



Best Practice Statement ~ *April 2004*

Admissions to Adult Mental Health In-Patient Services

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Introduction

NHS Quality Improvement Scotland (NHS QIS) was established as a Special Health Board on 1 January 2003 as a result of bringing together the Clinical Resource and Audit Group (CRAG), Clinical Standards Board for Scotland (CSBS), Health Technology Board for Scotland (HTBS), Nursing and Midwifery Practice Development Unit (NMPDU) and the Scottish Health Advisory Service (SHAS).

The purpose of NHS QIS is to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

Background to Best Practice Statements

While many examples of clinical guidelines exist there is a lack of reliable statements focusing specifically on nursing and midwifery practice. The development of best practice statements reflects the current emphasis on delivering care that is patient-centred, cost-effective and fair, and will attempt to reduce existing variations in practice. The common practice that should follow their implementation will allow comparable standards of care for patients wherever they access services.

A series of 'best practice statements' designed to offer guidance on best practice relating to specific areas of practice and to encourage a consistent and cohesive approach to care has been produced by the former NMPDU.

What is a Best Practice Statement?

A best practice statement is a statement to describe best and achievable practice in a specific area of care. The term 'best practice' reflects the commitment of NHS QIS to sharing local excellence at national level. Best practice statements are underpinned by a number of shared principles (page ii).



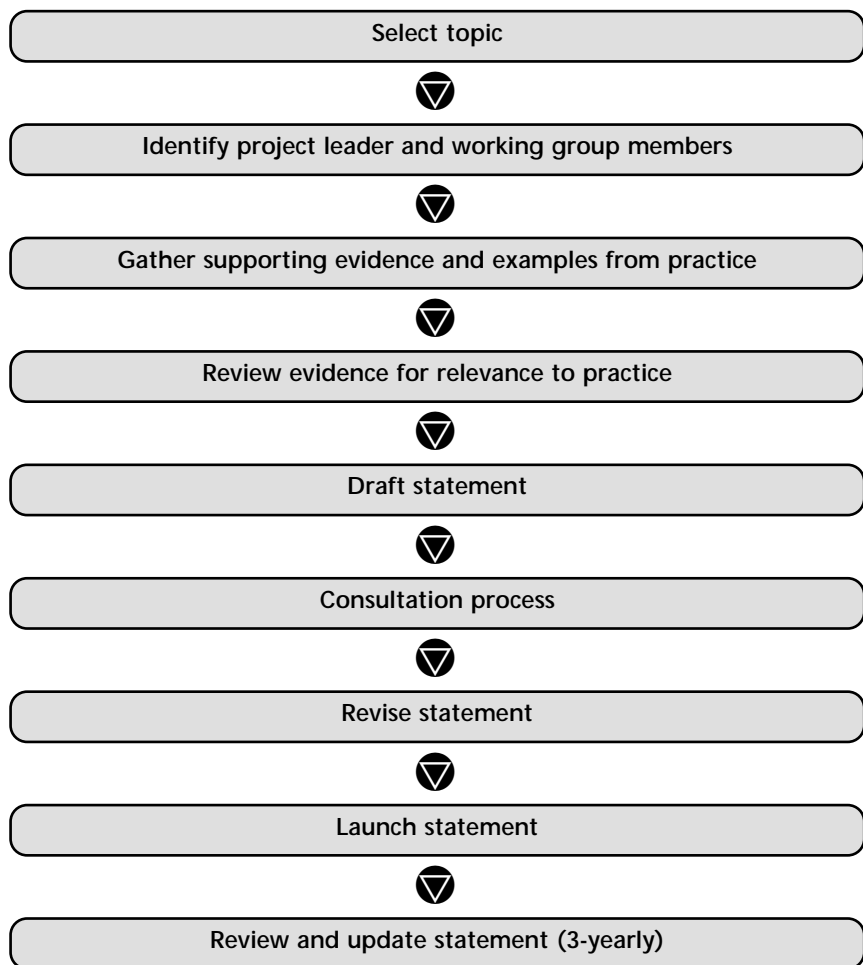
Key Principles of Best Practice Statements

- Best practice statements are intended to guide practice and promote a consistent and cohesive approach to care.
- Best practice statements are primarily intended for use by registered nurses, midwives and the staff who support them, but they may contribute to multidisciplinary working and other members of the healthcare team may find them helpful.
- Statements are derived from the best available evidence at the time they are produced, recognising that levels and types of evidence vary; where a statement is developed in the absence of research evidence and is predominantly based on consensus this will be noted.
- Information is gathered from a broad range of sources in order to identify existing or previous initiatives at local and national level, incorporate work of a qualitative and quantitative nature and establish consensus.
- Statements are targeted at practitioners, using language that is accessible and meaningful.
- Consultation with relevant organisations and individuals is undertaken.
- Statements are reviewed and updated every 3 years.
- Responsibility for implementation of statements will rest at local level.
- Key sources of evidence and available resources are provided.

Key Stages in the Development of Best Practice Statements

A systematic process has been followed as outlined below.

The development process for this statement began in January 2003 and was led by a working group of clinicians and service users, supported by a steering group and a multidisciplinary reference group of clinical and academic staff representing NHS Trusts across Scotland.





Use of Evidence in Best Practice Statements

The need to embrace evidence in its broadest sense has been acknowledged by NHS QIS in the development of best practice statements. Best practice statements represent a unique synthesis of research evidence, evidence complemented by audit, patient surveys and evidence derived from expert opinion, professional consensus and patient/public experience.

The process for developing these statements adopts a rigorous, transparent and consistent 'bottom-up' approach to articulating best practice that involves professionals and patients, and is based on all types of available evidence.

The following stages describe the process of identifying and reviewing evidence for inclusion in statements:

1. Define question
2. Review evidence from a range of sources including published literature, grey literature and other relevant sources, eg patient groups, manufacturers, professional groups
3. Integrate evidence with patient-related factors, eg issues of access, equity and ethics
4. Develop recommendations
5. Evaluate process and impact of recommendations.

Best Practice Statement on Admissions to Adult Mental Health In-Patient Services

This best practice statement has been produced by NHS QIS in collaboration with a multidisciplinary working, reference and steering group. While the aim of the statement is to offer guidance to nurses within adult mental health acute in-patient services, the emphasis throughout is on multi-professional working and collaboration. The importance of communication, access to and the sharing of information across services and disciplines is crucial in attaining best practice for patients entering these services and is echoed throughout the statement. The focus of the statement is admission to adult mental health acute in-patient services, and while the principles may be applied to other specialist services the statement does not address specific needs within, eg child and adolescent mental health and learning disability. Nor does it attempt to address the specific challenges faced by remote and rural areas (BID 79, 2003).

Recommendations on information for staff, access to training, and also contact with learning disability specialists to offer support and advice, are detailed within *Promoting Health, Supporting Inclusion* (Scottish Executive, 2002) and the Mental Welfare Commission *Annual Report 2001-2002*.

While The Mental Health (Care and Treatment) (Scotland) Act 2003 contains new provisions for the care of people under 18 who need admission to hospital for the treatment of a mental disorder, regardless of whether the person is subject to informal or compulsory admission, Section 23 of the Act gives Health Boards a duty to provide “such services and accommodation as are sufficient for the particular needs of that child or young person”. The specific challenges faced in implementing these services are highlighted in the review of in-patient services, *Needs Assessment Report on Child and Adolescent Mental Health* (PHIS, 2003).

This best practice statement forms part of a range of NHS QIS initiatives addressing issues in mental health. While the focus of this statement is admissions to adult mental health acute in-patient services, it is fully intended that it will complement other parts of the NHS QIS work programme such as the schizophrenia standards referred to in this document and the core mental health standards that are currently being developed. This statement will be a key element in developing policy and practice to support healthcare governance at local level.

The wide range of advice and guidance produced by NHS QIS reflects the breadth of activity and diverse needs of NHSScotland. All information produced by NHS QIS shares the common goal of improving patient care either directly or indirectly.



Format of Statement

The statement is divided into six sections covering:

Section 1:	Risk Assessment and Management
Section 2:	Pre-Admission/Initial Assessment of Need
Section 3:	Admission to Hospital - Exchange of Information
Section 4:	Assessment and Care Planning
Section 5:	Assessment of Psycho-Social Needs
Section 6:	Discharge Planning

Each section contains a table corresponding to the what, why and how of best practice, ie summarising the statement, the reason for the statement and how to achieve the statement or to demonstrate it is being achieved. Key points, key challenges and points of note relating to admissions to adult mental health in-patient services are included in each section.

Key points highlight the underpinning philosophy of the statement and/or explicit skill requirements to achieve best practice. Key challenges of the statement reflect existing examples of best practice and highlight areas that may require specific action. Points of note offer explicit empirical evidence to support the general principle/ethos of the statement.

How Can the Statement be Used?

The best practice statement on admission to adult mental health in-patient services can be used in a variety of ways, although primarily it is intended to serve as a guide to best practice and promote a consistent and cohesive approach to care. The statement is intended to be realistic but challenging and can be used:

- as a basis for developing and improving care;
- to stimulate learning among nursing teams;
- to promote effective multi-professional team working;
- to serve as a measure for quality in admissions in mental health; and
- to stimulate ideas and priorities for research.

Who Was Involved in Developing the Statement?

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Practice Development Network Members

Individual link nurses/midwives from every NHS Trust in Scotland, representatives from academic departments of nursing/midwifery and the Nursing, Midwifery & Allied Health Professions Research Unit (NMAHPRU).

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Section 1: Risk Assessment and Management

Key Points ~

1. *Risk assessment/management is central to every stage of the admission process and should be a routine part of in-patient care.*
2. *Risk assessment/management is a dynamic, ongoing process, not a single event/episode on admission.*
3. *Observation levels determined by risk assessment require explicit policies and procedures on reviewing observation levels, (CRAG 2002).*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>As part of acute in-patient care, registered nurses in conjunction with other relevant health professionals carry out an initial risk assessment. This should take place at the pre-admission phase and continue to evolve throughout the admission procedure and in-patient stay.</p>	<p>Risk assessment/management is crucial for determining the needs of the patient in order that optimum levels of care can be provided.</p>	<p>There is documented evidence that:</p> <ul style="list-style-type: none"> • Risk assessment has been carried out. • Formal measures/tools have been used.
<p>All patients are assessed using a combination of formal* assessment measures and structured clinical judgment to determine their level of risk.</p> <p>Risk assessment takes into account both historical (static) and current (dynamic) risk factors.</p>	<p>Risk assessment enables the initiation and maintenance of accurate risk management strategies.</p>	<p>Areas of risk have been assessed and identified, eg self-harm, violence towards others, absconding, treatment non-compliance, vulnerability and threat to vulnerable groups.</p> <p>Risk management plans have been identified.</p> <p>Risk assessment/management plans have been shared with all staff.</p> <p>If risk assessment/management plans are not shared with the patient, the reasons why have been documented.</p> <p>Observation levels derived from risk assessment have been discussed with the patient.</p> <p>Patients are re-assessed in response to changes in their physical/mental condition, social circumstances.</p>

* Some formal risk assessment measures require specific training prior to use.

Key Challenges ~

1. *Development of multi-professional risk assessment documentation.*
2. *The implementation of Critical Incident Review (CIR) protocol as part of the wider system of clinical risk management.*
3. *Supporting staff in acquiring the skill of risk assessment (NES, 2000).*

Points of Note ~

- In the absence of standardised validated risk assessment measures, the Mental Health Reference Group (2000) and the Royal College of Psychiatrists Council Report CR53 (1996) offer extremely useful guidance and risk assessment templates.
- 'Risk assessment/management is a complex process involving objective data, data from third parties and the judgement of the clinicians involved' (CRAG, 2002).
- 'The risk management process should enable the optimum level of care to be given to a client. Risk management involves the assessment of risk relating to client care, care systems and the environment of care' (UKCC, 1998).
- 'No single worker has the ability to detect, assess severity of and make arrangements to minimise risk - a systematic and co-ordinated approach is necessary' (Mental Health Reference Group, 2000).

Section 2: Pre-Admission/Initial Assessment of Need

Key Points ~

1. *Positive indications for admission to acute in-patient care should be evident and careful consideration should be given to alternative services capable of meeting an individual's needs.*
2. *The underpinning philosophy of in-patient care is that the service provider can meet the needs of the individual.*
3. *Pre-admission assessment should take place in a private and safe environment, outwith the admission ward, where risk assessment allows.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Registered nurses, in conjunction with medical staff, conduct an initial assessment of need by means of clinical interview.</p>	<p>Multi-professional working facilitates collaborative assessment and holistic care planning between health professionals.</p> <p>Joint assessment reduces the repetitive nature of gathering assessment information from the patient and promotes inter-disciplinary working.</p>	<p>There is documented evidence of initial assessment from both nursing and medical staff, detailing the following:</p> <ul style="list-style-type: none"> • Alternatives to admission identified and reasons for inappropriateness recorded. • Current presenting problems. • Inclusion of patient/carer in the decision-making process (carer inclusion with patient's consent). • Initial risk assessment.* • Mental health needs. • Physical needs. • Presenting mental state. • Psychological needs. • Social needs.

Key Challenges ~

1. *Involving nursing staff in the pre-admission assessment and decision-making process.*
2. *Ensuring access to, and use of, previous assessment information (physical, psychological, mental health and social functioning) from statutory and voluntary agencies in informing assessment.*
3. *Encouraging service design that is 'needs-led'.*
4. *Development of liaison nurse roles within A&E departments (Cook and Wilson, 1999).***

Point of Note ~

- 'A&E departments in hospitals should have a 'liaison nurse', ie someone trained in mental health who could deal sensitively with cases involving mental distress or self-harm' (Scottish Needs Assessment Programme, 2002; Scottish Association for Mental Health, 2003).

* Expanded upon in Section 1: Risk Assessment and Management.

** Monklands District General Hospital Liaison Services.

Section 3: Admission To Hospital – Exchange of Information

Key Points –

1. *Admission to hospital can be a distressing experience for both the patient and their carer. Nurses should be aware of this potential distress and provide information for the patient and carer throughout the admission procedure and in-patient period.*
2. *To provide accurate information on patients' rights, mental health nurses require up-to-date knowledge of current mental health issues and related legislation.*
3. *Other agencies/services engaged with the patient must be informed of their in-patient status and invited to exchange any relevant information.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Registered nurses guide the patient and carer through the admission procedure, ensuring that the process is clearly explained and understood whilst ensuring that all relevant documentation is completed.</p> <p>Information is provided in a format/language that the patient understands and is re-iterated throughout their stay (Highland Users Group, 2001; Scottish Association for Mental Health, 2003).</p> <p>The admission procedure is carried out in conjunction with other relevant health professionals. Admission takes place in an environment that ensures comfort and privacy (Highland Users Group, 2001; Scottish Association for Mental Health, 2003).</p>	<p>Patients require information on what is happening and what is likely to happen during the admission procedure and in-patient period (Highland Users Group, 2001; Scottish Association for Mental Health, 2003).</p> <p>To satisfy/fulfil requirements of The Mental Health (Care and Treatment) (Scotland) Act 2003.</p> <p>Joint assessment reduces the repetitive nature of gathering assessment information from the patient and promotes inter-disciplinary working.</p>	<p>There is documented evidence that relevant information has been given to the patient (and carer where practicable with patient consent), including the following:</p> <ul style="list-style-type: none"> • Advocacy service. • Agreed observation levels discussed with patient. • Benefits/accommodation. • Chaplaincy services. • Condition and presentation of symptoms. • Current/ongoing assessment of risk. • Effects and side-effects of medication. • Keyworker/named nurse. • Mental Welfare Commission. • Orientation to environment. • Other disciplines involved in care, eg occupational therapy, psychology, psychiatry, social work. • Patient rights under detention. • Visiting hours. • Ward routine, eg meal times, medication, case reviews, use of telephone.

Section 3: Admission To Hospital – Exchange of Information (continued)

Key Challenges ~

1. *To provide information for specific groups such as ethnic minorities or patients with a hearing impairment, who may require use of specialist services such as interpreters.*
2. *Increasing awareness of cultural and religious factors that may impact on patient and carers understanding or experience of mental illness and acute services.*
3. *Involvement of specialist services such as addiction services that may be required due to the high levels of co-morbidity.*
4. *Ensuring that the provision of information to patients and carers, throughout the in-patient stay, is a recurring collaborative process.*
5. *Awareness of policy/legislation that may impact on the needs of individuals admitted to mental health services, eg adults with incapacity, learning disability, adults with hearing or visual impairment.*
6. *Elements such as housing benefits and other financial implications requiring attention must be carefully considered as early as possible on admission in order to allow a multi-agency approach to support the patient following discharge (Simons et al, 2002).*

Point of Note ~

- *'Giving users and carers information about the illness and available services/treatments improves understanding. This helps maintain vital relationships and improve outcomes for users and carers in the longer term' (CSBS, 2001).*

Section 4: Assessment and Care Planning

Key Points ~

1. *Assessment and care planning should be a collaborative exchange between nursing staff, other relevant disciplines, the patient and the patient's carer with informed consent, and begin when a patient presents for pre-admission assessment.*
2. *Ongoing risk assessment/management builds upon pre-admission risk assessment information.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
<p>Registered nurses, in consultation with other relevant health professionals, carry out an assessment of need by means of a combination of clinical interview/standardised assessment tools and outcome measures, eg AVON, BPRS, Camberwell Assessment of Need (Slade et al, 1996) and HoNOS.</p>	<p>Outcome measures in acute psychiatry allow the efficacy of treatment to be measured.</p> <p>An accurate assessment of need provides a basis for care planning and ensures a patient-centred approach.</p> <p>This facilitates the building of an initial care plan on pre-admission information.</p> <p>Outcome measures offer clinicians information useful for the development of evidence-based clinical practice and allow them to 'build up a picture of the effectiveness of various therapeutic approaches' (Sperlinger, 2002).</p>	<p>There is documented evidence of:</p> <ul style="list-style-type: none"> • Initial nursing care plan in place with recorded planned reviews. • Assessment/outcome measures used.
<p>Registered nurses, in conjunction with other relevant health professionals agree on the required level of observation and communicate this information to the patient, carer and all members of the care team (CRAG, 2002).</p>	<p>Care planning incorporates ongoing risk assessment including risk of harm to self and others. The purpose of observation is to 'provide a period of safety, during temporary periods of distress' with observation levels set at the 'least restrictive level, for the least amount of time in the least restrictive setting' (CRAG, 2002).</p>	<p>There is documented evidence of:</p> <ul style="list-style-type: none"> • Ongoing risk assessment/management plan. • Therapeutic engagement during periods of increased observation. • Current observation status with review date.

Section 4: Assessment and Care Planning (continued)

Key Challenges ~

1. *Encapsulate a person-centered assessment.*
2. *Identifying and dealing with specific vulnerabilities, eg adolescents, ethnic minorities, patients with disabilities and single sex environments.*
3. *Increasing awareness of the impact of cultural and religious factors on assessment and care planning*
4. *Encouraging service design that is 'needs-led and patient-centered'.*
5. *Continuing involvement of community mental health team to support the process of discharge planning from admission.*
6. *Incorporating data from outcome measures to inform service design/efficacy.*

Points of Note ~

- 'The specific outcome measures to be used by particular services or clinicians will be dependant on the purpose for which they are required. Outcome measures are not an end in themselves, but a tool to enable clinicians and others to reflect on their work and to facilitate the improvement of the services provided to users' (Sperlinger, 2002).
- 'Observation is a process that ensures close monitoring of, and engagement with, someone who needs (for a period of time) intensive care and support. It is a formal structured process and therefore is fundamentally different from the normal monitoring of patients within a ward or care setting' (CRAG, 2002).

Section 5: Assessment of Psycho-Social Needs

Key Points ~

1. *There is sufficient evidence to support the use of psycho-social interventions in psychiatry (SIGN 1998; CSBS, 2001).*
2. *Psycho-social interventions can range from psycho-education for the patient/carer, to family therapy and cognitive behavioural psychotherapy for anxiety, depression, schizophrenia, eating disorders, substance misuse/addiction etc.*

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Registered nurses in conjunction with other relevant disciplines are involved in assessing the patient's psycho-social needs.	<p>The evidence base to support the use of psychological approaches to care is increasing, as is the professional base capable of providing this service (Scottish Office, 1997; HDL, 2001).</p> <p>Multi-professional working facilitates the provision of psycho-educational/psychological approaches to care for both the patient and carer.</p> <p>To satisfy/fulfil requirements of The Mental Health (Care and Treatment) (Scotland) Act 2003.</p>	<p>There is documented evidence of:</p> <ul style="list-style-type: none"> • Multi-professional, psychological-based formulation and care plan including risk assessment.

Key Challenge ~

1. *Provision of education, training, support and clinical supervision for nursing staff to enable their involvement in assessment, delivery and evaluation of psycho-social interventions.*

Point of Note ~

- 'As a registered nurse, midwife or health visitor, you are personally accountable for your practice and, in the exercise of your professional accountability, must maintain and improve your professional knowledge and competence' (UKCC, 1998).

Section 6: Discharge Planning

Key Points ~

1. Adequate discharge planning requires dedicated time from all disciplines involved in the patient's care to agree and implement an adequate level of support required to make the transition from in-patient care for all patients.
2. As community mental health teams and/or primary care teams are deemed a necessary part of support on discharge, then information on in-patient care, progress to date and current risk assessment are essential. This should be available to all disciplines/services (DOH, 1999).
3. 'The discharge of patients is planned prior to discharge and all relevant information is communicated at the appropriate time to the patient and to those involved in continuing provision of care' (CSBS, 2002).

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
Registered nurses, in conjunction with other relevant disciplines, determine the level of support required for the transition from in-patient care back to the community. This will initiate an interim discharge care plan prior to discharge.	Discharge planning is a gradual, well-planned and collaborative process reviewed regularly throughout in-patient stay. Effective discharge planning begins on or shortly after admission and is a continual process. Communication and transfer of information among healthcare professionals are essential to a seamless process.	There is documented evidence that discharge plans have been initiated and reviewed.
Discharge planning incorporates current/ongoing risk assessment/management plans.	Risk assessment enables the initiation and maintenance of accurate risk management strategies.	There is documented evidence that ongoing risk assessment/management has been included in the discharge plan.

Key Challenges ~

1. Supporting community mental health teams continued contact with the in-patient to facilitate a seamless transition of care.
2. Applying the principles of discharge planning to the use of 'pass' and 'leave of absence', including risk assessment/management plan.
3. Where follow-up is advised, patients are seen by community mental health teams and/or a community psychiatric nurse within 2-7 days post-discharge depending on assessed need (DOH, 1999; 2001).
4. Involving nurses in the Care Programme Approach (CPA) for patients who require it.

Points of Note ~

- When a person who has a diagnosis of schizophrenia is being discharged from hospital and care is being transferred to the community, those caring for the person, both in the hospital and in the community, work together with the person so that the care provided after discharge is well co-ordinated, is based on the person's needs, and is reviewed regularly' (CSBS, 2001).
- Details about and arrangements for transport, provision of medication, emergency contact arrangements and final notification to community services need to be communicated to professional staff, users and carers' (Simons et al, 2002).

Glossary of Terms

advocacy service	An individual (paid or voluntary) who acts independently on behalf of, and in the interests of, patients/users who may feel unable to represent themselves in their contacts with a healthcare or other facility. Independent advocacy is when advocacy is provided independently from those providing care, to ensure that there are no conflicts of interest. An advocate may not be a legally qualified person, but may be trained and supported by an advocacy project/service.
Care Programme Approach (CPA)	A process which aims to ensure that people with severe and enduring mental illness (such as schizophrenia) who also have complex social care needs are provided with co-ordinated care and supervision.
cognitive psychotherapy	See psycho-social interventions.
co-morbidity	The co-existence of more than a single mental disorder, eg anxiety and depression, schizophrenia and addiction.
community mental health team	A group of professionals from a variety of different disciplines (eg medical, nursing, social work) who work together to provide a range of mental health services outwith the hospital setting.
CRAG	Clinical Resource and Audit Group. Now part of NHS Quality Improvement Scotland (NHS QIS).
critical incident review	Multidisciplinary analysis and review of the management of critical incidents as a form of learning tool.
CSBS	Clinical Standards Board for Scotland. Now part of NHS Quality Improvement Scotland (NHS QIS).
discharge planning	Gradual process of assessing the level of support in order to make the transition from in-patient care to community care.
DOH	Department of Health.
informed consent	The principle by which a patient/user is informed about the nature, purpose and likely effects of any treatment proposed before being asked to consent to accepting it.

keyworker	Nurse identified as responsible for the nursing assessment, implementation and care planning during in-patient stay.
liaison nurse	Nurse who provides a means of communication between different groups or units within an organization, eg psychiatry and A&E, primary care and secondary care.
NES	NHS Education for Scotland.
observation	A process that ensures close monitoring of and engagement with someone who needs (for a period of time) intensive care and support. It is a formal structured process and therefore is fundamentally different from the normal monitoring of patients within a ward or care setting.
outcome measure	A measure of the effects, beneficial or adverse, which a person experiences as a result of the care, treatments or services they have received.
PHIS	Public Health Institute of Scotland. Now part of Health Scotland.
psycho-social interventions	(Psycho) education programmes: directed at either patients or carers/family members and have several aims. Improvement in knowledge of illness and its course and in compliance with treatment has been shown. There is also evidence of greater satisfaction with services provided. Some programmes go beyond the provision of information and take an educational approach to skills training or problem-solving.

Family interventions: The aims of ‘Family Intervention’ include reduction of frequency of relapse into illness and reduction of hospital admissions, reduction in the burden of care on families and carers, and improvement in compliance with medication.

Cognitive behavioural therapies: are a collection of therapeutic approaches carried out with the aim of changing behaviour and altering thought patterns. The therapist helps the person to identify their own untrue or destructive beliefs in order to reduce distress and develop coping strategies.

risk assessment	Comprehensive assessment of the presence of risk factors both current and historical to determine current levels of risk to self and others.
risk management	A systematic approach to the management of risk, to reduce loss of life, financial loss, loss of staff availability, staff and patient/client/user safety, loss of availability of buildings or equipment, or loss of reputation.
SIGN	Scottish Intercollegiate Guidelines Network.
therapeutic engagement	Observation where consideration is given to the use of activity, discussion and distraction processes, but recognition of the need for silence and as much privacy as is achievable.
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting. Now Nursing & Midwifery Council (NMC).

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Our Commitment

Our work will be undertaken in line with the following values:

- **patient and public focus**
 - ~ promoting a patient-focused NHS that is responsive to the views of the public
- **independence**
 - ~ reaching our own conclusions and communicating what we find
- **partnership**
 - ~ involving patients, carers and the public in all parts of our work
 - ~ working with and supporting NHS staff in improving quality
 - ~ collaborating with other organisations such as public bodies, voluntary organisations and manufacturers to avoid duplication of effort
- **evidence-based**
 - ~ basing conclusions and recommendations on the best evidence available
- **openness and transparency**
 - ~ promoting understanding of our work
 - ~ explaining the rationale for our recommendations and conclusions
 - ~ communicating in language and formats that are easily accessible
- **quality assurance**
 - ~ aiming to focus our work on areas where significant improvements can be made
 - ~ ensuring that our work is subject to internal and external quality assurance and evaluation
- **professionalism**
 - ~ promoting excellence individually and as teams and ensuring value for money in the use of public resources (human and financial)
- **sensitivity**
 - ~ recognising the needs, opinions and beliefs of individuals and organisations and respecting and encouraging diversity

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