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**Contact Person 2:**

**Job Title:**

**Tel:**

**Email:**

**Tel:**

**Email:**

**Purchase Order Number:**

**Invoice Details**

**For the attention of:**

**Job Title / Designation:**

**Address:**

**Please select one of the following membership options**.

**Peer/Developmental**

1 Year £2710 +VAT [ ]

**Accreditation**

1 Year £2710 +VAT [ ]

3 Years £7720 +VAT [ ]

**Associate**

1 Year £610 +VAT [ ]

For further information please contact:

**op@rcpsych.ac.uk**

**0208 618 4134**

**Joining Form**

**Subscription**

**Contact Person 1:**

**Job Title:**

**Tel:**

**Email:**

**Ward/Unit Name:**

**Trust/ Organisation:**

**Address**:

**Tell us something about your ward.**

**What would you like any visiting professionals, service users or carers to know about you?**



**Please answer the following questions.**

**We want to better support networking between our members. We will use this information to support this and encourage further learning in the network. We may use your answers when publicising your review and introducing you to other network members.**

**What does your team do well?**

**What would you consider to be your achievements?**



**What could your ward improve on? What would you consider to be the ward’s challenges?**

****

**Why are you joining the network?**

**How do you think your ward will benefit from QNOAMHS membership?**



**Please tell us how you heard about the Quality Network for Older Adult Mental Health Services?**



**Expectations of Membership**

**By completing and submitting this form you are agreeing to the following expectations of membership:**

* **The link person(s) provided will be the main point of contact for all matters relating to the Quality Network for Older Adults Mental Health Services and your membership. They will respond to all necessary correspondence in a timely manner.**
* **Inform the Network Team if the stated link people are no longer the best point of contact for the service and provide new contact details.**
* **Provide at least two members of staff to attend peer review or accreditation visits per year and authorise accompanying travel costs.**
* **Provide at least one member of staff to attend lead reviewer training and support leading of accreditation visits per year.**
* **Inform all members of the staff team about the unit’s membership to the Quality Network. Make information about the network and your membership available to service users and carers.**

**Accreditation**

* **Accreditation runs on a three year cycle – Year 1 = accreditation visit, Year2/3 = interim update**
* **Year 1 – The accreditation review year has three phases;**

**1) self-review, 2) peer-review and 3) Accreditation Committee**

* 1. **The self-review phase of the accreditation review includes questionnaires from a variety of perspectives, policy and health record audits**
	2. **On the peer review day reviewers will look for evidence that your service is meeting the quality standards**
	3. **The data is then viewed by the Accreditation Committee (AC) who recommend an accreditation status. There are three accreditation statuses: accredited, deferred and not accredited. Services will be accredited for a maximum of three years, subject to terms and conditions**
* **Service reports remain confidential but accreditation status will be published on the Quality Network website**
* **Once accredited teams continue to provide data to show that they are maintaining the quality of their service during the three year period by completing an interim review**

**Confirmation:**

**I have read and agree to the terms and conditions of Quality Network for Older Adults Mental Health Services membership (please contact the team if you do not have a copy of this document)**

**I would like to become a member of the Quality Network. I understand that by accepting these conditions I agree to be invoiced annually unless I inform the Network Team otherwise. I recognise that as a member there are defined responsibilities which my service must fulfil in order to contribute to the ongoing success of the network.**

|  |  |
| --- | --- |
| **Signed Name:**  | **Date:**  |

**Please return to Quality Network for Older Adults Mental Health Services (QNOAMHS):**

**21 Prescot Street, London, E1 8BB**

**Email:** **op@rcpsych.ac.uk**

**Tel: 0208 618 4065**