

Harrow Community Mental Health Team

Operational Policy

March 2016

6th Draft

(NB. Areas highlighted in red require further work.)

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Appendix 1 - Zoning Mechanism

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DRAFT

Purpose

This policy outlines the principles of the community mental health service model. It covers the key requirements for staff providing adult community mental health services for adults in Harrow.

This policy is essential reading for the following groups of staff:

- ALL staff, students, volunteers and locum/agency workers in the Harrow Community Mental Health Teams.

The following groups of staff need to be aware of the existence of this policy:

- Operational Managers
- ALL staff, students, volunteers and locum/agency workers in the Community Mental Health Teams in adjacent CNWL boroughs.

Key points of the policy

- Guiding principles of the service model
- Service criteria
- Referral, assessment and allocation
- Effective Care Coordination and Team Working
- Caseload Management
- Interventions
- Discharge and Transfer
- Key Relationships
- Clinical Supervision, Training and Development
- Governance structures

1. INTRODUCTION

Community Mental Health Teams (CMHTs) in Harrow are at the heart of secondary care mental health services. As part of the service redesign, CMHTs will undertake assessments and, where allocation within the team is appropriate, a range of more specialist assessments and interventions. CMHTs offer a specialist multi-disciplinary service for individuals suffering with mental ill health. They form part of an integrated whole system approach that is delivered in conjunction with inpatient, crisis and specialist mental health services.

Within Harrow, the modernisation agenda and wider system changes will all have an impact on the operation of CMHTs. In particular, the introduction of a Primary Care Mental Health Service through the Mental Health Measure and 'New Ways of Working' should lead to CMHTs being primarily involved with service users most requiring the assistance of the secondary services.

The service offered by the CMHTs is based on current national policy and good practice guidelines, CNWL Care Programme Approach (CPA) guidance and the Department of Health Mental Health Policy Implementation Guidance. It will aim to deliver recovery orientated services in line with the recovery principles adopted by the Trust.

CMHTs deliver social care services for individuals experiencing mental ill health on behalf of Harrow Council. This is delivered within the framework of the Care Act 2014.

CMHTs are committed to:

- Personalisation, giving service users greater choice and control over their lives.
- Better access to services and to information that will assist service users in their recovery.
- Taking into account user satisfaction as a measure of the quality of the services provided in CMHTs.

2. Guiding Principles

CMHTs and practitioners have traditionally focused on helping people recover from symptoms, distress and disability through offering treatment i.e. 'clinical recovery,' and social care support. The more recent emphasis is on people's wellbeing; recovering to a valued pattern of life and living and recovery of relationships, opportunities, hope, independence and security i.e. 'personal recovery.'

The CMHT model supports and blends both clinical and personal recovery approaches.

Whereas clinical recovery is linked to the implementation of evidence based treatment guidelines, personal recovery is more related to 'recruiting the individual as an active agent in their own recovery.' Services are about enabling people to take or regain responsibility and control, build on strengths, exercise choice, seek and find hope and purpose on their own terms, and take opportunities to discover their unique personal recovery pathway.

3. Service Model

Most mental health problems are managed within Primary Care with a small proportion of people identified as needing support from secondary treatment and social care packages.

Therefore three distinct functions are required of CMHTs:

- Giving information and advice on the management of mental health problems by other professionals – in particular advice to primary care.
- Providing assessment, treatment and care for those with time-limited disorders who can benefit from specialist interventions.
- Providing assessment, treatment and care for those with more complex and enduring needs.

The CMHT will be able to:

- Establish effective liaison with local Primary Care Team members, Local Authority departments, third sector organisations and other referring agents to support local care.
- Provide prompt and expert holistic assessment of mental health problems.
- Provide effective, evidence based treatments to reduce and shorten distress and suffering.
- Provide effective social care packages through a personalisation process that are outcome focussed.
- Support service users back into employment, education or training and ensure that service users and carers are not socially isolated from their local community.
- Support the service user to access resources to build resilience and independence.
- Ensure that inappropriate or unnecessary treatments are avoided.
- Establish a detailed understanding of all local resources relevant to support of individuals with mental health problems and promote effective interagency working.
- Assist patients and carers (based on assessment) in accessing such support, both to reduce distress but also to maximise personal recovery and wellbeing.
- Provide advice and support to service users, families and carers.
- Gain a detailed understanding of the local population, its mental health needs and priorities, and provide a service that is sensitive to this; and religious and gender needs.
- Provide a culturally competent service including ready access to interpreter services for minority languages and British Sign Language.

3.1 Primary Care Alignment

Access to CMHTs is based on the alignment with GP practices in Harrow. There are two CMHTs (East and West CMHT) aligned to a number of Primary Care Practices in a defined geographical locality.

There are 6 GP Peer Groups across Harrow listed as below.

West CMHT will be aligned with Peer Groups 1-3

GP Peer Group 1	GP Peer Group 2	GP Peer Group 3
1. Kings Road Surgery 2. Simpson House Medical Centre 3. Wasu Medical Centre 4. GP Direct 5. Shaftesbury Medical Centre 6. Roxbourne Medical Centre	1. Pinner View Medical Centre 2. Pinner Road Surgery 3. Savita Medical Centre 4. Headstone Lane Medical Centre 5. Headstone Road Surgery 6. Ridgeway Surgery 7. Civic Medical Centre	1. Elliott Hall Medical Centre 2. Hatch End Medical Centre 3. Pinn Medical Centre 4. Enderley Road Medical Centre

East CMHT will be aligned with Peer Groups 4-6.

GP Peer Group 4	GP Peer Group 5	GP Peer Group 6
1. Kenton Bridge Medical Centre – Dr Raja 2. Kenton Bridge Medical Centre – Dr Golden 3. Northwick Surgery 4. St Peters Medical Centre 5. Streatfield Health Centre 6. Kenton Clinic	1. Stanmore Medical Centre 2. Aspri Medical Centre 3. Belmont Health Centre 4. Enterprise Practice 5. Circle Practice 6. Stanmore Surgery	1. Honeypot Medical Centre 2. Streatfield Medical Centre 3. Bacon Lane Surgery 4. Zain Medical Centre 5. Harness Practice 6. Charlton Road Medical Centre

Non GP Peer Group

Existing cases as of February 2016 will be assigned to East CMHT and from 1st March 2016 new cases will be assigned based on service users' geographical address.

Out of Borough GPs

Patients with GPs in neighbouring boroughs will be allocated as follows:

East CMHT - Brent, Barnet and Hertfordshire

West CMHT - Hillingdon and Ealing

Foreign Nationals who are inpatients requiring follow up will be allocated as follows:

East CMHT - Dr Oyewole

West CMHT - Dr Whelan

3.2 Zoning

Zoning is based on a recovery approach that seeks to reflect the stages of a journey that a person may go through during an episode of ill health. The level of intensity of support by the team is expected to be highest at the most acute phase of illness or relapse, and should reduce, supporting people towards a greater sense of empowerment and independence in managing their health and well-being, as they move toward their optimum level of recovery.

CMHTs will utilise zoning as the team caseload and risk management approach. The zoning approach will be used to visually indicate the current condition of each service user within the team caseload. Service users will be allocated to a zone: Red, Amber or Green depending on their presentation and risk. (Appendix 1)

- **Red zone** – service users who are at high risk and have a high level of need and are currently in crisis, maybe likely to require admission without further support and require frequent review and intensive support and/or changes to care plans and crisis plans.
 - **Amber zone** – service users for whom the current crisis has passed but are still at risk of relapse or a further mental health or social crisis.
 - **Green zone** – service users who are settled in their mental health and social situation. They are monitored for progress with their recovery and their appropriateness for discharge.
- The appropriate zone will be identified following the outcome of the initial assessment.
 - The team response to service users within the different zones will vary depending on the needs of the individual service user.
 - Review of the Zoning board/database will take place regularly as part of the team meeting process with the whole team present, including the team leader and team Consultant Psychiatrist.
 - For service users in the red zone, review will include completion of previously agreed actions and, where not completed, what support is appropriate to ensure the actions are completed.
 - Individual caseload management supervision must also be undertaken at least monthly and include monitoring complexity of need and the zoned mix of the case load.

3.3 Care Programme Approach

The team will use the Care Programme Approach to provide a framework for effective mental health care for service users with severe mental health problems requiring input from multi professionals. The main elements for professionals in the team will endeavour to achieve the following:

- Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care required from a variety of providers;
- The appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate care and;
- Regular review and, where necessary, agreed changes to the care plan.

Risk Management

Risk management, where risk is caused by a treatable mental illness/disorder, is an on-going and essential part of the CPA process. All members of the team, when in contact with service users, have a responsibility to consider risk management. The risk management plan must be completed for each service user on CPA, reviewed every six months, or updated as appropriate.

It may be appropriate to seek advice from the Forensic Outreach Service (WLMHT) when risk has led to offending behaviour or risks to others are a cause for concern.

Crisis and Contingency Planning

Service users on CPA require, as part of their care plan, a crisis and contingency plan and a Crisis Card. These plans form a key element of their care plan and must be based on the individual circumstances of the service user. Service users may choose to include Advance Directive as part of their contingency planning process.

3.4 Lead Professional Care (LPC)

The patients who are on LPC are those patients who require support from only one discipline (Medical or Non-medical). This would be regardless of their diagnosis. The patients in this category self-manage their mental health problems and have an informal support network. They pose low risk to themselves or others. They are able to maintain contact with services.

The service user will have regular reviews up to 6-9 months and the expectation would be to follow the care pathway in considering transfer of care to GP, PCMHS and Shared Care. The service user should be involved and agree with the care plan and the care plan letter will be sent to the GP and service user offered a copy.

Medical LPC:

Medical LPC will provide mental health services for those patients who are newly referred or assessed by Community Mental Health Teams. These patients are under the regular care of a registered medical practitioner, working in psychiatry, due to complex medical needs and psychiatric medication. The medical practitioner will be expected to review the case in the MDT as required and three monthly as a minimum.

At the MDT review meeting, consideration would be given to transfer of care to GP, PCMHS, Shared Care and non medical LPC. For cases requiring more support, consideration would be given for allocation of care co ordination under CPA.

Non-Medical LPC:

These are patients under the regular care of a non-medical practitioner working in psychiatry, such as Social Workers, Community Psychiatric Nurses and Occupational Therapists.

They will be offered services as defined under the LPC as above but who:

1. Have not had a hospital admission in the last six months
2. Are not frequent A& E attendees
3. Have problems that are predominantly psycho social.
4. Do not have regular and serious self-harm problems.
5. Have no forensic involvement or under probation.
6. Are not regular callers to the Urgent Advice Line/SPA about medications or medically related problems.

Any concerns about patients in either category will be assessed in the CMHT team meetings. The transfer between Non-Medical LPC and Medical LPC would be decided in the CMHT team meetings without delay.

In case of the need for a contingency or crisis intervention, HTT and other emergency services should take referrals from the LPC provider, regardless of the discipline.

The nature for continuing provision of care needs to be reconsidered following the crisis, emergency service requirement or inpatient admissions.

3.5 Harrow Psychotropic Medication and Physical Health Clinic

The Harrow Psychotropic Medication and Physical Health Clinic will provide a service to secondary mental health patients on either long acting depot medication or Clozapine. This team is a borough wide service covering the West and East Community Mental Health Teams. The operational management is hosted within the West CMHT. It has the resource of four qualified registered mental health nurses and a phlebotomist.

The team deals with both Lead professional care cases (Case manager) as well as Care Programming Approach cases (Community Psychiatric Nurse). The team operates five days a week as follows:

- Monday - Clozapine point of care testing
- Tuesday - Clozapine point of care testing
- Wednesday - Depot Clinic
- Thursday - Depot Clinic
- Friday - Community Home visits and administration

Nurses working in the team are phlebotomy trained and have expertise carrying out baseline physical health checks such as blood pressure, respiration, pulse, blood glucose, BMI and also monitoring of side effects using the GASS tool. Nurses also provide psycho education interventions in addressing: smoking cessation, management of weight and promoting a healthy lifestyle. They work in collaboration with Harrow GPs to ensure patients have an annual physical health check.

As part of their roles and responsibilities, the nurses also attend outpatient consultations (LPC) with the prescribing doctors to feedback relevant issues such as compliance, side effects and updates in regard to patients' mental well-being. Any emerging needs are captured through the completion of a core assessment that may lead to the application of a Personal Budget (PB) or sign posting to other statutory or non-statutory services locally i.e. Psychology, safeguarding etc.

3.6 Psychological Treatments (POP)

In addition to the core CMHTs, the therapy services i.e. Psychology, Occupational Therapy and Psychotherapy (POP) will form a core component of the weekly team meetings to ensure that service users are able to access the most appropriate service quickly and easily. POP staff will be located in the CMHTs but work together across the teams to ensure the most appropriate treatment is provided. A range of treatments/interventions will be available.

The details of the care pathway to be added including the 'point of contact' role in relation to the PD pathway.

Waiting times for access to psychological services and issues around clinical accountability during that period to be clarified and added.

3.7 Housing

Each Harrow CMHT has a Mental Health Housing Liaison Officer. The role entails dealing with complex housing related issues and close liaison with the local authority and preventing homelessness within the vulnerable client group. The role involves regular meetings with the local authority Housing Department to discuss any clients that may be potentially in breach of their tenancy agreement and what support could be introduced to avoid eviction proceedings.

3.8 Employment

The Employment Service in Harrow CMHT currently consists of one Band 6 Employment Team Leader and one Band 5 Employment Specialist on secondment from the Harrow Xcite project at Harrow Council until December 2016, funded by Job Centre Plus. Employment Specialists work with 35 people over a year, aiming to get 17 into paid employment.

The Employment Specialists provide an employment provision to CPA and LPC clients who require support with looking for paid employment. The team engage with local and London wide employers to secure paid opportunities for client to suit their needs. They use the Individual Placement and Support Model, which is evidence based.

IPS has been shown to be more effective the more closely it follows these eight principles:

- i. It aims to get people into competitive employment.
- ii. It is open to all those who want to work.
- iii. It tries to find jobs consistent with people's preferences.
- iv. It works quickly.
- v. It brings employment specialists into clinical teams.
- vi. Employment specialists develop relationships with employers based upon a person's work preferences.
- vii. It provides time unlimited, individualised support for the person and their employer.
- viii. Benefits counselling is included.

4. Team Location and Opening Hours

East CMHT and West CMHT
Bentley House
15-21 Headstone Drive
Harrow HA3 5QY
Tel No: 0208 424 7701
Fax No: 0208 424 7702

Generic email address for

East CMHT – harroweastcmht.cnwl@nhs.net

West CMHT – harrowwestcmht.cnwl@nhs.net

The CMHT will operate between hours of 9.00am – 5.00pm Monday to Friday working towards extended hours as required.

Some services will provide a level of flexibility to accommodate service users who are in employment and/or have caring responsibilities.

The CMHTs will have an answer phone message directing callers to the Mental Health Urgent Advice Line when the CMHT is closed giving details of emergency contact numbers out of hours.

5. Team Membership

The CMHTs unite specialist medical, nursing, social work/AMHP, occupational therapy, psychology, psychotherapy, support workers, housing liaison and employment specialist workers and administrative staff within a team base and a single integrated management structure.

Each CMHT has a Team Manager who is responsible for the safety, effectiveness and quality of the service provided, including the achievement of performance targets. There are two Team Leaders in each CMHT who are responsible for the day to day delivery of the service.

Consultant Psychiatrists provide medical leadership within the CMHTs and they, and their junior doctors, carry out medical assessments, diagnosis and medical treatments within the teams. The skills, knowledge and experience of Consultant Psychiatrists will be used to best effect by concentrating on service users with the most complex needs, acting as a consultant to multi-disciplinary teams and promoting distributed responsibility.

All disciplines will contribute both professional and generic skills to their team. Each team member is professionally responsible for service users under their care and for recognising the limits of their own competence and job description. This includes the responsibility to seek appropriate supervision both within the team and within their professional structure.

Non-registered staff will work under the clinical guidance and direction of appropriate professionals.

Team Structure (Appendix 2)

6. Key Relationships

- The CMHT will establish and sustain links with other services to ensure that action is taken to update the risk assessment and care plan at points of transition. This includes links with:
 - The Single Point Access
 - Home Treatment Rapid Response Teams (HTRRT)
 - Early Intervention Services
 - Inpatient care
 - Co-occurring Substance Misuse Services
 - Rehabilitation Services
 - Eating Disorder Services
 - Forensic Services
 - CAMHS
 - Older Peoples Services
 - Local Primary Mental Health Services
 - Co-occurring Learning Disability Services
 - Criminal Justice Agencies, including Court Diversion Schemes
 - Independent Advocacy Services
 - Third Sector Providers
 - Housing Agencies.

- Children's Services
- Safeguarding Teams

7. Service User Profile and Eligibility for Services

Establishing access criteria based on agreed principles for service provision is important in ensuring the prioritisation and targeting of resources to those people with the greatest and most immediate need. This will be determined primarily by the level of risk and need identified during the triage and assessment processes. It will be a matter for professional judgement and will be determined on a case by case basis taking into account the summation of a variety of factors. In relation to social care, services must carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care, and apply the national threshold as outlined in the Care Act.

The majority of people engaged by adult CMHTs will be of working age. Age limits need to be determined in line with locally agreed protocols for transitions from adolescent to adult and adult to older adult services.

The focus on provision of services by the CMHT should be on those with a severe and/or enduring mental disorder and, within this focus, the delivery of services should be prioritised on an assessment of need, risk and vulnerability and those deemed eligible under the Care Act.

Referrals for service users under the age of 18 should be referred to the Community Adolescent Mental Health Services (CAMHS). People in the care of CAMHS who are likely to need ongoing care from an adult CMHT should be subject to robust handover processes to ensure effective transfer to adult mental health services (see transition protocol). If a service user first presents at the age of 17 and six months, they should be taken on by an adult CMHT directly rather waiting for six months until they become 18.

Service users who have reached the age of 65 years will continue to receive mental health services from the CMHT until such a time as their needs are assessed as having changed, due to their age, and adult services are less able to meet their needs. Transition of care to Mental Health Services for Older People will then be planned via the CPA process according to the following criteria:

- First presentation of severe functional mental illness over the age of 65 or people over 65 who have been closed to the CMHT for a period in excess of five years, should be referred to Mental Health Services for Older People.
- People suffering from an established primary progressive dementia related illness (including alcohol related) of any age with behavioural and psychological symptoms of dementia should be referred to Mental Health Services for Older People.

Members of staff, or their close relatives requiring mental health services, will normally be offered a service out of the area in which they work.

7.1 Learning Disability

Having a learning disability should not act as a barrier to acceptance by the CMHT as long as the CMHT is best placed to meet their individual need. In cases where this is not immediately clear, assessments should be carried out jointly by representatives of both CMHT and the Learning Disability Services.

7.2 Co-occurring Alcohol/Substance Use

Service users with co-occurring alcohol/substance misuse problems are defined as those with severe mental illness and drug and/or alcohol problems. This group are likely to meet the eligibility criteria for services from a CMHT.

- It is acknowledged that service users may often present particular risks to themselves or others, and require good care co-ordination. Those with a dual diagnosis as defined will be the primary responsibility of the CMHT
- Such individuals should be referred as necessary by CMHTs to Community Drug and Alcohol Services for expert advice or a specific treatment package. Community Drug and Alcohol Services will also give advice as necessary to those providing medically assisted withdrawal programmes to service users with a dual diagnosis on acute inpatient units.
- Each CMHT should have an identified link worker for alcohol and substance misuse to provide advice and support to other team members for this client group.

7.3 Offender Care

Service users with an offending history known to specialist forensic services e.g. West London will be referred directly to Harrow FoCuS.

Service users with an offending history referred by any other agency will be accepted for assessment by the CMHT and a decision then made to allocate or onward referral as appropriate, which may include Harrow FoCuS.

7.4 Inclusion Criteria:

- All referrals that have been screened and triaged by SPA where the need for assessment by secondary mental health services has been identified.
- Internal referrals from teams such as the HTRRT, the inpatient wards, Primary Care Mental Health Service, A&E Liaison Teams and other secondary/tertiary mental health services.
- Green cards – patients who have been given a green card by CMHT will be able to self refer as long as they have been discharged from the secondary mental health services in the last six months.
- Referrals from the Local Authority adult services where social care needs have been identified and they require further assessment under the Care Act (2014) or a specialist diagnosis.
- Referrals from the Local Authority Adult Safeguarding Teams.

7.5 Exceptions:

- Those with physical frailty, irrespective of age – Older People and Healthy Ageing.
- Those being referred with a primary problem of memory difficulties - Older People and Healthy Ageing.
- Those whose needs should be met by a specialist service, for example Eating Disorders, Learning Disability or FoCuS.
- Under 18 – CAMHS
- First onset psychosis aged 14-35 - Early Intervention in Psychosis Team
- Referrals for Mental Health Assessment. Follow local Borough procedures.
- Primary Care – follow local procedures.

Usually people of no fixed abode are registered with a local GP and these should be allocated to the appropriate CMHT as above.

Service users not registered with a GP practice that appear to require access to services from the CMHT will be allocated to their nearest CMHT based on proximity to their home address. This also applies to asylum seekers and refugees.

If a person does not normally reside in Harrow ordinarily, CMHT access is determined by the GP practice in the Borough where they are registered. In such cases, any referral should be assessed, treatment arranged by the CMHT receiving the referral if this is required, and a plan agreed to ensure any risks are managed until they return to their home area. The home area GP and other involved mental health professionals should be informed of any assessment and treatment.

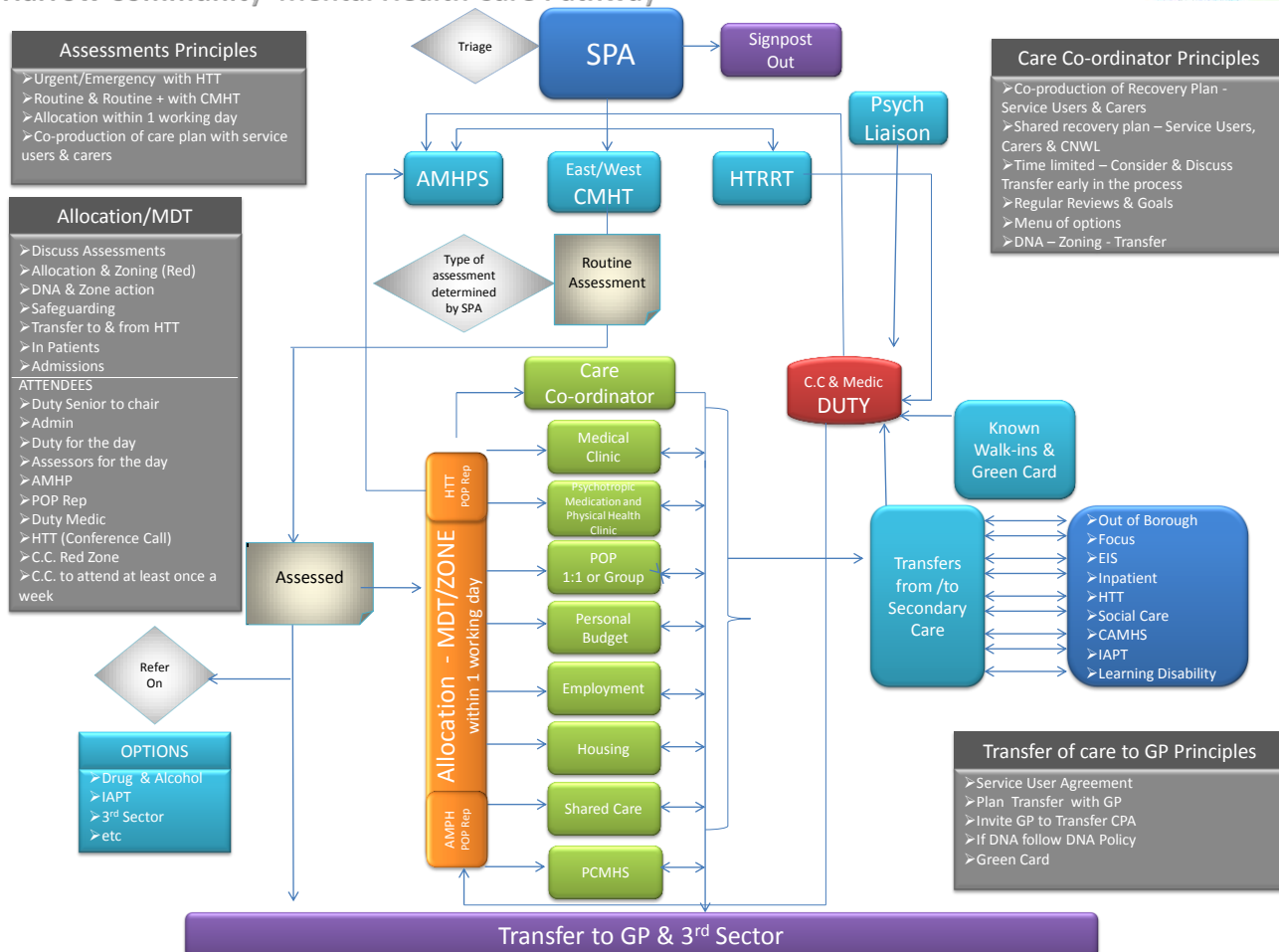
If a person not usually resident in Harrow requires admission to a Mental Health Unit they may be admitted in an emergency under the out of area treatment ruling (OATS). Following admission, they should be transferred, as soon as is reasonable, to the area responsible for their care.

If a period of treatment is commenced, a Care Co-coordinator should be allocated and when/if transfer is agreed this should be via the CPA process (see Care Programme Approach).

People who were homeless prior to an inpatient admission should be allocated to a CMHT based on their GP or home address on discharge.

8 The Care Pathway

Harrow Community Mental Health Care Pathway



9 Referral Process

The majority of referrals to the CMHT teams will be received through the Single Point of Access (SPA).

There may also be the transfer of care of cases that have been open to other secondary care teams.

The internal referrals will be received directly by the respective teams as per GP Peer Group.

Each locality team will hold a daily MDT meeting each morning to review all new referrals

- When referrals are passed to the team by the SPA it will be assumed by the team that the person meets these criteria for assessment by the CMHT/ Psychological Therapy Services and, except in exceptional circumstance, referrals will not be re-triaged by the CMHT.

- The SPA will send referrals to the team via JADE with all supporting documentation but will also email the team daily with referrals made, and will contact the team by telephone if further discussion is needed in individual cases.
- The SPA will write up the outcome of their telephone triage in the JADE progress notes under agreed assessment headings.
- The case will remain the clinical responsibility of the SPA until the time of the first appointment when it will transfer to the community team (including when the referee does not attend the appointment).
- The SPA will carry out any subsequent work needed before the assessment where this can be done by phone. If any face to face or more complex work is needed pre-assessment, this will be discussed and agreed with the community team so that it is clear which actions are to be undertaken by whom.
- Where the SPA has determined that a face to face assessment is needed it will book these directly (via JADE) in slots agreed with the team.
- The SPA will send out letters to GPs/patients which summarise the triage process/outcome, confirm appointment details and provide information about the service and the assessment process to help manage expectations in advance of the service provided by the CMHT.
- Where possible, the SPA will recommend which professions might best be placed to carry out an assessment, although this will always be subject to the resources available to the team.
- Before booking the assessment, it may be necessary for the SPA to speak in person with the team to determine when particular professionals are available.
- Each locality team should make provision to respond to requests for internal urgent/routine+ assessments that can be booked at short notice.
- The SPA team and CMHT will communicate regularly to review any particular cases and, more generally, the referral process to ensure that the referral process continues to reflect the needs of both services.
- All new referrals via PCMHS, where there has been a face to face contact, will be reviewed by the MDT meeting and allocated to a named worker according to the assessment of need and care and treatment plan determined by the team. This care and treatment plan will be reviewed.
- All referrals into the CMHT will be processed by duty seniors and an acknowledgement of receipt to the referrer sent within four hours. The referrer will be notified in writing of the outcome of the referral within three working days (this may take the form of a copy of the appointment letter going to the user, for example).
- The nature of the response and speed of response will depend on the clinical picture and risk assessment arising from the referral.

The agreed standards for assessment are as follows:

Category	Response times
Emergency	4 Hours - SPA to refer directly to HTT/RRT
Urgent	Less than 24 hours from referral (AMHP/HTT/RTT)
Routine (Plus)	Typically less than 7 days from referral (according to need)
Routine	Less than 4 weeks from referral

- Any urgent/emergency referrals will be directed to SPA/RRT or A&E.

All referrals (including those that may not have been sent to SPA) into the CMHT will be passed to the designated Duty Senior/Officer on the day. If a routine internal assessment is indicated, an attempt will be made to contact the user directly by telephone in the first instance. If they are not contactable the patient will be booked into a routine assessment slot and a letter sent informing them of this.

All referrals are to be offered a first assessment within 28 days. Following the assessment, the referrer will be notified of the outcome, in writing, within five working days (a summary form, completed at the assessment, may be used for this).

10 Assessment Procedures

Each CMHT team will have a total of 15 assessment slots per team, per week, made up of the following:

Each CMHT will have 10 new assessments from SPA and five internal assessments from inpatient/HomeTreatment Rapid Response Team (HTRRT)/Accident and Emergency (A&E)/Early Intervention Service (EIS)/Child and Adolescent Mental Health Services (CAMHS)/Learning Disability (LD) and London Borough of Harrow (LBH). For those requiring assessment in the service, an assessment will be booked in one of the routine assessment slots.

Booked assessments are arranged Monday to Friday and are carried out by Doctors, CMHNs, Social Workers, and Occupational Therapists. There will be three assessments per day on a rota basis.

All service users with appointments with CMHT to be sent a text requesting confirmation of attendance seven days in advance of their appointment. This pertains to new internal and follow up appointments.

Where there is no phone number or the message fails, a reminder letter will be sent out. This task will be carried out by an administrator and will include a courtesy call/text 48 hours in advance of their appointment.

Any available appointment slots due to Did Not Attend (DNAs) and/or cancellations will be reported to the Duty Senior that day.

Following a service user DNA, the clinician needs to review the case and attempt to make contact with the referrer and service user as appropriate. The clinician will bring the case to MDT and/or discuss with the team leader to agree next action. The clinician should not routinely offer a follow up appointment for a DNA. (Appendix 3)

To assist in quality control, all people assessed should be given a user feedback sheet for completion, to be handed back to the assessor and given to the team manager.

All completed assessments (medical, non medical and joint) will be discussed in the MDT meeting where the following decisions will be made:

- To transfer the patient back to the GP
- To signpost/refer to a voluntary sector service
- To allocate to care co-ordinator/case manager, lead professional, PCMH service, Psychotropic Medication and Physical Health Clinic, POP, Personal Budget, Employment/Housing
- To refer to another CNWL service.

10.1 Assessment Documentation

Post assessment, the following documents must be completed on Jade:

All assessments should consider eligibility for services in accordance with the Care Act 2014

- Initial assessment
- Primary and Secondary diagnosis (including Smoker)
- Risk assessment
- Bromley screening tool
- MH Clustering Tool
- Carer activity form
- MH3 Outcome of Assessment Form
- Core Assessment.

Only patients who require long term care co-ordination (not LPC) will have a Core Assessment completed by their allocated worker. This needs to be reviewed and amended at least on a yearly basis and when there are significant changes in need.

11 Mental Health Act Assessments

The Harrow AMHP Service is a borough wide service and will be operationally hosted in the East CMHT for:

- Undertaking Mental Health Act assessments on people who are not known to the CMHT teams.
- Assessments on in-patient wards not yet referred to a community team.
- S136 assessments on people not known to the CMHT teams.
- The Harrow AMHP will also receive and action referrals for Community Treatment Orders (CTOs), Guardianship, Mental Health Act assessments for service users referred from other services including Older Adults, Learning Disabilities, CAMHS and the Eating Disorder Service.

Should the team find themselves with insufficient capacity to cover urgent assessments under the Act due to a high number of urgent referrals on a particular day, during sickness absence or annual leave, AMHPs from both CMHT teams will be expected to provide cover equitably.

Each CMHT teams will be staffed with Approved Mental Health Professionals (AMHPs) and contribute to a monthly rota. All statutory Mental Health Act work generated from within each CMHT Team will be actioned by the AMHPs within the respective Team. In this way, AMHPs in the teams will undertake Mental Health Act assessments including assessments under s136 and statutory functions related to CTOs and Guardianship on service users open to the team.

AMHPs that provide care co-ordination for a service user who needs a Mental Health Act Assessment will be expected to undertake that assessment with the team doctor who knows the patient.

Requests for an assessment under the Mental Health Act 1983 (Amended 2007) will be discussed at the daily MDT meeting to agree action. Referrals accepted and allocated for a formal assessment under the Mental Health Act will be recorded on Jade by the administration team.

Requests for an assessment under the Mental Health Act 1983 (Amended 2007) will be managed during normal office hours via the Approved Mental Health Professional (AMHP) rota, a copy of which will be held by the team administrator.

A response to an appropriate referral for an assessment under the Mental Health Act will be made to the referrer within four hours. Following consultation, the assessment should be completed on the same day whenever that is possible.

AMHP assessments that are commenced during office hours remain the responsibility of the AMHP until the assessment is completed, even if this is outside normal office hours. It is only in exceptional circumstances that the AMHP located within the Psychiatry Liaison Service based at NPH will take over the assessment.

Outside office hours (until 11.00pm) and during Bank Holidays, assessments under the Mental Health Act will be undertaken by the AMHP located within the Psychiatry Liaison Service. Harrow Council undertakes assessments from 11.00pm until 9.00am.

Whenever possible, requests for a Mental Health Assessment should be communicated at the earliest part of the day so that the assessment can be completed during the working day. Where possible, HTRRT will attend assessments under the Mental Health Act in order to ascertain whether hospital admission is appropriate or whether a package of home treatment can be provided.

12 Duty Service

At least one professionally qualified duty worker is available in the office to offer advice to people who drop-in, to provide urgent CMHT assessments, and to be involved in any activity deemed to be an appropriate task for a duty worker between the hours of 9.00am – 5.00pm Monday to Friday.

- The duty worker will provide cover for the care of service users in the event of an emergency, unplanned absence of their care coordinator and those eligible for a fast track access to services (Green Card)
- The Team Leader (or in the absence of the Team Leader the CMHT Manager) is responsible for the management of the duty system, and is available on site to offer support, advice and guidance to the duty worker or contactable by telephone if called off site.

- The Team Leader (or in the absence of the Team Leader the CMHT Manager) holds responsibility for ensuring any crisis occurring in the building which may affect the health and safety of staff or service users is managed appropriately and in accordance with Health and Safety Policies.

12.1 Duty Interventions

- Screening new referrals
- Taking calls from service users and carers when the care coordinator is not available
- Responding to urgent safeguarding issues
- Deal with people walking in with enquiries
- Dealing with assessing urgent/crisis situations

If further urgent intervention/consultation is required and the next MDT meeting is the following day, then the case must be discussed with the Duty Team Leader and, if indicated, Consultant or Staff Grade Psychiatrist.

12.2 Appropriate Adult

When requested, the CMHT will provide an Appropriate Adult (normally the allocated worker) for known service users who are open to the service. The team is not resourced to respond to requests for Appropriate Adults for service users not known to the service.

13 Multi-Disciplinary Team Meeting

The model will support a more timely response to new referrals which will all be reviewed in daily MDT meetings and the appropriate 'zone' identified. This will enable teams to maintain a cycle of reviewing and allocating available resource to need.

The MDT will take place on a daily basis starting at 9.15am promptly and ending at 10.15am. The meeting will be chaired by a senior member of staff. The purpose of this meeting is to discuss the outcome of assessments, allocations and zoning, DNA's, any safeguarding issues, transfers to and from HTRRT and transfers back to GPs, and other transfers to and from other internal and external teams/services.

- **Daily MDT Meeting:**
 - Assessment discussion
 - Assessment allocation
 - Zoning
 - CTO recalls
 - Safeguarding alerts
 - Transfers to and from HTT
 - DNA
- **Daily MDT attendees:**
 - Team Leader (Chair)
 - Admin
 - Duty for the day
 - Consultant Psychiatrist
 - Assessors
 - AMHP
 - Duty Medic
 - HTT/RRT (Conference Call at 10am)
 - CC with Red Zone patients
 - All CC to attend at least once a week

- **Weekly MDT Meetings**

Once a week one of the daily meetings will be extended for two hours. The meeting will be attended by all members of the multi disciplinary team to discuss the team caseload in more detail using the principles of zoning.

The CMHT services will utilise the zoning approach to proactively review the caseload of the whole team on a regular basis. The approach provides a means to manage caseloads and to target resources most efficiently while transparently monitoring caseload capacity of staff and quality of work undertaken

The agenda of these meetings will include the following standing items:

- Discussion of any complex initial assessments that will benefit from the advice offered by the multi-disciplinary team.
- Discussion of existing cases of concern that will benefit from the advice offered by the multi disciplinary team.
- Feedback from ward rounds and HTRRT.
- Any other urgent issues requiring discussion to inform the day to day work of the multi disciplinary team including immediate learning from patient safety issues

14 Effective Care Coordination, Team Working

- Each service user will be assigned a care co-ordinator with overall CPA responsibility or a Lead Professional/Named Worker for ensuring appropriate assessment, care and review by themselves and others in the team.
- CPA is for people who have more complex needs, are at most risk, or have mental health problems compounded by disadvantage.
- Lead Professional Care (LPC) is for people who need secondary mental health services but have more straightforward needs involving:
 - contact with only one professional or one agency and/or
 - a simple care plan with needs under two headings or less and/or
 - needs which are normally stable – and any occasional additional needs can be met by brief/adhoc additional services
- The CMHT will undertake multidisciplinary reviews in accordance with CPA guidance.
- Service users on CPA should have a minimum of monthly face-to-face contact and should be seen at home at least twice a year, subject to risk assessment.
- The CMHT will be responsible for carrying out out-of-borough placement reviews when the Local Authority/CCG retains funding responsibility but a CPA transfer has taken place.
- Cross cover should be within the team rather than necessarily being profession specific and continuity of care should be provided by the team.
- The team will be able to switch back and forth between two levels of support:
 - a) Individual care co ordination by a member of the team and b) a team case management approach for service users that require a period of more intensive support and monitoring.

15 Caseload Management

- For planning services, a standard caseload for a full time care co-ordinator will be around 30-35 cases and part time staff/AMHPs will have their caseload reduced pro-rata. However, these figures clearly require modification (downwards or upwards) in the light of such factors as complexity of need/the zoned mix of the case load and the approach to team working. Service users in placements will be regarded as a third of a case. Similarly 'point of contact' cases will be regarded as a third of a case but this weighting will be reviewed during periods of high frequency contact.
- Admin will maintain the zoning board/data base on a daily basis to enable easy summary of information and specific detail when required to better manage caseload allocation and safer transfer.
- Robust diary management of all clinical diaries should demonstrate the allocation of 20 clinical hours a week per practitioner and support good allocation of non-clinical time to clinical and managerial supervision, training and appraisals.
- All clinicians will be expected to provide 20 hours of face to face contact per week. This may be in groups as well as individual case work.
- Each clinician will receive individual caseload management supervision from their line manager/supervisor at least monthly; this will include monitoring complexity of need and the zoned mix of the case load. Caseload management will assist the clinician in reviewing the intensity of the support being offered and identify whether a case is being managed in the right zone/service.
- The proactive management of resources to improve flow through the service will be supported by the setting of clear expectations with service users with regard to accessing service, the provision available and the timescales within which it will be provided. Improved goal setting in care and treatment plans will be critical alongside regular reviews of progress.
- Individual and team training needs will be identified through the weekly team sessions and individual management and professional supervision.
- Record keeping on Jade will be an expectation for all staff, supported by robust mechanisms for managerial and clinical supervision both individually and within the team.

All service users with appointments with CMHT to be sent a text requesting confirmation of attendance seven days in advance of their appointment. This pertains to new internal and follow up appointments.

Where there is no phone number or the message fails, a reminder letter will be sent out. This task will be carried out by an administrator and will include a courtesy call 48 hours in advance of their appointment.

Following a service user DNA the clinician needs to review the case and attempt to make contact with the referrer and service user as appropriate. The clinician will bring the case to MDT and/or discuss with the Team Leader to agree next action. The clinician should not routinely offer a follow up appointment for a DNA.

Full caseload review to be completed and relevant DNA cases to be discharged.

16 Interventions

- The CMHT will be able to provide and/or access general evidence based interventions for all those who need them in a timely manner.
- General interventions will include as a minimum:
 - Effective medication arrangements including across primary and secondary care so that any changes are communicated appropriately.
 - Access to a range of core psychological therapies.
 - Access to psycho-social support and interventions (e.g. housing, employment, benefits, training/education and activities of daily living).
 - Relapse prevention interventions.
 - Substance misuse assessment including the delivery of basic harm minimisation interventions and motivational interviewing (more complex cases may need referral to specialist services).
 - Support to ensure physical health needs are met.
 - Relevant assessment/support to closely involved family and/or carer(s).
- Improving physical healthcare to reduce premature mortality in people with severe mental illness must be addressed.
- Early Intervention services must be available to everyone experiencing psychosis for the first time, whatever their age. People must routinely receive care and treatment from a single multidisciplinary community team with appropriate skills and training in EIS.

17 Safeguarding Children and Vulnerable Adults

Safeguarding Children

Safeguarding children is the responsibility of all members of the team. The 'Think Family' approach should be embedded in practice so that at every stage of the care pathway clinicians/practitioners consider the needs of families as a whole and the needs of children in particular.

If a clinician is concerned that a child's welfare is not thriving, possibly due to poor parenting and/or abuse or neglect, they should notify the Multi-Agency Safeguarding Hub (MASH) hosted by the Local Authority by:

- Completing and sending a Common Assessment Framework (referral) to duty&assess@harrow.gov.uk.cjsm.net
- And/or calling the MASH directly on 020 8901 2690

The Clinician should also complete an Incident report via Datix.

Safeguarding Adults at Risk of Abuse

Raising Concerns

All people open to the Community Mental Health Teams will have care and support needs by virtue of their mental health issues.

Within this context, if a clinician suspects or is told by a patient they are experiencing or at risk of abuse/neglect, and as a result of their care and support needs the patient is unable to

protect themselves from either the risk or experience of abuse/neglect, then the clinician should:

- Raise a Safeguarding Concern by completing an Incident report via Datix.
- Inform their Supervisor

Conducting Enquiries/Allocation of Safeguarding Adults Manager

Due to the nature and content of the S75 agreement between the London Borough of Harrow and CNWL, CNWL have delegated responsibility and authority to conduct Enquiries under S42 of the Care Act 2014 in response to receiving Concerns about patients open to services and/or those not open to services but with suspected mental health difficulties.

There is a separate CNWL Harrow Mental Health Services Operational Policy for how team managers and senior practitioners within the CMHTs are allocated to perform the role of Safeguarding Adults Manager (SAM) in conducting Safeguarding Adult Enquiries. In the event of disagreements about allocation of the SAM role, the Deputy Director/Community Services Manager is the Senior Manager who arbitrates and decides who will perform this role for the Enquiry in question.

A SAM will conduct an Enquiry in accordance with London Multi-Agency Adult Safeguarding Policy and Procedures (December 2015). They will record the Enquiry in accordance with the separate CNWL Harrow Mental Health Services Protocol for recording Safeguarding Adult Enquiries.

Enquiry Officer/Lead

Department of Health guidance issued to support the Care Act stipulates any clinician employed with Harrow Mental Health Services can perform the role of Enquiry Officer/Lead. It is therefore at the discretion of the SAM to determine who is best placed to perform this role. It will usually, but not always, be a patient's Care Coordinator or Lead Professional.

When the adult at risk does not have a case open to services, the SAM for the Enquiry will identify a clinician within the team to perform the Enquiry Officer role and allocate them to the case. This could be the Duty Officer on the day for the process of initial information gathering/enquiry, but can be transferred/allocated to another after. (It is advised that allocation of Safeguarding work is formalised by adding the clinician who is the Enquiry Officer as a provider to the adult at risk's case on Jade).

Capacity/Training

It is the responsibility of team managers to ensure there are sufficiently trained SAMs within their teams, and that other staff have sufficient training to perform the role of Enquiry Officer/Lead.

18 Care Act compliance :

18.1 Personal Budgets and Direct Payments

All assessments undertaken by teams on service users referred to them will be Care Act 2014 compliant and will fulfil statutory duties under section 9 and 10 of the Care Act to consider for every person assessed whether they appear to have a need for care and support (social care). In some cases, the person assessed may require provision of information and advice and sign posting elsewhere to reduce prevent or delay developing any social care needs. For others, initial assessment may evidence the need to progress to a full assessment of eligibility for social care provision under the Care Act. If eligible, service

users will have a personal budget calculated and will be supported by the team to consider how to meet their eligible needs using the personal budget as agreed in their care and support plan.

Further discussion is required with the Local Authority regarding the budgetary requirements of carer's personal budgets and the infrastructure mechanisms to deliver them.

18.2 Carers

On identification of a carer as part of the initial assessment of the service user, the carer will be offered an assessment. If assessment is required, this will be allocated to one of the Carer Support Workers located in the CMHT.

Teams will adhere to statutory requirements under the Care Act to provide a carer's assessment in line with the Council's Standard Operating Procedures. As above, this may lead to provision of information, advice and signposting or may, if the carer is assessed to have eligible needs, a personal budget and a support plan agreeing how the budget will be spent to support the carer.

- All regular and substantial carers will be offered an assessment of their own needs. They will be offered appropriate services within resources available and will have a written care plan, which will be reviewed no less than once annually.
- Carers and relatives will be consulted about the service user's care, with the client's consent. Where consent to share information is refused, information can still be provided to the CMHT by carers and relatives and generic information about care provided to CMHT clients also given by the team to the carers or relatives. Where issues of risk are high, and consultation and information sharing is refused, discussion should take place at an MDT meeting about this issue and the outcome documented.

More to be added on the interface and partnership working with 3rd sector carer groups

19 CMHT Discharge & Transfer

Discharge planning and the expectations of recovery and move on from secondary mental health services should be integrated from the start of the person's journey. The model recognises, however, that each individual's recovery journey is personal and for some people who have been engaged with secondary mental health services for extended periods there may be a need to reflect this in the discharge planning process. It is the intention of the model that service users in the Green Zone should have discharge planning as a central goal.

Discharge from the CMHT to the Primary Care Team will be considered when:

- Service users are on LPC and require only minimal intervention
- They require to be seen at less than three monthly intervals
- The diagnosis and treatment plan are clearly established and the service user can attend their GP for follow-up.
- They do not require specialist interventions.
- They will be able to attend their primary care clinician for review and treatment.
- They are believed to be compliant with treatment.
- There are no significant risk factors.
- Key stakeholders (GP/ service user/carers) have agreed to the discharge as part of the CPA process.

The CPA review meeting is where the service user and the care team meet to discuss the Care Plan and discharge from the CMHT will be discussed.

At the point where it is considered the service user has recovered to a degree they no longer require specialist secondary mental health services, consideration will be given as to whether the service user can be:

- a) Discharged/transferred directly to the GP.
- b) Discharged /transferred to the GP but with the support of the Primary Care Mental Health Service (for short term support for up to six months) to facilitate subsequent full discharge.
- c) Managed under Shared Care in line with the protocols.

Prior to any discharge from the CMHT, an aftercare plan will be agreed with the service user and this will include a contingency plan identifying risk factors, warning signs and actions to be taken in the event of any difficulty occurring after the discharge back to the GP takes place.

Should a service user refuse to engage with the CMHT or refuse to continue to accept services, the situation will be discussed within a multi-disciplinary team meeting. Risks to self and others will be assessed and an action plan, dependent on risks and need, agreed. The GP will be informed immediately.

Discharge from services may occur following non-attendance at outpatient clinics. Procedures are identified above.

All transfers/discharge will be made in accordance with the Safe Discharge policy. Services users will be issued with a Green Card where appropriate (see below).

19.1 Green Card

The Green Card has been developed to provide reassurance for service users who may have concerns/anxieties about being discharged to their GP. It ensures a quick direct access back to the team without GP or SPA referral.

All service users being discharged directly to GP (not those going to PCMH) who have been with the service/team for more than one year will be given a card to enable them to access the team directly, via duty, for a period up to six months post discharge.

The duty service will assess whether reallocation to the CMHT is the most appropriate option for the individual or will sign post on. Duty will pass on to the daily Multi-Disciplinary Team (MDT) meeting for allocation should that be required.

19.2 S.117

To be added when details of review and discharge process agreed.

20 Staff Safety

- Team members should comply with the Trust 'Lone Worker Policy', have access to mobile telephones and be able to raise any concerns about lone visiting with their manager or at the regular multidisciplinary team meetings.
- Each team will maintain a local system for managing lone working in the community which must have the provision of a system for monitoring the

whereabouts of all staff at all times, and a system for contacting staff if they have not returned to base, or signed off at the end of the day by contacting the team leader or nominated representative.

- The Trust operates a zero tolerance policy which provides guidance to all trust staff on how to prevent risk to themselves, service users and the general public.

21 Supervision Arrangements

A range of supervision is required to meet the needs of staff in a multidisciplinary Community Mental Health Team.

All staff should have supervision at least monthly with their clinical line manager. This should provide ongoing guidance on the management of complex cases, caseload management and monitoring of practice.

21.1 Clinical Supervision

Best practice would be that all CMHT staff should have access to clinical supervision. This should be with a professional not necessarily from the CMHT or the same professional background, but mutual agreement to support and guide them in their clinical practice.

CMHT members who are managed by a member of a discipline other than their own should receive additional or joint supervision provided by an appropriate member of their own discipline.

The Zoning approach is used in conjunction with individual caseload supervision to provide a comprehensive system of both individual staff and team caseload supervision.

21.2 Managerial Supervision

All staff will receive management supervision on a monthly basis and will address performance, sickness and absence, annual leave, training and personal development.

21.3 Appraisal

- All staff will participate in the CNWL Appraisal process.
- Appraisal will be carried out annually.

22 Induction, Training and Professional Development

Staff development and training is a high priority for the Trust and each member of staff has an annual appraisal and a Personal Development Plan identifying training needs.

- All new staff will attend an induction programme. Induction programmes will be prepared for all locum staff to include reference to the appropriate policies and procedures such as CPA and Risk Management. Staff will attend all statutory/mandatory training sessions appropriate to their individual professional status. It is the responsibility of the direct line manager of the new employee to ensure that the process of induction is completed.

- Training and development will reflect the needs of the CMHTs and of the individual, as described in their personal development plan to include their profession specific needs. The Trust recognises that Continuing Professional Development is a key element of ensuring the delivery of the highest possible quality of service. Role development and scope of practice is also increasingly relevant to the provision of staff training and supervision. All staff will be appraised annually via the KSF.
- Training will also focus on the development of psychotherapeutic competences integral to the care delivery of all staff.
- The CMHT will have annual team away day for the purpose of reviewing activities, policies and team building.
- CMHTs have a responsibility to ensure that appropriate staff are put forward for the Approved Mental Health Professional (AMHP) training course.
- CMHTs will have a monthly teaching/training forum
- CMHTs staff regularly supports students from all disciplines to be based within the teams.

23 Governance Structure

CMHT staff are committed to delivering services that are safe, effective and offer a positive experience for service users. Each CMHT will hold a monthly business meeting and cover managerial, performance and care quality issues including a practice governance agenda item to review, reflect, prioritise and learn the lessons identified from practice issues such as serious incidents, near misses, complaints, compliments, audit information and performance data.

This meeting will be attended by all members of the multi disciplinary team and will include update on Trust wide practice governance issues, discussion of local practice governance issues, consideration of performance data, updates on new policies and practice initiatives that may include visiting speakers, information from executive and senior management to be cascaded to all levels of staff and any other matters of business as required.

Team managers, clinical team leaders and senior practitioners, will have direct responsibility for particular areas of quality and performance in the team, for example, Safeguarding, Carers etc.

- Each CMHT will carry out and report on regular local audits of performance and comply with trustwide audits. Each team will also monitor service user feedback and comply with Trustwide service user surveys.
- The Community Service Manager will meet regularly with the team managers to ensure effective functioning of the team. Borough interface issues both clinical and managerial will be discussed at the borough interface meetings.

The CMHT Manager, Team Leaders, Consultant Psychiatrists and any other relevant professionals leads will meet on a regular basis (at least quarterly) to review the performance, quality of the service and utilising data and evidence to address any barriers to service provision.

There is a matrix of key policies available on Trustnet. All staff in the CMHT teams should adhere to the policies identified as 'essential,' which include CPA, Clinical Risk Assessment, Safeguarding, Consent, Supervision and Appraisal, Information Governance, Recovery, Personalisation and Personal Budgets.

24 Concerns and Complaints

The CMHTs must be responsive to service user feedback, including through the complaints process, as this lies at the heart of providing personalised care. Posters and patient information, i.e. leaflets about complaints procedures and PALs contact details, should be widely available for patients to access, including in waiting areas. All staff should be familiar with the Trust Patient and Carer Feedback Policy (July 2015) available on the Trust intranet.

Teams are committed to responding quickly, sensitively and openly to concerns and complaints. Informal concerns are addressed as early as possible since this often prevents these becoming formal complaints. Complaints should be viewed as a way of informing the service of its performance and areas requiring improvement.

Any complaints made by service users or carers relating to the service, whether formal or informal, should be dealt with according to the Trust Complaints Policy in a collaborative manner involving the service users and/or other organisations e.g. Local Authority where appropriate. Where possible, the issue is resolved within 25 days.

There is a local mechanism in place to ensure the quality of the Trust response to formal complaints before sign off by the Borough Director. Interpreters and advocacy are used as appropriate.

Complaints and concerns must be regularly discussed in team meetings, logged and collated, and the team manager holds an informed overview of these. Where there are themes, these are recognised, and, in the light of this, local protocols and practices are reviewed and actions taken as appropriate to improve.

25 Serious Incidents

All incidents should be reported on the Trust Incident Reporting System DATIX. The incident will then be sent to reviewers where it will be graded. Where the clinical information and risk matrix indicates, staff will be required to complete an Initial Management Report. This will automatically appear within the Datix report. All patient deaths should be verbally reported to the Borough Director as soon as the service becomes aware of the incident.

In addition, the staff are required to make themselves familiar with, and follow, the Trust policies on Incidents and Serious and Untoward Incidents. If a staff member feels that there has been a near miss or serious incident they should inform their line manager immediately for advice and support.

26 Emergency Planning

The CMHTs are committed to ensuring service continuity as much as possible during an emergency.

The CMHTs should ensure that all staff are familiar with the Trust and the Local Authority's emergency plans. Each team will have access to the Business Continuity Plan in relation to their place of work.

27 Managing Disputes Between Services

All disputes should be resolved, where possible, at a local level between Team Managers/Consultants in the respective teams. Where this is not possible, disputes should be escalated to service manager level and resolved. Issues relating to care pathway disputes should be taken to the local Borough Interface meeting.

Any disputes that cannot be resolved between service managers should be escalated to the Borough Director/Clinical Director.

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Appendix 1 – Zoning Mechanism

There have been several different approaches used by the Trust to stratify where a service user is in the care process and/or what level of need they have.

To address this variation and bring consistency and transparency across boroughs, the Trust has developed the framework below to guide zoning in CMHTs. The purpose of the approach is to ensure that demands on clinicians are manageable to enable the delivery of high quality services.

The zoning approach will be used to proactively review the caseload of the whole team on a regular basis with the team leaders present. The approach provides a means to manage caseloads and to target resources most efficiently while transparently monitoring caseload capacity of staff and quality of work undertaken. The zoning approach is used in conjunction with individual caseload management supervision to provide a comprehensive system of both individual staff and team caseload supervision.

Adult Mental Health Services will utilise zoning as a team caseload and risk management approach. The “RAG” rated system will be used to visually indicate the current condition of each service user within the team caseload. Service users will be coded as Red, Amber or Green/1, 2 or 3 depending on their presentation and risk.

Red zone/zone 1 – service users, who are at high risk and have a high level of need and are currently in crisis, may require admission without further support and require frequent review and intensive support and/or material changes to care/crisis plans.

Cases in this zone are discussed by the multi-disciplinary team on a regular (on a daily basis) which should include at least two senior staff. There will be a named worker allocated but all members of the team could provide discrete interventions into the care and treatment plan depending on individual or profession specific specialist skills. They are likely to require team review because:

- they are new assessments
- of a current clinical concern or risk in their presentation
- They have lost contact or not attended an appointment
- may require HTRRT assessment
- may require assessment under the Mental Health Act
- may have been transferred back to the team following (i) a period of rapid response support (ii) a period of home treatment support (iii) discharge following admission to hospital

Amber zone/zone 2 – service users for whom the current crisis has passed, but are still at risk of relapse or a further mental health or social crisis.

Cases in this zone will have been assessed and a treatment plan agreed. There will be a named worker allocated but all members of the team could provide discrete interventions into the care and treatment plan depending on individual or profession specific specialist skills. These cases are monitored through caseload management supervision and must be reviewed by the full MDT within three months to ensure that the care and treatment plan is goal focused and to monitor active progress is being maintained to achieving these goals.

Green zone/zone 3 – service users who are settled in their mental health and social situation. They are monitored for the progress with their recovery and their appropriateness for discharge.

Cases in this zone will be moving towards discharge which may include stepping down to Primary Care Mental Health Services. Interventions may be group work based, may involve peer support workers and support workers, accessing the Recovery College and preparing people for discharge and independent management of their health. Service users will be encouraged to take over and hold responsibility for their care plan, which should be reflected in the goal setting that is agreed with the team. These cases will be monitored through caseload management supervision and be reviewed by the full MDT within three months to ensure that the care and treatment plan is goal focused and to monitor active progress is being maintained to achieving these goals.

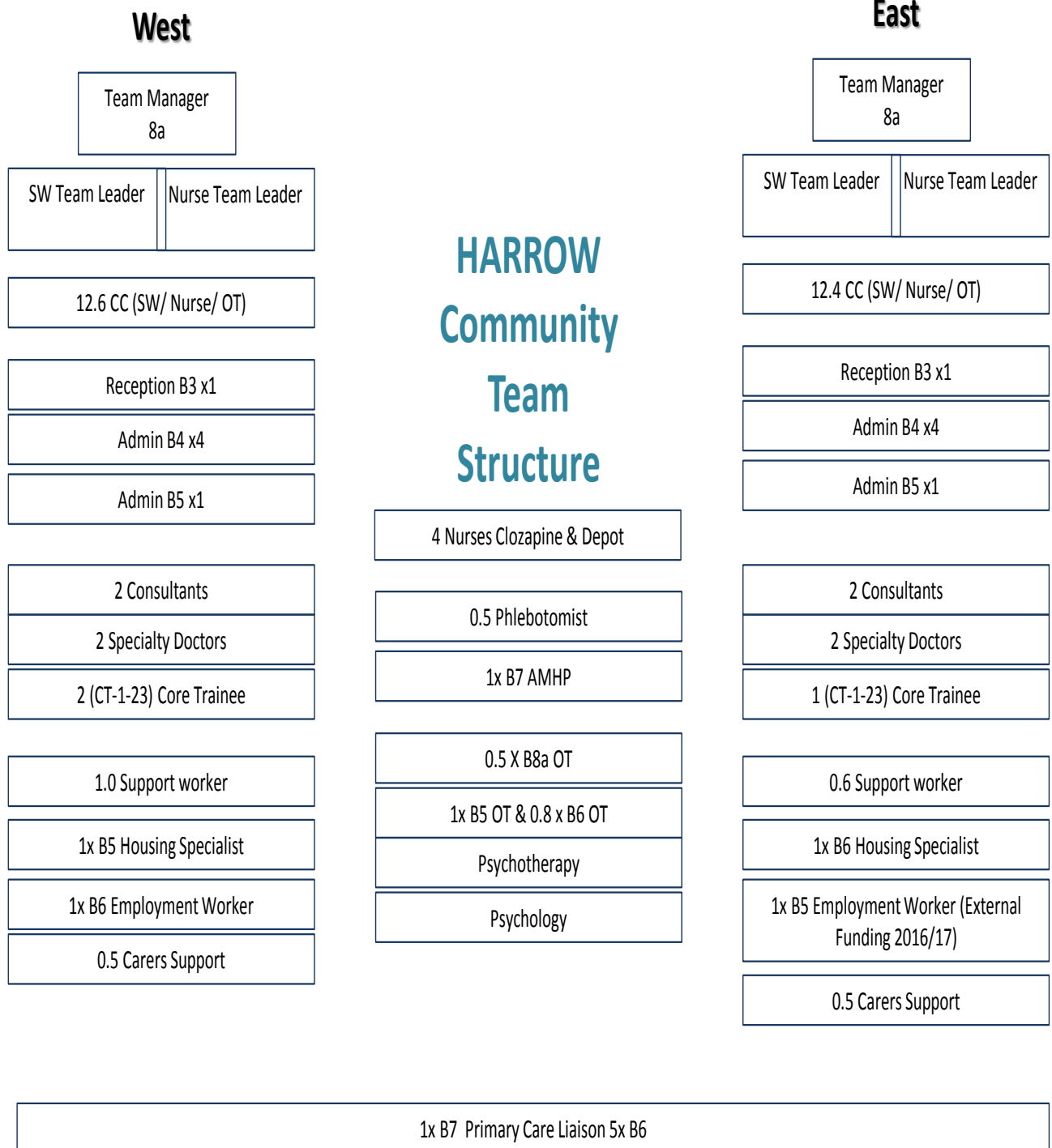
The team response to service users within the different zones will vary depending on the needs of the individual service user. Those in red and amber zones are likely to require more frequent review.

Review of the zoning board/database within the CMHT will take place as part of the team meeting process with the team leads present.

Review of cases will monitor that previously agreed actions have been completed and, if not, what support is appropriate to ensure the actions are completed. The use of the zoning board/database will also be to undertake a transparent review of the whole team caseload in order to identify any possible staff training needs in order to implement care plans.

Individual teams may apply another colour code in addition to the central “RAG” colour codes in order to reflect and highlight the situations of service users within their service, i.e. those within residential placements, inpatients etc.

Appendix 2 – Harrow Community Team Structure



Appendix 3 – Did Not Attend/Clinical Disengagement Standard Operational Procedure

Purpose: This SOP sets out the procedures Trust staff are expected to follow to ensure an appropriate response when patients disengage from or do not attend Trust services

Essential for: All clinical staff and service managers

Supporting: CPA, Clinical Risk Assessment and Management & Safeguarding policies

Principles

- 1.1. It is recognised that for some patients there could be a high clinical risk if they do not attend (DNA) for scheduled appointments.
- 1.2. It is recognised that disengagement is a strong feature in domestic abuse, serious neglect and physical abuse including children.
- 1.3. The Trust's CPA Policy and Clinical Risk Policy sets out the core framework for ensuring that care is managed both safely and effectively. This SOP should be read in conjunction with those documents.
- 1.4. This SOP details the actions to be taken when patients disengage, partially or fully with services. This includes:
 - Potential patients who have been referred but not yet assessed.
 - Those who have been accepted and those receiving treatment.

Procedure

2. Patients referred to, but not yet assessed by services
 - 2.1. If a patient misses an appointment/assessment without explanation or contact with the service, the allocated worker/assessor must:
 - 2.2. In the case of an urgent referral, or where there are suspected significant risks (of any kind) identified at triage or subsequently:
 - Discuss the issues with the team leader/manager and document initial decision in the electronic patient record.
 - Attempt direct contact, by use of the telephone immediately after the missed appointment, to ascertain the reasons and assess the current risk. If contact is made, another appointment should be offered to the patient to be seen as soon as possible, depending on documented assessed risk. If no contact has been possible, discuss with the team leader/team manager and agree actions which may include undertaking an urgent home visit as soon as possible depending on assessed risk. Consideration should be made for a Mental Health Act (MHA) Assessment.
 - 2.3. If, despite interventions, there is no contact:
 - Consideration should be made to continue the following day to contact the patient by phone or make a further home visit.
 - The patient should be designated as 'out of contact' at the community team's Multi-Disciplinary Team (MDT) meeting
 - Inform the GP/ referrer immediately and discuss next steps with them which may include either sending an opt in letter asking the patient to contact the service for a further appointment or closing the referral depending on perceived risk by the GP. Discussions should include consideration of an assessment under the Mental Health Act 1983 (if they have not already done so).
 - Check with referrer that the patient demographics are correct.
 - Liaise with family and other agencies involved to gather information if appropriate.

- In the absence of the patient's consent, it is recommended that the next of kin is informed only if the risks outweigh the patient's wishes not to share information with a relative.
 - Establish and document clear time limits for action and review.
- 2.4. In the case of a non-urgent referral, and where there is no reason to suspect immediate risk to self or others:
- After reviewing the referral and any clinical notes, write to the referrer with copy to the patient stating the person did not attend for appointment. Ask the patient to contact the service if they would like another appointment with an appropriate deadline for contact.
 - If the allocated worker has any concerns about the safety or appropriateness of taking no further action in relation to engaging the patient at this stage, they must discuss the case with the team leader/team manager.
3. Patients assessed and accepted by Specialist Mental Health Services and living in the community
- 3.1. When the care co-ordinator, lead professional/team suspects that a patient is out of contact they must:
- Attempt to contact them by telephone and/or if appropriate, undertake a home visit.
 - Liaise with family and other agencies involved to gather information if appropriate.
 - In the absence of the patient's consent it is recommended that the next of kin is informed only if the MDT considers that the risks outweigh the patient's wishes not to share information with a relative.
 - Consider whether the risks are such that the police are requested to undertake a welfare visit.
 - Document any concerns, the reasons for them, and any attempts at contact.
- 3.2. If the Patient can still not be contacted then:
- 3.3. In the case of a patient not on Care Programme Approach (CPA) and with no known significant risk:
- The GP and any other referrer should be informed and asked whether further attempts should be made to contact the patient or consider whether they should be discharged back to primary care.
- 3.4. In the case of a patient on CPA and/or at known risk:
- Implement the Disengagement Follow up Procedure (see 4 below)
 - This decision should be made following discussion in the MDT and the outcome documented within record.
4. Disengagement Follow up Procedure
- 4.1. The Care Co-ordinator/Lead Professional will have responsibility for ensuring the following:
- Informing all those involved in the provision of care for the patient.
 - Reviewing the risk assessment, advance statement, relapse prevention plan, personal recovery plan and care plan based on current information.
 - In the absence of indications to the contrary, the care co-ordinator/lead professional should make further attempts to contact the patient .
 - Discussing the situation with the team leader/team manager.

- Documenting all actions and attempted contacts in the record .
- For patients who are deemed to be at significant increased risk due to disengagement the team should hold an urgent review meeting.

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