COLLEGE CENTRE FOR QUALITY IMPROVEMENT

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Accreditation for Community Mental Health Services (ACOMHS)

Standards for Adult Community Mental Health Services
Second Edition

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January 2020
Publication number: CCQI 329

Accreditation for Community Mental Health Services (ACOMHS)

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Publication number: CCQI 329

Revision date: 2022

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Artwork displayed on front cover created by Prisha Shah

Foreword

Community mental health services remain the centre piece of mental health services with ACOHMS underpinning continuous quality improvement leading to the delivery of high-quality compassionate care. The first edition of the ACOMHS standards were published in 2016 and this second edition reflects changes in national clinical standards and the harmonising of standards across accreditation schemes through the integration of the College Centre for Quality Improvement (CCQI) Core Community Standards. The standards are in line with the NHS England & National Collaborating Centre for Mental Health Community Mental Health Framework for Adults & Older Adults, which will be rolled out to services over the coming years alongside investment. The standards aim to support the challenge that change brings to front line services.

ACOHMS standards are designed to fit the wide range of community teams that exist, and the standards have been developed alongside ACOMHS member services and the ACOMHS Advisory Group which includes professionals, service users and carers. The standards measure markers associated with highly effective community mental health teams. For accredited teams ACOHMS is an important test and subsequent recognition of the quality of their service.

I welcome the publication of the second edition standards and on behalf of the Advisory Group would like to thank those involved in the consultations and the Royal College of Psychiatrists' ACOMHS Team for all their work in revising the standards.

Norman Young
Chair of ACOMHS Accreditation Committee & Advisory Group
January 2020

Introduction

Accreditation for Community Mental Health Services (ACOMHS) has been in existence since 2016 and these standards have been developed for the purpose of the review of all models of community mental health services. They can also be used as a guide for new and developing services.

The standards have been drawn from key documents and expert consensus and have been subject to extensive consultation via our standards development group, which includes patients & carers, and email forums with professional groups involved in the provision of community mental health teams. They incorporate the College Centre for Quality Improvement (CCQI) Core Community Standards, as well as specialist standards relating specifically to community mental health teams.

The standards cover the follow topics:

- Access and assessment
- Care planning and treatment
- Working with other services and discharge
- Patient and carer experience
- Environment and facilities
- Governance

Who are these standards for?

These standards are designed to be applicable to community mental health services for working age adults 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 community mental health services differ widely in their configuration and the models used, these standards focus on the function of a team in order to make them as widely accessible as possible.

Categorisation of standards

To support in their use during the process, each standard has been categorised as follows:

- **Type 1:** Criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment;
- **Type 2:** Criteria that a service would be expected to meet;
- **Type 3:** Criteria that are desirable for a service to meet, or criteria that are not the direct responsibility of the service.

Notation

College Centre for Quality Improvement (CCQI) Core Community Standards are marked with the core standard number throughout the document. Those that are not marked with a core number are specialist standards relating to community mental health services that are not included in the core set.

Terms used in this document

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

References

Please see the list at the end of this document for full references. These are referred to by the number in square brackets in the 'ref.' column throughout the document.

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

Standards for Adult Community Mental Health Services

Access and assessment

No.	Type	Standard	Ref
Access, referral and waiting times			
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. *Core 1.1*	[1] [4]
2	1	The service provides information about how to make a referral and waiting times for assessment and treatment. *Core 1.3*	[1]
3	1	A clinical member of staff is available to discuss emergency referrals during working hours. *Core 1.4*	[1]
4	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. *Core 1.5*	[1]
5	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 alternative options.	[19]
6	1	Acceptance to the service is based on need and risk; the service does not use specific 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 disorders. *Guidance: Self-harm, substance misuse, social background, criminal history, learning disability or personality disorder are not barriers to acceptance by the service.*	[3]
7	2	If a patient is unable to attend appointments for assessment and treatment due to specific behaviour relating to their mental health (such as obsessive behaviour and other fears) or their physical health, arrangements can be made to conduct these at a patients' home, if necessary.	[10] [15]

8	2	New patients receive an assessment within 4 weeks of referral. *Guidance: If the service sees people with suspected psychosis, they are assessed within 2 weeks of referral.*	[3] [4]
9	3	Everyone can access the service using public transport or transport provided by the service. *Core 1.2*	[1]
Preparing for the assessment			
10	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 if they have difficulty in getting there). *Core 2.1*	[1]
11	1	Patients are given accessible written information which staff members talk through with them. The information includes: • Their rights and 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. *Core 2.2*	[1]
12	2	Patients are provided with information and choice about their assessment and appointments. *Guidance: This includes choice of time, day, venue, gender of staff or access in another language.*	[10]
Initial assessment			
13	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.* *Core 3.1*	[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; • Suicide risk. *Core 3.2*	[1]
15	1	A physical health review takes place as part of the initial assessment, or as soon as possible. *Core 3.3*	[1] [5]
16	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. *Core 3.4*	[1]
17	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. *Core 3.5*	[1]
18	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. *Core 3.6*	[1]
19	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. *Core 16.1*	[1]
20	1	Patients are asked if they and their carers wish to have copies of correspondence about their health and treatment. *Core 15.1*	[1]
Capacity and consent			
21	1	Assessments of patients' capacity (and competency for patients under the age of 16) to consent to care and treatment are performed in accordance with current legislation. *Core 11.1*	[1]

22	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.*	[11]
Following up patients who do not attend appointments			
23	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. *Core 4.1*	[1]
24	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.* *Core 4.2*	[1]

Care planning and treatment

Reviews and care planning			
25	1	Patients know who is co-ordinating their care and how to contact them if they have any questions. *Core 5.1*	[1] [3]
26	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.* *Core 5.2*	[1]

27	1	Every patient has a written care plan, reflecting their individual needs. Staff members actively seek to collaborate with patients and their carers (with patient consent) when developing the care plan. *Guidance: The care plan clearly outlines:* • *Agreed intervention strategies for physical and mental health;* • *Measurable goals and outcomes;* • *Strategies for self-management;* • *Any advance decisions or stated wishes that the patient has made;* • *Crisis and contingency plans;* • *Review dates and discharge framework.* *Core 5.3*	[1] [3]
28	1	The team knows how to respond to carers when the patient does not consent to their involvement. *Core 16.3*	[1]
Care and treatment – therapies and activities			
29	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. *Core 6.1.1*	[1] [2] [3]
30	1	Patients' preferences are taken into account during the selection of medication, therapies and activities, and are acted upon as far as possible.	[10] [14]
31	1	There is dedicated sessional time from psychologists to: • Provide assessment and formulation of patients' psychological needs; • Ensure the safe and effective provision of evidence based psychological interventions adapted to patients' needs through a defined pathway. *Core 6.1.2*	[1]
32	2	There is dedicated sessional time from psychologists to support a whole team approach for psychological management. *Core 6.1.3*	[1]
33	1	There is dedicated sessional input from occupational therapists to: • Provide an occupational assessment for those patients who require it; • Ensure the safe and effective provision of evidence based occupational interventions adapted to patients' needs. *Core 6.1.4*	[1]

34	3	There is dedicated sessional input from creative therapists. *Core 6.1.5*	[1]
35	2	The service is able to provide care to people with a personality disorder, or signpost/refer them on for care. *Guidance: Care for patients with a personality disorder is provided in a team approach with a consistent clinical model and good understanding of this group.*	[3]
36	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 programmes such as Individual Placement & Support (IPS) or pre-vocational training.* *Core 6.1.6*	[1] [3]
37	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.* *Core 6.1.7*	[1]
38	1	The team supports patients to undertake activities to support them to build their social and community networks. *Core 6.1.8*	[1] [3]
39	1	All staff members who deliver therapies and activities are appropriately trained and supervised. *Core 6.1.9*	[1]
40	3	The service makes use of digital technologies as an additional resource to support patients' care. *Guidance: This could include self-management apps, digital consultations and digital enabled models of therapy.*	[3] [4]
Care and treatment – medication			

41	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. *Core 6.2.1*	[1]
42	1	Patients have their medication 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.* *Core 6.2.2*	[1]
43	3	Patients, carers and prescribers can contact a specialist pharmacist to discuss medications. *Core 6.2.3*	[1]
44	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. *Core 6.2.4*	[1]
45	1	The service collects data on the safe prescription of high-risk medication such as; lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines. The service uses this data to make improvements and continues to monitor the safe prescription of these medications on an on-going basis.	[16]
Care and treatment – physical healthcare			
46	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. *Core 7.1*	[1] [5]
47	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. *Core 7.2*	[1]

48	1	The team including bank and agency staff are able to identify and manage an acute physical health emergency. *Core 7.3*	[1]
49	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. *Core 7.4*	[1]
Risk and safeguarding			
50	1	The team records which patients are responsible for the care of children and vulnerable adults and takes appropriate safeguarding action when necessary. *Core 8.1*	[1]

Working with other services and discharge

No.	Type	Standard	Ref
Discharge planning and transfer of care			
51	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. *Core 9.1*	[1]
52	2	There are agreements with other agencies for patients to re-access the service if needed, without following the initial referral pathway. *Guidance: There may be exceptions where patients require a generic assessment and it may be appropriate to follow the initial referral pathway.*	[3] [17]

53	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; • Contacting the relevant agencies to notify them of the discharge.	[19]
54	1	The community team makes sure that patients who are discharged from hospital are followed up within 3 days. If the person has identified suicide risk, follow up is done within 48 hours. Guidance: *The exact timing will depend on clinical need and there is a policy in place to manage situations where this does not happen.* *Core 9.2*	[1] [2]
55	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. *Guidance: This also includes patients not being discharged until they are accepted by the new team.* *Core 9.3*	[1]
56	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. *Core 9.4*	[1]
57	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. *Core 9.5*	[1] [3]
Interface with other services			
58	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.* *Core 10.1*	[1]

59	1	The team supports patients to access: • Housing support; • Support with finances, benefits and debt management; • Social services. *Core 10.2*	[1] [3]
60	2	The service supports patients to access voluntary, community and social enterprise (VCSE) organisations, as well as community assets. *Guidance: These community assets may include services such as libraries, leisure centres, art & music venues, community centres.*	[3] [4]
61	1	The service/organisation has a care pathway for the care of women 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/unit unless there is a specific reason not to do so. *Core 10.3*	[1]
62	1	The service has a policy for the care of patients with dual diagnosis of mental health problems and alcohol or substance misuse that includes: • Liaison and shared protocols between mental health and substance misuse services to enable joint working; • 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.	[3] [12]
63	1	The service has a physical health care pathway with clearly identified and agreed responsibilities with primary care. *Guidance: This could include the agreed use of the Lester UK Adaptation of the positive cardiometabolic health resource, Rethink integrated physical healthcare pathway and NICE guidelines on physical healthcare.*	[13] [17]
64	1	The team follows a joint working protocol/care pathway with the Home Treatment/Crisis Resolution Team, in services that have access to one. *Guidance: This includes joint care reviews and jointly organising admissions to hospital for patients in crisis.*	[13]

65	3	The team has a healthcare pathway with links to regional and national highly specialist services for obsessive-compulsive disorder (OCD).	[15]
66	1	The team follows an agreed protocol with local police, which ensures effective liaison on incidents of criminal activity/harassment/violence.	[19]
67	3	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.*	[8]
68	3	The service has a meeting, at least annually, with all stakeholders to consider topics such as referrals, service developments, issues of concern and to re-affirm good practice. *Guidance: Stakeholders could include staff member representatives from inpatient, community and primary care teams as well as patient and carer representatives.*	[19]

Patient and carer experience

No.	Type	Standard	Ref
Treating patients with compassion, dignity and respect			
69	1	Staff members treat patients and carers with compassion, dignity and respect. *Core 14.1*	[1]
70	1	Patients feel listened to and understood by staff members. *Core 14.2*	[1]

71	1	The service can demonstrate that it promotes culturally and spiritually sensitive practice.	[6] [10]
72	1	Staff members are knowledgeable about, and sensitive to, the mental health need of patients from minority or hard-to-reach groups. This may include: • Black, Asian and minority ethnic groups; • Asylum seekers or refugees; • Lesbian, gay, bisexual or transgender people; • Travellers.	[3] [6] [10]
73	1	Information for patients and carers is written simply and clearly and can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to use formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary.	[18]
74	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. *Core 15.2*	[1]
Patient involvement			
75	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. *Core 12.1*	[1]
76	2	Services are developed in partnership with appropriately experienced patients and carers who have an active role in decision making. *Core 12.2*	[1] [3]
77	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. *Core 12.3*	[1] [14]
Carer engagement and support			

78	1	Carers (with patient consent) are involved in discussions and decisions about the patient's care, treatment and discharge planning. *Core 13.1*	[1] [7]
79	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.* *Core 13.2*	[1] [7]
80	1	Carers are offered individual time with staff members to discuss concerns, family history and their own needs. *Guidance: The team utilise the Triangle of Care audit tool for discussions.* *Core 13.3*	[1] [7]
81	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.* *Core 13.4*	[1] [7]
82	3	The service actively encourages carers to attend carer support networks or groups. There is a designated staff member to support carers. *Core 13.5*	[1] [7]
83	3	There is an assessment for family work and education as part of the patient's treatment, where appropriate.	[7] [15]

Environment and facilities

No.	Type	Standard	Ref
Service environment			
84	2	The environment is clean comfortable and welcoming. *Core 17.1*	[1]
85	1	Clinical rooms are private, and conversations cannot be overheard. *Core 17.2*	[1]
86	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.* *Core 17.3*	[1]
87	1	Staff members follow a lone working policy and feel safe when conducting home visits. *Core 17.4*	[1]
88	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. *Core 17.5*	[1]
89	2	There are sufficient IT resources (e.g. computer terminals) to provide all practitioners with easy access to key information e.g. information about services, conditions and treatment, patient records, clinical outcome and service performance measurements.	[9]
90	1	An audit of environmental risk is conducted annually, and a risk management strategy is agreed.	[9]
91	1	A collective response to alarm calls and fire drills is agreed before incidents occur. This is rehearsed at least 6 monthly.	[19]
92	1	Emergency medical resuscitation equipment, as required by trust/organisation guidelines, is available within three minutes and is maintained and checked weekly, and after each use.	[19]

Staffing and training

No.	Type	Standard	Ref
Staffing levels			
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 patient population. The team includes:			
93	1	Consultant Psychiatrist(s)	[3] [6]
94	1	Registered Mental Health Nurse(s)	[3] [6]
95	1	Occupational Therapist(s)	[3] [6]
96	1	Psychologist(s)	[3] [6]
97	1	Service lead	[19]
98	2	Social Worker(s)	[6]
99	2	Support Worker(s) *Guidance: An unqualified professional, e.g. healthcare assistant, occupational therapy assistant, psychology assistant etc.*	[6]
100	2	GP Link Worker(s)	[3]
101	3	Pharmacist(s)	[19]
102	2	Employment Advisor(s)	[3]
103	2	Peer Support Worker(s) *Guidance: A patient or carer employed by the team to support other patients and/or carers.*	[10]

104	2	Welfare and Benefits Advisor(s)	[19]
105	2	Administrative assistance to meet the needs of the service.	[6]
106	3	Full-time care co-ordinators have a caseload of no more than 35 (reduced pro-rata for part-time staff).	[6]
107	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. *Guidance: Some services may have an agreement with a local GP to provide this medical cover.* *Core 19.3*	[1] [2]
108	2	There has been a review of the staff members and skill mix of the team within the past 12 months. This is to identify any gaps in the team and to develop a balanced workforce which meets the needs of the service.	[13]
109	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. *Core 19.1*	[1]
110	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. *Core 19.2*	[1]
Staff recruitment, induction and supervision			
111	2	Appropriately experienced patient or carer representatives are involved in the interview process for recruiting staff members. *Core 20.1*	[1]

112	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.* *Core 20.2*	[1]
113	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.* *Core 20.3*	[1]
114	2	All staff members receive line management supervision at least monthly. *Core 20.4*	[1]
115	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. *Core 18.1*	[1]
116	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. *Core 18.2*	[1]
117	2	The team has protected time for team building and discussing service development at least once a year, at a minimum.	[13]
Staff wellbeing			
118	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.* *Core 21.1*	[1]

119	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.* *Core 21.2*	[1]
120	1	Staff members, patients and carers who are affected by a serious incident are offered post incident support. *Core 21.3*	[1]
Staff training			
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:			
121	1	The use of legal frameworks, such as the Mental Health Act (or equivalent) and the Mental Capacity Act (or equivalent); 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;* 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.* Recognising and communicating with patients with cognitive impairment or learning disabilities; Statutory and mandatory training. *Guidance: This includes equality and diversity, information governance and basic life support.* *Core 21.1 a,b,c,d,e & f*	[1]
122	1	All staff have received up to date training on medication as required by their role. *Guidance: This includes storage, administration, legal issues, encouraging concordance and awareness of side effects.*	[19]

123	2	Staff have received training on carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality. *Core 22.1g*	[1]
124	2	Experts by experience are involved in delivering and developing staff training face-to-face. *Core 22.2*	[1]
125	2	The team includes staff members who are trained in a range of evidence-based therapies. *Guidance: This could include Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Exposure Response Prevention Therapy (ERP).*	[3] [15]
126	3	Shared in-house multi-disciplinary team training, education and practice development activities occur in the service at least every 3 months.	[19]

Governance

No.	Type	Standard	Ref
Clinical outcome measurement			
127	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. *Core 23.1*	[1]
128	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. *Core 23.2*	[1]
129	2	The service's clinical outcome data are reviewed at least every six months. The data is shared with commissioners, the team, service users and carers, and used to make improvements to the service. *Core 23.3*	[1]

Audit and service evaluation			
130	2	A range of local and multi-centre clinical audits is conducted which include the use of evidence-based treatments, as a minimum.	[13]
131	3	The service has audited the provision of carer education and support programmes in the last 3 years.	[19]
Governance			
132	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.* *Core 16.4*	[1]
133	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this. *Core 24.1*	[1]
134	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. *Core 24.2*	[1]
135	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. *Core 24.3*	[1]
136	2	The team use quality improvement methods to implement service improvements. *Core 24.4*	[1]
137	2	The team actively encourage service users and carers to be involved in QI initiatives. *Core 24.5*	[1]

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