Community Mental Health Teams Operational Policy

Document Reference No.	KMPT.CliG.121.06
Replacing document	KMPT.CliG.121.05
Target audience	CMHTs, Kent and Medway Partnership, KCC, GPs, Service Users, Carers
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Group responsible for developing document	CRCG Senior Management Team
Status	Authorised
Authorised/Ratified By	Clinical Effectiveness and Outcomes Group (CEOG)
Authorised/Ratified On	January 2022
Date of Implementation	January 2022
Review Date	January 2025
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	March 2022
Number of Pages	58
Contact Point for Queries	kmpt.policies@nhs.net
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DOCUMENT TRACKING SHEET

Community Mental Health Teams Operational Policy

Version	Status	Date	Issued to/approved by	Comments
1.0	Operational	13/03/2015	CRCG Clinical Governance Meeting	
2.0	Operational	01/04/15	CRCG Clinical Governance meeting KCC PAT Team	
3.0	Final	15/10/18	CRCG Clinical Governance meeting	Ratified
3.1	Draft	February 2020		
4.0	Final	April 2020	Clinical Effectiveness and Outcomes Group (CEOG)	Ratified
4.1	Final	November 2020	Chief Operating Officer	Addition of Autism/ ADHD SOP as an appendix
4.2	Final	February 2021	Head of Service CMHT	Updated Appendix I
4.3	Draft	March 2021	Deputy Chief Operating Officer CRGG/ACG	Section 6.13 added A day in the life of a CMHT appendix amended
5.0	Final	April 2021	Trust Wide Patient Safety and Mortality Review Group	Virtually ratified
6.0	Final	January 2022	Clinical Effectiveness and Outcomes Group (CEOG)	Ratified
6.1	Final	May 2022	Lead Clinical Quality Manager	PSP Brief Guide document included for reference in 'A day in the life' appendix

REFERENCES

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Cluster specification	
CPA and DNA Policy	
Record Keeping Policy	
Mental Health Concordat	
CMHT Interface	
KPIs/CQINs	

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
April 2020	Associate Medical Director, Community Recovery Care Group		Reviewed throughout and appendices updated
November 2020	Learning Disability and Autism Lead		Addition of Appendix III: Autistic Spectrum Conditions (ASC) and ADHD Referral Pathway Standard Operating Procedure
February 2021	Head of Service CMHT		Updated Appendix I: A day in the life of a CMHT
March 2021	Deputy Chief Operating Officer CRGG/ACG		Section 6.13 added: Action Following Assessment- to support immediate clinical decision following an assessment when a patient has been identified a RED/ high risk. This will include urgent allocation to care co- ordination. Also added to flow chart at section 3 in A day in the life of a CMHT appendix. Active Review process and allocation for care co-ordination
June 2021	CRCG	Appendix IV	Addition of RiO requirements
November 2021	CRCG	Appendix I	Amendments to The Day in the life of a CMHT
May 2022	CRCG	Appendix E	PSP Brief Guide document included for reference in the 'A day in the life..' appendix

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1 INTRODUCTION

1.1 The Policy is designed to provide information on the role and function of KMPT community mental health teams (CMHTs) in Kent and Medway Partnership Trust (KMPT).

1.2 KMPT provide core services to meet the needs of people of people with acute, serious and enduring mental health problems.

1.3 This policy relates to Community Mental Health Teams (CMHT) for adults over the age of 18 years and those persons over 65 years who are open of caseload at the time of their 65th birthday.

1.4 KMPT provides community mental health services across the integrated care system (ICS) into 4 integrated care provider (ICP) localities and currently has 9 separate Community Mental Health Team (CMHT) bases:

- DGS - Dartford, Gravesend and Swanley (North Kent ICP)
- Medway (Medway & Swale ICP)
- Swale (Medway & Swale ICP)
- Maidstone (West Kent ICP)
- South West Kent (West Kent ICP)
- Canterbury & Coastal (East Kent ICP)
- Ashford (East Kent ICP)
- Thanet (East Kent ICP)
- SKC – South Kent Coast (East Kent ICP)

2 VALUES AND PRINCIPLES

Guiding Principles:

2.1 The Community Mental Health Teams (CMHTs) provide recovery oriented care to enable those who are experiencing mental illness to stabilise, maintain work and live independently in the community, and to optimise their physical and mental health and wellbeing.

2.2 The service forms an integral part of a continuum of support for people with mental health needs.

2.3 The service will not meet all the needs of people with complex mental health conditions, the services work in partnership or signpost to other services such as employment, housing, or community opportunities.

2.4 People will have a diagnosable mental illness.

2.5 The CMHTs offer community based provision to adults with specialist mental health needs of sufficient severity or complexity to require specialist intervention.

2.6 Provision follows a multi-disciplinary approach that is flexible and prompt and includes comprehensive assessment of mental health needs, and provision of effective, evidence-based treatment.

2.7 The services are accessible, non-discriminatory; respect cultural values and user friendly. Our services aim to reduce the stigma attached to mental illness and ensure that treatment and care is delivered in the least restrictive manner possible.

2.8 CMHTs take a lead role in promoting a partnership approach by proactively working with both statutory and non-statutory agencies.

2.9 All KMPT services use an electronic patient record (RiO) clinical recording system. All records are held within the system and staff are required to record all relevant activity and contact in line with KMPT policy.

3 SERVICE DESCRIPTION

3.1 This description provides a general outline of CMHT services

3.2 The CMHT is comprised of a staff group with a comprehensive skill mix including medical, nursing, psychology, occupational therapy, peer support, vocational and management and administration skills within each team. We have allocated Local authority social work support.

3.3 The teams employ a multi-disciplinary team approach, valuing professional expertise and opinion, and working together with the person using the service and their carers/family as appropriate.

3.4 Each CMHT has a leadership team consisting of Locality Manager, medical lead, Consultant Psychologist/Psychotherapist, Operational Team Managers and Occupational Therapy lead

3.5 CMHT services are delivered during core hours of operation between 09:00 and 17:00 hours, Monday to Friday.

3.6 There is a commitment to working in partnership with people using services and carers.

4 AIMS

4.1 The service aims to provide comprehensive, integrated and expert assessment of mental health functioning leading to individualised, effective, evidence based therapeutic treatment to reduce and shorten distress and optimise wellbeing.

4.2 The care provided aligns to NICE guidance delivered through structured care treatment pathways.

4.3 Ongoing assessment, interventions and monitoring of those people with severe and persistent mental illness associated with significant impairment, or characterised by poor intervention adherence requiring proactive follow-up.

4.4 Any mental disorder with eligible needs, where there is a significant risk of self-harm or harm to others (e.g. acute depression or severe personality disorder).

4.5 People requiring interventions under the Mental Health Act

4.6 People in CMHT reaching the age of 65 with enduring or ongoing mental illness, will remain the responsibility of that CMHT unless their needs relate to organic disorders or frailty (Cluster 18).

4.7 Timely transfer to the GP and/or other appropriate services following completion of interventions and treatment

4.8 To identify what needs the person may have and what outcomes they are looking to achieve to maintain or improve their mental wellbeing.

5 DUTY

5.1 Duty is a system and process within a team that enables the service to respond to urgent and unexpected mental health needs, in a timely and knowledgeable manner and to provide an appropriate, responsive and safe outcome.

5.2 See standard duty procedure for secondary care Community Mental Health Service in Appendix (i) section 8 of the CMHT day in the life pack for full details.

5.3 The following actions are not duty functions;

- Duty does not hold screened cases awaiting assessment
- Duty does not hold cases when staff are long term absent
- Duty does not hold cases awaiting internal re-allocation
- Duty does not hold cases waiting to be allocated to a professional
- Duty does not hold cases awaiting psychology/psychotherapy
- Duty does not care co-ordinate
- Duty does not conduct SPoA assessment (these are planned work)

RiO Requirements: See Duty in Appendix IV

6 ACCESS TO COMMUNITY MENTAL HEALTH TEAMS

Who the service is for:

6.1 Adults aged 18 and over registered with a Kent or Medway GP; where the GP has concerns regarding the presence of mental illness of a severe or enduring nature.

6.2 People within 6 months of attaining their 18th birthday who are under the care of the Children and Adolescent Mental Health Service (CAMHS), in accordance of the CAMHS transition protocol.

6.3 People referred will have multiple, complex mental health needs including a clinically diagnosable mental health problem – such as severe problems presenting as clusters 'common mental disorders' (4-7,) psychoses (10-13), bipolar disorders (11, 12-17) and emotional difficulties (6-8) plus and of the following:

- Significant risk of persistent self-harm or neglect
- Poor response to previous mental health treatments in primary care
- History of violence or persistent offending
- Dual diagnosis of serious mental illness and substance misuse
- Dual diagnosis of serious mental illness and learning disability
- Dual diagnosis of serious mental illness and neurodevelopmental disorder

- Detained under Mental Health Act (1983) on at least one occasion in the past 2 years
- Serious mental illness with unstable accommodation or homelessness
- Enduring interpersonal difficulties, in the context of existing mental health problems
- Unresolved difficulties including those related to mood, anxiety, abuse and eating disorders
- Mental health problems exacerbated by personality disorder

Referrals and Screening

6.4 Referrals can be received either in writing, electronically or by telephone. (In 21/22 e-referrals will be the preferred method for receipt of referrals)

Essential Referral Information:

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

6.6 Referrals need to include the:

- Individual's name
- Gender
- Date of birth
- Full address including postcode and the address to where they are being discharged (if different) and access details e.g. key safe (if applicable)
- NHS number
- Telephone/emergency contact numbers
- Next of kin contact details
- Name/telephone number of the GP practice
- If known already to the CMHT or other KMPT services
- Reason for referral indicating diagnosis, including last GP contact
- Name of referring person and contact number
- Previous medical history that is relevant to the person's current needs, to include current medication, allergies and infections
- Any advance decisions
- Relevant social circumstance(s)
- Any known contraindications to lone visiting and/or safety/risk issues
- Substance misuse issues including alcohol, over the counter and history of substance misuse / treatment
- Any caring responsibilities (children or other adults)
- Physical health conditions or co-morbidities / complexities
- If the person is eligible for Section 117 aftercare and any services being received as part of their section 117 aftercare entitlement.

6.7 Referrers will be expected and required to provide an outline of concerns and sufficient information to enable effective triage including:

- Mental health symptoms that the person has and for how long
- What interventions (biological, psychological and social) they have had and response to them
- What risks the person presents with (to self, to health and to others)
- Physical health history
- Social situation, circumstances and any safeguarding concerns
- Current medication
- Whether the person is aware of referral and their expectations from it.

RiO Requirements: See Referrals received in Appendix: IV

RiO Requirements: See Scanning and Uploading in Appendix: IV

CMHTs do not provide a service to people with the following conditions

- Mild anxiety and depressive disorders
- Neurodevelopment Disorder e.g. ASD or ADHD disorders without associated mental illness diagnosis
- Anger control and violence without associated mental illness diagnosis
- Disorders of sexual preference (e.g. paedophilia, fetishism)
- Addictive behaviour (e.g. persistent drug or alcohol misuse or gambling) without associated mental illness diagnosis
- Learning disability without associated mental illness diagnosis

Process

6.8 Referrals received by the team will be reviewed each working day by the MDT at the triage review meeting

6.9 Within RiO the referral screening document is to be used and completed as follows:

- Date of screening
- Referral link and client type (mental health)
- Reason for referral - brief documentation of MDT discussion or review of referral
- Planned outcome - document 'RAG' rating of referral and plan
- Result of screening drop down box

Action following triage:

6.10 The CMHT triage team will make the response time decision based on referral information

- Accepted for immediate action = equivalent RED RAG referral rating and rapid response required 72 hours (during working week and referred to Crisis Team over weekend or bank holidays)
- Accepted for assessment = equivalent of GREEN routine response required 28 day assessment
- Person does not have level of complexity requiring specialist care/the person is likely to have needs met by other available services; IAPT, drug and alcohol, social care

6.11 If there is not enough information within the referral to make a decision request for further information will be made and referral re-opened once the information has been provided.

6.12 People who are not accepted for assessment will be informed by a letter clarifying the reason why and signposting to alternative community options where available. The referrer/GP will be copied into the letter.

RiO Requirements: See Triage/ Screening in Appendix: IV

6.13 **Action Following Assessment**

6.13.1 Following the assessment if the patient has been rated a high risk of harm to self or others, the assessor must discuss the patient with the team manager/their line manager/ a senior clinician and immediate/same day action must be taken and the rationale for the clinical decision taken recorded in the patient's clinical notes. This may include:

- Psychiatric review; or
- Transition to CRHT for gate keeping assessment for either admission to an acute psychiatric bed or home treatment; or
- Allocation for care co-ordination; or
- Adding the patient to the agenda for the next day's RED board meeting, which is held every morning; or
- A combination of the above.

6.13.2 To note, the Active Review process is a system in place to keep patients safe whilst they are awaiting commencement of treatment. If, following an assessment, a patient needs immediate allocation for care co-ordination and there is no capacity amongst staff to be allocated as the patient's care coordinator at that time, the team managers will be required to undertake a caseload review and re-allocate a non CPA patient from a clinician's caseload onto the Active Review caseload, where clinically safe to do so, thus creating capacity for immediate care co-ordination for the patient to that particular clinician.

Internal transitions

6.14 KMPT internal transfers are accepted from the following teams when on-going specialist treatment is required and identified:

- Single Point of Access
- Crisis Home Treatment Teams

- Liaison services
- In-Patient wards
- Early Intervention in Psychosis Service
- Criminal Justice Liaison and Diversion Service
- Perinatal services
- Neuropsychiatry services
- MHLD
- Rehabilitation Services.

6.15 On transfer from another KMPT service, as a minimum standard the following information will be required including:

- RiO Assessment
- Presenting situation
- Mental state examination
- Risk assessment
- Formulation (understanding assessment information and developing
- an appropriate plan)
- A working diagnosis (shared with the person)
- Cluster (note cluster 3 and below does not meet the criteria for CMHT)

Transfers where someone is moving permanently to Kent from outside the area:

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

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

- Recent Risk Assessment;
- Historical Risk Summary;
- Recent Care Plan;
- GP details;
- Full medication Chart;
- Copy of latest CPA Review / Outpatient Letter;
- Previous section history, including section 117 status

6.18 In line with best practice existing named practitioners should attend a first outpatient appointment with receiving team whenever possible.

The Health of the Nation Outcome Scales (HoNoOS)/Clustering

6.19 The Health of the Nation Outcome Scales (HoNOS) is the agreed clinician reported outcome measure for application across the Trust. The CMHTs will use HoNOS/clustering in line with the agreed trust policy and all clinicians are responsible for using HoNOS in their routine clinical practice; ensuring age appropriate and learning disability versions of HoNOS are used.

6.20 HoNOS/clustering should be completed at the following key periods during a care episode:

- If eligible for treatment following CAPA choice appointment
- At review
- On admission to hospital – within a week of admission, at 4 weekly intervals and at discharge
- HoNOS at planned discharge from secondary care services
- At transfer of care
- If there is a significant change in circumstances, including working with the Crisis Team/Home Treatment Team

RiO Requirements: See HoNOS in Appendix: IV

RiO Requirements: See Assessment in Appendix: IV

RiO Requirements: See Consent in Appendix: IV

RiO Requirements: See Notices in Appendix: IV

Rio Requirements: See Outcome Measures in Appendix: IV

7.1 Those people with complex needs or need support from a number of services or are most at risk, are all subject to CPA Pathway. Other people with more straightforward support needs will not require the CPA Pathway but will still receive time limited support from the CMHT through the non–CPA Pathway.

Non-CPA and the Care Programme Approach

7.2 To effectively target engagement, co-ordination and risk management support to the people that most need it, the list in Appendix (i) section 5 should be employed to decide if CMHT

7.3 support should continue in line with non-CPA or whether the Care Programme Approach (CPA) is needed. The list is not exhaustive and there is not a minimum or essential number of items on the list that should indicate the need for CPA. However, it is also critical to stress that clinical

and professional experience, training and judgement should be used in using this list to evaluate which people may require support of CPA.

7.4 If it is felt at any point that the Care Programme Approach is required, then the care pathway should be changed to CPA and a care coordinator identified. The Care Programme Approach (CPA) Policy should then be followed. Staff are required to read, understand and work to the KMPT CPA policy as part of this policy.

7.5 Identification and allocation of lead worker or care coordinator will only be led by the locality manager or team managers; recorded on RiO and in the relevant meeting notes.

Important Note:

When staff are absent no new allocations will made to staff when they are absent (either planned or unplanned) On return to work allocation onto caseload will take place in the relevant meeting and be fully considered as part of the return to work process in supervision Before person leaves the team, they have a responsibility to review their caseload, agree handovers or transfers of people back to the GP or Primary Care. Any unallocated caseload will be held for the shortest time possible by team leaders, who will reallocate to an appropriate other as soon as is practicable

Process for Non-CPA

7.6 For people who do not require care under CPA but have needs that are best supported by specialist mental health services they will be accepted onto caseload, often for a short period of up to six months.

7.7 Their needs are described as being more straightforward and less complex.

- Present with low risks to self or others but are likely to respond to short term treatment
- Likely to require short term clinical treatment such as initial interventions
- Have a long term mental health issue, are stable in presentation but require a level of on-going monitoring to ensure mental health stability is maintained
- Step down from CPA, in the process of recovery, likely to be transferred back to their GP

Documentation requirements:

- Clinical progress notes
- Personal Support Plan – developed at the second appointment and updated every six months thereafter or sooner if changes are required
- The care plan should make it clear if the patient is receiving services under section 117 of the MHA 1983 (amended 2007)
- Risk assessment – completed at the initial assessment and updated as risks change or otherwise on an annual basis
- HoNOS - annual reviews undertaken, unless a change in circumstance dictates the need for an earlier review
- Review details – review every six to eight weeks with an annual review of needs documented within the progress notes or within a GP letter. If at review the persons needs have become more complex then transfer to Care Programme Approach should be considered.

Important Note:

To note: People not requiring CPA care are not expected to require long term treatment. More frequent reviews are encouraged as part to the delivery of treatment interventions to ensure people only remain on team caseloads due to need. The named practitioner is expected to review their caseload in supervision at least once every three months to support good caseload management

RiO Requirements: See Editable Letters in Appendix: IV

RiO Requirements: See Psychology in Appendix: IV

RiO Requirements: See Appointments in Appendix: IV

The multi-disciplinary team

7.8 Every person on caseload will be allocated to a named worker. When required this will be one of the following

- Nurse
- Occupational Therapist
- Psychologist
- Doctor
- Support Time & Recovery Worker
- Peer Support worker

7.9 All members of the team are expected to share caseload management responsibility with people allocated to specific roles as their need dictates.

7.10 Any person requiring social care will be referred to the relevant social care teams as required.

RiO Requirements: See Progress Note in Appendix: IV

Doctors as Lead Healthcare Professionals (HCP)

7.11 Key Criteria for doctors as Lead HCP

- Non-CPA only - suitable for individuals receiving care from one agency, who are able to self-manage their mental health problems and maintain contact with services. They are likely to have the following characteristics;
  - Their needs are described as being more straightforward and less complex
  - Present with low risks
  - Do not need active engagement

- In the process of recovery, close to discharge or being transferred to shared care

- Medical need is identified as the sole need
- Doctors can identify themselves as lead HCP or there must be a discussion with the doctor prior to allocation. It may be that the doctor will wish to review the person prior to this decision being made
- The expectation is that doctors will work towards the discharge of the majority of those on their caseload to primary care
- Allocated caseloads will be expected to be approximately 20. The consultant has the right to agree to further allocations above 20 dependent on capacity and complexity of presentation.
- Any changes in the needs of the person or associated risks will trigger re-allocation immediately with support from the team leader.
- Any additional unplanned clinical support will be the responsibility of the duty system and the team leader, should the doctor not be available given dedicated clinics and/or job planned activities. If the doctor is available, he/she will manage the case as indicated – however the need for additional support indicates the likelihood of need for re-allocation/care coordination

Monitoring of caseload under Medical lead HCP

7.12 All doctors will review their allocated cases at least once a month. This will form part of the case load clinics with the support of the team leaders. Administrative processes will be put in place to facilitate completion of the necessary ongoing documentation for non-CPA patients.

RiO Requirements: See Doctors Medication Changes in Appendix IV

Important note

Psychologists are expected to operate as a joint member of the MDT; they can be Lead HCPs for people who are not on CPA and once psychological interventions have started. Psychology will manage their waiting lists and reviews in line with trust policy

When CPA is no longer needed

7.13 Clinical staff will consider at every formal review whether the support provided by CPA continues to be needed. As people's needs change, or the need for coordination support is minimised, moving towards self-directed support will be the natural progression and the need for intensive care co-ordination support and CPA will end. It should be the aim of interventions (wherever possible) to gradually move service users from CPA to non-CPA, and discharge/transfer back to primary care/GP.

7.14 Some individuals who are concordant with treatment, well supported in the community and/or have recovered from a complex episode of mental illness are inappropriately identified as needing the CPA. This group of people may remain with the CMHT for a longer period of time due to the need for ongoing review and previous complexity of presentation.

7.15 It is important to support people to access any services for which they continue to be eligible and need, either from the NHS, local council, or other community services, including section 117 aftercare arrangements.

7.16 The MDT will agree to the removal of CPA ensuring it is not prematurely removed because a person is stable when a high intensity of support is maintaining his/her wellbeing.

7.17 A thorough risk assessment, with full involvement, will be undertaken before a decision is made the support of CPA is no longer needed.

The Long Term Care Framework

7.18 Long Term Care can be defined as ongoing contact for a condition that cannot, at present be cured but is controlled by medication and or other treatment/therapies. For the purposes of the framework Long Term Care is considered for people who have an illness of a psychotic nature as defined clearly in the Care Cluster descriptions for KMPT with defined periods of expected care.

7.19 If there are planned or unplanned absences of lead HCPs and Care Coordinators then the handover protocol is to be followed see Appendix (i), section 11. This also outlines processes if people receiving treatment or carers request a change of staff working with them.

72 HOUR FOLLOW UP

For 72 hour flow charts see Appendix (i), section 7 of Day in the Life of the CMHT.

7.20 Evidence suggests that people with mental health problems, especially those with severe and enduring mental illness, are at particular risk of committing suicide and that the period immediately following discharge from inpatient care is recognised as a time of increased vulnerability.

7.21 Research has found that the period following discharge from a mental health inpatient unit back into the community setting can come with increased risk of self-harm.

7.22 Finding from the National Confidential Inquiry into Suicide and Safety in Mental Health (2018) showed that most post discharge deaths by suicide occurred in the first week after leaving inpatient care. The highest frequency recorded on the third day post discharge, with many clients dying by suicide before their first follow up appointment. Based on these findings many services have already changed practice to complete a follow up contact within 2 – 3 days post discharge for all inpatients on CPA, non CPA and unassigned care.

7.23 People who have been on in a mental health ward require a face to face follow up within 72 hrs following discharge. The 72 hour post discharge protocol outlines the agreement between the Community Recovery Care Group (CRCG) and Acute Services regarding the process of how care will be transferred from Inpatient units to younger adults' community care group.

8 CARE PLANNING

8.1 Care planning is to ensure individuals are clear about the treatment they will be offered.

8.2 The four guiding principles for planning and delivering care in a Community Mental Health Team.

- **Care and treatment will be a health care plan;** that is, addressing the biological and psychological needs of people accessing CMHT cares. This includes physical health and wellbeing.

- **Care and treatment will be coordinated and integrated;** that is health, local authority, third sector and any other appropriate bodies working together in a co-ordinated way
- **Individuals will be involved and engaged**: that is adopting a personalised approach that involves and engages with people who access mental health services to identify, plan, develop, deliver and evaluate a range of services to meet their needs.
- **Care and treatment will be delivered in a planned way:** The majority of contacts will occur in clinic appointments.

8.3 Every person will have a care plan and staff will be supported to develop good care plans that are based on a clear formulation (decision making) with evidence based intervention and choice being offered at all stages.

8.4 The care plan will be developed with the person using services and their carer, whether a family member, supporter or formal carer (when appropriate).

8.5 Relapse management planning is built into care planning as standard**.**

8.6 **The Care Plan will:**

- Describe goal oriented interventions with clear expectation of outcomes with timeframes for review.
- Always include views of the person.
- If appropriate there may be a separate care plan for the carer
- The interventions will be clear and outcome timeframes agreed.
- Record identified risks and how these will be managed
- Include relapse prevention information and/or a rapid access plan
- Include advance statements/decisions where they are drawn up
- Be written up by the responsible named practitioner
- Any contributors to care and treatment delivery will provide a progress report to the review process and/or will attend the review meeting.
- Will be shared with carers where this is agreed as relevant and appropriate.

9 REVIEW

9.1 **The principles of review are:**

- The person is reviewed as frequently as clinically required
- When the person receiving care requests a review
- When a carer requests a review of care and it is deemed appropriate

9.2 Consideration will be given to whether the person receiving service may wish to have an advocate, friend, relative and/or a professional interpreter where needed at a review meeting. It is important that the person will always be involved in their review of their care.

9.3 **Organising a review:**

- The venue for the care review is agreed
- Invitation/ feedback letter is sent to all those involved in working with the person

• The person is prepared for the care review and feedback is collected about the effectiveness of the interventions provided

9.4 **The review will consider:**

The person's view of the treatment plan including:

- Progress towards identified goals
- New/altered needs
- Changes to risks related to mental illness
- Relapse management plans
- A review of physical health related to mental health care and treatment.
- Services from which the person would benefit from that are unavailable (these should be noted and discussed with line managers)
- The need for continued Section 117 aftercare services in line with the section 117 policy.
- The need for or review of existing advance decisions
- The date by which the care plan will next be reviewed
- If the person requires CPA Care Co-ordination
- Discharge planning – the likely time frame for discharge and plans to enable a successful discharge (to review housing, community support, work and job prospects, links with voluntary sector etc.)

9.5 The recording of the review is updated with the date for the next review (if applicable) agreed as part of this review and booked accordingly. All persons can expect at least 6 monthly review of their care with a named practitioner.

Review Pathway:	**Frequency**	**End date – Final review**
Initial Intervention Programme	At week 1 and session 4	2 months – if the person requires on-going care they move onto the relevant treatment plan/pathway with an agreed review date
Change programme	During each session	6 months – if the person requires on-going care they move onto the relevant treatment plan/pathway with an agreed review date
CPA	Formal: Initially: 3 monthly. On-going: 6 monthly minimum MDT review.	As appropriate but at least 6 months To note: when completing a CPA review check if Section 117 review is required. Complete both reviews at the same time
Non CPA and without any other review requirements	3 monthly booked review with named practitioner	Most people on non CPA will be discharged back to their GP within 12 months of services commencing
Active Review	As agreed with the person on AR caseload	6 months face to face if the person has been on the AR caseload 6 months or longer
Section 117 – Any person with a funded health and/or social care package	Reviews should be in line with timeframe for intervention.	Minimum annually Complete this review at the same time as other review such as CPA in line with the section 117 policy.

9.6 **Active Review**

For Active Review SoP see Appendix (i), section 4, Day in the life of CMHT.

The Active Review process ensures a standardised procedure to review the risks and needs of people waiting for core intervention. This ensures that patient safety is the key priority while people are waiting for treatment in community mental health teams. By reviewing their needs, this process enables us to understand and monitor if a person's situation changes to ascertain if they can be better helped by another service, or no longer requires CMHT care.

9.7 People may be required to wait for the core interventions:

- A medical review, if not seen previously by a doctor. If they have been seen by a doctor and a further medical review is the only intervention required then consideration should be given to allocation of the doctor as Lead HCP.
- Recovery Groups, STEPPS, Change Programme for People with PD, Initial interventions
- Specialist psychological treatment

9.8 Those waiting for the above input will automatically be placed into the Active Review Process.

9.9 All CMHT staff are expected to know and understand the Active Review process.

10 DISCHARGE/TRANSFER FROM CMHT TO GP

10.1 Appropriate discharge or transfer for people to primary care/GP is a positive outcome and part of the recovery process. Discharge from the service should be sensitive to the needs of individual and their carers, including information (written and verbal to patient and written to GP) about how services can be accessed in case of future relapse or crisis.

10.2 **Indicators for discharge:**

- Agreed treatment has been completed and no further interventions are indicated
- A break in treatment will be of benefit to the person to test out the interventions delivered
- The care can be managed by the GP or other community services. This may indicate referral to IAPT if the person has improved since referral but still requires
- Interventions for depression and anxiety that do not require any specialist treatment
- The person is believed to be compliant with medication and able to manage this safely
- Any risk factors are satisfactorily managed (noting that risk in itself does not indicate a need to remain in specialist mental health service).
- Discharge has been agreed upon as part of the CPA process
- Discharge due to non-engagement with services as per policy

10.3 Clinicians within the teams should discuss discharge plans within the agreed team process to ensure safe but efficient discharge processes. This should be part of, but not limited to, the regular caseload review process.

10.4 A written discharge summary will be produced in RiO and provided to both the person and their GP and will include:

- The diagnosis on acceptance to services and the diagnosis and progress on discharge (whether in remission, partially treated etc.)
- A summary of interventions provided and the effectiveness of those interventions
- Details of any continuing needs and how they are to be met with recommendations for the on-going or future treatment (including medication)
- Signposting and referral to online resources as well as for community and third sector support options
- Identified triggers and/or indication of the early warning signs of future deterioration of the individual's mental health
- Details of any entitlement to care under section 117 as per section 117 policy
- Arrangements for referral back to CMHT if required

10.5 If a person on case load has been previously treated in a secure unit or has been under a Forensic legal framework then discharge from Secondary to Primary Care should not happen without first consulting the Kent Forensic Psychiatry Service.

Important note:

Reluctant Discharge A person can be discharged even if reluctant to accept the plan. If the person is discharged, their carer or GP are strongly opposed to the discharge plans then the reasons need to be established by the practitioner. An attempt to alleviate the concerns (for example, would a rapid re-referral plan assist) needs to be made. If the situation does not resolve the MDT will discuss with an aim to find a resolution. This may require a face to face review of the person by the Team Leader and Consultant to give a second opinion. In all cases the discussion and plan for rapid re-referral (where an agreed care need) will be clearly documented

RiO Requirements: See Discharges in Appendix: IV

11 DNA PROCESS - DISENGAGEMENT OR DIFFICULT TO CONTACT

For DNA policy see Appendix (i) section 9, Day in the life of the CMHT

11.1 While non-attendance is sometimes unavoidable the expectation is that people will attend, especially if the appointment has been arranged at a time of their choice as per full booking within the Choice and Partnership Approach (CAPA) model or a pre-arranged home visit.

11.2 When people on caseload disengage or become difficult to contact the named worker **must always** assess the impact for the individual. Review of risk assessment and care plan will inform further intervention. Professional judgement will dictate whether this is raised as a matter for serious concern using the risk management escalation process such as the RED board meeting

- Care plans MUST have a written contingency plan if there is an identified risk of disengagement.
- Care co-ordinators / practitioners must raise all instances of disengagement and failure to comply with essential treatment etc. at RED board meeting or team meetings when a positive action will be agreed and recorded on RiO.

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

11.3 The KMPT DNA Policy sets out how to manage DNAs in order to maximise resources without compromising safety and access to services and care.

11.4 Actions will be determined by known level of risk and symptomatology and should always be discussed with a senior member of the team and documented within RiO progress notes.

11.5 Staff are expected to have read, understand and use the policy and procedure for managing patients who Do Not Attend and/or are unable to be contacted for full detail.

Important note:

Out of hours the CRHTT will accept referrals from CMHT where CMHT have been unable to make contact to assess and review the mental state of the person but significant risk factors are evident and meet the threshold for CRHTT involvement.

12 STAFF OR FAMILY OF STAFF WHO NEED CARE

12.1 In order to maintain service users confidentiality and dignity, staff or close family of staff members (who become service users of KMPT), will have services provided for them by a CMHT other than that which they are a staff member / have family as a staff member.

12.2 Each individual will be offered a service from the next nearest CMHT, and venues for contact should be considered to allow for maximum convenience for the person receiving services. Arrangements of services are made in full consultation with the service user.

13 LOCAL AUTHORITY RESPONSIBILITIES

13.1 We work in partnership with social care in line with local arrangements between Kent County Council, Medway Council and KMPT. Key social care responsibilities include settled accommodation and tenure in the community; social care review under Section 117, enabling people to stay safe; development of skills to keep and find employment and related vocational activity; personalisation and self-directed support. For Section 117 responsibilities refer to national and Kent and Medway Protocols.

Social Care Assessment

13.2 All social care assessments will be completed on referral to the relevant local authority service. Care will either be transferred to social care and the person discharged from KMPT or jointly supported by both the CMHT and the mental health social care team

Safeguarding Vulnerable Adults

13.3 A ‘vulnerable adult’ is defined as ‘a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation’ (Law Commission 1995).

13.4 The lead agency for Adult Protection across Kent and Medway is Medway Council or Kent County Council. Where an Adult Protection concern is considered serious, a formal referral under the Multi-Agency Safeguarding Vulnerable Adults Adult Protection Policy will be made.

RiO Requirements: See Safeguarding in Appendix: IV

Mental Capacity Act 2006

13.5 Including Best Interests Assessments (BIAs) and Deprivation of Liberty Safeguards (DOLS)

Carers' Assessments

13.6 The Care Act 2014 provides that where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, local authorities must carry out a carer's assessment.

14 STAFF WORKING PRACTICES

Remote Working:

14.1 The need to deliver services locally will continue to be an essential part of Community Mental Health Teams. In order to enable this to happen across wide locality areas, remote systems will be available for practitioners to access KMPT applications and RIO information and enable the clinicians to access data securely from remote locations

14.2 Mobile devices and confidential information, whether manual or electronic, must be protected by adequate security, for example, they must be:

- Kept out of sight, for example, in the locked boot of the car, when transported
- Not left unattended, for example, not left in the car boot overnight
- Locked away when not being used
- Kept secure and guarded from theft, unauthorised access and adverse environmental events particularly when taken home
- Encrypted

14.3 The Trust is committed to providing an appropriate working environment to facilitate its staff whether they are at their main base, one of the other Trust sites or working from any other remote site. Trust agreed bases will be available for remote working. Within these premises there must be access to appropriate workspace that is fit for purpose and meets Health and Safety requirement. Health and Safety Assessments must be completed for all remote bases and filed within the locality Health and Safety folder.

14.4 There is a need for all community workers to feel supported in their day to day work and ensure that team functioning is not jeopardised by remote working. Team Managers must ensure that team meetings are regularly scheduled and that there is a commitment for all members of the multi-disciplinary team to attend. In addition to this, regular supervision (both peer and individual) and arrangements for ad-hoc telephone support must be put in place.

Home working:

14.5 Periodic home working is allowed at the discretion of the team/locality manager. It is not anticipated that there will be a regular commitment to home working although occasionally,

taking into account individual circumstances or the nature of the work to be undertaken, home working can be considered

14.6 In determining whether or not periodic home working is appropriate, the Line Manager must ensure that appropriate cover is available within the team and that the appropriate resources and equipment are available to support working from home.

14.7 The Remote Working Policy must be followed and all relevant assessments undertaken to support staff with working from home

Lone Working:

14.8 The Trust recognises that staff may have to work alone in the delivery of clinical and non-clinical services. As with any potential risk to Health and Safety and welfare of staff, the risks associated with lone working need to be identified, assessed and managed.

14.9 Local protocols must be in place and form part of all local induction for all new staff.

14.10 Lone working policy must be followed at all times; it is the employee's responsibility to ensure they have read, understood and work to the policy.

Staff Supervision

14.11 Supervision is an important part of managing, motivating, supporting and training staff. Supervision will be carried out in line with KMPT Supervision policy.

- All staff should expect to receive managerial supervision in line with Trust policy
- Clinical supervision may be a separate process which should supplement managerial supervision.
- As part of the governance structure staff are expected to discuss caseload in their supervision at least once every three months

14.12 Psychological therapists will support the whole team in delivering psychological interventions through supervision, consultation and joint work, particularly group work and care pathway programmes

Training and Development

14.13 Training and Development will reflect the needs of the Trust and of the individual, as described in their personal development plan. Continuing professional development is a key element of ensuring the delivery of the highest possible quality of service.

14.14 All staff will be appraised annually through their professional aligned processes with a six-month review. All new staff will attend the Trust induction programme as well as receive a local induction to include reference to appropriate policies and procedures.

14.15 The priority for training will be attendance on statutory/mandatory training courses that are appropriate to their individual professional status. Once completed, other training opportunities will be identified and agreed within individual appraisal that supports the delivery of the service and approved by line managers.

14.16 Students and trainees from various disciplines will be attached to the CMHT as part of their training. All such students will be advised of the CMHT operational policy and will have clearly understood supervision and mentor arrangements within the team. It is the duty of all disciplines

to provide practice supervision to students. People using services have a right to choose whether a student is present during their appointment.

15 ESCALATION OF CONCERNS

For RED BOARD process see Appendix (ii)

15.1 All safety concerns which cannot be safely managed by the named worker or Care Coordinator alone will be escalated to the MDT for discussion which could be at daily Red Board meetings, weekly MDT meetings and local risk forums. This will include concerns relating to interface with other KMPT services or other external specialist services. Where clinical or operational concerns are not resolved at team level these should be escalated to the Associate Medical Director or Head of Service, respectively.

15.2 There are certain clinical indicators which when met require a person to be included in the RED board process.

- The person is assessed as experiencing acute mental health symptoms which lead to associated acute risks
- The person is about to be or has just been discharged from a mental health hospital
- The person is under the care of the Crisis Resolution and Home Treatment team
- The person has been referred from a place of safety following assessment under Section 136 of the Mental Health Act.
- The person is taking clozapine and has indicated that they have not had a bowel movement
- The person has missed their depot injection.
- The person requires a 72 hour follow up.
- The person Did Not Attend and if identified as high risk (RAG Red), the escalation process outlined in the DNA Policy is to be followed. By 1500 hours appropriate actions have been taken.

16 COMMUNICATION

16.1 Timely and quality communication with GPs supports recovery, wellbeing and safety. CMHTs will communicate with GPs at key points in the delivery of care as outlined in Table 1 below.

16.2 CMHTs have standard letter templates for communicating with GPs (and service users) which can be found in Appendix I.

17 HEALTH AND SAFETY

17.1 Health and Safety risk is inherent in the delivery of health and social care. The Trust is committed to the identification, assessment and reduction of all risk to all through a process of risk assessment.

17.2 Health and Safety risk assessment is a management responsibility, however, all employees must take reasonable care for their own health and safety at work. They must also take care of the health and safety of other persons. Employees must also co-operate with their employer in meeting statutory requirements. Health and Safety at Work Act 1974

17.3 Staff should always refer to the Trust Health and Safety policy.

18 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

18.1 The policy will be implemented via each team through their local team governance meetings and the meetings minuted for evidence of awareness.

19 EQUALITY IMPACT ASSESSMENT SUMMARY

19.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

20 HUMAN RIGHTS

20.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

21 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	***How will it be monitored***	***Who will monitor***	***Frequency***	***Evidence to demonstrate monitoring***	***Action to be taken in the event of non-compliance***
Adherence of operational team working to all aspects of this policy	Audit, and weekly and monthly IQPR data	Care Group Quality Performance Review	Monthly	Minutes of COG and Care group Meetings	Actions to be planned within COG and Care group Meetings

The day in the life of a KMPT Community Mental Health Team

A Guide

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1 INTRODUCTION

The pack aims to provide consistency across Community Mental Health Teams (CMHTs). The pack provides standardised documents which support the operational practices of the CMHTs.

It is an expectation that all CMHT staff should familiarize themselves with this document as it illustrates the how the CMHT functions on a day to day basis.

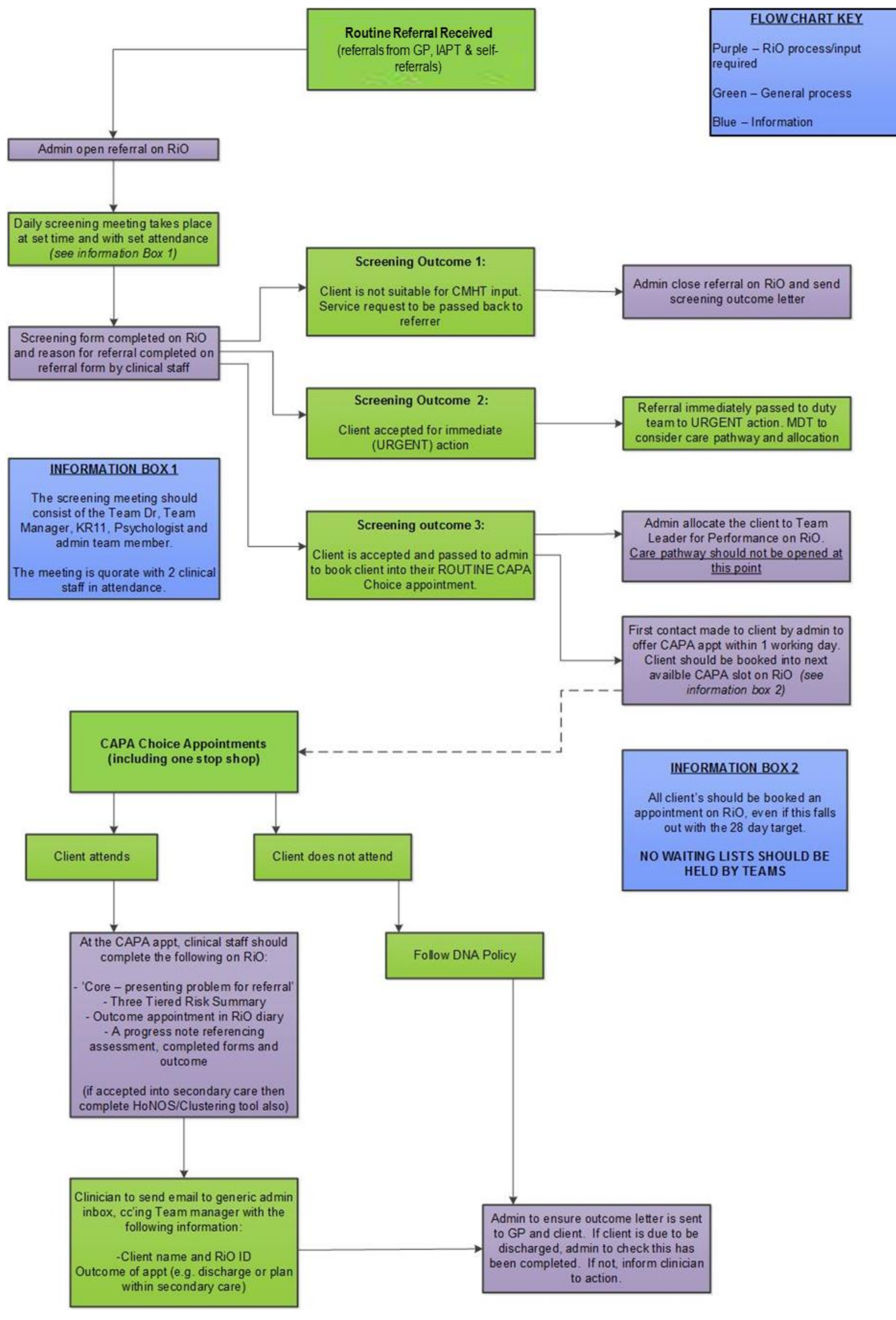
This document should also form part of new staff's induction. Where there is a requirement for local adaptations this will need to be passed through the Care Groups Governance process for agreement.

All staff need to read this pack alongside the CMHT operational policy and any other related policy.

2 CMHT STAFF MEETINGS

Frequency	Title	Purpose	Duration	Attendance	Terms reference
Daily	Red Board Meeting	Manage High Risk Individuals	Max 45 mins	MDT Representation	Appendix i
Weekly	Business/ Clinical Team meeting	Review & Action of operational decisions & issues	Max ½ day	MDT Representation	Appendix ii
Monthly	Clinical Risk Forum	Multi-professional, clinical review of high risk cases which contribute towards robust care planning, community safety and local risk management.	2 hours	• Consultant Psychiatrist • Consultant Psychologist or Senior Psychologist • Team Manager • Lead HCP • Other staff involved in the care of the high risk service user • Administrator Representative of partner agencies • Locality Manager	Appendix iii
Monthly	Caseload Clinics	Interactive meeting, where clinicians discuss their caseloads	1 hour per clinician (can form part of supervision)	Team Managers & Clinicians	N/A
Monthly	Reflective Practice	To improve practice through reflection on clinical and team practices	1 – 1.5 hours	MDT	N/A
6 monthly	Team away	Structured team away day to celebrate successes in the team, share learning, CPD and develop innovation.	A Full day	The whole Team	N/A

3 INITIAL ASSESSMENT SOP AND FLOW CHART



Following the assessment if the patient has been rated RED harm to self or others, the assessor must discuss the patient with the team manager/their line manager/ a senior clinician and immediate/same day action must be taken and the rationale for the clinical decision taken recorded in the patient's clinical notes. This may include:

- Psychiatric review; or
- Transition to CRHT for gate keeping assessment for either admission to an acute psychiatric bed or home treatment; or
- Allocation for care co-ordination; or
- Adding the patient to the agenda for the next day's RED board meeting, which is held every morning; or
- A combination of the above.

4 ACTIVE REVIEW

Non-CPA clients waiting to be offered a service following assessment will be placed on the Active Review Process

↓

The Active Review Process consists of a Band 6/7 Lead, a Band 5 or an STR worker. There is also allocated admin support

↓

Clients on Active review will receive the following:

-Letter informing them or the process and giving the date and time of first telephone contact.

-A plan of contact can then be agreed during the phone call i.e. fortnightly, monthly calls which will be reflected in the PSP

- Safety Plan
- clients will be added to the correct Intervention tab on RiO

→ If risk changes and concerns are raised during telephone contacts, the client will be discussed at the daily RED Board Meeting

↓

If telephone contact is not achieved, the DNA Policy should be followed

↓

All clients on Active Review should be reviewed by the MDT on a 3 monthly basis

↓

If a client remains on Active Review for 6 months, they should be seen and their risk assessment and care plan updated

↓

Once a client begins to receive the Service they have been waiting for, they should be moved to the caseload of the HCP working with them

5 CPA

Those people with complex needs or need support from a number of services or are most at risk, are all subject to CPA Pathway. Other people with more straightforward support needs will not require the CPA Pathway but will still receive time limited support from the CMHT through the non–CPA Pathway.

Those considered requiring CPA care will have a severe mental illness (including personality disorder) with high degree of clinical complexity and one or more of the following:

- Current or potential risk(s), including:
  - Suicide, self-harm, harm to others (including history of offending)
  - Relapse history requiring urgent response
  - Self-neglect/non concordance with treatment plan
  - Vulnerable adult; adult/child protection e.g.
    - Exploitation e.g. financial/sexual
    - Financial difficulties related to mental illness
    - Disinhibition
    - Physical/emotional abuse
    - Cognitive impairment
    - Child protection issues

- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team
- Significant reliance on carer(s) or has own significant caring responsibilities

- Experiencing disadvantage or difficulty as a result of:
  - Parenting responsibilities
  - Physical health problems/disability
  - Unsettled accommodation/housing issues
  - Employment issues when mentally ill
  - Significant impairment of function due to mental illness
  - Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues.

- The needs of person from the key groups below should be fully explored to make sure that the range of their needs are examined, understood and addressed when deciding their need for support under CPA. The default position for people with high levels of need and risk would normally be care provision under CPA unless a thorough assessment of need and risk shows otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in care records.
- **Key Groups:**
  - Who have parenting responsibilities
  - Who have significant caring responsibilities
  - With duel diagnosis (substance misuse)
  - With a history of violence or self-harm
  - Who are in unsettled accommodation

6 NON CPA

For people who do not require care under CPA but have needs that are best supported by specialist mental health services they will be accepted onto caseload, often for a short period of up to six months.

Their needs are described as being more straightforward and less complex

- Present with low risks to self or others but are likely to respond to short term treatment
- Likely to require short term clinical treatment such as initial interventions
- Have a long term mental health issue, are stable in presentation but require a level of on-going monitoring to ensure mental health stability is maintained
- Step down from CPA, in the process of recovery, likely to be transferred back to their GP

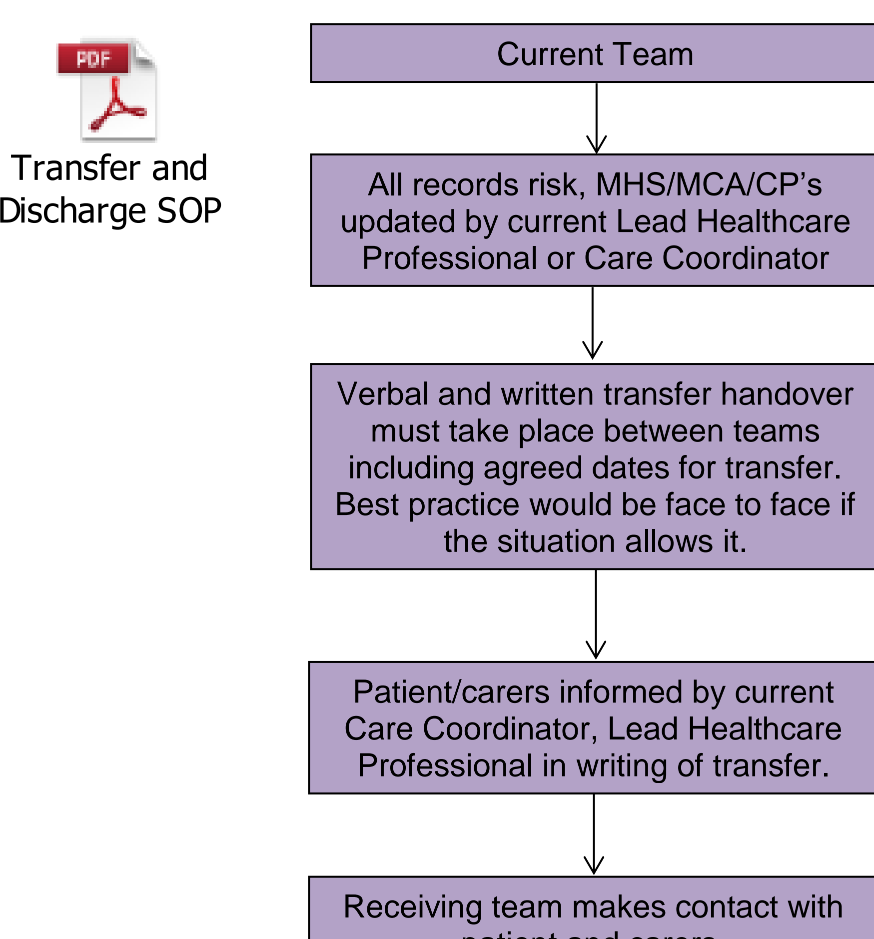
Documentation requirements:

- Clinical progress notes
- Care plan - the care plan is in the form of a Personal Support Plan that goes to the person. This should include a clear understanding of how care and interventions will be carried out, by whom, and must be developed in collaboration with the person being treated. A copy is provided to the person in all cases, unless in very rare occasions when the decision not to share must be agreed by all involved and the rationale clearly documented on RiO. It should be updated to reflect changes, or otherwise on a six monthly basis. A brief guide can be found in appendix
- Risk assessment – completed at initial assessment and updated thereafter if there is a change in risk circumstances, or otherwise on an annual basis
- HoNOS / Cluster – at initial assessment then as required and at necessary time periods
- Physical health check if required
- RiO diary appointment and outcome
- Core assessment – at initial assessment and updated as required
- Review every 6-8 weeks

Important Note:

To note: People not requiring CPA care are not expected to require long term treatment. More frequent reviews are encouraged as part to the delivery of treatment interventions to ensure people only remain on team caseloads due to need. The named practitioner is expected to review their caseload in supervision at least once every three months to support good caseload management

7 DISCHARGE AND TRANSFER



4.3 (policy) Discharge for patients with a forensic history
* Any patients with forensic history who are being considered for discharge must be consulted by Kent Forensic Psychiatry Service.

4.5 (policy) Discharge of patients that move their address outside of Kent and Medway
* Patient must give consent. If patient has capacity but refuses then Team to use K&M Agency information sharing protocol. If patient lacks capacity MCA must occur and best interests considered.

8 PROTOCOL FOR THE TRANSFER OF CARE BETWEEN THE CMHTS AND THE INPATIENT REHABILIATION SERVICE

For full protocol see i-connect

Key extract:

3 PROCESS

3.1 When a service user is admitted to an inpatient rehabilitation bed and is accepted for a period of inpatient rehabilitation the following process will be followed to provide a seamless transfer of care to the Inpatient Rehabilitation Service and then back to the CMHT prior to discharge

3.1.1 A handover meeting take place at or around week 4 of the admission, where the decision regarding hand over of care including the Lead Health Care Professional (HCP) role will be agreed based on the therapeutic relationship, predicted length of stay, service user need and risks to engagement/therapeutic relationship

3.1.2 Once the handover meeting has taken place the CMHT will close the CMHT referral on Rio

3.1.3 Inpatient rehabilitation will provide a brief monthly report to the link worker for all service users in the service which will include the proposed discharge pathway and proposed discharge date (please see Appendix A for details)

3.1.4 Inpatient rehabilitation staff will notify the link worker and dial into the MDT meeting to escalate any concerns or risks especially if these may lead to the placement being compromised. The details of the MDT meetings will be provided by the link worker

3.1.5 The Lead HCP from the Inpatient Rehabilitation Service will notify the link work and CMHT administration team of the service user's proposed discharge date three months in advance and request reallocation of a Lead HCP in the CMHT

3.1.6 The CMHT Team Manager will arrange re-allocation of a care coordinator within 4 weeks

3.1.7 A handover meeting will take place at least 6 weeks prior to the proposed discharge date and care will transfer back to the CMHT

3.1.8 The Inpatient Rehabilitation referral will be closed on discharge from the service

4 KEY RESPONSIBILITIES

4.1 Community Mental Health Teams

4.1.1 Each CMHT will identify a link worker to provide a liaison role between the CMHT and the inpatient rehabilitation units

4.1.2 The Lead HCP or link worker will attend the handover meeting four weeks after the service user is admitted to the rehabilitation unit

4.1.3 Where concerns or risks are raised by the Inpatient Rehabilitation Service, the link worker will highlight these to the CMHT in the red board meeting and provide details of the MDT meeting to the Lead HCP in the Inpatient Rehabilitation so they can dial in to discuss it further

4.1.4 Following notification of the potential discharge date the Team Manager in the CMHT will allocate a lead HCP in the CMHT within four weeks; where possible consistency of the lead HCP will be prioritised

4.1.5 The identified lead HCP will attend the handover CPA meeting at least 6 weeks prior to the proposed discharge date

4.1.6 Where there is a change in the service user's admission status care will transfer back to the CMHT

4.2 Inpatient Rehabilitation Teams

4.2.1 The unit manager will be responsible for arranging the handover CPA Meeting four weeks after the service user is admitted to the unit

4.2.2 The unit manager will be responsible for identifying the Lead HCP from the substantive inpatient staff team

4.2.3 Following transfer of care the Lead HCP within the Inpatient Rehabilitation Service will take responsibility for all care plan review meetings CPA and placement paperwork (e.g. S117 NEL Form, CANFOR)

4.2.4 Following transfer of care, where and individual is held under a section of the Mental Health Act (typically section 3 or section 37) the lead HCP within the Inpatient Rehabilitation Service will complete a joint nursing and Social Circumstances Report for the MHA Tribunals for service users held under the Mental Health Act (please see Appendix B for the templates agreed by the Mental Health Act compliance Manager)

4.2.5 Inpatient rehabilitation staff will notify the link worker and dial into the CMHT MDT (patch) meeting to escalate any concerns or risks especially if these may lead to the placement being compromised. The details of the MDT meetings will be provided by the link worker

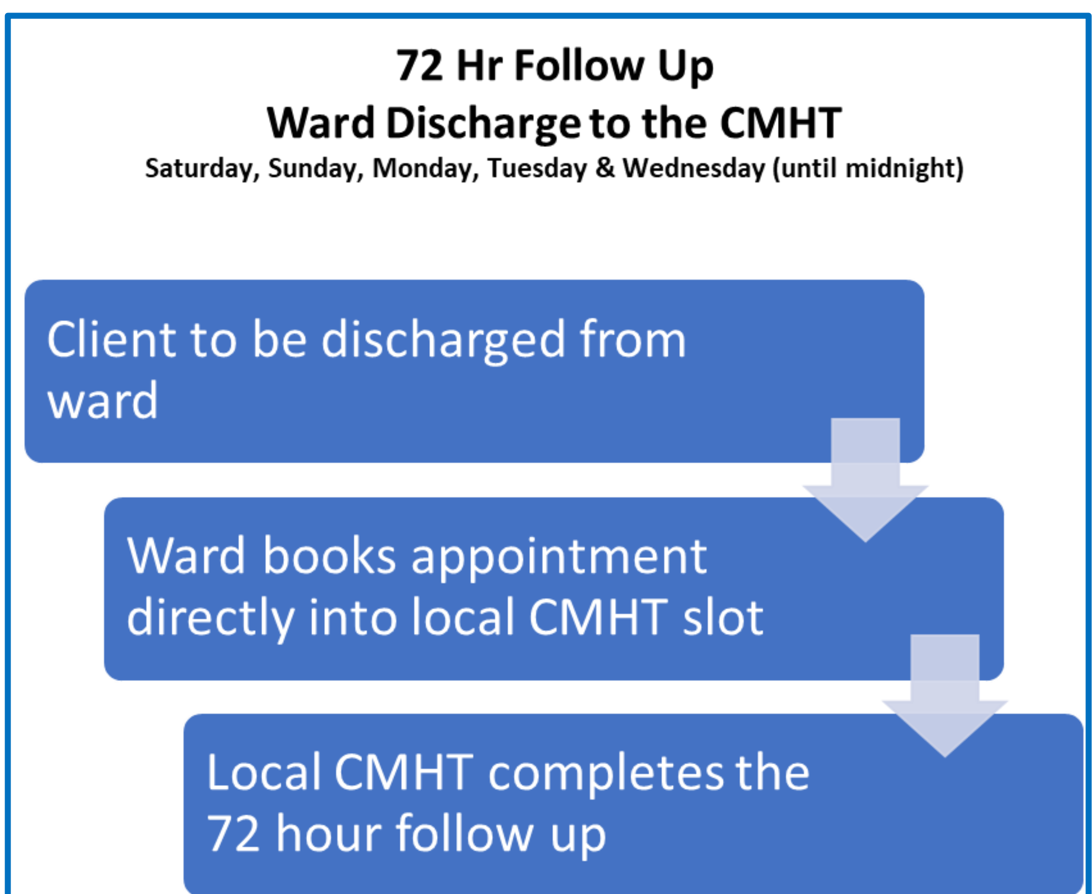
4.2.6 The lead HCP from the Inpatient Rehabilitation Service will notify the relevant CMHT of the service users proposed discharge date three months in advance by emailing the identified link worker and the CMHT 'admin inbox' (please see Appendix C for details)

4.2.7 Should a Lead HCP not be allocated in the CMHT within the specified timeframe this will be escalated via the Rehabilitation Service Manager to the CMHT and Specialist Heads of Service

4.2.8 Once a Lead HCP has been identified in the CMHT, the Lead HCP from the Inpatient Rehabilitation Service will arrange a handover CPA at least 6 weeks before the proposed discharge date to transfer the service users care back to the CMHT

9 72 HOUR FOLLOW UP

Flowchart – Ward to CMHT



Flowchart – Ward to CRHT

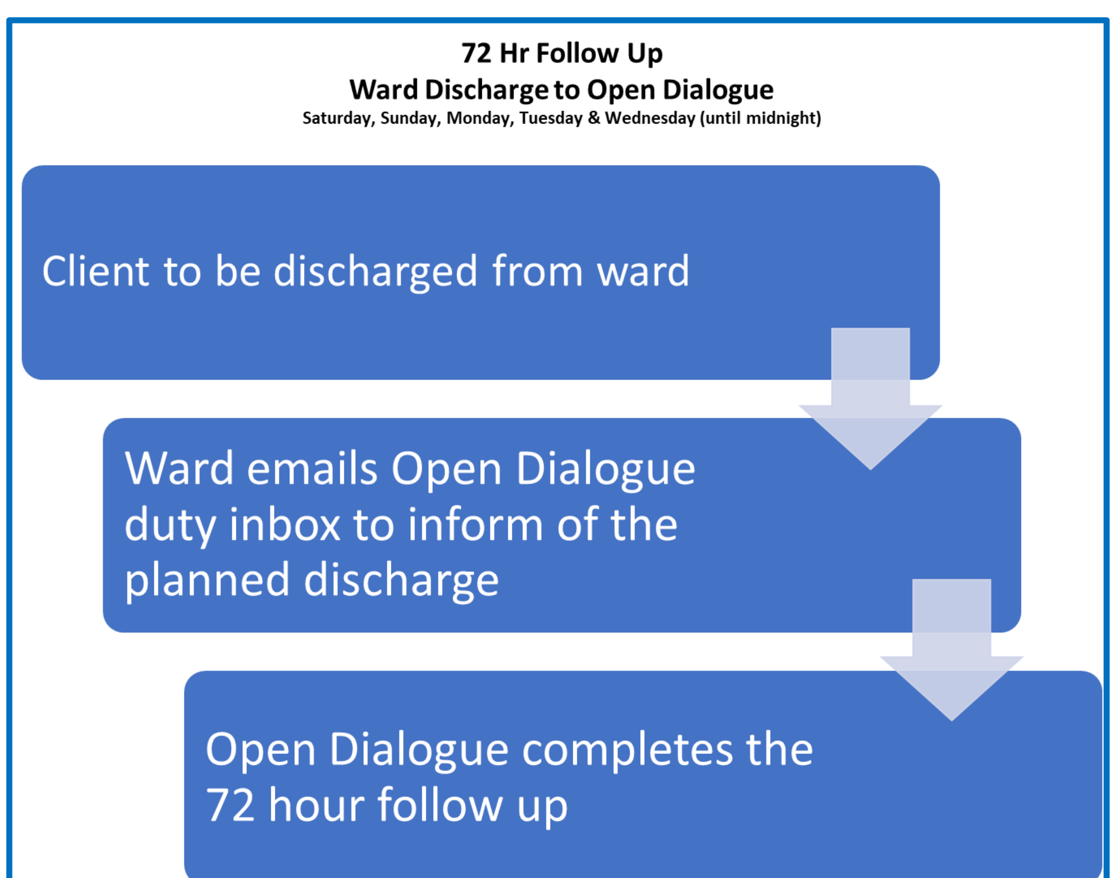
Thursday, Friday, Bank Holidays & Saturdays which fall on a bank holiday weekend)

Client to be discharged from ward

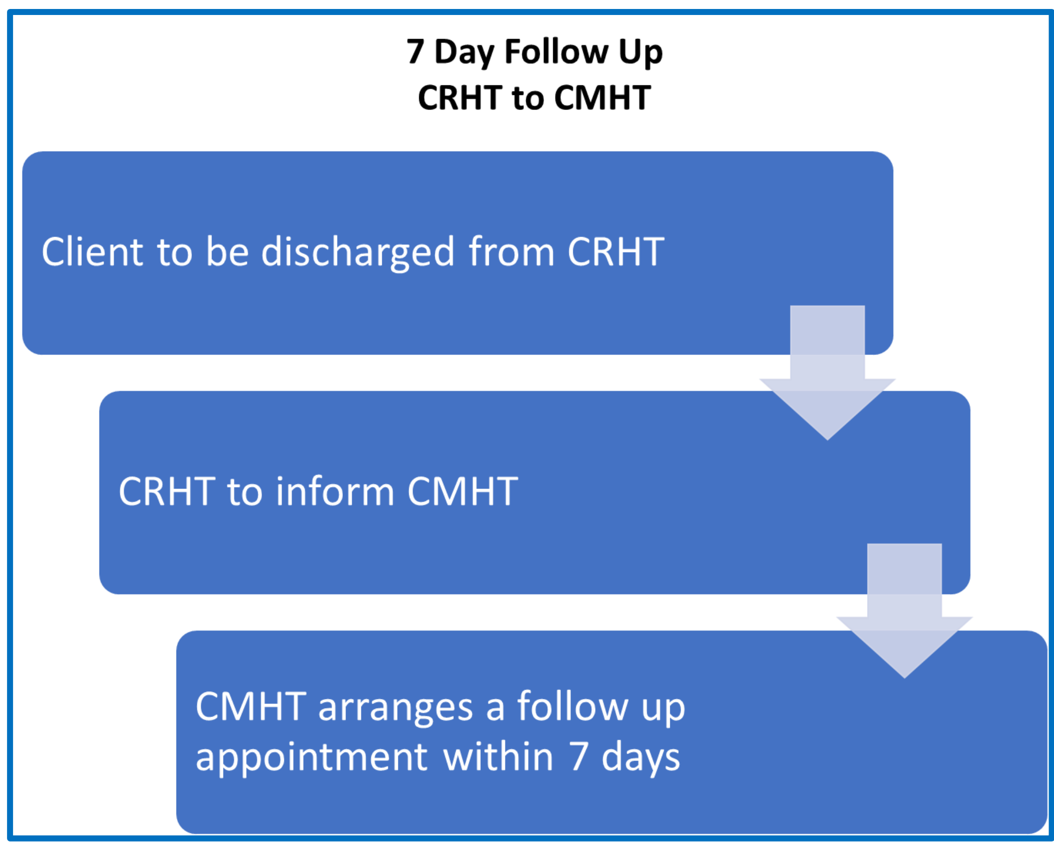
Ward contacts local CRHT to inform them that an appointment is required within 72 hours

CRHT completes the 72 hour follow up

Flowchart - Ward to Open Dialogue



Flowchart – CRHT to CMHT (7 day)



10 INTERFACE PROTOCOL – LIAISON PSYCHIATRY SERVICE TO CMHT PROCESS

Liaison Psychiatry and Community Mental Health Teams Interface Protocol for working and non-working age adults.

This protocol outlines the agreement between the Liaison Psychiatry Services and the Community Mental Health Teams (CMHT) for younger adults and Community Mental health services for older adults (CMHSOP) with regard to the process of how care will be passed from the Liaison service to the CMHT/CMHSOP for patients who are deemed eligible for secondary mental health services.

The CMHT/CMHSOP will see the patient for a follow up appointment within 72 Hours following discharge from the acute hospital. Liaison Staff will refer patients already known to CMHT/CMHSOP if patient remains admitted in Acute Hospital but has been discharged from Liaison caseload. Patients who are not known to the service will be referred to CMHT/CMHSOP after discharge from the acute hospital. The purpose of this initial meeting will be to review the initial assessment and to agree with the service user how any on-going identified needs will be met from within the community.

During office hours (Monday to Friday 9am to 5pm)

1. Liaison clinicians will telephone the relevant CMHT/CMHSOP and have a clinical discussion of the case with the duty worker. They will also email the correct team indicating the patient details, contact details and the immediacy of contact
2. As far as is possible, an appointment time will be identified, to be passed to the patient before discharge from Liaison services
3. Liaison will provide the patient with the CMHT/CMHSOP contact details, including the KMPT website details, the Mental Health Matters Helpline number and the single point of access number. Any information available regarding the patients mental health problem should also be shared.
4. Liaison will email the team and upload the Initial action plan to the CMHT/CMHSOP and General Practitioner (GP) The patient will receive a copy.

Out of office hours

1. Liaison will email and upload on RIO the discharge summary to the CMHT/CMHSOP, GP and any other relevant agencies involved. The patient will receive a copy
2. Liaison will provide the patient with the CMHT/CMHSOP contact details, including the KMPT website details, the Mental Health Matters Helpline number and the single point of access number. Any information available regarding the patients mental health problem should also be shared.

When the above information is received by the CMHT/CMHSOP, they will arrange to see the patient within the 72 Hrs

Community Mental Health Services for Older Persons (CMHSOP)

Patients being referred to CMHSOPS should be seen face to face within 72Hrs of being discharged from the Acute Hospital. This includes Functional and Complex Dementia presentations.

Routine Memory assessment requests should be discussed in the daily Triage meeting and a clinical decision made at that stage.

Additional information

CMHT/CMHSOP Lead health care professional (HCP) should advise the Liaison Service of patients under their care who are admitted to one of the 7 district general hospitals in Kent and Medway. This should highlight the type of support that might be required during the patient's admission.

Community mental health clinicians must only direct people on their caseload to attend A&E if they are physically unwell or injured requiring emergency medical intervention. Accident and Emergency is not a default alternative

for a mental health assessment by liaison with the absence of an emergency medical need that requires immediate attention.

Escalation

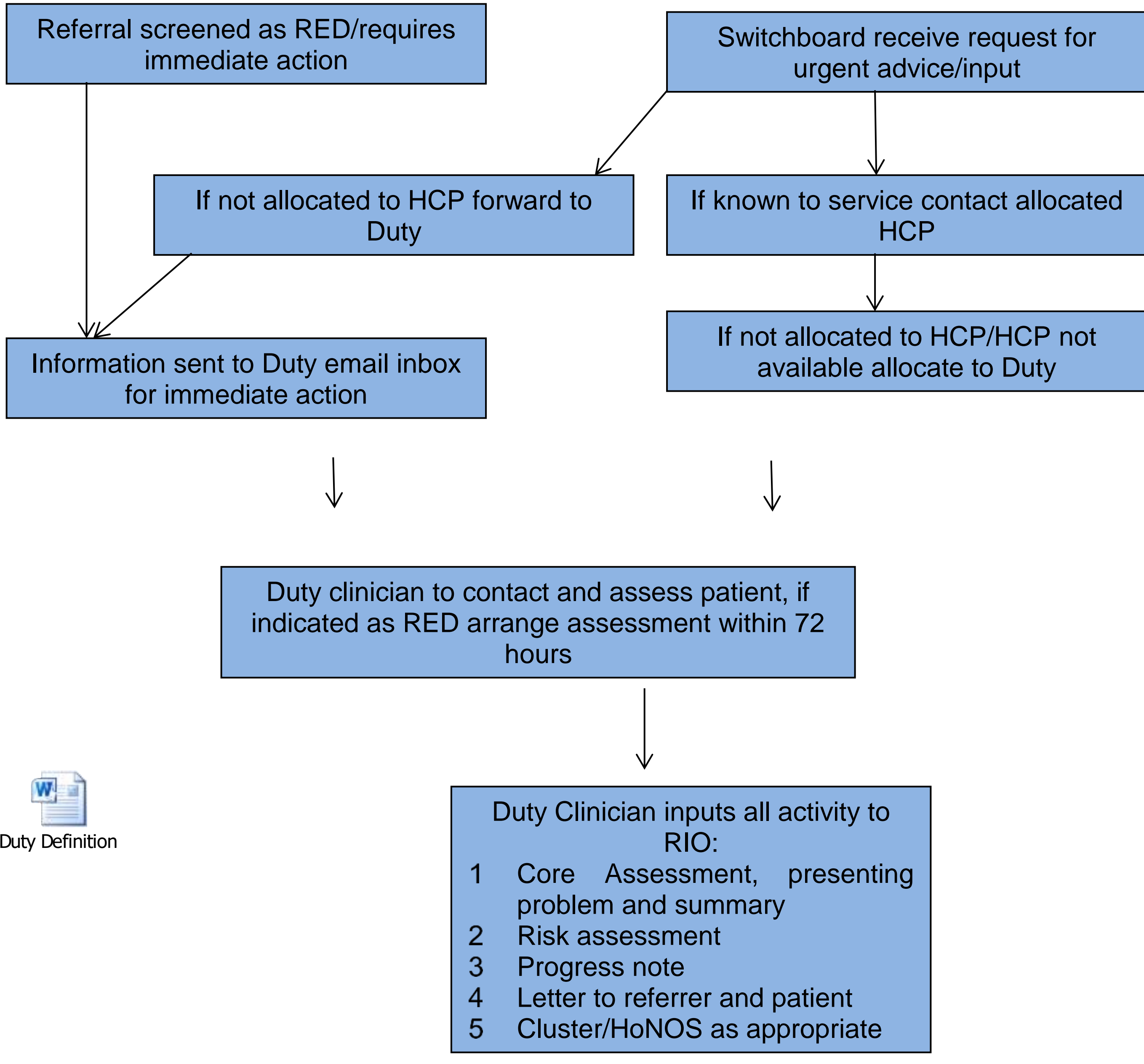
Any concerns in relation to the compliance with this protocol should be discussed between the relevant Liaison Team Manager and CMHT/CMHSOP Manager in real time.

Review

This protocol will be reviewed in January 2023

11 DUTY

Duty Flowchart



12 CANCELLATION AND DNA

DNA PROCESS - Disengagement or difficult to contact

DNA Policy.pdf

The KMPT DNA Policy sets out how to manage DNAs in order to maximise resources without compromising safety and access to services and care.

When people disengage or become difficult to contact the named worker must always assess the impact for the individual. Review of risk assessment and care plan will inform further intervention. Professional judgement will dictate whether this is raised as a matter for serious concern using the risk management escalation process such as the RED board meeting

- Care plans MUST have a written contingency plan if there is an identified risk of disengagement.
- Care co-ordinators / practitioners must raise all instances of disengagement and failure to comply with essential treatment etc. at RED board meeting (for medium/high risk and/or for people on a CTO, or prescribed Clozapine or a depot medication) or team meetings when a positive action will be agreed and recorded on RiO.
- Where a home visit fails because the individual is not at home or there is no answer then a record of attempts to contact should be made. A plan of action to be recorded and concerns escalated appropriately.
- Staff must follow locally agreed protocols for pursuing welfare checks

Staff are expected to have read, understand and use the policy and procedure for managing patients who Do Not Attend and/or are unable to be contacted for full detail

Important note:

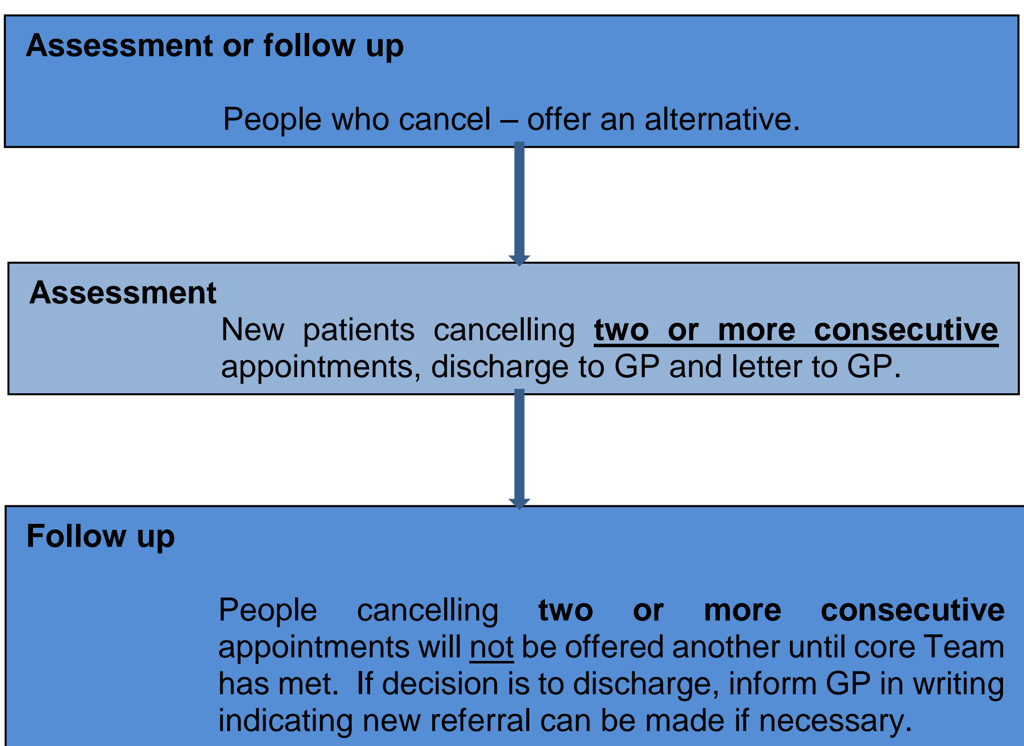
Out of hours the CRHTT will accept referrals from CMHT where CMHT have been unable to make contact to assess and review the mental state of the person but significant risk factors are evident and meet the threshold for CRHTT involvement.

Low Risk

Medium/High Risk

Cancellation

Cancel appointment by patient



13 SICKNESS PROTOCOL

STAFF SICKNESS – PROTOCOL & COVER ARRANGEMENTS
From the Frist Day – Two Weeks (Short Term Sickness)
➢ Staff will report sickness at the beginning of the working day by 9:30 am at the latest. ➢ Staff will report sickness by way of a telephone call, and **speak** to the Team Manager. ➢ The Team Manager will advise Admin of sickness absence. ➢ Admin will update reception & duty staff, the whiteboard and electronic records. ➢ Staff **must not** report sickness by text, email or telephone message. ➢ Details of RIO diary commitments to be obtained and actions agreed. ➢ Staff will flag up any immediate concerns re: specific clients so a plan is agreed. ➢ The absent staff member will maintain contact with a Team Manager to ensure ongoing cover for diary commitments. ➢ If there is no appointment/no concern re: a client during this period, no contact will be made. If a client contacts the Service to speak to their care co-ordinator, s/he will be informed by Admin that the care co-ordinator is absent, and a message will be left for the care co-ordinator, or the client transferred to duty worker, for clinical contact.
From Two Weeks
➢ Letter sent to all clients, copied to GP, advising that the care co-ordinator is absent, with advice to contact duty if needed. ➢ Team Manager to ensure message slot is removed. ➢ Team Manager to ensure Admin staff contact IT helpdesk to arrange 'out of office' message on staff members email. ➢ **Admin** staff to review RIO diary of all clients on caseload, to identify any booked **CPA reviews/professional meetings** etc. List of appointments to be provided to locality senior/locality allocation meeting to identify cover as needed.
Two – Four Weeks
➢ Team Manager/Supervisor and Consultant Psychiatrist will review the care co-ordinator's caseload and RAG rate accordingly. ➢ Caseload distributed between staff, and allocated as additional worker/HCP in order to provide a named point of contact, and monitor needs and risk.
Two months+
➢ Team Manager/Supervisor and Consultant Psychiatrist to review caseload. ➢ All cases to be re-allocated.

14 PLANNED LEAVE PROCESS

Case Handover/ Case Update

Form to be completed by the care coordinator / Lead HCP prior to planned leave / absence, or when leaving the team permanently.

Step One: two months in advance of planned leave, care coordinator / Lead HCP complete the documentation below providing the required details for the whole caseload and share this with the Locality Manager and Team Managers

Step Two: Locality Manager and Team Managers work with the team to agree covering personnel per patient and document this on the documentation below

Step Three: Locality Manager or Team Manager to provide the updated documentation to the care coordinator / Lead HCP

Step Four: Care coordinator / Lead HCP to arrange handover meeting(s) with their covering colleagues in order to give a verbal handover of key information (this may repeat or supplement the information provided in the documentation below)

Step Five: Care coordinator to arrange a return handover meeting with their covering colleagues in advance of going on leave. This meeting will aim to take place within 14 days of their return (if not leaving the team permanently)

Step Six: Care coordinator writes to all patients providing them with the name and contact details of the covering member of staff

Form to be distributed to Locality Manager, Team Manager and duty.

Name of professional:

Date:

Dear Colleagues,

I will be away on annual leave from ……… and will return to work on (complete if not leaving the team permanently)………

Please see below for my caseload updates

	Name of Service User and RiO Number	Case update of core issues including any risk / safeguarding issues, homelessness, interventions e.g. groups, psychology, STR, crisis team	Any upcoming appointments e.g. depot or CPAs / anything that needs to be done in my absence	Name of person covering	Send letter informing of absence (Y/N)
1.					
2.					
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15 DEPOT CLINIC

The '*Safe Administration and Monitoring of Intra Muscular Injection Medication*' policy must be read and understood by all staff working in or supporting depot clinics. To complement this policy, the '*Safe Administration and Monitoring of Intra Muscular Injection Medication within Community Settings Standard Operating Procedure*' must also be utilised by the same staff groups on a day to day basis to support the practical application of safe and consistent depot clinics.

IMI Administration Policy.pdf

IMI Administration SOP.pdf

APPENDIX A TERMS OF REFERENCE

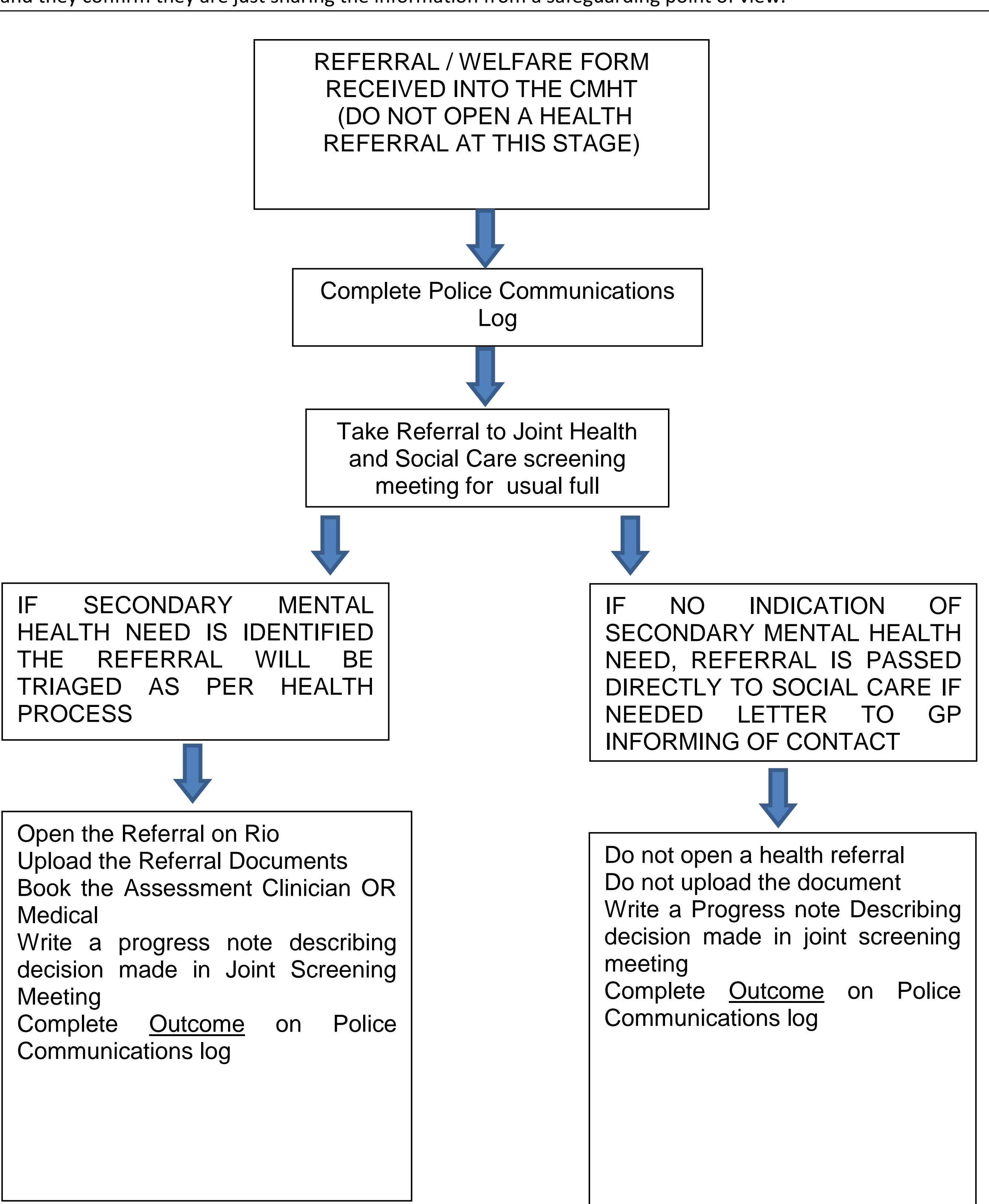
A	REDProcessGuidelinesKMPT.docx
B	Business Meeting Quality V2.docx Business Meeting Performance V2.doc Business Meeting Serious Incident V2. Business Meeting Patient Safety V2.do Business Meeting Anything Goes V1.d
C	Risk Forum

APPENDIX B STANDARDISED LETTERS

- All standardised letters are to be found on RiO
- These are accessed via clicking on the 'Clinical Documentation' tab and selecting the 'Editable Letters' link
- On every occasion that a letter needs to be written, the letter template will be pulled directly from RiO at that point in time. In no circumstances should the RiO template be saved to a local or shared drive and used from that source
- All letters will be written to the patient and copied to the GP (unless there are extenuating circumstances)
- Once a letter has been written it must be sent to the patient without delay. Letters should not be checked as routine by a Team Manager or equivalent

APPENDIX C HOW TO DEAL WITH COMMUNICATIONS RECEIVED FROM THE POLICE

When officers attend a call and there is a concern for someone who may be displaying Mental Health problems, they may complete a referral which they send to Social Services / Mental Health. This is for information and for Social Services/Mental Health to take necessary action, there is no expectation from the police of how services will respond and they confirm they are just sharing the information from a safeguarding point of view.



APPENDIX D POLICE COMMUNICATION LOG

Police Communications Log

Copy of Police
Communications Log -

APPENDIX E PERSONAL SUPPORT PLAN BRIEF GUIDE

APPENDIX III: AUTISTIC SPECTRUM CONDITIONS (ASC) AND ADHD REFERRAL PATHWAY STANDARD OPERATING PROCEDURE

APPENDIX IV: RIO REQUIREMENTS

RiO Requirements (Clinician/Admin)	
DUTY	Staff member to complete presenting problem for referral in Core, and Risk, diary appointment should be recorded and outcome, and a progress note entered to reference assessment and plan. Open a cluster if coming in to service. If known to service, update anything which has changed in Core. Admin to complete assessment outcome letter see CRCG template in editable letters. Duty Team also carry out the 72 follow ups and follow the above process, including letter to the client with the outcome of the assessment.
REFERRALS RECEIVED	Urgent referrals which have previously been screened by SPoA will go direct to an assessment appointment, SPoA DNA's will go to the screening meeting, after being opened by admin.

	Admin will open all other referrals received to the team . They may come in via email or letter from GP or KCC. These will sit on the Team caseload awaiting screening. Any documents to be uploaded to the documents section in RiO by admin. Police referrals are discussed in the screening meeting, but are not opened or uploaded until a decision is made that the client will be taken on.
SCREENING	At the screening meeting the Screening page to be completed on RiO by clinician. Brief progress note to be entered referring to screening tool and with outcome. If a client is not taken in to Service the referral should be closed. Referral reason to be entered if this has not already been done. CRCG Signposting letter to be sent out by admin. If client is going to be offered an assessment the client is moved from Team Caseload to the caseload of the Performance Team Manager. Client is telephoned to arrange appointment, entered on Rio and letter sent out.
ASSESSMENT	Following assessment Core and Risk should be completed. Cluster should be completed following MDT meeting. Letter created from the Core and sent out by admin. Progress note is also completed by clinician which references the Core, and the appointment outcomed. If client is taken on under non-cpa pathway a pathway should be opened and client allocated to ART with an intervention tab opened, showing what they are waiting for. For example, Initial Interventions, Psychiatric Review, STEPPS or Psychology. A letter should be sent out to client with the Keep Safe Plan. Client should be moved from the Performance Team Manager to the ART Lead. Support calls should be made to clients on ART every 4 weeks. PCSP should be completed and sent to client after every contact. If client is going to be on CPA then they should be allocated a Care Coordinator and pathway opened. Care Plan should be completed and distributed. Every 6 months complete Risk Assessment and Care Plan and have a CPA review, or earlier if there is a change to their care need or risk.

HONOS & CLUSTERING	

HoNOS & Clustering

HoNOS should be completed following assessment, as well as when there is a significant clinical change and on discharge. This is for all patients.

Cluster	Classification	Minimal Review interval
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	4 weeks
6	Non-psychotic disorders of overvalued Ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual
9		
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness	6 months
17	Psychosis and affective disorder difficult to engage	6 months
18	Cognitive impairment (low need)	6 months

CONSENT

Clinician to record on RiO if consent is given by the patient to share information with specified people

Clinician or admin to record on RiO when consent is given by the patient to have a appointment via video (Lifesize or Attend Anywhere)

NOTICES	Complete and remember to remove where necessary
SAFEGUARDING	Complete safeguarding form on RiO, if a safeguarding alert has been raised, add to care plan and risk assessment as per Safeguarding policy.
EDITABLE LETTERS	**Editable Letters** – Staff should only use the CRCG templates on RiO. Letters to the GP should be sent via E-Correspondence. These Care Group Letters are : **CRCG Assessment Outcome Letter** – this is the letter following assessment, information captured from Core. **CRCG Cancellation letter** – Letter to be used if client or Trust cancels appointment, giving an alternative date. **CRCG Change of Care Coordinator** **CRCG CPA Invite** - appointment letter specifically for CPA's **CRCG DNA Letter** – transferring back to GP **CRCG Depo DNA Letter** – **CRCG First Assessment Letter** – Appointment letter for first appointment – following telephone contact arranging appointment **CRCG Signposting Letter** – Letter following screening where client is not taken on to Service **CRCG Transfer to GP** – Discharger letter for non CPA clients **CRCG II First Appointment letter** – **CRCG II First DNA letter** – offering another appointment **CRCG II Invite letter** – Introducing II to client enclosing preparation pack **CRCG II Second DNA Letter**- Option to discharge from CMHT or discharge from II **CRCG II Summary Letter**- End of all 4 sessions including forward plan **GP Letter** – to be used for doctor's clinic letters

Medication changes by doctors and NMP's	These should be clearly documented on RiO under progress notes and a letter sent to client copying in GP. These should always be signed by the prescriber or cross checked and counter signed by another clinician.
SCANNING & UPLOADING	All patient related documents to be scanned and uploaded using the naming convention – do not upload complaints.
PROGRESS NOTES	**Progress notes should include the following:** Setting and purpose of visit Who was present Mental health presentation Medication Care Planning Social and environmental issues Actions taken during visit Identified risks and needs Plan **Progress note for Depo clinics should include:** Mood & Mental Health Physical Health: Care Planning: Physical Observations: Risks and needs: Social Circumstances: GASS: Administered by: Chaperone: Consent: Drug:

Dosage:

Frequency

Route/Site:

Batch No:

Expiry Date:

Any additional actions:

Plan/Next Depot Due:

Progress note for Clozapine clients should include :

CPMS Number:

Chaperone:

Consent:

Comments:

Mental Health:

Physical Health:

Bloods taken today from: R/L arm:

Blood pressure**:** (weekly for 18 weeks, fortnightly for up to one year, then 4 weekly)

Pulse**:** (weekly for 18 weeks, fortnightly for up to one year, then 4 weekly)

Weight (including waist measurement and BMI): (baseline, weekly for 6 weeks, 3 monthly for 1 year, then annually).

Current dose of Clozapine daily:

Next appointment:

PATIENT RELATED OUTCOME MEASURES

Each intervention delivered has patient related outcome measures that need to be completed at the beginning and end of the intervention. These can be found under 'Outcome Measures' on RiO. The table below indicates which measure is required for each intervention and when. Please ensure that the ReQol-10 is always linked to the CMHT referral.

Intervention	Outcome Measure on RiO	Beginning of Intervention	Middle of Intervention	End of Intervention

Entry/Exit into service	HoNos & Clustering	X	Update when clinical change has occurred	X
	ReQol-10	X	6 monthly time points by lead hcp	X
Initial Interventions (ii)	GAD7	X		X
	PHQ9	X		X
	WAS	X		X
	ReQol-10			X (If discharging from service)
Recovering Occupations Group	Group Outcome Measure	X		X
	MOHOST	X		X
Individual OT	MOHOST	X		X
	ReQol-10			X (If discharging from service)
CED Change	BEST	X		X
	ReQol-10			X (If discharging from service)
STEPPS	CORE-34	X		X
	BEST	X		X
	WAS	X		X
	Zannarini-BPD	X		X
	ReQol-10			X (If discharging from service)
CBT for Psychosis Group (CBTp)	CORE-34	X		X
	WAS	X		X
	CHOICE Short Form	X		X
	Self-esteem rating scale	X		X
	ReQol-10			X (If discharging from service)
Individual Psychological Therapy	CORE-34	X		X
	ReQol-10			X (If discharging from service)
Mentalisation Based Therapy (MBT Group)	CORE-34	X	X	X
	Zannarini-BPD	X	X	X
	SIPP-SV	X	X	X
	WAS	X	X	X
	ReQol-10			X (If discharging from service)

Referral to Psychology:

PSYCHOLOGY	Psychology referral is opened by admin on RiO. If accepted by psychology, patient will be offered a screening appointment. If not accepted by psychology, admin will close the referral. **Screening by Psychology** Booked as 'First appointment' in RiO diary. Patient will receive a 'Screening Outcome Letter'; cc to GP if patient has consented. If not accepted for treatment, admin will close the referral. **Psychological Treatment** Booked as 'Treatment' in RiO diary. Complete CORE-34 questionnaire in first treatment session. Patient receives a 'Psychological Treatment Plan' cc to GP if patient has consented. Clinician will open the intervention tab Input the CORE-34 as 'First Therapy Session', Transfer patient to clinician's caseload. HoNOS, clustering, care plans and risk assessment will be updated when required or when a change in the client's presentation determines so. **End of Psychological treatment and remain in CMHT** Patient will complete a CORE-34 outcome measure in penultimate session; clinician inputs this onto RiO under 'Outcome Measures' as 'Last Therapy Session' Patient will receive a 'Discharge Summary' cc to GP if patient has consented. Clinician updates clustering & HoNOS. Clinician closes the Intervention tab, closes the referral and removes from caseload. **End of Psychological treatment and discharge from Service** Patient will complete a CORE-34 outcome measure in penultimate session; clinician inputs this onto RiO under 'Outcome Measures' as 'Last Therapy Session' Patient will receive a 'Discharge Summary' cc to GP if patient has consented. Clinician updates clustering & HoNOS, then closes the cluster. Closes Intervention tabs. Closes the referral, removes from caseload and closes care spell. Requests admin close the CMHT referral.
DISCHARGES	Close referral, end care spell, close intervention tab & send letter to client cc GP