Cheshire and Wirral Partnership NHS
NHS Foundation Trust

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Adult Mental Health Service Operational Procedure - Wirral

Lead executive	General Manager - Wirral
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Type of document	Local operational procedure
Target audience	All Adult Mental Health Service Staff
Document purpose	Model for delivering care to people who are open to the Adult Community Mental Health Service

Approving meeting	Wirral CMB	22-Oct-15
Implementation date	22-Oct	

CWP documents to be read in conjunction with	
MP1	Medicines Policy
CP42	CPA Policy
GR33	Lone Worker Policy
HR22	Supervision Policy
HR2.6	Annual Leave Policy
CP3	Trust Records Policy
CP37	Policy and procedure for managing informal service users' non-compliance with treatment and managing DNA (did not attend) or cancelled appointment
CP40	Safeguarding Children Policy
CP10	Safeguarding Adult Policy
CP1	Admissions, Discharge and Transfer of Care policy
	Wirral Single Point of Access Operational Procedure
	Home treatment procedure

Document change history	
What is different?	Rewritten to represent changes to service as a result of implementing the StAR model
Appendices / electronic forms	Yes
What is the impact of change?	No

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP

Document consultation	
Wirral locality	Consultation with service users, carers and all community staff in CWP Wirral
External agencies	Service Users and Carers groups in Wirral

Financial resource implications	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	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	Yes	This policy is applicable to all individuals aged 18 years and above
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	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?		
Yes		
Is the impact of the document likely to be negative?	No	
- If so can the impact be avoided?	N/A	
- What alternatives are there to achieving the document without the impact?	N/A	
- Can we reduce the impact by taking different action?	N/A	
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. 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	

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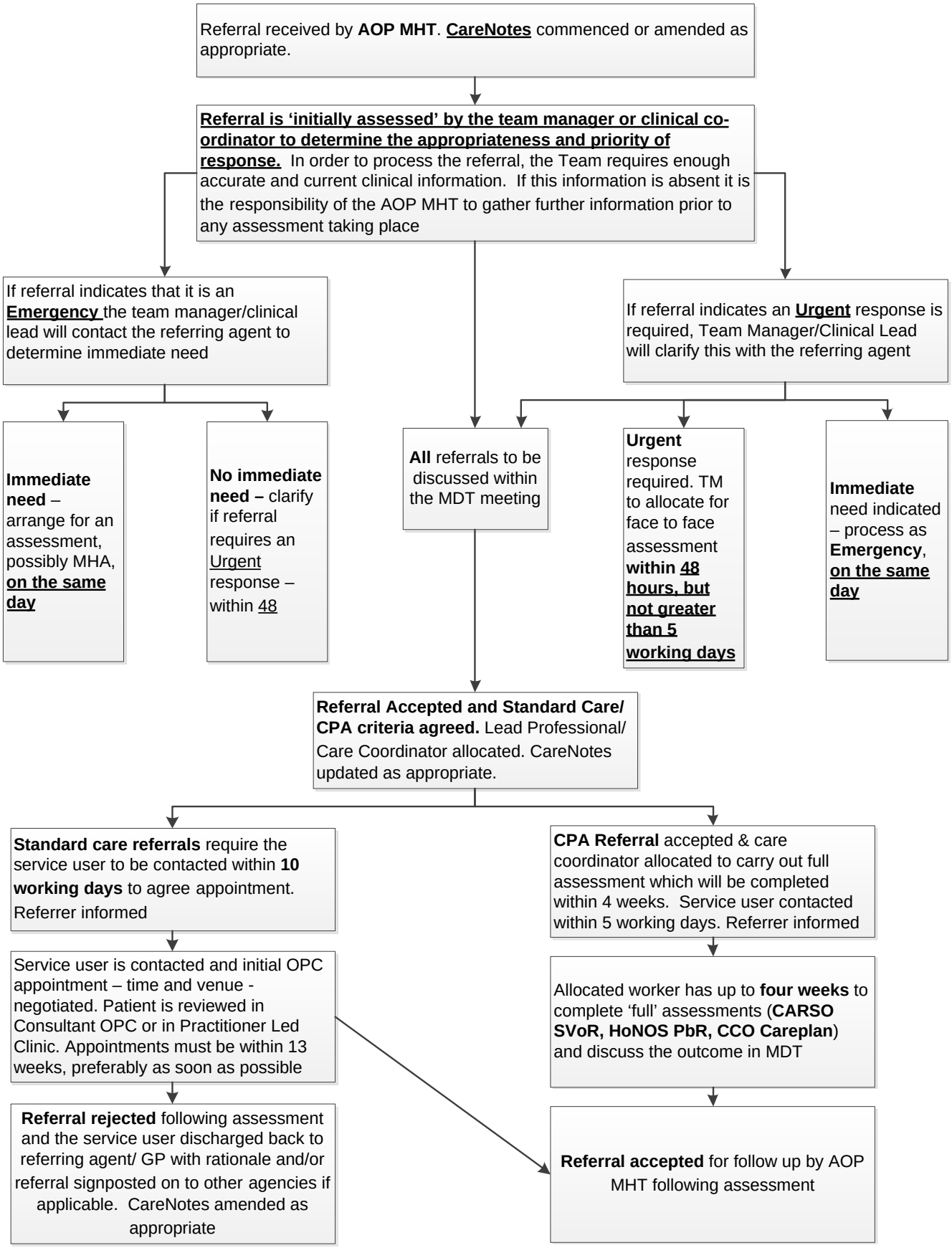
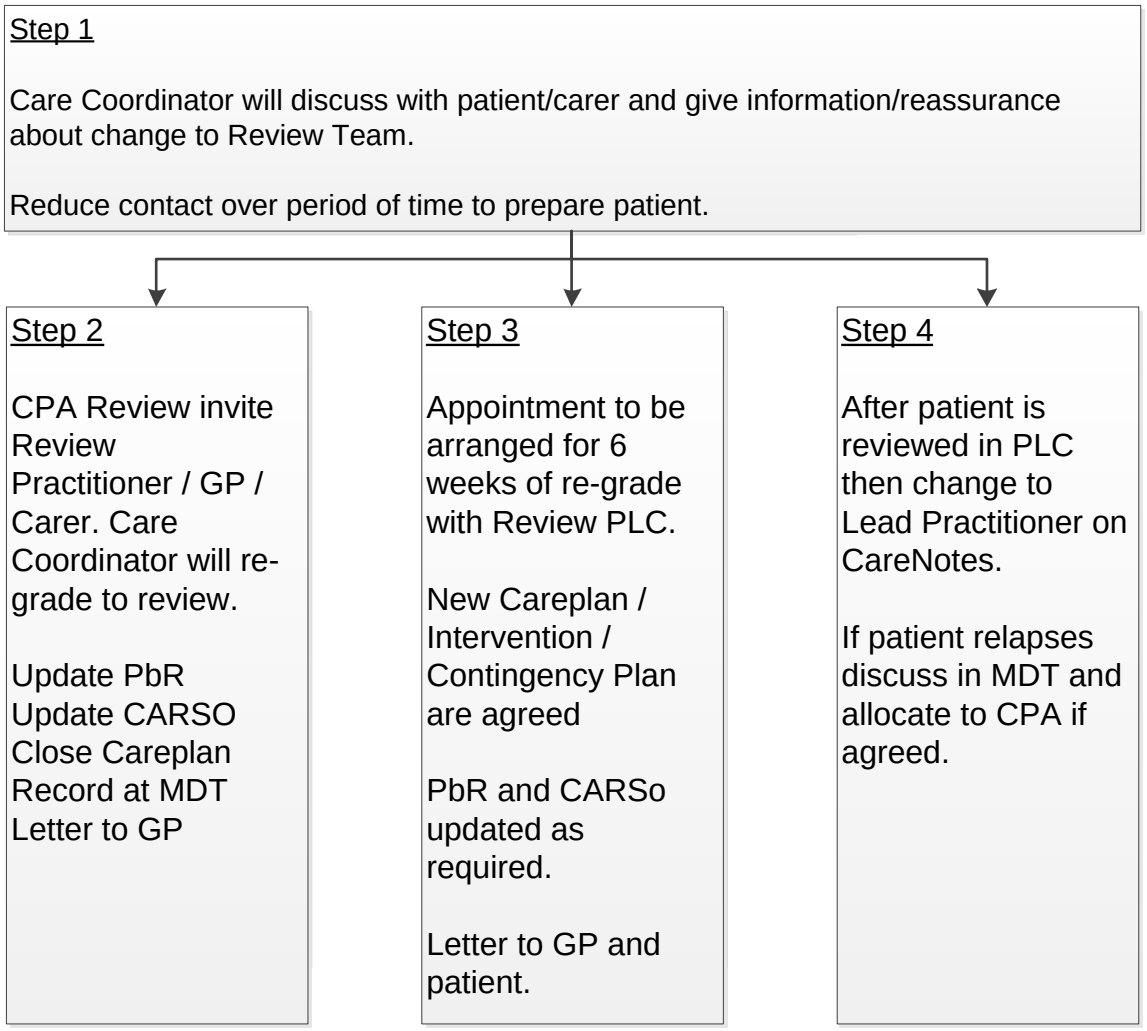
Quick Reference Flow Chart 1 – Referral



Quick Reference Flow Chart 2 – Transfer/Re-grade, CPA to Review



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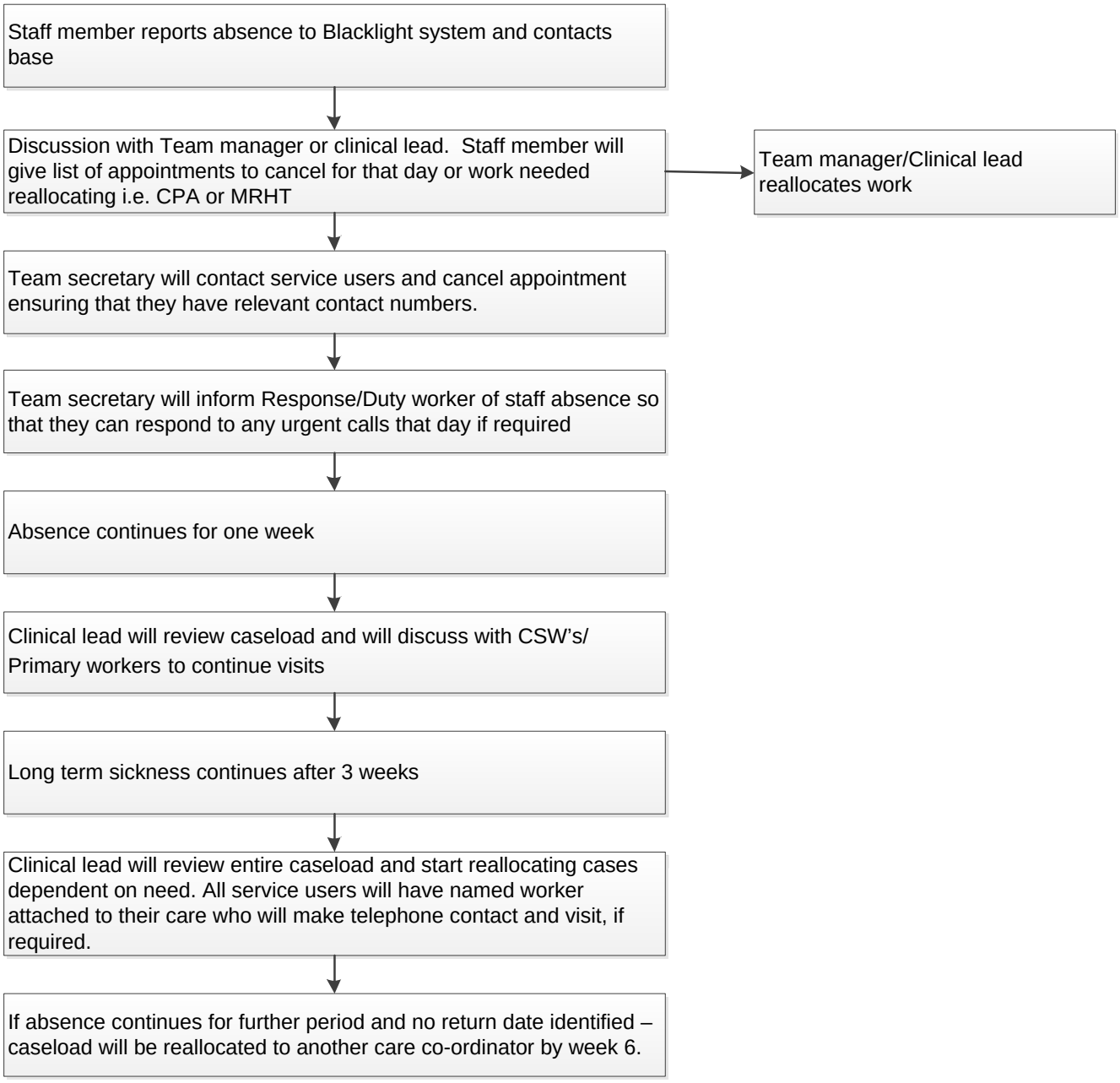

1. Introduction

This policy describes how Cheshire and Wirral Partnership NHS Foundation Trust (CWP) – Wirral 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 Mental Health Services (formerly CMHTs) 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.

2. Operational Procedure perspective

This document is underpinned by relevant national and local policy.
This document is set within the context of the Trust's strategic objectives of recovery orientated services and the integrated business plan.

3. Adult and Older Persons Mental Health Service (A&OA MHS)

The A&OA MHS comprises specialist, secondary care community mental health teams 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, and who are eligible for services under Fair Access to Care, meeting the criteria for substantial or critical needs. The service users are ordinarily registered with GP practices within the localities (although some individuals may be homeless or living within the area temporarily and yet to register with a GP).Those service users aged 14-35 years with either first episode psychosis or suspected first episode psychosis, will be referred to the Early Intervention Team via the appropriate pathway.

The Wirral A&OA MHS are integrated teams in adult aged 18-65 i.e.: CWP employed staff work alongside LA staff using the Care programme Approach to provide for the individuals' health and social care needs. In Older Adults teams they are co-located, but not integrated.

In recognition of the National Service Framework (NSF) and Fair Access to Care (Critical or Substantial needs) the A&OA MHS will prioritise those individuals whose mental health and accompanying social care needs impacts most severely on their ability to function within the community. The A&OA MHS 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

A&OA MHSs are divided into functions so that service users are placed in the part of the service which best meets their needs. A process pathway refers to the interlinked services and agencies working together to support service user and carer needs and achieve the desired outcomes. An effective pathway is one where all those involved in providing the service share aims, priorities and values as well as operational policies. In agreeing the effective pathway they stipulate potential steps and stages along the path and the desired standard expected that every recipient of services should receive.

The functions or parts of the A&OA MHS are:

Recovery – CPA level of care
Review – Standard Care
Assertive Outreach - for some service users on a CPA level of care who may require more intensive support.

4. Multi-disciplinary teams

The multi-disciplinary A&OA MHS unites specialist Medical, Nursing, Approved Mental Health Practitioners [social workers], Occupational Therapists, Psychologists, Physiotherapists, Advanced Nurse Practitioners 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 A&OA MHS will;

- Provide assessment diagnosis and treatment via the CPA/Standard Care process, working within the Mental Health Act and Mental Capacity Act.
- Promote service user recovery and social inclusion utilising Wellness Recovery Action Planning (WRAP) and other recovery orientated tools.

- Focus upon improving the mental and physical well-being of service users.
- Work in partnership with service users and carers
- Ensure care is delivered in the least restrictive and disruptive manner possible.
- Reduce the stigma associated with mental health care.
- Stabilise social functioning and protect community tenure.
- Utilise the experience and knowledge of all team members to help facilitate a holistic approach to our service users.
- Work in collaboration with Primary Care.

5. Hours of operation

The A&OA MHS will generally operate between 09.00 and 17.00 hrs, Monday to Friday with flexible hours for specific tasks or interventions. No crisis provision is made out of hours by the A&OA MHS. Occasionally staff may be required to work beyond their normal hours to assist in supporting a service user who presented in crisis during working hours of the team. When doing so, staff must adhere to the GR33 Lone Worker Policy.

6. Service user groups covered

All people who require a specialist Mental Health assessment are referred to the Wirral Access Team who will carry out an assessment and advise whether the individual requires specialist mental health care under the A&OA MHS. Referrers will need to demonstrate that the person has had appropriate treatment within Primary Care and has not adequately responded, and that there is a reasonable expectation that specialist input from the A&OA MHS is better placed to address the unresolved problem.

Eligible referrals to the Access Team will be accepted from:

- GPs
- Primary Care Mental Health Teams.
- Local authority duty/emergency teams (including ACCESS)
- Out of CWP area teams/services.

The normal expectation is that people with depression will have had at least two trials of antidepressant therapy within Primary Care over a period of approximately six months. If this does not prove successful then it would be appropriate to refer into to the Access Team for an assessment.

Social Care Access teams will continue to complete contact assessments on all individuals who present to them. Where the contact assessment does not indicate the presence of an eligible need they will be advised and redirected. Social Care Access teams will refer on to Access Service, those referrals which require a specialist assessment. These referrals will include requests for assessment under the MHA, as well as the NHS and Community Care Act. The referrals will be assessed and the passed on to the appropriate A&OA MHS for further assessment and management.

Adult and Older Adult Mental Health service provision is age related, those who are 18-65 years being provided by Adult Teams and over 65s by the Older Adult team

However, those people aged 65 and above who are already known to services, and whose health and social care needs can be appropriately met by the adult MHT's, will remain within this service. Should their mental health needs be age related, eg:, dementia, or should it be agreed that their needs will be better met by Older Adult services, they will be supported by the specific Older Adult MHT. Transition protocols for transfer of care will be utilised to ensure safe transfer of care.

Patients with Dementia, or suspected cognitive impairment, will be assessed and managed in accordance with the Dementia Pathway.

7. Exclusion criteria

People under the age of 18 years.

People who are not suffering from a severe, or persistent mental disorder, associated with a high level of mental distress, which impacts on their level of functioning in the community.

8. Referrals to A&OA MHS

Referrals to A&OA MHS's are usually received from Access Team or directly from Acute Care services following an inpatient stay if not previously known to the service.

Agencies such as housing departments, educational establishments, general hospital services and recognised local charitable organisations, can also access the A&OA MHS through the Access Team

Some referrals may be sent directly to A&OA MHSs, eg:

- Transfers from other community teams, including Early Intervention Team, CAMHS, LD services, Wirral Memory Assessment Service, CAT, ARBI
- Liaison Psychiatry Service
- Crisis Resolution Home Treatment Team (CRHTT)
- Acute Care service
- Other MH agencies / Trusts outside CWP

All referrals to the A&OA MHS are triaged upon receipt by the Team Manager or the Clinical Lead to establish the priority of response and whether the individual requires allocating to CPA or standard care

9. Processing referrals

All documentation, including written referrals, must be date stamped upon receipt – response times will be audited against this date. Some referrals may be received via email, these should be retained as a record of date of receipt.

In order to process the referral, the Team require accurate and current clinical and patient information. If this information is absent it is the responsibility of the Access Team, (or A&OA MHS if the referral is sent directly to the team), to gather further information at first contact.

All referrals to A&OA MHSs 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 that are required to process the referral - Electronic Patient Record (EPR), Address, GP and Referral – the referral will then become the responsibility of the team.

All members of the team are responsible for maintaining the data quality of service users' electronic records.

10. Response times for referrals

Response Standards for referral to A&OA MHS's are to be prioritised under the following three categories: Routine, Urgent and Emergency.

The referral to the A&OA MHS will be triaged by Team Manager or Clinical Lead

Routine referrals are those requiring an assessment by a mental health professional or a Nurse Practitioner

Receipt of the referral into the A&OA MHS will be acknowledged to the referring agent. The service user will be contacted within 10 working days by letter or telephone. Assessment should be completed within 13 weeks.

If no response is received from the referred individual within 2 weeks, 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 referral will discussed in MDT meeting to decide and document the appropriate action – this may include making a home visit or informing/discharging back to the referrer.

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

If the assessment has identified a need for an urgent response, then the A&OA MHS will contact and assess the service user within the timeframe specified by Access Services, 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 Crisis Resolution Home Treatment team and/or Acute Care services.

The Team Manager or a nominated 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 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 Access 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 A&OA MHS.

Face to face contact will be made with the service user within 5 days, or earlier if specified by Access Team/ referrer.

Emergency referrals are those requiring an immediate response by the A&OA MHS for a Medical or Mental Health Act assessment. These referrals will usually be associated with a high level of risk factors. 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

It is expected that the referring agent would contact the team via telephone or fax to avoid unnecessary delays. Response time for emergency referrals will be on the same day as receipt of referral.

The Team Manager or a nominated member of the team will ensure that all relevant information including risk factors are gathered from the referring agent and others 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 emergency, as opposed to routine or urgent.

Some of the emergency referrals may require a MHA assessment. This information will then be passed to the Duty manager to arrange a MHA assessment by Consultant, S12 approved doctor, and Approved Mental Health Practitioner. The service user and the referring agent will be notified of the time of the face to face assessment.

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 and arrange a face to face assessment.

11. Allocation of referrals

All new referrals to A&OA MHS will be discussed within the formal weekly multidisciplinary team [MDT] allocation meeting. However, allocation may take place outside of the MDT.

There is a requirement to place the service user on either Standard Care or CPA care., the decision is usually made by the team, based on the information they have about the service user, at the weekly MDT meeting those on standard care will be allocated a Lead Professional and those on CPA will be allocated a Care Co-ordinator by the Team Manager or Clinical Lead.

If the service user is to be placed on CPA care, they will be contacted by the allocated care coordinator within 5 days of allocation. Allocation to a care co-ordinator should be made within 7 working days of receipt of the referral..

If allocation cannot be achieved, then the Clinical Lead or the Team Manager will contact the patient to arrange an assessment within 5 days. An outpatient clinic appointment (or domiciliary visit, if appropriate) will be arranged with Consultant or other medic in the team, as soon as possible.

The allocated care coordinator has 4 weeks to engage with the service user and complete the care plan, CARSO SVoR, contingency plan and other documentation on carenotes as per CPA policy.

If the service user is placed on Standard Care they will be contacted within 10 working days, and assessed by a lead professional, (who may be an Advanced Nurse Practitioner/ Nurse Practitioner/ Occupational Therapist/ Consultant/ Specialist Registrar or Junior doctor), within 13 weeks of allocation to standard care. All attempts will be made to see the new patient as soon as possible.

Standard clinic letter templates will be used to communicate the outcome of assessment to the service user's GP/ referrer.

Following their assessment, if it is decided that the service user does not require further contact with secondary care services, they will be discharged back to the referrer. A letter will be sent to the referrer with details of assessment and the rationale for discharge. This may involve the A&OA MHS signposting the referral on to other more appropriate services.

12. Care Pathways in A&OA MHS

From April 2013 Wirral Community Mental Health Services have adopted the **'Stepped Approach to Recovery' [StAR model]** and have configured the teams accordingly. The Community Mental Health teams are divided into functions ie: Recovery and Review and Assertive Outreach so that service users are placed in the most appropriate part of the service which best meets their needs.

13. Recovery Function

The Recovery team within the A&OA MHS provides community based care to 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 in the Recovery Team are on CPA care as per the CP42 Care Programme Approach Policy, and are allocated a care coordinator, who coordinates their care.

A CPA review meeting to review and update their care plan and risk plan will be held at least annually for all service users on CPA level of care (Appendix 1)

Details of interventions provided and documentation used in the Recovery function are given in Appendix 2.

A care notes assist pathway has been developed for the Recovery and Assertive Outreach functions which should be used by care co-ordinators to manage their case load.

15. Assertive Outreach Function

Adult and Older Persons Mental Health Teams also provide an Assertive Outreach function. Assertive outreach is a way of working with an identified client group of severely mentally ill adults who do not effectively engage with mental health services. 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. It works with people in their own environment, engages with the user's support system of family, friends and others.

14. Review Function

All service users who are reasonably stable in mental health, and do not pose significant risks, will be allocated to the Review Team.

Patients in the Review team are on Standard care as per the CP42 Care Programme Approach Policy

Patients on standard care are usually reviewed in an out patient clinic setting, and are not routinely visited at home unless they are unable to access a clinic setting.

Patients may be reviewed by nurse practitioners, other qualified professionals or medical staff.

Review team practitioners will also review certain groups of patients in wellbeing clinics such as Lithium clinic, Depot clinic, and clinics for patients on Clozapine.

Those patients in the review team will also include stable patients residing in supported accommodation, residential homes and nursing homes.

Standard care patients will be seen at least once in 6 months by Nurse Practitioners in Practitioner Led Clinics, or at least annually by medical staff in outpatient clinics. See Appendix 3 for details

Patients remain in the Review team for as long as they need to. Should their needs increase, then patients will be transferred to the Recovery team to be placed under CPA care with allocation of a care coordinator before being transferred back to review once they become more settled., Patients in the review team may also be discharged to the care of the GP in primary care.

15. Multi-disciplinary team meetings

Each A&OA MHS will hold a weekly formal and minuted MDT allocation meeting.
Membership will include all members of the A&OA MHS
The agreed specific meeting agenda will be used by all A&OA MHSs.
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 a designated responsibility for actions, they are required to report on progress at the next MDT 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 written/verbal 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 Meeting minutes once a month as part of the team manager supervision.

16. Priority response to calls from service users/carers

Due to the nature of serious and enduring mental health problems, service users' 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 immediately, and if left unsupported, such changes can lead to hospital admission or acts of harm to self or others. It is therefore necessary for the team to make an appropriate and timely response to situations considered likely to develop into a crisis, or where a marked deterioration in mental health has occurred. In particular, those service users identified as higher risk, will need to be prioritised and responses planned urgently.

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 within the A&OA MHS.

A response rota comprising of all members of the integrated multidisciplinary team will be coordinated by the Clinical Lead.

Service users, particularly those on CPA, will have Crisis and Contingency plans and possibly an Advance Statement within their care plan, and these will be referred to and adhered to, wherever possible.

Calls regarding service users on standard care open to the Review Team, will be addressed by the response rota professional. Wherever possible, attempts will be made to consult with the Consultant or Lead Professional who provides routine care to the service user.

17. Requests for change of consultant/ care coordinator/ team

All service users will access mental health services via A&OA MHSs based on GP catchment area. Service users may sometimes request alternative consultant/team member. If service user requests an alternative consultant/ care coordinator, the Team Manager will discuss with the service user as to the reason for change.

If service user still wishes to change consultant, then the request for change will be put in writing by service user, and sent to the relevant Clinical Director to allocate alternative consultant.

If service user wishes to change the care coordinator, this will be facilitated by the Clinical Lead/Team Manager of the team.

If service user wishes to change the team, the request will sent in writing to the Clinical Director to allocate another consultant and team in Wirral.

If an out of area GP/ Consultant requests A&OA MHS input from Wirral services, then locality Clinical Director and General Manager will discuss with referring Consultant/ Clinical Director, making it explicit to referrer and service user that only standard care by a Wirral consultant/team can be offered. Accepting Clinical Director will then allocate consultant/ team.

18. 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 remain open to the team during the in-patient episode. Ensuring that the service user and relevant carers receive appropriate support during the inpatient episode, remains a high priority for the team. The care co-ordinator should make regular visits to the ward, liaise with ward staff, and attend all CPA and discharge meetings

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 service user.

The principles of CPA apply to those service users in prison, meeting relevant care pathways. The care co-ordinator will make every effort to attend CPA reviews whilst the service user is in prison. 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.

19. Failed visits/contact

In the case of a failed visit CMHT staff are advised to refer 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 prior to discharge. DNA letter template will be used to inform GP of DNA on the same day by OPC reception staff.

All DNA’s, whether failed visits or non attendance at clinic should be followed up and an assessment of risk made in order to decide whether the situation requires an urgent or non urgent response. A record will be made in carenotes by the care co-ordinator or lead professional under the heading of Did not attend or Failed Visit of any identified risks, as well as the rationale for decision/ plans for review of the patient..

20. Transfer between Wirral/ other CWP teams/ Out of area

Patients may be transferred out of a Wirral team to another team in Wirral, 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 Wirral, 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) 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.

21. Joint working with other teams

Some patients may be opened to A&OA MHSs as well as other CWP teams in Wirral, or teams in other CWP sites. Patients may be open to A&OA MHS as well ADHD service, Personality Disorder Provision, Complex Needs Service, and Drugs and Alcohol services

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 and the CCO informed of any changes to level of risk or circumstances of the service user.

Patients who are on standard care will also remain open to the team with the main Consultant/Lead Professional from the A&OA MHS. However, some standard care patients may be discharged from A&OA MHS 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 A&OA MHS to the other team should be taken in consultation with the consultant/team manager of the other team.

22. 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 recognize 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 Team Manager / Clinical Lead are responsible for ensuring that the main standards of the Triangle of Care are 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.

23. Safeguarding

"Safeguarding is everybody's business; everyone 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 for procedures

24. 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 A&OA MHS 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 A&OA MHS 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.

25. Discharge from services

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

Discharge from services must be preceded by a review by the Lead Professional or Consultant. 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 teams may require a transfer to Older Peoples services or to Primary Care, or even a transfer to services out of area. Transition protocols and Admission, Discharge and Transfer policy CP1 should be adhered to.

If a service user is to be discharged from secondary care services, they should, where appropriate, be informed of how to 'fast-track' back into services.

The GP will be informed, in writing, of the discharge from secondary care services with an appropriate care plan for monitoring of the service user's mental health and treatment, as well as a contingency plan for the management of any potential risks.

26. Supervision/ Appraisals/ Absences

Team members are guided to the GR14 Supervision Policy,

''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 that is reviewed after 6 months as per Trust policy.

27. Lone working

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

A crucial element of lone working is the 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 Lone Worker Policy as a priority.

28. Unplanned absence of staff

Absence of team members for any reason must be addressed as soon as possible by the Team manager or Clinical Lead. See Quick reference flowchart 3 for details
The team manager is responsible for managing Sickness / Absence through adherence to the policy -

29. Storage and carriage of medication

All staff are directed to MP1 Medicines Policy.

30. Transporting service users

Any member of staff using their vehicle for work purposes must ensure it is appropriately insured for such use. Team Managers are responsible for ensuring that all 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 potential risks identified (ie, whether they pose a danger to themselves, the driver, other passengers or other road users). A management plan must be formulated and risks appropriately communicated to senior managers.

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

31. Record keeping

All staff are directed to the agreed Trust policy (CP3 Health Records Policy).

In addition to the existing policies it is essential that each contact with, or concerning a service user, is recorded in their clinical record /Care -Notes, as soon as possible after the event and the same day if the record contains any changes to risk factors or service user circumstances. In all cases the record must be completed within 2 working days of the event taking place.

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 the service users' health records, rather than have a separate social services record. This reduces the risk of missed information and 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.

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 is good practice 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 mins, 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 casenotes,

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, ie, updating the care plan, completing relevant documentation, and informing the GP/patient.

Appendix 2 - Recovery Team

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 organisations 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
- Personalised Budget
- Housing
- Access to Health and Wellbeing Hub
- Access to Psychological therapies
- Referral to other services, eg 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 frequently if required)
- 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
  Falls Risk assessment , where appropriate
- Scheduled event/ Clinical note on carenotes
- 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 Team
Patients who are relapsing may be referred to Home Treatment Team, for either home treatment, or admission to acute care services.

Appendix 3 - Review Team

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 guideleines. 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 regraded 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 cCBT 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

- 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 cCBT 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 the Review Team 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 referred back to Recovery Team 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