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ROYAL COLLEGE OF PSYCHIATRISTS

ACOMHS
ACCREDITATION FOR COMMUNITY MENTAL HEALTH SERVICES

ACCREDITATION FOR COMMUNITY MENTAL HEALTH SERVICES (ACOMHS)

STANDARDS FOR ADULT COMMUNITY MENTAL HEALTH SERVICES

THIRD EDITION

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Foreword

Community mental health services play a crucial role in delivering mental health care for adults and older adults with severe mental health needs as close to home as possible. There have been increased investment into community mental health services across parts of the United Kingdom which sets out that the NHS will develop new and innovative models of care which aims to improve mental health of communities.

ACOMHS sits within the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) and has developed standards for Adult Community Mental Health Services since 2016 and this revised third edition of the standards are in line and reflect the changes in community mental health provision during this time. The standards demonstrate continuous quality improvement and the delivery of collaborative high quality compassionate care.

ACOMHS offers accreditation to community mental health teams who can evidence they are meeting a required threshold of standards and this recognition demonstrates the high quality of care that teams are delivering.

The standards have been revised and developed with ACOMHS members, relevant stakeholders and the ACOMHS Advisory group which includes professionals and patient and carer representatives. On behalf of the Advisory group, I would like to thank those involved in the consultations and the Royal College of Psychiatrists' ACOMHS project team for their work.

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Introduction

The Accreditation for Community Mental Health Services (ACOMHS) network has been established since 2016 and these standards have been developed for the purpose of the review of a wide range of models for community mental health services.

These standards have been drawn from key documents and expert consensus and have been subject to extensive consultation with professional groups involved in the provision of community mental health services, and with people with lived experience. They incorporate the College Centre for Quality Improvement (CCQI) Core Community Standards, as well as additional specialist standards.

The standards have been developed for the purpose of review as part of the Accreditation for Community Mental Health Services (ACOMHS) network. (ACTION). They can also be used as a guide for new or developing services. The standards cover the follow topics:

1. Access, Referral & Assessment
2. Care Planning and Treatment
3. Multi-Agency Working
4. Patient and Carer Experience
5. Environment and Facilities
6. Staffing and Training
7. Leadership and Governance

Who are these standards for?

These standards are designed to be applicable to adult community mental health services and can be used by professionals to assess the quality of the team. The standards may also be of interest to commissioners, patients, carers, researchers and policy makers.

Since adult community mental health services differ widely in their configuration and models used, these standards focus on the function of the team in order to make them as widely accessible as possible.

Categorisation of standards

Each standard has been categorised as follows:
Type 1: Essential standards. Failure to meet these would result in a significant threat to patient 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.
The full set of standards is aspirational, and it is unlikely that any service would meet them all.

Terms used in this document

In this document, the community mental health team is referred to as 'the team' or the 'service'. People who are cared for by the community mental health team are referred to as 'patients' and their loved ones are referred to as 'carers'.

The standards are available to download on our website:
www.rcpsych.ac.uk/acomhs

Sustainability Principles

The third edition of the ACOMHS standards have been mapped against sustainability principles developed by the Royal College of Psychiatrists Sustainability Committee. The Royal College of Psychiatrists is striving to improve the sustainability of mental health care, by designing and delivering services with the sustainability principles at the core.

The aim of this process is to raise awareness around sustainability in mental health services and to work towards making psychiatric services sustainable in the long run. In recent years the mounting economic, social, and environmental constraints have put the mental healthcare system under enormous pressure, and it is vital to ensure that high-value services continue despite these constraints. Developing a sustainable approach to our clinical practice is a crucial step in ensuring that mental health services will continue to provide high-quality care in the 21st century in the face of these constraints.

Sustainability in health services involves improving quality, cost, and best practice, with a particular focus on reducing the impact on the environment and the resources used in delivering health interventions. A sustainable mental health service is patient-centred, focused on recovery, self-monitoring, independent living, and actively reduces the need for intervention.

Sustainability is written into the NHS constitution (Department of Health, 2013). In Principle 6 of the constitution, it states that the 'NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.'

It is vital for professionals involved in designing mental health services to have a good understanding of sustainability i.e., the resources needed for each intervention, and to have an awareness of the effects of these interventions across economic, environmental, and social domains. Adoption of these principles across mental healthcare would lead to a less resource intensive and

more sustainable service.

The five Sustainability Principles are as follows:

1. **Prioritise prevention**

   Preventing poor mental health can reduce mental health need and therefore ultimately reduce the burden on health services (prevention involves tackling the social and environmental determinants alongside the biological determinants of health).

2. **Empower individuals and communities**

   This involves improving awareness of mental health problems, promoting opportunities for self-management and independent living, and ensuring patients and carers are at the centre of decision making. It also requires supporting community projects that improve social networks, build new skills, support employment (where appropriate) and ensure appropriate housing.

3. **Improve value**

   This involves delivering interventions that provide the maximum patient benefit for the least cost by getting the right intervention at the right time, to the right person, while minimising waste.

4. **Consider carbon**

   This requires working with providers to reduce the carbon impacts of interventions and models of care (e.g., emails instead of letters, telehealth clinics instead of face-to-face contacts). Reducing over-medication, adopting a recovery approach, exploiting the therapeutic value of natural settings and nurturing support networks are examples that can improve patient care while reducing economic and environmental costs.

5. **Staff sustainability**

   This requires actively supporting employees to maintain their health and well-being. Contributions to the service should be recognised and effective team working facilitated. Employees should be encouraged to develop their skills and supported to access training, mentorship, and supervision.

Sustainable Service Accreditation

Services that meet 90% or more of the standards relevant to Sustainability Principles (which can be identified throughout this document by the green leaf logo) will be awarded a “Sustainable Service Accreditation” certification in recognition of provision of a sustainable mental health service.

Sustainability will automatically be examined alongside the usual review process and services will not have to submit extra evidence for this.

Whether a service is awarded the sustainability certification or not will not affect

Standards for Adult Community Mental Health Services

Access, Referral & Assessment

No.	Type	Standard	Ref.
Referral Process			
1	1	The service provides information about how to make a referral and waiting times for assessment and treatment.	[1]
2	1	A clinical member of staff is available to discuss urgent referrals during working hours.	[1]
3	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 urgent referral which should be passed across immediately.	[1]
4	1	Outcomes of referrals are fed back to the referrer, patient and carer (with the patient's consent). If a referral is not accepted, the team advises the referrer, patient and carer on why it was not accepted and signposts to alternative options. *Guidance: This could include onward referrals to VCSE or similar organisations for support.*	[2]
5	2	There are agreements in place for patients to re-access the community team if needed, without following the initial referral pathway. *Guidance: These are identified and clearly communicated with the patient on discharge.*	[13]
Equity of Access			
6	2	Everyone can access the service using public transport or transport provided by the service.	[1]
7	1	Acceptance to the service is based on need and risk; the service does not use blanket exclusion criteria when deciding which patient to assess. The decision to offer secondary services should be based on NICE stepped care models for specific mental health conditions. *Guidance: Self-harm, alcohol and substance misuse, social background, criminal history, learning disability or personality disorder are not barriers to acceptance by the service and reasonable adjustments are put in place.*	[3]
8	1	The team reviews demographic data at least annually about the people who use the service. Data is compared with local population statistics and action is taken to address any inequalities of access that are identified.	[1]

Engagement with Services			
9	1	The team follows up patients who have not attended an appointment. 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. *Guidance: Different engagement techniques are in place to match the patients' needs and where patients consent, the patient's network including carer is contacted to discuss engagement.*	[1]
10	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.*	[1]
11	1	The team proactively engage with patients with serious mental illness during periods where engagement is challenging. There is appropriate intensive and assertive mental health care and treatment available to meet their needs. *Guidance: For this patient group, DNA (did not attend) should not be a reason for discharge. If/when discharge from the team occurs, then a clear record of the decision-making process is included within the patients' electronic record.*	[13]
Assessment Process			
12	2	New patients receive an assessment and support within 4 weeks of referral. *Guidance: If the service sees people with suspected psychosis, they are assessed within 2 weeks of referral.*	[4]
13	1	For non-urgent 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 if they have difficulty in getting there).	[1]

14	1	Patients have a comprehensive evidence-based assessment which includes their: • Mental health and medication; • Psychosocial and psychological needs; • Strengths and areas for development. *Guidance: Where possible, any existing information is utilised in the assessment to avoid duplication.*	[1]
15	1	A physical health review takes place as part of the initial assessment, or as soon as possible. *Guidance: Where possible, any existing information is utilised in the assessment to avoid duplication.* Sustainability Principle: Prioritise Prevention	[1]
16	1	Patients have a risk assessment and safety plan which is co-produced with the patients and their network where possible (including their carer and relevant agencies with consideration of confidentiality) and updated regularly. *Guidance: The assessment considers risk to self, risk to others and risk from others.* Sustainability Principle: Prioritise Prevention	[1]
17	1	The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary.	[1]
18	1	Assessments of patients' capacity to consent to care and treatment are performed in accordance with current legislation.	[1]
19	1	There are systems in place to ensure that the service takes account of any advance decisions that the patient has made. *Guidance: These are accessible, and staff members know where to find them.*	[7]
20	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. The patient receives a copy.	[1]
Patient Confidentiality			
21	1	Confidentiality and its limits are explained to the patient and carer, both verbally and in writing. Patient preferences for sharing information with third parties are respected and reviewed regularly.	[1]

22	1	The team knows how to respond to carers when the patient does not consent to their involvement. *Guidance: The team may receive information from the carer in confidence.*	[1]
23	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.*	[1]
Provision of Information			
24	1	Patients are given accessible written information which staff members talk through with them as soon as is practically possible. The information includes, where relevant: • Their rights and consent to treatment; • 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.	[1]
25	1	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment.	[1]
26	1	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.	[1]

Care Planning and Treatment

No.	Type	Standard	Ref.
Care Planning			
27	1	Patients are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.	[1]
28	2	The team offers appointments both in person and virtually and patient preference as well as clinical needs is taken into account. *Guidance: Conducting a first assessment in-person is recognised as good practice.*	[1]

29	1	Every patient has a personalised care plan which is regularly reviewed and updated. *Guidance: Staff, patients and their network, including carers (with patient consent) coproduce the care plan together.*	[1]
30	1	Clinical outcome measurement is collected at least two time points (at assessment and discharge). *Guidance: This includes patient-reported outcome measurements where possible.*	[1]
31	2	Progress against patient-defined goals is reviewed collaboratively between the patient and staff members during clinical review meetings and at discharge.	[1]
32	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. *Guidance: Clinical formulations are coproduced where possible.*	[1]
33	1	Patients know who is coordinating their care and how to contact them if they have any questions.	[1]
Supporting Physical Healthcare			
34	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 patients' care plan.	[1]
35	1	Patients are offered personalised healthy lifestyle interventions, such as advice on healthy eating, lower risk drinking, physical activity and access to smoking cessation services. This is documented in the patients care plan. Sustainability Principle: Consider Carbon	[1]
36	2	There are systems in place to ensure that patients with serious mental illness (SMI) receive annual physical health checks. *Guidance: This could be done within the team or within another community service and reasonable adjustments to support attendance are put in place.*	[6]

Medication			
37	1	When medication is prescribed, specific treatment goals are set with the patient, the risks (including interactions) and benefits are discussed, a timescale for response is set and patient consent is recorded.	[1]
38	1	Patients have their medication reviewed regularly. Medication reviews include an assessment of therapeutic response, safety, management of side effects, adherence to medication regime and the consideration of de-prescribing, if appropriate. *Guidance: Side effect monitoring tools can be used to support reviews.* Sustainability Principle: Consider Carbon	[1]
39	2	Patients and carers are able to discuss medications with a specialist pharmacist.	[1]
40	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. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	[1]
41	1	Patients who are prescribed mood stabilisers or antipsychotics have the appropriate physical health assessments at the start of treatment (baseline), at three months and then annually (or six-monthly for young people) If a physical health abnormality is identified this is acted upon.	[1]
Therapies and Interventions			
42	1	Following assessment, patients promptly begin recovery-focussed evidence-based therapeutic interventions which are appropriate for their bio-psychosocial needs.	[1]
43	2	There is an assessment for family work and education as part of the patient's treatment, where appropriate.	[8]
44	2	The team has dedicated sessional input from arts therapists.	[1]

45	2	The team supports patients to access local green space on a regular basis. *Guidance: This could include signposting to local walking groups or arranging regular group activities to visit green spaces. Consideration should be given to how all patients are able to access these sessions including, for example, access to appropriate foot-or rainwear.*	[1]
Provision of Information			
46	1	Information for patients and carers is available in accessible formats for neurodiverse people and people with sight/hearing/cognitive difficulties or learning disabilities and can be provided in languages other than English (ensuring cultural relevance if necessary).	[9]
47	1	Patients (and carers, with patient consent) are offered written and verbal information about the patients' 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.* Sustainability Principle: Staff Empowerment	[1]
Team Processes			
48	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.*	[1]
49	2	The service makes use of digital technologies, such as mobile applications, as an additional resource to support a patients' care.	[3]

Multi-Agency Working

No.	Type	Standard	Ref.
Links and Pathways with Other Services			
50	2	The service works with and supports patients to access advocacy, voluntary, community and social enterprise (VCSE) organisations, as well as community assets. *Guidance: These community assets may include services such as Recovery Colleges, libraries, leisure centres, art & music venues, community centres.*	[3]

51	2	The team supports patients to undertake structured activities such as work, education and volunteering, if required/wanted. *Guidance: For patients who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes. This includes referral to the Individual Placement and Support service and third sector services where appropriate.*	[3]
52	1	The team supports patients to access: • Housing support; • Support with finances, benefits and debt management; • Social services.	[1]
53	1	The service has a pathway with primary care which clearly identifies joint working and agreed responsibilities. *Guidance: This could include agreements on monitoring physical healthcare and the team providing specialist advice to primary care when required.*	[3]
54	1	The service/organisation has a care pathway for the care of women and pregnant people in the perinatal period (pregnancy and 12 months post-partum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team unless there is a specific reason not to do so.	[1]
55	2	Where appropriate, there is formalised joint working and information sharing arrangements in place to support continuity of care for patients transitioning between community and prison mental health services. *Guidance:* • *Patients should be formally handed over from community to prison mental health services & not discharged when they enter custody;* • *Patients should remain open to community team caseloads until it is clear they are not returning to the community in the near future;* • *Community services should accept direct referrals from prison mental health services.*	[11]

56	1	There is active collaboration between Children and Young People's Mental Health Services and Working Age Adult Services for service users who are approaching the age for transfer between services. This starts at least 6 months before the date of transfer. *Guidance: Patients and their carers should be involved in deciding what will help them in this transfer between services.*	[1]
57	2	The service has a policy for the care of patients with comorbid/ co-occurring mental health problems and alcohol or substance use disorder that includes: • Liaison and joint working shared protocols between mental health and community addiction substance misuse services to facilitate; • Drug/alcohol screening to support decisions about care/treatment options; • Liaison between mental health, statutory and voluntary agencies; • Staff training; • Access to evidence-based treatments.	[10]
58	1	Patients can access help from mental health services 24 hours a day, seven days a week. *Guidance: Out of hours, this may involve crisis lines/crisis resolution and home treatment teams, psychiatric liaison teams.*	[1]
Continuity of Care			
59	2	The team has the ability to step up care and when a patient under the care of the community team is admitted mental health inpatient care, the team maintains proactive engagement with the ward other relevant services to support care and transition.	[4]
60	1	The team makes sure that patients who are discharged from mental health inpatient care are followed up within 72 hours.	[1]
61	1	There is a pathway in place to identify patients in need of intensive and assertive community care.	[13]
Transfer of Care			

62	2	A discharge letter is sent to the patient and all relevant parties within a week 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.	[1]
63	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.	[1]
64	2	Teams provide support to patients when their care is being transferred to another community team, or back to the care of their GP.	[1]
65	1	The team follows a protocol to manage patients who discharge themselves against medical advice. This includes: • Recording the patient's capacity to understand the risks of self-discharge; • Exploring the reasons why a patient may want to discharge themselves and actively try and address these issues, where possible; • Contacting the relevant agencies to notify them of the discharge.	[2]

Patient & Carer Experience

No.	Type	Standard	Ref.
Provision of Patient Centred Care			
66	1	Staff members treat patients and carers with compassion, dignity and respect.	[1]
67	1	Patients feel listened to and understood by staff members.	[1]
68	1	Patients feel welcomed by staff members when attending their appointments. *Guidance: Staff members introduce themselves to patients and address them using their preferred name and preferred pronouns.*	[1]
69	1	Reasonable adjustments are made, if required, for patients with disability, including those with autism and/or learning disability. Any reasonable adjustments are recorded in patients notes.	[1]

70	2	Where possible, the service will take into consideration patient preferences for their appointments. *Guidance: This includes choice of time, day, venue or gender of staff member for appointments.*	[2]
71	1	The service can demonstrate that it promotes culturally and spiritually sensitive practice.	[2]
Supporting Carers			
72	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. This includes attendance at review meetings where the patient consents.	[1]
73	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 patients' initial assessment, or at the first opportunity.*	[1]
74	2	Carers are offered individual time with staff members to discuss concerns, family history and their own needs. Sustainability Principle: Empowering Individuals	[1]
75	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.*	[1]
76	2	Where appropriate, the service actively encourages carers to attend carer support networks or groups. *Guidance: There is a designated staff member to support carers.*	[1]

Environment and Facilities

No.	Type	Standard	Ref.
77	1	The environment is clean, comfortable and welcoming.	[1]
78	1	Clinical rooms are private, and conversations cannot be overheard.	[1]

79	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.*	[1]
80	1	There are measures in place to ensure staff are as safe as possible when conducting home visits. These include: • Having a lone working policy; • Conducting a risk assessment; • Identifying control measures that prevent or reduce any risks.	[1]
81	1	There is a system by which staff are able to raise an alarm if needed.	[1]

Staffing and Training

No.	Type	Standard	Ref.
82	2	There has been a review of the staff members and skill mix of the service within the past 12 months. This is to identify any gaps in the service and to develop a balanced workforce which meets the needs of the service.	[2]
83	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. Sustainability Principle: Prioritise Prevention	[1]
84	1	When a staff member is on leave, the team provides adequate cover for the patients who are allocated to that staff member.	[1]
85	1	There is an identified senior clinician available at all times who is available on the phone or at the team base within an hour. Video consultation may be used in exceptional circumstances. *Guidance: Some services may have an agreement with a local GP to provide this medical cover.*	[1]
86	2	The service has enough administrative assistance to meet the needs of the service.	[2]

The multi-disciplinary team consists of staff from a number of different professional backgrounds that enables them to deliver a full range of treatments/therapies appropriate to the population they serve. The team includes dedicated sessional input:			
87	1	Consultant Psychiatrist(s).	[2]
88	1	Registered Mental Health Nurse(s).	[2]
89	1	Occupational Therapist(s). *Guidance: They provide an occupational assessment for those patients who require it and ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs.*	[1]
90	1	Psychologist(s). *Guidance: They provide assessment and formulation of patients' psychological needs and ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway.*	[1]
The team has dedicated sessional input or can evidence timely access to the below professionals as part of their local mental health system offer:			
91	2	Psychological therapists who are trained in a range of evidence-based psychological therapies. *Guidance: This includes NICE recommended interventions such as Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT).*	[5]
92	2	Social Worker(s).	[2]
93	2	Primary Care Practitioner(s).	[2]
94	2	Specialist Mental Health Pharmacist(s).	[2]
95	2	Peer Support Worker(s). *Guidance: Staff who have lived experience and support patients and carers.*	[2]
Supporting Staff			
96	1	The service actively supports staff health and well-being. *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.* Sustainability Principle: Staff Empowerment	[1]

97	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.*	[1]
98	2	All staff members receive line management supervision at least monthly.	[1]
99	2	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. Sustainability Principle: Staff Empowerment	[1]
100	2	There is dedicated sessional time from psychologists to support a whole team approach for psychological management.	[1]
101	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.*	[1]
102	1	Staff members, patients and carers who are affected by a serious incident are offered post incident support. *Guidance: This includes attention to physical and emotional wellbeing of the people involved and post-incident reflection and learning review.* Sustainability Principle: Empowering Individuals	[1]
103	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. Sustainability Principle: Staff Empowerment	[1]
104	2	The team has protected time for team building and discussing service development at least once a year, at a minimum.	[2]
Training and Staff Development			

105	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.*	[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:			
106	1	The use of legal frameworks, such as the Mental Health Act, Mental Capacity Act, Humans Rights Act & Equality Act (or equivalents). Physical health assessment. *Guidance: This includes training in understanding physical health problems, understanding physical observations and when to refer the patient for specialist input.* Safeguarding vulnerable adults and children. *Guidance: This includes recognising and responding to the signs of abuse, exploitation or neglect;* Sustainability Principle: Prioritise Prevention Risk assessment and risk management. *Guidance: This includes assessing and managing suicide risk and self-harm* Recognising and communicating with patients with cognitive impairment, neurodiversity and learning disabilities.	[1]
107	1	Autism Awareness Training.	[12]
108	2	Trauma Informed Care.	[5]
109	1	Inequalities in mental health access, experiences and outcomes for patients with different protected characteristics. Training and associated supervision should support the development and application of skills and competencies required in role to deliver equitable care.	[1]
110	2	Staff have received training on carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.	[1]
111	1	The team including bank and agency staff are able to identify and manage an acute physical health emergency.	[1]

		Sustainability Principle: Prioritise Prevention	
112	2	Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months.	[2]

Leadership and Governance

No.	Type	Standard	Ref.
Responding To, and Learning from Incidents			
113	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.	[1]
114	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.	[1]
115	1	Lessons learned from 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.	[1]
Lived Experience Input			
116	2	Services are developed in partnership with experienced patients and carers who have an active role in decision making.	[1]
117	2	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting staff members. *Guidance: These representatives should have experience of the relevant service.* Sustainability Principle: Empowering Individuals	[1]
118	2	Patient and carer representatives are involved in delivering and developing staff training.	[1]
119	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. Sustainability Principle: Empowering Individuals	[1]
120	2	Feedback received from patients and carers is analysed and explored to identify any differences of experiences according to protected characteristics.	[1]

Audit and Quality Improvement			
121	2	The team is actively involved in quality improvement activity.	[1]
122	2	The team actively encourages patients and carers to be involved in quality improvement initiatives.	[1]
123	2	The service reviews the environmental and social value of its current practices against the organisation's or NHS green plan. It identifies areas for improvement and develops a plan to increase sustainability in line with principles of sustainable services (prevention, service user empowerment, maximising value/minimising waste and low carbon interventions). *Guidance: Progress against this improvement plan is reviewed at least quarterly with the team.*	[1]
124	1	The service collects data on the safe prescription of high-risk medication such as lithium, high dose antipsychotic drugs, antipsychotics in combination and benzodiazepines. The service uses this data to make improvements and continues to monitor the safe prescription of these medications on an on-going basis.	[2]
125	2	The service's clinical outcome data are reviewed at least every six months. The data is shared with ICB, the team, patients and carers, and used to make improvements to the service.	[1]
126	2	The service meets with stakeholders regularly to consider topics such as service developments, joint working and population health. *Guidance: Stakeholders could include staff representatives from inpatient, local community and primary care teams, third sector organisations, mental health ICB representatives and lived experience representatives.*	[3]

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