Quality Network for Veteran Mental Health Services

Quality Standards for Veteran Mental Health Services

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Introduction

The Quality Network for Veteran Mental Health Services has been established in 2020 to support in the quality improvement of veteran mental health services in the UK. It is one of over 20 networks within the College Centre for Quality Improvement (CCQI) within the Royal College of Psychiatrists.

These standards have been developed from recommendations in key literature, research and in consultation with a range of stakeholders. Care has been taken to ensure that the development of these standards has taken into consideration a wide range of sources, including research, policies, NICE Guidelines and the views of professionals working in veteran mental health services.

Categorisation of standards

Each standard has been categorised as follows:

Type 1: Essential standards. Failure to meet these would result in a significant threat to service user safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.

Type 2: Expected standards that most services should meet.

Type 3: Desirable standards that high performing services should meet.

The full set of standards is aspirational and it is unlikely that any service would meet them all.

The Standards

Std No	Type	Standard	Ref
Access, referral and waiting times			
1	3	Everyone can access the service using public transport or transport provided by the service.	1
2	1	The service provides information about how to make a referral and waiting times for assessment and treatment. **Guidance**: *This includes providing information to the patient on how long they might wait for an assessment and then treatment from the service, from the time of receiving a referral.*	1
3	2	Referrers, patients and carers are provided with clear information on who can access the service.	2
4	2	If the service is open to self-referrals, it can demonstrate that it is actively promoting this to different sections of the community.	2
5	1	The team assess patients, who are referred to the service, within an agreed timeframe.	1
6	2	There are systems in place to monitor waiting times and ensure adherence to local and/or national waiting times standards. **Guidance**: *Consideration is given to priority groups.*	2
7	2	Patients are not excluded based solely on comorbid drug or alcohol misuse problems.	1, 2
Assessment			
8	1	The team makes written communication in advance of the patient's assessment taking place. This includes: • Written information describing the service. • The name and title of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them; • How to contact the team if they have any queries or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).	1, 2
9	1	Patients feel welcomed by staff members when attending the team base for their appointments. **Guidance**: *Staff members introduce themselves to patients and address them using the name and title they prefer.*	1

10	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: • Their rights regarding consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments.	1
11	2	The team ensures that screening, assessment and interventions are culturally and linguistically appropriate.	3
12	1	Patients have a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development. • Suicide risk.	1, 3
13	1	Patients receive patient-centred assessments, which include a risk assessment, and where risk is identified, a risk formulation and management plan. **Guidance**: *Risk assessment includes risk to self, risk to others and risk from others*	2
14	1	When assessing for PTSD, staff members ask people specific questions about: • re-experiencing, • avoidance, • hyperarousal, • dissociation, • negative alterations in mood and thinking, • and associated functional impairment.	3
15	2	Assessments include consideration of activities that promote social inclusion such as education, employment, volunteering and other occupations such as leisure activities and caring for dependents.	2
16	2	Assessments include consideration of adverse circumstances that may be maintaining presenting difficulties (e.g. debt, employment situation, housing situation, social isolation) and signpost to additional sources of information and support where appropriate.	2

17	1	A physical health review takes place as part of the initial assessment, or as soon as possible. **Guidance**: *If the service do not carry out physical health checks, there are links to ensure this is carried out by the patient's GP.*	1, 3
18	1	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.	1
19	1	All patients have a documented diagnosis and/or a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	1
20	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.	1
Following up patients who do not attend appointments			
21	1	The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient.	1
22	1	If a patient does not attend for an assessment/appointment, the assessor contacts the referrer. **Guidance**: *If the patient is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.*	1
Reviews and care planning			
23	1	Patients know who is co-ordinating their care and how to contact them if they have any questions.	1

24	1	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy. **Guidance**: *The care plan clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *Measurable goals and outcomes;* • *Strategies for self-management;* • *Any advance directives or statements that the patient has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework.*	1, 2
25	1	Patients are actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.	1
26	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
27	1	The team records which patients are responsible for the care of children and adults at risk of harm and takes appropriate safeguarding action when necessary.	1
Care and treatment: Therapies and activities			
28	1	Patients 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, 2
29	1	All treatments delivered are in accordance with appropriate guidelines e.g. Nice guidelines, Matrix for Scotland and Welsh matrix for psychological therapies.	1
30	2	The team supports patients to undertake structured activities such as work, education and volunteering. **Guidance**: *For patients who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes.*	1
31	1	The team supports patients to undertake activities to support them to build their social and community networks.	1
32	2	The number of sessions of psychological therapies is informed by the evidence base and individual need.	2
Care and treatment: Medication			

33	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded. If the team does not prescribe, this information is requested from the GP or relevant service.	1
34	1	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. **Guidance**: *Side effect monitoring tools can be used to support reviews.*	1
35	1	Patients, carers and prescribers can contact a specialist pharmacist to discuss medications.	1
Physical healthcare			
36	1	Staff members arrange for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan. **Guidance**: *This could be done by the patient's GP.*	1
37	1	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.	1
38	1	Patients 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. The team maintains responsibility for monitoring the patient's physical health.	1
Discharge planning and transfer of care			
39	1	When patients are transferred between community services there is a handover which ensures that the new team have an up to date care plan and risk assessment.	1

40	2	Teams provide specific transition support to patients when their care is being transferred to another community team, or back to the care of their GP. **Guidance** *this should include:* • *the setting and who will provide their care ensure there is effective sharing of information between all services involved involve the person and, if appropriate, their family or carers in meetings to plan the transition address any worries the person has, for example about changes to their routine or anxiety about meeting new people.* • *During transitions between services for people with PTSD who need ongoing care, the referring team should not discharge the person before a care plan has been agreed in the new service.*	1, 3
41	1	There are consistent arrangements for liaison with referrers at the end of therapy, if appropriate, and signposting to other services, if required.	2
Interface with other services			
42	1	Patients 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, Veterans Gateway.*	1, 2
43	1	The team supports patients to access: • Housing support; • Support with finances, benefits and debt management; • Social services.	1
44	2	The service/organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months postpartum) 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
45	1	Where management is shared between primary and secondary care, healthcare professionals should agree who is responsible for monitoring people. This agreement should be put in writing (if appropriate, using the Care Programme Approach) and involve the person and, if appropriate, their family or carers.	3
46	3	The service have good working links with other agencies to promote and support veteran mental health.	

Capacity and consent			
47	1	Assessments of patients' capacity to consent to care and treatment in hospital are performed in accordance with current legislation.	1
Patient and carer involvement			
48	1	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.	1
49	2	Services are developed in partnership with appropriately experienced patients and carers and have an active role in decision making.	1
Carer engagement and support			
50	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	1, 3
51	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 patient's initial assessment, or at the first opportunity.*	1
52	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	1
53	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
54	3	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.	1
55	2	The service provides information and support to family members and carers of patients. This could cover: • their treatment and management of problems, including the person's possible risk to themselves and others; • discussing with family members and carers how they are being affected by the person's mental health • and how they can support the person to access treatment, including what to do if they do not engage with, or drop out of treatment.	3

Compassion, dignity and respect			
56	1	Staff members treat patients and carers with compassion, dignity and respect.	1
57	1	Patients feel listened to and understood by staff members.	1
Providing information to patients and carers			
58	1	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.	1
59	2	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	1, 3
60	1	The service can provide information in a range of formats to suit individual needs. **Guidance**: *The service should be able to provide key information in languages other than English, and in an accessible format for people with sight, hearing, learning or literacy difficulties).*	2
61	1	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment. **Guidance**: *Verbal information could be provided in a one-to-one meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites.*	1
62	2	Patients are provided with information on their treatment (covering choice of time of day, venue, type of therapy, therapist gender and access in a language other than English).	1, 3
63	2	Patients are provided with information about who to speak to if they are experiencing difficulties with the therapy process, which they do not feel able to speak to the therapist about.	2
64	3	The service supports patients to access peer support groups.	3
Patient confidentiality			
65	1	Confidentiality and its limits are explained to the patient and carer, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	1
66	1	The team knows how to respond to carers when the patient does not consent to their involvement.	1

67	1	All patient information is kept in accordance with current legislation. **Guidance**: *This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	1
Service environment			
68	2	The environment is clean comfortable, welcoming and safe, with procedures/measures in place to ensure safety of patients, carers and staff.	1, 2
69	1	Clinical rooms are private, and conversations cannot be overheard.	1
70	1	The environment complies with current legislation on disabled access. **Guidance**: *Relevant assistive technology equipment, such handrails, are provided to meet individual needs and to maximise independence.*	1
71	1	Staff members follow a lone working policy and feel safe when conducting home visits.	1
72	1	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for patients, carers and staff members.	1
73	2	The team avoid exposing people to triggers that could worsen their symptoms or stop them from engaging with treatment, for example, assessing or treating people in noisy or restricted environments.	3
Leadership, team working and culture			
74	3	Staff members are able to access reflective practice groups at least every six weeks where teams can meet to think about team dynamics and develop their clinical practice.	1
75	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
76	1	Staff know how to escalate concerns about a patient's risk to more senior staff.	
Staffing levels			

77	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
78	1	When a staff member is on leave, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.	1
Staff recruitment, induction and supervision			
79	2	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting staff members.	1
80	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
81	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
82	2	All staff members receive line management supervision at least monthly.	1
83	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	1
84	1	Therapists are receiving regular and appropriate clinical supervision (in accordance with their grade and accrediting body), from a suitably trained supervisor who is qualified in the relevant modality/ies.	2
Staff wellbeing			
85	1	The service 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

86	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
87	1	Staff members, patients and carers who are affected by a serious incident are offered post incident support.	1
Staff training and development			
88	1	The team including bank and agency staff are able to identify and manage an acute physical health emergency.	1
89	1	Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines.	1
90	1	Staff receive training on the use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	1
91	1	Staff receive training on physical health assessment appropriate to their role. **Guidance**: *This includes training in understanding physical health problems, understanding physical observations and when to refer the patient for specialist input.*	1
92	1	Staff receive training on safeguarding adults and children. **Guidance**: *This includes recognising and responding to the signs of abuse, exploitation or neglect.*	1
93	1	Staff receive training on 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.*	1
94	1	Staff receive training on military mental health and trauma related disorders including PTSD.	
95	2	Staff receive training on military culture.	
96	1	Staff receive training on recognising and communicating with patients with cognitive impairment or learning disabilities.	1
97	1	Staff receive statutory and mandatory training. **Guidance**: *This includes equality and diversity, information governance and basic life support.*	1

98	2	Staff receive training on carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	1
99	2	Patients and carers are involved in delivering and developing staff training face-to-face.	1
100	1	All qualified psychological therapists are members of a relevant professional or regulatory body.	2
101	1	All members of staff who provide therapies on behalf of the service have received formal training to perform as a competent practitioner in each of the therapies they provide. Or, if still in training, they practice under supervision of an adequately trained qualified therapist.	2
Clinical outcomes and measurement			
102	2	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	1
103	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
104	2	The service's clinical outcome data are reviewed at least every six months. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.	1
105	2	Outcome monitoring includes changes in functioning, quality of life, well-being etc., i.e. goes beyond monitoring changes in clinical symptoms	2
The service learns from feedback, complaints and indents			
106	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	1
107	1	When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.	1
108	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. Should a serious event occur, the service will also undertake a structured Serious Events Analysis (SEA) and the results communicated appropriately.	1, 2, 4
109	2	The team use quality improvement methods to implement service improvements.	1
110	2	The team actively encourages patients and carers to be involved in QI initiatives.	1

111	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
Governance			
112	1	The service has a written policy on managing different levels of risk.	2
113	1	The service has a strategy in place to promote equality and diversity and to address any barriers to access.	2
114	1	The service can demonstrate that it promotes culturally sensitive practice.	2
115	2	The service routinely collects data that can be used to measure equity of access and equity of delivery against protected characteristics.	2
116	2	Data are used to understand who is accessing the service, identify under-represented groups and improve the accessibility of the service.	2
117	2	There are coherent care pathways linking the service with other health and social care provision.	2
118	1	There is a complaints and compliments policy/procedure in place. Periodic analysis should be carried out to identify trends or themes and issues reported and action taken accordingly.	4
119	2	Gaps in local service provision are identified and steps are taken to improve availability of appropriate treatment options for patients with unmet needs, either within the service or by highlighting the need for the development of alternative services.	2

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