Standards for Community-Based Mental Health Services

Third edition, 2019

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COLLEGE CENTRE FOR QUALITY IMPROVEMENT CCQI

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Contents

Foreword

I am pleased to introduce the Royal College of Psychiatrists' third edition of core standards for community mental health services. These standards, which have been closely aligned to the patient experience, are designed to be used across all mental health services to improve the quality of care provided. The standards cover important areas such as: providing timely evidence-based care and treatment, supporting and involving patients and carers and treating them with dignity, looking after staff, evaluating and improving services.

Setting core standards for mental health services allows healthcare professionals, patients and carers to have a shared understanding of what a good quality service looks like and promotes a reduction in unnecessary variation in how services are delivered, and the quality of the care offered.

These standards will be used across all College Centre for Quality Improvement (CCQI) quality networks and accreditation programmes. The College's first quality network was established in 2001 and there are now over 20 networks using a similar methodology with a wide range of mental health services. Over 1500 services around the UK participate in these programmes. This new edition of the core standards will ensure that the CCQI's work continues to make a significant contribution to improving the quality of mental health services as the networks reach their 20th anniversary.

I would like to thank the patients, carers, healthcare professionals and CCQI (College Centre for Quality Improvement) staff who have worked to develop this third edition of the core standards.

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Registrar of the Royal College of Psychiatrists

Introduction

Description and scope of the standards

The third edition of the core standards for community-based mental health services has been revised by the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI). It is based on the first edition which was created by the CCQI and the British Standards Institution (BSI) in 2015.

The community-based standards cover access to services and what a good assessment looks like as well as care, treatment and discharge planning. They also cover the service environment, staffing and governance.

How the standards were developed

A literature review was undertaken to identify any evidence published since publication of the second edition which could be used to update standards and create new standards. The standards then underwent a consultation process. This was done by a working group of multi-disciplinary mental health professionals, patient representatives and CCQI staff that was led by Dr Rob Chaplin (Clinical Lead for Accreditation, CCQI).

The group reviewed all standards considering how critical they were to quality and their proximity to patient experience. Other factors considered included their measurability, if there was any repetition and whether the content was appropriate for core standards and could be applied across a range of mental health services. As a result, the standards have reduced in length by approximately 30%. We believe that this will enable participating services and reviewers to focus on the issues that are key to quality.

The following principles were used to guide the development of these standards:

- **Access:** Patients have access to the care and treatment that they need, when and where they need it.
- **Compassion:** All services are committed to the compassionate care of patients, carers and staff.
- **Valuing relationships:** The value of relationships between people is of primary importance.
- **Service user and carer involvement:** Patients and carers are involved in all aspects of care.
- **Learning environment:** The environment fosters a continuous learning culture.
- **Leadership, management, effective and efficient care:** Services are well led and effectively managed and resourced.
- **Safety:** Services are safe for patients, carers and staff.

How the core standards will be used

The core standards will be used by the quality networks and accreditation programmes within the CCQI. Each project will take on the relevant core standards which will be used alongside their own specialist standards that relate to the service type being reviewed.

Use of terminology

The core inpatient standards use the terms ‘patient’ and ‘carer’. The decision was made to use these terms during the consultation process for the first edition of the core standards. When projects come to take on these standards, they may change these terms to best suit their specialty. For example, child and adolescent mental health services may wish to replace the term ‘patient’ with ‘young person’.

Some of the standards have a ‘p’ next to their number which denotes a ‘placeholder’ standard. When projects come to take on the placeholder standards, they will be expected to adapt the standards to meet their specialty requirements.

Criteria

All criteria are rated as Type 1, 2 or 3.

Type 1: Essential standards. Failure to meet these would result in a significant threat to service user safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence-based care and treatment.

Type 2: Expected standards that most services should meet.

Type 3: Desirable standards that high performing services should meet.

Number	Type	Standard	Ref
1		**Access, referral and waiting times**	
1.1	1	The service reviews data at least annually about the people who use it. Data are compared with local population statistics and actions taken to address any inequalities of access that are identified.	1,2
1.2	3	Everyone can access the service using public transport or transport provided by the service.	2
1.3	1	The service provides information about how to make a referral and waiting times for assessment and treatment.	2, 5, 6, 7, 8
1.4	1	A clinical member of staff is available to discuss emergency referrals during working hours.	9
1.5	2	Where referrals are made through a single point of access, these are passed on to the community team within one working day unless it is an emergency referral which should be passed across immediately.	2, 9, 10, 11
1.6	1	The team assess patients, who are referred to the service, within an agreed timeframe.	2, 10, 11
2		**Preparing for the assessment**	
2.1	1	For non-emergency assessments, the team makes written communication in advance to patients that includes: • The name and title of the professional they will see; • An explanation of the assessment process; • Information on who can accompany them; • How to contact the team if they have any queries or require support (e.g. access to an interpreter, how to change the appointment time or have difficulty in getting there).	2, 12, 13
2.2	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes: • Their rights regarding consent to treatment; • Their rights under the Mental Health Act; • How to access advocacy services; • How to access a second opinion; • Interpreting services; • How to view their records; • How to raise concerns, complaints and give compliments.	2, 8, 13, 14, 15, 16
3		**Initial assessment**	
3.1	1	Patients feel welcomed by staff members when attending the team base for their appointments. *Guidance: Staff members introduce themselves to patients and address them using the name and title they prefer.*	2, 17, 18

Number	Type	Standard	Ref
3.2	1	Patients have a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development. • Suicide risk.	2, 3, 13, 16, 19
3.3	1	A physical health review takes place as part of the initial assessment, or as soon as possible.	2, 4, 20, 21
3.4	1	Patients have a risk assessment and management plan which is co-produced, updated regularly and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers risk to self, risk to others and risk from others.	2, 3, 8, 22, 23
3.5	1	All patients have a documented diagnosis and a clinical formulation. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised.	2, 24
3.6	2	The team sends correspondence detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.	25
4		**Following up patients who do not attend appointments**	
4.1	1	The team follows up patients who have not attended an appointment/assessment. If patients are unable to be engaged, a decision is made by the assessor/team, based on patient need and risk, as to how long to continue to follow up the patient.	2, 8, 26
4.2	1	If a patient does not attend for an assessment / appointment, the assessor contacts the referrer. Guidance: If the patient is likely to be considered a risk to themselves or others, the team contacts the referrer immediately to discuss a risk action plan.	2, 3, 26
5		**Reviews and care planning**	
5.1	1	Patients know who is co-ordinating their care and how to contact them if they have any questions.	27
5.2	1	The team has a timetabled meeting at least once a week to discuss allocation of referrals, current assessments and reviews. *Guidance: Referrals that are urgent or that the team feel do not require discussion can be allocated before the meeting.*	2, 26, 28
5.3	1	Every patient has a written care plan, reflecting their individual needs. Staff members collaborate with patients and their carers (with patient consent) when developing the care plan and they are offered a copy. *Guidance: The care plan clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *Measurable goals and outcomes;* • *Strategies for self-management;* • *Any advance directives or statements that the patient has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework.*	2, 13, 29, 30

Number	Type	Standard	Ref
6.1		**Care and treatment – therapies and activities**	
6.1.1	1	Patients begin evidence-based interventions, which are appropriate for their bio-psychosocial needs, within an agreed timeframe: Any exceptions are documented in the case notes.	2,10,15,31,32
6.1.2	1	There is dedicated sessional time from psychologists (1) to provide assessment and formulation of patients' psychological needs; (2) to ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway.	33,34
6.1.3	2	There is dedicated sessional time from psychologists to support a whole team approach for psychological management.	33,34
6.1.4	1	There is dedicated sessional input from Occupational therapists (1) to provide an occupational assessment for those patients who require it; (2) to ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs.	2,14
6.1.5	3	There is dedicated sessional input from creative therapists.	2,14
6.1.6	2	The team supports patients to undertake structured activities such as work, education and volunteering. *Guidance: For patients who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes.*	2,17,31,36
6.1.7	1	Patients (and carers, with patient consent) are offered written and verbal information about the patient's mental illness and treatment. *Guidance: Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites.*	2,7,8,17,30,35
6.1.8	1	The team supports patients to undertake activities to support them to build their social and community networks.	2, 17, 31, 36
6.1.9	1	All staff members who deliver therapies and activities are appropriately trained and supervised.	25, 31, 34, 35
6.2		**Care and treatment – medication**	
6.2.1	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are reviewed, a timescale for response is set and patient consent is recorded.	2
6.2.2	1	Patients have their medications reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects and adherence to medication regime. *Guidance: Side effect monitoring tools can be used to support reviews.*	2, 25
6.2.3	1	Patients, carers and prescribers can contact a specialist pharmacist to discuss medications.	2, 25

Number	Type	Standard	Ref
6.2.4	1	For patients who are taking antipsychotic medication, the team maintains responsibility for monitoring their physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	7
7		**Physical healthcare**	
7.1	1	Staff members arrange for patients to access screening, monitoring and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan.	41, 4
7.2	1	Patients are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the patient's care plan.	7, 39, 40
7.3	1	The team including bank and agency staff are able to identify and manage an acute physical health emergency.	2
7.4	1	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at 6 weeks, at 3 months and then annually (or every six months for young people) unless a physical health abnormality arises.	2, 7, 40, 41, 43
8		**Risk and safeguarding**	
8.1	1	The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	17, 44, 45
9		**Discharge planning and transfer of care**	
9.1	2	A discharge letter is sent to the patient and all relevant parties within 10 days of discharge. The letter includes the plan for: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • Details of when, where and who will follow up with the patient as appropriate.	2, 17, 46
9.2	1	The community team makes sure that patients who are discharged from hospital are followed up within 3 days.	2, 47, 48, 76
9.3	1	When patients are transferred between community services there is a handover which ensures that the new team have an up to date care plan and risk assessment.	50
9.4	2	Teams provide specific transition support to patients when their care is being transferred to another community team, or back to the care of their GP.	2, 46

Number	Type	Standard	Ref
9.5	1	There is active collaboration between Children and Young People's Mental Health Services and Working Age Adult Services for patients who are approaching the age for transfer between services. This starts at least 6 months before the date of transfer.	49

10 Interface with other services

10.1	1	Patients can access help, from mental health services, 24 hours a day, 7 days a week. *Guidance: Out of hours, this may involve crisis/home treatment teams, psychiatric liaison teams.*	2, 11, 45
10.2	1	The team supports patients to access: • Housing support; • Support with finances, benefits and debt management; • Social services.	2, 27
10.3	1	The service/organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months postpartum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.	2, 5

11 Capacity and consent

11.1	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment in hospital are performed in accordance with current legislation.	2, 8, 14, 17, 51

12 Patient involvement

12.1	1	The service asks patients and carers for their feedback about their experiences of using the service and this is used to improve the service.	8,52
12.2	2	Services are developed in partnership with appropriately experienced patients and carers and have an active role in decision making.	36, 52, 53
12.3	1	Patients are actively involved in shared decision-making about their mental and physical healthcare, treatment and discharge planning and supported in self-management.	7, 8, 17, 36, 52

Number	Type	Standard	Ref
13		**Carer engagement and support**	
13.1	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning.	55
13.2	1	Carers are supported to access a statutory carers' assessment, provided by an appropriate agency. *Guidance: This advice is offered at the time of the patient's initial assessment, or at the first opportunity.*	55
13.3	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs.	2, 16, 55
13.4	2	The team provides each carer with accessible carer's information. *Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes:* • The names and contact details of key staff members in the team and who to contact in an emergency; • Local sources of advice and support such as local carers' groups, carers' workshops and relevant charities.	3, 4, 7, 55
13.5	3	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers.	3, 26, 53, 54, 55
14		**Compassion dignity and respect**	
14.1	1	Staff members treat patients and carers with compassion, dignity and respect.	52, 64
14.2	1	Patients feel listened to and understood by staff members.	27
15		**Providing information to patients and carers**	
15.1	1	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.	18, 45
15.2	2	The service uses interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation. The patient's relatives are not used in this role unless there are exceptional circumstances.	2, 17, 45
16		**Patient confidentiality**	
16.1	1	Confidentiality and its limits are explained to the patient and carer, both verbally and in writing. Patient preferences for sharing information with 3rd parties are respected and reviewed regularly.	2, 17, 57
16.2	1	The team knows how to respond to carers when the patient does not consent to their involvement.	2, 18

Number	Type	Standard	Ref
16.3	1	All patient information is kept in accordance with current legislation. *Guidance: This includes transfer of patient identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access.*	17, 57
17		**Service environment**	
17.1	2	The environment is clean comfortable and welcoming.	2, 57, 61
17.2	1	Clinical rooms are private, and conversations cannot be overheard.	26
17.3	1	The environment complies with current legislation on disabled access. *Guidance: Relevant assistive technology equipment, such handrails, are provided to meet individual needs and to maximise independence.*	4, 17, 55, 58
17.4	1	Staff members follow a lone working policy and feel safe when conducting home visits.	2, 45, 59
17.5	1	There is an alarm system in place (e.g. panic buttons or personal alarms) and this is easily accessible for patients, carers and staff members.	2, 17
18		**Leadership, team working and culture**	
18.1	3	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet to think about team dynamics and develop their clinical practice.	2
18.2	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns or whistleblowing.	3, 57, 62, 63
19		**Staffing levels**	
19.1	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan, such as the minor and temporary reduction of non-essential services.	2, 65
19.2	1	When a staff member is on leave, the team puts a plan in place to provide adequate cover for the patients who are allocated to that staff member.	2
19.3	1	There is an identified senior clinician available at all times who can attend the team base within an hour. *Guidance: Some services may have an agreement with a local GP to provide this medical cover.*	2, 17

Number	Type	Standard	Ref
20		**Staff recruitment, induction and supervision**	
20.1	2	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting staff members.	13
20.2	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. *Guidance: This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met.*	15, 37, 65, 66
20.3	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. *Guidance: Supervision should be profession-specific as per professional guidelines and provided by someone with appropriate clinical experience and qualifications.*	2, 17, 38
20.4	2	All staff members receive line management supervision at least monthly.	2
21		**Staff wellbeing**	
21.1	1	The service actively supports staff health and wellbeing. *Guidance: For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*	37, 65, 68, 69
21.2	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. *Guidance: They have the right to one uninterrupted 20 minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks.*	2, 17, 70
21.3	1	Staff members, patients and carers who are affected by a serious incident are offered post incident support.	16, 70, 71
22		**Staff training and development**	
22.1		Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines. This training includes:	
22.1a	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent).	5, 51
22.1b	1	Physical health assessment. *Guidance: This includes training in understanding physical health problems, understanding physical observations and when to refer the patient for specialist input.*	2, 7, 71

Number	Type	Standard	Ref
22.1c	1	Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect.*	2, 22, 23, 72
22.1d	1	Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm and the prevention and management of aggression and violence.*	2, 23, 24, 72
22.1e	1	Recognising and communicating with patients with cognitive impairment or learning disabilities.	2, 45
22.1f	1	Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance and basic life support.*	2, 17
22.1g	2	Carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	16, 54
22.2	2	Experts by experience are involved in delivering and developing staff training face-to-face.	13
23		**Clinical outcome measurement**	
23.1	1	Clinical outcome measurement data, including progress against user defined goals, is collected as a minimum at assessment, after 6 months, 12 months and then annually until discharge. Staff can access this data.	2
23.2	2	Staff members review patients' progress against patient-defined goals in collaboration with the patient at the start of treatment, during clinical review meetings and at discharge.	2, 38
23.3	2	The service's clinical outcome data are reviewed at least every six months. The data are shared with commissioners, the team, patients and carers, and used to make improvements to the service.	2, 38
24		**The service learns from feedback, complaints and incidents**	
24.1	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	2, 40, 70, 73
24.2	1	When mistakes are made in care this is discussed with the patient themselves and their carer, in line with the Duty of Candour agreement.	74
24.3	1	Lessons learned from untoward incidents and complaints are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.	8, 71, 73, 75
24.4	2	The team use quality improvement methods to implement service improvements.	2
24.5	2	The team actively encourages patients and carers to be involved in QI initiatives.	2

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