's welcome pack. The information is co-produced with service users and complies with accessible information standards.*	[1]
3	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 *Guidance: The community team then contacts the service user within the appropriate timeframe.*	[1] [2]
4	1	A clinical member of staff is available to discuss emergency referrals during working hours.	[1]
5	1	Outcomes of referrals are fed back to the service user, referrer and carer (with the service user's consent) in an accessible format. If a referral is not accepted, the team advises the referrer, service user and carer on alternative options.	[22]
6	1	The team assess service users, who are referred to the service, within a locally agreed timeframe.	[1]
7	3	Everyone can access the service using public transport or transport provided by the service.	[1]
Preparing for the assessment			
8	1	For non-emergency assessments, the team makes written communication in advance to service users 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. information on access to an interpreter or how to change the appointment time).	[1]

9	1	Service users are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: • Their rights and consent to treatment; • Their rights under the Mental Health Act (where applicable); • 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.	[1] [2]
10	1	Service users are provided with information and choice about their assessment and appointment. *Guidance: This includes choice in time of day, venue, gender of staff or access in another language. Ideally assessments for challenging behaviour should be performed in a setting in which the service user spends the majority of their time (i.e. day centre/home). All information should comply with accessible information standards.*	[20] [8]
Initial assessment			
11	1	Service users feel welcomed by staff members when attending the team base for their appointments. *Guidance: Staff members introduce themselves to service users and address them using the name and title they prefer.*	[1] [20]
12	1	Service users have a comprehensive evidence-based assessment which includes their: • Mental health; • Medication; • Psychosocial and psychological needs; • Strengths and areas for development; • Risk. *Guidance: Team assess service users as per NICE guidelines for mental health in learning disability.*	[1] [2] [4]
13	1	The assessment should be flexible and on-going and may require multiple appointments and collateral information gathering where appropriate.	[4]
14	1	A physical health review takes place as part of the initial assessment, or as soon as possible (where applicable).	[1] [2]
15	1	When challenging behaviour is part of the presentation, a functional behavioural assessment should be included in the initial assessment. This should identify possible triggers, emotional factors and functions of their behaviour in order to develop a shared understanding of the function of behaviour that challenges.	[4] [5]

16	3	For adults with Down's syndrome, the team can refer them to have a baseline assessment of cognitive functioning and adaptive behaviour at age 30.	[9]
17	1	Service users 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.	[1]
18	1	All service users have a documented diagnosis and/or clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	[1] [2]
19	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.	[1]
20	1	Confidentiality and its limits are explained to the service user and carer, both verbally and in writing. Service user preferences for sharing information with 3rd parties are respected and reviewed regularly.	[1]
21	1	Service users are asked if they and their carers wish to have copies of correspondence about their health and treatment.	[1]
Capacity and consent			
22	1	Assessments of service users' capacity to consent to care and treatment are performed in accordance with current legislation.	[1]
23	1	There are systems in place to ensure that the service takes account of any advance directives or statements that the service user has made. *Guidance: These are accessible and staff members know where to find them.*	[16]
Following up service users who do not attend appointments			
24	1	The team follows up service users who have not attended an appointment/assessment. If service users are unable to be engaged, a decision is made by the assessor/team, based on service user need and risk, as to how long to continue to follow up the service user.	[1]

25	1	If a service user does not attend an assessment/appointment, the assessor contacts the referrer. *Guidance: If the service user is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.*	[1]

2. Care Planning and Treatment

No.	Type	Standard	Ref.
Reviews and care planning			
26	1	Service users should know who is co-ordinating their care and how to contact them if they have any questions. Service users who present with challenging behaviour or have a primary mental illness should have an allocated key-worker/care coordinator.	[1] [3] [4]
27	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.*	[1]
28	1	Every service user has an accessible and written care plan, reflecting their individual needs. Staff members actively seek to collaborate with service users and their carers (with service user consent) when developing the care plan and they are offered a copy. *Guidance: The care plan outlines:* • *Agreed intervention strategies for physical and mental health;* • *Strategies for self-management;* • *Behaviour support plans;* • *Any advance directives or statements that the service user has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework*.	[1] [20] [3]
29	2	Staff members review service users' progress against user-defined goals in collaboration with the service user at the start of treatment, during clinical review meetings and at discharge.	[1]
30	1	The team knows how to respond to carers when the service user does not consent to their involvement.	[1]

Treatment – therapies and activities			
31	1	Service users begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within an agreed timeframe. Any exceptions are documented in the case notes.	[1] [4]
32	2	Support and interventions should be person-centred and in the case of challenging behaviour, this should be a place where the service user regularly spends time.	[3] [5]
33	1	When providing support or interventions, the level of learning disability, developmental stage, communication difficulties and physical co-morbidities are taken into account. *Guidance: This may require adaptations i.e. longer/additional sessions to pace treatment to the needs of the service user. Teams should consider using tools adapted for people with learning disability or take into account level of learning disability if using non-adapted tools.*	[3] [4]
34	1	There is dedicated sessional time from psychologists to: • Provide assessment and formulation of service users' psychological needs; • Ensure the safe and effective provision of evidence based psychological interventions adapted to service users' needs through a defined pathway.	[1]
35	2	There is dedicated sessional time from psychologists to support a whole team approach for psychological management.	[1]
36	1	There is dedicated sessional input from occupational therapists to: • Provide an occupational assessment for those service users who require it; • Ensure the safe and effective provision of evidence based occupational interventions adapted to service users' needs.	[1]
37	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	[1]
38	3	There is dedicated sessional input from creative therapists.	[1]
39	2	The team signposts service users to structured activities such as work and education. *Guidance: For service users who wish to find or return to work, this could include supporting them to access prevocational training or employment programmes. This is managed through the care plan.*	[1]

40	1	Service users (and carers, with service user consent) are offered accessible written and verbal information about the service user's mental illness, behaviour that challenges 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 and a copy of their care plan.*	[1] [2]
41	1	The team supports service users to undertake activities to support them to build their social and community networks.	[1]
42	1	The team is proactive in recognising the needs of families and carers. *Guidance: The team utilise the Triangle of Care audit tool for self assessment. This may include information about communication needs, sign-posting to relevant support networks, or formal sessions/workshops with families and carers to develop their skills in managing mental illness or behaviours that challenge.*	[13] [3]
Treatment – medication			
43	1	When medication is prescribed, specific treatment goals are set with the service user, the risks (including interactions) and benefits are reviewed, a timescale for response is set and service user consent is recorded.	[1] [4]
44	1	When medication for challenging behaviour is prescribed, a specific rationale should be recorded, and reviews planned as per national guidance. This is prescribed alongside psychosocial interventions.	[4] [5]
45	1	Service users 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.*	[1] [5]
46	1	The safe use of high risk medication is audited at a service level, at least annually. *Guidance: This includes medications such as Lithium, high dose antipsychotic drugs, antipsychotics in combination and benzodiazepines.*	[22]
47	3	Service users, carers and prescribers are able to contact a specialist pharmacist and/or pharmacy technician to discuss medications.	[1] [4]

48	1	For service users who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	[1] [5]
Treatment – physical healthcare			
49	1	Staff members arrange for service users to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the service user's care plan.	[1]
50	2	Community learning disability team provide support to primary and secondary care teams in capacity and best interest decisions for physical health interventions.	[16]
51	2	Community learning disability teams have a pathway for comorbid epilepsy. *Guidance: Clinicians should be able to demonstrate that they have this expertise or are able to access the expertise required.*	[19]
52	1	Service users are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the service users' care plan.	[1]
53	1	The team including bank and agency staff are able to identify and manage an acute physical health emergency.	[1]
54	1	Service users who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at 6 weeks, at 3 months and then annually (or every six months for young people) unless a physical health abnormality arises.	[1] [4]
Risk & safeguarding			
55	1	The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	[1] [14]

3. Working with other services and discharge

No.	Type	Standard	Ref.
Discharge planning and transfer of care			
56	1	When a service user is admitted to a psychiatric hospital, a community team representative is actively involved to support the inpatient team to make adjustments for the service user with learning disability, and participates in discharge planning.	[3]
57	1	The community team makes sure that service users who are discharged from hospital are followed up within 3 days.	[1]
58	2	A discharge letter is sent to the service user 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 service user as appropriate.	[1]
59	2	Teams provide specific transition support to service users when their care is being transferred to another community team, or back to the care of their GP.	[1]
60	1	When service users are transferred between community services there is handover which ensures that the new team have an up to date care plan and assessment.	[1]
61	1	There is active collaboration between Children and Young People's Services and Adult Services for service users who are approaching the age for transfer between services. This starts at least 6 months before the date of transfer.	[1] [4]
62	1	The team follows a protocol to manage service users who discharge themselves against medical advice. This includes: • Recording the service user's capacity to understand the risks of self-discharge; • Contacting relevant agencies to notify them of the discharge.	[22]
Interface with other services			
63	1	Service users can access help from mental health services, 24 hours a day, 7 days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams.*	[1]

64	2	The team works with service users, carers, commissioners and LA colleagues to enable treatment in the community in people's homes where possible.	[3] [2]
65	1	The team supports service users to access: • Housing support; • Support with finances, benefits and debt management; • Social services.	[1]
66	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.	[1]
67	1	The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team, in services that have access to one. *Guidance: This includes joint care reviews and jointly organising admissions to hospital for service users in crisis.*	[20] [4]
68	1	The team follows a joint working protocol/care pathway with primary health care teams. *Guidance: This includes the team informing the service user's GP of any significant changes to the service user's mental health and medication, or of their referral to other teams. It also includes teams following shared prescribing protocols with the GP.*	[4] [7]
69	3	Health records, including communication passports and hospital passports, should be available/accessible by other services with protocols of sharing information.	[3]
70	2	The team follows a joint working protocol/care pathway with health/social/support & education services.	[3]
71	1	The service has a policy for the care of service users with dual diagnosis of mental health and alcohol and substance misuse that includes: • Liaison and shared protocols between services to enable joint working • Drug/alcohol screening to support decisions about care/treatment options; • Liaison between statutory and voluntary agencies; • Staff training; • Access to evidence-based treatments.	[15]
72	1	The team follows an agreed protocol with police, which ensures effective liaison on incidents of criminal activity/harassment/violence.	[6]

73	1	The service has specialist knowledge to ensure appropriate support and treatment is provided for people with learning disabilities suffering from dementia, or works alongside specialist mental health services to provide this.	[9]

4. Service user and carer experience

No.	Type	Standard	Ref.
Treating service users with compassion, dignity and respect			
74	1	Staff members treat service users and carers with compassion, dignity and respect.	[1] [20]
75	1	Service users feel listened to and understood by staff members.	[1]
76	1	When talking to service users and carers, health professionals communicate clearly, avoiding the use of jargon.	[8] [10]
77	1	The service can demonstrate that it promotes culturally and spiritually sensitive practice.	[7]
78	1	Staff members are knowledgeable about, and sensitive to, the mental health need of service users from minority or hard-to-reach groups. This may include: • Black, Asian and minority ethnic groups; • Asylum seekers or refugees; • Lesbian, gay, bisexual or transgender people; • Travellers.	[7] [22]
79	1	Information for service users and carers is written simply and clearly and 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. *Guidance: Give consideration to the Royal College of Speech & Language Therapists 'Five good communication standards'.*	[4] [8] [10]
80	2	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The service user's relatives are not used in this role unless there are exceptional circumstances.	[1]
Service user involvement			

81	1	The service asks service users and carers for their feedback about their experiences of using the service and this is used to improve the service.	[1]
82	2	Services are developed in partnership with appropriately experienced service users and carers and have an active role in decision making.	[1]
83	1	Service users are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	[1]
Carer engagement and support			
84	1	Carers (with service user consent) are involved in discussions and decisions about the service user's care, treatment and discharge planning.	[1]
85	1	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This advice is offered at the time of the service users initial assessment, or at the first opportunity.*	[1]
86	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	[1]
87	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*.	[1]
88	3	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.	[1]

5. Environment and facilities

No.	Type	Standard	Ref.
Service environment			
89	2	The environment is clean comfortable and welcoming.	[1]

90	1	Clinical rooms are private, and conversations cannot be overheard.	[1]
91	2	Clinical rooms are set up to be communication sensitive environments. *Guidance: Give consideration to the Royal College of Speech & Language Therapists 'Five good communication standards'.*	[10]
92	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.*	[1]
93	1	Staff members follow a lone working policy and feel safe when conducting home visits.	[1]
94	1	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for service users, carers and staff members.	[1]
95	2	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information e.g. information about services, conditions and treatment, service user records, clinical outcome and service performance measurements.	[12]
96	1	A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least 6 monthly.	[22]
97	1	An audit of the environmental risk is conducted annually and a risk management strategy is agreed.	[12]
98	1	Emergency resuscitation equipment, as required by Trust/Organisation guidelines, is available within three minutes and is maintained and checked weekly, and after each use.	[22]

6. Staffing and training

No.	Type	Standard	Ref.
Staffing levels			
The multi-disciplinary team consists of staff from a number of different professional backgrounds that enables them to deliver a full range of treatments/therapies appropriate to the service user population. The team includes:			
99	1	Consultant Psychiatrist(s)	[2] [3]

100	1	Registered Learning Disability Nurse(s)	[2] [3]
101	1	Occupational Therapist(s)	[2] [3]
102	1	Psychologist(s)	[2] [3]
103	1	Speech & Language Therapist(s)	[2] [3]
104	1	Healthcare Assistant(s)	[2] [3]
105	2	Service Lead	[2] [3]
106	2	Social Worker(s)	[2] [3]
107	2	Physiotherapist(s)	[2] [3]
108	2	Behavioural Support Specialist(s)	[2] [3]
109	3	Art Therapist(s)	[2] [3]
110	3	Pharmacist(s)	[2] [3]
111	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	[1]
112	1	When a staff member is on leave, the team puts a plan in place to provide adequate cover for the service users who are allocated to that staff member.	[1]
113	1	There is an identified senior clinician available at all times who is available on the phone or at the team base within an hour. *Guidance: Some services may have an agreement with a local GP to provide this medical cover.*	[1] [2]
Staff recruitment, induction and supervision			
114	2	Appropriately experienced service user or carer representatives are involved in the interview process for recruiting staff members.	[1]

115	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.*	[1]
116	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.*	[1]
117	2	All staff members receive line management supervision at least monthly.	[1]
118	3	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet to think about team dynamics and develop their clinical practice.	[1]
119	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.	[1]
120	2	Team managers and senior managers promote positive risk taking to encourage service user recovery.	[22]
Staff wellbeing			
121	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.*	[1]
122	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: They have the right to one uninterrupted 20 minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	[1]
123	1	Staff members, service users and carers who are affected by a serious incident are offered post incident support.	[1]
Staff training			
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:			

124	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent); Physical health assessment; *Guidance: This includes training in understanding physical health problems, understanding physical observations and when to refer the service user for specialist input.* Safeguarding vulnerable adults and children; *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.* 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.* Recognising and communicating with service users with cognitive impairment or learning disabilities; Statutory and mandatory training. *Guidance: Includes equality and diversity, information governance, basic life support.*	[1] [3]
125	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	[1]
126	2	Experts by experience are involved in delivering and developing staff training face-to-face.	[1]
127	3	Staff training and support of local services should be a core role of specialist health professionals to promote better understanding on learning disability in the wider workforce.	[3]

7. Governance

No.	Type	Standard	Ref.
128	1	Clinical outcome measurement data, including progress against user defined goals, is collected as a minimum at assessment, after 6 months, 12 months and then annually until discharge. Staff can access this data.	[1] [7]

129	2	The service's clinical outcome data are reviewed at least every six months. The data is shared with commissioners, the team, service users and carers, and used to make improvements to the service.	[1] [7]
130	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	[1]
131	1	When mistakes are made in care this is discussed with the service users themselves and their carer, in line with the Duty of Candour agreement.	[1]
132	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.	[1]
133	2	The service contributes data to the national learning disability mortality review body.	[11]
134	1	All service user information is kept in accordance with current legislation. *Guidance: This includes transfer of service user identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices and using swipe cards and having password protected computer access.*	[1]
135	2	The team use quality improvement methods to implement service improvements.	[1]
136	2	The team actively encourage service users and carers to be involved in QI initiatives.	[1]

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[7] Joint Commissioning Panel for Mental Health, Guidance for commissioners of mental health services for people with learning disabilities, May 2013.

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