Cheshire and Wirral Partnership NHS
NHS Foundation Trust

**Document level:** West Locality
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# Adult Mental Health Services West (CMHT) Operational Procedure

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| Lead executive | General Manager |
| Authors details | Clinical Lead, Adult Mental Health Service West |

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| Type of document | Policy |
| Target audience | All community staff |
| Document purpose | Model for delivering care for people who are open to all adult community mental health teams. |

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| Approving meeting | West Quality, Governance and Effectiveness meeting | 19-Jun-2015 |
| Implementation date | 19-Jun-2015 | |

| CWP documents to be read in conjunction with | |
|---|---|
| MP1 | Medicines policy |
| CP42 | Care Programme Approach (CPA) and non CPA (standard care) policy |
| GR33 | Lone worker policy |
| HR22 | Supervision policy |
| HR2.6 | Annual leave and bank holiday policy |
| CP3 | Health records policy |
| CP37 | Policy for managing informal service users' non-compliance with treatment and managing DNA (Do Not Attend) or cancelled appointments |
| CP40 | Safeguarding Children policy (including safeguarding children training) |
| CP10 | Safeguarding Adult policy (including domestic abuse) |
| CP1 | Admission and discharge from hospital policy |

| **Document change history** | |
|---|---|
| What is different? | Review of the document to support current practice and new appendix added |
| Appendices / electronic forms | Organisational arrangements and timeframes |
| What is the impact of change? | To support current practice |

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| Training requirements | Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Learning and Development (L&D) |

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| Financial resource implications | None |

| External references |
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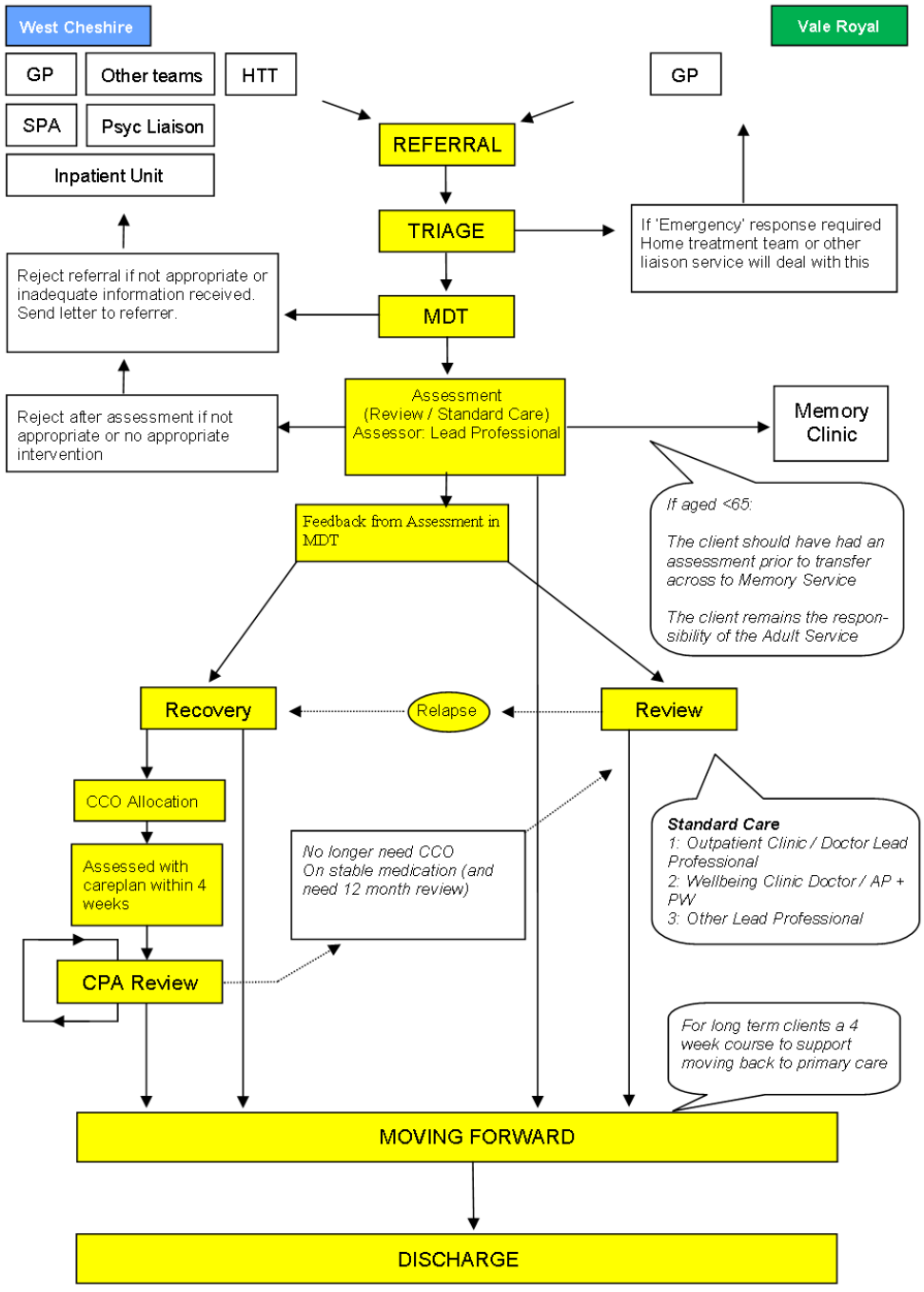
| None |

| **Equality Impact Assessment (EIA) - Initial assessment** | **Yes/No** | **Comments** |
|---|---|---|
| Does this document affect one group less or more favourably than another on the basis of: | | |
| - Race | No | |
| - Ethnic origins (including gypsies and travellers) | No | |

| Equality Impact Assessment (EIA) - Initial assessment | Yes/No | Comments |
|---|---|---|
| - Nationality<br>- Gender<br>- Culture<br>- Religion or belief<br>- Sexual orientation including lesbian, gay and bisexual people<br>- Age<br>- Disability - learning disabilities, physical disability, sensory impairment and mental health problems | No<br>No<br>No<br>No<br>No<br>No<br>No | |
| Is there any evidence that some groups are affected differently? | No | |
| If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? | | |
| No | | |
| Is the impact of the document likely to be negative?<br>- If so can the impact be avoided?<br>- What alternatives are there to achieving the document without the impact?<br>- Can we reduce the impact by taking different action? | No<br>No<br>No<br>No | |
| Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.<br><br>If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department. | | |
| Was a full impact assessment required? | No | |
| What is the level of impact? | Low | |

**Content**

## Quick reference flowchart



## 1. Introduction and philosophy

This policy describes how Cheshire and Wirral Partnership NHS Foundation Trust (CWP) – West provides effective, responsive and integrated clinical services for individuals aged 18 years and above with a severe and enduring mental illness, for whom there is no other specialist service available. It relates to service users in community settings. It is important to acknowledge that they have complex needs including mental health, physical health, social issues, e.g. housing, relationship and family problems, and risk of suicide, victimisation and violence.

### 1.1 Policy perspective

Service delivery will be underpinned by national guidance in relation to the care programme approach, Mental Capacity Act, Mental Health Act, Human Rights Legislation and other national health and guidance legislation including The Care Act. In recognition of the National Service Framework (NSF) the CMHT (Community Mental Health Team) will prioritise those individuals whose mental health and accompanying social care needs impacts most severely on their ability to function within the community. The CMHTs will ensure that access is equitable across local communities through agreed Care Pathways. The purpose of a Care Pathway is to ease the service user's journey and to assist staff to deliver the most appropriate care at the most appropriate level, promote effective recovery and reduce disability

This policy is set within the context of the Trust's strategic objectives of recovery orientated services and the integrated business plan.

### 1.2 Policy objectives

The objectives of this policy are to:

- Provide a consistent, coherent and integrated model of service provision;
- To continue to review existing needs of service users;
- Outline care pathways to guide the service user through their recovery journey and exit through services.
- Provide a comprehensive range of services for the treatment and management of severe and enduring mental illness which are culturally sensitive to the needs of service users and family or carer;
- To provide and further enhance the education and training packages which support an integrated delivery model;
- To continue to develop a culture of continuous evaluation and development including that of learning from good practice.

In addition to the above, the service will embrace the 6 C's of Care, Compassion, Courage, Communication, Competence and Commitment outlined in the Francis Report 2013, and strive to provide service users and carers with the opportunities, choice and hope that will empower them to achieve a meaningful life and a positive sense of belonging to their community

The Adult mental health services aspire to continuously improve the quality of care it delivers by tackling unwarranted risks and supports everyone in delivering the best care possible for the best health outcomes of service users. The principles of zero harm and the Stop Listen Think Campaign are central to the team's philosophy, sharing learning through incidents, celebrating our successes and continuously developing our service through innovation evidence based practice and redesign.

### 1.3 Adult Mental Health Service's

These teams are:

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| Adult Mental Health Service Chester | ADMHSC |
| Ellesmere Port Adult Mental Health Service | EPAMHS |
| Vale Royal Adult Mental Health Service | VRAMHS |

The three west adult mental health teams are specialist, secondary care community mental health service offering assessment, diagnosis and treatment to individuals aged 18 years and above, with severe and enduring mental health problems for whom there are no other specialist services available.

Those service users who present with a first episode psychosis will be referred to the Early Intervention Team via the appropriate pathway.

### 1.4 Multi-disciplinary teams

The West Adult Mental Health Teams are integrated teams i.e.: CWP employed staff work alongside LA staff using the Care programme Approach to provide for the individuals' health and social care needs.

A multi-disciplinary Adult MHT unites specialist medical, nursing, Approved Mental Health Practitioners [social workers], Occupational Therapists, Psychologists, Physiotherapists, Advanced Nurse Practitioner and Nurse Practitioners, clinical support staff, & admin staff within an integrated team, sited within a team base, with a single operational management structure.

Using an integrated multi-disciplinary approach all members of the MHTs will;

- Reduce the stigma associated with mental health care.
- Work in partnership with service users and carers.
- Provide assessment diagnosis and treatment via the CPA (Care Programme Approach) /Standard Care process, working within the Mental Health Act and Mental Capacity Act.
- Focus upon improving the mental and physical well-being of service users.
- Utilise the experience and knowledge of all team members to help facilitate a holistic approach to our service users.
- Ensure care is delivered in the least restrictive and disruptive manner possible.
- Stabilise social functioning and protect community tenure.
- Work in collaboration with Primary Care.
- Promote service user recovery and social inclusion utilising Wellness Recovery Action Planning (WRAP).

### 1.5 The Model

From April 2013, CWP Community Mental Health Services have adopted the 'Stepped Approach to Recovery' [StAR model], reconfiguring community teams. In West, the model has been locally adapted to reflect local needs. Practitioners within the community mental health teams have a mixed caseload incorporating both recovery (CPA) and review (standard care). This approach ensures that service users receive the most appropriate level of care whilst maintaining continuity during their recovery journey. .

The level of care identified - CPA or standard care represents the individual`s current level of need and interventions required to support recovery.

A person`s level of care can change depending on needs. When service user`s needs change this will be reflected in a change in the level of interventions offered and CPA status. All changes to care are managed via a care review. A care review will involve the lead professional/care co-ordinator and the service user and carer (where appropriate). A care review will result in an updated plan of care which is recorded and communicated with the service user and relevant stakeholders.

Care reviews are undertaken when an individual moves between recovery (CPA) and review (standard care). The related episode will be opened and closed on care notes accordingly. The care plan and contingency plan will reflect this.

For service users on CPA level of care, they will have a care co-ordinator (CCO) who is their lead professional and a consultant psychiatrist in line with the CPA policy. For service users on standard care their lead professional could, for example, be a Consultant or an advanced nurse practitioner/ nurse practitioner/ or other practitioner within the team ( OT, social worker).

All service users whose mental health is stable and who do not pose significant risk will be allocated to the Review element of the service. These patients will be usually reviewed in an outpatient clinic setting

by a clinician (e.g. – Consultant, Advanced Practitioner, Clinical Lead). For individuals subject to Section 117 aftercare and whose mental health is stable, an annual review supported by an appropriate professional will take place. (E.g. where there is a social care need for the individual this will include an appropriate social care professional)

Where individuals are in 24 hour supported accommodation (residential or nursing home), a care review determines whether the individual remains under secondary care or is discharged from services.

## 2. Care pathway

### 2.1 Criteria for the team

Criteria for inclusion for the team is; people who are over the age of 18, people who suffering from a severe, or persistent mental disorder, associated with high level mental distress, which impacts on their level of functioning in the community.
Service users over the age of 65 are referred to older adult CMHT.

### 2.2 Referrals to CMHT's

Referrals to Chester and Ellesmere port CMHT's are usually received from the Single point of access (SPA). It is expected that all new referrals via SPA will have been screened and assessed as needing secondary community mental health services.

Within Vale Royal, they do not currently have a Single Point of Access. The GP refers to the CMHT or IAPT (Improving Access to Psychological Therapies). If appropriate for CMHT the team will contact and invite for assessment and the response and processing of referrals is the same for all west CMHT's as detailed below except for emergency referrals

Upon receipt of the referral, a senior clinician undertakes screening to determine the level of urgency. If the referral is deemed urgent, the team manager or clinical lead will allocate to a duty worker to arrange urgent assessment. This will usually take place within 2 working days.

All referrals are reviewed at the weekly MDT meeting to determine the response required.

### 2.3 Other type of referrals to team:

- Transfers from other CMHTs, including Early Intervention Team, CAMHS, LD services
- Liaison Psychiatry Service
- CRHTT
- Criminal Justice Liaison Service
- Acute Care services
- Other MH agencies / Trusts outside CWP

### 2.4 Processing referrals

- All documentation, including written referrals, must be date stamped upon receipt – this is the date response times will be audited against.
- In order to process the referral, the Team requires enough accurate and current clinical and patient information. If this information is absent it is the responsibility of the allocated member of staff on the Duty rota for that day within the CMHT to inform the referrer and request further information be provided prior to the referral being processed
- All referrals to CMHTs will have a CareNotes record commenced (or where a record exists, continued). Upon receipt of the referral, the initial record will be developed, ideally, by administrative staff and consist of the minimum documents are required to process the referral; Electronic Patient Record (EPR), Address, GP and Referral – the referral will then become the responsibility of the 'clinical' team. All members of the team are responsible for improving the data quality of service users' electronic records.
- A Carenotes Assist for CMHTs will be developed to ensure completeness of forms on the patient's carenotes.

## 2.5 Response times for referrals

Response Standards for referral to CMHT's are to be prioritised under the following three categories; Routine, Urgent and Emergency (emergency response is for service users who are already under the care of the CMHT)

The referral to the CMHT will be triaged by Team Manager or Clinical Lead

## 2.6 Routine referrals

Those requiring a non-urgent assessment by a mental health professional or a Nurse Practitioner

- Receipt of the referral into the CMHT will be acknowledged in writing to the referring agent by a standard template letter following the allocation meeting. The service user will be contacted within 10 working days by letter or telephone. Assessment should be completed within 13 weeks of the referral to the team.
- If no response is received from the referred individual, a further contact will be made via letter or telephone requesting them to contact the team within the next 7 days
- If there is still no response the MDT will discuss and decide the appropriate action – this may include making a home visit or informing/discharging back to the referrer.

## 2.7 Urgent referrals

Those requiring a prompt assessment and may have associated risk factors. It is expected that the referring agent would contact the team via telephone and fax or email, to avoid unnecessary delays.

- If the assessment has identified a need for an urgent response, then the CMHT will contact the service user within the timeframe specified by the SPA, usually 48 hours, but not greater than 5 working days. At the time of the assessment other services may also be involved due to the nature of the presentation such as Home Treatment and/or Inpatient services.
- The Team Manager or a nominated other member of the team will ensure that all necessary information including risk factors, are gathered from the referring agent and others who may be involved in the service users care.
- The Team Manager or other nominated member of the team will clarify with the referring agent the reasons why the referral is classed as urgent, as opposed to routine or emergency.
- There is an expectation that the SPA Team Practitioner will have had face to face contact with the service user within the previous 24 hours and completed a first assessment, prior to referral to CMHT.
- Face to face contact will be made with the service user within 5 days, or earlier if specified by SPA

## 2.8 Emergency referrals

- Those requiring an immediate response. The CMHT does not offer an emergency service as this is provided via the Acute Care Pathway (Home Treatment Team)
- The services that provide an emergency response include; SPA, Home Treatment Team (Acute Care), liaison and EDT (Emergency Duty Team) service.
- In Vale Royal, they do not currently have a SPA. The CMHT in Vale Royal receive referrals directly from GP`s. There is an expectation that the GP or referring agent will have had face to face contact with the service user within the previous 24 hours. The information will then be passed to the medical staff and / or Approved Mental Health Practitioner for assessment. The service user and the referring agent will be notified of the time of the face to face assessment. Response time for emergency referrals will be on the same day of receipt of referral. In the event that the service user cannot be contacted, then the referral will be discussed with the Emergency Duty Team who will then attempt to contact the service user out of hours.

## 2.9 Allocation of referrals

- All new referrals to CMHT will be discussed within the formal weekly MDT allocation meeting. All referrals requiring assessment from a CMHT will be allocated for assessment. Referrals are

not always allocated in the meeting and can be allocated outside the meeting to meet clinical need and facilitate caseload management.

- There is a requirement to identify whether the service user is on either Standard Care or CPA. Those on standard care will be allocated a Lead Professional and those on CPA will be allocated a Care Co-ordinator (CCO).
- If the service user is to be placed on CPA care, they should be seen by the allocated care coordinator within 5 days of allocation. If allocation cannot be achieved following MDT and they are awaiting allocation then the Clinical Lead or the Team Manager will contact the patient which is awaiting allocation of a CCO to inform them of the current plan and advise the contingency plan which is to contact the team / duty worker with in office hours and out of hours numbers.
- The allocated care coordinator has 4 weeks to engage with the service user and complete assessment which leads to formulation of care plan CARSO (Summarised View of Risk SVoR), Contingency plan and other documentation on carenotes as per CPA policy.
- If the service user is Standard Care they should be contacted within 10 working days, and assessed by a lead professional, (who may be an Advanced Nurse Practitioner/ Nurse Practitioner/ Consultant/ Specialist Registrar or Junior doctor), within 13 weeks of allocation to the CMHT. All attempts will be made to see the new patient as soon as possible. Standard clinic letter templates will be used to communicate the assessment to the service user's GP.
- If the MDT decides, following their assessment that the service user does not require further contact with secondary care services, they will be discharged back to the referrer in writing with a rationale for discharge. This may involve the CMHT signposting the referral on to other more appropriate services. This will be communicated to the referring agent.

### 2.10 Assessment

All new routine referrals to the team will be assessed within a 13 week timescale following a referral from the SPA. For referrals from inpatients, a care coordinator assessment is required to determine need. All patients who are accepted from inpatients should be assessed by a doctor from the CMHT within 4 weeks of discharge from the ward.

The assessment clinic enables practitioners and medical staff from the team to assess new referrals, the lead assessor should be listed on carenotes as lead professional. In some circumstances, assessments can take place in the service user`s home. All care notes information will be collected to inform the careplan, including the assessment document, MSE (mental state examination), Physical health check, CARSO, HONOS (Health of the Nation Outcome Scale) score, PBR Cluster (Payment by Results). A medical review complements the holistic assessment and formulation of care plan. The care plan is recorded within the careplan section of care notes or in a recognized template used predominately by medical staff in the team.

The assessment process seeks to provide a timely formulation of need and improve service user outcomes. Once the assessment process is complete, the decision will be made on the outcome of the assessment and feedback to the MDT, with a pathway decision made as per flowchart.

### 2.11 Recovery

- The Recovery element of the CMHT works with service users who suffer from severe and enduring mental disorders, often complicated by other physical and co-morbid problems such as alcohol and substance misuse. Service Users under Recovery are on CPA care as per the CPA policy, CP42 Care Programme Approach policy, are allocated a care coordinator, who coordinates their care.
- All service users on CPA will have a minimum of an annual CPA review meeting to review and update their care plan. All service users should have a CPA prior to discharge from hospital and any other changes that need reviewing and the care plan changed accordingly and updated. All CTO service users and assertive outreach service users should be reviewed to a minimum of six monthly.
- **Assertive Outreach function offered by CMHT,** Assertive outreach is a way of working with an identified adult client group who have severe mental illness who do not effectively engage

with mental health services. The approach is characterised by working with clients in their own environment, wherever that may be. This flexibility of approach allows services to be provided to people who may not otherwise receive them, where they feel most comfortable. Workers may also visit or accompany clients when they use other services. This encourages a two-way engagement that helps to develop trust and rapport and to establish links with other agencies. It is multi-disciplinary; comprising a range of professional disciplines (occupational therapists, physiotherapists, nurses, social workers, social service workers, psychiatrists, psychologists, support workers, recovery mentors and housing/benefit workers). There is intensive frequency of client contact (up to several visits a week depending on need). There is an emphasis on engaging with clients and developing a therapeutic relationship. It offers specific evidence-based interventions such as cognitive behavioural therapy in psychosis. It works with people in their own environment, engages with the user's support system of family, friends and others.

- All out of area CPA recovery service users should be referred to CRAC (Complex Recovery Assessment and Consultation) team to manage their care under CPA until at time they are ready to be stepped back to community care and the CMHT will take the transfer back

### 2.12 Review

All service users whose mental health is stable, do not pose significant risks, and are requiring less intervention from the team to meet identified needs who are not yet ready for discharge will be allocated to Review (standard care). Service users in Review are on Standard care as per the CPA policy. Service users on standard care are usually reviewed in an outpatient clinic setting, and are not routinely visited at home. Service users may be reviewed by nurse practitioners/ mental health practitioners or medical staff. Nurse practitioners will also review certain groups of patients in clinics under the health and wellbeing clinic part of the service, such as Lithium clinic, Depot clinic, and clozapine clinic. Service users also who are stable and residing in supported accommodation and residential homes may fall under this level of care. Standard care patients will be seen at least once in 6 months by Nurse Practitioners/ mental health practitioners and annually by medical staff. Service users subject to 117 aftercare arrangements who are stable also would fall under this category.

In west there are three different ways that review/ standard care can be implemented through the teams' model

1. Service user attending outpatient clinic who are on standard care where there lead professional is from the medical team either consultant psychiatrist, associate specialist or junior doctor or advance nurse practitioner

2. Service users are at a stage of their recovery whereby the main intervention that is required for them to meet their optimum health can be delivered through the health and wellbeing part of the service which hosts a number of clinics including clozapine/ depot and lithium clinics. Service users who attend these clinics can be under recovery or review. A number of these service users are at a stage of their recovery where they can be managed on standard care and reviewed a minimum of annually. Service users who attend health and wellbeing hub for therapeutic intervention who their lead professional is the doctor or an advance nurse practitioner and for more routine contact through the health and wellbeing clinics have a named primary worker who is typically a nurse who they see in the clinic setting. The doctor or advanced practitioner is the lead professional and the primary worker is a point of contact and can ensure their annual medical review takes place and that their prescription is up to date and their documentation is on care notes is in line with trust policy for service users on standard care. The primary worker (PW) is responsible for the HONOS PBR/ physical health brief and up to date administration of the prescription and the prescribed medication through the clinic setting. The PW is point of contact for service user and carer. Also reviewing needs and if more than this level of care is required to regrade to CPA.

3. Service users that have another professional from the team who are on standard care, this professional is known on carenotes as their lead professional, this occurs usually when a

service user is heading towards discharge and has no more need to see the doctor from the team.

Robust arrangements should be documented in the contingency plan for all service users and carers to know what to do if things go wrong and they should be booked into an urgent review appointment with a doctor if the need requires. The doctor's annual clinic letter is the care plan, contingency plan and risk assessment and the service users should be offered a copy of this plan of care. Section 117 service users that have no other needs other than an annual 117 review can be managed by a lead professional under the review part of the team. Any standard care patient that is taken out of consultant caseload and has another practitioner as a lead professional can be booked into consultant clinic if required as a review appointment and not as a new patient appointment.

### 2.13 Early onset dementia

Any referrals for under 65 dementia assessment are referred to the adult team for assessment prior to being accepted by the memory service. Care coordination sits with the adult service. Differential diagnosis requested to exclude other mental health conditions. Physical assessment, bloods and scan should be done by GP prior to adult team assessing. Service users once assessed and seen by memory service if no ongoing social care needs can be discharged back to the GP.

### 2.14 Family and carers

Where there are family / carers involved with the service user, their contribution to their care and recovery must be recognised by services. Carers who spend more time with the service user will know what they are like when well, and will often recognise the early signs of relapse.

**"The Triangle of Care - Carers Included: A Best Practice Guide in Acute Mental Health Care",** recommends better partnership working between service users and their carers, and Mental Health Services.

The main standards of the Triangle of Care should be embedded within the work of all team members The six key elements state that:

1) Carers and the essential role they play are identified at first contact, or as soon as possible thereafter and documented in carenotes
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols regarding confidentiality and sharing information are in place.
4) Defined post(s) responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available – including offering all carers a Carer's assessment and developing a carers' support plan.

An effective Triangle of Care will only be complete if there is a willingness by the professional and carer to engage. This three-way partnership between service user, carer and clinicians, with all the voices being heard and influencing care treatment decisions will produce the best chance of recovery for the service user. This places an onus on professionals and services to actively encourage this partnership.

### 2.15 Safeguarding

Safeguarding is everybody's business within CWP has a responsibility for, and are committed towards safeguarding and promoting the welfare of vulnerable adults, children and young people staff are directed to CP10 safeguarding Adult policy and CP40 safeguarding Children policy documents and procedures

Safeguarding policies to be followed by all staff and home visits are required by workers where there is an active safeguarding case and representation at TAF/ child protection conferences etc. and joint working arrangements as required

### 2.16 Recovery College

Recovery College was launched in autumn 2012 and its headquarters are currently based in Blacon Chester at the healthy living centre, with some satellite college facilities through the west CWP footprint. Service users have access to enrolling on a number of courses at the college and a range of skills and interventions are delivered through an educational model

### 2.17 Moving Forward

Moving forward is now on the recovery college prospectus and was originally designed as a consolidation recovery based group to enable service users who were anxious about being discharged the opportunity to consolidate skills around WRAP etc., to give confidence and skills in managing their health condition and what to do if things go wrong.

### 2.18 Exit from services

For effective functioning of an integrated CMHT, to prioritise those service users with greatest level of need and complexity and to promote service user recovery, it is crucial that discharge is considered at each review.

Discharge from services must be preceded by a review by the Lead Professional. Consideration of risk, need, strengths and mental health will inform decisions of the MDT whether to discharge an individual from secondary care. Alternatively, exit from adult CMHTs may require a transfer to Older Peoples services or to Primary Care or even a transfer to services out of area. Transition and Transfer protocols should be adhered to.

If a service user is to be discharged from secondary care services, they should be informed of how to be referred back into into services. For west this is through a new referral from the GP to the SPA. If the service user is then referred back to specialist mental health services an assessment will take place. The GP will be informed, in writing, of the discharge from secondary care services.

## 3. Team operation

### 3.1 Multi-disciplinary community team meetings

- Each CMHT will hold a weekly formal MDT allocation meeting.
- Membership will include all members of the CMHT
- The agreed specific CMHT meeting agenda will be used by all CMHTs.
- Formal minutes will be recorded using the Trustwide template.
- An action log will be completed following each meeting with actions being time limited and allocated to specific named individuals.
- Where individuals have this designated responsibility for actions, they are required to report on progress to the meeting.
- If for any reason the person is unable to attend the next meeting, they will be asked to provide the chair of the meeting with information regarding the action and carry it forward, if appropriate, to the next meeting.
- Clinical Service Managers will monitor these procedures by checking the MDT Allocation Meeting minutes once a month as part of the team manager supervision.

### 3.2 Duty system

- Due to the nature of serious and enduring mental health problems, service user's health can deteriorate quickly and reach crisis in a matter of hours. It may not always be possible for their care coordinator/lead professional to respond and if left unsupported such changes can lead to hospital admission or acts of harm to self or others. It is therefore necessary for an appropriate response to situations considered likely to develop into a crisis or where there is a marked deterioration in health. In particular, those service users identified as higher risk, via a weighting matrix, will need to be prioritised and responses planned.

- To facilitate such a flexible and responsive service, the Team Manager/Clinical Lead will ensure a system is in place to support and provide an appropriate response to issues that arise relating to service users and career's referred to, and within the CMHT.
- The duty rota comprising of members of the multidisciplinary team will be coordinated by team manager/ clinical lead/ team sec
- Service users, particularly those on CPA, will have Crisis and Contingency plans within their care plan and these will be referred to and adhered to wherever possible.
- Calls regarding service users on standard care open under the review will be addressed by the duty rota professional. Wherever possible, attempts will be made to consult with the Consultant or Lead Professional/ primary worker who provides routine care to the service user.

### 3.3 Requests for change of consultant/ care coordinator/ team

- All service users will access mental health services via CMHTs based on GP catchment area.
- Service users may request alternative consultant/team member.
- If service user requests an alternative consultant, Team Manager will discuss with the service user as to the reason for change.
- If service user still wishes to change consultant or team, then request for change must be put in writing by service user, and sent to the Clinical Director to allocate alternative consultant.
- If GP requests for out of catchment area input, request must be sent in writing to local Clinical Director and General Manager to allocate a consultant and team within Wirral Locality.
- If GP requests out of West mental health input, local Clinical Director and General Manager will discuss with Clinical Director in adjacent sub-division, making it explicit to referrer and service user that only standard care by a consultant can be offered. Clinical Director in adjacent locality will discuss needs and risks and consider available resources with referring Clinical Director prior to acceptance. Accepting Clinical Director will allocate consultant input. If accepting consultant feels CMHT involvement is required, they will discuss with referring Clinical Director who will allocate a CMHT within the referring area

### 3.4 Support for users in hospital, secure units and prisons

- Service Users who require admission to an acute in-patient unit or a secure setting continue to need the support of community staff during the in-patient episode. Ensuring the service user and relevant carers receive appropriate support is seen as high priority by CMHT staff.
- If the service user has to be placed in an acute or Psychiatric Intensive Care Unit (PICU) away from the local area, the Care Co-ordinator will ensure that weekly contact (preferably face to face) is maintained with the service user and the acute care team throughout their stay. Transfer back to the local area will be arranged as soon as clinically possible.
- If the service user is an in-patient within a medium or low secure unit the Care Co-ordinator will make every effort to attend CPA reviews. The regularity of other contacts with the service user will be agreed taking into account the individual needs of the individual.
- The principles of CPA apply to those service users in prison, meeting relevant care pathways. The Co-ordinator will make every effort to attend CPA reviews. The regularity of other contacts with the service user will be agreed taking into account the needs of the individual.

- Staff must refer to and be familiar with, and adhere to, the CP42 Care Programme Approach policy

### 3.5 Failed visits/contact

- In the case of a failed visit staff are referred to the 'CP37 Policy and procedure for managing informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointments
- Service users must not routinely be discharged because of failed attendance at Out-Patient Clinics. Non-attendees must be discussed in MDT meetings to determine appropriate team response and prior to discharge.
- A record will be made in carenotes of any identified risks, discussion in MDT, and reason for decision/ plans for review of the patient by care coordinator or Lead professional.

### 3.6 Transfer between West / other CWP teams/ Out of area

Patients may be transferred out of a West team to another team in West, or to a team in another site or another Trust.

All transfers should be discussed in MDT. A time frame will be set for completion of transfer to new team.

Transfer will usually be initiated by a letter to the receiving team from the care coordinator (for CPA patients) and from the Lead Professional or Consultant for standard care patients. The letter will be accompanied by all relevant documentation including updated Careplan and CARSO SVoR (for CPA patients). If the transfer is within West, or to another CWP team, then reference will be made to the relevant documents in Carenotes.

For CPA patients, a date for CPA Transfer meeting will be set with the receiving team – usually the Team Manager or Clinical Lead of the new team. The patient will be requested to attend to meet the new care coordinator. The new consultant may also attend this meeting, or as soon as possible after the transfer is agreed.

Once the patient has been reviewed by the new consultant from the receiving team, details will be amended on carenotes to reflect the changes in name of team/ consultant/ care coordinator.

For standard care patients, the transfer will be completed once the patient has been reviewed by the new consultant, after which details will be amended on carenotes by the new team.

When a consensus regarding an appropriate course of action cannot be reached there is a process of arbitration which involves an appropriate professional (Clinical Director/ General Manager via Clinical Service Line Manager, social Services Manager) who will provide an independent opinion and plan of action. This will ensure that the patients' individual needs are met in the most appropriate way. If there is disagreement about issues such as acceptance of cases into service, this needs to be escalated up the line management route to enable resolution to take place as soon as possible.

### 3.7 Joint working with other teams

Some patients may be opened to Adult MHTs as well as other CWP teams in West, or teams in other CWP sites including LD, forensic liaison. Patients may be open to Adult MHT as well ADHD service, Personality Disorder Provision, Complex Needs Service. Drugs and alcohol are not provided by CWP and information protocols are being developed.

For patients who are on CPA, care coordination will remain within CMHT, with a care coordinator allocated from the CMHT. CPA reviews for these patients should be held jointly with professionals from the other teams.

Patients who are on standard care will also remain open to the team with the main Consultant/Lead Professional from the Adult MHT. However, some standard care patients may be discharged from Adult MHT to the other team, if it is decided their needs are best met by the other team. The decision to discharge the patient from the Adult MHT to the other team should be taken in consultation with the consultant/team manager of the other team.

### 3.8 Supervision/ Appraisals

Team members are guided to the GR14 Supervision Policy, developed by Cheshire County Council, CWP and Wirral Social Services. The policy states;

''There are many definitions of supervision. For the purpose of this policy, supervision comprises of three core elements and effective supervision requires each element to be addressed by the line manager and or in partnership with an identified other. Specific requirements will also be required for child protection and vulnerable adult issues''.

The three supervision elements are; Line Management, Clinical Support and Professional Support.
All team members must engage in 6 weekly supervision sessions and one annual appraisal with their line manager.

All team members must also have an annual appraisal as per Trust policy or their employer policy (social services).

### 3.9 Absence

Absence of team members for any reason must be addressed as soon as possible by the Team manager or Clinical Lead.

All CMHT team staff must phone into black light to report a sickness absence 01244 397589, they also must then phone the team and if available speak with the team manager or clinical lead. All appointments to be cancelled must be given to the team secretary to cancel. Team secretary will inform duty worker of staff absence so they can respond to any urgent calls that day if required.

If absence extends over a week Team manager/ clinical lead will review caseload and discuss with other team members. If long term sickness occurs which is absence over three weeks, Team manager/ clinical lead will review entire caseload and start reallocating cases dependant on need. Usually high risk complex cases. All service users will have a named worker attached to their care who will make telephone contact and visit, if required. Letter would also be sent to inform service users that named worker on long term sick and they can use team duty system and out of hours numbers if required. If absence continues for further period and no return date identified – caseload will be reallocated to another care co-ordinator by week 6. If this cannot be achieved this would be escalated to service manager/ general manager

### 3.10 Training

All staff are aware of the ongoing mandatory requirements in order for them to be compliant. Staff are also aware of the behavioral related increment scheme where staff must be 100% compliant with MEL have 6 recorded supervision sessions management and clinical supervision if clinical staff, and a recorded appraisal in a 12 month period in order to be able to pass through the increment stage on their recruitment anniversary. Social services staff have their own training and appraisal requirements which must be met.

### 3.11 Caseload weighting

To ensure fair and equitable distribution of service user centered workload, whilst recognizing other demands upon time, a system of caseload weighting is necessary. This system will assist both practitioners and managers to appropriately respond to referrals to the service and ensure staff are enabled to effectively time manage.

To ensure equity, all caseloads will be assessed and weightings should be distributed appropriately across the team. The more complex service users should have a team approach to care and be care co-ordinated by the more skilled and experienced members of the team.

In west the teams use a traffic light caseload weighting system, of red amber green.

Red = weekly contact under HTT or inpatient high input

Amber = routine CPA recovery fortnightly/ three weekly/ monthly visits

Green= less than monthly standard care/ primary worker or working towards being regarded from CPA

This is managed through supervision and team caseload spreadsheet

Apart from face-to-face service user contact, other essential duties must be taken into account such as meetings, supervision, training, ASW and joint visits etc.

### 3.12 Visiting 'lists' – lone working/ safe system of work

Maintaining the safety of staff is a high priority of the CMHT. Team Managers have a duty to implement local procedures and systems for their team members to ensure safe working conditions exist.

Staff must be familiar with and adhere to, the GR33 Lone Working Policy, and Checking-in via the 'Buddy' system. A crucial element of lone working is appropriate use of the 'buddy' system. A 'buddy' is a person who is the nominated contact for the lone worker during the period in which they will be working alone. Staff must be aware of their safety at all times and are referred to the GR33 Worker Policy as a priority.

Staff must update their personal details so they are available to enable the team's safe system of work and business continuity plan to work effectively. All teams must have a safe word for staff phoning into the team. This safe word should be displayed in admin office and team base so staff remain familiar with it, if a risk issue is present. It is the individual workers responsibility to ensure they use these tools and adhere to the policy. All staff personal information must be up to date with contact numbers/ care registration details/ home address for safe system of work. This information is stored safely in the team base. No lone working should take place unless the lone working policy is being adhered to. The team adhere to being open and transparent with their whereabouts. Duty workers through team admin should have access to all staff whereabouts, as well as team manager and clinical lead.

Electronic outlook diaries are an essential tool in working in large community teams in order for teams to adhere to the lone working policy. All staff should use this form of communication and share their calendar with the team admin and line manager. For those who do not use this form of whereabouts a team board should be filled in. Team brief is a weekly meeting held to share some of the weekly whereabouts and manages the out of hour's visits/ buddy system.

## 4. Storage and carriage of medication

Staff are directed to MP1 Medicines Policy.

### 4.1 Transporting service users

Any member of staff using their vehicle for work purposes must ensure it is appropriately insured for such use. Team Managers will ensure that staff hold a current, full, driving licence and their vehicles are appropriately insured.

At times staff may need to transport service users from one location to another. All service users must be assessed, prior to transportation and where potential risk is identified (i.e. they may pose a danger to themselves, the driver, other passengers or other road users) then a management plan must be formulated and risks appropriately communicated to senior managers.

If the assessed risk is deemed to be unacceptable then staff must not use their own vehicles to transport service users.

### 4.2 Record keeping

Staff are directed to the agreed organisational policies (CP3 Health Records Policy).

In addition to the existing policies it is essential each contact with or concerning a service user is recorded in their clinical/CareNotes as soon as possible after the event **but within a maximum of 48 hours**, **or the next working day in the event of a weekend or Bank Holiday**

When not in use, all paper records relating to service users must be stored as per CP3 Trust Records Policy.

From 1 April 2002 it was agreed that health and social services would have a joint record for patients. As the greater volume of information is within the health record, it was agreed that this would be the record used and social services would enter information into that, rather than have a separate social services record. This reduced the risk of missed information and reduced duplication of entries. The Trust is the holder of the record; therefore any requests for access to the record are processed by the Trust. Please refer to CP3 Health Records Policy for the agreement to have shared records.

### 4.3 Quality and effectiveness performance

Team members have a responsibility to keep up to date with data quality and keeping timescales in line with policy. A carenotes assist is being developed to help facilitate this. Mobile technology is available for most workers to enable them to work more collaboratively with service users in developing care plans. Individual workers have dashboards on their carenotes to help identify areas needing immediate improvement.

### 4.4 Business continuity

Each team has their own business continuity plan which is CWP West Community Services (Mental Health) in the event of a serious untoward incident or natural disaster including extreme shortage of staff

### 4.5 Physical health

CQUIN for physical health also the trust is committed to smoke free and all service users in the community should be aware of this if they have to come into hospital.

### 4.6 Nice guidance

A number of NICE guidance are relevant to adult mental health services and guidance should be used to develop our services

### 4.7 Audit

Each team participates in a quarterly safety matrix external audit where the results are shared with the team

### 4.8 Communication

Each start of the week the teams have a briefing around staff/ annual leave/ TOIL, cover arrangements, any relevant safety issues or issues to be identified at start of the week

Teams also have a weekly MDT, as discussed earlier

The team has a monthly business meeting where the information from management meetings and trust board are feedback as well as knowing how we are doing as a team monthly data, targets team performance training as well as guest speakers and future team developments and innovation and any learning from incidents.

All team meetings are mandatory for all team members and apologies should be sent in the event of circumstances where nonattendance cannot be avoided. Feedback should be given around clinical issues if non-attendance. Business etiquette rules apply in team meetings around the use of mobile phones and mobile technology. Technology should only be used in meeting if in order to engage with the meeting by being active on carenotes etc.

For internal communications between teams all adult teams have generic email accounts in order to communicate more effectively with wards and CRHT/ internal systems per team manage this

### 4.9 Equality and Diversity

The team will operate under the NHS Equality and Diversity system, offering a service to those in need of secondary mental health services regardless of race, gender, sexual orientation, age, religion or disability. The MHT will, where necessary, actively plan reasonable adjustments to the plan of care

to ensure that those from the protected groups can access and benefit from services. This could include arranging interpretation services or leaflets in different languages or easy read format.

The MHT will endeavour to actively engage with voluntary groups who represent people from the protected groups, and to work towards improving equity of access and treatment for those who may otherwise be excluded from the care they need.

### 4.10 Team base

Each team has their own team base and generic email account

Adult Mental health service Chester is based at
Upton lea resource centre
Bowmere Hospital
Countess of Chester health park Chester
Liverpool Road
Chester
CH2 1BQ
Tel 01244 397499
Adultmentalhealthservicechester@cwp.nhs.uk

Ellesmere Port adult mental health Service
Cherrybank resource Centre
85 Wellington Road
Ellesmere Port
CH65 OBD
0151 4888360/ 4888411

Vale Royal Adult mental health Service
Vale House Resource Centre
Winsford
ValeRoyalAMHS@cwp.nhs.uk

**Hours of operation**

Adult Mental Health services are Monday – Friday 9-5 services
The team does offer flexibility where, for service users that work and cannot see the team within the core hours and safe systems of out of hours is implemented for this
Out of hours CRHT is the out of hours response telephone number 01244 397357

## Appendix 1 - Organisation of Planned CPA Reviews In CMHTS

The date for the CPA review will be booked every 10 months for CPA patients, or 6 months in cases of patients on Assertive Outreach caseload. The date should be rearranged if the care coordinator or consultant is unable to attend, but must take place within 12 months of the previous review.

The care coordinator should provide the full list of invitees to the team secretary one month before the review so that all relevant persons are invited for the meeting. The invitees will include the patient, any carers involved in the patient's care, and other relevant personnel involved in provision of care such as social care staff, clinical support worker, care home staff, as well as the GP. Those who cannot attend the meeting will be requested to send their feedback in writing prior to the meeting.

Prior to the CPA review, the care coordinator will arrange for all routine blood tests to be done, and results brought to the meeting. An annual health check should also be undertaken prior to the meeting. This may take place in primary care, or in a specialist clinic in CWP. Care coordinator will ensure that the patient is booked in for the annual health check prior to the meeting. Any new physical health concerns will be identified and communicated at the meeting. The full list of current prescribed medication will be obtained from the GP surgery. It may be appropriate for the care coordinator to meet with the service user prior to the meeting to discuss what will happen at the CPA review meeting, and identify any issues that the patient may wish to bring up in the CPA review meeting.

CPA reviews will last for 30-45 minutes, or longer if required. The existing care plan in carenotes will be discussed and updated by the care coordinator. The review will consist of a mental health review, review of physical health issues, medication and side effects, compliance issues, risks to service user/ others/ any other risks, leisure and accommodation issues, and future goals for recovery. Contingency plans in the event of a relapse, and relevant contact numbers will also be updated.

Following the CPA review, the care coordinator will update the care plan and provide the service user a copy of the care plan within 4 weeks. A signed copy of the care plan will be kept in paper case notes, while an electronic copy will be updated on carenotes records of the patient. Copies of the careplan will be sent to the GP and other professionals involved in the patient's care.

The care coordinator will also update the CARSO Summarised View of Risk, HoNOS PbR, and other relevant data on Carenotes.

The consultant will review and update the ICD 10 Diagnoses, both primary mental health and secondary physical health diagnoses, if required. The consultant will also dictate a clinic letter using the clinic letter template, which will be typed and sent to the GP within 10 working days post review. Any changes to medication will be faxed to the GP on the day of review. The date for the next CPA review meeting will be decided at the meeting and booked by admin staff.

CPA Reviews may also be organised urgently when concerns are raised by the care coordinator. CPA reviews are also held in acute care settings when the patient is admitted to the wards. Patients discharged from Acute Care Services will have a CPA review in the community within 4 weeks from discharge. Patients in out of area facilities will have their reviews in their place of residence. The same principles will apply, i.e., updating the care plan, completing relevant documentation, and informing the GP/patient.

**Appendix 2 - Recovery**

This group includes patients on **CPA care** who are suffering from acute mental illness, and are complex and high risk, including:

- Assertive Outreach
- Complex Dementia patients
- CTO
- Dual Diagnosis
- Relapsing/revolving door patients
- Patients with history of non-compliance
- Homeless patients
- Patients with high risk of suicide/self harm
- Complex personality disorders
- Patients with special co-morbid conditions such as ADHD and ASD
- Patients with serious physical health problems
- Patients with safeguarding issues

**Interventions for CPA patients:**

These patients will have an identified care coordinator and possibly a support worker. They may also have key workers from other services and partner organizations who will be involved in providing a package of care

- CPA reviews (annually or more frequently if indicated)
- Mental health and medication review (annually or as when required)
- Physical health review (annually)
- OT assessment
- Advocacy services
- Crisis Respite
- Personalisation
- Housing
- Access to Health and Wellbeing Hub
- Access to Psychological therapies
- Referral to other services, e.g. Drugs and Alcohol/ADHD/Complex Needs
- Hospital Managers and MHRT meetings for CTO patients
- Carers' assessment and carer support plan
- MHA assessments
- Safeguarding
- WRAP plan
- Advanced statement
- Recovery star
- Access to Recovery College
- 7 day follow up following discharge from Acute Care service

**Documentation:**

- CCO Careplan (annually) or more frequent if needs updating
- CARSO Summarized View of Risk (annually or more frequently if required)
- HoNOS PbR/ HoNOS OP (as per clustering pathway)
- Care review form (annually)
- AUDIT
- Smoking status on Physical Health Review Form on carenotes
- Scheduled event/ Clinical note on carenotes/ combined event
- ICD 10 form (primary and secondary)
- CTO reports as and when required
- Employment status
- Accommodation status

- Clinic letter to GP, and copy to service user (if patient has consented to receiving copy of clinic letter)

These patients are likely to require long term care under CPA as per CPA policy
Patients who achieve stability and are no longer deemed to be high risk, will then be re-graded and transferred to the Review stream and may be managed under standard care with or without a primary worker depending on needs/ interventions required.
Patients who are relapsing may be referred to Home Treatment Team, for either home treatment, or admission to acute care services.

**Appendix 3 - Review**

**Assessments of new referrals:**

These will be carried out by Consultants, trainee or SAS doctors. This may also be done jointly with a member of the team (care coordinator/ Review team practitioner).

- Appointment booked by Receptionist/secretary
- Appointment letter sent to service user with leaflet with instructions about reaching team base, and advised to bring list of medication
- When patient attends for appointment, requested to fill in form to update personal data including mobile phone number, social inclusion and employment details
- Patient offered one hour appointment with consultant, trainee doctor, or team member
- Service user and carer details checked, service user opt in to receive copy of clinic letters and text reminders
- Full mental health assessment completed
- Diagnosis (provisional or confirmed) discussed with patient
- Further investigations discussed and arranged with GP
- Patient given advice regarding treatment and then either discharged back to GP OR
- Patient accepted into the service and offered a range of evidence based treatments appropriate for the diagnosis made by assessor
- Medication leaflets offered
- Physical health issues discussed. Patient advised to have routine bloods and ECG as per Trust guidelines. Routine bloods to be arranged (if not already done)
- Appointment made for Advocacy services if appropriate
- Assessment notes completed and letter dictated to GP (copy to patient enclosing relevant leaflets if patient has consented to receiving copy of clinic letter)
- Carenotes forms completed – CARSO, HoNOS PbR, ICD 10 diagnoses for all patients
- Follow up appointment arranged in 2-4 weeks, or as deemed appropriate.
- New patient assessment discussed in MDT and recorded in MDT notes.

Patients who are stable and do not pose high risks to self and others, will subsequently be monitored in Consultant led or Practitioner led clinics

**Practitioner Led Clinics**

Practitioner Led clinics will be conducted by Advanced Nurse Practitioner and other Nurse Practitioners to review patients who were previously on CPA care and are now regarded to standard care, as well as standard care patients previously seen in Consultant led clinics. They will be generally stable in mental health.

They include:

- Patients in residential/supported accommodation
- Patients stable on depot medication
- Patients stable on Clozapine, Lithium, and other psychotropic medication
- Patients who are stable and require annual review of S117 Aftercare
- Patients who are stable and require annual review of care packages

Interventions:

- 6 monthly Mental Health and medication reviews in Out Patient Clinics (or more frequently if required)
- Physical Health review
- Access to Health and Well Being Hub
- Access to Psychological interventions
- Referral to other services when appropriate
- Carers' assessment and carer support plan
- Access to CBT and employment support
- Access to Recovery College

**Documentation:**

- CARSO summarized view of risk (annually or whenever required)
- HoNOS PbR/ HoNos OA (as per clustering pathway)
- ICD 10 form (primary and secondary)
- Clinical note in carenotes
- Letter to GP – using standard template, and copy to service user (if patient has consented to receiving copy of clinic letter)

**Consultant Led Clinics:**

This group includes patients who are currently stable in mental health and on standard care to be reviewed and discharged

- Patients previously CPA, now stable on standard care, who are on S117 aftercare
- Patients who still require monitoring of their medication, and consultant input

**Interventions:**

- Annual Mental Health and medication reviews in Out Patient Clinics (or more frequently if required)
- Physical Health review
- Access to Health and Well Being Hub
- Access to Psychological interventions
- Referral to other services when appropriate
- Access to CBT and employment support
- Access to Recovery College

**Documentation:**

- CARSO summarized view of risk (annually or whenever required)
- HoNOS PbR (as per clustering pathway)
- ICD 10 form (optional, only if diagnosis needs to be updated)
- Letter to GP – using standard template, and copy to service user (if patient has consented to receiving copy of clinic letter)

Some patients in Review will continue to be reviewed in Practitioner led clinics, while others will be facilitated along the pathway towards discharge from services.

Any relapsing patient may be reviewed and regarded back to CPA and be under Recovery for CPA care.

Patients who are relapsing and pose high risks, may be referred to CRHTT for Home Treatment or assessment for admission to Acute Care

Health and wellbeing clinics include clozapine, lithium and depot. Further operating procedures to be developed to support the effective functioning of the clinics