HTAS
HOME TREATMENT
ACCREDITATION SCHEME

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Home Treatment Accreditation Scheme (HTAS)

1st National Report

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Foreword

The Home Treatment Accreditation Scheme (HTAS) continued to go from strength to strength in 2015. We published the second edition of our accreditation standards in March and have seen changes this year that bring greater consistency of working across other College accreditation schemes. We recognise that we are spearheading quality in our home treatment services at a time when mental health services are under enormous financial pressure and, in that context, are delighted that we now have 26 teams accredited throughout the country.

Our annual conference in October in Birmingham was well attended with member teams and prospective teams and gave us the opportunity to reflect on our practice and share both concerns and successes. Key messages from the day, accentuated by Geraldine Strathdee, National Director for Mental Health, our keynote speaker, were the need for home treatment teams to provide evidence of their effectiveness; to demonstrate that teams have a crucial role to play in the acute care pathway; are integral to all the important work being carried out related to the Mental Health Concordat and, significantly, play an absolutely vital role in caring for people in suicidal crises. Home Treatment Teams play a central role in suicide prevention.

Accreditation demonstrates quality of service provision and this goes hand in hand with effectiveness. Accredited teams indicate to the public, to commissioners and to other professionals that this is a team that is effective, value for money and central to delivering recovery.

Nigel Crompton

Chair of the HTAS Accreditation Committee

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Section 1: Introduction to HTAS

The Home Treatment Accreditation Scheme (HTAS) is an accreditation programme for Crisis Resolution and Home Treatment (CRHT) teams in the UK. It assesses teams through a process of self and peer review, against a set of evidence-based standards. All necessary materials and guidance are supplied by HTAS. The process is a supportive one, designed to congratulate teams for aspects of their work which they do well, in addition to identifying areas for improvement and suggesting ways these could be improved. Teams that meet sufficient standards are awarded accreditation by the Royal College of Psychiatrists.

The Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) manages a number of quality improvement and accreditation programmes, including Accreditation for Inpatient Mental Health Services (AIMS). Responding to requests to offer accreditation for other elements of the Acute Care Pathway, accreditation for CRHTs was decided upon as the initial focus for project development.

HTAS was developed between 2011-12; a team of experts from different professions involved in the work of CRHTs were brought together to help develop the programme and its standards, a process which was guided by staff from the CCQI.

The structure of the programme is the same as other accreditation programmes such as AIMS. In addition, some core standards were drawn directly from AIMS and other accreditation programmes, although the vast majority were developed specifically for CRHTs. The standards were designed to be as inclusive as possible – it was agreed early on in the development process that HTAS did not want to promote a specific model of care. The aim was to accredit teams based on their functions and the standard of care delivered rather than the composition of the team or model of care, and the programme did not seek to penalise teams for acceptable variations in their ways of working.

A pilot phase of the programme was conducted in 2012, and following this the process and standards were further revised with the input of the standards development group and members who took part in the pilot. The nationwide programme launched in 2013.

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Section 2: The Accreditation Process

Accreditation involves assessing services against a set of evidence-based standards through the processes of self review and peer review.

Standards

The relative importance of standards are rated using the following system:
Type 1 standards are essential to safety, rights, dignity and the law.
Type 2 standards are those that an accredited team would be expected to meet.
Type 3 standards are those that an excellent team would be expected to meet, or standards that are not the direct responsibility of the team.

Self review

Teams undergo a self review period of three months, which requires them to gather data using a range of audit tools including:

- Service User Questionnaires

The teams are asked to distribute paper questionnaires to service users who have received care from them within the 3 month data collection period. Service users are asked about visits from the team, their contact with staff and discharge from the team. The teams also have the option of asking service users to complete the questionnaire online using login details provided by the HTAS project team.

- Carer Questionnaires

The teams are given carer questionnaires to hand out to carers of those who are treated by the team during the 3 month self review period. Carers are asked about visits from the team, support that was available for them, medication and discharge. The teams also have the option of asking carers to complete the questionnaire online using login details provided by the HTAS project team.

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- Organisational Checklist

Each team is asked to complete an organisational checklist online which asks about the policies and procedures governing the team. It is recommended that this is completed at a team meeting with as many staff as possible present.

- Health Record Audits

The teams are each asked to audit a set of 20 health records against specific criteria.

- Staff Questionnaires

All staff from each team are asked to complete a staff questionnaire which asks questions about the induction they received when they joined the team, training, supervision, liaison with acute inpatient wards, the assessment process and contact with service users and carers.

- Team Manager Questionnaires

Each team manager is asked to complete a questionnaire which asks similar questions to the staff questionnaire as well as questions about service provision, service structure and psychosocial interventions.

Peer review

Following self review, the teams receive a peer review; a one-day visit delivered by a multidisciplinary team of reviewers, including peers who work in other member teams, a service user or carer and a member of the HTAS team or a representative from the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). The data collected from each team during the self review period is compiled into a booklet which is sent to the members of the peer review team and the host team before the visit. The peer review team's role is to validate the self review findings, identify areas of achievement as well as areas for improvement, and suggest ideas for addressing the latter. All peer reviewers attend a one day training course

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delivered by HTAS which allows them to become familiar with the peer review process and peer review booklet.

The peer review day comprises several different meetings; some meetings are attended by all members of the peer review team, while during other sessions the peer review team are divided in order to attend concurrent meetings.

- Staff Meeting

The full review team meet with as many members of the home treatment team as possible, without the team manager present. The responses from the staff questionnaires and checklist are discussed.

- Team Manager, Inpatient Ward and Community Mental Health Team (CMHT) Meeting

Two professional members of the review team meet with the team manager and representatives from the inpatient ward and CMHT to discuss the responses to the team manager questionnaire, including liaison between the 3 teams.

- Health Record Review

Two professional members of the review team meet with a member of the host team to discuss health records, policies and procedures. The host team provide anonymised or training versions of their health records; no real service user records are seen.

- Service User and Carer Meetings

Two meetings take place simultaneously on the peer review day – a face to face meeting and a telephone meeting. The service user/carer representative on the review team and a professional member of the review team attend the face to face meeting to ask service users and carers about their experiences of being treated by/caring for someone being treated by the team. The other two members of the review team telephone service users and carers who are unable to attend the face

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to face meeting to ask them about their experiences of being treated by/caring for someone being treated by the team.

- Review Team Meeting

After these meetings the review team meet in private to discuss the findings and consider whether the standards should be rated as Met or Not Met. Following this meeting, the review team then meet with the host team to provide feedback.

Accreditation decision

On the basis of the self review and peer review data, the HTAS Accreditation Committee (AC), which meets quarterly, decide an accreditation status for the team. The AC acts as part of the Combined Committee for Accreditation, this Committee has an overall Chair who assures governance and consistency across those projects measuring the quality of services which are managed by the CCQI.

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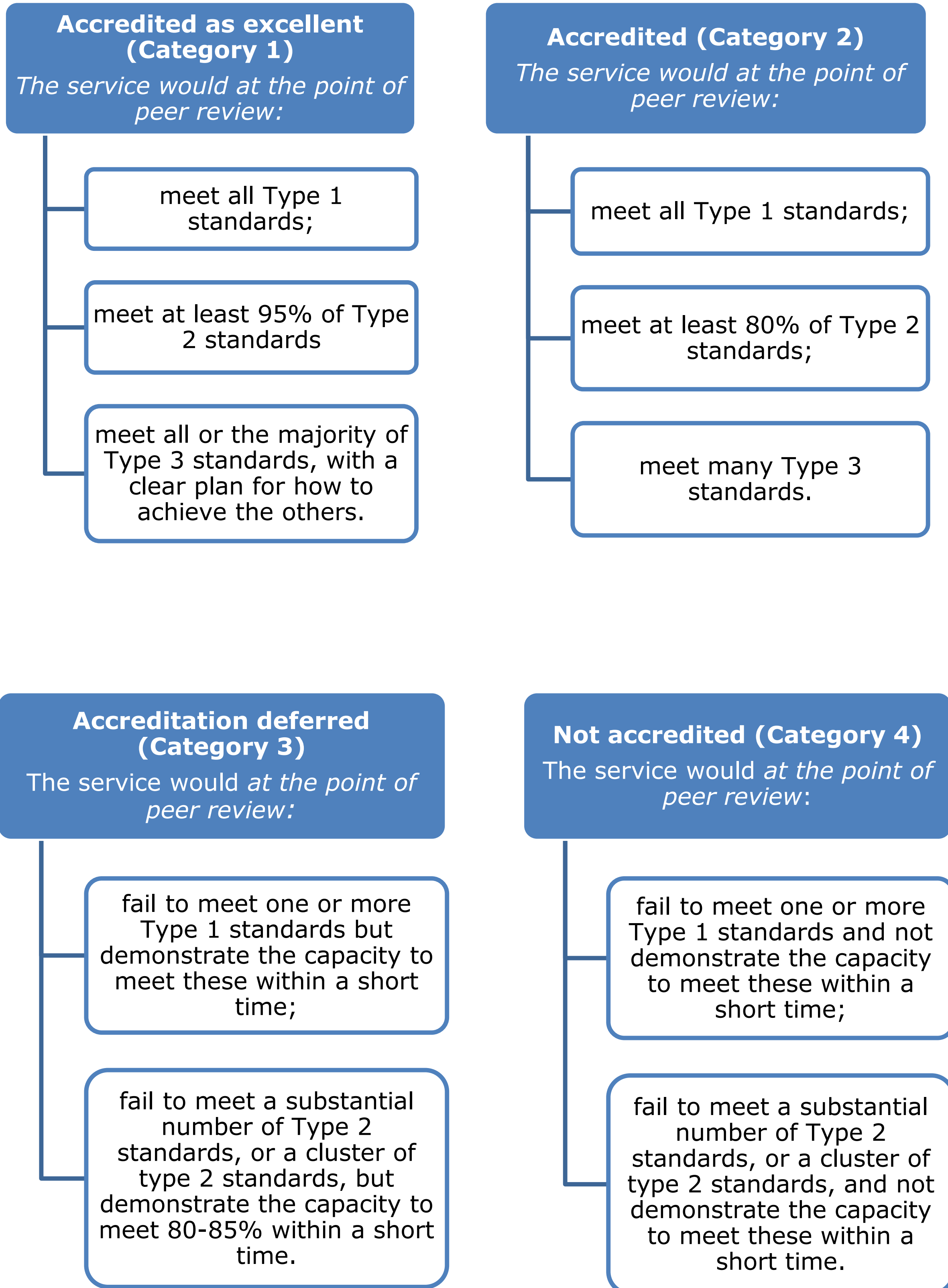

Figure 1. Categories of accreditation

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Teams that do not achieve the required criteria for accreditation at the first AC are usually given a deferral period of 3 or 6 months, depending on the reason for deferral. At the end of the deferral period, teams are asked to submit further evidence for the AC to consider – at which point the AC would then award accreditation or request an additional deferral period.

Figure 2. HTAS Accreditation Cycle

Ongoing quality improvement

The HTAS process does not stop at the point of accreditation. Members are encouraged to continue thinking about how they can improve the quality of their service by submitting action plans shortly after being awarded accreditation. These action plans will incorporate the areas for improvement identified by the peer review team, and progress against the action plan will be taken into account as part of the brief interim review, which takes place 18 months after initial accreditation. HTAS accreditation lasts for 3 years, after which time services undergo the full review cycle again. The areas for improvement from the last cycle are discussed at the team's next peer review visit.

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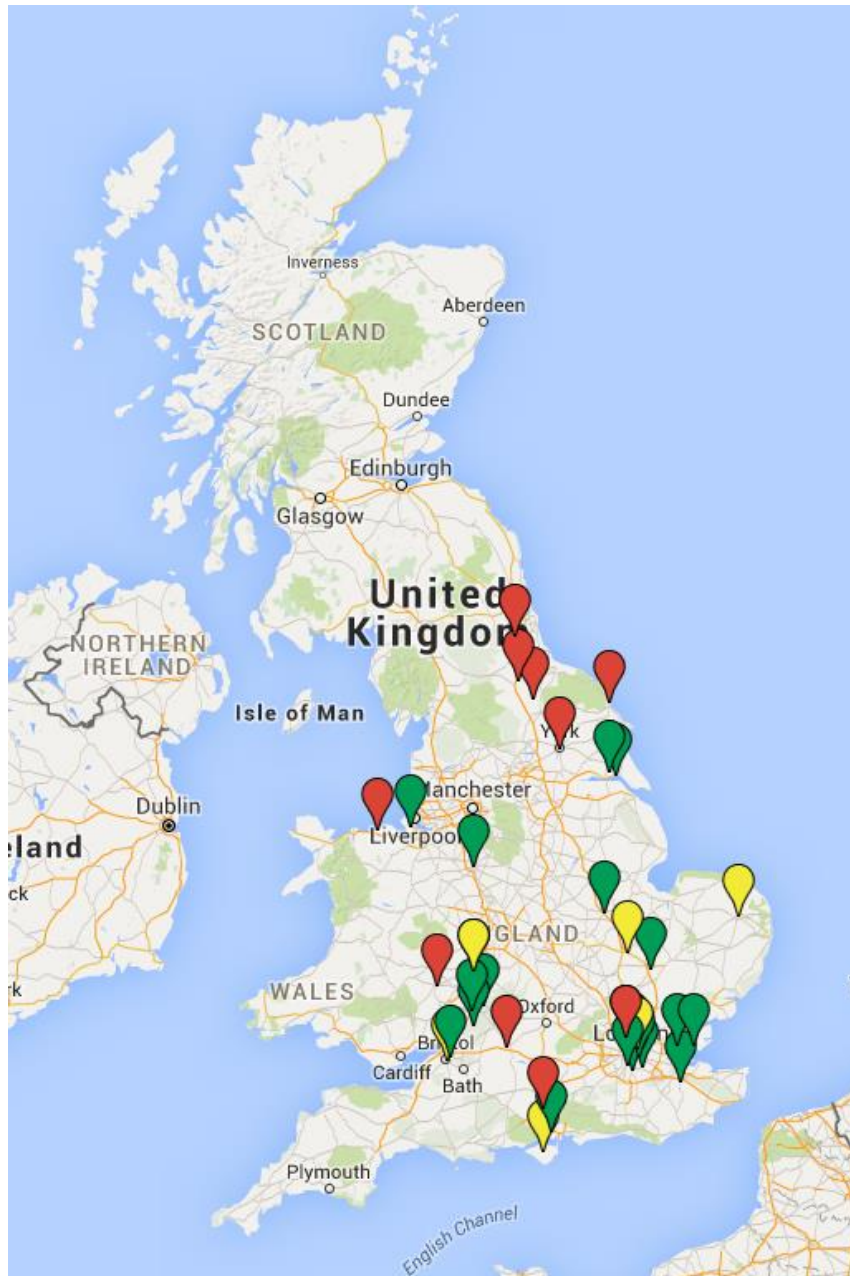
Section 3: Performance of HTAS members

As of June 2015, 40 Home Treatment Teams are members of HTAS. Their locations can be seen in figure 3.



In review	Accredited as excellent	Accredited

Figure 3 – Map showing location of HTAS members

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The accreditation status of the member teams is shown in Table 1.

Accreditation status	Number of teams
Accredited as excellent	7
Accredited	19
Accreditation deferred	2
Not accredited	0
In review stage	12

Table 1 – Accreditation status of HTAS members as of June 2015

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Section 4: Contextual Data

All teams participating in HTAS are asked to complete a contextual data questionnaire to enable the peer reviewers visiting them to learn about their service prior to their peer review visit. Between March 2013 and March 2015 HTAS received 19 completed contextual data questionnaires. The data showed that 100% of the participating teams assessed service users within 24 hours, and that there was much variation between teams in terms of numbers of staffing, caseload and number of service users seen within the past 2 weeks. This data can be seen in Table 2.

Question (n=number of teams)	Mean	Median	Mode	Range
Current caseload (n=19)	25.6	23	18	16-58
Number of service users seen within last 2 weeks (n=18)	35.4	27	34	12-108
Average time period between referral and the first assessment (n=19)	7.4 hours	4 hours	4 hours	0-24 hours
Number of staff working in the team (n=19)	26.8	25	22	10-51

Table 2 – Aggregated data from contextual data questionnaires

Teams are also asked to provide a breakdown of the number of professions who have dedicated sessional time with them. 100% of teams received dedicated sessional time from registered nurses and psychiatrists. Less than half of teams had dedicated sessional time from an Occupational Therapist, a Pharmacist or a Nurse Prescriber. In addition, only 1 team received dedicated sessional time from a peer support worker. Table 3 shows the number of teams with dedicated sessional time from each profession, and graph 1 shows the average number in each team.

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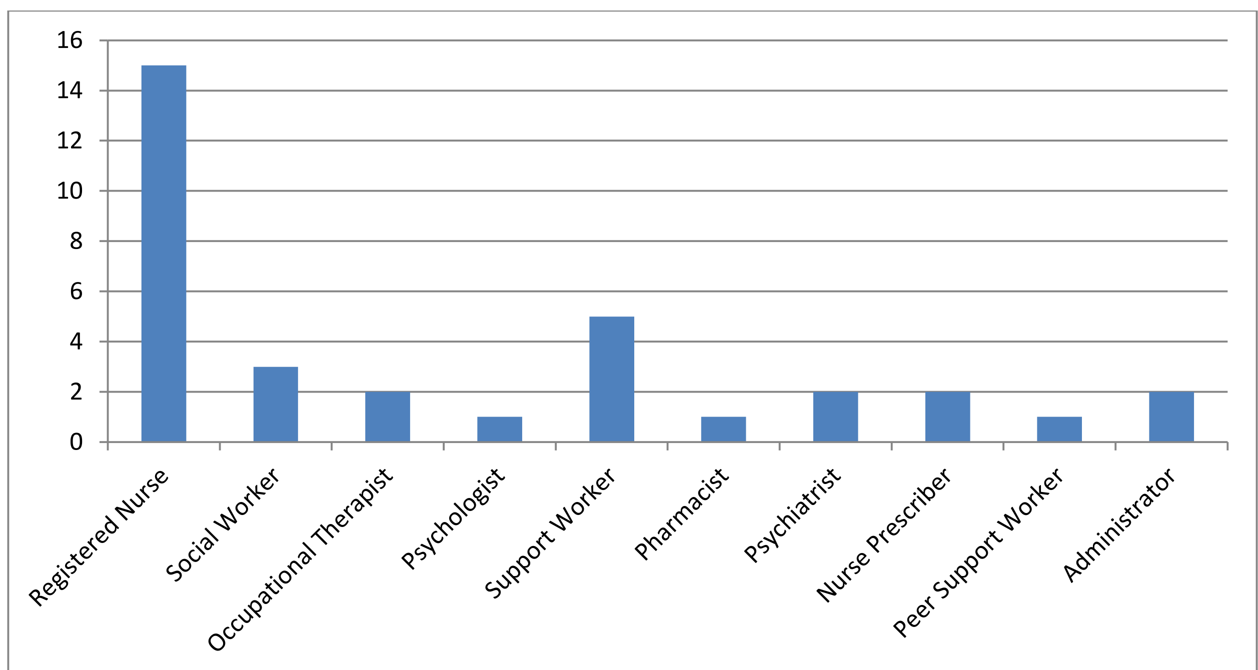
Profession	% of teams with dedicated sessional time
Registered nurse	100%
Social worker	94.7%
Occupational Therapist	42.1%
Psychologist	57.9%
Support worker	84.2%
Pharmacist	36.8%
Psychiatrist	100%
Nurse Prescriber	47.4%
Peer support worker	5.3%
Administrator	89.5%

Table 3: Different types of professions working within Home Treatment Teams



Graph 1: Average number of professionals working in Home Treatment Teams

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Section 5: Key themes in 2013-14 data

Staff training

As part of the self review process, teams are asked to collect feedback from staff working in the team. The staff questionnaire covers a number of topics including induction; supervision; training; liaison with acute inpatient services; consent and confidentiality; the assessment; discharge; medicines management; contact with service users and carers; information for service users and carers and support for carers. Team managers are asked to complete a separate questionnaire.

Between March 2013 and March 2015 HTAS received 252 staff questionnaires and 13 team manager questionnaires.

Over 90% of staff who completed the questionnaires had completed training in medication, reflective practice and debriefing, the Mental Health Act and Mental Capacity Act, personal safety issues and diversity awareness. A full list of training completed by staff is shown in Table 4.

Topic (number of respondents staff/team managers)	% of staff	% of team managers
Delivering crisis resolution/home treatment interventions (228/13)	88.1%	92.3%
Carer awareness, family inclusive practice and social systems in the home treatment team (228/13)	64.0%	92.3%
Basic counselling skills (228/13)	77.6%	92.3%
Medication (191/13)	92.6%	92.3%
Reflective practice and debriefing (228/13)	90.3%	100%
Mental Health Act and Mental Capacity Act (179/13)	98.3%	100%
Personal safety issues (228/13)	93.4%	92.3%
Suicide prevention (227/13)	68.2%	84.6%

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Self harm (227/13)	81.9%	84.6%
Alcohol and substance misuse (227/13)	81.0%	92.3%
Diversity awareness (227/13)	96.4%	84.6%
Clinical leadership (168/13)	60.7%	100%

Table 4 – Training completed by staff working in Home Treatment Teams

Less than two-thirds of staff had completed training in carer awareness, family inclusive practice and social systems in the home treatment team and clinical leadership.

It is important to note that 'training' does not have to be a formal course, this could include training completed as part of a University or college course, in-house training, on the job training, e-learning and conferences. In addition to this, many teams make improvements to their service provision in between their self review and peer review, and so if a clear need was identified for staff training, teams may have addressed this by the time they had their peer review visit. Training in carer awareness, family inclusive practice and systems in the home treatment team, basic counselling skills, medication, the Mental Health Act, Mental Capacity Act, personal safety issues, suicide prevention, self harm and diversity awareness are Type 1 standards, therefore it is mandatory for teams to evidence that staff have completed training in these areas (where applicable) in order for teams to achieve accreditation.

Team building and support for staff

When asked if they receive clinical supervision at least every 8 weeks, 86.4% of staff and 76.9% of team managers said that they did. Similarly, 84.6% of both staff and team managers said they receive managerial supervision at least every 8 weeks. However, 90.7% of staff and 100% of team managers received regular team supervision.

The staff and team manager questionnaires showed that only around two thirds of staff (65.4% staff; 69.2% team managers) had taken part in team building in the last year, and training in colleague support and working within the team framework. Given that staff working in Home Treatment Teams are very busy and dealing with

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service users in crisis, it is important that they take time away from the service to bond as a team, and that they know how to support each other.

Health Record Audit

Teams are required to audit the health records of 20 service users who have been assessed and treated by their service within the 3 month data collection period. Between March 2013 and March 2015 HTAS received 234 completed health record audits. The results from the health record audit showed that all service users had received a screening to establish that home treatment was suitable for them; an investigation into the nature of the crisis and the presented problems; identification of immediate social stressors and social networks; identification of the presence of mental health problems and their severity; identification of the clinical signs and symptoms of the mental health problem, and a risk screening and assessment. Details of other checks completed as part of a service user's assessment are shown in Table 5.

The routine assessment gathered from multiple sources includes:	% of health records showing this was completed
Identification of the service user's primary carer(s), or lack thereof	**97.4%**
Psychiatric history including past records and family history	**99.5%**
An investigation of comorbid physical health problems	**94.0%**
An assessment of practical problems of daily living	**97.0%**
The identification of people affected by the crisis, and for whom it is a crisis	**98.7%**
Identification of dependents and their needs, including childcare issues	**88.0%**
A social assessment	**96.5%**
A physical health review examination and investigations, which has been completed at	**89.7%**

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least annually	
A multidisciplinary assessment of the service user's needs	**98.2%**
A multidisciplinary assessment of the service user's level of risk	**98.7%**
Planning for supported transition to other services	**98.2%**
An assessment of basic psychological and social needs	**98.2%**

Table 5 – Health record audit data

Table 5 shows that most checks had been completed as part of the service user's assessment in over 90% of cases. Physical health reviews and identification of dependents and their needs had been completed in less than 90% of cases, suggesting that there is room for improvement here. Again, it is important to note that these audits were submitted as part of the self review process, and it is common for teams to introduce a checklist which covers all of these areas prior to their peer review visit taking place or their report being reviewed by the HTAS Accreditation Committee. If teams do introduce a new checklist HTAS asks them to complete a reaudit of 5-10 health records in order to evidence that it is in use and working effectively.

Referrals to the team

The checklist data received showed that 100% of teams have agreed protocols for both incoming and outgoing referrals, as well as an agreed response time for accepting referrals, with the outcome agreed with the referrer. However, only 66.6% of teams had distributed their acceptance criteria to all referrers, and just over half of teams (58.3%) were able to accept direct referrals from service users.

Crisis Houses

Of 12 teams who completed the checklist, 33.3% had access to a crisis house or other non-hospital residential service. For those teams who did have access, 100% of crisis houses were aware of the therapeutic aims of crisis resolution/home treatment and clearly defined clinical responsibility while a service user is in a crisis house as well as responsibility for the storage and administration of medication.

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75% of the teams who had access to a crisis house said that they liaised with crisis houses and there were arrangements for emergency medical care while a service user is in a crisis house.

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Section 6: Service user and carer questionnaires

Teams were required to distribute questionnaires to service users and carers who had received care during the self-review period. There were 150 responses to the service user questionnaire and 73 responses to the carer questionnaire.

Your visits from the team

The majority of service users (97%) said that the team had contacted them to arrange a time to meet, and 91% said that if there was going to be a delay, staff had let them know in advance. This was slightly lower for carers; 84% said that the home treatment team had contacted them and/or the person they cared for to arrange a time to meet, and 84% said they had been made aware if there was going to be a delay. Eighty three percent of service users said the team told them how often they would like to meet and how long the meetings would last, but only 70% of carers reported having this information.

Ninety three percent of service users reported that staff had explained the reason for their assessment, and 85% stated they were asked where they would like to meet for their assessment. Fewer (74%) said they were asked who they would like to be present, or told roughly how long they could expect to be cared for by the home treatment team (76%).

The majority of people who responded to the questionnaire left very positive comments about their visits. The following is illustrative:

"Every member of the team was very understanding and accommodating with my visit requirements."

Your contact with the team

Almost all service users (99%) said they had been given a number they could call for help at any time. The figure for carers was 78%. Seventy three percent of service users, and 68% of carers, responded that they knew the name of the person from the team who was responsible for their care. However, 100% of team managers responded 'yes' to the question on whether service users had a dedicated named worker, which suggests that there is further work to be done in terms of making service users aware of this.

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A second area where room for improvement was identified was the information provided to service users. Fifty six percent of people were told how to make a compliment or complaint, 43% were made aware of how they could access their records and 64% were offered information about mentoring, befriending and advocacy.

Admission to hospital

For those service users who needed to be admitted to hospital, the majority (87%) said that the home treatment team had explained the reasons why, although the figure was lower for carers (73%). Most service users (98%) said they had been involved when their care was transferred from the ward to the home treatment team.

The free-text comments that were left regarding admission to hospital indicated that service users particularly valued continuity of care, for example:

"Good having home treatment team on ward rounds. Made transition a lot easier."

Discharge from the home treatment team

In general, service users were well informed about their discharge, with 87% told when their care was being transferred to the Community Mental Health Team, 90% told when they were going to be discharged and 89% told who would be looking after their care once they were discharged. However, only 64% were provided with a copy of their care plan. The figures were slightly lower for carers, with 85% being told both when the person they cared for was going to be discharged and when their care would be transferred to the Community Mental Health Team. Eighty one percent were aware of who would be looking after the care after discharge. Again, far fewer (54%) were provided with a copy of the care plan.

Confidentiality

Confidentiality appeared to be a strong point for the majority of teams. Ninety one percent of service users had been asked whether it was ok for information to be shared with family/carers, and 100% of people who said they did not want information shared felt that the team had respected their wishes. Comments indicated that this is something that was greatly appreciated by service users:

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"Extremely reassured that confidentiality is adhered to."

Support for carers

In the HTAS Pilot Report (2014), support for carers was highlighted as an area for development. It is therefore encouraging that some progress has been made in this area, although there is still work to be done.

Eighty eight percent of carers said the team had explained what was happening at each stage of the person's care, one percent higher than during the pilot. However, the percentage of carers who were offered individual time with staff, and an assessment of their own needs, had risen (see table 6). Eighty percent of people reported being given written information including the names and contact details of key staff, as well as local sources of advice and support. Where support was given, it is evident that this was greatly appreciated by carers:

"The home treatment team were very helpful and made me feel safer and secure as a carer. They updated me on local activities for carers and supplied all relevant numbers."

Fewer carers (68%) were offered a referral to a carer support service. Seventy eight percent of carers were supported to link with services that could help with ongoing care, and 66% were given information on mental health problems and their rights as a carer. These represent improvements since the pilot, but there are still further improvements needed. As with service users, only just over half of carers (56%) were aware of how to make a compliment or complaint, and only 41% had been offered information on mentoring, befriending or advocacy.

The following comment highlights some of the difficulties that carers may encounter when they are not adequately supported:

"I was met for a carer's assessment but felt that much of the form, i.e., questions, were not relevant to my situation. Accessing help from the carer's support service was left to me to arrange and I had little spare energy or appetite to do this initially…currently, I feel unsupported in coping with some very real emotional challenges."

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Question	% answering 'yes' in the pilot report	% answering 'yes' since March 2013
Did the home treatment team explain what was happening at each stage of the service user's care?	87%	88%
If this is your first contact with the home treatment team, were you offered individual time with staff to discuss your family history, any worries you may have and your own needs?	64%	80%
If this is your first contact with the home treatment team, were you given written information which includes the names and contact details of key staff and local sources of advice and support?	Not asked	85%
Were you offered an assessment of your own needs?	50%	74%
Were you offered a referral to the Carer Support Service?	58%	68%
Were you supported by the team to link with services who can help with the ongoing care of the person you care for?	61%	78%
Were you given information on mental health problems, what you can do to help, your rights as a carer and an up to date directory of local services you can access?	64%	66%

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Were you told how to make a complaint or compliment on the care that the person you care for received?	-	56%

Table 6 – Support for carers

Medication and therapies

It is encouraging that 80% of carers have been involved in the plan for managing the medication of the person they care for. However, only 69% were offered advice by the team to enable them to manage the medication of the person they care for and only 40% were able to contact a pharmacist. Where carers are involved in managing medication, it is essential that they receive appropriate support to do so, as is illustrated by the following comment:

"I knew when to give correct meds, but had little support or help in encouraging the person to take meds on occasion - causing stress and worry."

Overall, it should be highlighted that the majority of comments left on the questionnaire were extremely positive, and teams should be congratulated for the feedback they have received:

"The home treatment team are friendly, informative and very, very good at their job. They have incredible patience and understanding."

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Section 7: National Recommendations

Training in carer awareness

Less than two thirds of staff (64%) had completed training in carer awareness, family inclusive practice and social systems in the home treatment team. While this report suggests that progress has been made in supporting carers since the HTAS pilot report was published in 2014, there is still room for improvement. Ensuring that staff are adequately trained in carer awareness could be a first step in improving support for carers.

Physical health reviews

The case note audit data showed that physical health reviews had been completed for less than 90% of service users. It is important that a service user's physical health needs are met as well as their mental health needs.

Ensuring service users know who is responsible for their care

All team managers said that all service users had a dedicated named worker, however less than three quarters of service users and carers were aware of the person in the team who was responsible for their care. While it is not expected that a service user's named worker will attend every visit, it is important that they know who they are should they need to contact them.

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Section 8: HTAS' Goals for 2015/16

Information management system

HTAS is moving towards using an online information management system. Teams will be able to join the scheme online, enter self review data, monitor their returns and access their reports directly through an online portal. This will provide members with quicker and easier access to their data. More information about the move to this new system will be provided for members in due course.

Advisory group

HTAS is in the process of setting up an advisory group. The group will be multi-disciplinary, made up of staff working in home treatment teams which are members of HTAS, service users and carers. The advisory group will advise the HTAS project team about the promotion and further development of the work of the project, the methods underpinning the work of the programme and the engagement and involvement of other organisations, service users and carers in the work of the project. The first meeting will take place in November 2015.

Special interest days

In May 2015 HTAS held a special interest day focusing on suicide prevention. The event was run in collaboration with 3 other CCQI quality improvement programmes and approximately 100 people attended. The next event will take place in February 2016 at the Royal College of Psychiatrists and will focus on issues that lesbian, gay, bisexual and transgender people face when using mental health services. Further information about the event will be available in due course.

Developmental membership

HTAS are planning to offer a developmental membership option for teams who would like to be part of the network but who aren't yet ready to undergo the full accreditation process. Teams will be able to access peer reviewer training days, the HTAS audit tools and receive discounted places at our annual Forum.

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Section 9: Opportunities for HTAS members

Attending peer review visits

Staff from HTAS member teams have the opportunity to attend peer review visits to other teams, which is an excellent learning opportunity. Peer reviewers are able to observe how other teams function, talk to staff, share knowledge and good practice, and create useful contacts. Staff that wish to become peer reviewers attend a one-day training event run by HTAS, which is free to attend for members. Trained peer reviewers are then asked to volunteer for visits, which happen around the UK throughout the year.

HTAS Forum

HTAS holds an annual conference for staff working in home treatment teams, service users and carers. Members are entitled to free or discounted places at the event, and non-members pay a small fee to attend. Members are encouraged to submit proposals to present or deliver workshops at the event.

The 2nd HTAS National Forum took place at the Royal College of Psychiatrists in London on 31st October 2014; approximately 100 delegates attended. There were a variety of talks, and particularly well received were presentations from those who had direct experience of home treatment teams, either as service users or carers. There were also presentations from member services who have developed effective partnerships with police and ambulance services, as well as an update on the Crisis Concordat. In addition, there were very informative talks on suicide awareness, dual diagnosis and the CRT fidelity study, being conducted at University College London.

HTAS Chat email discussion group

HTAS members can join the email discussion group, which is a forum where home treatment staff can receive advice from their peers in other home treatment teams around the UK. Queries are sent to a central email address, and are then distributed to the group which currently has over 60 members. Members of the group can respond to these queries and replies are distributed to the group as a whole, so that others can benefit from the information.

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Recent topics include: ageless services, recovery and physical health checks.

To join HTAS Chat, email ‘JOIN’ to HTASCHAT@rcpsych.ac.uk

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Appendix 1

Benchmarking – teams listed in order of compliance with Type 2 standards and overall compliance

NB – includes all of those teams who have completed one cycle and who were accredited at the time of publication

Rank	Team number	% overall standards met
1	20	97.9
2	5	97.7
2	14	97.7
4	22	97.4
4	23	97.4
6	7	96.6
7	27	96.3
8	25	96.2
9	6	96.1
9	8	96.1
11	24	95.7
12	9	95.4
13	26	94.2
13	29	94.2
15	18	94.1
16	19	93.7
16	21	93.7
18	13	93.6
19	15	93.1
20	2	92.7
21	28	92.6
22	3	92.0
23	4	91.6
24	17	89.9
25	1	89.7
26	10	89.1
26	11	89.1
28	16	87.7

Rank	Team number	% Type 2 standards met
1	5	97.9
1	14	97.9
3	20	97.1
4	23	96.1
5	8	95.8
6	25	95.2
7	27	95.1
8	7	94.7
8	9	94.7
10	24	94.2
10	21	94.2
12	22	94.1
12	26	94.1
14	6	93.7
15	19	93.2
16	18	93.1
17	15	91.6
18	13	91.5
19	29	91.2
20	3	90.5
21	2	88.4
22	28	88.3
23	4	86.3
23	17	86.3
25	11	85.3
25	1	85.3
25	10	85.3
28	16	81.1

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