



Self-harm

Quality standard

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This standard is based on NG225 and CG136.

This standard should be read in conjunction with QS8, QS14, QS15, QS48, QS88, QS102, QS95, QS115, QS159, QS175 and QS189.

Quality statements

Statement 1 People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.

Statement 2 People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety.

Statement 3 People who have self-harmed receive a psychosocial assessment.

Statement 4 People who have self-harmed receive the observation they need while in the healthcare setting.

Statement 5 People who have self-harmed are cared for in a safe physical environment while in the healthcare setting.

Statement 6 People receiving continuing support for self-harm have a collaboratively developed care plan.

Statement 7 People receiving continuing support for self-harm have a discussion with their healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

Statement 8 People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

Quality statement 1: Compassion, respect and dignity

Quality statement

People who have self-harmed are cared for with compassion and the same respect and dignity as any service user.

Rationale

Everyone who uses healthcare services should be treated with compassion, respect and dignity. For people who have self-harmed, however, staff attitudes are often reported as contributing to poor experiences of care. Punitive or judgemental staff attitudes can be distressing for people who have self-harmed and may lead to further self-harm or avoidance of medical attention.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to provide staff training on treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from staff training records.

Process

Proportion of staff in contact with people who have self-harmed who have received

training on treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

Numerator – the number of staff in the denominator who have received training on treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

Denominator – the number of staff in contact with people who have self-harmed.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from staff training records.

Outcome

Evidence from feedback that people who have self-harmed feel they are treated with compassion and the same respect and dignity as any service user.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations. [NHS Patient Surveys](#) ask questions about dignity when using services; however, data on diagnosis are not collected.

What the quality statement means for different audiences

Service providers ensure that training is provided on treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

All staff ensure that they treat people who have self-harmed with compassion and the same respect and dignity as any service user.

Commissioners ensure that they commission services in which all staff who come into contact with people who have self-harmed are trained in treating people with compassion, respect and dignity that includes specific reference to people who self-harm.

People who have self-harmed are cared for with compassion and the same respect and

dignity as any service user.

Source guidance

Self-harm: assessment, management and preventing recurrence. NICE guideline NG225 (2022), recommendations 1.7.1, 1.14.1 and 1.14.2

Definitions of terms used in this quality statement

People who have self-harmed

People who have carried out intentional self-poisoning or injury, irrespective of the apparent purpose of the act. [Adapted from NICE's guideline on self-harm, terms used in this guideline; self-harm]

Staff

Everyone employed by or working in all sectors that provide care and support for people who have self-harmed. It is not restricted to qualified healthcare professionals, and could include reception staff, administrative staff and others. It applies to primary care, ambulance services, emergency departments, minor injury units, community services and inpatient settings. [Adapted from NICE's guideline on self-harm and expert opinion]

Quality statement 2: Initial assessments

Quality statement

People who have self-harmed have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety.

Rationale

An initial assessment can identify ways to keep the person safe after an episode of self-harm and can be used to inform future safety plans and referral. People who have self-harmed value positive, compassionate support after an episode of self-harm.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that initial assessments of people who have self-harmed include physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

Proportion of people who have self-harmed who have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety.

Numerator – the number of people in the denominator who have an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety.

Denominator – the number of people with a new episode of self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers ensure that people who have self-harmed have an initial assessment after an episode of self-harm that includes physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety.

Healthcare professionals ensure that people who have self-harmed have an initial assessment after an episode of self-harm that includes physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety.

Commissioners ensure that they commission services that undertake an initial assessment of physical health, mental state, safeguarding concerns, social circumstances and immediate concerns about their safety for people after an episode of self-harm.

People who have self-harmed have their physical health, mental state, social circumstances and immediate concerns about their safety assessed after an episode of self-harm.

Source guidance

Self-harm: assessment, management and preventing recurrence. NICE guideline NG225 (2022), recommendations 1.3.1, 1.7.1, 1.7.9 and 1.7.12

Definitions of terms used in this quality statement

People who have self-harmed

People who have carried out intentional self-poisoning or injury, irrespective of the apparent purpose of the act. [Adapted from [NICE's guideline on self-harm](#), terms used in this guideline; self-harm]

Initial assessment

The first assessment by a healthcare professional after an episode of self-harm. It applies to people first seen in primary care, ambulance services, emergency departments or minor injury units. It also applies to the first assessment of episodes of self-harm in inpatient settings. An initial assessment should be undertaken each time a person presents with an episode of self-harm. It should include, relevant to the setting:

- information about the home environment
- information about the social and family support network
- the history leading to self-harm
- any medicines found at their home
- the severity of the injury and how urgently medical treatment is needed
- the person's emotional and mental state, and level of distress
- whether there is immediate concern about the person's safety
- whether there are any safeguarding concerns
- whether the person has a care plan
- the person's willingness to accept medical treatment and mental healthcare
- the appropriate nursing observation level
- if there is a need to refer the person to a specialist mental health service for assessment.

[Adpated from NICE's guideline on self-harm, recommendations 1.7.2, 1.7.9, and 1.7.12, and expert opinion]

Quality statement 3: Psychosocial assessments

Quality statement

People who have self-harmed receive a psychosocial assessment.

Rationale

A psychosocial assessment is aimed at identifying personal factors that might explain an act of self-harm. It should be carried out each time a person presents with an episode of self-harm. It should start a collaborative therapeutic relationship and be used to form an effective management plan.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that mental health professionals undertake psychosocial assessments with people who have self-harmed.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

Proportion of people who have self-harmed who receive a psychosocial assessment.

Numerator – the number of people in the denominator who receive a psychosocial

assessment.

Denominator – the number of people with a new episode of self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers ensure that systems are in place for mental health professionals to undertake psychosocial assessments for people who have self-harmed.

Mental health professionals ensure that people are offered a psychosocial assessment after an episode of self-harm.

Commissioners ensure that they commission services that provide psychosocial assessments for people after an episode of self-harm.

People who have self-harmed are offered a psychosocial assessment that considers their strengths, vulnerabilities and needs, and reasons for harming themselves.

Source guidance

Self-harm: assessment, management and preventing recurrence. NICE guideline NG225 (2022), recommendations 1.5.1, 1.5.9 to 1.5.12, 1.5.15 and 1.6.6

Definitions of terms used in this quality statement

People who have self-harmed

People who have carried out intentional self-poisoning or injury, irrespective of the apparent purpose of the act. [Adapted from NICE's guideline on self-harm, terms used in this guideline; self-harm]

Psychosocial assessment

A psychosocial assessment explores the functions of self-harm for the person and identifies the person's strengths, vulnerabilities and needs. This includes:

- historic factors
- changeable and current factors
- future factors, including specific upcoming events or circumstances
- protective or mitigating factors.

The psychosocial assessment should take into account:

- the person's values, wishes and what matters to them
- the need for psychological interventions, social care and support or occupational or vocational rehabilitation
- any learning disabilities, neurodevelopmental conditions or mental health problems
- the person's treatment preferences
- that each person who self-harms does so for their own reasons
- that each episode of self-harm should be treated in its own right, and a person's reasons for self-harm may vary from episode to episode
- whether it is appropriate to involve their family and carers.

[Adapted from [NICE's guideline on self-harm](#), recommendations 1.5.9 and 1.5.10]

Equality and diversity considerations

Children and young people, people with a learning disability and older people who have self-harmed should have a psychosocial assessment by a mental health professional experienced in assessing people in those groups who self-harm. A psychosocial assessment in children and young people should additionally ask about their social, peer group, education and home situations, any caring responsibilities, the use of social media or the internet and the effects of these on mental health and wellbeing and any child protection or safeguarding issues.

In older people a psychosocial assessment should pay particular attention to the potential presence of depression, cognitive impairment and physical ill health and frailty; include an assessment of the person's social and home situation, including any role they have as a carer; recognise the increased potential for loneliness and isolation and that there are higher rates of suicide after an episode of self-harm for older people. [[NICE's guideline on self-harm](#), recommendations 1.5.11 to 1.5.13]

Quality statement 4: Observation

Quality statement

People who have self-harmed receive the observation they need while in the healthcare setting.

Rationale

Observation of people who have self-harmed when they are in a healthcare setting can reduce distress, ensure that the person feels supported and maintain physical safety.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people who have self-harmed receive the observation they need while in the healthcare setting.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Process

Proportion of people who have self-harmed who have a record of observation arrangements while in the healthcare setting.

Numerator – the number of people in the denominator with a record of observation arrangements while in the healthcare setting.

Denominator – the number of people with a new episode of self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Number of episodes of self-harm occurring in healthcare settings.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The NHS National Reporting and Learning System contains national and local figures on patient safety incidents including self-harm.

What the quality statement means for different audiences

Service providers ensure that staff carry out observation in the healthcare setting according to the needs of people who have self-harmed.

Healthcare professionals ensure that people who have self-harmed receive the observation they need while in the healthcare setting.

Commissioners ensure that they commission services that observe people who have self-harmed according to their needs while in the healthcare setting.

People who have self-harmed are checked regularly by healthcare staff, and are accompanied when required, when they are in hospital or another part of the health service, to make sure they are safe.

Source guidance

Self-harm: assessment, management and preventing recurrence. NICE guideline NG225 (2022), recommendations 1.7.12, 1.7.16, 1.7.23 and 1.8.12

Definitions of terms used in this quality statement

People who have self-harmed

People who have carried out intentional self-poisoning or injury, irrespective of the apparent purpose of the act. [Adapted from [NICE's guideline on self-harm](#), terms used in this guideline; self-harm]

Observation

A therapeutic intervention most commonly used in hospital settings, which allows staff to monitor and assess the mental and physical health of people who might harm themselves and/or others. It should be seen as an opportunity for active engagement as well as sensitive supervision. Observation applies to people being treated in primary care, ambulance services, emergency departments, minor injury units and inpatient settings. [Adapted from [NICE's guideline on self-harm](#), section 1.7 and terms used in this guideline; clinical observation]

Quality statement 5: Safe physical environments

Quality statement

People who have self-harmed are cared for in a safe physical environment while in the healthcare setting.

Rationale

Caring for people who have self-harmed in a safe physical environment within the healthcare setting can reduce distress, help them to feel supported and maintain physical safety in the healthcare setting.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to undertake assessments of the safety of the environment in healthcare settings.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations.

Outcome

Number of episodes of self-harm occurring in healthcare settings.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and

provider organisations, for example from patient records. The NHS National Reporting and Learning System contains national and local figures on patient safety incidents, including self-harm.

What the quality statement means for different audiences

Service providers ensure that they undertake assessments of the safety of the environment to ensure that healthcare settings are safe for people who have self-harmed.

Healthcare professionals ensure that people who have self-harmed are cared for in a safe physical environment while in the healthcare setting.

Commissioners ensure that they commission services that provide safe physical environments in healthcare settings for people who have self-harmed.

People who have self-harmed are cared for in a safe physical environment.

Source guidance

Self-harm: assessment, management and preventing recurrence. NICE guideline NG225 (2022), recommendations 1.7.16, 1.12.6 and 1.12.7

Definitions of terms used in this quality statement

People who have self-harmed

People who have carried out intentional self-poisoning or injury, irrespective of the apparent purpose of the act. [Adapted from NICE's guideline on self-harm, terms used in this guideline; self-harm]

Safe physical environment

People who have self-harmed should be offered an environment that is safe and balances respect for the person's autonomy against the need for restrictions.

Consideration should be given to removing items that may be used to self-harm. The person who has self-harmed should be involved in this decision.

A safe physical environment refers to primary care settings, ambulance services, emergency departments, minor injury units and inpatient settings where people who have self-harmed are being cared for. [Adapted from [NICE's guideline on self-harm](#), section 1.7 and recommendations 1.12.6 and 1.12.7]

Quality statement 6: Care plans

Quality statement

People receiving continuing support for self-harm have a collaboratively developed care plan.

Rationale

A care plan can help support recovery of people who self-harm. It documents the person's needs and safety considerations, and should be developed with the person and their family and carers.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that people receiving continuing support for self-harm have a collaboratively developed care plan.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations.

Process

Proportion of people receiving continuing support for self-harm who have a collaboratively developed care plan.

Numerator – the number of people in the denominator who have a collaboratively developed care plan.

Denominator – the number of people receiving continuing support for self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations for example, from patient records.

What the quality statement means for different audiences

Service providers ensure that collaboratively developed care plans are in place for people receiving continuing support for self-harm.

Healthcare professionals ensure that people receiving continuing support for self-harm have a collaboratively developed care plan.

Commissioners ensure that they commission services that have collaboratively developed care plans in place for people receiving continuing support for self-harm.

People who are having long-term support after self-harming have a care plan developed with their healthcare professional that helps to support their recovery.

Source guidance

Self-harm: assessment, management and preventing recurrence. NICE guideline NG225 (2022), recommendations 1.5.15 and 1.5.17

Definitions of terms used in this quality statement

People receiving continuing support for self-harm

People who have carried out intentional self-poisoning or injury, irrespective of the apparent purpose of the act, and who are receiving longer-term psychological treatment and management. This includes people with both single and recurrent episodes of self-harm. It does not include people having immediate physical treatment or management for self-harm in emergency departments. [Adapted from NICE's guideline on self-harm, terms used in this guideline; self-harm, and evidence review J]

Care plan

The plan of treatment or healthcare to be provided to the service user. It typically documents the needs and safety considerations of the service user, the interventions that will support their recovery, as well as the key professionals involved in their care. [[NICE's guideline on self-harm](#), terms used in this guideline]

Quality statement 7: Psychological interventions

Quality statement

People receiving continuing support for self-harm have a discussion with their healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

Rationale

There is some evidence that psychological therapies specifically structured for people who self-harm can be effective in reducing repetition of self-harm. The decision to refer for psychological therapy should be based on a discussion between the person and healthcare professional about the likely benefits.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to provide psychological interventions specifically structured for people who self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations.

Process

a) Proportion of people receiving continuing support for self-harm who have a record of a discussion with their healthcare professional about the potential benefits of psychological

interventions specifically structured for people who self-harm.

Numerator – the number of people in the denominator who have a record of a discussion with their healthcare professional about the potential benefits of psychological interventions specifically structured for people who self-harm.

Denominator – the number of people receiving continuing support for self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of adults who self-harm who accept referral for structured, person-centred cognitive behavioural therapy that is specifically tailored for adults who self-harm and receive at least 4 sessions.

Numerator – the number of people in the denominator who accept referral for structured, person-centred cognitive behavioural therapy that is specifically tailored for adults who self-harm and receive at least 4 sessions.

Denominator – the number of adults who self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

c) Proportion of children and young people with significant emotional dysregulation difficulties and frequent episodes of self-harm who discuss referral for dialectical behaviour therapy adapted for adolescents with a healthcare professional.

Numerator – the number of people in the denominator who discuss referral for dialectical behaviour therapy adapted for adolescents with a healthcare professional.

Denominator – the number of children and young people with significant emotional dysregulation difficulties and frequent episodes of self-harm.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and

provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers ensure that systems are in place for healthcare professionals to refer people receiving continuing support for self-harm for a psychological intervention specifically structured for people who self-harm.

Healthcare professionals ensure that they discuss with people receiving continuing support for self-harm the potential benefits of psychological interventions specifically structured for people who self-harm.

Commissioners ensure that they commission services that discuss potential benefits of psychological interventions specifically structured for people who self-harm with people receiving continuing support for self-harm and can refer them.

People who are having long-term support after self-harming discuss the possible benefits of psychological treatments for self-harm with their healthcare professional.

Source guidance

- [Self-harm: assessment, management and preventing recurrence. NICE guideline NG225 \(2022\)](#), recommendations 1.11.3 and 1.11.4
- [Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. NICE guideline CG136 \(2011\)](#), recommendation 1.1.5

Definitions of terms used in this quality statement

People receiving continuing support for self-harm

People who have carried out intentional self-poisoning or injury, irrespective of the apparent purpose of the act, and who are receiving longer-term psychological treatment and management. This includes people with both single and recurrent episodes of

self-harm. It does not include people having immediate physical treatment or management for self-harm in emergency departments. [Adapted from [NICE's guideline on self-harm](#), terms used in this guideline; self-harm, and evidence review J]

Psychological interventions

Structured, person-centred, cognitive behavioural therapy (CBT)-informed psychological interventions that are specifically tailored for adults who self-harm. Dialectical behaviour therapy adapted for adolescents (DBT-A) should be considered for children and young people with significant emotional dysregulation difficulties who have frequent episodes of self-harm. [Adapted from [NICE's guideline on self-harm](#), recommendations 1.11.3 and 1.11.4]

Quality statement 8: Moving between services

Quality statement

People receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

Rationale

Moving to different mental health services (for example, from services for young people to services for adults) can be a difficult period for people who self-harm. Unless there are plans to manage these transitions, people can feel isolated and unsupported, and be at increased risk of further self-harm. It is important that people using services are involved in agreeing how their support will be managed and understand who they can contact in a crisis.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements to ensure that providers collaboratively plan in advance and coordinate effectively when people who have self-harmed move between mental health services.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations.

Process

Proportion of people receiving continuing support for self-harm and moving between mental health services who have a collaboratively developed plan describing how support will be provided during the transition.

Numerator – the number of people in the denominator with a collaboratively developed plan describing how support will be provided during the transition.

Denominator – the number of people receiving continuing support for self-harm and moving between mental health services.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers ensure that systems are in place to coordinate effectively with other providers when people who have self-harmed move between mental health services.

Healthcare professionals ensure that people receiving continuing support for self-harm and moving between mental health services have a collaboratively developed plan describing how support will be provided during the transition.

Commissioners ensure that they commission services that provide people receiving continuing support for self-harm and moving between mental health services with a collaboratively developed plan describing how support will be provided during the transition.

People who are having long-term support after self-harming and are moving between mental health services agree a plan with their healthcare professionals that describes how they will be supported while they move from one service to another.

Source guidance

Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services. NICE guideline CG136 (2011), recommendation 1.7.1

Definition of terms used in this quality statement

People receiving continuing support for self-harm and moving between mental health services

People who have carried out intentional self-poisoning or injury, irrespective of the apparent purpose of the act, who are receiving longer-term psychological treatment and management and are moving from child and adolescent to adult mental health services, or from one adult mental health service to another. This includes people with both single and recurrent episodes of self-harm. It does not include people having immediate physical treatment or management for self-harm in emergency departments. [Adapted from NICE's guideline on self-harm, terms used in this guideline; self-harm, and evidence review J, NICE's guideline on service user experience in adult mental health, recommendation 1.7.1, and expert opinion]

Update information

September 2022: Changes have been made to align this quality standard with the updated [NICE guideline on self-harm](#). Statements 2, 3, 4, 5, 6 and 7 have been updated to reflect changes to the guidance on self-harm. Terminology has been updated in line with the guideline but overall meaning and intent of the statements remains the same. Links, definitions, data sources and source guidance sections have also been updated throughout.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. The updated [NICE guideline on self-harm](#) includes information on resource impact before recommendations section 1.1.

Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Royal College of Emergency Medicine](#)
- [Royal College of Psychiatrists \(RCPsych\)](#)