DRAFT Mental health care assessment framework

Contents

SAFE 2
Safety culture 2
Managing risks during care and treatment 5
Safe systems, pathways and transitions 8
Safe environments and infection prevention and control 15
Safe staffing 18
Safe delivery of treatments and medicines 21
EFFECTIVE 25
Assessing needs 25
Delivering evidence-based care and treatment 28
Outcomes 30
Supporting people to live healthier lives 33
Consent to care and treatment 35
CARING 38
Kindness, compassion and dignity 38
Person-centred care 41
Independence, choice, and control 43
RESPONSIVE 46
Care provision, integration, and continuity 46
Listening and responding to feedback 48
Timely and equitable access 51
Equity in experience 53
WELL-LED 56
Strategic direction 56
Workforce equity and culture 60
Capable and compassionate leaders 64
Governance 67
Management of risk, performance and issues 70
Partnerships and communities 72
Improvement, innovation and learning 75

SAFE

People are protected from abuse and avoidable harm.

I statements

- ✓ **I feel safe and am supported to understand and manage any risks.**
- ✓ **I know what to do and who I can contact when I realise that things might be at risk of going wrong or my health condition may be worsening.**
- ✓ **I can plan ahead and stay in control in emergencies. I know who to contact and how to contact them and people follow my advance wishes and decisions as much as possible.**
- ✓ **If my treatment, including medication, must change, I know why and am involved in the decision'** (Not authentic TLAP statement)
- ✓ **When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.**
- ✓ **I have considerate support delivered by competent people.**

Safety culture

Is there a positive and equitable safety culture, where risks are proactively managed, concerns are listened to, incidents are thoroughly investigated, and lessons are learned to improve care?

Scope of this key line of enquiry and topic areas include:

- Safe culture
- Raising safety concerns
- Closed cultures
- Duty of candour
- Safety data by protected equality characteristics
- Use of force policy
- Trauma informed, psychologically safe culture
- Incident management
- Learning from lives and deaths (LeDeR) reports

Outstanding	Good	Requires improvement	Inadequate
• The service has an exemplary culture of openness, psychological safety and compassionate leadership. Specialist safety roles are highly visible, influential and act as system leaders, modelling expectations and empowering all staff to raise concerns that are valued and used to strengthen collective learning. People more likely to face safety risks are encouraged and enabled to participate. • Reporting and learning systems are accessible, fair and responsive. All staff, including temporary workers, are trained and supported to use them, and learning from incidents, near misses and positive outcomes drives continuous improvement. Safety intelligence is treated as a critical asset for the service, with data reviewed continuously to identify and mitigate emerging risks. • The service contributes to wider system improvement by learning from other	• Safety is a top priority that involves everyone, including staff and people using the service. There are clear roles and responsibilities for safety. • A culture of safety and learning is embedded throughout all levels of the service. This is based on openness, transparency and learning from events that potentially put people and staff at risk of harm, or that have caused them harm. Staff understand health inequalities as a safety issue and know the steps to mitigate these. • Any safety risks that result from inequalities, or affect particular groups of people, are identified and acted on. • Care is monitored and assured to ensure its safety. Risks are proactively identified and mitigated. They are not overlooked or ignored but are dealt with willingly as an opportunity to put things right, learn and improve. • Patient safety data is analysed by protected equality characteristics to identify any inequalities. The service takes	• Safety is recognised as important but is not consistently prioritised and does not always involve staff and people who use the service. • Roles and responsibilities for safety are not clear to everyone and there may be gaps. • The safety and learning culture is not fully embedded throughout all levels of the service. There is limited or inconsistent learning from incidents that could potentially expose people to the risk of harm, or that have caused them avoidable harm. • There is limited analysis or understanding of safety risks that affect particular groups of people. • There is limited monitoring of care to assure its safety. Risks of harm, including those in alerts and recalls, are inconsistently identified and managed. • People and staff do not always feel supported to raise safety concerns. They do not always	• Safety is not prioritised within the service. Roles and responsibilities for safety are either not clear or do not exist and there is no clear accountability for safety. • There is no effective culture of safety and learning. A lack of transparency and openness means that safety incidents may be ignored or not reported, and a closed culture is more likely to develop. • There is no analysis or understanding of safety risks that affect particular groups of people, leading to higher risks of harm for some groups. • There is a lack of monitoring and assurance of the safety of care. Risks of harm, including those in alerts and recalls, are not identified and managed. • People and staff do not feel supported to raise safety concerns and there is evidence that when they have done so, they have not been treated with compassion and understanding and may have been blamed or treated negatively.

organisations, sharing innovations and co-producing key policies with people who use services – including the annual update of the use-of-force policy informed by insights from incidents and risks.	appropriate action to address these inequalities. • Everyone is encouraged and supported to raise safety concerns, including staff, people using the service, their families, visitors, carers and advocates. They feel confident that they will be treated with compassion and understanding, and will not be blamed, or treated negatively if they do so. The service takes appropriate action to keep everyone safe. • The review of safety information, including safeguarding incidents, complaints and concerns, is prioritised to proactively identify, manage and control risks before safety incidents happen. • Staff have a good understanding of the duty of candour. When an unintended or unexpected incident has occurred, staff are open and transparent with people and those close to them. There is a proportionate approach to recording, investigating and responding to them. Lessons are learned, enabling good practice to be continually identified and embedded, and lessons are shared internally and externally. Where harm has occurred, people are given full details of	feel confident that they will be treated with compassion and understanding and may have concerns that they will be blamed or treated negatively. • The review of safety information, including complaints and concerns, is inconsistent and safety risks are not always identified or mitigated to prevent harm. • There are systems for reporting safety incidents and complaints, but these are not well-established and may not be used consistently. Learning from safety incidents and complaints is limited or inconsistent and does not always result in changes that improve care for others. • When a notifiable safety incident has occurred, the service is not consistently open and transparent with people, those close to them and staff. People may receive some support, but it is insufficient or inconsistently provided. • In mental health units: the policy on the use of force has not been updated to learn from identified risks.	• Information about safety, including complaints and concerns, is not reviewed and safety risks are not identified or managed to prevent exposure to the significant risk of harm or harm. • Systems for reporting safety incidents and complaints are either absent, not used or inappropriate. As a result, the service does not learn from incidents and complaints. • When a safety incident has occurred, the service is not open or transparent with people, their loved ones and staff. People do not receive the support they need. • In mental health unit’s there is no policy on the use of force that complies with relevant legislation.

	what happened, why, and what has been learned. • The service is always open and transparent with people and staff. Where harm has occurred, people receive full details of what happened, why, and what has been learned. • Leaders are aware of themes and trends in safety incidents and there is a leadership commitment to improving safety in the service. • In mental health units, the policy on the use of force is updated annually, taking account of incidents and risks identified in the previous year.		

Managing risks during care and treatment

Is care and treatment planned and monitored to identify and manage risks, emergencies, and deterioration?

Scope of this key line of enquiry and topic areas include:

- Managing deterioration and emergencies
- Restrictive practice, including seclusion, segregation and physical and chemical restraint
- Managing periods of increased demand
- Clinical records
- Risk assessment and management
- Crisis planning
- Positive risk taking

- De-escalation
- Involving families and carers
- Blanket restrictions
- Sexual safety risk assessment
- Approach for delivering therapeutic observations
- Lone working

Outstanding	Good	Requires improvement	Inadequate
• The service exemplifies person centred risk management, ensuring each person’s risks are understood, reviewed and managed with exceptional rigour and compassion. Staff proactively seek creative and sector leading approaches to minimise restrictions and work seamlessly with partners when risks escalate beyond the service’s control. • Working within an exemplary trauma informed and psychologically safe culture, staff anticipate and expertly manage deterioration, emergencies and clinical risks. Risk assessments for people with complex needs are consistently co-produced, proactively updated, and informed by timely specialist input.	• The service proactively and holistically identifies, monitors and promptly acts on potential and unintended risks relating to a person’s care including deterioration, emergencies, co-occurring conditions and clinical risks. This reduces potential harm and protects people from exposure to the risk of avoidable harm. • People and those close to them, and advocates are informed about and involved in the delivery and management of their care and individual treatments, including the potential risks and side effects. They are listened to when they raise concerns about the safety of care and are supported to plan for the event of a mental health crisis. • People’s care plans and clinical records are accurate and kept-up-to date to allow the safe	• Specific risks to an individual person are only partially or sometimes understood, and people’s care is not always well-monitored and assured. Management of deterioration, emergencies and clinical risks to reduce the risk of harm or exposure to the risk of harm may be inconsistent. People’s care plans may be incomplete, generic or difficult to access and do not always cover foreseeable risks and how they should be managed. Where people have more than one condition or diagnosis, their risk assessments are not always joined up. • Risk assessments exist but may not be proportionate and do not always fully consider people’s choices or include the views of families and carers, where appropriate. This may	• Risks to an individual person are not understood or are ignored, leaving them exposed to avoidable harm or the risk of harm occurring. Deterioration, emergencies and clinical risks are not managed well. Care plans are either missing, incomplete or inaccurate and do not predict foreseeable risks. Where people have more than one condition or diagnosis, their risk assessments are not joined up. The approach to managing risk is inappropriate. People’s choices about care and treatment are not listened to or considered. • People do not feel listened to when they raise concerns about the safety of their care. Their voices are ignored or dismissed.

	delivery of care and treatment. They reflect any foreseeable risks and how these should be managed. • There is a balanced and proportionate approach to risk planning that supports people and those close to them, and advocates which respects people’s choices about their care and treatment. • There are appropriate risk management policies, procedures and practices which make sure that any restrictions on people’s freedom, choice and control are necessary, lawful, proportionate and safe. This particularly includes where people lack mental capacity. People’s care plans reflect any foreseeable risks that may need restrictions. • The service only ever uses restrictive practices as a last resort and only where it is lawful and legitimate. It reports any use of restrictive practices and has a strategy to reduce their use. • Staff work proactively to meet people’s needs and always take a least restrictive approach to avoid the need for restrictive practices. Staff have the knowledge to identify unlawful	lead to unnecessary restrictions or gaps in safety. • People do not always feel listened to when they raise concerns about the safety of their care. • The approach to imposing restrictions on people is not always proportionate and there may be examples of inappropriate use of restraint. Staff may lack knowledge to consistently identify unlawful restrictive practice, and their skills (where necessary) in de-escalation techniques may be limited. Staff do not always work to avoid the need for restrictive practices. The service does not consistently report use of restrictive practices and there is limited strategy to reduce their use. • If seclusion or segregation is used, it is not always appropriate, plans to reduce or stop using it are not always clear, and the arrangements are not regularly reviewed.	• The approach to imposing restrictions on people is disproportionate. Restraint is used in place of other more appropriate options. Staff lack knowledge to identify unlawful restrictive practice and do not have skills (where necessary) in de-escalation techniques. Staff do not work to avoid the need for restrictive practices. The service does not report use of restrictive practices and there is no strategy to reduce their use. • If seclusion or segregation is used, it is not appropriate, plans to reduce or stop using it are not clear, and the arrangements are not reviewed.

	restrictive practice. They understand what is causing people’s distress and have skills (where necessary) in de-escalation techniques. • When people communicate their needs, emotions or distress staff support them consistently and can manage this in a positive way that protects their rights and safety. • If seclusion or segregation is used, it is always appropriate and in line with best practice and there are clear plans to reduce or end it, and the arrangements are frequently reviewed.		

Safe systems, pathways and transitions

Are there systems to enable collaborative working across care pathways and services, to ensure that safety and continuity of care are prioritised?

Scope of this key line of enquiry and topic areas include:

- Care co-ordination, shared care and information sharing
- Continuity and transitions of care (including from children to adult services)
- Referrals
- Admissions and discharges
- Handover and patient flow
- Named care co-ordinators/key workers
- Proactive post discharge follow-up
- Integrated multi-disciplinary team (MDT) working

Outstanding	Good	Requires improvement	Inadequate
• Safety and continuity are embedded as core principles throughout the entire care journey. A fully integrated, collaborative working approach unites people and those close to them, advocates, staff teams, and partner organisations to ensure a safe, seamless experience across referrals, admissions, transitions, and discharge, including when people interact with multiple services. • Shared systems and processes to ensure safe care are proactively governed through collective stewardship, rigorous risk identification, clearly defined accountabilities, continual monitoring, and a strong culture of shared learning and improvement. • Plans for people's care during transition are in place before they move between services, enabling risks to be identified and mitigated and for continuity of safeguarding. Staff have timely, comprehensive	• Safety and continuity are prioritised throughout the care journey through a collaborative working, joined-up approach involving people and those close to them, advocates, staff and partners. This includes referrals, admissions and discharge, and where people are moving between or accessing multiple services. • There is a collaborative working approach with clear accountabilities to proactively manage shared systems and processes for safe care. This includes identifying risks, ongoing monitoring and shared learning and improvement to deliver optimal patient flow and timely discharge. • Plans for people's care during transitions are established before they move between services to eliminate any avoidable risks and ensure they receive continuity of care. Staff have timely access to the information they need to understand people's needs and appropriately assess, plan and deliver their care and treatment. • Transition, referral and discharge arrangements are safe and	• Care journeys are fragmented, disjointed and slow because of a lack of cohesion and continuity between services and mental health teams which may result in issues with patient flow. • Discharge planning is not always organised, leaving people uncertain about the arrangements for ongoing care. • Safety and continuity are acknowledged but not consistently prioritised throughout the care journey. Joined-up working is not embedded or consistently applied. Working collaboratively between people, staff and partners is variable, with some gaps in communication at key transition points. • Although there are shared systems and processes for safe care, collaborative working across care pathways may be limited, and processes are not fully embedded or used consistently. • Plans for people's care during transitions are not always	• There is a lack of post discharge support, which has a negative impact on people's mental health and increases the risk of a relapse. • People's discharge from hospital is premature, rushed, and sometimes happens while they are still unwell. This may be because of bed shortages and pressures on other services. • Poor communication between services results in missed information, confusion about medicines and treatment plans, and undermines care co-ordination and meeting people's needs. • Care teams lack full access to diagnostic and functional assessments, preventing a person's individual needs being met. • Safety and continuity are not prioritised throughout the care journey. The approach to care is not joined up and there is little or no collaborative working between people, staff and partners. Points of transition, including referrals, admissions

access to the information they need to understand each person’s needs and to assess, plan, and deliver safe care. • The service continuously reviews and develops its admission and discharge processes to ensure seamless patient pathways and flow through the system. It works with partners to alleviate pressure points and to find creative solutions for optimal continuity of care and transitions at a local, neighbourhood and system level. • Children and young people, along with their parents and carers, are empowered and supported to navigate services confidently. They experience well-co-ordinated, developmentally sensitive transitions into adult services, underpinned by clear, consistent ways of working between teams, settings, and partner agencies, which result in exceptional outcomes.	consider a person’s individual needs and the needs of their families and carers, their individual’s circumstances, co-occurring conditions, ongoing care arrangements and expected outcomes. • Children and young people, their parents and carers are involved and supported to navigate care and engage with education settings. Their transition into adult services is properly co-ordinated, with clear ways of working between teams and services. • Staff are proactive in working with other services when there is a need for multidisciplinary involvement, and any actions are appropriately owned and followed up as needed. • People experience continuous care delivered between services or mental health teams. Staff work cohesively, which improves their understanding of individuals care and treatment, reduces the need for people to repeat their story, and supports positive recovery outcomes. • Named care co-ordinators or key workers provide consistency and advocacy, improving care when	established before they move between services and continuity of care may be inconsistent. • Staff do not always have timely access to the information they need to understand people’s needs and appropriately assess, plan and deliver their care and treatment. • Plans for transition, referral and discharge are inconsistently completed and do not always consider people’s individual needs, circumstances, ongoing care arrangements and expected outcomes. • Children and young people and their parents (or those with parental responsibility) and carers are not always involved and supported to navigate care and education settings, and do not always experience properly co-ordinated transitions into adult services. • Processes to ensure internal pathways, such as the follow up of chronic conditions, are not always rigorous. Care involving multiple teams is not always well-co-ordinated, or work is not collaborative.	and discharge, are likely to be chaotic or unsafe. • There is no effective collaborative working approach to managing shared systems and processes to ensure safe care. Accountabilities across care pathways are unclear and there is a lack of ongoing monitoring and sharing of learning and improvement. • Poor patient flow may place people at risk of harm. • Plans for people's care during transitions are not established before they move between services. This results in avoidable risks and means that people do not experience continuity of care. • Staff do not have timely access to the information they need to understand people’s needs and appropriately assess, plan and deliver their care and treatment. • Plans for transition, referral and discharge are deficient, not safe or do not consider people’s individual needs, circumstances, ongoing care arrangements and expected outcomes.

	people experience delays accessing services. • Good support after discharge from the service, including regular visits and appointments, helps people to recover and makes them feel re-assured. • There are rigorous processes in place to ensure internal pathways, such as the follow up of chronic conditions, are safe. Care involving multiple teams is well-co-ordinated, with collaborative working in planning and delivery. • Multidisciplinary teams work effectively together to support safe delivery of care and treatment.	• Multidisciplinary teams do not always work effectively together or do not always support safe delivery of care and treatment.	• Children and young people and their parents and carers are not involved or supported to navigate care and education settings, and experience poorly co-ordinated transitions into adult services, or achieve worse outcomes. • Processes to ensure internal pathways, such as the follow up of chronic conditions, are not rigorous or safe. Care involving multiple teams is not co-ordinated. • Multidisciplinary teams do not work effectively together, or they do not support the safe delivery of care and treatment.

Safeguarding

Are there systems and processes in place to safeguard people from abuse and improper treatment and support their right to live safely?

Scope of this key line of enquiry and topic areas include:

- Safeguarding systems, processes and practices
- Protection of human rights
- Discrimination, including in relation to protected equality characteristics
- Harassment and victimisation
- Sexual safety and empowerment
- Mental capacity
- Deprivation of Liberty Safeguards (DoLS) (Liberty Protection Safeguard s)

- Online safety

Outstanding	Good	Requires improvement	Inadequate
• There is a strong and proactive commitment to taking immediate action to preventing and responding to abuse and neglect. This includes building strong relationships with partners and developing clear processes to work together across services. • Staff seek innovative ways to ensure that people's human and legal rights are respected.	• There is a strong commitment to taking immediate action to keep people safe from abuse and neglect. This includes collaborative working with partners. People are helped to understand what safeguarding means, how to stay safe, and how to raise concerns when they don't feel safe. • There are effective safeguarding systems, processes and practices managed by appropriately trained staff, which protect people from abuse, neglect, improper treatment, harassment and potential breaches of their article 3 human rights under the European Convention on Human Rights. They are clearly communicated and accessible to people and staff. Where children and young people use or visit the service, safeguarding arrangements are in line with national guidance and best practice. • People are supported to feel safe. When people feel unsafe or experience abuse, improper treatment or neglect, the service takes action quickly and supports	• Safeguarding systems, processes and practices are not always reliable or appropriate to keep people safe. They are not always managed by appropriately trained staff and are communicated inconsistently across the service. They are not always accessible. • There is a limited understanding of the term safeguarding. Staff are not always clear how to recognise abuse or who to report it to. People are not always supported to understand what safeguarding and keeping safe mean. They don't always know how to raise concerns for themselves and others and are not encouraged to do so. • Staff do not always take immediate action to keep people safe from abuse and neglect. They do not always work collaboratively with partners. • There is an inconsistent approach to helping people to understand what safeguarding means and how to raise	• Safeguarding systems, processes and practices are not fit for purpose. • Safeguarding is not a priority. Staff do not recognise or respond appropriately to signs of abuse and they don't take immediate action to keep people safe. • People are not helped to understand what safeguarding means or how to raise concerns when they don't feel safe. • People are not protected from discrimination, harassment, victimisation, psychological harm, or hate crimes. This includes discrimination related to protected equality characteristics. The service does not have processes in place to prevent discrimination and promote equality. Staff do not act when discrimination occurs. • Staff demonstrate little understanding of what constitutes a closed culture. The service does not have processes in place to prevent

	them appropriately. Risks are shared and managed with people and those close to them and advocates. • People are protected from discrimination, harassment, and victimisation, including behaviour that may amount to abuse, psychological harm, or a hate crime. This includes discrimination related to protected equality characteristics. Providers have effective systems and leadership in place to prevent discrimination, promote equality, and respond appropriately when it occurs. • People are protected from harassment and abuse in the local community and are supported to understand different forms of harassment and abuse and develop skills to protect themselves. This is done in a way that does not infringe on their independence and rights. • Staff and leaders understand what constitutes a closed culture and the risks of this to people, including organisational abuse. There are systems and processes in place to prevent closed cultures from developing, identify concerns and take appropriate action.	concerns when they don't feel safe. • The service inconsistently protects people from discrimination, harassment, victimisation, psychological harm, or hate crimes. This includes discrimination related protected equality characteristics. The service has processes in place to prevent discrimination, and promote equality, but they are inconsistently applied. Staff do not always act when discrimination occurs. • Staff do not always understand what constitutes a closed culture. Processes to prevent closed cultures from developing may be inconsistent. Staff do not always feel confident to identify concerns and take appropriate action. • There is a limited understanding of Deprivation of Liberty Safeguards (DoLS) and they are not always used appropriately. • Where children and young people use or visit the service, safeguarding arrangements do	closed cultures from developing. Staff are not able to identify concerns or take appropriate action. • There is no understanding of Deprivation of Liberty Safeguards (DoLS) and they are not used appropriately or in the best interest of the person. • Where children and young people use or visit the service, safeguarding arrangements do not align with national guidance and good practice.

	• Online safety is considered, and people are supported to understand how they can protect themselves online. • People are supported to have intimate relationships if they wish to have these. • Staff have a good understanding of safeguarding, appropriate for their role, and know how to recognise and report signs of abuse. There are clear roles and responsibilities around safeguarding. Staff understand their individual responsibilities in preventing discrimination in relation to people’s protected equality characteristics. • People are supported to understand what safeguarding and keeping safe means. They understand how to raise concerns for themselves and others and are encouraged and empowered to do so. • The service acts quickly and appropriately when people are experiencing and are at risk of abuse and neglect. • A person is deprived of their liberty only when it is in their best interests to do so and in line with the relevant legislation under the Mental Capacity Act, Deprivation	not always align with national guidance and good practice.	

	of Liberty Standards (DoLS) or Mental Health Act. Staff understand the relevant legal framework and use the appropriate codes of practice and processes correctly. • There are no delays in recognising a potential deprivation of liberty and in seeking appropriate authorisation. The service reviews people's care arrangements and adjusts these where applicable.		

Safe environments and infection prevention and control

Are the premises and equipment suitable and safe for delivery of care, and are potential risks within the care environment detected and managed appropriately to keep people and staff safe?

Scope of this key line of enquiry and topic areas include:

- Premises and buildings (including gas, electrical and fire safety)
- Equipment, including equipment to assess and monitor physical health, medical devices.
- Infection prevention and control
- Environmental risks (adverse weather such as heatwaves and flooding)
- Digital systems/technology assurance
- Anti ligature, therapeutic, sensory appropriate environments
- Contactless patient monitoring systems
- Same sex provision and shared sleeping arrangements
- Call systems
- Building note compliance and relevant environmental legislation

Outstanding	Good	Requires improvement	Inadequate
• Environments are co-designed with people who have lived experience and they incorporate therapeutic, sensory-appropriate, anti-ligature and psychologically safe design principles. Spaces actively promote recovery, autonomy, dignity and the reduction of restrictive practice. Innovative and creative design features demonstrably improve emotional safety and wellbeing for diverse groups of people using the service. • Systems to manage facilities, premises, equipment and technology are exemplary, ensuring that risks are appropriately identified and managed across their life cycle. • Systems for assessing and managing risks from infection are exemplary, deeply embedded and fully adapted to the realities of mental health care. Infection prevention and control roles are clearly defined, highly	• The facilities, premises, equipment and technology are safe to use, well-maintained and consistently support the delivery of safe and effective care. Staff are clear about their responsibilities with regard to safe environments. • The size, setting and design of the service aligns with best practice and legislation. • People are cared for in safe and age-appropriate environments that are designed to meet their needs. There are designated spaces to meet people's cultural and sensory needs. • The signage, decoration and other adaptions to the premises help to meet people's needs and keep them safe. • Any changes to the environment are risk assessed and do not impose any restrictions on people's liberty or cause any distress to people. • There is a comprehensive system to proactively identify and manage risks in the care environment. • There is an effective approach to assessing and managing the risk	• Systems to detect and control potential risks in the care environment are inconsistent. As a result, the facilities, premises, equipment and technology are not always safe to use, well-maintained, stored safely, clean or used properly. • Environments do not always meet people's physical and psychological needs. The premises are not always suitable for the purposes for which they are being used. • The service does not always consider how changes to the environment might affect people. It does not always mitigate risks associated with changing the environment, which may result in restrictions to people's liberty and causes distress. • There are fire safety procedures in place, but they are not always effective. Staff do not always know what to do if there is a fire. Where the provider is not responsible for the premises, it does not always take reasonable action to appropriately escalate concerns.	• Systems to detect and control potential risks in the care environment are ineffective. As a result, the facilities, premises, equipment and technology systems are unsafe. • The environment does not meet people's needs and the premises are not suitable for the purposes for which they are being used. • The service does not consider how changes to the environment might affect people. It does not mitigate risks associated with changing the environment, meaning that changes often result in restrictions to people's liberty and cause distress. • Fire safety procedures are either ineffective or do not exist. Staff do not know what to do if there is a fire. Where the provider is not responsible for the premises, it does not appropriately escalate concerns. • The service does not act on alerts, recalls and safety information in a timely way.

skilled and visible in everyday practice.	of infection, in line with current national guidance. Staff have clear roles and responsibilities around infection prevention and control. Information about the risk of infection is shared appropriately with relevant partners, including agency staff, contractors, people using the service and visitors. • Equipment, supplies and technology used for delivering care and treatment are suitable for the intended purpose, stored securely, well maintained, safe and used properly. • Safety alerts, recalls and safety information are promptly reviewed and acted on. • There are effective fire safety procedures in place. Where the provider is not responsible for the premises, staff takes reasonable and prompt action to appropriately escalate concerns. • Staff carry out comprehensive risk assessments to consider how the environment can keep people safe from physical and psychological harm. For example, in relation to sexual safety or sensory needs. • The environment is safe for staff to work in.	• The service does not always act on alerts, recalls and safety information in a timely way. • Staff do not always consider how environments can keep people safe from physical and psychological harm. Infection prevention and control is not always appropriately managed. Staff do not always follow good practice in relation to infection prevention and control, and information about the risk of infection is not always shared with partners. • The environment is not always safe for staff to work in.	• There is no consideration about how the environment can keep people safe from physical and psychological harm. • There is no system to assess and manage the risk of infection. Staff are not clear on their responsibilities around infection prevention and control. Information about the risk of infection is not known or shared. • The environment is not safe for staff to work in.

	• The service provides safe, well-supervised environments for all visitors, including children who attend adult settings, where there is a welcoming, supportive atmosphere.		

Safe staffing

Are there are enough qualified, skilled and experienced staff to keep people safe and meet their needs, with strategies to manage demand and capacity safely?

Scope of this key line of enquiry and topic areas include:

- Workforce capacity and capability (including vacancies, turnover and sickness)
- Safe recruitment (including DBS)
- Staffing levels and skills mix
- Skills, qualifications and revalidation
- Learning, development, performance and competency
- Support, appraisal and supervision
- Agency staff, volunteers and unpaid carers
- Mental health specific acuity tools
- Mental health specific training including use of force, restraint, life support and Mental Health Act
- Learning disability and autism training
- Training co-produced/co delivered with people with lived experience
- Appropriate multi-disciplinary team composition

Outstanding	Good	Requires improvement	Inadequate
• The service demonstrates exemplary foresight in workforce planning, using demand and capacity	• There are appropriate staffing levels and skill mix to meet the needs of people. Where required staffing levels cannot be met,	• There are periods of understaffing or inappropriate skill mix, which are not addressed quickly. Agency,	• Substantial staff shortages and inappropriate skill mix are common. Agency, bank and locum staff are not used to

modelling, population trends and escalation data to anticipate pressures well ahead of need. Staffing levels and skill mix are optimised continuously using real-time intelligence, mental-health-specific acuity tools and feedback from people with lived experience, ensuring safe, proactive and personalised care even during crisis or system pressure. • Recruitment and development are exceptional. Values-based recruitment ensures staff have outstanding competence, cultural humility and trauma-informed practice skills, with lived experience meaningfully shaping decisions. Staff are proactively supported to develop advanced specialist skills and are empowered to lead improvement, share learning and influence practice across the system. • Support, supervision and training are exemplary: reflective, restorative, psychologically safe and embedded across all roles. Leaders prioritise wellbeing,	leaders support staff who deliver care to develop short-term adaptations to make sure people continue to receive consistently safe, good quality care that meets their needs. • The service takes action to protect staff from fatigue, and leaders understand its impact on the safety of those who use services. • There are rigorous and safe recruitment practices to make sure that all staff, including agency staff and volunteers, are suitably skilled, experienced qualified and competent and able to carry out their role. • Staff receive training appropriate and relevant to their role and the patient group they serve. Staff at all levels have opportunities to learn and develop their practice. • Representatives for people and those close to them are involved in delivering and developing relevant staff training. • Staff receive the support they need to deliver safe care. This includes supervision, appraisal, development and, where needed, professional revalidation. Poor performance is managed appropriately.	bank and locum staff are not always used in a way that ensures people's safety is protected at all times. • Inconsistent recruitment practices result in staff not always being suitably skilled, experienced or competent to carry out their role. • There is limited understanding about how staff fatigue can affect patient safety. • Staff do not always receive appropriate training or training is not delivered soon enough. There are few opportunities for staff to learn and develop. • Systems to ensure staff receive adequate supervision, appraisal and development are deficient. Poor performance is not always appropriately managed. • Training in the use of force is certified as complying with the Restraint Reduction Network's training standards, but the training needs analysis isn't updated annually. • People's care is adversely affected because of regular changes in staff.	make sure people continue to receive safe care. Staff fatigue is not considered. • Recruitment practices are unsafe. Staff are not suitably skilled, experienced, qualified or competent to carry out their role. • Staff do not receive appropriate training. • Staff are not given opportunities to develop, and they do not receive supervision or appraisal. Poor performance is ignored. • Training in the use of force is not compliant with the Restraint Reduction Network's training standards. • People are at risk of harm because of regular changes in staff.

emotional safety and professional growth. Training in the use of force is trauma-informed, co-produced and co-delivered with people who have experienced restrictive interventions, contributing to sector-leading reductions in restraint.	• People’s support systems, including volunteers, carers and families, are offered appropriate training to support their caring responsibilities, such as manual handling and medicines management. • Training in the use of force is certified as complying with the Restraint Reduction Network’s training standards. The training needs analysis is updated annually. • Recruitment, disciplinary and capability processes are fair and are reviewed to ensure there is no disadvantage based on protected equality characteristics. • Staff at all levels have opportunities to learn. • The provider has systems for investigating any allegations (both in work and external to work) against people in positions of trust (PiPOT) who it employs and takes actions to ensure there is no risk to people using the service.		

Safe delivery of treatments and medicines

Are medicines and treatments delivered safely and in a timely way, in line with people's needs and preferences?

Scope of this key line of enquiry and topic areas include:

- Roles and responsibilities, delegation in relation to medicines
- Prescribing and medicines and treatment review
- Self-medication
- Consent/decisions/covert administration (including Mental Capacity Act and Mental Health Act)
- Controlled drugs
- Self-medication
- Storage and disposal of medicines
- Antimicrobial stewardship
- STOMP/STAMP
- Innovative medicines and safe medical technology
- Non-pharmacological anxiety/agitation strategies
- Treatment under MHA compliant with Code of Practice and appropriate authorisations.
- Physical health monitoring for the initiation and maintenance of a relevant treatment
- Monitoring high dose anti-psychotics

Outstanding	Good	Requires improvement	Inadequate
• People (or their representatives) are active partners in decisions, assessments and reviews about their medicines, where possible. The service implements creative, person-centred solutions to enable this.	• People (or their representatives) are appropriately involved in decisions, assessments and reviews about their medicines. This information is clearly documented in their records. Medicines information is accessible in all formats. People, or their representatives, can access support from pharmacy or	• People are not always involved in decisions, assessments and reviews about their medicines, and this is inconsistently documented. • Staff have a limited understanding on what to do when a person lacks capacity to make decisions concerning their medicines.	• Staff do not involve people when making decisions, assessments and reviews about their medicines and these decisions are not recorded properly. Staff have little or no knowledge on what to do when a person lacks capacity concerning their medicines.

• There is a comprehensive system to proactively promote the safe optimisation of medicines. Staff at all levels are clear about roles and responsibilities in relation to medicines, supported by a co-ordinated, multi-professional approach across the healthcare system to ensure effective use of medicines. • Staff contribute to innovation and research on medicine.	a relevant healthcare professional throughout their care. • The approach to medicines reflects current national or professional guidance, best available evidence and relevant best practice. • People’s medicines are appropriately prescribed, supplied and administered in line with relevant legislation, current national guidance and best practice. People are supported to safely self-administer their medicines where appropriate. • There are clear roles and responsibilities that support the safe optimisation of medicines. Staff understand their responsibilities to support the safe optimisation of medicines, including the importance of medicine reviews, physical health monitoring, audits and good record keeping. • Where a person lacks capacity to make decisions about their medicines, formal processes (under the Mental Capacity Act 2005) and assessments are undertaken before they are administered. This includes	• The service does not always follow relevant national guidelines and legislation around prescribing, supplying and administering medicines, including controlled drugs. • Staff do not always understand their responsibilities to support the safe optimisation of medicines, including the importance of medicine reviews, physical health monitoring, audits and good record keeping. • Where medicines are prescribed for the management of anxiety and agitation, care plans and records are not always accurate or do not always reflect people’s individual needs.	• People’s behaviour is inappropriately controlled by medicine. • People are at risk because staff do not prescribe, supply and administer medicines, including controlled drugs, safely. Legislation, current national guidance and best practice is not followed. • People’s physical health and any side effects of medicines are not monitored or recorded in line with local and national guidance. • Where medicines are prescribed to manage anxiety and agitation, care plans and records are not accurate or do not reflect people’s individual needs. There are no assurances that these medicines are being used appropriately and safely. • Staff are not clear about their responsibilities to support the safe optimisation of medicines. There are no medicine reviews or audits to monitor safety performance. • Record keeping for medicines is poor, particularly when people move between healthcare settings.

	exploring alternative ways of administration. • People’s behaviour is not inappropriately controlled by excessive or inappropriate use of medicines. • The service actively considers opportunities to reduce over-medicating people, in line with STOMP/STAMP/STOP principles. • Where a person receives treatment under the Mental Health Act (MHA) 1983, treatment is given in line with the appropriate MHA authorisations, and review processes are followed in line with the code of practice. There are appropriate care plans and risk assessments in place to support people to manage anxiety and agitation including non-pharmacological approaches. There are clear records detailing when a medicine is used and why it was needed, and this informs care planning. • Accurate, up-to-date information about people’s medicines is available, particularly when they move between healthcare settings or services.		

	• There are appropriate arrangements for the safe management, use and oversight of controlled drugs in line with legislation and best practice. • Use of medicines benchmarking, learning and quality improvement initiatives mean people consistently experience positive and improving outcomes in line with legislation, standards and evidence-based guidance. Quality of life and equity are considered in outcome measures.		

EFFECTIVE

People’s care, treatment and support achieves good outcomes, helps them to maintain quality of life and is based on the best available evidence.

I statements

- ✓ **I can get information and advice about my health, care and support and how I can be as well as possible – physically, mentally and emotionally.**
- ✓ **I have care and support that is co-ordinated, and everyone works well together and with me.**
- ✓ **I am supported by people who listen carefully so they know what matters to me and how to support me to live the life I want.**
- ✓ **I can live the life I want and do the things that are important to me as independently as possible.**

Assessing needs

Are people’s needs holistically assessed and reviewed with them, and their families and carers, to maximise the effectiveness of their care, treatment and support?

Scope of this key line of enquiry and topic areas include:

- Assessing people’s needs (including accessibility and communication needs)
- Person-centred approach to assessment
- Carer assessments and support
- Care planning
- Clinical assessment tools
- Lawful, rights-upholding assessment
- Trauma-informed assessment
- Systematic consideration of neurodiversity and co-occurring conditions
- Physical health needs assessments
- Assessing any drug and alcohol dependence

Outstanding	Good	Requires improvement	Inadequate
• The service shows an exceptional and unwavering commitment to equity and inclusion. Care plans proactively identify and address inequalities or vulnerabilities that could lead to exclusion, ensuring support is fair, personalised and removes barriers to participation and wellbeing. • Staff anticipate people's emotions, distress and early warning signs with insight and professional curiosity. Their consistently compassionate and attuned support prevents deterioration, fosters psychological safety and results in excellent and improving outcomes. • Carers and advocates are active partners in care, and their needs are assessed and supported. Risk assessments are developed collaboratively, proportionate and empowering. In mental health units, information about the use of force is co-produced with people with lived experience and	• Assessments and care plans are person-centred. They reflect people's physical, mental, emotional, sensory, cultural, social, and communication needs. They also include the needs of people who may have more than one condition or diagnosis, and needs related to protected equality characteristics. • People and those close to them and advocates are involved in the assessment of their individual needs. They are confident that their needs have been assessed, are fully understood, and that they will be supported to maximise their involvement in an environment that is suited to their needs. • Person-centred assessments enable people to receive care or treatment that has the best possible outcomes. Assessments focus on people's strengths, understand neurodiversity and co-occurring conditions and staff use a trauma-informed approach to during assessments. • Staff use a range of tools to assess and anticipate people's needs, wellbeing, emotions and level of distress to ensure those	• Assessments and care plans do not consistently reflect people's holistic needs. • People are not consistently involved, or supported to be involved, in the assessment of their needs. They are not confident that their individual needs have been appropriately assessed or do not consistently understand the assessment process. • Care assessments do not consider the full range of people's diverse needs, including those related to protected equality characteristics, communication, nutrition, hydration and pain relief. • People's needs, emotions or levels of distress are not consistently or routinely assessed, or there are limited tools available to support staff to understand and reflect them in assessments and care plans. • Assessments are not consistently up-to-date, or there are delays in completing them. People's care, treatment	• Care plans are not tailored to people's individual requirements because assessments do not consider their holistic needs**.** • People are not routinely involved in the assessment of their needs, or they are assessed in a way they do not understand. • Assessments and care plans do not reflect people's diverse needs. Discriminatory decisions may have been made related to people's protected equality characteristics. Care or treatment is based on discriminatory decisions rather than a full assessment of a person's needs, including those related to communication, nutrition, hydration and pain relief. • People's needs, emotions or levels of distress are not included in their needs assessment. Staff do not have tools available to support them to understand people. • Assessments are delayed, not completed or not updated. People's care, treatment and support needs are not

provided promptly in accessible formats.	needs are understood and reflected in assessments. Staff have a compassionate and person-centred approach, using assessments to prevent deterioration or escalation. • Assessments are completed at the earliest opportunity, kept up-to-date and regularly reviewed with the person and those close to them, where possible. • Where appropriate, families, carers, advocates, professionals and other stakeholders are proactively identified and meaningfully involved in the assessment of people's needs and when reviewing them. • The needs of people's carers are also assessed and met. This supports their health and wellbeing in their carer roles and helps them to provide safe and effective care to the people they support. • Where people are subject to the Mental Health Act 1983 (MHA), their rights are protected and staff comply with the MHA Code of Practice. Any departure from the Code of Practice guidance is clearly justified, risk-assessed and communicated openly to	and support needs are not routinely reviewed, where appropriate. • The needs of carers of people using services are not consistently considered as a priority in helping them to provide safe and effective care to the people they support. • Risk assessments about care are not consistently person-centred or proportionate. They may not be reviewed regularly or reviewed with the person, where possible. • Staff do not always adhere to the Mental Health Act Code of Practice. Deviation from Code of Practice guidance is not always clearly recorded. • For mental health units: information for people and their families about the use of force by staff is only available in a single format or is not routinely provided.	reviewed where appropriate, including after incidents. • The needs of carers of people using services are not considered to help them provide safe and effective care to the people they support. • Risk assessments about care are not person-centred or proportionate. • Staff fail to comply with the Mental Health Act Code of Practice or other legislation. • The service does not provide any information for people and their families about the use of force by staff.

	people and those close to them, where appropriate. - For mental health units: information for people, and their families about the use of force by staff is made available as soon after admission as possible. It is available in a range of formats to meet individual needs including easy to read format.		

Delivering evidence-based care and treatment

Is care and treatment delivered in line with current legislation, standards, evidence-based guidance and good practice?

Scope of this key line of enquiry and topic areas include:

- Best practice guidance and standards
- Nutrition and hydration
- GIRFT (Getting it right first time) recommendations
- Clinical reviews/medical committees
- Service accreditation schemes
- Lawful least-restrictive treatment
- Access to full range of psychological therapies, occupational therapies and therapeutic activity.
- Planned, risk assessed mental health act leave
- Recovery orientated care delivery
- Physical health interventions

Outstanding	Good	Requires improvement	Inadequate
- People receive a range of care and treatment options that are person-centred,	- People receive evidence-based care, treatment and support that aligns with good practice	- People's care, treatment and support does not always reflect current evidence-based	- People's care, treatment and support does not reflect current evidence-based guidance,

evidence-based and responsive to their individual needs, preferences and aspirations, recognising their strengths, cultures and histories, and resulting in better outcomes. • There are rigorous, inclusive and evidence-driven systems and processes that continually enhance people’s care, treatment and mental health outcomes. The service has proactive, well-designed systems that keep staff ahead of national legislation, evidence-based mental health practice and required standards, while actively supporting innovation and research within a psychologically safe environment. • People are proactively empowered to share the decision making about their care and treatment, informed by the latest good practice. They, those close to them and advocates are fully and actively involved in ensuring these decisions are clearly reflected in personalised care plans.	standards, guidance and technological advances. People receive the right care, in the right place, and at the right time. • There are effective approaches to monitor people’s care and treatment. The service participates in external audits and benchmarking, and the results are used to improve quality effectively. • All staff understand the current legislation, national standards and good practice guidance relevant to their service and apply these effectively. There are good systems to ensure they keep up-to-date and that they embed this in their service. • People are told about current good practice that is relevant to their care, and they, and those close to them are involved in how this is reflected in the care, treatment and support they receive. • Staff and leaders are encouraged to learn about new and innovative approaches based on evidence that shows they can improve how their service delivers care. • There is a clear strategy for managing people’s co-occurring	guidance, standards, best practice and technological advancements. People do not always receive the right care, in the right place, at the right time. • The service’s systems do not always ensure that staff are up-to-date with national legislation, evidence-based good practice and required standards. • People are not always told about current good practice that is relevant to their care, and they are not always involved in how this is reflected in their care plan. • Staff and leaders are not routinely encouraged to learn about new evidence-based approaches to improve how the service delivers care. Benchmarking with similar services is not proactively used to identify and address where improvements are needed. • There is a strategy for managing co-occurring conditions and multiple diagnoses, but it is not clear to everyone, and staff are uncertain about roles and responsibilities in managing them.	standards, practice or technology. People do not receive the right care, in the right place at the right time. • The provider’s systems do not ensure that staff are up-to-date with national legislation, evidence-based good practice and required standards, or there are no systems to do so. • People are not told about current good practice that is relevant to their care, and they are not involved in how this is reflected in their care plan. • Staff and leaders are not supported or encouraged to learn about new evidence-based approaches to improve care delivery. Benchmarking with similar services is not used to identify and address where improvements are needed. • There is no strategy to manage co-occurring conditions and multiple diagnoses. Staff do not know about roles and responsibilities in managing them. • People’s nutrition and hydration needs are not assessed or met, including

• Staff and leaders are encouraged to learn about new and innovative approaches to delivering care, which are based on evidence of improvements. They use benchmarking and collaborative working with similar services to identify and address improvements, embracing a learning and improvement culture.	conditions and multiple diagnoses. Staff are clear about roles and responsibilities to manage them by working with other services. • People have access to a full range of psychological therapy, occupational therapy and activities suitable for their needs. • People's nutrition and hydration needs are assessed and met, including personal, cultural and sensory preferences. • Where people are subject to the Mental Health Act 1983 (MHA), decisions made about care and treatment comply with the MHA and the MHA Code of Practice. Any departure from the Code of Practice guidance is clearly justified and risk assessed. • People are able to take appropriate leave from hospital for recreation and rehabilitation, and care plans reflect this.	• People's nutrition and hydration needs are not consistently assessed or met and may not include their personal or cultural preferences. • Decisions made about care and treatment do not always adhere to the Mental Health Act Code of Practice. Deviation from Code of Practice guidance is not always clearly recorded.	their personal or cultural preferences. • Decisions made about care and treatment do not comply with the Mental Health Act Code of Practice or other legislation.

Outcomes

Does the service monitor outcomes and compare performance to improve the effectiveness of care for all?

Scope of this key line of enquiry and topic areas include:

- Clinical audits

- Research and clinical trials
- Peer review
- Benchmarking
- Quality improvement initiatives
- Monitoring and improving outcomes
- Inequalities in outcomes
- Approved mental health outcome measures including quality of life
- Equity in analysis of outcomes by protected equality characteristics

Outstanding	Good	Requires improvement	Inadequate
• Outcomes for people who use services are consistently better than expected. They are recorded using approved outcome measures, and compared with other similar services. Inequalities are addressed so outcomes are equitable for all. • Effective use of benchmarking, learning and quality improvement initiatives mean people consistently experience positive and improving outcomes that are better than agreed expectations in legislation, standards and evidence-based guidance, with quality of life and equity considered in outcome measures.	• People have positive consistent outcomes that meet agreed expectations as set out in legislation, standards and evidence-based clinical guidance because they receive effective care and treatment that meets their needs. • There are effective approaches to routinely collect and monitor information about people's care and treatment and their outcomes. Outcome measures consider quality of life. This information is used to improve care. • Where relevant, the service participates in local and national clinical audits and other monitoring activities such as reviews of services, benchmarking and peer review and approved service	• People are at risk of not receiving effective care or treatment. There is a lack of consistency in the effectiveness of the care, treatment and support that people receive. • People's outcomes from their care and treatment are below expectations when compared with similar services. Information on outcomes is not always monitored regularly or thoroughly. The results of monitoring are not always used effectively to improve quality. Participation in external audits and benchmarking is limited. • Outcomes for people are below expectations compared with similar services. Meeting expectations as set out in legislation, standards and	• People's care is ineffective or there is insufficient assurance in place to demonstrate otherwise. • There is very limited or no monitoring of the outcomes of care and treatment. People's outcomes are very variable or significantly worse than expected when compared with other similar services. Necessary action is not taken to improve people's outcomes. • Outcomes for people are very variable or significantly worse than expected when compared with other similar services. • There are very limited or no monitoring of the outcomes of care and treatment. Necessary action is not taken to improve people's outcomes.

• There are proactive, rigorous and inclusive systems that continually monitor, understand, and enhance people’s outcomes. All staff are actively engaged in activities to monitor and improve quality and outcomes (including, where appropriate, monitoring outcomes for people once they have transferred to other services). Opportunities to participate in benchmarking and peer review are proactively pursued, including participation in approved accreditation schemes. • High performance is recognised by credible external bodies. • The service uses outcomes measures to review performance and drive improvements, including by comparing outcomes across groups with different characteristics, such as protected equality characteristics. • Care is culturally sensitive and non-discriminatory, leading to consistently better	accreditation schemes. Accurate and up-to-date information about effectiveness is shared internally and externally, and all staff understand it. The information is used to improve the quality of people’s care, treatment and outcomes, and this improvement is checked and monitored. • Staff and leaders use benchmarking with similar services to identify where improvements in outcomes are needed, and to address these. • Leaders know of, and act on, any disproportionality in outcomes by protected equality characteristics. • People have good outcomes because their rights are understood and acted upon. Experiences of discrimination or inequality are used to improve outcomes as well as care. • Leaders and staff understand discrimination and inequality factors that intersect to disadvantage groups and take action with partners and communities. Evidence shows improvements in outcomes for marginalised groups. • Leaders and staff consistently use data, research and engagement to identify equity	evidence-based clinical guidance is variable. • Outcomes of people’s care and treatment are not always monitored regularly or thoroughly. Participation in benchmarking is limited. The results of monitoring are not always used effectively to improve quality. • People do not consistently feel their experiences of discrimination or inequality are acted upon in ways that improve outcomes. • Leaders and staff lack consistent understanding of discrimination and inequality factors that affect outcomes. Links with communities and use of data are inconsistent, limiting their ability to improve outcomes. • Leaders and staff are reactive in working toward equitable outcomes. Systems to gather, use and monitor information about equity in outcomes may be missing, weak or poorly used. • The service does not fully comply with equality and human rights law but is aware	• People’s experiences of discrimination and inequality are not acted upon, and positive outcomes are declining. • Leaders and staff are unaware of discrimination and inequality affecting outcomes and do not consider this when delivering the service. They do not use data or community insight to understand or address outcome disparities. • Leaders and staff do not recognise unequal outcomes or take action to improve them. People feel their protected equality characteristics, ethnicity or culture negatively affect their outcomes. • The service does not comply with legal equality and human rights requirements and is not aware of areas of non-compliance.

outcomes for marginalised communities and individuals. • Leaders and staff build strong partnerships with system partners and communities to understand and address discrimination and inequality in the local and wider system, including intersecting factors affecting outcomes. • Leaders and staff use data and research proactively and work in evidence-based ways with partners and communities to understand issues affecting equity in outcomes. This drives high-quality, equitable outcomes by recognising barriers, acting on insights, allocating resources and embedding learning and innovation.	barriers and allocate resources to improve people’s outcomes. • The service complies with equality and human rights law by preventing discrimination, providing culturally sensitive and non-discriminatory care and making reasonable adjustments to support equity in outcomes. • The service analyses outcomes for people with different protected equality characteristics to identify and address health inequalities, taking action to achieve equitable outcomes.	of non-compliance and taking steps to address it.	

Supporting people to live healthier lives

Are people supported to manage their own health and wellbeing and, where the service is responsible, how does it improve the health of its population?

Scope of this key line of enquiry and topic areas include:

- Population health and prevention (including health inequalities)
- Identification and early health interventions
- Supporting access to healthcare services – GP, dentists, secondary care, social care, etc

- Healthier lives promotion
- Physical activity
- Care Education and Treatment Reviews
- Population data used to target prevention
- Mental Health Act empowerment principle

Outstanding	Good	Requires improvement	Inadequate
• Staff develop a deep understanding of people's preferences, strengths, cultures, protected equality characteristics and lived experience to deliver genuinely person-centred care and treatment. They empower people and, where appropriate, those close to them, to manage their health and wellbeing, access wider healthcare services and make informed, healthier choices. • The service fosters an open, inclusive and psychologically safe culture, using proactive, equity-driven approaches to recognise diverse needs, remove barriers, and embed preventative practice through continuous learning and innovation. • Population health data is used to drive prevention and improve outcomes across	• People are empowered and supported to manage their own health, care, treatment and wellbeing needs by staff who understand their individual needs and preferences. • People are supported to review their health and wellbeing needs, and to access other health or social care services. • People are encouraged and supported to make healthier choices to help promote, and maintain, their health and wellbeing. • The service focuses on identifying preventative approaches to improve long-term health and positive outcomes. When risks to people's health and wellbeing are detected, people are supported to prevent deterioration. • The service considers and acts on health inequalities and barriers that may affect different	• People are not consistently supported to manage their own health, care, treatment and wellbeing needs. Staff do not always understand their needs and preferences. • People are not consistently or regularly supported to review their health and wellbeing needs where appropriate and necessary. They do not always receive support to access other healthcare services. • People are not always encouraged and supported to make healthier choices to help promote and maintain their health and wellbeing. • There is limited focus on prevention and early identification of health needs to improve long-term health outcomes. When risks to people's health and wellbeing are detected, they are not	• People are not supported to manage their own health, care, treatment and wellbeing needs. Staff do not know their needs and preferences. • People are not supported or involved in regularly reviewing their health and wellbeing needs where appropriate and necessary. They do not receive support to access other healthcare services. • People are not encouraged or supported to make healthier choices to help promote and maintain their health and wellbeing. • There is no focus on prevention and early identification of health needs. Staff are reactive, rather than proactive in supporting people to live healthier lives, and those who need extra support are not identified. Risks to people's

communities. Staff work proactively with external health-promotion partners, sharing insights across neighbourhoods and creating seamless opportunities for people to develop skills, improve wellbeing and access community resources that aid recovery.	people when taking preventative approaches. • The service uses population health data to drive proactive, preventative action that improves people's outcomes and acts on health inequalities. • Where people are subject to the Mental Health Act 1983 (MHA), decisions made about care and treatment comply with the empowerment and involvement guiding principle and the MHA Code of Practice. Any departure from guidance is clearly justified and risk assessed.	always supported to prevent deterioration. • Where relevant, population health data is inconsistently understood to drive preventative action or improve outcomes. • Decisions made about care and treatment do not always adhere to the Mental Health Act and Code of Practice. Deviation from guidance is not always clearly recorded.	health and wellbeing are not detected. • Where relevant, services have no awareness of, or do not use population health data to drive preventative action or improve outcomes. • Decisions made about care and treatment do not comply with the Mental Health Act and Code of Practice or other legislation.

Consent to care and treatment

Are people supported to understand, and exercise, their right to consent to care and treatment?

Scope of this key line of enquiry and topic areas include:

- Right and capacity to consent
- Advocacy and support
- Information and communication about people's rights, including consumer rights
- Mental Capacity Act
- Mental Health Act
- Lawful, rights-based decisions
- Independent advocacy

Outstanding	Good	Requires improvement	Inadequate

• Capacity to consent is assessed with exceptional compassion, curiosity and respect. People are supported through a trauma-informed and culturally sensitive approach that enables them or their relevant representatives to fully understand their rights and play an active, empowered role in decisions about their care. • People consistently receive clear, inclusive and accessible information about their rights, including the right to advocacy. Staff skilfully adapt their communication methods to meet individual communication needs, cultural backgrounds, past experiences, and preferences, ensuring every person feels listened to, valued and fully involved. • Information and advice are exemplary in quality: always accurate, current, evidence-based and tailored to diverse communication needs. This ensures people can make genuinely informed decisions, even in complex	• Capacity to consent is assessed, and people (or their relevant representatives) understand their rights and are involved in decisions about their care. • Decisions are made in line with the Mental Capacity Act 2005, involving carers or advocates when needed. • People are supported to understand their rights to consent to care and treatment, including rights to advocacy. They understand they have the right to change their mind and withdraw their consent, and staff respect this. • People's rights are communicated in a way that meets their communication needs. This includes their human rights, rights under the Mental Capacity Act 2005, rights under the Equality Act (2010) and any other relevant legislation. These rights are promoted and protected. • People are supported to access independent advocacy, including statutory or non-statutory when available, and advocates are appropriately involved by the service.	• Capacity to consent is not consistently assessed in the appropriate circumstances. People (or their relevant representatives) do not always understand their rights and are not consistently involved in decisions about their care. • People are not always supported to understand their rights to consent to care and treatment or their rights to advocacy. • Decisions are not always made in line with the Mental Capacity Act 2005. Carers or advocates are inconsistently involved in decision making. • Information and advice about consent is not always accurate or up-to-date or does not always meet people's communication needs. Information about care and treatment, including on contracts and charges, where appropriate, is not always provided in a clear or transparent way that people can understand. • The laws and principles that apply to consent for children, young people and those with parental responsibility (or court	• Capacity to consent is not appropriately assessed. People (or their relevant representatives) do not understand their rights and they are not involved in decisions about their care. • People are not supported to understand their rights to consent to care and treatment or their rights to advocacy. • Decisions are not made in line with the Mental Capacity Act 2005. Carers or advocates are rarely or never involved in decision making. • Information and advice about consent is inaccurate or out-of-date, and is not provided in a way that meets people's communication needs. Information about care, including contracts and charges, where appropriate, is unclear, not transparent, or difficult for people to understand. • The laws and principles that apply to consent for children, young people and those with parental responsibility (pr court appointed representatives) are not understood or adhered to.

or emotionally challenging circumstances. • Openness and integrity are embedded throughout all care processes. People receive transparent, personalised explanations about all aspects of their care, including treatment options, therapeutic approaches, the Mental Health Act, community treatment orders, contracts and charges. The service's values-driven culture means staff consistently go beyond expectations to ensure people feel safe, respected and in control.	• Information and advice about consent is accurate, up-to-date, and meets people's communication needs. Clear, transparent information about care and treatment is provided, including on contracts and charges where appropriate. • The service has clear policies and procedures to follow when assessing capacity and making best-interest decisions. These are in line with appropriate legislation and staff document these decisions consistently and transparently. • The laws and principles that apply to consent for children, young people and those with parental responsibility (or court appointed representatives) are understood and adhered to. • Where people are subject to the Mental Health Act 1983 (MHA), consent to care and treatment provisions, rights to access independent mental health advocates and the MHA Code of Practice are complied with. Any departure from the Code of Practice guidance is clearly justified.	appointed representatives) are not always understood and adhered to. • Staff do not always adhere to the Mental Health Act Code of Practice. Deviation from Code of Practice guidance is not always clearly recorded.	This places children and young people at risk. • Staff fail to comply with the Mental Health Act Code of Practice or other legislation.

CARING

Staff involve and treat people with compassion, kindness, dignity and respect.

I statements

- ✓ **I am treated with respect and dignity.**
- ✓ **I am supported to manage my health in a way that makes sense to me.**
- ✓ **I am in control of planning my care and support. If I need help with this, people who know and care about me are involved.**
- ✓ **I can keep in touch and meet up with people who are important to me, including family, friends and people who share my interests, identity and culture.**
- ✓ **I can live the life I want and do the things that are important to me as independently as possible.**
- ✓ **I am supported to plan ahead for important changes in life that I can anticipate.**
- ✓ **I am supported to make decisions by people who see things from my point of view, with concern for what matters to me, my wellbeing and health.**

Kindness, compassion and dignity

Are people treated with kindness, empathy, compassion and respect, and is their privacy and dignity maintained?

Scope of this key line of enquiry and topic areas include:

- Respect and dignity
- Caring and compassion staff
- Privacy and confidentiality
- Emotional wellbeing
- Communication
- Anticipating need and responding quickly
- Consistent trauma informed relational practice
- Cultural sensitivity and anti-discriminatory approach

Outstanding	Good	Requires improvement	Inadequate
• The service has an exceptional, values-driven culture of person-centred, trauma-informed and non-discriminatory care. Staff show deep cultural sensitivity, proactively challenge inequity and protect people’s privacy, dignity and individual identity. • People consistently report feeling genuinely cared for, respected and understood. Those who have experienced discrimination or marginalisation describe compassionate, equitable care that exceeds expectations. • Staff demonstrate exemplary therapeutic relationships, showing kindness, patience, empathy and curiosity. They anticipate discomfort or distress and use trauma-informed approaches to maintain emotional safety and prevent escalation. • Feedback from people and those close to them and external partners is consistently positive, reflecting the strong, trusting	• People are cared for with kindness, compassion, dignity and respect by all those involved in their care. People experience care and treatment in a nurturing and supportive environment. Staff communicate clearly, in a kind and respectful way. They listen actively to people to understand and respond to their individual needs and preferences. Families, carers and advocates are listened to, and communicated with, clearly and respectfully. • Staff genuinely care about people’s wellbeing and show it in a thoughtful, meaningful way. They quickly anticipate and prioritise people’s comfort and wellbeing, using appropriate tools and communication to meet people’s individual needs effectively and avoid any preventable discomfort, concern or distress. When people show discomfort or distress or have urgent needs, staff respond in a positive way. This protects people’s rights and dignity, and staff learn to understand the causes of people’s distress in order to avoid it happening again.	• People are not always cared for with kindness, compassion, dignity and respect. They do not always experience care and treatment in a nurturing and supportive environment. • Some people who use the service, those who are close to them and other stakeholders have concerns about the way staff treat people. • Staff do not always prioritise people’s privacy, dignity and confidentiality. • Staff do not always understand the need to make sure that people’s privacy and dignity is always maintained. While this may not be intentional, it results in people not always feeling they are respected, valued or safe. • The service does not prioritise a caring environment. • Staff are reactive when people experience preventable harm, concern or distress.	• People are not cared for with kindness, compassion, dignity and respect. They do not experience care and treatment in a nurturing and supportive environment. • People’s privacy, dignity and confidentiality is not respected. There is a demonstrable lack of understanding of privacy, dignity and confidentiality or staff do not see this as a priority. • The lack of kindness, respect and compassion is usually serious and widespread. People feel staff do not take them seriously, leading to feeling that staff do not care about them. • People do not feel cared for and feedback about staff interactions is negative. • Staff are rude, impatient, judgmental, disrespectful or dismissive of people using their services or of those close to them. • People do not receive support to cope emotionally with their care and condition.

relationships at the heart of the service. Staff provide holistic support that addresses people's emotional, psychological, cultural, social and physical needs.	• Staff understand and support people's human rights to ensure that privacy, confidentiality, and respect are consistently upheld where possible. • There is a culture of kindness and respect across teams and partner organisations. Staff display positive behaviours when they interact with people, including when they talk about them with other professionals and stakeholders. • People and those close to them are aware of support networks, community services, and the options for advocacy support to help them navigate their care journey. • Where people are subject to the Mental Health Act 1983 (MHA), care and treatment is provided with dignity and respect, and the MHA Code of Practice is complied with. Any departure from the Code of Practice guidance is clearly justified and recorded.		• The routines and preferences of staff take priority, and they have little understanding of the impact of this approach on the wellbeing and needs of people using the service. • The service does not provide a caring environment and approach to people's care and treatment. People feel undermined, belittled and ignored by staff. • Staff do not respond when people experience preventable discomfort, concern or distress.

Person-centred care

Is care and treatment delivered in a person-centred way?

Scope of this key line of enquiry and topic areas include:

- Empowerment and decision making
- Personal, cultural, social and religious needs

Outstanding	Good	Requires improvement	Inadequate
• People’s individual needs and preferences are at the heart of the service, which delivers a fully tailored, holistic care experience. • Staff recognise and respect the totality of people’s needs. They always take people’s personal, cultural, social and religious needs into account, and find innovative ways to meet them. • There is a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that meets these needs, which is accessible and promotes equality. This includes people with protected equality characteristics, people who may be approaching the end of their life, people from different cultural	• People receive the most appropriate and personalised care and treatment for them and the service takes a trauma-informed approach, making reasonable adjustments where necessary. • Staff treat people as individuals, considering any relevant protected equality characteristics. They ensure people's personal, cultural, social and religious needs are understood and met. • Staff understand people’s needs, which results in positive experiences and better care outcomes. • People's communication needs are met to enable them to engage in decisions about their care and treatment, to enhance both their experience and outcomes. • There is a balanced and proportionate approach to supporting people and respecting	• Services are not delivered in a person-centred way that focuses on people’s holistic needs. • People’s emotional, social, cultural or religious needs are not always viewed as important or reflected in their care, treatment and support. • People feel excluded from care planning, with little involvement in treatment and decisions about medicines. • Staff may focus on the task rather than treating people as an individual. • There is some flexibility to take account of individual needs as they arise, but the service does not meet the needs of all the people who use it. • There are shortfalls in how the needs and preferences of different people are taken into account, for example on the	• People feel dismissed, belittled or ignored and not listened to. This contributes to deterioration, relapse, and re-admission where concerns are missed. • Poor communication with support workers creates confusion for people and a deterioration in their mental well-being. • Services are planned and delivered without consideration of people’s needs and preferences. • People’s basic needs are not met. • Their emotional, social, cultural or religious preferences and choices are not considered in their care, treatment and support. • Some people are unable to use the service because it does not meet their needs or preferences.

backgrounds and people who are in vulnerable circumstances or who have complex needs.	the choices they make about their care, treatment and support. • People are supported to understand their rights and their understanding is reviewed throughout their care and treatment. • People feel involved in their care, with opportunities to suggest treatment options and participate in decisions. People and those close to them and advocates, are regularly involved in planning, and are fully supported and empowered to make decisions about care and treatment, where appropriate. • People feel involved in their care, with opportunities to suggest treatment options and participate in decisions. • Named key workers play a crucial role in advocating for people and their needs. • Staff make sure people and those close to them, can make choices about accessing and using technology where it is available to support the delivery of care, treatment and support.	grounds of protected equality characteristics and for people who may be approaching the end of their life, who are in vulnerable circumstances or who have complex needs. • Staff do not always adhere to the Mental Health Act Code of Practice. Deviation from Code of Practice guidance is not always clearly recorded.	• Staff fail to comply with the Mental Health Act Code of Practice or other legislation.

Independence, choice, and control

Are people empowered to maintain their independence and to make choices about their care and plans for their future, where they are able to?

Scope of this key line of enquiry and topic areas include:

- Supporting communication and choice
- Access to friends and family (visiting rights) and community
- Specialist/adaptive equipment
- Supporting independence, activities and wellbeing
- Complex care needs
- End of life decisions and palliative care
- Involved, lawful decisions
- Co-production in decisions; flexible, personalised care.
- Support for community participation

Outstanding	Good	Requires improvement	Inadequate
• People and those close to them and advocates are genuine partners in care, with lived experience and preferences shaping all decisions through embedded co-production. • Staff create the conditions for true shared decision-making, building trust, offering accessible information and enabling choices that reflect each person’s identity, culture and care and treatment goals.	• People are supported to have choice and control over their own care, and to make decisions about their care, treatment and wellbeing, where possible. • Staff work with people to support, empower and enable them to achieve their goals. This includes what matters to them about their future care preferences around independence and care interventions. • Staff respect people as autonomous individuals. They understand the power they have as care givers and act accordingly	• Some staff do not consider involving people and those close to them as an important part of providing care. • People are not encouraged or enabled to manage their own care. • Information is not always accessible to all. People say that staff do not always explain things clearly, give them time to respond, or help them to understand the information they are given about their care and condition. This includes	• People are not involved in their own care or treatment, and neither are those close to them. • People do not know how to seek help or are ignored when they do so. Their basic care needs are not met. • People do not know or understand what is going to happen to them during their care. They do not know who to ask for help. • People are unable to access the care they need. Services are not set up to support

• Care is highly flexible, personalised and seamless, adapting responsively to individual needs, transitions and complex circumstances. • People are proactively empowered to have a voice, develop confidence and manage their own health, with exceptional support to maximise long-term independence. • People's rights, relationships and life choices are fully supported, including decisions at the end of life, within a rights-based, person-led approach rooted in the Human Rights Act and Mental Capacity Act and strengthened by strong community involvement, where appropriate.	to protect and promote people's human rights under the European Convention on Human Rights. • People are supported to receive visits from people they want to see and to be accompanied to appointments. This is done in accordance with relevant legislation, considering the person's age, and appropriate balance between their right to a private and family life, their independence, choice and control, risk and safety. The laws and principles that apply specifically to protecting children are adhered to when making decisions about appropriate access and visiting. • In line with relevant legislation and assessment, people can choose to take part in their local communities and meaningful activities that support their identity, and maximise their dignity, independence, health and wellbeing. • There is a range of appropriate equipment and technology to support and maximise people's independence, and to result in a good experience and outcomes from care and treatment.	during referral, discharge, transition or transfers. • Equality considerations are not always taken into account and reasonable adjustments in line with the Equality Act (2010) are not always made. • People's choices about their care and treatment, including in the context of end-of-life care, are not treated as a high priority. • Staff do not always adhere to the Mental Health Act Code of Practice. Deviation from Code of Practice guidance is not always clearly recorded.	people who may be approaching the end of their life, people who have complex needs, or those in vulnerable circumstances. • Services are not set up to provide accessible information, or reasonable adjustments in line with the Equality Act (2010). • The service does not support people to feel part of their local community. People may feel isolated and disconnected from their lives. • Staff fail to comply with the Mental Health Act Code of Practice or other legislation.

	• Children, their parents or carers are supported to plan for their future, ensuring their changing needs are considered and they have time to make informed choices about their future. • People who may be approaching the end of their life are identified to ensure their needs are met and the right support is provided. Where appropriate, end of life care planning is encouraged, including people’s preferences and informed decisions about resuscitation. People are informed and assured that they can update their choices. This information is shared with other services and staff appropriately. • Where people are subject to the Mental Health Act 1983 (MHA), care and treatment follows the empowerment and involvement guiding principle, and the MHA Code of Practice is complied with. Any departure from the Code of Practice guidance is clearly justified.		

RESPONSIVE

Services are organised so that they meet people’s needs.

I statements

- ✓ **I have care and support that is co-ordinated, and everyone works well together and with me.**
- ✓ **I can get information and advice that is accurate, up to date and provided in a way that I can understand.**
- ✓ **I am encouraged and enabled to feed back about my care in ways that work for me and I know how it was acted on.** (Not authentic TLAP statement)
- ✓ **I can get information and advice that helps me think about and plan my life.**

Care provision, integration, and continuity

Is care co-ordinated and delivered in a flexible, joined-up way that reflects diverse needs and promotes choice and continuity?

Scope of this key line of enquiry and topic areas include:

- Availability and provision of services
- Eligibility/funding
- Continuity of care, support and treatment
- Barriers for marginalised groups
- Culturally informed, trauma aware practice

Outstanding	Good	Requires improvement	Inadequate
• The service actively champions equity, inclusion and personalised choice. Teams work with curiosity and cultural humility to ensure people experience seamless, responsive and consistent support that	• The service understands the characteristics and needs of the population it serves and uses this insight to design and deliver flexible services that offer choice and continuity of care. • People can receive care and treatment from different services	• The service does not consistently reflect the needs of the population it serves. People’s care and treatment may offer limited flexibility, choice or continuity of care, or the different services are not very well integrated.	• The service does not reflect the needs of the population it serves. People receive little or no flexibility, choice or continuity in their care and treatment. Services are not integrated.

honours their identity, preferences and circumstances. Barriers that prevent access to care, continuity of care or participation in service-led activities are anticipated and removed wherever possible. • The service embeds partnership working with local communities and takes proactive, sustained action to address health inequalities. Leaders and staff routinely examine data, listen to lived experience, challenge biases and assumptions, and hold themselves accountable for reducing disparities. They demonstrate a clear, ongoing commitment to ensuring that every group – especially those at greatest risk of exclusion – receives equitable, high-quality mental health care. • Teams use culturally informed, trauma-aware and anti-discriminatory practice to ensure people experience seamless access to care, continuity of care and genuinely responsive support that reflects who they are	that are flexible and provide joined up care that understands the diverse health and social care needs of their local communities. • People's care and treatment is co-ordinated and responsive and delivered in a way that meets their assessed needs. • Delivering and co-ordinating services is multidisciplinary where appropriate, and considers the needs and preferences of different people and communities, including those with protected equality characteristics and those at most risk of a poorer experience of care.	• People's care and treatment is not always co-ordinated, responsive or delivered in a way that meets their assessed needs. • The needs and preferences of difference people and communities, and those most at risk of a poorer experience of care are not consistently considered when delivering or co-ordinating services. People in these groups may describe poor experiences of care and treatment.	• People's care and treatment is not co-ordinated, responsive or delivered in a way that meets their assessed needs. • The needs and preferences of difference people and communities, and those most at risk of a poorer experience of care are not considered when delivering and co-ordinating services. People may describe discrimination or unsatisfactory experiences of care and treatment.

and what matters most to them. • People receive exceptionally well-coordinated, holistic and person-centred care that fully reflects their assessed needs, preferences, strengths, cultures, histories and aspirations. Staff understand and value the whole person – including identity, lived experience, trauma, discrimination, social context and support networks – and adapt care and treatment thoughtfully to achieve the best possible outcomes, recovery and wellbeing.			

Listening and responding to feedback

Are people supported to give feedback and raise concerns, and are they confident that action will be taken as a result?

Scope of this key line of enquiry and topic areas include:

- Feedback and complaints
- Advocacy and support to raise concerns
- Carer support
- Mental Health Act complaints with CQC
- People/carers involvement
- Complaints monitored by protected equality characteristics

Outstanding	Good	Requires improvement	Inadequate
• There are consistently high levels of constructive engagement with people who use services, including equality groups that represent the population served. The service is developed with their full participation as equal partners. Where children and young people use the service, they and their parents and carers are engaged in a meaningful way. • Rigorous and constructive challenge from people who use services, the public and stakeholders is actively encouraged and seen as a vital way of holding the service to account. • People and those close to them and communities are meaningfully and regularly involved in reviewing how the service manages and responds to complaints. Their lived experience, insights and expectations directly shape improvements, ensuring the complaints process is transparent, accessible, culturally	• Staff take time to listen to people and give them the opportunity to share concerns. • People and those close to them, advocates and communities know how to give feedback about their experiences of care. They can do so in a range of accessible ways. • People and those close to them, advocates and communities feel confident that if they complain, they will be taken seriously and treated compassionately, with no fear of detriment. • The ability to raise concerns, make complaints and give feedback is supported through access to information, translation and interpretation. This could include making reasonable adjustments or culturally and trauma-informed approaches to support people to do this. • Staff investigate complaints and concerns openly and thoroughly, and within a suitable timeframe. • People and those close to them are advised of the option to raise complaints over care and treatment under the MHA with CQC.	• People do not find it easy to raise concerns or make complaints or are worried about doing so. Complaints and concerns cannot be made in completely accessible ways. • When people raise complaints or concerns, the service may not always take their views fully on board, investigate them thoroughly and in a timely way, or change practice to improve. • The complaints system may be managed inconsistently and there is little evidence of the learning being applied in practice within the service. • People may suffer discrimination, detriment and harassment if they complain. • There is some evidence of people and those close to them being informed of their right to make complaints over care and treatment under the MHA with CQC, but questions over consistency. • There is insufficient engagement with people who use services, or insufficient attention to appropriately engaging those with particular	• People feel unable to express their views about the care and support they receive from the service. The provider's complaints and concerns system is unclear and inaccessible. • Complaints are not dealt with in an open, transparent, timely and objective way. The service's response to complaints suggests a defensive attitude. • People may suffer discrimination, detriment and harassment if they complain. • There is minimal or no engagement with people who use services, the public or external partners. The service does not respond to any feedback. • Staff are unaware or are dismissive of what people think of their care and treatment. • There is no evidence that people and those close to them are informed of their right to make complaints over care and treatment under the MHA with CQC

sensitive and continually strengthened. The service values this involvement as essential to learning, accountability and delivering the highest possible quality of mental health care. The service also proactively provides information and support on how to raise complaints about care and treatment under the MHA with CQC. • A range of innovative approaches is used to gather feedback from people who use services and the public, including those from different equality groups. There is a demonstrable commitment to acting on this feedback, and the service takes a leadership role in quality improvement by learning from other services and proactively sharing its own learning. • Investigations are comprehensive and the service uses innovative ways of looking into concerns, including the use of external professionals to make sure there is an independent and objective approach.	• People are kept informed about how their feedback was acted on. Where improvements are required as a result, people (including those close to them and advocates) can be involved in shaping the solutions and measuring the impact. • Learning from complaints and concerns is seen as an opportunity to improve the service. The provider can demonstrate where improvements have been made as a result of learning from reviews, and staff can give examples of how they have incorporated learning into their daily practice. • Where people find it difficult to give their feedback, share ideas or make a complaint, there are methods to enable them to do this. Staff recognise that people need to have access to, and maintain links with, their advocacy and support networks in the community and they support people to do this. • Leaders know of and act on any disproportionality in complaints and concerns protected equality characteristics and/or themes, such as reasonable adjustments.	protected equality characteristics. Feedback is not always reported or acted on in a timely way. • Staff do not always readily give timely and accessible information about advocacy and further support to people and those close to them.	• People's feedback is inappropriately managed and acted on. The service is unable to provide examples of improvements made as a result of feedback and complaints. • People and those close to them are not given suitable information about or access to advocacy and support.

Timely and equitable access

Does the service ensure that everyone can access equitable and timely care, treatment and support?

Scope of this key line of enquiry and topic areas include:

- Access to services
- Accessible premises
- Waiting times/delays/cancellations
- Emergency unplanned care access/out-of-hours arrangements
- Access to post-treatment support
- Reasonable adjustments
- Digital exclusion (communication barriers)
- Access to crisis provision
- Data driven actions to improve access equity
- Out of area placements

Outstanding	Good	Requires improvement	Inadequate
• There is a proactive approach to understanding the access needs and preferences of different groups of people, including those with protected equality characteristics. This removes barriers to accessing care. • People do not experience barriers or delays in accessing care, they are key partners in the development of the service and their involvement is used to	• People can access care, treatment and support when they need to and in a way that works for them, which promotes equality, removes barriers and protects their rights. • Leaders and staff work proactively to achieve equitable and timely access to care in line with best practice, quality standards and legal requirements, including those on equality and human rights. This includes making reasonable	• People cannot always access care, treatment and support when they need to or in a way that works for them. • When there are long waiting times, delays or cancellations, action to address this is not always taken quickly or is not always effective. • Staff have a limited understanding about how to ensure their service is accessible to all. The service will occasionally allocate	• Long waiting times for community mental health support hinders recovery, increases risk of relapse and makes it difficult to access psychological care after discharge from hospital. • Long delays in getting access to crisis support and inadequate care leads to relapse and hospital re-admissions. • People are unable to access the care and treatment they need. Services are not set up to support people who may

improve access for all. Where people are supported by unpaid carers, flexibility in accessing the service is prioritised. • The service proactively seeks to identify and address any delays to care, treatment or support. This includes working with external partners. • The service is responsive and adapts quickly to people's individual needs, offering flexible appointments, drop-in times and outreach for those who struggle to attend clinics. • Innovative technology, including artificial intelligence and online services, is used to ensure people have timely access to care, treatment and support.	adjustments for disabled people, meeting information and communication needs, addressing communication barriers, and having accessible premises and equipment. • The service takes action to minimise the length of time people wait for care, treatment and support. Waiting lists are well-managed and risk assessed to ensure need is prioritised. • When people are in crisis they can get quick access to care at the service, or are directed to the most appropriate service for their needs. People are supported to access care from other services, including advising where to go for post-treatment support, local out-of-hours services and care in an emergency. Where appropriate, people are supported to access physical health care and monitoring. • Leaders and staff take action to address discrimination and inequality that disadvantage different groups of people in accessing care, treatment and support, whether this is from the wider society, within the service's processes and culture, or from individuals.	resources to tackle inequalities in access. • Information and advice about how to access other services, including post-treatment support, local out-of-hours services and emergency services, is inconsistent. • The service only sometimes uses feedback to improve access for people more likely to experience barriers or delays in accessing their care. • Where people need it, there is limited flexibility in appointments or how care is provided, and alternative strategies are not always used.	have difficulties accessing services. • People experience unacceptable waits for some services. • Staff do not understand how to ensure their service is accessible to all. Barriers to accessing care, such as cultural barriers, are not understood or removed. • The service does not give people any information or advice about how to access other services, including post-treatment support, local out-of-hours services or emergency services. • The service does not seek feedback to improve access for people who are more likely to experience barriers or delays in accessing their care. • There is no flexibility in appointments or how care is provided and alternative strategies are not considered.

	• The service uses feedback from people and those close to them, advocates and communities and other evidence to improve access for people who are more likely to experience barriers or delays in getting access to care. Services are designed to make them accessible and timely for people including those most likely to have difficulty in accessing care. When there are physical, digital, or cultural barriers, they are removed. • The service uses technology to ensure people have timely access to care, treatment and support. • The service uses evidence and data to prioritise, allocate resource and opportunities as needed to tackle inequalities and achieve equity of access. • Children aged 18 and under have clear pathways to access care and their parents and carers are able to be involved.		

Equity in experience

Does the service tailor people’s care, treatment and support effectively, to ensure equity in experience?

Scope of this key line of enquiry and topic areas include:

- Benchmark of expectations

- Barriers to care, treatment and support
- Inequalities in experience
- People/communities whose voices are seldom heard
- Accessibility, transparency and communication
- Translation and interpretation
- Accessible Information Standard
- Addressing disproportionate detention

Outstanding	Good	Requires improvement	Inadequate
Leaders and staff create a supportive, empowering environment where communication is always culturally sensitive, non-discriminatory and inclusive. People feel their diversity is valued, and they are empowered to give their views and understand their rights. Leaders and staff take purposeful steps to understand, listen and respond to people's experiences of discrimination and inequality. People do not feel their protected equality characteristics, ethnicity or culture lead to different responses or impact their experience of care. Staff foster a psychologically safe culture where concerns	People have good experiences of care because they feel staff empower them to give their views and understand their rights, including equality and human rights. People's experiences of discrimination, inequality and infringements of their rights are listened to and acted upon to improve their experience. Leaders and staff are open about and aware of discrimination and inequality factors that may intersect to disadvantage people, whether from individuals, societal barriers or organisational processes. Evidence shows staff work with partners and communities to improve the experiences of marginalised groups. Leaders and staff engage consistently with people and communities to achieve equity in	People do not always understand their rights, including equality and human rights. If they experience discrimination or inequality, they do not consistently feel listened to or that their experiences are acted on. People with protected equality characteristics, including ethnicity and culture, do not always feel confident that their views will be responded to effectively or compassionately. Leaders and staff are not consistently aware of what causes discrimination and inequality that could disadvantage groups using the service. They lack strong links with local communities or do not use available data well to improve people's experiences.	People do not understand their rights and are not supported to do so. Their experiences of discrimination and inequality are not listened to, understood or acted on. Positive experiences are declining. Staff do not welcome people's views or respond appropriately. Leaders and staff are unaware of discrimination and inequality affecting people's experiences. This is not considered in planning or delivering the service. No links exist with local communities, and data and research are not used to understand or respond to barriers. Leaders and staff do not recognise unequal experiences or take action to address them. People feel strongly that their protected equality

about equity in experience are acknowledged and addressed transparently. There are established channels and processes so that culturally rooted feedback from people and communities is recognised and responded to in a timely and fair way. • People can expect information and communication to be tailored to their needs, made accessible, inclusive, consistently reviewed and shared to support person-centred care. • All people, regardless of background, can easily get the appropriate and effective mental health support they need.	experience, using data and research to recognise intersecting barriers and respond in a timely and resource-appropriate way. • People's information and communication needs are identified, recorded, highlighted and shared. Information is tailored to their needs through culturally sensitive and inclusive reasonable adjustments, accessible formats, interpretation, translation and digital support. These needs are continuously met and reviewed to support their experience of care.	• Leaders and staff are reactive rather than proactive in working toward equity in experience. Systems and processes to gather, use and monitor information about equity may be missing or weak. Where information exists, it is not consistently used to recognise and respond to people's experiences. • People do not consistently receive information tailored to their needs, including culturally sensitive adjustments, accessible formats, interpretation, translation or support with digital services. These needs are not always identified, recorded, shared or reviewed. • People are at risk from misogyny, sexual abuse and breaches of their privacy.	characteristics, ethnicity or culture negatively affects how they are treated. • People do not receive information tailored to their needs; culturally sensitive adjustments, accessible formats, interpretation, translation and digital support are not provided. Needs are not identified, recorded, shared or reviewed.

WELL-LED

The leadership, management and governance of the organisation make sure it is providing high-quality care that's based around people's individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Strategic direction

Is there a clear vision and strategy that addresses the changing needs of the population and communities it serves?

Scope of this key line of enquiry and topic areas include:

- Strategy and vision
- Values
- Organisation sustainability
- Addressing social impact
- Environmental sustainability: Staff awareness and practice, carbon reduction practices – e.g. travel and transport, medicines and supply chain, estates and facilities, efficient service delivery with resource optimisation
- Equity-driven strategy
- Anti-racism focus
- Neighbourhood/system-level alignment

Outstanding	Good	Requires improvement	Inadequate
• There is a clear, compelling and shared vision, strategy and supporting objectives that responds proactively to the changing needs of its population and communities. These are co-produced with staff, people and those close to them, and community partners. The vision, strategy	• Leaders ensure there is a clear shared vision and strategy that responds to the needs of the population and communities served. The vision and values are communicated effectively, and staff across the service understand them and how their role contributes to delivering them.	• The service's vision, strategy and plans have some significant gaps or weaknesses that undermine their credibility. They are either incomplete, out of date, not sufficiently clear or not well-understood. • Equality, diversity and inclusion principles, including tackling racism and stigma, are not	• There is no credible statement of the service's vision and guiding values. These are either outdated or not underpinned by detailed and realistic plans and objectives. • Equality, diversity and inclusion principles, including a commitment to anti-racism and cultural humility, are often

and supporting objectives are well-understood, owned and embedded across the service. • The strategy delivers measurable improvements in population health, access to care, and people's experience and outcomes, including demonstrable reductions in health inequalities. Equality, diversity and inclusion are embedded as core strategic priorities, with anti-racism, cultural humility and stigma-awareness integral to long-term care models, workforce strategies and service transformation. • An inclusive, culturally sensitive and non-discriminatory person-centred approach is engrained in the values of the service and is evident in everyday interactions with staff, people who use the service and the public. People feel respected, listened to and safe, and services are designed around what matters most to communities served.	• The vision, strategy and supporting objectives have been developed through a structured planning process, with meaningful engagement of staff, people and those close to them, communities and external partners. Equality, diversity and inclusion are reflected within the strategy, with anti-racism, cultural humility and stigma-awareness recognised as important strategic principles, although their application may vary across services. • The strategy is credible and achievable, promoting high-quality, person-centred, culturally sensitive and non-discriminatory care. There is clear intent to reduce health inequalities supported by identified priorities and improvement actions. Progress in outcomes is evident, and further areas of work are allocated to leaders. There are clear plans to deliver further improvements. • Leaders provide effective oversight of the strategy through regular monitoring of progress against delivery plans, key performance indicators and risks. Leaders use data, insight and research to inform decision	consistently promoted and they are not necessarily central to the service's vision, values and strategy. • The service's strategy and vision may not have been co-developed with staff, people who use the service and other stakeholders, so there is no feeling of co-ownership among these groups. • Results of consultations with stakeholders and feedback from staff and people using the service are not always taken into account in developing and evaluating strategies or plans. Culturally rooted feedback is not always gathered, considered and made available in transparent and accessible ways. • The plan and strategy do not fully reflect the local health and care systemin which the service operates. Use of engagement, data and research to help inform them is limited and not always effective. • System-wide collaborative working with partnership agencies and community-led organisations is inconsistent,	neglected, if not altogether absent from the service's strategy and vision. • Key stakeholders have not been engaged in creating the service's strategy. Collaborative working and co-production with people and local communities to gather feedback, including culturally rooted forms of feedback, is not happening. • Staff do not understand the service's vision and values and do not understand how their role contributes to achieving the strategy. • Strategies and plans are not aligned with the wider health and care systemin which the service operates. • There is no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. • Leaders at all levels are not held accountable for the delivery of the strategy. • Staff feel disengaged, disempowered and often feel no pride in their service. Staff with protected equality characteristics or from diverse

• Leaders provide visible, values-driven leadership, actively shaping and testing the strategic direction through curiosity, constructive challenge and learning. They analyse data, people’s lived experience, insight from staff and research evidence to ensure that the strategy remains relevant, equitable and impactful. • Staff are proud of the service and consistently report high levels of engagement, pride and trust in leadership. They report that the service is an inclusive, supportive and empowering place to work. Staff feel alignment and ownership of the service’s culture, vision and values. • Strategies and plans are fully aligned with those of the wider health and care system and actively shape it, and the service plays a strong role within the system. Through effective collaborative working with system partners, community-led organisations and local stakeholders, the service contributes to shared	making and to understand the needs of the local population. • The strategy has clear, time-bound equity goals, with resourced plans and key performance indicators. • Staff and leaders use data, research and information to ensure any risks to delivering the strategy, including relevant local factors, are understood and have an action plan to address them. They monitor and review progress against delivery of the strategy and relevant local plans, and system wide plans, where appropriate. • Sustainability is actively considered, with actions taken to reduce the impact of care on the environment, to support sustainable practice, reduce waste and minimise energy use. • Staff are empowered to know how environmental sustainability relates to their role including through planning and delivering care, preventing diseases and good practice in the use of medicines. • Where appropriate, the vision, strategy and supporting objectives support mental health services to be delivered in	and leaders are not always visible. • Leaders at all levels are not always held to account for the delivery of the strategy. • Staff do not always feel actively engaged or empowered. Some staff with protected equality characteristics or from diverse ethnic and cultural backgrounds feel they are treated differently. They do not always feel pride in their service and do not always trust its leadership. • Sustainability is not a primary consideration at this service. • Where appropriate, the vision, strategy and supporting objectives do not always enable mental health services to be delivered in trusted, community-based settings that are accessible and culturally relevant to people who use them.	ethnic and cultural backgrounds are treated differently. • Sustainability is either completely absent from the service’s strategy and vision, or it is poorly or ineffectively communicated. • Staff are unaware of their responsibilities or contribution in relation to reducing waste and minimising the use of energy. • The vision, strategy and supporting objectives do not consider or enable mental health services to be delivered in trusted, community-based settings that are accessible and culturally relevant to people who use them.

priorities and continually improving outcomes. - The strategy and vision are ambitious, challenging and innovative, yet grounded in a clear understanding of risk, capacity and resources. - Feedback from staff and people using the service includes culturally rooted forms of insight., This is systematically gathered, analysed and used to inform decision making. The service demonstrates how learning from feedback leads to tangible improvement, and shares this transparently in accessible ways with staff, people and communities. - There is strong collaborative and team-working, with a shared focus on improving the quality, experience and sustainability. - Environmental sustainability is embedded within strategic decision making, and leaders recognise its role in improving population health, delivering value and ensuring the long-term sustainability of services. Staff understand how sustainability relates to their roles and take pride in	trusted, community-based settings that are accessible and culturally relevant to people who use them.		

initiatives that reduce waste, minimise energy use and support greener models of care.			

Workforce equity and culture

Is there an inclusive and fair culture that prioritises the safety and wellbeing of staff, supports speaking up and addresses workforce inequalities?

Scope of this key line of enquiry and topic areas include:

- Workforce diversity
- Workplace discrimination and equitable treatment of staff
- Bullying, harassment and victimisation of staff
- Gender pay gap
- Speaking up culture
- Freedom to Speak Up Guardian, whistleblowing
- Support and wellbeing of workforce
- Agency staff and volunteers
- Caseloads/workload and lone working
- Staff safety (including sexual safety)
- Staff feedback and surveys
- Address workforce inequalities by protected characteristics

Outstanding	Good	Requires improvement	Inadequate
• Leaders and staff at all levels live the service's values, which include a strong, shared commitment and effective action towards ensuring that equality,	• The service prioritises equality, diversity and inclusion, and proactively identifies and addresses workforce inequalities. Awareness of anti-racism practice, cultural humility and	• Equality, diversity and inclusion are not sufficiently prioritised at this service. Anti-racism, cultural humility and stigma awareness are not core strategic principles and are not	• The principles of equality, diversity and inclusion are insufficiently embedded in the culture of the service. Inequality is not identified and addressed. Anti-racism,

diversity and inclusion are embedded throughout the service. • Leaders and staff share a steady, long-term focus, supported by evidence on ensuring high-quality and effective care for all people and communities served by the service. • Leaders at all levels are held to account for modelling inclusive behaviours and addressing poor culture, with clear consequences where expectations are not met. They demonstrate commitment to equality and diversity, leading by example to actively prevent discrimination and promote anti-racist and cultural humility principles. • Leaders and staff across all levels engage, understand, and are representative of the communities they serve. • Bullying, harassment and discrimination are completely absent from the service's practices. All staff, regardless of background, feel equally valued.	stigma are core strategic principles and are reflected in the values of all staff and leaders. • The service fosters a culture of compassion, openness, trust, inclusiveness and continuous improvement. Processes for communication and sharing information are transparent and accessible. • Leaders are alerted to and quickly address any examples of poor culture that may have a detrimental impact on staff and affect the quality of people's care. • Recruitment, disciplinary and capability processes are fair and are reviewed to ensure there is no disadvantage based on any protected equality characteristics. Recruitment processes and employment practices are lawful and free from exploitation. • The service takes active steps to ensure staff and leaders are representative of the people and communities it serves. • The service actively asks for feedback from staff and people using the service including some feedback that reflects their cultural background. It considers feedback in shaping and	always reflected in the values of all staff and leaders. • Leaders do not always identify or address the causes of workforce inequality • Staff, including those with protected equality characteristics, do not always feel they are treated equitably. Staff do not all feel their contributions are valued in the same way. • Leaders of the service do not always engage or ensure they are sufficiently visible or representative of the staff and local communities. • The culture of the service needs to improve. Processes for communication and sharing information are not always transparent and accessible. • There is insufficient reassurance that all staff and leaders will not tolerate bullying, harassment and discrimination. • Speaking up processes may be in place, but they are not sufficiently well advertised or understood. • Staff are apprehensive about speaking up and are not	cultural humility and stigma awareness are missing from core strategic principles and are not evident in the values of staff and leaders. • Staff, especially those with protected equality characteristics, do not feel they are treated equitably. Staff from different ethnic backgrounds report cultural ignorance, discrimination and racism issues. • There are high levels of bullying, harassment, discrimination or violence, and the service is not taking adequate action to reduce this. • Reporting systems are not adequate, or do not exist, and there is no reassurance that staff concerns will be listened to and acted on. • The culture of the service is closed (there is little transparency, trust or open communication) and processes for communication and sharing information are not transparent and accessible. There is no reassurance that whistleblowers will be treated fairly, without fear of detriment.

• There is an open, curious and transparent culture where people feel psychologically safe to speak up about anything that gets in the way of providing high-quality care. The service uses innovative ways to ensure that processes for communication and to share information are transparent and accessible. • Speaking up is embedded as a cultural norm. Leaders actively seek challenge, respond, are visible and demonstrate through their actions that raising concerns leads to learning and improvement, not blame. • The service’s open learning culture and the high morale and wellbeing of its staff are conducive to the positive experience and outcomes of people and those close to them. • Feedback from staff, including complaints and concerns, is continuously taken into account to improve services and satisfaction. These are seen as learning opportunities and leaders are held accountable for the	reviewing the strategy. Information about feedback and resulting actions is shared in accessible ways. • Leaders take action to improve where there are any disparities in the experience of staff with protected equality characteristics, or those from excluded and marginalised groups. Any interventions are monitored to evaluate their impact. Leaders make reasonable adjustments to support disabled staff to carry out their roles well. • Leaders take steps to remove bias from practices to ensure equality of opportunity and experience for the workforce in their place of work, and throughout their employment. Checking accountability includes ongoing review of policies and procedures to tackle structural and institutional discrimination and bias to achieve a fair culture for all. • There is zero tolerance for bullying, harassment and discrimination. The service supports staff who face discrimination, whether this comes from managers, colleagues or people using the service. There is a clear focus on	certain that their concerns will be listened to and acted on. • Feedback from staff, including complaints and concerns, is not always considered in a culturally sensitive and non-discriminatory way. There is insufficient reassurance that their feedback is used to make lasting improvements. • Levels of satisfaction with the service vary and may be lower for those with protected equality characteristics. • The wellbeing of staff is not always sufficiently prioritised. Some staff do not feel psychologically safe. Morale among staff and levels of pride in the service and engagement need to improve.	• Learning is not embedded in the service’s culture. There are high levels of defensiveness and no leadership accountability or ownership of staff feedback and concerns. Staff report feeling psychologically unsafe. • The wellbeing of staff is a very low priority and there are no measures to support flexibility and to improve staff morale and engagement. • Staff do not feel pride in their service and would not recommend it to others as a place to work or receive care.

commitments they make in this regard. Staff from all backgrounds are certain that their concerns will be listened to and acted on, without any fear of detriment. • There are consistently high levels of satisfaction across the workforce, including among those with protected equality characteristics. Staff are proud of the service as a place to work, feel psychologically safe and speak highly of its open, inclusive and non-discriminatory culture. • Staff wellbeing is a high priority for the service's leadership. The service exceeds its statutory responsibilities for the health, safety and well-being of staff and is a modern employer with a variety of measures to support flexible ways of working to improve staff morale, retention and engagement.	supporting those with protected equality characteristics and those from excluded and marginalised groups. • Staff receive personalised culturally-sensitive and non-discriminatory support and feel listened to, valued and involved in decision making. Staff from different backgrounds feel they are treated equally. • The service meets its statutory responsibilities for the health and safety of staff. Steps are taken to support the wellbeing of staff through resources, rest, and cultivating a positive work environment. There is culturally-sensitive and non-discriminatory support for those who are struggling at work. This has a positive impact on the care they deliver to people. • There are processes to enable staff to speak up and raise concerns. All staff, including temporary colleagues, can easily access these processes. Staff are empowered and supported to give feedback, raise concerns, and contribute to improvements. They feel confident that they will be treated with compassion and understanding, and will not be		

	blamed, or treated negatively if they do so. • Where in place, Freedom to Speak Up Guardians have access to dedicated time for their role, up-to-date training, and work proactively with the leaders to remove barriers to speaking up and to improve the speaking up culture. • There is a culture of speaking up where staff actively raise concerns and those who do (including whistleblowers) are valued and supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.		

Capable and compassionate leaders

Do leaders at all levels have the capacity and capability to effectively deliver high quality care with accountability and empathy?

Scope of this key line of enquiry and topic areas include:

- Leadership competency, support and development
- Safe recruitment of leaders/Fit and Proper Person Regulations (FPPR)
- Role expectations and personal accountability
- Succession planning and talent management
- Visible, inclusive leadership

Outstanding	Good	Requires improvement	Inadequate

• Leadership is supportive and people-focused, with leaders at all levels empowered to act and work collaboratively to deliver excellent and sustainable care. • Leaders are proactively visible, accessible and responsive. They embody integrity, honesty and openness, and build strong, respectful relationships with staff, people and local communities through inclusive and transparent engagement. Leaders’ visibility and engagement results in demonstrable improvements in experience, access and outcomes, including for marginalised and under-served groups. • There is a coherent, service-wide leadership development and succession process, aligned to strategic priorities and future risk. This actively identifies, nurtures and progresses diverse talent, reflects the communities served, and ensures continuity, resilience and long-term sustainability of leadership capacity.	• Leaders at all levels have the experience, capacity, capability and integrity to ensure that the service’s vision and strategy can be delivered. Leadership is generally supportive, inclusive and people focused, enabling the delivery of safe, effective and compassionate care. • Leaders are held to account for delivering high-quality care and for modelling inclusive, compassionate behaviours, with clear expectations and consequences where expectations are not met. • Leaders at every level are visible and lead by example, modelling integrity, honesty and openness, encouraging mutual trust between staff, leaders, people and communities, and the systems they work in. • Leaders are knowledgeable and use engagement, data and research to understand the issues and priorities for the quality of services, including social and cultural contexts that affect staff and people who use the service. • Leaders at all levels can identify and access appropriate support and development in their role.	• Leaders do not have all the necessary experience, capacity, capability or integrity to ensure the service’s vision can be delivered, • Staff do not consistently know who their leaders are or how to gain access to them. Leaders do not prioritise modelling integrity, openness and mutual trust between staff, other leaders, people and their communities, and the systems they work in are not prioritised. • Leaders are not always aware of the risks, issues and challenges in the service and do not always make effective use of engagement, data and research to do so. Leaders are not always knowledgeable about their roles and their accountability for quality. Social and cultural contexts are not always considered as contributing factors to quality, or this is not embedded practice. • The need to develop leaders is not always identified. Action is not consistently taken to support high-quality culturally sensitive and non-discriminatory leadership through safe, effective and	• Leaders do not have the necessary experience, capacity, capability or integrity to lead effectively, including in a culturally sensitive and non-discriminatory way. There is no stable leadership team, with high unplanned turnover and/or vacancies. • Staff do not know who their leaders are or what they do or are unable to get access to them. Staff, people and communities lack trust in leaders and there are no external system relationships in place. • Leaders are disconnected from what is really happening in services, and they cannot identify or do not understand the risks, issues and challenges described by staff. This includes wider social and cultural contexts that may be affecting the quality of care. • There is little or no attention to succession planning and inclusive and diverse development of leaders. • There are few examples of leaders making a demonstrable impact on the quality or sustainability of services.

• Leaders operate confidently at system level, shaping shared priorities across the health system and modelling compassionate leadership beyond the service's boundaries. They embrace opportunities to have a positive impact on the wider health and care system. • There are comprehensive and successful leadership strategies to ensure and sustain their delivery. Leaders use analyses of evidence from feedback from staff, performance data, talent metrics and lived experience to develop them. There is strong collaborative, team working and support across all functions. Staff are engaged, empowered and united by shared values, with a clear sense of belonging and a common focus on improving the quality of care and people's experiences. • Leaders actively create and sustain a culture of psychological safety, where staff feel confident to speak up, challenge and innovate. Leadership behaviours demonstrably enable	• High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning. • Leaders are supportive, culturally sensitive and non-discriminatory. They demonstrate empathy and act to champion high-quality care and improvement. • For mental health units: The responsible person appointed in compliance with the 2018 Act has either an established interest in reducing restrictive practice or a clinical background that includes use of restrictive practices.	inclusive recruitment and succession planning. • Leaders are not consistently supportive, which has a negative effect on embedding a demonstrable impact on the quality or sustainability of services. • When something goes wrong people receive an apology. However, it is not always timely or sincere, or they are not told about actions to prevent the same thing happening again. People do not all feel their contributions are valued or responded to in the same way. • For mental health units: The responsible person appointed in compliance with the 2018 Act has no experience or demonstrable interest in restrictive practice.	• When something goes wrong, people do not receive an apology, or actions are not taken to prevent the same thing happening again. People are not all treated in the same way. • For mental health units: Either a responsible person has been appointed in compliance with the 2018 Act, or the responsible person does not have a relevant clinical background.

continuous improvement and high levels of staff engagement and morale. • For mental health units: The responsible person appointed in compliance with the Mental Health Units (use of force) Act 2018 (‘the 2018 Act’) meets regularly with colleagues who have delegated responsibility for compliance with the 2018 act. The RP has an interest in reducing restrictive practice and a clinical background that includes experience of using restrictive practices. • There is visible and inspiring leadership that models commitment to equality and diversity and leads by example.			

Governance

Are there clear roles, responsibilities and systems of accountability to support good governance?

Scope of this key line of enquiry and topic areas include:

- Roles, responsibilities and accountability
- Governance and quality assurance
- Statutory and regulatory requirements
- Robust Mental Health Act oversight (reviewers, SOAD, trends, MHA fact sheets)

- Monitoring use of force
- Clear statutory compliance, including Mental Health Act 2025 implementation
- Shared governance arrangements (where appropriate)

Outstanding	Good	Requires improvement	Inadequate
• Governance arrangements are clear, coherent and continuously tested, enabling effective decision making, accountability and delivery of the service’s strategy. Governance systems are proactively reviewed to ensure they remain fit for purpose, proportionate and responsive to emerging risks, system changes and population needs. • Governance structures have a clear purpose, give strong oversight, and interact effectively. They are supported by well-defined authority to make decisions, escalation routes and accountabilities. These are consistently understood across the service and routinely tested through real-time issues and learning. • Governance systems are inclusive and empowering, enabling staff at all levels to identify risks, raise concerns	• There are clear and effective management and accountability arrangements that support the delivery of safe, high-quality and sustainable care These processes are well understood and used to maintain oversight of the service’s performance. • Managers are values-led and can account for the actions, behaviours and performance of staff. Leaders understand their responsibilities, escalation routes are defined and actions are tracked. • The board and other levels of governance in the service function effectively and interact with each other appropriately to support delivery of the service’s strategy. Governance structures, roles and responsibilities are understood across the service and are regularly reviewed to maintain fitness for purpose. • Structures, processes and systems of accountability, including the governance and management of partnerships,	• The governance, management and accountability arrangements are not clear or do not always operate effectively. There has been no recent review of the governance arrangements, strategy, or plans. • Managers can not routinely account for the actions, behaviours and performance of staff. Workforce planning does not always achieve its purpose, and leaders are reactive to workforce challenges. • Staff are not always clear about their roles, what they are accountable for, and to whom. • Cyber security is managed reactively, and there are gaps in maintaining a secure service. • Where relevant, governance, accountability and management arrangements to ensure the legal requirements and duties of the MHA are complied with, are not always	• The governance arrangements and their purpose are unclear, and there is a lack of clarity about authority to make decisions and how individual members of staff are held to account. There is no process to review key items such as the strategy, values, objectives, plans or the governance framework. • Staff and their managers are not clear on their roles or accountabilities. There is a lack of systematic performance management of individual members of staff, or appropriate use of incentives or sanctions. • Cyber security is not a priority and there are examples of breaches of cyber and data legislation. • Where relevant, governance, accountability and management arrangements to ensure the legal requirements and duties of the MHA are

and contribute to improvement. The service demonstrates a learning-focused governance culture, where insight from staff, people who use services and partners informs action and improvement. • Leaders are assured of the service's performance through analysis of quantitative data, qualitative insight, audit, lived experience and external assurance. Focus is on patterns, trends and root causes rather than isolated metrics, and this intelligence is used to challenge, learn and improve. • Governance of partnerships, joint working arrangements and shared services is rigorous and mature, with clear shared objectives, defined accountabilities and joint risk management. The service plays a leading role in the health and care system governance, supporting working collaboratively that delivers improved outcomes across the wider health and care system.	joint working arrangements and shared services, are clearly set out, understood and effective. Staff are clear about their roles and accountabilities. • Governance arrangements support the delivery of safe, effective and equitable care, including implementation of relevant quality frameworks, recognised standards and best practice. Leaders use these frameworks to address known risks and inequalities. • Leaders implement relevant or mandatory quality frameworks, recognised standards, best practices or equivalents to improve equity in experience and outcomes for people using services and tackle known inequalities. • Where relevant, there are effective governance, accountability and management arrangements to ensure the legal requirements and duties of any relevant legislation, including the Health and Social Care Act and the Mental Health Act, are complied with. • Reports from CQC's Mental Health Act (MHA) reviewers are reviewed by non-executive members, and the board is	effective or consistently implemented. • MHA reviewer reports are not routinely reviewed and statistical information on the MHA is not always monitored and compared with national data. There are relationships with stakeholders around the MHA, but they are not formalised to address any issues of implementation. • Reports on the performance of MHA managers are compiled but not reviewed at board level. SOAD requests and activity are not routinely reported to the board. • Data on the use of force submitted to the Mental Health Services Data Set is poor quality and not regularly reviewed by the executive team.	complied with, are not rigorous or appropriate. • The board does not review Mental Health Act reviewer reports. • Information relevant to monitoring the use of the MHA, including performance of MHA managers and SOAD activity, is not collected consistently, not reviewed appropriately or action is not taken as a result. • Data about the use of force is not consistently collected and/or submitted to the Mental Health Services Data Set.

• Governance arrangements explicitly support the delivery of high-quality, safe and equitable care, enabling risks to quality, safety and equity to be identified early and timely, proportionate action to address them. Relevant quality frameworks and recognised standards are implemented effectively and used to reduce inequalities in experience and outcomes.	aware that any required action has been taken to address identified issues. Statistical information on use of the MHA is monitored and patterns of admission and length of stay are considered and compared with national data. • The board receives reports on the performance of its MHA managers in reviewing detention and on second opinion appointed doctor (SOAD) requests and activity. Action is taken as required. The board makes sure that relationships with stakeholders, such as local authorities and the police, raise issues about MHA 2025 implementation. • Systems are in place to ensure that data about the use of force is collected, reviewed and submitted to the Mental Health Services Data Set. The executive team or equivalent regularly reviews the data.		

Management of risk, performance and issues

Are there clear and effective processes for managing risks, performance and issues?

Scope of this key line of enquiry and topic areas include:

- Organisational risk management

- Emergency preparedness (including climate events) and business continuity
- Workforce planning
- Use of resources
- Records/digital records
- Data security/data protection and General Data Protection Regulation (GDPR)
- Cyber security and Data Security and Protection Toolkit (DSPT)
- Statutory notifications
- Oversight and reduction of restrictive practice

Outstanding	Good	Requires improvement	Inadequate
• The service demonstrates a mature, intelligence-led approach to managing risk, performance and issues. The service assures itself that systems are effective through analysis of data and intelligence, focusing on pattens, trends and early warning signals rather than retrospective reporting. • Staff are engaged, respected and supported to use risk management systems effectively, with problems addressed openly and swiftly through working collaboratively and responsive leadership. • The service invests in innovative and best practice	• Workforce planning is thorough and proactive. It is regularly reviewed and monitored. • Data or notifications are consistently submitted to external organisations as required. • There are rigorous arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information is used effectively to monitor and improve the quality of care. • Service risks, performance, and outcome data are used to deliver high-quality, sustainable care. • Systems for managing performance and service risks support innovation while maintaining the quality of the service.	• Required data or notifications are inconsistently submitted to external organisations. • Arrangements for the availability, integrity and confidentiality of data that identifies people using the service, records and data management systems are not always rigorous. • Risks, issues and poor performance are not always dealt with appropriately or quickly enough. The risk management approach is applied inconsistently or is not linked effectively into planning processes. • The approach to service delivery and improvement is reactive and focused on short-term issues. Clinical and	• Required data or notifications are routinely not submitted to external organisations. • The information that is used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant. Finance and quality management are not integrated to support decision making. • There is inadequate access to and challenge of performance by leaders and staff. There are significant failings in systems and processes for managing or sharing data. • There is little understanding or management of risks and issues, and there are significant failures in performance management and

information systems and processes. - The service works in partnership, sharing accurate and timely data in a transparent and accessible way to improve care outcomes and experiences, and to make a positive difference to the local community and environment. - Systems are in place to ensure that data about the use of force is collected, reviewed and submitted to the Mental Health Services Data Set. The executive team or equivalent understands which services have the highest use of restrictive practice and where there are significant increases in use. Policies, practice and training are reviewed to take account of the data.	- Emergency preparedness and business continuity plans are rigorous, tested and sufficient for the size and capacity of the service.	internal audit processes are inconsistent in their implementation and impact. The sustainable delivery of good quality care is put at risk by the financial challenge. - Emergency preparedness and business continuity plans are not always appropriate for the type of service or its capacity. They are not tested regularly.	audit systems and processes. Risk or issue registers and action plans, if they exist at all, are rarely reviewed or updated. Meeting financial targets is seen as a priority at the expense of quality. - Emergency preparedness and business continuity plans are not rigorous or appropriate for the type of service or its capacity. They are not tested and leaders do not understand their value.

Partnerships and communities

Is the service working effectively with its population and partners to deliver high quality care and treatment that meet the diverse needs of the people who use them?

Scope of this key line of enquiry and topic areas include:

- Sharing good practice and learning

- Integration of health and social care
- Partnership and collaborative working
- Involvement and co-production
- Neighbourhood collaborative working
- Inclusive community engagement

Outstanding	Good	Requires improvement	Inadequate
• The service takes a lead role to improve the broader health of its population and tackles health inequalities across the local system at neighbourhood level, regionally or nationally. • Collaborative working is solidly part of practice and outcomes-focused at every level, with co-designed services that are seamlessly integrated and responsive to evolving population needs. As a result, people receive the right care, in the right place at the right time and there is notable evidence of improvements for under-served communities as a result. • Staff and leaders demonstrate sustained relationships within the local system at neighbourhood level and beyond. They foster a culture of trust and	• The service openly shares good practice and learning across the system at neighbourhood level, regionally or nationally. • Staff and leaders work collaboratively with all relevant stakeholders and agencies to deliver joined-up services that meet the diverse needs of the population served. This is delivering improvements for under-served communities. • Staff and leaders support good interpersonal relationships across partnerships. They communicate openly, build trust and encourage working collaboratively. • People and those close to them, staff and local stakeholders are regularly involved in shaping the design and delivery of the service. Their views and experiences are actively sought and used to inform decisions. Culturally sensitive and non-	• The service shares good practice and learning inconsistently or only within limited internal circles. Opportunities to contribute to wider system learning are missed, and there is limited evidence of proactive engagement with external partners and communities. • Staff and leaders demonstrate limited or inconsistent relationships across partnerships. Relationship building is sporadic or reactive, leading to missed opportunities for working collaboratively. • Staff and leaders engage with external stakeholders and agencies inconsistently or superficially. Working collaboratively is limited in scope or depth, and interdependencies are not fully recognised or used. People from different backgrounds report this has a negative	• The service does not share good practice or learning beyond its own service. There is little or no evidence of engagement with the wider system, and opportunities to contribute to collective improvement are routinely overlooked. • Staff and leaders do not actively support interpersonal relationships across partnerships. Communication is poor or absent. This undermines joint working, erodes trust and impedes progress across the system. • Staff and leaders do not work collaboratively meaningfully with external stakeholders or agencies. There is little or no recognition of interdependencies, and services operate in isolation. • People who use services, staff, and stakeholders are not

respect, enabling dialogue and working collaboratively to solve problems. • People who use services, staff and local stakeholders are meaningfully involved as equal partners in the design, delivery, and evaluation of services. Where applicable, board members are appointed to oversee how well these partnerships are working at executive level. • Co-production is embedded in the service culture, with diverse voices actively shaping decisions. Engagement is inclusive, culturally sensitive, non-discriminatory and sustained. • Feedback from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account. Leaders use engagement, data and research effectively, actively seek feedback, respond transparently, and use challenge to drive improvement and innovation. • Where appropriate, the service demonstrates shared accountability with partners, which involves aligned	discriminatory co-production is encouraged and includes diverse voices through inclusive engagement approaches. • Feedback from people and those close to them, the public, and stakeholders is responded to appropriately, and there is a clear commitment to accountability and continuous improvement. People from different backgrounds feel they are equally listened to and represented.	impact on their experience of care and their outcomes. • There is a limited or inconsistent approach to seeking the views of people who use services, staff and local stakeholders. Engagement is limited in reach or depth and may not reflect the diversity of the local population. Opportunities for co-production are missed or under-developed and there is little evidence that feedback meaningfully influences decisions, including at board level. • Challenge from people who use services, the public, or stakeholders is inconsistently acknowledged or acted on. Feedback mechanisms may exist but are under-used or lack transparency. People from different backgrounds feel they are responded to differently and their care is affected.	meaningfully involved in designing or delivering the service. Engagement is minimal or absent. There is no clear approach to co-production, and services are developed without input from those they affect. Board level oversight of this is ineffective or absent completely. Challenge from people who use services, the public, or stakeholders is discouraged, ignored, or met with defensiveness. There are limited mechanisms to give feedback, and accountability is weak or absent. People from different backgrounds are responded to differently and are experiencing poor care experiences and outcomes as a result.

priorities, joint governance and collective management of risk. Focus is on improving experience and outcomes for local populations and communities, not solely on the service's I interests. • Leaders champion co-production and co-design of the service with people who have lived experience across all areas of the service, and they maintain strong partnerships across other organisations, agencies and sectors in the system.			

Improvement, innovation and learning

Are there effective systems that enable continuous improvement, innovation and learning to drive high-quality, sustainable services?

Scope of this key line of enquiry and topic areas include:

- Innovation
- Learning and improvement
- Research
- Quality improvement capability
- Lived experience involvement
- Evidence-based innovation

Outstanding	Good	Requires improvement	Inadequate
• There is a fully embedded and effective systematic approach to quality	• Staff and leaders understand how to help improvement and innovation happen. Their	• Staff and leaders have limited understanding about how to make improvement happen.	• There is little innovation or service development.

improvement, which leaders understand is key to delivering high-quality, equitable care. • Learning is a continuous process, embedded through reflection, collective problem-solving, and sharing both mistakes and good practice. Learning is systemically shared internally and with other organisations to support improvement in the system and innovation in the sector. • People and communities, particularly those who are more likely to have poor health outcomes, are actively involved in research opportunities, and in developing and co-producing improvements and innovations. • Leaders foster an open culture of trust, which is honest about challenges and mistakes, and uses these as opportunities for learning. Leaders actively listen to staff and encourage collective problem solving and innovation. • The service invests in its people to ensure quality	approach is consistent and includes measuring outcomes and impact to drive improvement. • Learning is a continuous process, where mistakes and good practice are openly discussed and shared with other organisations. New improvements and innovations are monitored to support continuous improvement. • People and those close to them are actively involved in shaping and evaluating improvement and innovation. • Leaders actively listen to staff and encourage collective problem solving and innovation. • Staff are supported and given sufficient time to develop their skills around quality improvement and innovation. They are consistently encouraged to contribute improvement initiatives. • Staff and leaders engage with external partners, including those in research, and embed evidence-based practice into the service.	Their approach is often reactive and focused on short-term solutions. • Improvements are not always identified or action is not always taken. Where changes are made, the impact may not be fully understood or monitored. • People using services are only sometimes involved in improvement and innovation. • Leaders don’t always listen to or work collaboratively with staff to improve the service. There is weak or inconsistent investment and time to develop the skills of staff around quality improvement and innovation. People from different backgrounds feel they do not have the same opportunities. • Engagement with external partners to improve and innovate the service is limited. Opportunities to embed evidence-based practice may have been missed as a result.	• There is minimal evidence of learning and reflective practice. The impact of service changes on the quality of care is not evident or understood. • People using the service are rarely involved in improvement and innovation. People from different backgrounds are not given the same opportunities to do this. • Leaders do not work with staff to improve the service. There is minimal investment or insufficient time to develop the skills of staff around quality improvement and innovation. • There is little engagement with external partners to improve and innovate the service or embed evidence-based practices.

improvement is embedded in the way all staff work. There is a clear culturally sensitive, non-discriminatory strategy for how to develop staff capabilities. Staff from all backgrounds feel empowered to lead and deliver change. • There are strong external relationships that support research, improvement and innovation. Staff and leaders regularly engage with external partners, including those in research, and embed evidence-based practice into the service. The service leads on national improvement initiatives and research. There is notable evidence of improvements for marginalised communities as a result.			