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ROYAL COLLEGE OF PSYCHIATRISTS

PICU
QUALITY NETWORK FOR PSYCHIATRIC INTENSIVE CARE UNITS

QNPICU

5th National Report

September 2023 - July 2025

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Artwork displayed on the front cover: *Existence*, HM Prison & Young Offender Institution East Sutton Park, Commended Award for Watercolour and Gouache, 2024. Image courtesy of Koestler Arts.

FOREWORD

Psychiatric Intensive Care Units (PICUs) play an essential role in delivering specialised care for individuals experiencing the most acute phases of mental illness. As the acuity and complexity of inpatient presentations continue to increase, the importance of PICUs within the mental health system has never been greater. I am pleased to introduce this national report, which provides an overview of current practice across PICU services in the United Kingdom and reflects the shared commitment of staff, patients, carers and partner organisations to delivering compassionate and evidence-based care.

This is the fifth national report published by the Quality Network for Psychiatric Intensive Care Units (QNPICU), and uses the data collected from member services who completed their peer review against the Standards for QNPICU in Cycles 5 and 6 and accreditation reviews held between September 2023 and July 2025. The data have been drawn from services' peer review findings and cross-comparisons have also been conducted with previous years' data from 2020-2023.

During the 2023–2025 cycle, services have demonstrated notable strengths. Wards report strong team cohesion, good access to reflective practice and robust supervision. Patients and carers consistently highlight compassionate and respectful interactions, and most patients know how to contact key staff.

Compared with previous cycles, improvements are evident in discharge planning, safeguarding, access to clinical reviews and carer involvement. Staff also report feeling supported by managers and confident in raising concerns, features associated with safe and resilient clinical teams.

The peer reviews also identify areas requiring further development. Co-production remains a significant challenge, with limited involvement of patients and carers in training, recruitment and service development. Patients continue to raise concerns about personalised and weekend activity provision. Carer engagement requires strengthening, particularly regarding carers' assessments, accessible written information and support networks. Staff describe pressures related to safe staffing, reliance on unfamiliar agency staff, difficulty accessing breaks and variability in line management supervision. These themes highlight the operational pressures facing PICUs and the continuing need to embed quality standards more fully into everyday practice.

The QNPICU standards, which have been co-produced with clinicians, patients and carers, remain central to driving improvement. They continue to enable services to benchmark performance, identify strengths, address unmet standards and plan for accreditation. No service is expected to meet every standard at the point of review; instead, the standards provide a progressive roadmap for

sustained development. Improving levels of compliance over the years reflect the dedication of PICU teams to strengthening evidence-based practice and the therapeutic environment.

I would like to acknowledge the dedication of PICU staff across the country, whose commitment to therapeutic engagement and high-quality care makes a profound difference to patients and families. I am equally grateful to the patients and carers whose lived experience continues to shape and strengthen PICU practice. Finally, I extend my sincere thanks to the QNPICU team for their exceptional work in coordinating this report and leading the complex programme of national peer reviews and accreditation assessments.

I hope this report will help reinforce our shared responsibility to strengthen PICU services and set a clear direction for continued improvement across the country.

Dr Mehtab Ghazi Rahman
Consultant Psychiatrist & Chair of the QNPICU Accreditation Committee

Psychiatric intensive care units (PICUs) play a critical role in the mental health care system by providing short term, highly specialised treatment for individuals experiencing severe mental health crisis. These are patients who are too unwell or unsafe to be managed on general psychiatric wards due to risk of violence, aggression or acute psychosis. Due to the short nature of patient stay, averaging about 6 to 10 weeks, getting the care and treatment right first time matters.

As a QNPICU Accreditation Committee member and a carer representative, I am delighted to pen this foreword for the QNPICU National Report covering the peer reviews carried out between 2023 and 2025. This National aggregate report provides a comprehensive overview of psychiatric intensive care units' performance in meeting the QNPICU standards.

The report collates and analyses data from 44 participating PICU services to benchmark performance, identifies trends and share examples of good practice. The report also highlights areas requiring improvements to support ongoing service development, quality enhancements and adherence to best practice in psychiatric intensive care.

The College's PICU standards, updated in March 2025, has 140 revised standards following extensive consultation and covers the whole range of PICU operations. It provides a robust framework for all PICUs to develop their services and make continuous improvement in the care and treatment they provide to their

patients. The National report covers PICU services who took part in developmental and accreditation reviews. The data was collated via self-reviews followed by multi-disciplinary peer review teams which included patients and carer representatives.

I would like to express my appreciation to the QNPICU review teams including the patient and carer representatives for their exceptional hard work and dedication throughout the numerous reviews undertaken and also for distilling the findings of those reviews for this National report. I also acknowledge the co-operation and thoroughness of the host PICU services in conducting the initial self-review by involving patients and their families.

The National report captures data from all the of services reviewed, highlighting aggregate standards that are met or not, showcasing areas of good practice which can be replicated by other services and of course highlighting areas needing improvement with recommendations.

Looking forward this National report provides an excellent overview of the state of psychiatric intensive care but data alone does not drive progress – collaboration does. I hope this National report acts as a helpful resource for benchmarking between PICU services in supporting quality assurance and improvements.

Dino Patel
QNPICU Accreditation Committee Member & Carer Representative

ACKNOWLEDGEMENTS

The QNPICU team are grateful for the continued support received from both governance groups, the Accreditation Committee and the Advisory Group. Thank you also to our valued lived experience representatives (both current and previous) for all of their perspectives and involvement on the programme from its inception to date.

Also, thank you to the services who are members of QNPICU and included in this report, we hope that this provides a useful benchmarking report and to highlight good practice examples. We would also like to thank previous members of the QNPICU team and other CCQI colleagues for support with the development of this report, including Hannah Lucas-Motley and Syeda Tazrin.

INTRODUCTION

WHO WE ARE

Initially launched as AIMS – PICU in 2009, the Quality Network for Psychiatric Intensive Care Units (QNPICU) was established in 2017. It is one of over 30 quality improvement initiatives, research and audit projects within the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). Member services are reviewed against specialist standards for psychiatric intensive care units.

WHAT WE DO

We adopt a supportive, multi-disciplinary approach to quality improvement in psychiatric intensive care units. We serve to identify areas for improvement through a culture of openness and enquiry, adopting a model of engagement rather than inspection.

QNPICU facilitates quality improvement through a comprehensive peer review process, celebrating and sharing good practice as identified by staff, patients and carers.

For more information on the network and our processes, please visit our QNPICU website.

AIMS OF THIS REPORT

This national report serves several key aims:

- **Explore trends**: By presenting aggregated data, this report seeks to identify patterns across member wards, shedding light on compliance rates with QNPICU standards, and highlighting both strengths and areas for improvement within the wards.
- **Encourage continuous improvement**: Through detailed analysis, the report aims to promote continuous quality improvement in psychiatric intensive care units by identifying good practice, providing feedback, and offering guidance to wards engaged in or considering the accreditation process.
- **Support best practices**: The report not only benchmarks performance but also offers practical recommendations and showcases quality initiatives to help wards on their journey towards providing higher standards of care.
- **Facilitate peer learning**: By sharing the experiences of QNPICU services, the report aims to foster collaboration where member wards can learn from each other's successes and challenges.

JARGON BUSTER

QUALITY IMPROVEMENT: 'Quality improvement' throughout this report will refer to the process of working with and supporting psychiatric intensive care units to become effective, safe and patient-centred. We use our quality standards to assess performance and make realistic and achievable recommendations for service improvement.

NETWORK STANDARDS

QNPICU assess psychiatric intensive care teams in accordance with a set of standards. The standards have been developed with extensive consultation with multidisciplinary professionals involved in the provision of psychiatric intensive care services, and with experts by experience who have used services in the past.

The standards are used to generate a series of data collection tools for use in the self- and peer-review processes. Participating teams rate themselves against the standards during their self-review. Standards are for service providers and commissioners to help them ensure they provide high quality patient-centred care to people with enduring mental illness and their carers.

STANDARD TYPES

QNPICU standards are divided into three types:

Type 1 Standards: Essential criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment.

Type 2 Standards: Criteria that a ward would be expected to meet.

Type 3 Standards: Criteria that are desirable for a ward to meet, or criteria that are not the direct responsibility of the service.

STANDARD DOMAINS

QNPICU standards are grouped into 13 domains:

1) Admission and Assessment
2) Care Planning and Treatment
3) Physical Healthcare
4) Referral, Discharge and Transfer
5) Safeguarding
6) Medication Management
7) Patient Experience
8) Carer Engagement and Support
9) Environment and Facilities
10) Workforce
11) Workforce Training and Support
12) Reducing Restrictive Practices
13) Governance

To achieve every standard is aspirational, and it is not expected that a service would meet every standard on the day of their peer-review visit.

MEMBERSHIP

DEVELOPMENTAL

In Cycle 5, 17 peer-reviews took place.

In Cycle 6, 19 peer-reviews took place.

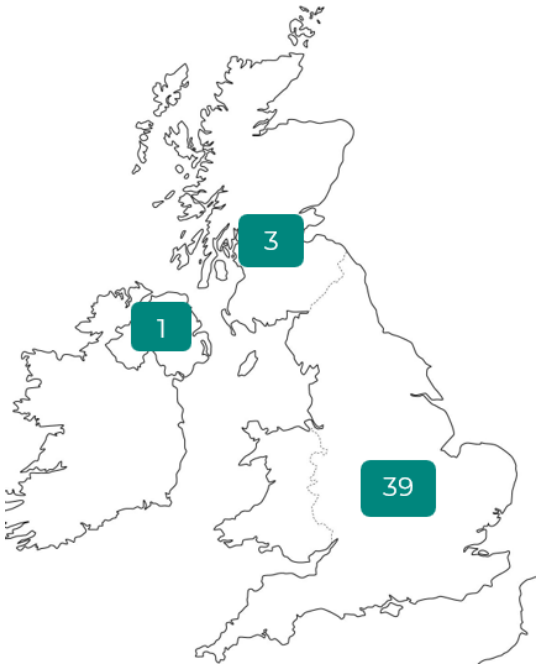
ACCREDITATION

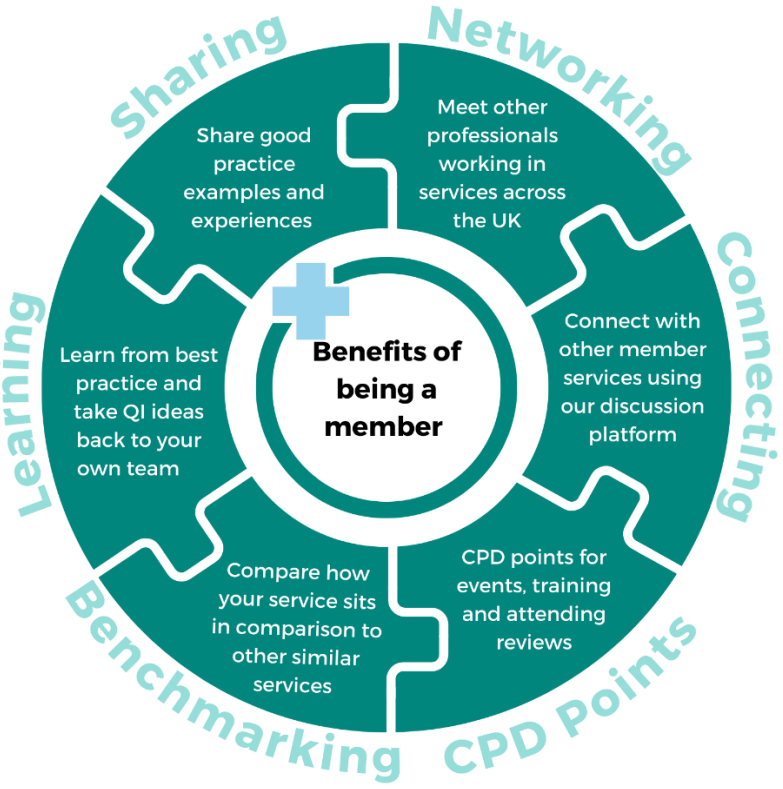
Between September 2023 and July 2025, 19 accreditation reviews took place.

BENEFITS

All services signed up to QNPICU will have access to a range of membership benefits.

These are summarised below.





DATA COLLECTION

179
Carers completed questionnaires

255
Patients completed questionnaires

1,140
Staff completed questionnaires

44
Wards

27
Trusts and organisations

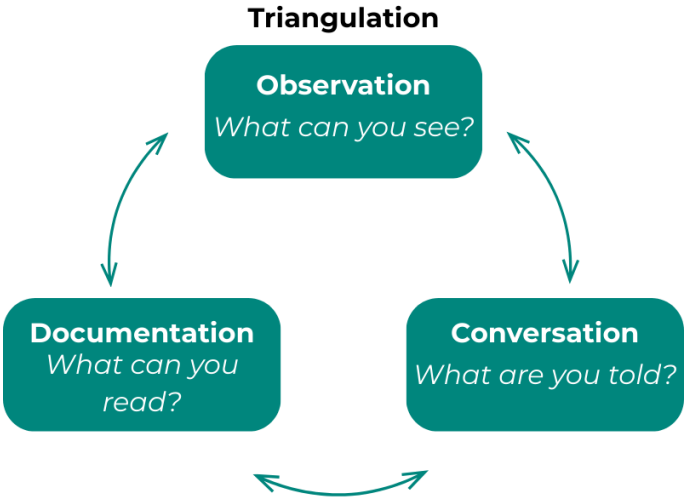
Contextual data was obtained from the information completed by services at the beginning of their self-review period.

How is a standard scored 'Met'?

We base the decision to score a standard as 'Met' on both the self-review findings and the evidence gathered during the peer-review day.

We collect evidence in three primary ways: through observation, conversation (including surveys) and documentation review (accreditation reviews only). If most of this information shows that the ward is meeting the standard's requirements, we mark it as 'Met'.

This approach, known as data triangulation, helps us balance any weaknesses in one set of data with the strengths of others, resulting in more dependable and credible results.



CONTEXTUAL DATA

This section will compare contextual data from services included in the previous national report (QNPICU Aggregated Report 2020-2023) and services reviewed in 2023-2025. There is no overlap of data in 2023.

2020-2023	2023-2025
55 Average length of stay ranging from 22 to 102 days	**49** Average length of stay ranging from 25 to 142 days
11 Average number of beds ranging from 7 to 15	**10** Average number of beds ranging from 6 to 15

STAFFING BREAKDOWN

Profession	Whole Time Equivalent (2020-2023)		Whole Time Equivalent (2023-2025)
Registered Nursing	10.40		11.82
Healthcare Assistants	14.95		17.49
Psychiatrists	1.17		1.27
Psychologists	0.71		0.73
Occupational Therapists (OT)	0.82		0.85
OT Assistant/Assistant Psychologist/ Student Nurse	2.01		2.20
Pharmacist/ Pharmacy Technician	1.09		0.93
Administrative Staff	1.17		1.13
Other Clinical (e.g. physiotherapist)	0.73		0.58
Other Non-Clinical (e.g. Social Worker, Chaplain)	0.86		0.70

STANDARDS COMPLIANCE

All services were assessed on their compliance with the third edition of the QNPICU standards (2023). Accreditation review data has not been included here as member services must meet approximately 90% of standards to be accredited.

On average, Cycle 5 members fully complied with 60% of QNPICU standards, as indicated by the final bar marked 'TNS' (total national sample) in Figure 1.

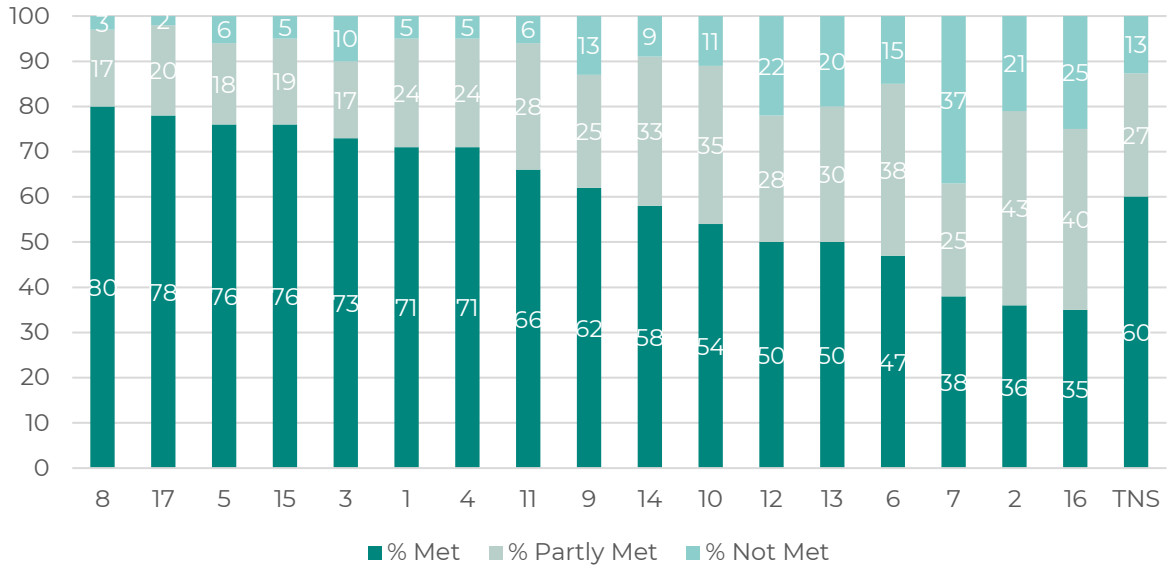


Figure 1: Percentage of Met, Partly Met and Not Met criteria by Cycle 5 service

On average, Cycle 6 members fully complied with 67% of QNPICU standards, as indicated by the final bar marked 'TNS' (total national sample) in Figure 2.

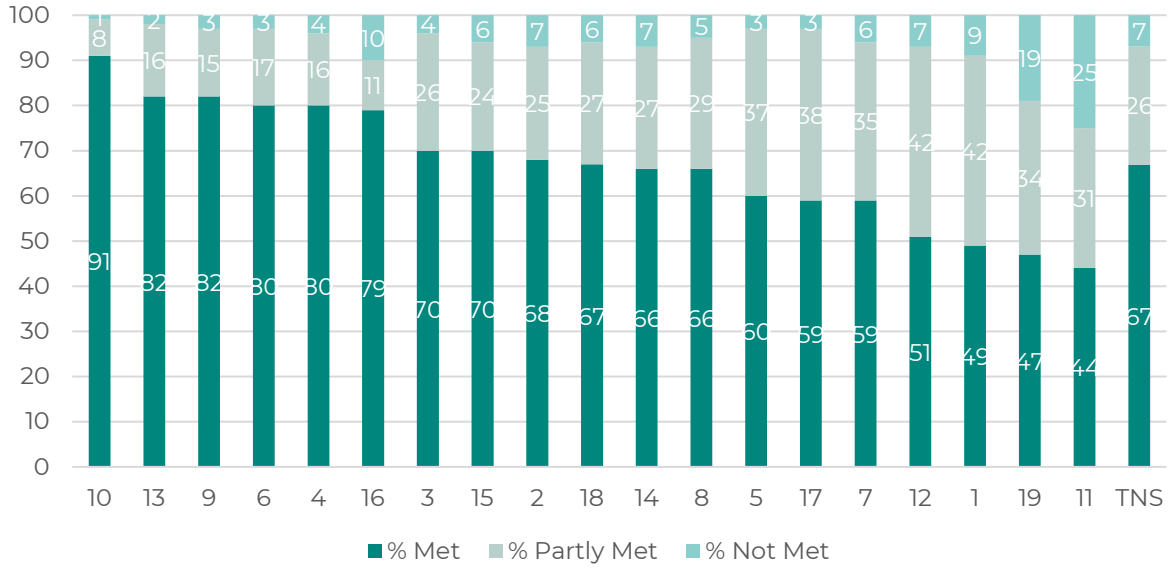
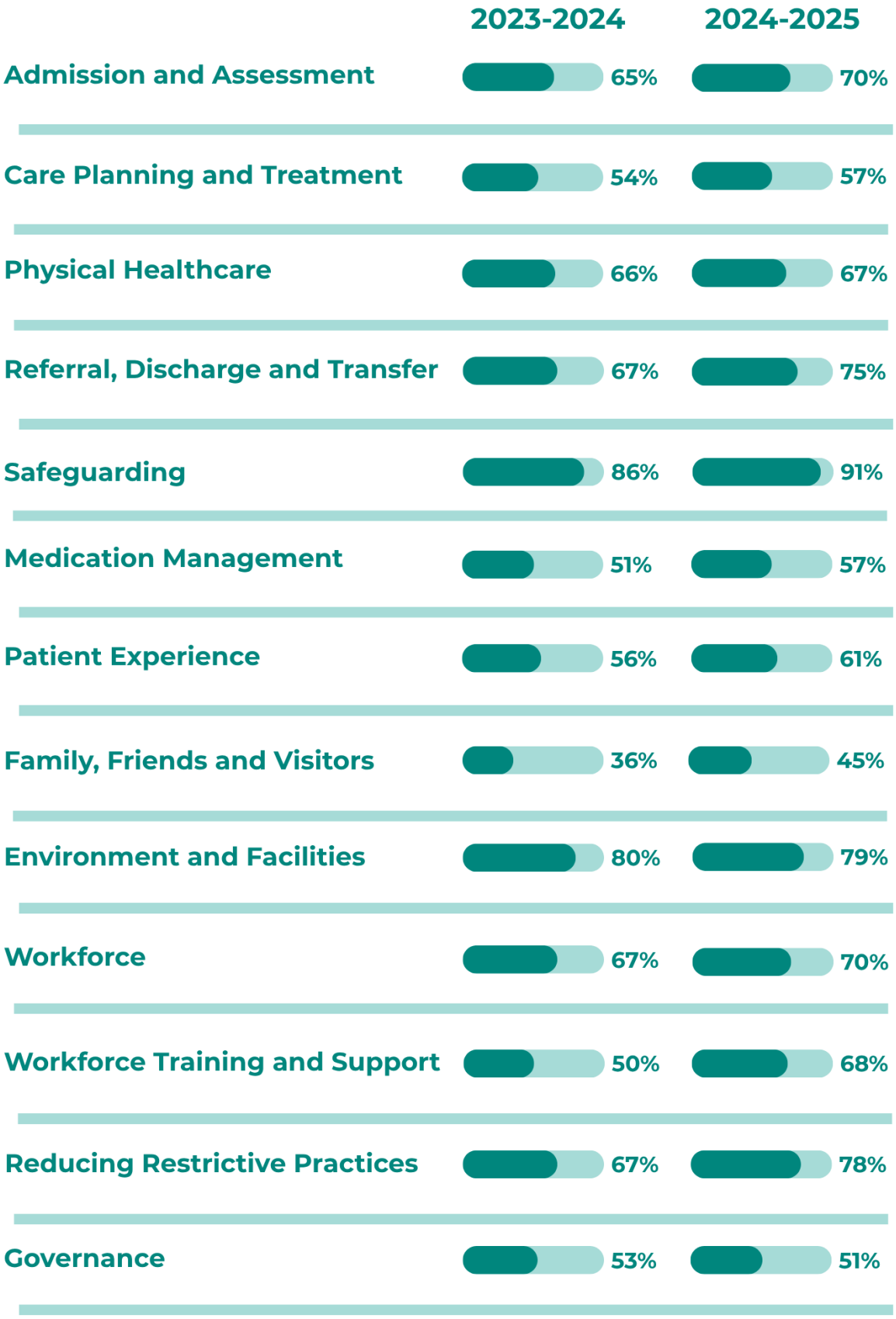


Figure 2: Percentage of Met, Partly Met and Not Met criteria by Cycle 6 service

Below is the average percentage of fully met standards on each of the subsections of the standards for Cycle 5 (2023-2024) and Cycle 6 (2024-2025). Accreditation review data has not been included here.



COMMONLY UNMET STANDARDS

76% of services did not meet the following standard at the point of their peer-review visit:

Standard 56 [3]: The service has a co-production strategy covering all aspects of service delivery.

Guidance: The strategy defines patient and carer involvement as an equal partnership between people who design and deliver services, people who use the services, their carers and people in the community.

Recommendation

- Liaise with peer-support workers/involvement champions to develop a co-production strategy. Various resources can be found online to support with this, such as NHS England and Health Equity Evidence Centre. Additionally, QNPICU's Knowledge Hub group can be used to network with other services and seek support.

65% of services did not meet the following standard at the point of their peer-review visit:

Standard 126.7 [2]: [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:] Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.

Recommendation

- Services should liaise with their Trust/organisation to arrange this training for all staff. Where this is not possible, services could consider developing their own training resources on this topic, ideally with carer input (either from current or previous carers). Further information can be found in QNPICU Carer Engagement and Involvement Guidance and QNPICU Staff Training Guidance.

53% of services did not meet the following standard at the point of their peer-review visit:

Standard 120 [2]: Patient and/or carer representatives are involved in delivering and developing staff training.

Guidance: Representatives can be from current or discharged patients and their carers.

Recommendation

- This can be part of a quality improvement (QI) project. Involvement may include organising groups/meetings for patients and carers to provide ideas and feedback on the contents and focus of the staff training. Additionally, patients and/or carer representatives should be involved in co-delivering/co-facilitating sessions. Services should liaise with their involvement leads and training departments to support with this work.

41% of services did not meet the following standard at the point of their peer-review visit:

Standard 147 [2]: Patient or carer representatives are involved in the interview process for recruiting potential staff members.

Guidance: The representatives should have experience of the relevant service. Representatives can be from current or discharged patients and their carers.

Recommendation

- Services should explore how current/discharged patients and/or carers can be involved in this process. For example, by developing interview questions or sitting in interview panels. Alternative ways to involve patients/carers in this could include giving applicants a tour of the service and allowing patients/carers to share feedback. This could be part of a QI project.

35% of services did not meet the following standard at the point of their peer-review visit:

Standard 57 [2]: Services are developed in partnership with appropriately experienced patients and carers and have an active role in decision making.

Recommendation

- Co-production is at the heart of this standard. Services should appoint patient and carer representatives (with lived experience of PICUs) and invite them to relevant strategic meetings. This can also be the role of peer-support workers. Services should ensure relevant development committees have lived experience representation that informs decision making, and liaising with relevant Trust/Organisation involvement leads will be vital.

PATIENT FEEDBACK SPOTLIGHT

We analysed qualitative and quantitative data from **249** patient surveys and patients spoken to during review days.

Positive feedback

Patient feedback indicated that they **know which member(s) of staff they can talk to if they have any questions** and **how to contact them**, with **88%** of survey responses supporting this. Patient feedback also expresses **feeling treated with compassion, dignity and respect** by staff, as well as **feeling listened to and understood** by staff, with **76%** of responses supporting both standards respectively.

Good practice examples

External organisations provide activities.

Patients chair community meetings.

Activity boxes allow patients to co-facilitate sessions.

A ward newsletter is created by patients and shared.

Areas for improvement

Feedback indicates for over **40%** of patients' activities are often **not engaging**, with **limited offering on weekends** and a lack of **personalised activity timetables**. Additionally, many services do not ask patients and carers for their **feedback about their experiences of the service** and use this to improve the service. During Cycle 5 only **18%** of services met this standard, though this increased to **37%** in Cycle 6.

Recommendations

Systems for collecting feedback from patients on the activities they find engaging and any additional activities they would like to see on the ward should be introduced in services. This should include meeting with patients to discuss which activities are feasible and creating a plan to introduce these to the ward timetable. Regular planning meetings should be held for patients to develop their own personalised timetable of activities and copies should be offered. Activities should cover seven days a week, including evenings and weekends, and could be nurse-led or led by external organisations.

Services should review their current systems to review feedback from patients and carers, and how this is embedded in relevant service development meetings/initiatives. Feedback should be collected in a variety of forms, including questionnaires, forums or suggestion boxes. 'You Said, We Did' boards should be introduced within services and regularly updated with how feedback is being used to improve the service.

CARER FEEDBACK SPOTLIGHT

We analysed qualitative and quantitative feedback from carers provided during peer-review days and **178** anonymous surveys.

In Cycle 5, **36%** of standards in the 'Family, Friends and Visitors' section were met. In Cycle 6, this increased to **45%** met. One potential influence on this increase could be the **network's focus on carer engagement and involvement**, including the **QNPICU Carer Engagement and Involvement Guidance Document** produced in collaboration with a carer representative, members and Carers Trust.

Positive feedback

Carers shared that they **feel listened to and understood** by staff, which is reflected in **90%** of surveys. Carers noted that they are **involved in their loved ones' care planning**, including being **invited to key meetings**, which is supported by **86%** of surveys. Carers reflected that the team **knows how to respond when their loved one does not consent** to their involvement. This is reflected in **82%** of services meeting this standard in Cycle 5, and **89%** of services meeting this in Cycle 6.

Areas for improvement

Many carers noted that they have **not been provided** with information or support around how to access **a statutory carers' assessment**. Overall, **12%** of services met this standard in Cycle 5, and **11%** met this in Cycle 6. They also reflected that they have **not been provided** with **accessible carers' information**, such as a welcome pack. **12%** of services met this standard in Cycle 5, increasing to **21%** met in Cycle 6. Lastly, most carers shared that they **do not have access** to a carers' **support group or network**. **18%** of services met this standard in Cycle 5, and **21%** of services met this standard in Cycle 6.

Recommendations

Carers should be provided with verbal and written information about what a carers' assessment is and its potential benefits, and staff should support carers to access this through an appropriate agency. Written information could be included within the carers' information pack and placed in visiting areas.

A welcome pack for carers should be developed which includes local and organisational information, contact details of the ward, information about key staff members and local sources of advice and support. *Advancing Practice: create a welcome video for carers which shows the ward, shares information about what to expect and could include patient and carer stories/feedback.*

Carers should be provided with information about carers support groups or networks within their local areas or within the service where applicable. *Advancing Practice: develop a local group/network if not in place, and host carers events quarterly/yearly in collaboration with those in the groups.*

STAFF FEEDBACK SPOTLIGHT

We analysed staff survey data from **1,140** individuals and feedback from the staff spoken to during peer reviews.

Positive feedback

Feedback from staff highlighted good **access to reflective practice** and **clinical supervision**, with **86%** and **83%** of respondents respectively supporting this. Standard data indicates **97%** of services have access to a dedicated **staff room** and **88%** of staff felt able to **challenge decisions** within the team. Commonly mentioned achievements within services in this area include staff **feeling supported by management** and having **good team cohesion** and peer-support.

Good practice examples

Bitesize training led by MDT members or external speakers.

Virtual means to support staff wellbeing via a VR Headset.

Staff are encouraged to ask for time off the ward if they feel tired/burnt out.

Access to trauma risk management (TRiM) is given.

Areas for improvement

Standard data indicates **44%** of staff have access to **monthly line management supervision** and **56%** of staff can **access their breaks**. Commonly mentioned challenges within services in this area also reflect this, with additional mentions of **unfamiliar agency staff use** affecting their ability to carry out their day-to-day duties and impacting their safety, due to lack of appropriate training or patient knowledge.

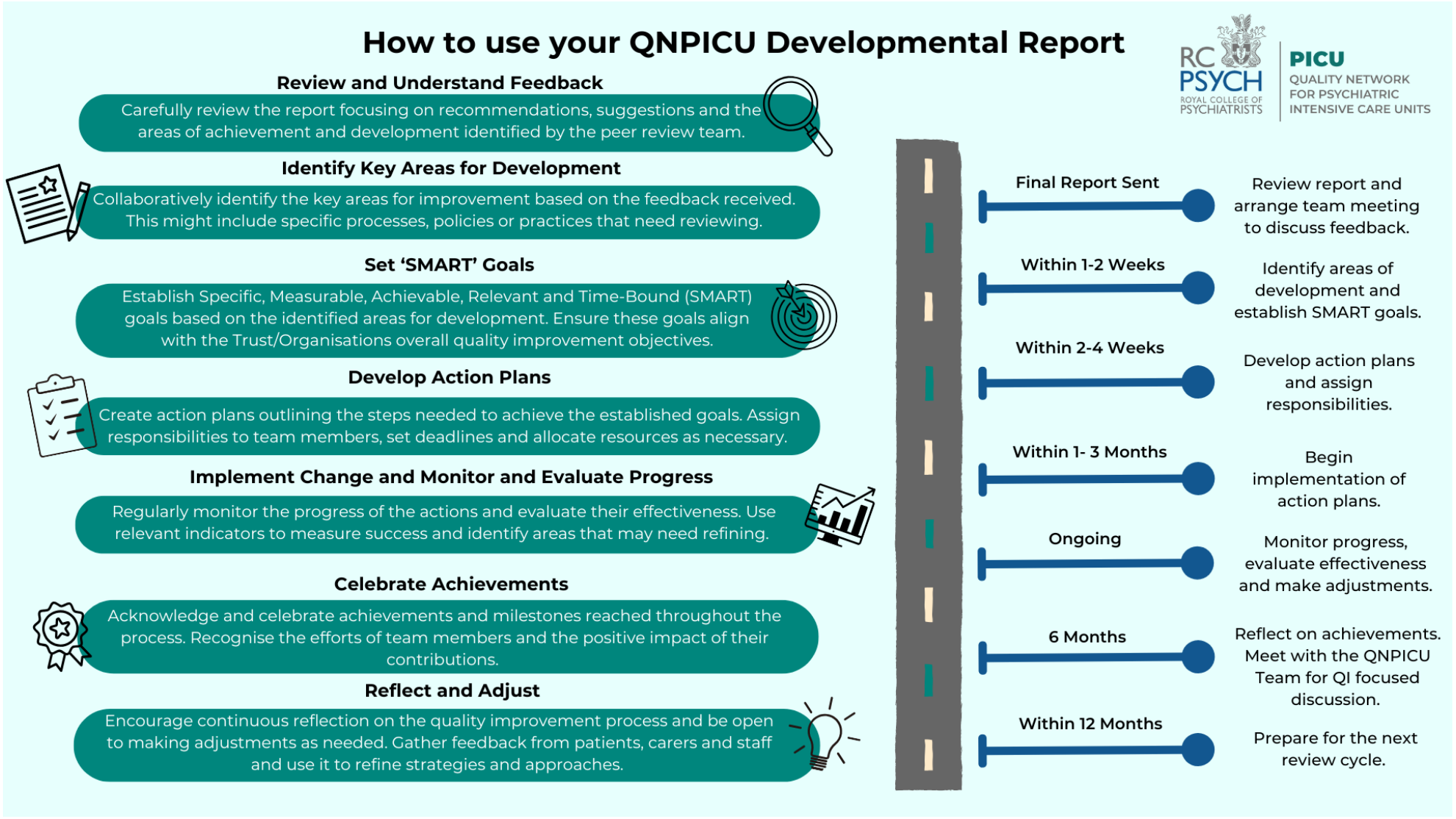
Recommendations

Teams should develop a process to schedule monthly line management supervision sessions. These may be more regular than indicated in the organisation's policies and relevant training may need to be provided to supervisors. This should be regularly audited and actions taken where relevant.

Wards should block-book agency staff that are familiar with the patients/ward processes. Where possible, investing in relevant training for agency/bank staff would support permanent staff in their day-to-day duties and feelings of safety. Providing training in relational security would further support the overall feelings of safety and understanding the patient group.

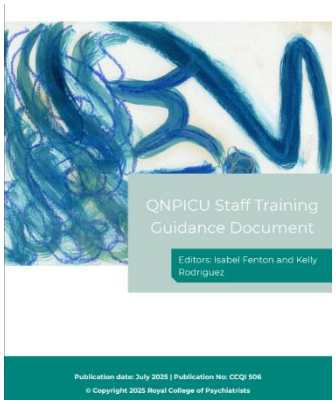
Teams should develop a process for allocating breaks and appropriate cover. Where breaks cannot be taken, reasons should be recorded and audited regularly to identify any actions needed. This should be an ongoing process and, where required, members of the multi-disciplinary team should support covering the ward whilst nursing staff take their breaks.

HOW TO USE YOUR DEVELOPMENTAL REPORT



TRAINING AND PUBLICATIONS

QNPICU STAFF TRAINING GUIDANCE



The QNPICU Staff Training Guidance Document is designed to support PICUs in identifying staff training needs in this clinical area.

Over the years, feedback collected from PICU staff during Quality Network peer-reviews reflected that there are notable gaps in training available to them relating to their clinical environment in PICUs; this has impacted the delivery of quality care.

This document aims to outline the essential and desirable training areas to address these gaps as informed by the Working Group and feedback from member services.

This document serves as a tool to guide PICUs in enhancing staff development and providing best quality care. It should be used as guidance to be tailored to the specific service and staff needs.

QNPICU BULLETIN

The first ever QNPICU Bulletin was published on the topic of "Celebrating Accredited Services".

The bulletin will serve in place of the newsletter, with the aim of highlighting good practice across member services, updates from the Network, events and other news.

This edition included an article from an accredited service showing how they celebrated such success, tips for accreditation and testimonials.

QNPICU PEER REVIEWER TRAINING

Reviewer training provides staff from member services with the opportunity to attend peer-reviews of other PICU services, having received training in the key components of the day and being prepared to facilitate successful peer-reviews.

Peer reviewers can be staff from any discipline and participants will gain practical and theoretical knowledge of all aspects of peer reviewing.

The training is free to member services and will be done virtually. The training lasts for a total of two hours.

To book a place, complete the online QNPICU reviewer training booking form. Delegates will be provided with a CPD certificate.

APPENDIX 1: ALL STANDARDS DATA

No.	Standard	Type	Percentage Met	
Admission and Assessment			**2023-2024**	**2024-2025**
1	The multi-disciplinary team make decisions about patient admission or transfer. They can refuse to accept patients if they anticipate that the patient mix will compromise safety and/or therapeutic activity. *Guidance: The service has admission criteria which follows national guidelines. An escalation process is in place for complex situations.*	1	100	95
2	The service provides information to referrers about how to make a referral.	1	71	89
3	Patients admitted to the ward outside the area in which they live have a review of their placement at least every three months.	1	88	95
4	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation.	1	59	74
5	Patients have a comprehensive mental health assessment which is started within four hours of admission. This involves the multi-disciplinary team and includes consideration of the patient's: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development. **Sustainability Principle: Improving Value**	1	59	74
6	On admission the following is given consideration: • The security of the patient's home; • Arrangements for dependants (children, people they are caring for); • Arrangements for pets.	1	47	68
7	The patient's preferred contact is contacted as soon as possible by a staff member (with patient consent) to notify them of the admission and to give them the ward/unit contact details. *Guidance: If consent is not given, this is recorded in patient records and reviewed regularly.*	1	59	58

8	Following assessment, patients promptly begin evidence-based therapeutic interventions which are appropriate to the bio-psychosocial needs.	1	94	95
9	There is a documented formalised review of care or ward round admission meeting within 72 hours of the patient's admission. Patients are supported to attend this with advanced preparation and feedback.	1	41	47
10	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: • Their rights regarding admission and consent to treatment; • Rights under the Mental Health Act (or equivalent); • How to access advocacy services; • How to access a second opinion; • How to access interpreting services; • How to view their health records; • How to raise concerns, complaints and give compliments.	1	24	26
11	Patients are given an information pack on admission that contains the following: • A description of the service; • The therapeutic programme; • Information about the staff team; • The unit code of conduct; • Key service policies (e.g. permitted items, smoking policy); • Resources to meet spiritual, cultural or gender needs.	2	71	53
Care Planning and Treatment			**2023-2024**	**2024-2025**
12	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy. *Guidance: Where possible, the patient writes the care plan themselves or with the support of staff.*	1	18	16
13	The multi-disciplinary team reviews and updates care plans at least weekly.	2	59	68

14	Patients have a risk assessment and safety plan which is co-produced (where possible), updated weekly and shared where necessary with relevant agencies (with consideration of confidentiality). *Guidance: This assessment considers risk to self, risk to others and risk from others.* **Sustainability Principle: Prioritise Prevention**	1	29	37
15	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.	2	41	26
16	Each patient is offered a one-hour session at least once a week with any nominated member of their care team to discuss progress, care plans and concerns. These sessions are documented.	1	41	37
17	Patients are involved (wherever possible) in decisions about their level of therapeutic observation by staff. *Guidance: Patients are also supported to understand how the level can be reduced.*	1	29	47
18	The service is able to refer patients to specialist alcohol and drug services. *Guidance: Patients can be referred during admission or on discharge from the ward.*	2	76	79
19	The service has a care pathway for patients who are pregnant or in the postpartum period. *Guidance: Patients who are over 32 weeks pregnant or up to 12 months postpartum should not be admitted to a general psychiatric ward unless there are exceptional circumstances.*	1	71	82
20	When the team meets for handover, adequate time is allocated to discuss patients' needs, risks and management plans.	1	82	95
21	When patients are absent without leave, the team (in accordance with local policy): • Updates the patient's risk management plan; • Makes efforts to locate the patient; • Alerts carers, people at risk and the relevant authorities; • Escalates as appropriate.	1	100	100
Physical Healthcare			**2023-2024**	**2024-2025**
22	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, then the reason is recorded, and repeated attempts are made. **Sustainability Principle: Prioritise Prevention**	1	71	58

23	Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission. *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.*	1	71	79
24	The team, including bank and agency staff, are able to identify and manage an acute physical health emergency. **Sustainability Principle: Prioritise Prevention**	1	76	95
25	Patients 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 patient's care plan. **Sustainability Principle: Consider Carbon**	1	47	37
Referral, Discharge and Transfer			**2023-2024**	**2024-2025**
26	The inpatient team invites a community team representative to participate and contribute to MDT reviews and discharge planning. *Guidance: If the representative is unable to attend in person, teleconferencing facilities may be used.*	2	76	89
27	Mental health practitioners carry out a thorough assessment of the patient's personal, social, safety and practical needs to formulate and mitigate risks on discharge. *Guidance: Where possible, this should be completed in partnership with carers.*	1	53	68
28	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 within 24 hours of discharge. *Guidance: The plan includes details of:* *• Care in the community/aftercare arrangements;* *• Crisis and contingency arrangements including details of who to contact;* *• Medication including monitoring arrangements;* *• Details of when, where and who will follow up with the patient.* **Sustainability Principle: Prioritise Prevention**	1	47	63
29	A discharge summary is sent within a week to the patient's GP and others concerned (with the patient's consent). The summary includes why the patient was admitted, how their condition has changed, and their diagnosis, medication and formulation.	2	53	68

30	Teams provide 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. *Guidance: This is likely to include support around any concerns at the transition and practical issues.*	3	76	79
31	The team makes sure that patients who are discharged from hospital have arrangements in place to be followed up within 72 hours of discharge.	1	94	84
Safeguarding			**2023-2024**	**2024-2025**
32	There is a local designated safeguarding lead who can give advice and ensure that all safeguarding issues are raised and resolved, in line with local policy. Inter-agency protocols for the safeguarding of adults and children are easily accessible on the ward.	1	82	89
33	Staff know how to prevent and respond to sexual exploitation, coercion, intimidation and abuse on the ward.	1	82	95
34	There is a system in place to respond to themes and trends in safeguarding alerts/referrals and there are mechanisms to share learning. *Guidance: An action plan is in place to address any issues raised, including where training needs are identified.*	2	94	89
Medication Management			**2023-2024**	**2024-2025**
35	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.	1	35	26
36 	Patients have their medications reviewed at least weekly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.* **Sustainability Principle: Consider Carbon**	1	59	68
37	Every patient's PRN medication is reviewed at least weekly: frequency, dose and indication.	1	71	79
38	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline) and at three months. If a physical health abnormality is identified, this is acted upon.	1	65	58
39	All staff members who administer medications have been assessed as competent to do so. The assessment is completed at least once every three years using a competency-based tool.	1	76	84

40	Patients, carers and prescribers are able to meet with a pharmacist to discuss medications.	2	0	26
Patient Experience			**2023-2024**	**2024-2025**
41	On admission to the ward, patients feel welcomed by staff members who explain why they are in hospital. *Guidance: Staff members show patients around and introduce themselves and other patients, offer patients refreshments and address patients using their preferred name and correct pronouns. Staff should enquire as relevant how they would like to be supported in regard to their gender.*	1	65	58
42	Individual staff members are easily identifiable. *Guidance: For example, by wearing or displaying appropriate photo identification.*	2	94	95
43	Patients know who the key people are in their team and how to contact them if they have any questions.	1	71	95
44	Staff members treat all patients and carers with compassion, dignity and respect.	1	53	63
45	Patients feel listened to and understood by staff members.	1	76	68
46	Patients and staff members feel safe on the ward.	1	53	47
47	All patients can access a charge point for electronic devices such as mobile phones.	3	100	100
48	Patients 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 in line with local policy. *Guidance: 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.*	1	100	95
49	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 family or carers, are respected and reviewed regularly.	1	35	42
50	All patients have access to an advocacy service, including IMHAs (Independent Mental Health Advocates).	1	59	79
51	The ward 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.	2	82	95
52	Patients and carers (with patient consent) are offered written and verbal information about the patient's mental illness and treatment.	1	24	11

53	There is a minuted ward community meeting that is attended by patients and staff members. The frequency of this meeting is weekly, unless otherwise agreed with the patient group. *Guidance: This is an opportunity for patients to share experiences, to highlight issues of safety and quality on the ward, to be consulted about changes to the ward environment and to review the quality and provision of activities with staff members. Where possible, patients are given the opportunity to chair or co-chair these meetings or an advocate is invited to chair.*	2	65	68
54 	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service. *Guidance: Feedback can be collected in a variety of forms, including feedback surveys, focus groups, community meetings and patient representatives.* **Sustainability Principle: Empowering Individuals**	1	18	37
55	Feedback received from patients and carers is analysed and explored to identify any differences of experiences by protected characteristics.	2	47	26
56	The service has a co-production strategy covering all aspects of service delivery. *Guidance: The strategy defines patient and carer involvement as an equal partnership between people who design and deliver services, people who use the services, their carers and people in the community.*	3	12	47
57	Services are developed in partnership with appropriately experienced patients and carers and have an active role in decision making.	2	47	42
58	Every patient has a seven-day personalised therapeutic/recreational timetable of activities to promote social inclusion, which the team encourages them to engage with.	2	24	21
59 	Patients have access to safe outdoor space every day. *Guidance: Unless individual risk assessments dictate otherwise. Any exceptions should be documented in case notes.* **Sustainability Principle: Consider Carbon**	1	88	74
60 	Patients, according to risk assessment, have access to regular 'green' walking sessions, where green space is accessible. *Guidance: Consideration should be given to how all patients are able to access this session including, for example, access to appropriate foot or rainwear.* **Sustainability Principle: Consider Carbon**	2	29	32

61	Patients receive psychoeducation on topics about activities of daily living, interpersonal communication, relationships, coping with stigma, stress management and anger management.	2	24	42
62	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 may include access to: • Voluntary organisations; • Community centres; • Local religious/cultural groups; • Peer support networks; • Recovery colleges.	2	24	21
63	The team supports patients to access support with finances, benefits, debt management and housing needs.	1	53	89
64	All patients can access a range of current culturally specific resources for entertainment, which reflect the service's population. *Guidance: This may include recent magazines, daily newspapers, books, board games, a TV and DVD player with DVDs, computers and internet access (where risk assessment allows).*	2	88	74
65	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.	1	76	63
66	Patients have access to relevant faith-specific support, preferably through someone with an understanding of mental health issues.	2	88	63
67	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.	1	59	79
68	The team and patient jointly develop a leave plan, which is shared with the patient, that includes: • Conditions of the leave; • A risk assessment and risk management plan that includes an explanation of what to do if problems arise on leave; • Contact details of the service and crisis numbers.	1	18	68

Family, Friends and Visitors			2023-2024	2024-2025
69	The team provides each carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. a carer's information pack). This includes both local and Organisation-wide information. 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. Updated information should be sent as required, e.g. a letter, when staff contacts change.*	2	12	21
70	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: Anyone over the age of 18 who is providing regular support to someone is entitled to a statutory carers' assessment, regardless of the amount/type of care provided. For young carers, the local council/Organisation has a legal duty to look into the responsibilities a young carer has taken on and how this could be affecting them.*	1	12	11
71 	Carers are offered individual time with staff members, within 48 hours of the patient's admission, to discuss concerns, family history and their own needs. *Guidance: Individual time could be offered face-to-face, over the telephone or by video-conference.* **Sustainability Principle: Empowering Individuals**	2	29	47
72	Carers feel listened to and supported by the ward staff members. *Guidance: Conversations are documented.*	2	65	68
73 	Carers are supported to participate actively in decision making and care planning for the person they care for, where the patient consents. This includes attendance at ward reviews. *Guidance: Carers are invited to attend meetings in advance and arrangements are made for carers to attend ward rounds, review meetings, CPA meetings and discharge meetings. When carers are unable to attend meetings in person, virtual attendance at meetings is offered and/or feedback is sought in advance of the meeting.* **Sustainability Principle: Empowering Individuals**	1	35	53
74	The team knows how to respond to carers when the patient does not consent to their involvement.	1	82	89

	Guidance: The ward can receive information from the carer in confidence. Legally, carers can be given general information about the condition of the person cared for when patient consent is withdrawn. General information about the hospital, its service provision as well as education about mental ill-health and recovery should still be available to carers. (Carers Toolkit, NHS England).			
75	Carers have access to a carer support network or group. This could be provided by the service, or the team could signpost carers to an existing network. *Guidance: This could be a group/network which meets face-to-face or communicates electronically.*	2	18	21
76	Staff agree leave plans with the patient's carer where appropriate, allowing carers sufficient time to prepare.	1	35	53
Environment and Facilities			**2023-2024**	**2024-2025**
77	In reception: • A single main entry point is controlled by an airlock; • The airlock entrance is access-controlled from within a main staff area and can be operated by specifically-designated electronic fobs and keys; • The entrance has an emergency override allowing both doors to open at the same time. This is to enable people to enter/exit the ward through the airlock in an emergency.	1	82	95
78	There is a key management system in place which accounts for all secure keys/passes including spare/replacement keys which should be held under the control of a senior manager. There is a process to ensure that: • Keys are not issued until a security induction has been completed; • Keys are only issued upon the presentation of valid ID; • A list of approved key holders is updated monthly identifying new starters who have completed their induction training and any leavers from the service.	1	88	79
79	Windows that form part of the external secure perimeter are designed to prevent the passage of contraband.	1	88	89
80	Staff members, patients and visitors are able to raise alarms using panic buttons, strip alarms or personal alarms. There is an agreed response when an alarm is used.	1	76	79
81	Lockable facilities are provided for:	2	71	89

	• Patients for their personal possessions (with a staff override feature) with maintained records of access; • Staff away from the patient area for the storage of any items not allowed within patient areas (which are locally determined); • Visitors away from patient areas to store prohibited or restricted items whilst they are in the service.			
82	There are clear lines of sight to enable staff members to view patients. Measures are taken to address blind spots and ensure sightlines are not impeded e.g. by using mirrors.	1	76	74
83	Furnishings within the ward minimise the potential for fixtures and fittings to be used as weapons, barriers or ligature points. Fixtures, fittings and installations in outdoor spaces (e.g. garden areas or courtyards) are protected or designed to prevent climbing and tampering.	1	76	74
84	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.	1	59	89
85	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such as hoists and handrails, are provided to meet individual needs and to maximise independence.*	1	71	68
86	Emergency medical resuscitation equipment is available immediately and is maintained and checked weekly, and after each use.	1	100	95
87	All patients have single bedrooms.	2	100	100
88	The ward has at least one bathroom/shower room for every three patients.	2	100	74
89	Every patient has an en-suite bathroom.	3	82	53
90	Male and female patients have separate bedrooms, toilets and washing facilities. Room allocation should accommodate a spectrum of gender and patient gender self-identification should be supported wherever possible. *Guidance: Self-identification as male or female should be accepted, and allocation to a gendered room done with patients' agreement. Where this 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.*	1	100	88

91	Wards are able to designate gender neutral bedrooms and toilet facilities for those patients who would prefer a non-gendered care environment.	3	94	79
92	Staff members respect the patient's personal space, e.g., by knocking and waiting before entering their bedroom. *Guidance: Unless individual risk assessments dictate otherwise. Any exceptions should be documented in case notes.*	1	71	74
93	Bathrooms, toilets and bedrooms are lockable from the inside with external staff override.	1	82	79
94	Patient bedroom and bathroom doors are designed to prevent holding, barring or blocking.	1	88	89
95	All doors (with the exception of those in bedrooms, bathrooms and toilets) are fitted with a robust clear observation panel.	2	100	84
96	Staff members and patients can control heating, ventilation and light on the ward. *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.*	2	88	74
97	Patients are able to personalise their bedroom spaces. *Guidance: For example, by putting up photos and pictures.*	2	88	79
98	Patients are consulted about changes to the ward environment.	2	29	42
99	There is a separable gender-specific space which can be used as required.	1	60	91
100	The ward has a designated room for physical examination and minor medical procedures.	2	82	95
101	Patients have access (subject to risk assessment) to a room with: • Activities (containing board games, art and stereo equipment); • Internet and social media (with appropriate safeguards in place); • A television and DVD player, or equivalent; • Physical exercise equipment.	2	88	95
102	There are facilities for patients to make their own hot and cold drinks and snacks which are available 24-hours a day. *Guidance: Hot drinks may be available on a risk-assessed basis.*	2	65	42
103	The ward has at least one quiet room or de-escalation space other than patient bedrooms. *Guidance: The de-escalation space is designed specifically for the purpose of reducing arousal and/or agitation.*	2	94	95

104	In wards/units where seclusion is used, there is a designated room that meets the following requirements: • It allows clear observation; • It is well insulated and ventilated; • It has adequate lighting, including a window(s) that provides natural light; • It has direct access to toilet/washing facilities; • It has limited furnishings (which includes anti-tamper bed, pillow, mattress and blanket or covering); • It is safe and secure – it does not contain anything that could be potentially harmful; • It includes a means of two-way communication with the team; • It has a clock that patients can see. *Guidance: Wards that do not have seclusion facilities ensure that local policies fully describe alternatives to seclusion and define how patients' safety, dignity, privacy and health and well-being needs will be met.*	1	71	72
105	There is a designated visitors' room within the perimeter. The space must meet the following requirements: • Suitable to maintain safety, dignity, privacy and confidentiality; • Provide a homely environment; • Observations are not overly intrusive; • Accessible by patients and visitors. *Guidance: Policies are in place on child visiting procedures.*	1	53	89
106	When visits cannot be facilitated, patients have access to video technology to communicate with their friends and relatives.	1	53	58
107	The service has a family visiting room, which is welcoming, comfortable, clean, well equipped and available outside the main body of the ward. *Guidance: It is equipped with a range of age-appropriate facilities, such as toys, games and books.*	2	82	74
Workforce			**2023-2024**	**2024-2025**
108	There is a psychologist who is part of the multi-disciplinary team. They contribute to the assessment and formulation of the patients' psychological needs and the safe and effective provision of evidence based psychological interventions.	1	71	68

109	There is an occupational therapist who is part of the multi-disciplinary team. They work with patients requiring an occupational assessment and ensure the safe and effective provision of evidence based occupational interventions.	1	71	68
110	There is dedicated sessional input from arts or creative therapists.	3	41	53
111	There is a mental health pharmacist who is a core member of the multi-disciplinary team. Their duties include: • Performing medicine reconciliation on admission to ensure an accurate and complete medication history; • Applying medicines optimisation and evidence based criteria to ensure a person centred approach and the best possible outcomes from their medicines; • Contributing to guideline development, audit of high risk medicines and staff training on the use of medicines.	2	53	79
112 	The ward has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services. **Sustainability Principle: Empowering Staff**	1	94	100
113	The ward is 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.	2	71	68
114	There is an identified duty doctor available at all times to attend the ward, including out of hours. The doctor can attend the ward within 30 minutes in the event of an emergency.	1	71	68
115 	Ward-based staff members have access to a dedicated staff room. **Sustainability Principle: Empowering Staff**	2	100	95
116	Staff members are able to take breaks during their shift that comply with the European Working Time Directive.	1	59	53

	Guidance: Staff have the right to one uninterrupted 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.			
117	Systems are in place to enable staff members to report incidents quickly and effectively and managers encourage staff members to do this.	1	65	84
118	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing. **Sustainability Principle: Empowering Staff**	1	88	89
119	Staff members, patients and carers who are affected by a serious incident including restraint and rapid tranquilisation are offered post-incident support. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection. Other patients on the ward who are distressed by events are offered support and time to discuss their experiences.* **Sustainability Principle: Empowering Individuals**	1	59	42
120	Patient and/or carer representatives are involved in delivering and developing staff training. *Guidance: Representatives can be from current or discharged patients and their carers.*	2	24	42
Workforce Training and Support			**2023-2024**	**2024-2025**
121	All staff members receive individual line management supervision at least monthly.	2	41	47
122	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	76	58
123	Staff members are able to access reflective practice groups at least every six weeks where teams can meet together to think about team dynamics and develop their clinical practice. **Sustainability Principle: Empowering Staff**	3	82	84
124	The ward actively supports staff health and wellbeing. *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	71	47

	Sustainability Principle: Empowering Staff			
125	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.	1	65	79
126	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:			
126.1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	1	47	79
126.2	Physical health assessment and management. *Guidance: This could include training in understanding physical health problems, undertaking physical observations, basic life support, and Early Warning Signs.*	1	41	84
126.3	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation, or neglect.* **Sustainability Principle: Prioritise Prevention**	1	65	84
126.4	Risk assessment and management. *Guidance: This includes assessing and managing suicide risk and self-harm, and the prevention and management of challenging behaviour.* **Sustainability Principle: Prioritise Prevention**	1	53	74
126.5	Recognising and communicating with patients with cognitive impairment and learning disabilities.	1	41	58
126.6	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.	1	47	47
126.7	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	2	18	53
127	All staff undergo specific training in therapeutic observation when they are inducted into a Trust or changing wards. This includes: • Principles around positive engagement with patients;	1	35	84

	• When to increase or decrease observation levels and the necessary multi-disciplinary team discussions that should occur relating to this.			
128 	All staff members who deliver therapies and activities are appropriately trained and supervised. **Sustainability Principle: Empowering Staff**	1	18	74
Reducing Restrictive Practices			**2023-2024**	**2024-2025**
129	Patients are cared for in the least restrictive environment possible, while ensuring appropriate levels of safety. *Guidance: This includes avoiding the use of blanket rules and assessing risk on an individual basis.*	1	94	79
130	The team uses seclusion only as a last resort and for brief periods only.	1	76	94
131	When restraint is used, staff members restrain in adherence with accredited restraint techniques.	1	71	95
132	Any use of force (e.g. physical restraint, chemical restraint, seclusion and long term segregation) should be recorded in line with Mental Health Units (Use of Force) Act 2018 (or equivalent).	1	65	95
133	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 responded to.	1	47	79
134	In units where long term segregation is used, the area conforms to standards as prescribed by the Mental Health Act Code of Practice (or equivalent).	1	83	86
135	Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them.	2	53	74
136	In order to reduce the use of restrictive interventions, patients who have been harmful to themselves or others are supported to identify triggers and early warning signs. *Guidance: This includes positive behavioural support (PBS) plans.*	1	53	63
137	The multi-disciplinary team collects audit data on the use of restrictive interventions, including the ethnicity of the patients, and actively works to reduce its use year on year through use of audit and/or quality improvement methodology. *Guidance: Audit data is used to compare the service to national benchmarks where possible.*	1	65	47
Governance			**2023-2024**	**2024-2025**

138	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	1	82	79
139	Clinical outcome measurement is collected at two time points (at assessment and discharge). *Guidance: This includes patient-reported outcome measurements where possible. Clinical outcome measures can include Health of the Nation Outcome Scales (HoNOS), Global Assessment of Progress (GAP), Brief Psychiatric Rating Scale (BPRS), Daily Living Activities (DLA) Scale, Global Assessment of Functioning (GAF), DIALOG or Clinical Outcomes Routine Evaluation (CORE).*	1	41	47
140	The unit has mechanisms to review data at least annually about the people who are admitted. Data are compared and action is taken to address any inequalities in care planning and treatment. *Guidance: This includes data around the use of seclusion and length of stay in the unit for different groups.*	1	71	32
141	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	94	100
142	When serious mistakes are made in care, this is discussed with the patient themself and their carer, in line with the Duty of Candour agreement.	1	100	100
143	There are agreed protocols in place with local police to ensure effective and sensitive liaison regarding incidents of criminal activity, harassment or violence.	2	53	58
144	The ward team use quality improvement methods to implement service improvements.	2	41	26
145	The team actively encourages patients and carers to be involved in quality improvement initiatives.	2	12	32
146	The service supports research and the implementation of evidence-based interventions: • There is a local research strategy linked to the needs of patients and workforce; • Research includes projects co-produced with patients and carers and collaboratively engages with other services and stakeholders; • There is a mechanism in place for staff and patients to influence and contribute to research projects;	3	12	26

	• The service shares the outcomes of their research with patients, carers, staff and other stakeholders by means such as plain language summaries, research papers, posters and presentations. *Guidance: Research can include routinely evaluating the assessment and treatment models of care within the service.*			
147 	Patient or carer representatives are involved in the interview process for recruiting potential staff members. *Guidance: The representatives should have experience of the relevant service. Representatives can be from current or discharged patients and their carers.* **Sustainability Principle: Empowering Individuals**	2	47	47
148	The ward reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/minimising waste and low carbon interventions). Progress against this improvement plan is reviewed at least quarterly with the team.	3	35	11

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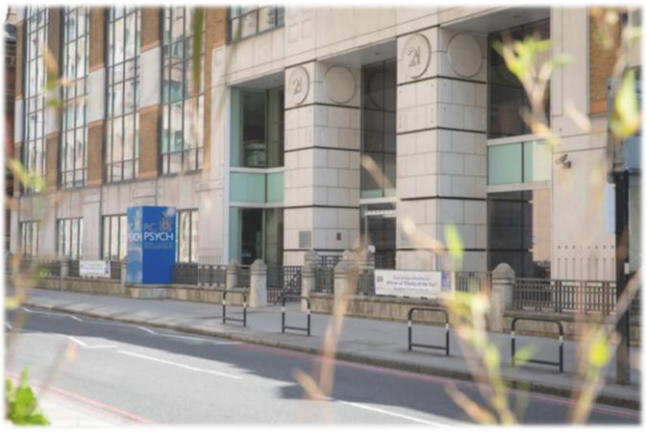

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