Livewell Southwest

Community Mental Health Team Operational Policy

Version 1
Review: October 2019

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

Author: **Professional Lead and CMHT Managers**

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Reader Information

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	2003 Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework 2006 Reaching Out: An action plan on social exclusion 2007 Mental Health Act 2009 The Personality Disorder Knowledge and Understanding Framework 2009 The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system National Institute for Health and Clinical Excellence (NICE) (2009a) *Antisocial Personality Disorder Treatment, Management and Prevention*, clinical guideline 77. National Institute for Mental Health in England (NIMHE) (2003a) Personality Disorder: No longer a diagnosis of exclusion – Policy implementation guidance for the development of services for people with personality disorder. NIMHE (2003b) Breaking the Cycle of Rejection. The Personality Disorder Capabilities Framework. NSF Policy Implementation Guide :- Assertive Outreach, Crisis Resolution and Home Treatment and Acute care Refocusing the Care Programme Approach DH 2008 Star wards: http://www.starwards.org.uk/ Productive mental health ward: http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_mental_health_ward.html NHS Outcomes Framework Adult Social Care Outcomes Framework A Recipe for Care - Not a Single Ingredient (Department of Health 2007) Age Equality (CSIP – 2007) Department of Health (2001, March). *The Mental Health Policy Implementation Guide* Department of Health (2006, April). *From values to action: The Chief Nursing Officer's review of mental health nursing* Institute for Innovation and Improvement: *Delivering Quality & Value Focus on Acute Admissions in Adult Mental Health* Department of Health and CSIP (2007, January) *Guidance Statement on Fidelity and Best Practice for Crisis Services* Everybody's Business (*Integrated Mental Health Services for older adults: a service development guide* published by

	Care Services Improvement Partnership, November 2005) Healthcare Commission (2007). *The Pathway to Recovery* Mental Health Services Mapping work and the DH Situation Reports (SITREPS) on delayed discharges. Social Care Institute for Excellence (2007). *Dignity in Care Campaign* Virtual Ward website at www.virtualward.org.uk: *Acute Care Pathway Discussion Paper* Emotional Wellbeing: Cases for change http://www.emotionalwellbeing.southcentral.nhs.uk/component/content/article/6-resources/367-mental-health-commissioning-pack Health and Safety at Work Act 1974 JCPMH Community Specialist Mental Health Services commissioning guide 2015 • CG22 (amended) - Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care • CG90 and 91 - Depression (update of CG23) • CG26 - Post-traumatic stress disorder (PTSD). • CG31 - Obsessive-compulsive disorder • CG38 – Bipolar Disorder • CG82 – Schizophrenia • CG78 – Borderline Personality Disorder
Associated documentation	LSW Line Management and Appraisal Policy LSW Caseload Management & Guidance CPA Policy Record Keeping Policy SystmOne Policy Lone working Policy Clinical Risk Assessment and Management- Best Practice Guidance". Depot Policy
Supersedes Document	New policy
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Document Review History

Version no.	Type of change	Date	Originator of change	Description of change
0:1	New document	Sept 2016	Professional Lead	New Policy
0.2	First comments	Sept 2016	Professional Lead	First comments included and recirculated
0.3	2nd Comments	Oct 2016	Professional Lead	Following redraft, to be circulated across MH.
0.4	Final Comments	17th October 2016	Professional Lead	
1	Ratified	2nd November 2016	PRG	(Ratified in principle – to go to January 2017 PRG)

Contents		Page

Community Mental Health Team Operational Policy

1 Introduction

1.1 This document provides a comprehensive and clear framework for the operational processes in relation to the Community Mental Health Teams (CMHT) within Plymouth. It is based upon the key service criteria identified within the Service Specification.

2 Purpose

2.1 The Policy is designed to provide information on the role and function of CMHT's giving guidance to referrers and those using services.

2.2 The teams covering each locality are linked to specific groups of General Practitioner (G.P.) Practices.

2.3 Each team needs to ensure that the service can deliver a bio-psycho-social model of mental health treatment and care and generally consists of: Psychiatrists and Community Mental Health Nurses (CMHNs), Occupational Therapists, Clinical Psychologists, Community Support Workers and Administration Staff. Students of various disciplines will often become temporary team members during placements but are supernumerary and will offer different experiences to the Individuals using services dependent on competence, confidence and training level.

2.4 We work collaboratively with those who use our services to meet their optimum functioning that is often referred to as recovery.

3 Definitions:

Advance Decision – a legally binding decision to refuse specified treatment made in advance by a person who has capacity to do so, to be applied at a future time.

Advance Statement of Wishes – a statement about the care someone would like to receive. This is not a legally binding statement however, if presented, should be recorded and consequential actions noted.

AOS – Assertive Outreach Service.

CAMHS – Child and Adolescent Mental Health Services.

Care Coordinator – the professional who, irrespective of their professional role, has responsibility for coordinating care, keeping in touch with the individual, ensuring the care plan is delivered and reviewed as required where the individual is being cared for under the Care Programme Approach (CPA) process.

Care Plan Evaluation – evaluating the current care plan (this is not a formal

CPA review).

Carer – someone who provides voluntary or paid for care by looking after and assisting a family member, friend, neighbour or employed under direct payments who requires support because of their mental health needs, and may or may not live with the person cared for. This does not include health and social care professionals, private agencies or 3rd sector carers.

CMHN – Community Mental Health Nurse - someone who works in the CMHT, maybe a Care Coordinator.

CMHT – Community Mental Health Team – a multi-disciplinary team supporting someone in the community.

CPA – Care Programme Approach – National overarching framework for providing mental health Care.

DNA – Did Not Attend.

DRSS – **Devon Referral Support Services** - The DRSS team provides referral support to GP practices and will facilitate the onward referral to providers by contacting the person to offer a choice of appointment dates and times via the E-Referral electronic referral system.

GP – General Practitioner.

HoNOS Health of the Nation Outcome Scales a National Measure of Recovery.

iAPT – Improving Access to Psychological Therapies based at Centre Court.

Lead Professional – The person who has lead responsibility for an individual's treatment and care where that person is being cared for under the Standard Care process. Where a clinician is the only person involved in the Individuals care then that person will be the lead professional.

LSW - Livewell Southwest.

MH – Mental Health.

MDT – Multi Disciplinary Team.

OPMH – Older Persons Mental Health.

PLN – Psychiatric Liaison Nurse.

Recovery – 'Recovery does not simply mean the absence of symptoms but refers to the process whereby a person gains more control in order to establish a meaningful and fulfilling life' (Kilbride & Pitt 2006).

RC – Responsible Clinician.

SEDCAS – Specialist Eating Disorders Assessment Service.

Standard Care – treatment and care provided for those whose needs do not require the support of CPA.

Step-down – when a person requires a lower level or no intervention from LSW.

Step-up – when a person requires a higher level of intervention from LSW.

STORM ® **Suicide** Prevention and Self-harm Mitigation Training - developing the skills needed to help a person at **risk** of **suicide** or self-harm to stay safe.

S1 / SystmOne – electronic health record in use within Livewell Southwest.

TAG - Threshold Assessment Grid - Risk Assessment Tool.

Youth Enquiry Service / The Zone - Other Commissioned provider - 2 services sit within The Zone - **Insight** which is an **Early Intervention Service for Psychosis** and **Icebreak the Team** working with young people experiencing **severe Emotional Distress.**

3rd Sector – voluntary sector agencies who are contracted to deliver a service to an individual or groups of individuals.

4 Duties and Responsibilities:

4.1 This Policy was devised by the Senior Management Team, Team Leaders and CMHT staff.

4.2 The **Chief Executive** is ultimately responsible for the content of all Policies and their implementation.

4.3 **Directors** are responsible for identifying, producing and implementing Livewell Southwest (LSW) Policies relevant to their area.

4.4 The **Locality Manager** and **Deputy Locality Managers** will support and enable individual operational Clinical Team Leaders and their teams to fulfil their responsibilities and ensure the effective implementation of this Policy within their specialty.

4.5 The **Modern Matron** and **Team Managers** are responsible for ensuring that the development of local procedures / documentation doesn't duplicate work and that implementation is achievable. As well as promoting strong operational leadership and safe systems of work, ensuring all staff within their responsibility is aware of the policy and the practice implications.

4.6 **Clinical staff members** have a responsibility for ensuring they have read understood and adhere to local Protocols and Policies pertaining to their practice and work.

5 Objectives and Service Philosophy of the CMHT:

5.1 Objectives:

5.1.1 The service forms an integral part of a continuum of support for people with mental health needs. The service will not meet all the needs of people with complex mental health conditions, the service will need to work in partnership or signpost to other services such as employment, housing, or community opportunities.

5.1.2 The service will work with individuals in a Recovery focus model with clearly defined expectations and timeframes.

- Provide evidence-based specialist interventions and treatment for Individuals with severe mental health problems, which reduce the considerable disruption and distress in their lives.
- Work with Individuals to manage their own mental health and maintain or regain maximum independence.
- Promote individuals social inclusion, including facilitating return to and to remain in employment, using support from other agencies or community networks.
- Work with Individuals and their support networks in understanding, reducing and managing risks.
- Ensure comprehensive care planning for all Individuals.
- Focus on recovery to get people back into work, education and 'life' as soon as is practicable and avoid the need for lengthy and expensive treatment in Mental Health Services.
- Liaise closely with primary care provision and the other Mental Health Teams, in providing the most appropriate level of intervention for an individual.
- Provide support and consultancy to other mental health professionals to assist with diagnosis, specialist treatment approaches and diagnostic formulation.
- The service will achieve effective engagement and treatment for Individuals with complex and multiple mental health **and** substance misuse needs. Where people have a dual diagnosis, partnership working with substance misuse services will be developed. Where individuals have engaged successfully with other agencies e.g. Substance misuse, but do not wish to engage with Mental health services it may be appropriate for those substance misuse services to remain lead agency but any mental health service will provide support and advice as appropriate.

5.2 Service Philosophy

- The CMHT will provide interventions with an emphasis on recovery, self - management and person centred approaches. CMHT work will be multidisciplinary and based upon a bio – psycho – social mode, with care plans developed to enable individuals to reach maximum potential.

- The CMHT will work in a solution focused way; focusing on the individual's strengths, working towards clear solutions for mutually defined problems.

- Users of the service can expect to be treated with dignity and respect.

- People who use services can expect to be actively involved and consulted on all elements of their involvement with the service and to have a Care Plan based on their individual needs, evidenced through assessment and ongoing review.

- Individuals can expect care that is person centred, and which does not discriminate against their culture, ethnicity, gender, age, sexuality, religion and / or disability.

- Each individual's involvement with the service should encourage independence, self-esteem and personal choice. The focus will be to build on existing strengths & assets.

  Staff members are expected to act in the best interests of users of the service in line with Professional Codes of Conduct, Organisation Policies, Protocols and Guidance.

- People who use services should expect to be listened to, and to have any concerns taken seriously and addressed promptly.

- People who use services have a right to privacy and confidentiality.

- People who use services have the right to request help and support for their relatives and carers, and for them to be involved in their care.

- Users of the service can expect to be fully involved in their movement through the service depending on assessed need, up to date clinical guidance and be involved in planning their discharge from the service when appropriate and mutually agreed goals have been met.

- CMHTs will provide a range of multidisciplinary mental health treatments and input, based on evidence based practice and practice based evidence.

- For those using services the ultimate aim of referral must be to achieve significant enough symptomatic mental health improvement and improvements in their own mental health management so that Individuals can make meaningful improvements on their daily living, and be able to manage their mental health under the care of their GP.

- Provide the opportunity for GP's and the CMHTs to have face-to-face discussions about individuals who may have needs in relation to their mental health, but who may not directly need CMHT services.

- To work collaboratively in delivering mental health care under any 'integrated care pathways within Primary Care Teams.

- Provide a suitable and nurturing training and learning environment for students, mental health professionals and colleagues.

5.3 Days / Hours of operation:

Core Operational Hours are currently 9 - 5 Monday – Friday, excluding Bank Holidays.

Outside of this time, LSW and other providers of mental health care have a continuum of services available 24/7, 365 days a year. These services include Home Treatment on call, Out of Hours, 111, Devon Doctors and Mental Health Matters.

All those on caseload within the CMHT will have a care-plan including crisis and contingency plans available to them, this is individualised and contains essential crisis information enabling effective management and guidance for other services out of hours. This must be offered to the individual Individuals but also recorded within the electronic health record. Where appropriate this plan will be shared with other services / carers.

- All practitioners will ensure that they are contactable during the routine working day. Mobile phones are made available for staff.

- Contact numbers must be maintained within the Locality base and distributed to all CMHT colleagues.

5.3.1 Duty

The purpose of the duty worker and duty function is to provide a short term response to the individuals on caseload or awaiting allocation for a Care Coordinator following assessment by the team.

For those on caseload or awaiting allocation; this function may be in response to a crisis for the individual or to provide short term, time limited planned support outside regular contacts. Normally the first point of contact for individuals on caseloads should be the Care Coordinator / Lead Professional.

The final function of Duty work is to provide a point of contact for the receipt of urgent referrals.

Each CMHT will have a nominated duty worker available on a daily basis, for the agreed timeframe that duty is available. It is good practice for this person to be free of routine commitments and to carry a mobile phone should they need to leave the team base.

The remit of the Duty role is covered within the CMHT induction.

6 Locally Defined Outcomes:

No Health Without Mental Health sets out a clear and compelling vision, centred around six objectives:

More people have better mental health	Patient Reported Outcome Measures. Data collection and dissemination of results of Health Of The Nation Outcome Scale (HoNOS).
More people will recover	Increase proportion of Individuals of working age retaining employment & if not currently working returning to work and/or meaningful activity. Increase proportion of people with mental illness or disability in settled accommodation (e.g. measured using HoNOS scale). Increase the proportion of people who use services who have control over their daily life.
Better physical health	Reduce excess under 75 mortality rates in adults with severe mental illness by implementing strategy with primary care and acute services to measure SMIs and improve outcomes.
Positive experience of care and support	Improve patient experience by increasing patient satisfaction and increasing those that report feeling safe and secure and managing their own condition (using CQC Patient Survey, NHS Survey). Improve carer quality of life by increasing carer satisfaction (using Carer Survey, NHS Survey).
Fewer people suffer avoidable harm	Reduction in safety incidents involving severe harm or death (e.g. suicide and undetermined deaths measured over 3-5 year cycles) through strategy to ensure prompt (negotiable – e.g. within 45 days) critical incident review and feedback to staff involved with regular collation and consideration by clinical governance structures. Provide right treatment at right time in line with the evidence base.
Fewer people experience stigma and discrimination	

Each objective in the Implementation Framework is relevant to secondary mental health services although some will be held jointly with primary health care and public health especially physical health care, early intervention, de-stigmatisation and suicide prevention.

NHS Outcomes framework Domains and Indicators

Domain 1	Preventing people from dying prematurely • Reducing premature death in people with serious mental illness	✓
Domain 2	Enhancing quality of life for people with long-term conditions • Ensuring people feel supported to manage their	✓

	condition • Enhancing the quality of life for people with mental illness	
Domain 3	Helping people to recover from episodes of ill-health or following injury • Improving outcomes form planned treatment • Improving outcomes form injuries or trauma	✓
Domain 4	Ensuring people have a positive experience of care • Friends and family test • Improving peoples experience of outpatient care • Improving access to primary care services • Improving experiences of healthcare for people with mental illness	✓
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm • Patient safety incidents reported • Reducing incidence of avoidable harm	✓

7 Key Working Relationships:

External	Internal
Carers services	Perinatal mental health pathway
Community Eating Disorder Service	SEDCAS
Custody & Courts Diversion & Liaison services	Plymouth Options / Psychotherapy services
Employment services	Asylum Seekers and Refugee Service
GP's and primary care	Glenbourne Inpatient Unit
Local Authority services e.g. social care, AMHP's, housing etc. either provided directly or commissioned by them.	Personality Disorder pathway
Other third sector providers	Recovery Services
Probation Services	CAMHs
Psychiatric intensive care services	Home Treatment Team
Street Triage Services	Community Forensic Team
Substance misuse services	Acute Psychiatric Liaison
Youth Enquiry Service (The Zone) - Insight and Icebreak Services	Out of hours phone support line (currently Mental Health Matters)
	Assertive Outreach Service
	Older Peoples Mental Health Service
	Learning Disabilities
	Other CMHT's

8 Referral, Inclusion Criteria and Transfers into Service:

8.1 Acceptance/Referral Criteria:

See Appendix One

Referrers must indicate on the referral the following:

Those with a Plymouth address or registered to Plymouth based GP including satellite surgeries. Where a practice has surgeries in Devon and Plymouth only patients registered at the Plymouth surgery will be included; for practical purposes this may be those people whose notes are located at a Plymouth surgery.

A clear purpose for acceptance to the CMHT services with an indication of likely length of engagement, if possible, with the CMHT and any outcomes anticipated from the outset should be included on the referral.

In general people 18 years of age or over should be referred to the CMHT and have substantial and complex mental health requirements. Substantial and complex are clinical judgements, but should include a composite consideration of instability, risk, severity and complexity.

The main route for referrals to CMHT's is from General Practitioners. Referrals will be made via the Devon Referral Support Service (DRSS). However other services may refer straight to the CMHT. This may include Street Triage and Court Diversion, Approved Mental Health Practitioners involved in MHA assessments. Psychiatric Liaison (Adult), Inpatient and HTT services, Asylum Seekers and Refugee Service, Community Forensic Team, Assertive Outreach, between CMHT's, Insight, Icebreak, Complex needs Team (Harbour), CAMHS, Police.

Referrals rejected by other services are not automatically accepted by the CMHT's as a default.

CMHT's do not accept self-referrals.

Intended users of the secondary care mental health CMHT specialist pathway will have multiple, complex needs including any of the following:

- A clinically diagnosable mental health problem, and;
- Significant risk of persistent self-harm or neglect;
- Poor response to previous treatment;
- Dual diagnosis of substance misuse **and serious mental illness**;
- Dual diagnosis of learning disability or Autism **and serious mental illness**;
- Detained under Mental Health Act (1983) on at least one occasion in the past 2 years and have a serious mental health problem.
- Unstable accommodation or homelessness **with a serious mental illness**
- Perinatal or Maternal mental health issues;
- Unresolved Difficulties including those related to mood, anxiety, abuse and eating disorders;
- Mental health problems exacerbated by personality disorder;
- Complex past history of Abuse, e.g. Sexual, in the context of existing mental health problems;

- Chronic Post Traumatic States (Unresolved);
- Recurring Patterns of Psychological Difficulty.

Additionally the service provides:-

- Autism diagnosis and advice re onward support such as social care assessment.
- ADHD diagnosis and prescribing initiation or at transitions to adulthood where medication review is required; where there are co-morbid mental health issues.
- ADHD Annual Review for on-going medication regimes, **it is the responsibility of the individual's GP to continue prescribing and monitor after initiation and stabilisation**.
- Perinatal advice and support – this may include advice to women who are well but have experienced difficulties in previous pregnancies or who are well on medication; but require a review in order to plan for pregnancy or due to pregnancy.
- Disorders requiring intensive treatments e.g. Psychotherapy, psycho educational interventions, medication management, medication maintenance requiring blood tests or other treatments not available in Primary Health Care Teams.
- Care for those with diagnoses/ disorders requiring bio-psycho-social intervention and multidisciplinary input.

8.2 Inclusion Care Clusters - from Service Specification:

Severe problems can present as 'common mental disorders' (Clusters 4-7) and also psychoses, bipolar disorders (10 and 11, 12-17) & emotional difficulties ('personality disorders') (6-8). See; the Mental Health Clustering Booklet – Guidance on Completion V4.1 here; Policies, PGDs and Protocols

8.3 Level of Urgency:

Referrers must indicate level of urgency for the referral:

- 1 day (Emergency) - referrals can be made directly to the Locality CMHT via the duty number and followed up with an electronic e-referral from the GP via DRSS on the same day.
- 2-7 days (urgent).
- 18 weeks (Routine).

8.4 Priority Access:

- Military veterans – in line with the armed forces covenant.
- Women with maternal mental health problems, severity assessment will need to consider the impact of pregnancy on the M/H condition and potential for rapid change.

8.5 Triage and rejection of referrals:

All referrals will be triaged daily by an appropriately qualified and experienced Clinician within the CMHT's. The clinical decision may involve a change in the

priority originally assigned. This should be recorded clearly in the clinical notes offering a rationale for the clinical decision being made.

Rejected referrals via e-referral should provide a clear summary of why the referral is not suitable for CMHT within 24 hours and where appropriate provide signposting or advice to the referrer.

Rejected 'Emergency' referrals – should be communicated to the referrer on the same day via a telephone conversation.

Referrers are responsible for sending accurate and most up to date biographical information and personal details. Not doing so may lead to delays or the referral cannot be **actionned** and therefore returned to the GP for clarification.

8.6 Transfer of Care

8.6.1 Internal Transfers:

Safe and successful care will be achieved through seamless services across the pathway. It is the responsibility of the team initiating any transfer of care to ensure that case records are available to the receiving team without delay.

Such transfers should not be considered as new referrals, once an individual is considered ready to move on to another part of the pathway of care, then the processes should begin without delay via CPA review / step down to standard care. Best practice indicates that individuals should not "normally" be transferred in a crisis unless it is to a service such as Home Treatment which specialises in crisis care.

When transfer of care to the appropriate CMHT is considered, the following will need to occur:

- It is the responsibility of the referring team to make contact with the receiving team to ensure that the referral is processed.
- The Care Co-ordinator or Lead Professional will then discuss and agree a pathway of care following established practice.
- The transfer of care to the CMHT will adhere to CPA guidelines.
- It will be considered as normal practice for Home Treatment Teams to withdraw intensive input when their short-term intervention period has reached a conclusion. The Home Treatment Team will need to ensure that the appropriate CMHT has actioned the referral and allocated a Care Coordinator.
- The review of care needs at the point of transfer to the CMHT, will determine the level of on-going care required. Discharge from care may result and this is acceptable as long as there is adherence to CPA, the principles of good practice and a rationale for this decision is provided.

8.6.2 Transfers where someone is moving permanently to Plymouth from outside:

Where referrals are from Mental Health services outside of the area but are as a result of the person moving house they should be accepted into services at the appropriate point of treatment pathway. When an individual is already subject to the Mental Health Act e.g. Community Treatment Order with another authority, a formal process for accepting responsibility needs to be followed. Advice should be sought from the Mental Health Act Office.

All Transfers of care should be accompanied by the following clinical Information:

- Recent Risk Assessment;
- Historical Risk Summary;
- Recent Care Plan;
- GP details;
- Full medication Chart;
- Copy of latest CPA Review / Outpatient Letter;

In line with best practice existing Care Coordinators should attend a first outpatient appointment with receiving team whenever possible.

8.6.3 Transfers where someone lives in a neighbouring catchment area but wishes to access Plymouth Services e.g. Saltash / Ivybridge:

All referrals need to be made via the DRSS route to the Lead Consultant who will triage the request and will allocate to the appropriate team. Referral acceptance or rejection will be facilitated by DRSS.

Only Outpatient provision will be available, the service is unable to provide home visits to anyone outside of the Plymouth catchment area. If an individual needs an inpatient admission or HTT care then it is expected this will be provided by their own area team.

8.7 CAMHS → CMHT Transitions:

A transition protocol is in place for movement between services such as CAMH's. The aim should be on a 'case-by-case' approach where younger people are approaching 18yrs. It has been acknowledged that this issue of a lower age limit will need to be reviewed in view of changes in commissioned services. There is no upper age limit, however, a case-by-case approach should be maintained where the most appropriate service/s are identified whilst promoting choice and partnership working.

A nominated CMHT representative will regularly attend the formal transition meetings; to represent all 4 locality teams.

8.8 Essential Referral Information:

The consent of the Individual should be gained prior to any referral to the service.

Referrals need to include the:

- Individual's name
- Gender
- Date of birth
- Full address including postcode and the address to where they are being discharged (if different) and access details e.g. key safe (if applicable)
- NHS number
- Telephone/emergency contact numbers
- Next of kin contact details
- Name/telephone number of the GP practice
- If known already to the CMHT
- Reason for referral indicating diagnosis , including last GP contact
- Name of referring person and contact number
- Previous medical history that is relevant to the person's current needs, to include current medication, allergies and infections
- Any advance decisions and TEP
- Relevant social circumstance(s)
- Any known contraindications to lone visiting and/or safety/risk issues
- Substance misuse issues including alcohol, over the counter and history of substance misuse / treatment
- Physical Health conditions or co-morbidities / complexities

8.9 Referral Information should include the following specific risk prompts

- Risky Behaviours
- Risk of Self-harm / suicide
- Risk to self/others
- Self-neglect and vulnerability

9 Exclusions:

9.1 Exclusion Criteria

This is not a service for holding people with general complexity or holding people who are waiting for other services e.g. Psychotherapy unless they meet CMHT criteria.

Those in care clusters 1, 2, 3 and 9.

Those eligible for Early Intervention Services for personality disorder or Psychosis, namely Icebreak and Insight; currently provided by The Zone. A

transition protocol will be in place for those individuals who need on-going support post the early intervention pathway.

Clients needing psychotherapy only; should be referred to the Psychotherapy service.

The service will not meet the following needs, except in respect of assessing and treating any co-morbid mental health disorder that would ordinarily be the remit of the service anyway:

- Brain damage or other organic disorders including dementia. Referrals which indicate memory difficulty should be screened for causes other than dementia before being referred on to OPMH.
- Anger control and violence without associated mental illness.
- Somatic problems such as chronic fatigue syndrome, chronic pain in the absence of significant presenting anxiety and depression or clear psychological cause.
- Disorders of sexual preference (e.g. paedophilia, fetishism without associated mental illness).
- Significant addictive behaviour i.e. persistent drug or alcohol misuse or gambling in the absence of severe mental illness.
- Eating Disorders* *Where the community eating disorder service identify a level of risk, complexity or ability to engage which are beyond their remit it may be more appropriate that coordination sits with adult mental health team in conjunction EDS or with the severe eating disorder service (SEDCAS).*
- Individuals who meet the criteria of the specialist gender Identity services commissioned by NHS England specialist commissioning.

Where people have the above primary needs but may have a co-morbid mental health need, the service will work cooperatively with the other relevant services in a “dual diagnosis” model to ensure an optimally coordinated service, adhering to the relevant strategy document and policy guidance.

Where there is a clearly identified Dual Diagnosis, then the co-ordination will sit either within the substance misuse service or CMHT depending on clinical need.

Where a referral is deemed ineligible / not meeting inclusion criteria a response will be sent to the referrer indicating reasons for decision, where appropriate sign posting information will be given.

See Appendix One

10 Assessment:

All referrals will be screened and triaged within the Multi-Disciplinary Team within 1 working day for urgent referrals and 2 working days for routine referrals.

Assessment timescales will be as indicated depending on referral priority.

If an assessment appointment is not attended then this should be discussed within the Multi-Disciplinary Team Meeting. The Team should then decide on the following action;

- Check appointment letter was sent.
- Check with GP practice we have the correct address recorded on SystmOne.
- Whether further discussion with referrer is required.
- Whether a further appointment is appropriate.
- Whether an “Opt in” letter is appropriate
- Whether the referral is closed and all appropriate parties informed including the GP.

All discussions and actions must be recorded on SystmOne.

Mental Health Assessments will be undertaken by the appropriate staff member(s), based on the information provided by the referrer and will be used to determine what intervention/action is required.

10.1 In some situations verbal contact with the referrer may be required to obtain further information or clarify issues to be addressed. It may be possible to come to a mutually agreed decision about on-going care without seeing the person who had been referred. In these cases staff must keep a record of this advice, including name and date of birth and NHS number. This must be entered under the individual clinical record. Similar concise records must be made for verbal advice provided when contacted by other professions, e.g. GP Services using the electronic record.

10.2 Following full comprehensive assessment, written feedback will be provided to the referrer and copied to the Individuals if agreed as part of the assessment by medical staff members or by CMHT other staff.

10.3 Assessments of Risk will be undertaken for all individuals at point of contact. As a minimum standard the Threshold Assessment Grid (TAG) must be completed at first face to face contact as per “Clinical Risk Assessment and Management-Best Practice Guidance (2008).

10.4 Decisions regarding the management of care (Standard Care / CPA) will be made based on information gained through the Assessment, Risk Assessment and professional clinical judgement of the assessor in consultation with the Multi-Disciplinary Team.

10.5 Assessments of Individuals under the influence of drugs or alcohol. When an urgent referral is received for someone who is intoxicated in the community, the person receiving the referral must ensure that the referrer makes arrangements in order to keep the individual safe until it is appropriate to carry out an assessment of the individual’s mental health needs.

If appropriate the referrer should be advised to contact an ambulance or the assistance of the police to convey the individual to the Emergency

Department at Derriford.

Best practice determines that it is preferable to carry out an assessment of individual's mental health needs when the individual is free / not under the influence from drugs or alcohol. However, this is not always possible and professional judgement should be used in relation to the timing of any assessments and the capabilities of those using services.

10.6 It is best practice that any non-medical assessments are undertaken by two members of staff particularly if the individual is not known to services, has any history of risky behaviour or there are any other areas of concern. If two members of staff are not available, it may be appropriate to proceed with an assessment but advice must be sought from the professional's line manager before proceeding with the assessment.

11 The service will provide: *See Appendix Five*

Please see Care Programme Approach (CPA) Policy for more specific information on CPA.

Comprehensive Person Centred Holistic CPA Assessment - of those accepted by the service, including the agreement of personal goals (outcomes) and the creation of an individual care plan.

Comprehensive Person Centred Care Plan -
There will be effective, timely (this will be linked to the urgency of referral) and appropriate communication mechanisms between clinicians, teams, agencies and families / carers.

- Care plans will be flexible and accessible to staff and those using services at all times, following person centred and recovery focused approaches.
- Care plans must include details of assessment and be in line with CPA. This will take the form of a full CPA care plan or Statement of Care as identified via the assessment process.
- Care plans will be written in partnership with the individual and where possible families/ carers following Triangle of Care principles. When a full CPA care plan is completed a signed copy will be kept with clinical records. If the client refuses to sign the care plan this should be documented on the care plan.
- Care plans or appropriate parts of care plans must be shared with GP in a timely and appropriate format, carers and any other identified professionals for which it may be beneficial where authority is given.
- Where assessment indicates the need for further intervention either a care plan or statement of care will be formulated in collaboration with the individual.
- Any plan of care must include crisis, contingency and risk management plans or Advanced Statements following "Clinical Risk Assessment and Management- Best Practice Guidance" (available on intranet).

Review frequency should be as recommended under CPA as a minimum or as appropriate to the individual's circumstances. Where PbR review guidance i.e. recommended cluster review period varies from CPA, the shorter review period should be used.

On-going Assessments and Review - including relevant diagnostic monitoring and treatments for those with Long Term Mental Health Problems as required as part of their on-going care-plan.

NHS Continuing Healthcare Assessments – Contribute to CHC assessments, reviews and case manage those on the caseload adopting the best practice principles described within the National Framework for NHS Continuing Healthcare.

Medication - assessment, support and advice to Individuals to safely administer their prescribed medication, enabling the individual to remain well wherever possible.

S117 Reviews – where a person is subject to S117

Mental Health Act provisions: including attendance at tribunals, completion of reports – please see flowchart available on intranet.

Reviews of those who are temporarily placed out of area and facilitate planned supported return.

Physical Health Monitoring – with support from Primary care.

Risk Management Processes - Where indicated.

12 Discharge from Service:

Discharge planning should be included from admission to the service - this must include consideration of what recovery means to the individual, personal and social resources which can support this. The support of the CMHT team is likely to form only a step in this recovery.

Individuals will be discharged from the CMHT when:

- The treatment and care received by the person has achieved the desired outcome(s) set by agreed realistic aims in partnership with themselves.
- They can safely self-manage – where appropriate. All individual where capable will be supported to undertake self-management of their condition and discharged when this is achieved.
- They are transferred to another more appropriate service e.g. Assertive Outreach Service (AOS).
- They move out of area.
- Death.
- They do not fulfil referral criteria following initial assessment.

- They are not willing to engage in a jointly agreed plan of care. In these instances individuals should be referred back to the GP with the offer of a joint meeting to plan the way forward.
- Admission to LSW Inpatient Services other than Glenbourne.

When discharge is agreed:

Professionals should use the CPA review documentation or Standard Care Clinic Letter Template:

- The role (if any) the CMHT has in the longer term recovery plan.
- The point the recovery process will move away from the CMHT.
- How discharge will be facilitated.
- The service should work with individuals, their families / carers where possible and primary care to plan for discharge from services.
- Where appropriate discharge should include contingency planning for the individual re-entering services at need without the need for a re-referral.

12.1 Discharge to another provider – external to Plymouth

An individual may choose to relocate to another area outside of Plymouth for various reasons; if this is the case then robust handover processes should be in place.

Individual areas may have their own specific requirements which will need to be complied with, but broadly speaking the following should be standard minimum practice.

12.2 When discharge is agreed:

Professionals should use the CPA review documentation or Standard Care Clinic Letter Template:

- The role (if any) the new CMHT has in the longer term recovery plan.
- The point the recovery process will move away from the current CMHT.
- How discharge will be facilitated.
- The service should work with individuals, their families/ carers where possible and primary care to plan for discharge from services.
- Where appropriate discharge should include contingency planning for the individual re-entering services without the need for a further referral.
- There should be an up to date care-plan, risk assessment plus consultant letter if on CPA. This should be emailed / faxed to the team being asked to take-over care.
- Receipt of the referral should be confirmed via telephone at the latest the next working day.
- Formal discharge should not be recorded on SystmOne until acknowledgement of the acceptance of the referral by the new team is confirmed.

13 Workforce Requirements:

All staff will be appropriately skilled, experienced and competent in their designated roles. It is recognised that CMHT staff require excellent skills in holistic person centred assessment, communication, time management and leadership skills as well as competence in specified procedures.

All staff will adhere to the mandatory training requirements which must include Information Governance and Confidentiality training.

Templates used within the CMHT's are available for all staff via healthnet.

13.1 Training:

Essential training identified for clinical staff bands 3 to 8 is:

- CPA training and CPA competencies
- Assessment and holistic centred care planning
- STORM Training
- KUF training
- Mental Health Act
- Mental Capacity Act
- Supervision – Clinical, Caseload and Line Management

Additional training required for all registered staff includes:

- Leadership and management
- Medicines management

Competencies available for CMHT staff currently include:

- CPA for both registered and unregistered staff
- Medicines assessment

Competency development is on-going across the organisation and CMHTs; this could change as more are developed. Competencies are available centrally via the intranet.

13.2 Supervision, Line Management and Appraisal:

All staff members are required to undertake Clinical Supervision as per LSW policy.

All staff will have line management supervision and an annual appraisal as per LSW policy.

All Staff will have caseload management supervision as per LSW policy.

13.3 Induction:

In keeping with good employment practice, it is essential that every new member of staff joining LSW or a new team within the organisation is appropriately inducted. This will help and support the individual to become familiar with ways of working, expectations and the general running of the Department.

All new staff will have a nominated mentor.

A checklist has been devised and is intended to cover basic induction requirements across the organisation. It is expected this will be supplemented by specific departmental information by the Manager and be carried out as part of the wider corporate induction process.

The appropriate Team Leader is responsible for ensuring the Induction process is completed satisfactorily. The new employee also has a responsibility to ask for further clarity or information where there are queries or doubts regarding particular aspects of working in LSW and the Department. This will apply to any temporary or Agency staff members who are employed to deliver care on behalf of LSW.

14 Individual Caseloads:

See Appendix Five

All staff working in the CMHT will be expected to carry a caseload. Caseloads are reviewed through Caseload Management Discussion and Line Management Supervision.

It is usual to allocate to a caseload through the weekly MDT meeting, but there other occasions when it may be necessary to allocate cases outside of this.

All staff must have access to their Caseload Report found in Reports Manager access to this will be included within induction.

http://picts313/Reports/Pages/Folder.aspx?ItemPath=%2fTeam+Reports&ViewMode=List

It is expected that individuals will complete a minimum of 4 face to face contacts a day. Exceptions to this will be managed through caseload discussion and line management on a regular basis.

14.1 Caseload supervision will be provided on a 4 to 6 weekly basis for individual clinicians or more frequently if required. Caseload supervision will be supported by Line Management which will be undertaken on a minimum of a 12 weekly basis.

14.2 Caseloads may consist of clients that are either care coordinated by the CMHT member, supported by a Lead Professional or co-worked with other team members. Caseloads will also take account of those clients not on CPA and managed under Standard Care.

14.3 Individual skills should be valued as a team resource and used directly or shared across the service.

14.4 It is recognised that the team or an individual worker is not able to provide the complete range of services an Individual may need. Facilitation of access to and support from other agencies may be necessary to gain needed resources.

14.5 Negotiation with a network of other service providers is an important function for the team and Individuals. Sharing of information is essential. Shared protocols to allow this will be developed. The Organisation's Information Sharing Protocols must be adhered to.

15 Continuity of Care for those on Caseload:

Care will be provided whenever possible by one CMHT. It is best practice to align the Responsible Clinician / Lead Professional and the Care Co-ordinator / MDT team from the same locality.

See Appendix Five

15.1. **The Care Co-ordinator / Lead Professional**: full details can be found in the CPA Policy regarding these roles.

- Lead and co-ordinate assessments required to produce a Care Plan and the plan for managing risk.
- Provide the main link between the services and the Individuals.
- Ensure that their records are kept up to date according to the Record Keeping Policy.
- Monitor the Care Plan and review it as outlined in the Staff Guidance.
- Be familiar with the Individuals' circumstances and consult them on their wishes that may relate to their cultural, family context or ethnic background.
- Maintain close contact and develop a therapeutic/working relationship.
- Plan for their own expected absence by ensuring that:

    1. Cover is arranged in advance by a named/duty person who will meet all the minimum standards for care.
    2. Unplanned absence should be covered by the clinical team who will meet all the minimum standards for care.
    3. Arrange reviews for Individuals at discharge/transfer and at a minimum of their PbR clustering. (Note for those under Ministry of Justice requirements: 3 monthly for people subject to Ministry of Justice requirements in the community and 4 monthly for those in an

in-patient setting). It is recognised that whilst an Individual is undergoing a period of in-patient treatment it may be more appropriate for the named nurse to coordinate the review. With regards to the clustering, once clustered the time is set which completes the cluster node with the time of when the next review is due. Staff can also set a recall which can sit on the recall screen.

4. Recognise that any member of the team or other agencies can call an emergency review where circumstances demand. The Care Co-ordinator must always be informed.

5. Identify clearly who should be invited to attend reviews, present information about the progress at reviews and chair reviews.

6. Co-ordinate Carers Assessments;

7. Take responsibility for maintaining policy standards and attending CPA training, completion of CPA competencies.

- Practitioners need to be aware that systems as well as CPA may apply to particular Individuals groups such as MAPPA, Deprivation of Liberty Safeguards (DOLS), S117 arrangements, Mental Capacity Act (MCA) and child protection arrangements.

15.2 **Continuity of regimes of medication**:

The care co-ordinator/lead professional will:

- Ensure (in conjunction with the consultant and GP) that there are regular reviews and monitoring of all prescribed medication.
- The monitoring of side-effects should be carried out in a format and frequency agreed with the RC and GP.
- The monitoring of therapeutic levels using blood tests should be carried out in a format and frequency agreed with the RC and GP.
- Adhere to the organisation's policy in relation to Depot Neuroleptics.
- Adhere to shared care agreements as appropriate.
- Ensure compliance with any new policies issued by the organisation such as "Lithium Passport".
- Working with MH pharmacists.

15.3 **Clients who disengage or become difficult to contact - DNA**

Where clients disengage or become difficult to contact the Care Co-ordinator / Lead Professional **must always** assess the impact for the individual. Review of Risk Assessment and Plan of Care will inform further intervention. Professional Judgement will dictate whether this is raised as a matter for serious concern using the Risk Management Process.

- Care plans MUST have a written contingency plan if there is an identified risk of disengagement.
- Care co-ordinators / Lead professionals must raise all instances of

disengagement and failure to comply with essential treatment etc. at weekly team meetings when a positive action will be agreed and recorded within the individual's Records on SystmOne as well as in the MDT records.

- Where a home visit fails because the individual is not at home or there is no answer then a record of attempts to contact should be made. A Plan of action to be recorded and concerns escalated appropriately.
- Staff must follow locally agreed protocols for pursuing welfare checks.

See Appendices Three and Six

15.4 **Escalation Arrangements for planned / unplanned absence:**

- Under normal circumstances, cover for annual leave, planned sickness or study will be provided by other members of the CMHT's. The Staff member is accountable for negotiation and agreement of who will provide specific interventions to identified individuals.

- It is the responsibility of each practitioner to make a list available detailing what arrangements have been made for specific interventions in respect of anyone on caseload who needs to be seen during any period of absence. This information will be made available to the Team Leader, team secretary and to the colleagues who have agreed to cover work during absences.

- Under circumstances of unplanned periods of absence, the Team Leader will review and delegate interventions according to need and risk. Agreement will be reached on what work is essential, what may be deferred for another day and who is the most appropriate professional to undertake the work.

- The team secretary or a member of the CMHT will notify clients of any cancellations immediately. This should be done by the quickest and most effective method preferably a telephone call. These should be recorded on SystmOne.

- Should the period of unplanned absence reach 2 weeks then the Team Leader will review the entire caseload of the Care Co-ordinator / Lead Professional. This will identify individuals whose documented needs and risk dictate immediate reallocation to another Professional and transfer of care will be facilitated by the Team Leader.

- The remainder of the individuals will receive a letter from the Team Leader highlighting an identified Professional within the team that can be contacted to address urgent / priority issues.

- At this point the caseload will be recorded in the MDT Team minutes indicating contingency plans and reallocated cases.

- The Locality Manager will be formally notified of the process identified to manage individuals including any known risk to client, staff and organisation.

- Absence of Consultants – to be discussed with the Clinical Lead for the CMHTs

or the Medical Director and Locality Manager.

- In extreme situations, where operational viability is threatened, for example by sickness across the team, then the Team Leader must report this to his/her Deputy /Locality Manager at the earliest opportunity. Incident Forms should be completed.

- Staff absences due to sickness will be addressed by using LSW's Sickness Management Policy

16 Responsibilities when those on caseload are accessing other Mental Health Services:

16.1 Inpatient Areas:

There is an expectation that those who are admitted and have an existing Care Coordinator will be supported by their Care Coordinator whilst an inpatient. This could include attending Ward Rounds, Mental Health Tribunals and S117 meetings where appropriate. The provision of Mental Health Tribunal Reports should be undertaken by Care Coordinators, as requested, for those on caseload. See hyperlink for guidance;

http://picts313/Reports/Pages/Report.aspx?ItemPath=%2fTeam+Reports%2fMHC601+Mental+Health+Caseload+Status+Report+by+Team

16.2 Psychiatric Liaison Nurses:

For those who present to the PLN team within the acute hospital who is known to the CMHT, it is important that the CMHT is aware of any contact with the team out of hours.

It is anticipated that the PLN contact, including how the CMHT was made aware of the contact) will be visible on S1 and the relevant CMHT alerted to the contact by a telephone call the next working day.

For new referrals to CMHT, the referral form should be completed, and notification sent to the team email address.

See Appendix One

16.3 Home Treatment Team involvement:

For those temporarily under HTT it is expected that 2 way communications will be maintained if there is previous CMHT involvement prior to referral. This is to ensure all transitions are as smooth and timely as possible. CMHT attendance at the weekly HTT review where appropriate is essential to ensure those timely transfer back to CMHT caseload occurs to avoid prolonged delays for HTT once their involvement is no longer required.

Where the person is not known to CMHT referrals will follow the usual process, and again regular attendance at the weekly MDT and timely transfer is important.

See Appendix One

17 Multidisciplinary Team Meetings:

Team meetings are important as a point of contact between practitioners of all disciplines within the CMHT. It is vital that the whole team are involved in such meetings, thus helping to ensure that the aims of the service are fulfilled. Meetings should be scheduled to allow the fullest possible participation of the MDT members, there is an expectation that all members of staff will attend and contribute regularly.

17.1 Purpose, Frequency, Being Quorate:

A weekly meeting of the full multi-disciplinary team will be held;

The purpose of the MDT is:

- Discuss difficult on-going cases;
- Discuss referrals, assessments and discharges. This enables the flexible use of staff skills within the team as other issues and priorities arise;
- The meeting will also review and allocate any individuals who require allocation of a Care Coordinator. *See Appendix Four*
- All clients open to the team can be discussed within the team MDT meetings, so collaborative working relationships between professionals involved in their care can be maintained;
- It is a focal point to bring the team together;
- Clinical discussion relating to safeguarding, incidents and Serious Incidents etc.

The meeting is not considered quorate if there is no medical representation. In these cases the MDT Chair should seek advice from the CMHT Lead consultant or Locality covering Consultant.

17.2 Recording of the MDT including additional reporting for those who are waiting for allocation of a Care Coordinator:

Minutes will be taken using an agreed set format that identifies outcomes, actions and staff responsible, this format is standard across all 4 Localities.

Minutes will be circulated to all staff, and stored on the teams shared drive.

All discussions regarding an individual must be recorded on SystmOne (as per record keeping standards). It is the responsibility of those bringing the individual to ensure it is recorded on SystmOne. The Chair of the MDT will nominate an individual present at the MDT to update SystmOne for those who do not have a nominated worker.

All those who are discussed in the MDT and who are awaiting allocation of a Care Coordinator must have a 2 weekly contact and TAG (minimum), be reviewed face to face if they are unexpectedly waiting longer than 18 weeks for allocation. They should have the template completed, Risk Assessment for Allocation and recorded on SystmOne. They should be clearly visible on the CMHT Care Coordination Waiting List, this will allow for oversight and visibility within LSW Reports Manager.

Guidance for managing the allocation list for a care coordinator can be found

http://pchnet.derriford.phnt.swest.nhs.uk/Portals/3/Adding%20a%20cmht%20allocation%20risk%20assessment.docx

See Appendix Four

17.3 Additional **Business Meetings:**

Each CMHT must meet on a regular basis to discuss team and management issues pertinent to the locality and within LSW. Such meetings (normally referred to as "Business Meetings") are crucial for good communication and it is expected that all colleagues will attend. These meetings will also provide the opportunity to discuss **successes** and **concerns** regarding matters of governance in relation to professional practice and service excellence.

It is anticipated that individual teams will decide how best to achieve this, either as part of or separately to the MDT.

17.4 **Recording / Escalating Concerns:**

It is the responsibility of the MDT Chair to escalate any concerns, risks, issues, notable practices or other information raised within these forums to the Deputy or Locality Manager.

18 Safety:

LSW takes its responsibility for staff safety seriously. All staff have a responsibility for safe working practices and to follow Health and Safety Policies, including Lone Working Violence and Aggression policies.

18.1 All staff must use local arrangements for recording times and destination when leaving the office. This is usually on a Whiteboard, and must be covered in Induction.

18.2 Where a home visit or other task is assessed as being high risk it is the responsibility of the practitioner concerned to inform their Manager of the predicted risk. A properly drawn up strategy to reduce this risk **must** be produced and all parties must be satisfied that every contingency has been considered. In extreme situations of risk Police advise that they should be involved in the risk assessment **before** the task is undertaken. Advice and support can be sought from the Local Security Management Specialist (LSMS) based in the Corporate Risk and Compliance Team 34777. There is guidance

within the Lone Working Policy including a template which staff should complete for high risk home visits.

18.3 All clients will be seen in the most appropriate setting in line with safe working practice policies.

18.4 It should be the normal practice that practitioners return to their base following completion of the last home visit. This practice is beneficial in these respects:

- It gives confirmation to managers that all team members are safe.
- It provides opportunities for any necessary de-briefing following client contact.
- It allows for the completion of contemporaneous records.

18.5 In the unusual event of a practitioner not being able to return to base they must phone in to confirm that they are safe and have concluded their client contact appointments. For occasions when planned visits after office closure are taking place then a plan must be made for checking on the individuals' safe return, as per lone worker policy.

18.6 All staff will have access to a SkyGuard Alarm which should be used at all times in accordance with organisational policy.

19 Improving Individuals and Carer's Experience and improving Learning for Clinical Teams:

There should be regular consultation with Individuals and their carers in order to accurately evaluate the quality of service provision. This can be done using a range of methods, e.g. questionnaires, forums/meetings and anonymous feedback to independent representatives.

All CMHTs will participate in administering the Family and Friends Test as well as reviewing and acting upon information received.

The CMHTs will also participate in the Annual Community Mental Health Individuals Survey, and where indicated produce an action plan.

The use of advocacy services is encouraged.

Mutual agreement and collaborative writing of care plans and letters.

The Triangle of Care and associated resources is a way of providing support to carers.

Access to personal notes will be in line with the organisation's policies.

The individual's rights to plan their own care in times of crisis or difficulty is recognised and respected. This will include the use of contingency/crisis plans. This should be undertaken with the individual users of the service by the Care Co-ordinator/Lead Professional.

It is also expected that CMHTs receive information from Serious Incidents Requiring Investigation, complaints, concerns and compliments as well as other investigations. It is not limited to incidents relating to CMHT as there could be learning from incidents in other areas that are applicable to CMHT working**.**

20 Monitoring compliance and Effectiveness:

Livewell Southwest will monitor and review this policy in partnership to ensure we are meeting the aims / objectives of the policy. The compliance and review processes will include:

- Caseload Discussion and Management;
- Line Management Supervision, Appraisals;
- Training;
- Regular Performance Monitoring as per LSW standards;
- Friends and Family;
- Annual CQC Patient Survey;
- CMHT specific Audits e.g. Depot Audit, Record keeping audits etc.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

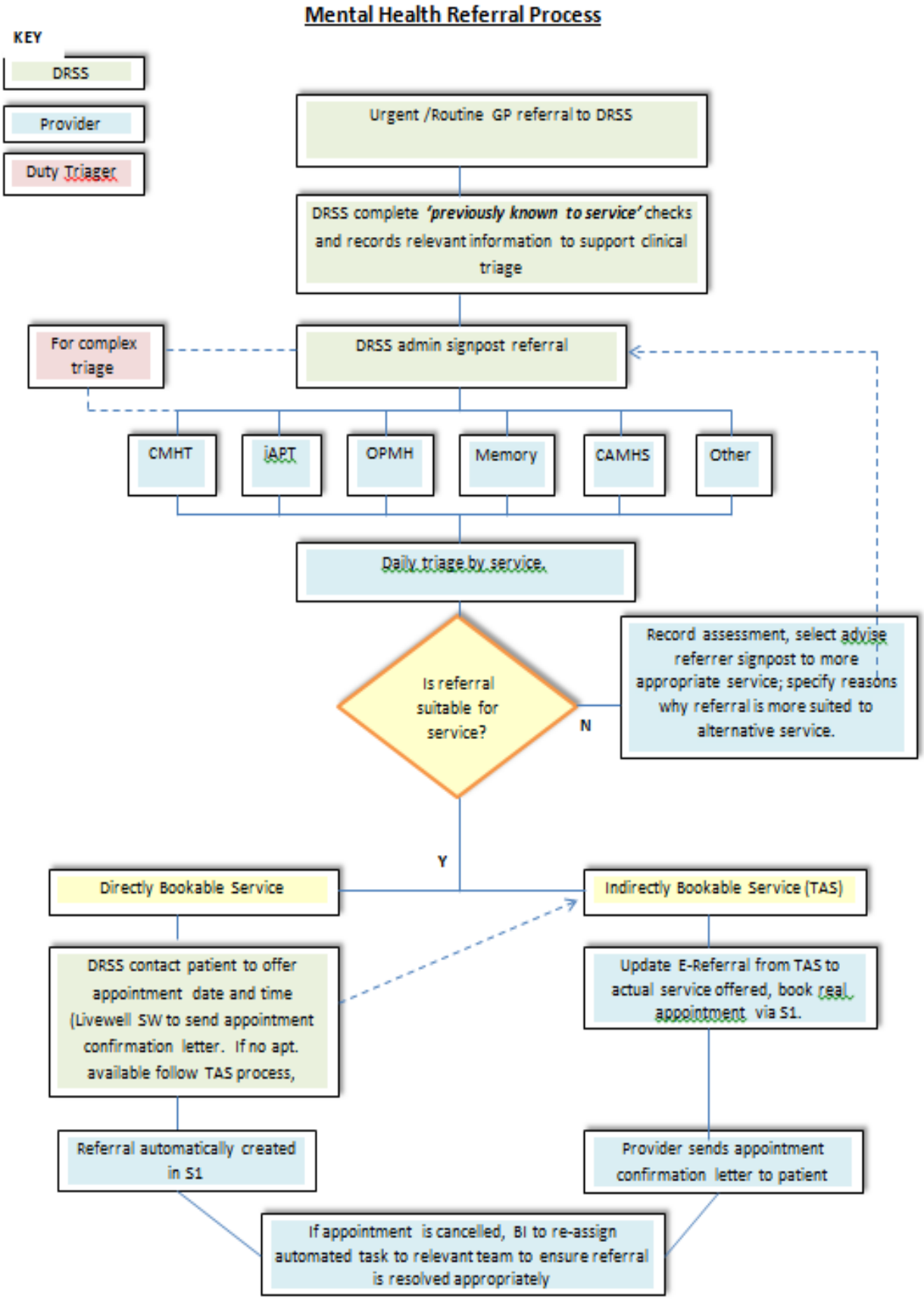
The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for Policy Ratification.

Signed: Director of Operations

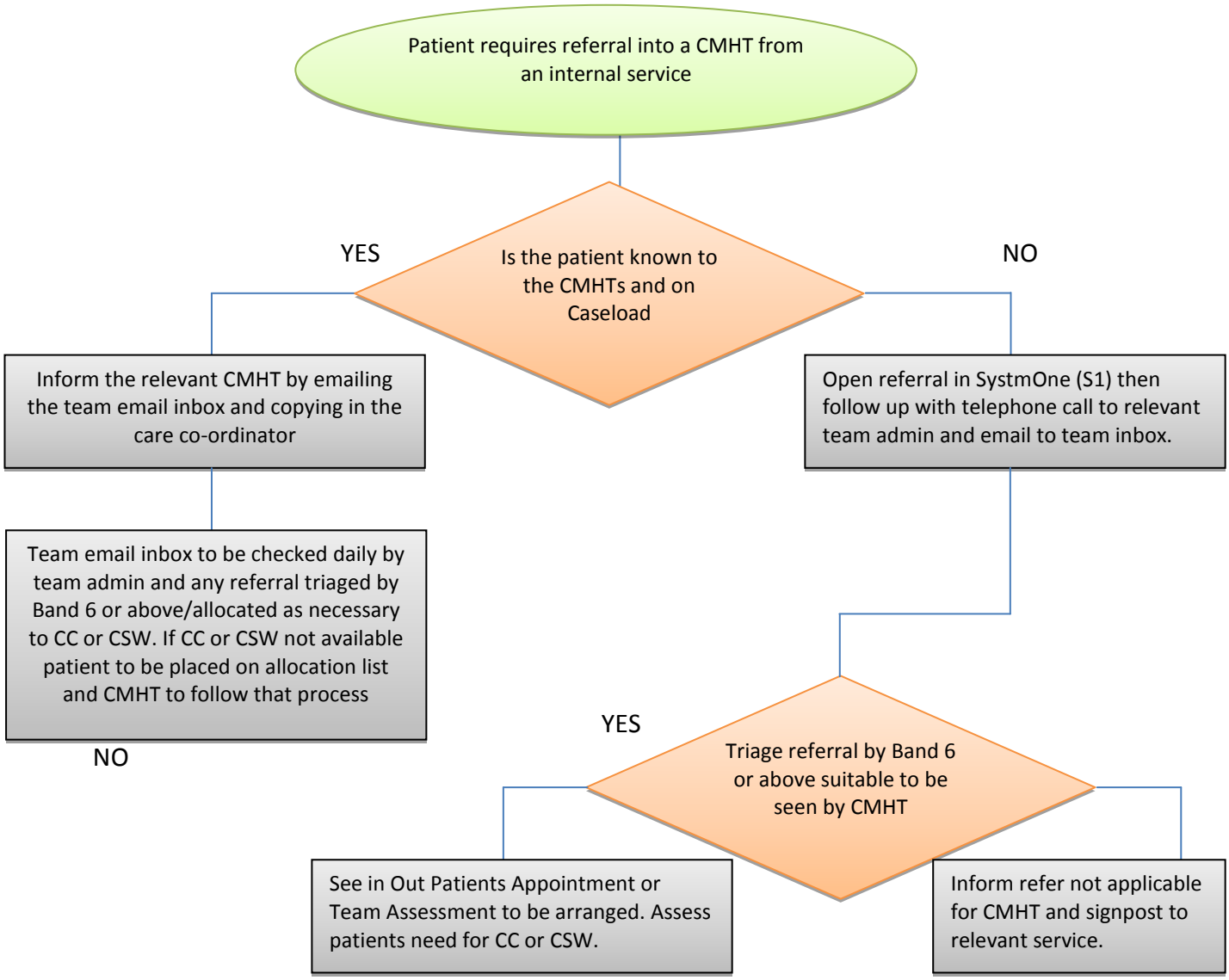
Date: 3rd November 2016

Appendix 1a Referral Processes - DRSS:



Appendix 1b Referral Processes – Other Internal Teams

People referred into CMHT internally from Wards or Community Service

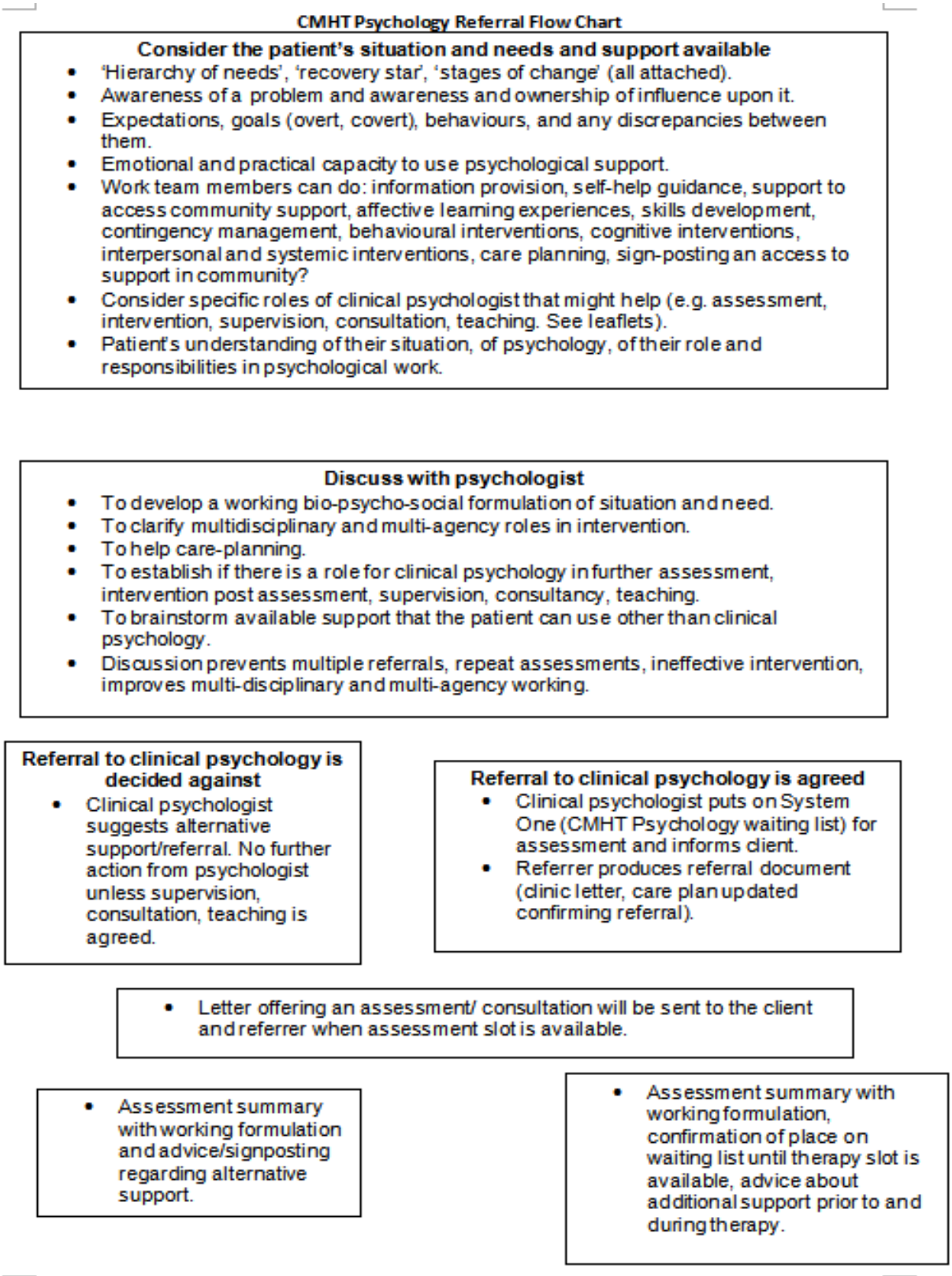


CMHT Team contact details

North: PCHCIC.nwcmht@nhs.net Tel: 01752 434447
East: PCHCIC.plymcmht@nhs.net Tel: 01752 435212
South: PCHCIC.SouthEastCMHT@nhs.net Tel: 01752 435382
West: mentalhealthsouthwest@nhs.net Tel: 01752 435249

Appendix 1c Referral Processes - Internal Referrals to CMHT Psychology

Further information is available from individual CMHT Psychologists or the Lead Psychologist.



Appendix 2 Triage / Prioritisation Guidelines:

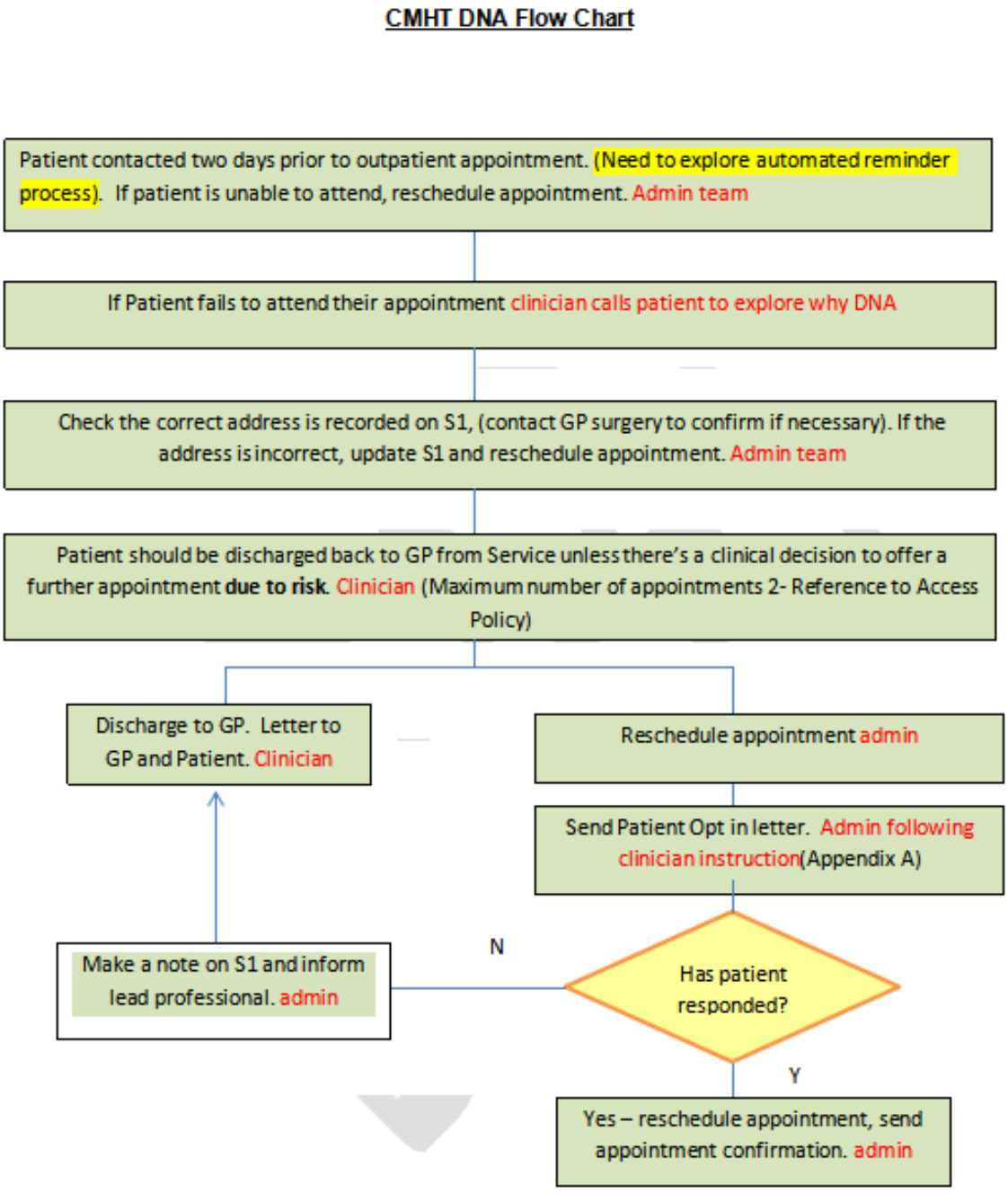
Prioritisation Guidelines for CMHT Referrals

	Duty System	Duty System	CMHT	CMHT	CMHT
Category: S1	**Emergency**		**Urgent**	**Routine**	**Referral returned / re-directed**
Timescale:	**As soon as possible (within 4 hours)**	**Within 1 working day**	**2 – 7 working days**	**Within 18 weeks**	**With same priority as received**
By Diagnosis and Risk	• Actively suicidal and has definite suicide plans • Requires / may require MHA Assessment • Threats of self harm or violence (or history of same) due to mental health problems • Danger to self and others due to mental health problems	• Acutely "Disturbed", psychotic and causing concern • Acutely manic and causing concern • Severe depression (which is affecting functioning) • Non "life threatening" self mutilation (or history of same) • Acute crisis which is impeding ability to access services without intensive help • Potentially "at risk" particularly in relation to self neglect or an inability to be "mindful" of self in others	• Moderate depression • Deterioration of mental state in a person who has previously been diagnosed as suffering from a mental health problem • Risk contained by current input	• Long standing psychological disorder with illness or distress eg. anxiety, phobia • Symptoms – which seem likely to be mental illness related and are interfering with daily living skills • No immediate risk	• Need more information in order to formulate "way forward" • People whose primary problem is part of exclusion criteria • People suffering from mental distress, as a result of life events, but who can access appropriate services themselves without intensive help • No "at risk" referral will be returned / re-directed without an assessment
By Social Demographics and Social Functioning	• In danger of committing a criminal offence due to mental illness • Symptoms of mental ill health are substantially interfering with daily living skills • Isolated and at risk • Vulnerable / danger from others	• Symptoms of mental ill health substantially interfering with daily living skills • Isolated and at risk • Carer distress • Concerning precipitating factors	• Chaotic family • Network of support, but symptoms of mental ill health causing concern and disruption • Risk contained presently by family / carers • Concerning precipitating factors	• Supportive family / carers / social network • Concerning precipitating factors	• No immediate risk
By other Clinical details / needs	• Likely to need hospitalisation • Forensic history and concerns	• Recently stopped / or refusing medication • Forensic history and concerns	• Recent discharge from Hospital / HTT • GP / Referrer / Carers and Patient willing to wait for assessment • Forensic history	• GP / referrer requests "routine" assessment	• GP / Referrer / Patient seeking advice
	Duty System	**Duty System**	**CMHT**	**CMHT**	**CMHT**

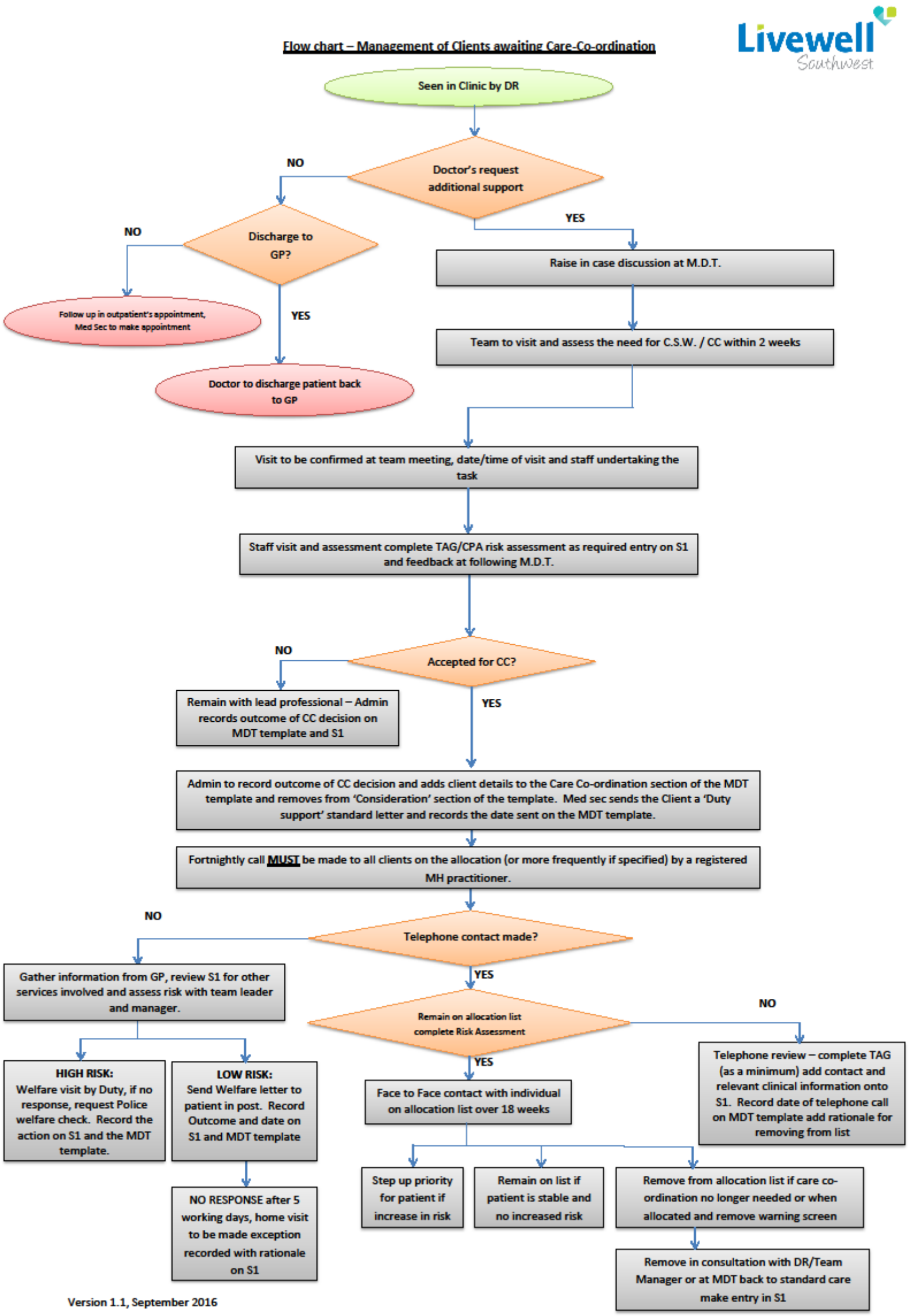
- The categories and timescales detailed on this sheet are standards the service undertakes to achieve
- The diagnosis / risk / social functioning and needs section are for guidance only

Appendix 3 Guidance For those who do not attend appointments / missed contacts – DNA's:

This is a flowchart for guidance; it does not replace structured clinical judgement. Rationale for any decisions made should be clearly recorded in SystmOne.



Appendix 4 Guidance for Managing those on the Allocation List for a Care Coordinator:



Appendix 5 Guidance Opening CPA Episode in CMHT:

When should I open a CPA Episode?

The CMHT would not open CPA for an Individual until there is a care coordinator available. However, they would not end CPA if someone has already been commenced on CPA and is awaiting re-allocation of a care coordinator. The team would be responsible for making sure that care was still provided within the framework of CPA until a care coordinator can be assigned, to assign a care coordinator to someone on CPA must be a high priority. If someone on standard care needs a risk assessment that is more comprehensive than a TAG, then a CPA risk assessment can be completed, as the case with a CPA care plan, however if this level of assessment is required the clinician should ask themselves whether the person's needs could be better addressed within the framework of CPA. A discussion should take place with the MDT and the person added to the awaiting care coordinator waiting list if requiring CPA.

Consultants / Lead Professional Responsibility:
If the consultant is acting as the lead professional then they should open a referral allocation in the name of the team, add the consultants name as a member of staff under this allocation and open up a responsibility of lead professional. If they are only acting as the consultant in the care of the Individual then they should only open a referral allocation in their name under the team's referral allocation.

The Person should only have one care coordinator if on CPA and no lead professional. The Individual should only have a lead professional if on standard care and no Care Co-ordinator.

There should be a referral allocation in the teams name and the member of staff should add their name under this allocation, this is so that if they want to use mobile working they will be able to download their own case load rather than the whole team and will also be able to search under referral allocations for their own caseload too.

All those being cared for within community mental health services with an open referral should have a team involved in their care and should be on standard care or CPA.

<u>Example Scenario:</u>

1) Patient needs a nurse to provide his depot injection but does not have any other outstanding needs and is being managed. Patient should be on standard care, there should be a referral allocation to the team, the nurse should add their name to the referral allocation and open a responsibility of lead professional (after discussing this is ok with the consultant) the consultant would only add their name to the referral allocation. There should only be one lead professional.
2) The patient has complex needs and has been assessed as needing to be on CPA- there should be a referral allocation to the team the nurse allocated would add their name to the referral allocation and open a care coordinator responsibility. The lead professional role opened (if the patient had already been on standard care) should be ended.

Appendix 6: Requesting Welfare Checks:

GUIDANCE FOR WELFARE CHECKS--CMHT STAFF

Welfare checks can be requested from the police when a clinician has concerns for the welfare of an individual who has missed a planned contact or is known to be out of contact with our service. This means the police may have to assist in gaining entry into someone's home.

It is good practice to discuss and document alternative contacts for individuals early in their clinical episode. It is important that people who use the service are made aware, early in the therapeutic relationship, that the CMHT will be concerned about non-attendance e.g. to planned and previously agreed appointments at the team base or to planned home visits. Individuals need to be aware that the CMHT have a responsibility to follow up when there is no contact. Emphasis needs to be given to good relationships, record keeping and clients taking responsibility for informing the service if they cannot attend or will not be at home when expected.

1. Concerns should be informed by MHA status, Risk Assessment, Risk history and records (medical and MDT) also previous patterns of behaviour should be considered.
2. Concerns should be discussed with senior colleague or manager and RC and advice acted upon.
3. Clinicians should use their experience, judgement and intuition.
4. Every effort should be made to contact the patient and those efforts documented. These may include:-
    a. Check with other professionals who are involved with the case.
    b. Telephone calls to land line
    c. Telephone calls to mobile
    d. Visits to home address
        - Checking and recording whether windows open/lights on and see if in the same state on next visit
        - Visit at different times of the day
        - If the individual is not at home, the clinician should consider leaving a letter giving contact details asking the individual to make contact with the team and advising that a Welfare Check by the Police may be requested if there is no contact
    e. Contact alternative contacts or next of kin.
    f. Consider contacting other known support such as MIND, floating support.
    g. Consider contacting local housing office/housing association.
    h. Consider contacting GP surgery
    i. Consider contacting Local Pharmacy (especially useful for people with daily pick up of medication)
    j. Consider requesting Out of Hours or HTT Duty worker continue to attempt to contact them in the evening or early morning if individuals are not contactable during the day.
    k. Consider checking whether admitted to Accident and Emergency, Derriford Hospital or if they have attended any Outpatients clinics.

l. Contact Neighbourhood Beat Officer to see if there has been any contact.
m. Send a letter to the individual. Invite them to make contact by phone and if necessary reverse the charge.

5. Having completed a thorough and timely process the decision to request a police welfare check should be made with Team Leader, senior colleague, RC or Manager.
6. There may be occasions when there are immediate concerns and a Welfare Check should be considered without following the processes outlined above.
7. Document decisions and actions carefully, thoroughly and in a timely manner on SystmOne..
8. To request a welfare check phone the police Non-Urgent 101 unless there is an immediate and significant risk to self or others in which case 999.