NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Suicide prevention

NICE quality standard

Draft for consultation

24 April 2019

This quality standard covers ways to reduce suicide and help people bereaved or affected by suicides in community and custodial settings. It describes high-quality actions in priority areas for improvement. It does not cover national strategies (including internet safety), general mental wellbeing, or areas such as the treatment and management of self-harm or mental health conditions.

It is for commissioners, service providers, health, public health and social care practitioners, and the public.

This is the draft quality standard for consultation (from 24 April to 23 May 2019). The final quality standard is expected to publish in September 2019.

Quality statements

Statement 1 Multi-agency suicide prevention partnerships have a core group of representatives and clear governance and accountability structures.

Statement 2 Multi-agency suicide prevention partnerships reduce access to methods of suicide based on local intelligence.

Statement 3 Multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage journalists and editors to follow best practice in suicide reporting.

Statement 4 People with active suicidal thoughts or plans are asked if they would like their family or carers to be involved in their care and made aware of the limits of confidentiality.

Statement 5 People bereaved or affected by a suspected suicide are given information and offered tailored support.

NICE has developed guidance and a quality standard on service user experience in adult mental health services (see the NICE pathway on service user experience in adult mental health services), which should be considered alongside these quality statements.

Other quality standards that are relevant to suicide prevention and should be considered when commissioning or providing services include:

- Supporting decision-making for people who lack mental capacity Publication expected April 2020
- Coexisting severe mental illness and substance misuse Publication expected September 2019
- Mental health of adults in contact with the criminal justice system (2018) NICE quality standard 163
- Transition between inpatient mental health settings and community or care home settings (2017) NICE quality standard 159
- Depression in children and young people (2013) NICE quality standard 48

- Self-harm (2013) NICE quality standard 34
- Drug use disorders (2012) NICE quality standard 23
- Alcohol-use disorders: diagnosis and management (2011) NICE quality standard 11
- Depression in adults (2011) NICE quality standard 8

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement?

Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Question 3 Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Questions about the individual quality statements

Question 4 For draft quality statement 1: Are local authorities the only organisation responsible for setting up suicide prevention partnerships in the community?

Local practice case studies

Question 5 Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to NICE local practice case studies on the NICE website. Examples of using NICE quality standards can also be submitted.

Quality statement 1: Multi-agency suicide prevention partnerships

Quality statement

Multi-agency suicide prevention partnerships have a core group of representatives and clear governance and accountability structures.

Rationale

By working together, local organisations can combine their expertise and resources to implement a range of interventions to prevent suicide. Organisations that have a key role in suicide prevention in the community and residential custodial and detention settings should have senior level representation on the core group of the suicide prevention partnership. Partnerships should also involve people with personal experience of suicide in the core group to promote understanding. Clear terms of reference and governance and accountability structures will improve effectiveness and sustainability.

Quality measures

Structure

a) Evidence that multi-agency suicide prevention partnerships have a core group of representatives.

Data source: Local data collection, for example, membership list including job titles and responsibilities for representatives.

b) Evidence that multi-agency suicide prevention partnerships have clear governance and accountability structures.

Data source: Local data collection, for example, terms of reference.

c) Evidence that multi-agency suicide prevention partnerships support people with personal experience to be involved in the core group.

Data source: Local data collection, for example, programme of induction and support for people with personal experience involved in the core group.

Outcome

a) Rate of emergency hospital admissions for intentional self-harm.

Data source: Public Health England's Suicide Prevention Profile includes data on the age-standardised rate of emergency hospital admissions for intentional self-harm in local authority areas.

b) Rate of self-harm in the community.

Data source: Local data collection, for example, community or school surveys. NHS Digital's survey of the mental health of children and young people in England includes survey questions on self-harm and attempted suicide.

c) Suicide rate.

Data source: Public Health England's Suicide Prevention Profile includes data on the rate of suicide in local authority areas for different population groups.

What the quality statement means for different audiences

Local authorities set up a multi-agency suicide prevention partnership with a core group of representatives from key organisations including people with personal experience of suicide. Representatives on the core group can make decisions and commit resources on behalf of their organisation, and have skills and knowledge in line with Health Education England's self-harm and suicide prevention competence frameworks. A programme of induction and support is provided to people with personal experience involved in the core group. Local authorities identify clear leadership for the partnership and ensure it has clear terms of reference, based on a shared understanding that suicide can be prevented. Clear governance and accountability structures are identified in the partnership's terms of reference, including oversight from local health and care planning groups such as the health and wellbeing board.

Residential custodial or detention providers set up a multi-agency suicide prevention partnership with a core group of representatives from key organisations including people with personal experience of suicide. Representatives on the core group can make decisions and commit resources on behalf of their organisation and

have skills and knowledge in line with Health Education England's self-harm and suicide prevention competence frameworks. People with personal experience are selected for and participate in the core group according to local protocols and can access a programme of induction and support. Residential custodial or detention providers identify clear leadership for the partnership and ensure it has clear terms of reference, based on a shared understanding that suicide can be prevented. Clear governance and accountability structures are identified in the partnership's terms of reference. Links with multi-agency partnerships in the community are clear, particularly in relation to managing prisoners and detainees in the community.

Source guidance

Preventing suicide in community and custodial settings (2018) NICE guideline NG105, recommendations 1.1.1, 1.1.2 and 1.1.4

Definitions of terms used in this quality statement

Core group of representatives

A suicide prevention partnership set up by a local authority in the community should include representatives from the following in the core group:

- clinical commissioning groups
- local public health services
- healthcare providers
- social care services
- voluntary and other third-sector organisations, including those used by people in high-risk groups
- emergency services
- criminal justice services
- police and custody suites
- people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement.

A suicide prevention partnership set up by a residential custodial and detention provider should include representatives from the following in the core group:

- governors or directors
- healthcare staff
- other staff
- pastoral support services
- voluntary and other third-sector organisations
- escort custody services
- liaison and diversion services
- emergency services
- offender management and resettlement services
- people with personal experience of a suicide attempt, suicidal thoughts and feelings, or a suicide bereavement, to be selected according to local protocols.

[NICE's guideline on preventing suicide in community and custodial settings, recommendations 1.1.3 and 1.1.5]

Equality and diversity considerations

Multi-agency suicide prevention partnerships should make reasonable adjustments to ensure that people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English, or who have reduced literacy skills, can participate in the core group. People should have access to an interpreter or advocate if needed.

Question for consultation

Are local authorities the only organisation responsible for setting up suicide prevention partnerships in the community?

Quality statement 2: Reducing access to methods of suicide

Quality statement

Multi-agency suicide prevention partnerships reduce access to methods of suicide based on local intelligence.

Rationale

Reducing access to methods of suicide and to locations where suicide is more likely to occur can act as a deterrent. A range of measures can be used to interrupt or disrupt people's plans, giving them time to stop and think, or make it more difficult for them to put themselves in danger. An understanding of local suicide trends will help suicide prevention partnerships to prioritise what action they need to take.

Quality measures

Structure

a) Evidence that multi-agency suicide prevention partnerships collect and analyse local data to inform the approach to reducing access to methods of suicide.

Data source: Local data collection, for example, rapid intelligence gathering process and suicide audit report.

b) Evidence that multi-agency suicide prevention partnerships identify how they will reduce access to methods of suicide.

Data source: Local data collection, for example, suicide action plan.

c) Evidence that multi-agency suicide prevention partnerships review progress in reducing access to methods of suicide at least annually.

Data source: Local data collection, for example, suicide action plan progress reports.

Outcome

a) Number of suicides in high-frequency locations.

Data source: Local data collection, for example, rapid intelligence gathering and suicide audit.

b) Suicide rate.

Data source: Public Health England's Suicide Prevention Profile includes data on the rate of suicide in local authority areas for different population groups.

What the quality statement means for different audiences

Multi-agency suicide prevention partnerships gather and analyse data from a range of sources to understand local patterns in suicide method and location. The partnership supports partner organisations to ensure that they comply with national guidance on issues such as providing and maintaining safer cells in residential custodial or detention settings, and safely prescribing painkillers in primary care. The partnership uses local intelligence to prioritise other actions to reduce access to methods of suicide. It includes these actions in the suicide prevention action plan and regularly reviews progress.

People in the community know that local organisations are working together to prevent suicide and keep people safe at places where suicide is more likely.

Source guidance

Preventing suicide in community and custodial settings (2018) NICE guideline NG105, recommendations 1.6.1, 1.6.2, and 1.6.3.

Definitions of terms used in this quality statement

Reducing access to methods of suicide

Suicide prevention partnerships should ensure local compliance with national guidance:

- In custodial settings, for example, provide safer cells (see the Ministry of Justice's Quick-time learning bulletin: safer cells).
- In the community, for example, restrict access to painkillers (see NHS England's Items which should not be routinely prescribed in primary care: guidance for CCGs, Medicines and Healthcare products Regulatory Agency's Best practice

guidance on the sale of medicines for pain relief [appendix 4 in the Blue guide], and Faculty of Pain Medicine's Opioids aware).

Reduce the opportunity for suicide in locations where suicide is more likely, for example by erecting physical barriers (see Public Health England's Preventing suicide in public places: a practice resource). Also consider other measures such as:

- providing information about how and where people can get help when they feel unable to cope
- using CCTV or other surveillance to allow staff to monitor when someone may need help
- increasing the number and visibility of staff, or times when staff are available.

[NICE's guideline on preventing suicide in community and custodial settings recommendations 1.6.2, 1.6.3 and 1.6.4]

Local intelligence

Suicide prevention partnerships should use local data including audit, Office for National Statistics and NHS data as well as rapid intelligence gathering to:

- identify emerging trends in suicide methods and locations
- understand local characteristics that may influence the methods used
- determine when to take action to reduce access to the means of suicide.

[NICE's guideline on preventing suicide in community and custodial settings recommendation 1.6.1]

Quality statement 3: Media reporting

Quality statement

Multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage journalists and editors to follow best practice in suicide reporting.

Rationale

Insensitive reporting of suicide may have harmful effects, including potentially increasing the risk of suicide. By promoting best practice, partnerships can encourage responsible reporting, which can help prevent people copying the suicide and prevent increasing distress for those bereaved by suicide.

Quality measures

Structure

a) Evidence that multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage best practice in suicide reporting.

Data source: Local data collection, for example, a partnership media plan.

b) Evidence that multi-agency suicide prevention partnerships have a named lead for the local media plan.

Data source: Local data collection, for example, description of partnership roles and responsibilities.

Outcome

a) Proportion of local media reports of a suspected suicide that meet best practice criteria.

Numerator – the number in the denominator that meet best practice criteria.

Denominator – the number of local media reports of a suspected suicide.

Data source: Local data collection, for example, audit of local media reports.

b) Suicide rate.

Data source: Public Health England's Suicide Prevention Profile includes data on the rate of suicide in local authority areas for different population groups.

What the quality statement means for different audiences

Multi-agency suicide prevention partnerships in the community develop a plan for liaising with local media organisations that encourages a positive relationship and promotes best practice in reporting suspected suicide. Partnerships identify a lead to coordinate the local media plan. Partnerships provide feedback to editors and journalists if a report of a suspected suicide is not in line with best practice guidelines.

Multi-agency suicide prevention partnerships in residential custodial and detention settings liaise with local media through the Ministry of Justice, if relevant, and encourage Ministry of Justice press officers to follow best practice in suicide reporting.

Local media journalists and editors are aware of best practice guidelines for reporting suicide and use them when writing reports of suspected suicide. Journalists and editors work with the local suicide prevention partnership to improve standards of reporting of suspected suicide, including responding to any feedback on specific reports.

Source guidance

Preventing suicide in community and custodial settings (2018) NICE guideline NG105, recommendations 1.10.1, 1.10.2 and 1.10.4.

Definitions of terms used in this quality statement

Best practice in suicide reporting

Highlight the need to:

- use sensitive language that is not stigmatising or in any other way distressing to people who have been affected
- reduce speculative reporting

- avoid presenting detail on methods.

Refer to: the World Health Organization's Preventing suicide: a resource for media professionals; the Samaritans' Media guidelines for reporting suicide; OFCOM's Broadcasting code; and the Independent Press Standards Organisation (IPSO).

[NICE's guideline on preventing suicide in community and custodial settings recommendations 1.10.2]

Quality statement 4: Involving family or carers

Quality statement

People with active suicidal thoughts or plans are asked if they would like their family or carers to be involved in their care and are made aware of the limits of confidentiality.

Rationale

Families and carers can help to support a person who has active suicidal thoughts or plans. They can also provide valuable input to an assessment of the person's needs to help keep them safe. But involving families and carers can be complex, and it is important to ask the person who they would, or would not, like to be involved if there is a serious concern over suicide risk. The person should have the opportunity to discuss information sharing and their right to confidentiality so that they are aware of the circumstances in which confidential information may need to be disclosed to family or carers.

Quality measures

Structure

a) Evidence of local arrangements to provide training on information sharing and confidentiality based on the consensus statement on information sharing and suicide prevention to practitioners in contact with people with active suicidal thoughts or plans.

Data source: Local data collection, for example, staff training records.

b) Evidence of local processes to ensure that people with active suicidal thoughts or plans are asked if they would like their family or carers to be involved in their care.

Data source: Local data collection, for example, local protocol.

c) Evidence of local processes to ensure that people with active suicidal thoughts or plans are made aware of the limits of confidentiality.

Data source: Local data collection, for example, local protocol.

Process

a) Proportion of people with active suicidal thoughts or plans who are asked if they would like their family or carers to be involved in their care.

Numerator – the number in the denominator who are asked if they would like their family or carers to be involved in their care.

Denominator – the number of people with active suicidal thoughts or plans.

Data source: Local data collection, for example, audit of patient records.

b) Proportion of people with active suicidal thoughts or plans who are made aware of the limits of confidentiality.

Numerator – the number in the denominator who are told about the limits of confidentiality.

Denominator – the number of people with active suicidal thoughts or plans.

Data source: Local data collection, for example, audit of patient records.

Outcome

a) Proportion of assessments for people with active suicidal thoughts or plans who want their family or carers involved, that involve family or carers.

Numerator – the number in the denominator that involve family or carers.

Denominator – the number of assessments for people with active suicidal thoughts or plans who want their family or carers involved.

Data source: Local data collection, for example, audit of patient records.

b) Satisfaction of families and carers with information sharing about suicide risk.

Data source: Local data collection, for example, survey of carers.

c) Suicide rate.

Data source: Public Health England's Suicide Prevention Profile includes data on the rate of suicide in local authority areas for different population groups.

What the quality statement means for different audiences

Service providers (such as general practices, hospitals, mental health trusts, prisons, social care providers, police, voluntary sector) ensure that processes are in place to ask people with active suicidal thoughts or plans if they would like their family or carers to be involved in their care, and to make these people aware of the limits of confidentiality. Providers ensure that if the person wants their family or carers involved in their care, the nature of their involvement, including how and when information is shared with them, is agreed. Providers ensure that staff are trained and aware of the Department of Health and Social Care's consensus statement on information sharing and suicide prevention.

Health and social care practitioners (such as A&E doctors, GPs, nurses, social workers, mental health professionals, allied health professionals) ask people with active suicidal thoughts or plans if they would like their family or carers to be involved in their care. They also make the person aware of the limits of confidentiality. If the person wants their family or carers involved, health and social care practitioners ensure they agree how they will be involved and when information will be shared with them.

Commissioners (such as local authorities, clinical commissioning groups and NHS England) commission services that ask people with active suicidal thoughts or plans if they would like their family or carers to be involved in their care. They also make the person aware of the limits of confidentiality.

People who feel suicidal are asked if they would like their family or carers to be involved in their care. If they want their family or carers to be involved, they agree how they will be involved and when information will be shared with them. People who feel suicidal are told about confidentiality and when it may be necessary to share information with their family or carers.

Source guidance

- Self-harm in over 8s: long-term management (2011) NICE guideline CG133, recommendations 1.1.13 and 1.1.22

- Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (2011) NICE guideline CG136, recommendations 1.1.4 and 1.1.14

Definitions of terms used in this quality statement

People with active suicidal thoughts or plans

People who disclose active suicidal thoughts or plans when asked about suicide ideation and intent. [Expert opinion]

Limits of confidentiality

If a person is at imminent risk of suicide, there may be sufficient doubts about their mental capacity to consent to information about their suicide risk being shared. In these circumstances, a professional judgement will need to be made, based on an understanding of the person and what would be in their best interest. This should take into account the person's previously expressed wishes and views in relation to sharing information with their family or carers. The judgement may be that it is right to share critical information. If the purpose of the disclosure is to prevent a person who lacks capacity from serious harm, there is an expectation that practitioners will disclose relevant confidential information, if it is in the person's best interest to do so. Disclosure may also be in the public interest because of the far-reaching impact that a suicide can have on others. [Department of Health and Social Care Information sharing and suicide prevention: consensus statement]

Equality and diversity considerations

Health and social care practitioners should ensure that people who temporarily lack mental capacity to consent to information sharing are asked if they want their family or carers to be involved in their care as soon as they are able to give consent.

Quality statement 5: Supporting people bereaved or affected by a suspected suicide

Quality statement

People bereaved or affected by a suspected suicide are given information and offered tailored support.

Rationale

People bereaved or affected by a suspected suicide are themselves at increased risk of suicide. Providing support after a suicide can reduce this risk, especially when tailored to the person's needs. It is important to identify people who may need support as soon as possible so that they can be given practical information and access support if, and when, they need to.

Quality measures

Structure

a) Evidence of local arrangements to use rapid intelligence gathering to identify people who may be bereaved or affected by a suspected suicide.

Data source: Local data collection, for example, data sharing agreements and reporting arrangements.

b) Evidence of local processes to give information to people bereaved or affected by a suspected suicide and to ask if they need help.

Data source: Local data collection, for example, local protocol.

c) Evidence of local arrangements to provide support to people bereaved or affected by a suspected suicide.

Data source: Local data collection, for example, service specifications.

Process

a) Proportion of people bereaved or affected by a suspected suicide who are given information.

Numerator – the number in the denominator who are given information.

Denominator – the number of people bereaved or affected by a suspected suicide.

Data source: Local data collection, for example, audit of case records.

b) Proportion of people bereaved or affected by a suspected suicide who are asked if they need help.

Numerator – the number in the denominator who are asked if they need help.

Denominator – the number of people bereaved or affected by a suspected suicide.

Data source: Local data collection, for example, audit of case records.

c) Proportion of people bereaved or affected by a suspected suicide and want help who are offered tailored support.

Numerator – the number in the denominator who are offered tailored support.

Denominator – the number of people bereaved or affected by a suspected suicide and want help.

Data source: Local data collection, for example, audit of case records.

Outcome

a) Satisfaction of people bereaved or affected by a suicide with information and support.

Data source: Local data collection, for example, survey of people bereaved or affected by a suicide.

b) Number of suicides by people bereaved or affected by a suicide.

Data source: Local data collection, for example, suicide audit.

What the quality statement means for different audiences

Multi-agency suicide prevention partnerships carry out rapid intelligence gathering to identify people who may be bereaved or affected by a suspected

suicide. Partnerships ensure that processes are in place across partner organisations to provide information to people who are bereaved or affected by a suspected suicide, to ask them if they need additional help and to refer them for support if required.

Service providers (such as police, hospitals, prisons, general practices, funeral directors, coroners' offices) ensure that processes are in place to provide information to people who are bereaved or affected by a suspected suicide, to ask them if they need additional help and to refer them for support if required. Providers ensure referral pathways to support services are in place.

Practitioners (such as police officers, GP's, nurses, mental health practitioners, prison staff, funeral directors, coroner's office staff) provide information to people who are bereaved or affected by a suspected suicide, ask them if they need additional help and refer them for support if needed.

Commissioners (such as local authorities, clinical commissioning groups and NHS England) commission services that provide support after a suicide with capacity to meet the needs of the local population. They also commission services that provide information to people who are bereaved or affected by a suicide, ask them if they need additional help and refer them for support if required.

People who are bereaved or affected by a suspected suicide are given practical information, such as an information booklet, and asked if they want any other help. If they do, they are put in touch with a support service.

Source guidance

Preventing suicide in community and custodial settings (2018) NICE guideline NG105, recommendation 1.8.2.

Definitions of terms used in this quality statement

People bereaved or affected by a suspected suicide

Those affected by a suspected suicide may include relatives, friends, classmates, colleagues, other prisoners or detainees, as well as first responders and other

professionals who provided support. [NICE's guideline on preventing suicide in community and custodial settings, recommendation 1.8.1]

Information

Practical information expressed in a sensitive way that helps people to cope and signposts to other services, such as Public Health England's Help is at hand guide. [Expert opinion and NICE's guideline on preventing suicide in community and custodial settings, recommendation 1.8.2]

Tailored support

Support that is focussed on the person's individual needs. It could include:

- support from trained peers who have been bereaved or affected by a suicide or suspected suicide
- adjustments to working patterns or the regime in residential custodial and detention settings
- other support identified in the National Suicide Prevention Alliance's resources on support after a suicide.

[NICE's guideline on preventing suicide in community and custodial settings, recommendation 1.8.3]

Equality and diversity considerations

Services that provide support after a suicide should make reasonable adjustments to ensure that people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English, or who have reduced literacy skills, can use the service. People should have access to an interpreter or advocate if needed.

Services that provide support after a suicide should ensure that they support people from black, Asian, other minority ethnic groups and people with religious beliefs in a culturally sensitive way.

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 quality standard advisory committees on the website for details of standing committee 3 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard has been included in the NICE Pathway on suicide prevention which brings together everything we have said on a topic in an interactive flowchart.

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 produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references

to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- calls to crisis response services
- suicide-related emergency service calls
- rate of self-harm in the community
- hospital attendances and admissions for self-harm
- suicide rate.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework
- NHS outcomes framework
- Public health outcomes framework for 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. Organisations are encouraged to use the resource impact statement for the source guidance to help estimate local costs.

Diversity, equality and language

During the development of this quality standard, equality issues were considered and equality assessments 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.

ISBN: