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<tr>
<th><strong>Title:</strong></th>
<th>Community Mental Health Team Operational Policy</th>
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<tr>
<td><strong>Purpose:</strong></td>
<td>To provide a robust policy to the management of service user care within the Community Mental Health Teams</td>
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<td><strong>Applicable to:</strong></td>
<td>All Trust staff working within CMHT’s</td>
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<td><strong>Document Author:</strong></td>
<td>Colin Quick (updated from Julie Dawson and Mike Marshall)</td>
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**Related legislation and national guidance:**
- NICE Guidance on Community Mental Health Teams
- PbR Guidance

**Associated Trust Policies and Documents:**
- Community Mental Health Team (CMHT) Operation Policy
- CPA and Care Process Policy
- Single Point of Access Operational Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy and Guidance
- Multi Agency Safeguarding Adults Policy
- Discharge Policy
- Security Management – Lone Working Policy
- People and Development Strategy
- Data protection policy
- Access to Health Records Policy and Procedure
- Complaints Policy including Easy to Read Policy

**Equality Impact Assessment:**
The Equality Impact Assessment Form was completed on 19 Sept 2013

**Training Requirements:**
None

*The organisation trains staff in line with the requirements set out in its training needs analysis and published in its Corporate Curriculum. Training which is categorised as statutory or essential must be completed in line with the training needs analysis and Corporate Curriculum.*
Compliance with statutory and essential training is monitored through the Learning and Development team with monthly manager’s reports and staff individual training records twice yearly. Training reports are also submitted quarterly through the Trust Quality and Governance Committee Meeting. Staff failing to complete this training will be accountable and could be subject to disciplinary action.

**Monitoring Arrangements:**
The policy will be reviewed on an annual basis via the Functional Community Services Policies and Procedures Group, which reports to the service lines Clinical Cabinet.

**Implementation:**
The policy will be disseminated to all teams, managers will ensure it is made available to all team members and will record receipt of the same.

New staff will be provided with a copy

Electronic version to be available of the Trust intranet

| Version Control |
|-----------------|-----------------|-----------------|-----------------|
| **Version**     | **Date Reviewed** | **Changes**     | **By Whom**     |
| January 2017    | Extended 6 months |                 |                 |
| July 2017       | Extended 6 months |                 |                 |

**This document Replaces:**
MH/005/09 – Community Mental Health Team Policy

This document can / cannot be released under the Freedom of Information Act.

This document can be accessed and printed via the Intranet Document Library and the Trust Website.
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1. Introduction

This procedure aims to outline the Adult Community Mental Health Teams of Cornwall and the Isles of Scilly within Cornwall Partnership NHS Foundation Trust, and define the services, operational procedures and pathways through the service. Community Mental Health Teams have an important and integral role to play in supporting service users and families in community settings and they provide the core function in support of all clinical pathways.

2. Service User Group

Most Mental Health problems are met within primary care (Goldberg and Huxley 1992). Less than a fifth are identified as having a severe and enduring mental illness and are referred on to secondary services for assessment and treatment.

In Cornwall, mild to moderate mental health problems are met within the primary care Framework, following initial assessment by the GP and referral to an appropriate IAPT provider.

The Community Mental Health Teams provide multi-disciplinary assessment, treatment and care of all adults with severe and enduring mental health problems. This will usually but not invariably follow initial assessment by GP’s, although GP’s will always be advised of CMHT involvement with their clients if the referral comes from another source. The definition of severe mental illness is taken from “Mental Health Policy Implementation Guide: Community Mental Health Teams.” DOH: 2002 and is outlined below:

Individuals who present with:

- Severe and persistent mental disorders associated with significant disability, predominately psychosis such as schizophrenia and bipolar disorder.
- Longer-term disorders of lesser severity but which are characterized by poor treatment adherence requiring proactive follow up.
- Any disorder where there is significant risk of self-harm or harm to others (e.g. acute depression) or where the level of support required exceeds that which a primary care team could offer.
- Disorders requiring skilled or intensive treatments (e.g. vocational rehabilitation, medication maintenance requiring blood tests) not available in primary care.
- Complex problems of management and engagement such as presented by patients requiring interventions under the MHA (1983).
- Severe disorders of personality where these can be shown to benefit by continued contact and support.

The CMHT’s prioritise those falling into this definition for care through the Care Programme Approach and is detailed in the CMHT eligibility criteria. It is however recognised that assessments cannot be limited to those already so defined and specialist assessment and advice, especially where severe mental illness is suspected, is a key role for CMHT’s.

In line with current Department of Health Guidance on “Fair Access to Care Services” the joint service eligibility criteria (Appendix 1) indicates whom CMHT’s will prioritise for eligibility to receive appropriate social care services and, if appropriate, other CMHT services. Following assessment it will be determined the level of need, those eligible to receive services will fall within the substantial and critical bands. It is possible that people will receive their social care input from Cornwall Partnership NHS Foundation Trust and their psychological therapy from IAPT this will be determined at the assessment stage.
The role of the CMHT concerning risk management is when the risk is caused by a severe and enduring mental illness; it is the responsibility of the mental health services to manage risk by managing the illness. Risk is not related to mental illness then it is not the responsibility of mental health services.

Those people with a dual diagnosis (drug and or alcohol misuse combined with a severe/enduring mental health problem) will, in most cases, receive their specialist mental health input from a CMHT and help with their substance misuse use from a specialist provider in this field.

The Valuing People and Green light proposals emphasise that people with a learning disability should use the same services, resources and facilities as the rest of the population and this includes mental health services. As with their other health needs people with a learning disability should be enabled to access general psychiatric services whenever possible. For specialist mental health services this access will primarily be through a CMHT. This will promote good team working across services and across both secondary and primary care.

3. Aims of the Service

Cornwall Partnership NHS Foundation Trust’s aim is to provide a service that respects the privacy, dignity, choices and confidentiality of each individual service user, acknowledging their culture, ethnicity, physical ability, gender, sexual orientation, and religious beliefs.

The overall aim is to provide a service of the highest quality that provides a comprehensive recovery focussed specialist mental health service to Cornwall residents within the framework of the Care Programme Approach.

This will be achieved by:

- Close and productive working relationships with all relevant statutory and voluntary services to deliver a seamless and community focused service, as per the CPA Handbook.
- A timely and flexible response to referrals in line with local and national standards.
- The provision of a comprehensive assessment of health and social care needs and the delivery of a range of bio psychosocial interventions based on need, and offered in a manner that promotes engagement, maximises independence and integration into local communities and promotes choice.
- Ensuring that by partnership working and signposting that service users have access to appropriate daytime activities, employment, vocational activities and advice regarding finance and housing support.
- An effective and supported staff team with access to quality supervision, annual appraisal and meaningful development opportunities. A caseload tool will be used for staff management with a maximum score of 225 for a full time worker.
- The involvement of service users, carers and referring agencies in the development and monitoring of quality standards, outcome measures and service delivery.

4. Involvement of Service Users and Carers

Services users and carers are integral in the delivery of the CPA process and the agreed packages of care. At all times service users must be involved in the care planning process and where appropriate and with the agreement of the service user, their identified carer. All carers are entitled to and will be offered a carers assessment.
Service users are required to receive a copy of their care plan; however it is acknowledged that the service user may refuse this. All service users will be offered the choice of receiving a copy of any correspondence relating to them.

5. **Effective Care Coordination (CPA)**

The Care Programme Approach was introduced in 1991 to provide a framework for effective mental health care. Its four main elements are:

- 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 coordinator to keep in close touch with the service user and to monitor and coordinate care
- Regular review and, where necessary, agree changes to the care plan

From the 1st October 2008, the term CPA was no longer used to describe the usual system of provision of mental health services to those with more straightforward needs in specialist mental health services (formally standard). Where a service user has straightforward needs and has contact with only one agency then an appropriate professional in that agency will be the person responsible for facilitating their care. Formal designated paperwork for care planning and the review process for these service users is not required. However a statement of care agreed with the service user should be recorded. This could be done in any clinical or practice notes, or in a letter, and this documentation will constitute the care plan. It is not necessary to engage in further bureaucracy for these individuals.

The term Care Programme Approach from October 2008 describes the approach used in specialist mental health care to assess, plan, review and coordinate the range of treatment, care and support needs for people in contact with specialist mental health services who have complex characteristics. It is called an “approach”, rather than just a system, because the way that these elements are carried out is as important as the actual tasks themselves.

The current characteristics of those needing CPA are described as individuals who need: multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who are at higher risk.

CPA is a process for managing complex and serious cases – it should not be use as a “gateway” to social services or as a “badge” of entitlement to receive any other services or benefits. Eligibility for services continues to be in accordance with statutory definitions and based upon assessment of individual need. Local mental health services will want to continue to work in an integrated and flexible way to make sure that those needs are met as effectively as possible. (Refocusing the Care Programme Approach, DOH: March 2008)

The minimum standard for CPA would be an allocated Care Coordinator, reviews at least every six months and regular input from a secondary care worker.

5.1 **Referral Procedure: Single Point of Access**

A single point of referral into specialist mental health services is essential in the effective implementation of the CPA.
This will ensure that all referrers and referrals receive a consistent approach.

The service will encourage all referrals to be made by telephone, however email and letter referrals will also be accepted and processed.

All referrals will be acknowledged within an agreed timescale, which will be no longer than 5 working days.

In the event of non-telephone referrals the SPoA Service will contact the referring person/agency for additional information if required. This will allow the service to correctly allocate the request for an assessment.

Referrals will be assigned to the appropriate assessment pathway based on the evidence provided by the referrer and in accordance to need and commissioning guidance

Self-referrals will be received, although contact will be made to the individuals GP to gain further information.

The service will work on the principle of offering an assessment to every person who is referred, unless there is agreement with the referrer on signposting to a more appropriate service.

It may be possible to determine at the point of referral whether the individual is eligible for secondary mental health services, this should be checked against the eligibility criteria. In most cases an assessment will be necessary to determine the appropriateness for secondary mental health services. Each referral will be triaged and the appropriate response will be coordinated. This will be conveyed to both the referrer and the person referred. If the individual is not suitable for secondary services then advice, guidance and signposting will be offered to the individual and the referrer.

The Service will take calls between 08:30 to 18:30, Monday to Friday The service will also be open on Bank Holidays (apart from Christmas Day and New Year’s Day) and will operate between the hours of 9 am to 5 pm.

**Out of Hours**

Outside of these hours the Single Point of Access will be continued by the Home Treatment Team for urgent ‘access to mental health services’. The two Services will work closely to ensure that systems and information work together.

**Same Day Response**

If the referral requires a same day due to immediate risk concerns the Duty Desk Worker will assess or if appropriate a referral will be passed to the Home Treatment Team for emergency assessment.

If the referrer requests an urgent Mental Health Act Assessment, this process will be facilitated by the CMHT Manager.

The CMHT Manager or Duty Desk Worker will determine the level of response required and will prioritise accordingly.
Urgent Response

If the referral is not an emergency but requires a quicker response than a routine assessment, then an appointment will be offered within seven days. The Duty Worker will arrange an assessment slot within the next available assessment clinic or via a home visit. During this appointment the initial assessment and cluster will be completed.

Routine Response

If the referral requires a routine response (within 20 working days) the referral will be allocated for assessment either within an assessment clinic or via a home visit, again during this appointment the initial assessment and cluster will be completed.

Transition from Child and Adolescent Mental Health Services (CAMHS) to Adult CMHT

Referrals received from CAMHS will follow the transitional protocol, which will commence unless the young person turns 17.

Transition from CMHT to Complex Care and Dementia Team

There is an agreement for the criteria for CCD which will be followed. Patients with severe mental illness and severe medical illness, and patients with a dementia, will be referred to the CCD team.

Transfer of service users between CMHT’s

Referrals received from one CMHT to another will be dealt with in line with the principles of good practice in the transfer of service user care subject to the Care Programme Approach.

Good practice equates to the service user being fully informed of any transfer, being introduced to the ‘taking’ CMHT at the earliest opportunity. Depending upon the service user’s needs, the referring CMHT should stay involved with the service user for a maximum of three months (only if practical) from the point of referral to the ‘taking’ CMHT. However this can be negotiated at a local level to reflect service user need.

There will be a CPA Review between care teams involving the service user to ensure effective transition.

Joint Working with the Learning Disability Service

As in accordance with Valuing People (2001) it is essential that both specialist services are committed to working collaboratively to meet individual service user needs, utilising their respective specialist knowledge and skills to support each other in the delivery of care where necessary. Good communication between the respective services is essential.

Service users with a learning disability and severe mental health problems are also supported by a Care Programme Approach which should include:-

- Individualised assessment and care packages
- Risk assessment
- Level of learning disability
- Severity of mental illness
- Physical and social care needs
• Communication needs
• Vulnerability
• Capacity to consent
• Direct actions in an emergency situation if required
• Active involvement and consent to the care plan wherever possible taking into account carer’s views and needs (unless this is not consented to by the service user).

5.2 Assessment

Assessment of need is an essential element of the CPA and is pivotal to the whole care planning process. Its importance has been reiterated in the ‘Fair Access to Services’ as well as ‘Effective Care Coordination in Mental Health Services’ documents.

At the first point of formal contact with Community Mental Health Teams the allocated worker will be responsible for the completion of an initial screening assessment. It is recognised however that the initial allocation of Care Coordination responsibilities is provisional and will be reviewed when the assessment is completed in line with identified needs.

The service user will be contacted via telephone and/or letter dependent on the response indicated and will be provided with a CMHT leaflet explaining the service and a date, time and venue for when the assessment will take place. The venue of the assessment must take into account service users choice balanced against any known risk.

The assessment process will consist of a comprehensive assessment and the completion of the following only where appropriate:

• Core Assessment Form
• Risk Assessment Tool
• Cluster assessment
• Care Plan
• Risk Plan
• Crisis and Contingency Plan
• Specialised Assessments for complex presentations
• Capacity Act Assessments
• FACS
• Carers Assessments

The core assessment, risk assessment and cluster will be completed for all service users assessed by the teams. The remainder will be completed if the person is taken on to receive ongoing treatment.

It is acknowledged that the completion of the above may be over one or more sessions/appointments and may involve the coordinated input of a variety of professionals.

Following Assessment one of the following will be offered:

• Advice and information, including recommendations for future management, or signposted to other services
• Input from the Community Mental Health Team as part of CPA (although not all patients taken on will be on CPA) and final allocation of CPA Care Coordinator taking
into account the Service User’s needs and wishes (The decision for involvement may require discussion at the MDT)
- Input from the Home Treatment Team.
- Input from the Early Intervention Service or other specialist services within the Secondary Mental Health Services.

Correspondence will be sent to the referrer and GP detailing the assessment and the care plan/recommendations. This should detail who completed the assessment and their professional occupation.

**Safeguarding Children**

Mental illness in a parent/carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family. It is required, at the point of assessment, to ascertain family living arrangements that include childcare. If there is a child care issue of concern, both Health and Children and Young People’s service should ensure that lines of communication are opened and remain open during the process of referral, assessment, care planning and reviews.

If it is identified that where there are children living within the home environment, this should be recorded and contact must be made with the designated Health Visitor, Social Services, school nursing service or other involved professionals to identify any areas of concern and to ascertain if there are any childcare concerns.

Any contact regarding child care issues must be documented on the Core Assessment Form and in the Risk Assessment.

**Safeguarding Adults**

Please refer to the Multi-agency protocol.

**5.3 Role of the Care Coordinator**

The person who is best placed to oversee care planning and resource allocation should usually take on the role of care coordinator. It is not expected that Consultant Psychiatrists or other medical staff act as CPA care coordinator for Service Users.

The care coordinator is responsible for the following:

- Delivering evidence based interventions
- Keeping appropriate level of contact with the service user and primary care as required
- Advising the other members of the care team of changes in the circumstances of the service user, which might require review or modification of the care plan
- Keep the care plan and contingency plan up to date together with other involved clinicians
- Reviewing carers needs
Caseload Management

Each Care Coordinator receives caseload management on a six weekly basis following a Caseload Review System. Maximum caseload weighting for each clinician should be 225.

5.4 Care Planning

All individuals under CPA will have a detailed care plan, based on a thorough assessment of their health and social care needs. This assessment will involve the user, their carer where appropriate and their general practitioner as central participants in the process. The service users must be given full information about the CPA process and a copy of the agreed care plan, which must:

- Identify the intervention and anticipated outcomes
- Record all the actions necessary to achieve the agreed goals
- In the event of disagreement, include reasons
- Give an estimated timescale by which the outcomes or goals will be achieved or reviewed
- Detail the contribution of all agencies involved
- Include appropriate crisis and contingency plans

The care plan must focus on the service user’s strengths; reflect diverse needs, cultural and ethnic background with the emphasis on recovery, social inclusion and citizenship. Each service user should be offered a copy of their care plan that they can agree and sign.

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 and reviewed every six months or updated as appropriate.

It may be appropriate to liaise with the forensics team when risks have 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, crisis and contingency plans. These plans form a key element of the care plan and must be based on the individual circumstances of the services user. Service users may choose to include Wellness Recovery Action Plans (WRAP) and/or Advanced Directives as part of the contingency planning process.

Review of Care Plans

Review and evaluation of the service user’s care plan should be on-going. At each review meeting the date of the next review must be set and recorded. Any member of the care team or the service user or their nominated carer are also able to ask for a review at any time. Service users should receive a review every six months; this is a minimum standard. A FACS review should be completed at each CPA review.
Support for Carers and Families

The needs of service users often relate not just to their own lives but also to the lives of the wider family. The Mental Health National Service Framework requires that all individuals who provide care for a person on CPA should:

- Have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis
- Have their own written care plan which is given to them and implemented in discussion with them

It is the responsibility of the care coordinator to approach the carer and provide relevant information and offer an assessment of their needs or refer to another appropriate service. It is however acknowledged that due to individual circumstances and need it may not be appropriate for the carer’s assessment to be carried out by the care coordinator and therefore another worker will be identified.

The Carers Support Services provides a service for carers and therefore all carers should be given the opportunity to receive support via this service.

5.5 Admission to Inpatient Unit

When a service user is admitted to the inpatient unit, the care coordinator should remain actively involved throughout the admission; participate when possible in the ward reviews and support when on leave with the Home Treatment Team or Section 17 leave in preparation for discharge from hospital.

5.6 Seven Day Follow-up/Discharge

All service users who have been admitted and who are discharged must be followed up, within seven days, by community services. This requires a face-to-face contact with the service user however in certain circumstances telephone contact maybe utilised, this should only be used if all attempts to secure a face-to-face contact have failed, and for example the individual has moved out of the county/local area.

Service users discharged on Sec 117 Aftercare should have their entitlement to Sec 117 acknowledged at a discharge-planning meeting. Their entitlement to continuation of Sec 117 should be reviewed every six months within a CPA review meeting with the Consultant, AMHP, service user and their care coordinator.

A ‘small number’ of vulnerable service users may be discharged on a supervised community treatment the order is to enable the service user to:

- Ensure they receive medical treatment for mental disorder
- Live in the community
- Improve engagement
- Allow for intervention upon clinical signs of relapse at an early stage

The CMHT allocated worker will ensure that appropriate treatment is available and that the service user does not need to be in hospital to receive it, but does need to be subject to compulsion to ensure that they comply.
5.7 Discharges from CMHT

An individual service user’s care plan is based on a thorough assessment of their health and social care needs and details interventions to meet the needs and anticipated outcomes for discharge. The outcomes for discharge will be regularly reviewed and will be discussed in formal review on discharge. In the event of disengagement from services attempts must be made to ascertain the individual’s mental state prior to discharge in their absence, this may require a multi-disciplinary discussion and if appropriate contact other services, carers and their GP.

Where a Service User is on CPA a discharge planning process will be instigated resulting in a CPA Review or 'Community Discharge Planning Meeting' to finalise discharge arrangements

Upon discharge the service user will be provided with a discharge care plan, which will detail the following:

- Services that they will continue to access and/or have been referred to
- The identification of informal support networks
- Medication regime including details of adverse effects
- Relapse signatures and action plan
- How to access services/contact numbers if deterioration in mental health occurs.
- If the service user is to receive a depot from the primary care team the date/time/place of appointment should be detailed.
- The GP and primary care team (where appropriate) will also be provided with the above care plan with details on how to refer back to the CMHT, if required.

If the service user is to receive a depot injection from the primary care team, the care coordinator will ascertain that the service user has attended their first appointment for their depot prior to being discharged. This will ensure that any further concern can be addressed and the service user does not ‘fall through the net’. Any primary care concerns regarding compliance should be fed back to the link worker.

6. Treatment and Clustering

The CMHT’s will work with service users within clusters 4 - 17. This covers all non-psychotic disorders that are severe in nature, as well as all psychotic disorders. The CMHT’s do not cover any organic conditions, nor where there are complex physical issues which require specialist intervention from the Complex Care and Dementia Service Line.

All service users who are assessed at cluster 3 and below (mild - moderate) will be referred to primary care services.

All treatment delivered will be in line with the Trust agreed care pathways, which ensure compliance against national standards. Care teams will plan and implement treatments based on these pathways providing service users with appropriate information on treatment options during the creation of any plan

7. The role of RiO in supporting the CPA Process

RiO is an integral element of the information infrastructure of Cornwall Partnership NHS Foundation Trust. RiO is an electronic case management system enabling all clinical information such as care plans and risk assessments to be held at a single accessible point and accessed by and contributed to by all people involved in the care of a service user.
Cornwall Partnership NHS Foundation Trust has adopted RiO as the primary means by which all clinical information will be recorded and through which the processes of CPA will be enacted.

RiO has as its key objectives:

- To support health and social care staff in the assessment, planning and delivery of care
- To improve the quality of person-based data and the efficient handling and processing of that data
- As an aid to caseload management
- To pick up referral trends within different teams in different areas of the county

As part of staff induction procedures and on-going Professional Development Plans all staff will receive training in the use of RiO and will be expected to use it as their primary case management and recording tool.

8. Interfaces with other Services:

Community Mental Health Teams interface with other CFT services and teams. Reference to the individual service operational procedures should be made when working alongside these services and/or referring service users for specific interventions.

9. Team Complement

Each of the CMHT’s is made-up of the following disciplines:

- Team Manager
- Consultant Psychiatrist
- Non-consultant psychiatrist medical staff
- Community Mental Health Nurses
- Social Workers (including Approved Mental Health Practitioners)
- Occupational Therapists
- Chartered Psychologists, Clinical and Counselling Psychologists
- In addition there may be Psychotherapists and psychological therapists (e.g. Cognitive Behaviour Therapists)
- Allied Health Professionals – e.g. Art Psychotherapists
- Mental Health Support Workers
- Administration

Clinical and managerial leadership

The relationship between the team manager and consultant psychiatrists for the team are crucial and provide the clinical and managerial leadership for the team. Whilst generally the consultants provide clinical leadership and team manager’s managerial leadership, both will be involved in clinical and managerial decisions and should work together closely.

Care Coordinators

Any professional qualified team member can take on the role of care coordinator. This will not usually be the Consultant Psychiatrist due to their potential role as Responsible Clinician. However, all other professional groups are able to take on this task.
The workers offer:

- Assessment
- Care Management as part of the CPA
- Effective partnerships with users and carers
- Psychological treatment
- Physical Health Care
- Medication management
- Basics of daily living
- Help in accessing local opportunities in work and education
- Support
- Family and carer support and help
- Relapse prevention
- A key role of the CMHT’s is to provide a Link Worker to all GP practices.

**Role of the Link Worker**

The basis for good practice in the link role is to develop and maintain effective communication strategies that enhance shared care working and provide support for primary care in supporting the well-being of mental health service users. A practice based case review meeting will be held at the GP surgery on monthly basis. The attendees of this meeting will be Practice GPs, Practice Manager, consultant Psychiatrist, CPN, Outlook SW representative and the person from the third sector.

- To improve the understanding of the role and function of the CMHT.
- Work in partnership with the Service User and those service providers supporting him/her.
- To ensure that primary care practitioners are aware of and have an understanding of the referral criteria for acceptance into specialist mental health services.
- To work with the practice to develop strategies that can improve the capacity of primary care to provide safe, evidenced-based care for people with common mental health problems who do not present with significant risk factors.
- To educate the primary care practitioners about the Specialist Mental Health Services assessment criteria and what constitutes an emergency referral.
- To work with the practice to increase awareness of current community provision which can offer service users alternative avenues for support and therapeutic help such as voluntary agencies.
- To discuss options and treatment plans with referrers when referrals are 'not appropriate for specialist care'.
- Attend joint training functions with primary care when appropriate to do so.
- The Link Worker may not necessarily be the person who carries out all of the assessments for those people referred from a given GP Practice.

**10. Operational Hours**

The Community Mental Health Teams operate between 08:45am – 5:15pm Monday to Friday, with flexible out of hours working for specific tasks, e.g. family work.
11. Lone working

Please refer to the Security Management – Lone Working Policy.

12. Training and Development

Please refer to CFT People and Development Strategy.

13. Service Evaluation

Service evaluation and audit will be carried out where possible jointly with service users and carers. There is access to external audit resources when necessary. Team managers will be responsible for the internal audits of teams and this will be reported to the Cornwall Partnership NHS Foundation Trust Clinical Effectiveness Group.

14. Confidentiality and Information Sharing

All information obtained will be treated with the strictest confidence, and in accordance with the requirements of the Data Protection Act 1998.

Personal information can normally only be disclosed with the explicit consent of the individual. In certain circumstances information can be disclosed without consent. Any disclosure is governed by explicit information sharing protocols.

All service user records are maintained in accordance with the Trust Policies and procedures that govern storage and dissemination of information.

In the event of receiving a request for information, staff should liaise with the Trust Records Management Department, in line with the Trust Access to Health Records Policy.

15. Access to Information

All service users have a right to access information held on them in accordance with the data protection legislation. Explicit arrangements exist within Cornwall Partnership NHS Foundation Trust on accessing personal information for both service users and staff. Under the Trust Access to Health Records Policy.

16. Contacting Us

We encourage comments; suggestions or concerns about the care and experience of care that service users receive. Comments or concerns should in the first instance be raised with the named practitioner and/or care coordinator. If the service user is not satisfied with the initial response the Team Manager can be contacted to address the concern informally. If the service users concerns are still not resolved these can be raised using the Complaints Policy including Easy to Read Policy for Cornwall Partnership NHS Foundation Trust. Details of this can be obtained from the Team Manager or by contacting the Patient Experience Team directly.

Service users can be directed to PALS (Patient Advice and Liaison Service) telephone (01208) 834620, or local Service User Forums.
Appendix 1 – Community Mental Health Team Eligibility Criteria

The following criteria give a guide for referrals to adult CMHTs in Cornwall

In general terms, the focus will be on those with more severe mental health problems, particularly if this causes substantial disability, causes recurring crises leading to frequent admissions or interventions or leads to significant risk to their own safety or that of others.

1) Individuals with severe and persistent mental health problems usually associated with substantial disability, most often psychosis or severe affective disorder.

2) Individuals with long-term mental health problems which, although less severe, are complicated by factors such as: poor engagement and cooperation, misuse of drugs or alcohol or significant social problems, which would necessitate a proactive approach to follow-up and support. Individuals in this category need some degree of motivation to engage with services. Not all referrals in this category will necessitate longer-term input.

3) Individuals with severe disorders of personality, often involving significant risk, when it can be established that there is benefit from continued mental health service contact and support.

4) Individuals with diagnoses (including depression, anxiety, obsessive-compulsive disorder, PTSD) which reach sufficient levels of severity or risk as defined by the stepped care criteria of NICE guidelines. Available at www.nice.org.uk

5) Individuals who have relapse prevention/Staywell plans arising from previous contact with the service, and who show signs or symptoms of a relapse.

6) In addition, requests for Mental Health Act Assessments, Appropriate Adult procedures and other social care interventions can be made.

7) Individuals presenting with a high risk of suicide will be assessed and treatment will be offered when it can be established that there is benefit.

It is good practice that there is a person to person discussion with the referrer and preferably that the referred individual is seen for a screening assessment by a member of the team, even if it appears from the written referral that these criteria are not met. Reasons for not proceeding to a more detailed assessment can then be given and signposting to other services as appropriate can be carried out. Where a General Practitioner requires clarification on the nature of an individual's mental health problems, but when these do not meet the criteria above, a one-off assessment with advice may be appropriate.
Equality Impact Assessment Proforma Initial Screening

<table>
<thead>
<tr>
<th>Section</th>
<th>A8 Operational Policies</th>
<th>Officer responsible for the assessment</th>
<th>Colin Quick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Procedural document to be assessed</td>
<td>CMHT Operational Policy</td>
<td>Date of Assessment</td>
<td>19 Sept 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is this a new or existing procedural document?</td>
<td>E</td>
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</tbody>
</table>

1. Briefly describe the aims, objectives and purpose of the procedural document.
   This document will provide a consistent approach to the daily operations of the Community Mental Health Teams.


3. Who is intended to benefit from this procedural document, and in what way?
   All CMHT’s and associated services will benefit from having a single operational process which will ensure consistency of approach and clinical management.

4. What outcomes are wanted from this procedural document?
   Consistent approach to caseload and team management.

5. What factors/forces could contribute/detract from the outcomes?
   Changes to service structure and commissioning arrangements.

6. Who are the main stakeholders in relation to the procedural document?
   CFT Functional Community Staff.

7. Who implements the procedural document, and who is responsible for the procedural document?
   Functional Community Management Team.

8. Are there concerns that the procedural document could have a differential impact on RACIAL groups?
   **Y**  **N**  **X**
   Please explain.

9. Are there concerns that the procedural document could have a differential impact due to GENDER?
   **Y**  **N**  **X**
<table>
<thead>
<tr>
<th>Question</th>
<th>Y</th>
<th>N</th>
<th>X</th>
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</thead>
<tbody>
<tr>
<td>10. Are there concerns that the policy <em>could</em> have a differential impact due to <strong>DISABILITY</strong>?</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11. Are there concerns that the policy <em>could</em> have a differential impact due to <strong>SEXUAL ORIENTATION</strong>?</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>12. Are there concerns that the procedural document <em>could</em> have a differential impact due to their <strong>AGE</strong>?</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>13. Are there concerns that the procedural document <em>could</em> have a differential impact due to their <strong>RELIGIOUS BELIEF</strong>?</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>14. Are there concerns that the procedural document <em>could</em> have a differential impact due to their <strong>MARRIAGE OR CIVIL PARTNERSHIP STATUS</strong>? (This MUST be considered for employment policies).</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>15. Are there concerns that the procedural document <em>could</em> have a differential impact due to <strong>GENDER REASSIGNMENT OR TRANSGENDER ISSUES</strong>?</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
What existing evidence (either presumed or otherwise) do you have for this?

16. Are there concerns that the procedural document could have a differential impact due to PREGNANCY OR MATERNITY?

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>X</th>
</tr>
</thead>
</table>

What existing evidence (either presumed or otherwise) do you have for this?

17. How have the Core Human Rights Values of:
   - Fairness;
   - Respect;
   - Equality;
   - Dignity;
   - Autonomy

   Been considered in the formulation of this procedural document/strategy

   If they haven’t please reconsider the document and amend to incorporate these values.
18. Which of the Human Rights Articles does this document impact?

<table>
<thead>
<tr>
<th>The right:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To life;</td>
<td></td>
<td></td>
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<tr>
<td>• Not to be tortured or treated in an inhuman or degrading way;</td>
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<td></td>
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<tr>
<td>• To be free from slavery or forced labour;</td>
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<td></td>
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<tr>
<td>• To liberty and security;</td>
<td></td>
<td></td>
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<tr>
<td>• To a fair trial;</td>
<td>X</td>
<td></td>
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<tr>
<td>• To no punishment without law;</td>
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<tr>
<td>• To respect for home and family life, home and correspondence;</td>
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<td></td>
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<td>• To freedom of thought, conscience and religion;</td>
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<td></td>
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<tr>
<td>• To freedom of expression;</td>
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<tr>
<td>• To freedom of assembly and association;</td>
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<td>• To marry and found a family;</td>
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<tr>
<td>• Not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention;</td>
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<tr>
<td>• To peaceful enjoyment of possessions and education;</td>
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<tr>
<td>• To free elections</td>
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</tbody>
</table>

What existing evidence (either presumed or otherwise) do you have for this?

How will you ensure that those responsible for implementing the Procedural document are aware of the Human Rights implications and equipped to deal with them?

19. Could the differential impact identified in 8 – 13 amounts to there being the potential for adverse impact in this procedural document?

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>X</th>
<th>Please explain</th>
</tr>
</thead>
</table>

20. Can this adverse impact be justified on the grounds of promoting equality of opportunity for one group? Or any other reason?

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Please explain for each equality heading (questions 8 –13) on a separate piece of paper.</th>
</tr>
</thead>
</table>

If Yes, describe why, and then proceed to a full EIA.

21. Should the procedural document proceed to a full equality impact assessment?

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>If No, are there any minor further amendments that should take place?</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>22. If a need for minor amendments is identified, what date were these completed and what actions were undertaken?</td>
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</tr>
</tbody>
</table>

Signed (completing officer)  
Colin Quick  
Signed (Service Lead)  
Date 19 September 2013  

Signed (Service Lead)  
Date  

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