Birmingham and Solihull Mental Health NHS Foundation Trust

Birmingham and Solihull Community Mental Health and Wellbeing Service

OPERATIONAL FRAMEWORK

Community Mental Health & Wellbeing Service

VERSION NO & DATE	2.1	September 2024
APPROVAL COMMITTEE	Community Clinical Governance Committee	
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EXECUTIVE DIRECTOR OF OPERATIONS	Vanessa Devlin	
POLICY LEAD	XXXX,XXXX and XXXX	
POLICY AUTHOR *(if different from above)*	XXXX,XXXX and XXXX	

***This document will be subject to periodic review as the delivery of the Community Mental Health Transformation Programme continues to progress.**

Caveat: This is an iterative document subject to periodic review. Given the inception of the NHS Long Term Plan (LTP), there will be ongoing changes to the structure and operational remit of secondary mental health services and CMHTs in particular, in the near future. Therefore, as it becomes clearer how the LTP will be operationalised, policy updates relating to implementing the relevant framework will be described. Ongoing dialogue with local commissioners and stakeholders will help determine some of the specific variation to current policy. Current work streams around the implementation of DIALOG+, acuity stratification and stepdown processes will be incorporated into policy, at the earliest opportunity.

Contents

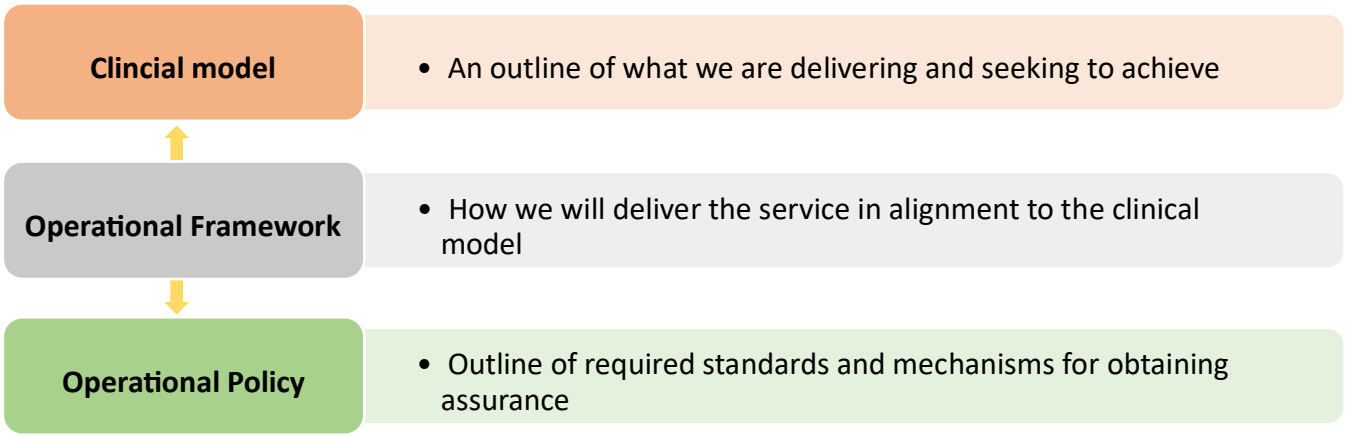
1 Scope

The purpose of this operational framework is to provide clear operational guidance for the Community Mental Health and Wellbeing Service (CMHWS).

The contents of this operational framework does not seek to define every eventuality or outline all elements of local decision making. It is expected that local teams within the CMHWS will work to define activities and good practice initiatives to enable timely and accessible support for individuals requiring assessment, support and interventions from the CMHWS.

The implementation and monitoring of this operational framework will be reviewed via the respective local clinical governance committees that are associated with the CMHWS.

The contents of this operational framework are informed by the three areas outlined below:



Caveat: Whilst this document currently describes the CMHWS team as comprising of two pathways, developments are underway to deliver this service as single integrated pathway in the long-term.

2 Executive Summary

The Community Mental Health and Wellbeing Service (CMHWS) will be delivered as a locality place-based provision across Birmingham and Solihull and will contribute to the development of a single integrated care pathway for those experiencing mental health and connected wellbeing difficulties.

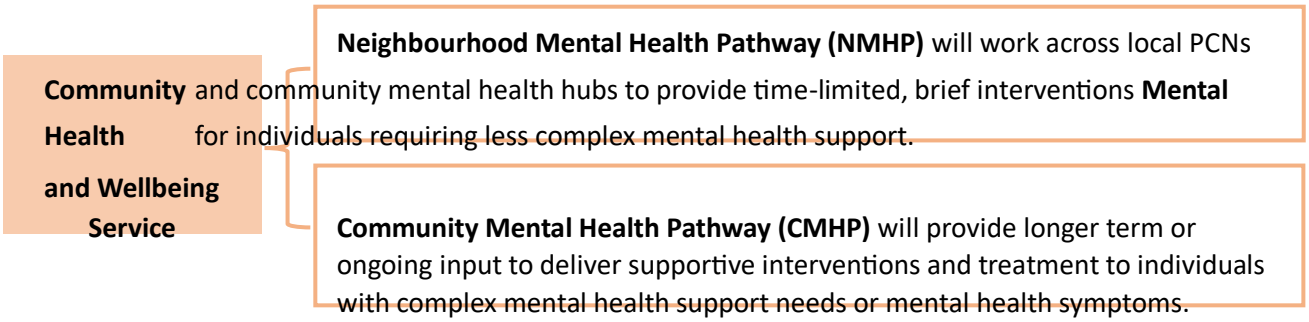
The primary aim of the CMHWS is to provide specialist, proportionate and needs led mental health interventions, within a timely manner, using a collaborative and multidisciplinary approach.

The single pathway will improve access by removing the need for multiple referral / transition points and allow for multiagency working across organisations. The service will be culturally sensitive and work in partnership with service users, carers, Primary Care colleagues, Voluntary, Community, Faith and Social Enterprise (VCFSE) partners and other related organisations.

Adhering to the core principles of the NHS long term plan and the delivery of an integrated placed-based community mental health provision seeks to reduce health inequalities and better meet local population need.

3 CMHWS Service Overview

The CMHWS provides support, care and treatment to individuals in the community to holistically meet the wider range of mental health and wellbeing needs. The CMHWS comprises of two core pathways: the Neighbourhood Mental Health Pathway and the Community Mental Health Pathway (CMHP):



The CMHWS service is commissioned to support individuals who are registered with a Birmingham or Solihull based GP, the age criteria for each locality is described below:

- Both the NMHP and CMHP for Solihull are accessible to individuals aged 18 onwards.
- Birmingham based NMHPs are accessible to individuals aged 18 onwards.
- Birmingham based CMHPs are accessible to individuals aged 25 onwards.

A multidisciplinary (MDT) and multi-agency team made up of a range of practitioners working across the CMHWS is essential to the delivery of an integrated service user pathway to effectively meet the biopsychosocial support needs of those experiencing mental health difficulties in the community.

The service will primarily operate between the hours of 09:00-17:00 Monday to Friday. However, MDT members may work flexibly between the hours of 8am - 8pm including weekends.

Locality based teams will work from the community hubs, local community satellite clinics, primary care premises and in the service user's home, where required, to deliver a place-based provision that better accommodates the needs of the local population.

The CMHWS is designed to:

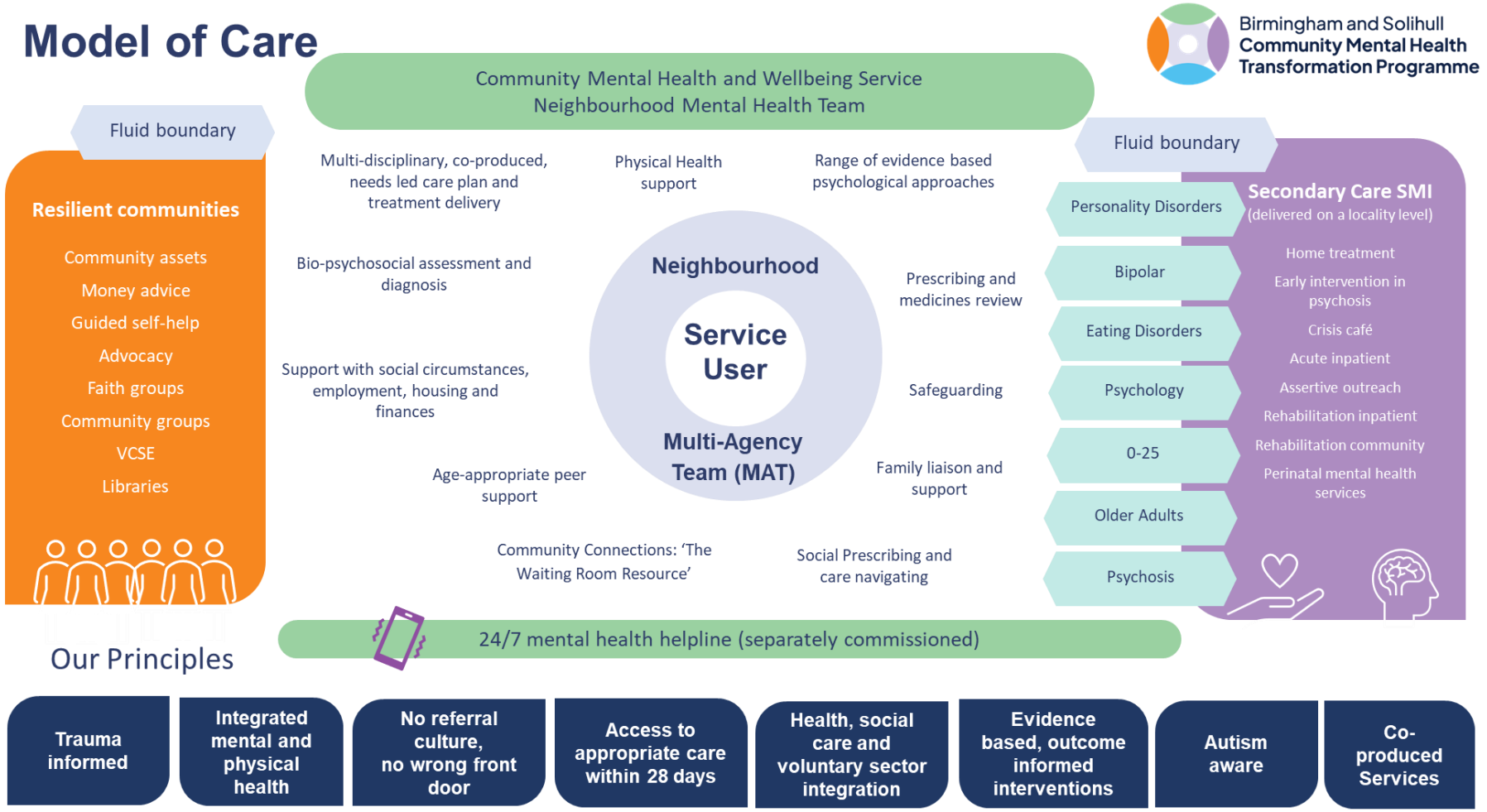
- Provide prompt and expertly led assessments to support the prevention and early intervention of mental health problems.
- Effectively provide holistic, evidence-based and recovery focused treatments and interventions.
- Adopt a flexible approach to accommodate people's changing needs over time and varying levels of complexity.
- Provide trauma informed care and actively avoid re-traumatisation.
- Improve social functioning, build resilience and widen the local community support.
- Provide advice and support to service users, families, carers and social networks.
- Establish effective relationships and work collaboratively with the multi-disciplinary team to determine need, agree interventions and provide updates where appropriate about on-going care.
- Work collaboratively with other service providers involved in the individual's care to ensure a shared care plan, including transition and maintaining continuity of care.
- Work proactively with other services to prevent admission and clinical escalation wherever avoidable / possible and promote appropriate timely discharge.
- Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.

- Provide a culturally competent service, including access to interpreter services for community languages and British Sign Language.

3.1

Community Mental Health and Wellbeing Service Model of Care

The CMHWS will operate as a unified core mental health team responsible for multiple functions across the pathway with support from and access to specialist services and neighbourhood partners. Depending on individual need, service users will be supported into other more intensive pathways of care, including but not exclusively; Crisis Resolution and Home Treatment Teams (CRHT), Acute Inpatient Services, Assertive Outreach Teams, Early Intervention Services, Forensic Services, Eating Disorder Services, Perinatal Services, Intensive Community Rehab Team and Dementia and Frailty Teams.



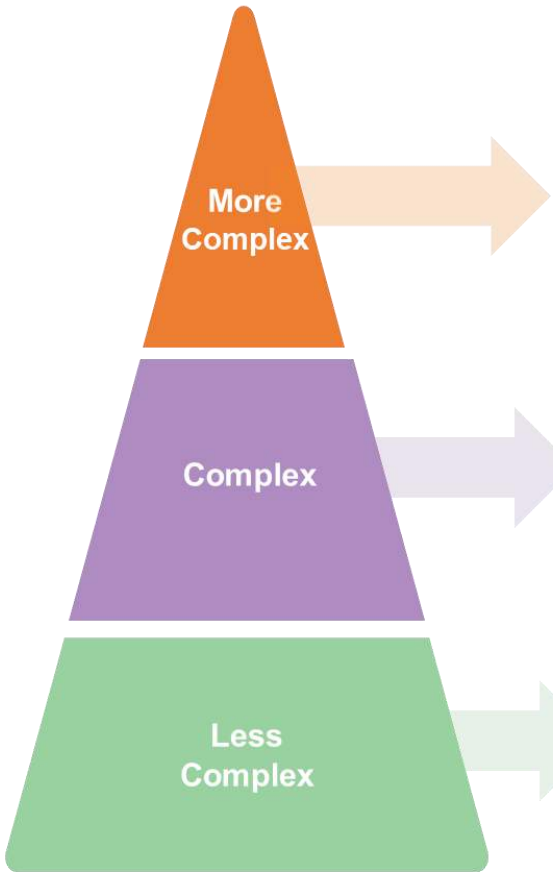
CMHWS – Complexity Model and Pathway Mapping

The CMHWS will adopt a flexible approach for the delivery of services accommodating people's changing needs over time as diagnosis in isolation does not give a clear indication of complexity or individual need. The use of the term 'complexity' is used to capture the different requirements for services that people with mental health support needs may have, ranging from 'less complex', 'complex' and 'more complex'.

Factors influencing someone's mental health and wellbeing needs

- **Nature, duration and severity of mental health problems** (including comorbidity and neurodevelopmental disorders)
- **Wellbeing factors** such as social issues, education, housing, finances, employment, criminal justice, inequalities, isolation etc
- Co-occurring **drug and alcohol** use disorders
- Problems associated with **ageing**, such as frailty
- Nature, duration and severity of **coexisting physical health problems**
- Availability and quality of personal and **social support networks**
- Associated **functional impairment**
- Effectiveness of current or **past treatment/and or support**
- Services' ability to **engage** with people and be **inclusive** & **accessible**.
- **Issues of risk:** incorporation of risk of harm to self and others

Complexity is cumulative and is not static, therefore the care offer must be flexible as people will need varying levels of support at different times.



Mental Health Support Offer

Specialist Mental Health Teams

- Service provisions such as ED, ICRT, Perinatal, CRHT,Forensic and marginalised groups such as homeless
- Support and interventions for those with more complex needs, including those with need for MH rehab
- Specialist multidisciplinary team working
- Have a named key-worker but care delivered through MDT approach
- Such teams function in a wider geographical area than placed-based services

Community Mental Health and Wellbeing Service

Community Mental Health Pathway (CMHP)

- Provide longer term or ongoing support and interventions to those complex mental health support needs or mental health symptoms
- DIALOG+ care planning delivering multidisciplinary support
- Access via MDT meetings
- Have a named key-worker but care delivered through MDT approach
- People may access additional specialist interventions from other services

Neighbourhood Mental Health Pathway (NMHP) and GPs in Primary Care

- Triage, assessment and signposting in primary care delivered by NMHP Practitioners using DIALOG+
- Time-limited, brief interventions and support for those with less complex needs including CMHP 'step down'
- Re-access CMHWS for support if needs change
- Access to local GP primary care support offer i.e., advice and information, access to social prescribing (not exhaustive)
- Those experiencing 'severe mental illness' can access yearly medication review and physical health check via GP

Level of care can be stepped up or down

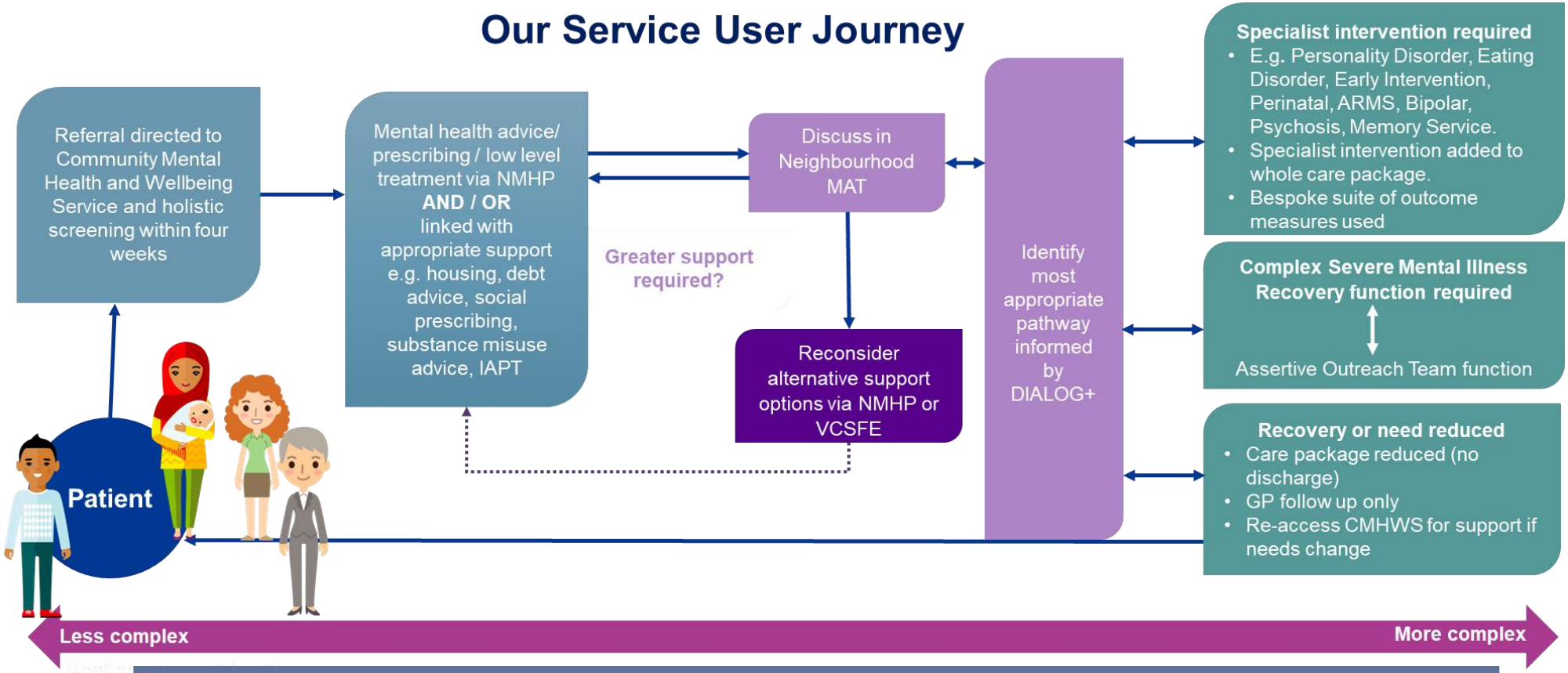
3.3

8

Service User Journey

3.4

The below graphic provides an overview. Details of the service journey are detailed in the following sections of this document



Throughout the patient journey:	
Meeting physical health needs	Therapeutic engagement, education and navigation to support the uptake of annual physical health checks and follow up of results.
Supporting social needs	Links to community assets and social prescribing as required to address social determinants of mental ill-health
DIALOG	Used collaboratively to identify needs, plan and measure clinical outcomes
24/7 support	Access to the 24/7 mental health helpline when needed (commissioned separately)

3.5

9

3.4 Team Composition

The CMHWS is a team of multidisciplinary professionals skilled in screening, assessment and delivering treatments and interventions to meet the bio-psychosocial support needs of those experiencing new or ongoing mental and wellbeing health difficulties. Multidisciplinary and multi-agency team working will enable discussions and concordance of joint care provisions to support the delivery of an integrated service user pathway.

The roles within the CMHWS may include the following (below list is not definitive and will be informed by local need):

- Psychiatrists
- Non-Medical Prescribers (e.g. Advanced Nurse Practitioners, Advanced Clinical Practitioners)
- Community Pharmacists
- Mental Health Practitioners
- Registered Nurses
- Social Workers
- Mental Health Connectors
- Occupational Therapists and Assistants
- Peer Support Workers
- Matrons
- Psychological Practitioners (Clinical/Counselling Psychologists, CBT therapists, Emotional Wellbeing Practitioners, Art Psychotherapists, Assistant Psychologists etc.) • Mental Health Support Workers/Support Time Recovery (STR) workers
- VCFSE Individual Placement Support (IPS) workers.

4 Referral and Access Arrangements

CMHWS is a non-urgent mental health provision, for individuals where the level of support required exceeds the primary care or the voluntary sector offer but doesn't meet the threshold for crisis teams.

Where individuals require an urgent mental health response at the point of referral or deteriorates beyond the threshold of the CMHWS, referrals should be re-directed to the appropriate crisis or specialist team.

To ensure that care is tailored accordingly for individuals accessing the CMHWS, specific consideration of reasonable adjustments or alternative engagement methods should be given to those with any learning disabilities, neuro-divergent conditions, cultural, religious or ethnicity related practices which affect compliance with treatment, disadvantages experienced by older adults and gender issues including the needs of transgendered and non-binary service users.

See the following sections for required considerations and practices related to:

- Equality, Diversity and Inclusion (section 17)
- Learning Disability and/or Autism Spectrum Condition (section 18)

The expected response times for the CMHWS from referral to first meaningful contact is four weeks in line with national wait time expectations, to improve pathways to reduce wait and access times. Further guidance from the national team will be reflected within this document when received.

4.1 CMHWS Referral Criteria

Each referral will be considered on an individual basis and where the CMHWS is identified as the most appropriate pathway, assessments and interventions (where clinically indicated) will be offered.

The CMWHS is **NOT** commissioned to provide a service:

- Where individuals are not registered with a Birmingham or Solihull GP.

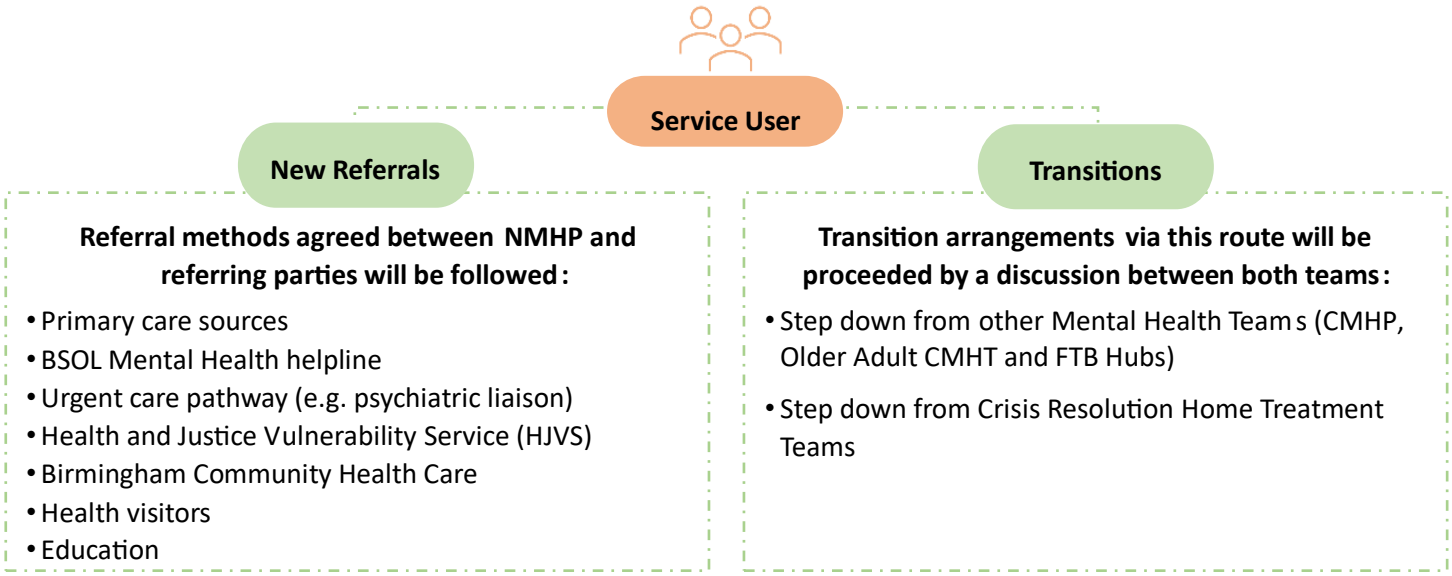
- For dementia assessment or dementia interventions
- For neurodevelopmental assessment, diagnosis & neurodevelopmental intervention.
- Where drug and/or alcohol misuse is the primary support need and individuals would be more appropriately supported by drug and alcohol services.

- Where Eating Disorder and/or Memory issues are identified as the primary mental health need, referrals should be directed to the respective service concordant with national and NICE guidance.
- For suspected or recently confirmed First Episode Psychosis (FEP). For both internal and external referrals due to suspected FEP service users must be seen face to face and treatment commenced within 14 calendar days from the date of referral. **These referrals should be immediately passed to the relevant Early intervention in Psychosis Service (EIS), or the CMHP where an individual is outside of the age range of EIS.**

4.2 NMHP Access and Referral Management Arrangements

Referrals into the NMHP may be via direct booking onto electronic patient record systems or designated email inboxes, dependent on the local agreement by NMHP hub managers and respective referrers.

As the service develops, referral sources may increase and referral process and/or pathways may change. Referral sources below is not an exhaustive list and may evolve over time:



For Discrepancies in clinical decision making see 'Escalation Process - Clinical Decision Making' (section 16)

4.2.1 NMHP Referral Management: Initial Contact

Upon receipt of new referrals, NMHP practitioners will make initial contact with the service user, to establish their support need. Discussions are facilitated using DIALOG, to identify mental health and well-being support needs.

Following the initial contact, there may be a need for a further assessment or to transition care to a more appropriate pathway. Outcomes following triage will include at least one of the following options below (note that multiple options may be available dependant on the needs identified within initial triage):

Signposting information, self-help guides and/ or advice provided for service user or GP. **SIGNPOSTING**

ALTERNATIVE SUPPORT	Referral or advice to engage with relevant health, social or community intervention inc. Talking Therapies.
NMHP APPOINTMENT	Service user invited to attend appointment for follow up and/or intervention
MAT	Case discussion presented to Neighbourhood Multi Agency Team (MAT) meeting
STEP UP CARE	Step up care to CMHP or other specialist mental health teams

Following triage, the outcome should be documented on Rio.

A 'message or task' should also be entered as on the GP system to advise the GP **DISCUSSION** of the outcome.

4.3 CMHP Access and Referral Management Arrangements

The Community Mental Health Pathway is not commissioned to accept self-referrals and will be accessible via the agreed access routes from NMHP, social services, police, psychiatric liaison, mental health providers and specialist mental health teams).

Service User

Step up via NMHP

Where the referring GP practice has an established NMHP provision

Referrals received from locality based NMHP will be triaged and assessed prior to transferring to the CMHP

Transitions

Where the referring GP practice DOES NOT have an established NMHP provision

Referrals via SPOA will be opened to the local team on Rio and assessed by the most appropriate clinician(s)

Transition / step down

Transition arrangements should per followed as agreed with the respective team.

For Discrepancies in clinical decision making see 'Escalation Process - Clinical Decision Making' (section 16)

4.3.1 CMHP Referral Management: Allocations

Daily allocation meetings will take place within each CMHP team to discuss new cases and decide upon the most appropriate pathway (below list is not exhaustive):

1 **REDIRECT TO NMHP**	**For referrals received from an alternative source** Redirect to NMHP (where there is an established provision) where service user need is better met by this pathway
2 **ALLOCATE A KEY WORKER FROM CMHP**	*Discussion between member of the allocation team and NMHP lead **Further assessment to identify need** Members of daily allocation meeting agree clinician best suited to carry out further assessment or required intervention.

5 Assessment

CMHWS assessments will be conducted by practitioners from either the NMHP or CMHP, dependant on the level of need and complexity and take place in the most appropriate setting.

Initial assessments will determine if there is a mental health need that can met by CMHWS and will consider the most appropriate intervention, treatment or pathway to meet individuals' needs.

Where an individual's care is stepped up to the CMHP, NMHP practitioners should focus on gaining an understanding of the past and present mental health problems, an individual's current functioning and mental state, relevant personal and social factors and any associated safety issues. Handover to take place during clinician to clinician discussion as part of step up.

Practitioners within the CMHP will build upon the initial assessments, assessment formulation and risk formulations using the 5P model, presenting needs and HoNoS outcome measure (see core clinical documentation).

Assessments should be inclusive, lead to the shared development of a personalised care plan (DIALOG+) and have input from the service user, their support network and other professionals where appropriate.

All assessment should be reviewed throughout the delivery of support, care and treatment, to ensure the care plan remains up to date, appropriate to the person's needs and to determine if the care provided needs to change or end.

The outcome of all assessments should be clearly communicated to the individual and all those involved in the assessment and shared formulation of the presenting problems, within two weeks. Where it is identified that the needs of a service user are better met by another service, this will be clearly communicated to the individual and the referrer with advice, in the most appropriate way.

Expected outcomes following assessment include, but are not limited to:

CMHWS Assessment Outcomes

ADVICE AND NO FURTHER ACTION	Advice with no further action: Signposting information, self-help guides and/or advice for service user or GP.
IDENTIFY THE APPROPRIATE MENTAL HEALTH AND WELLBEING PATHWAY	**Referral to, or advice to engage with a particular health, social or community intervention Transition e.g. Talking Therapies Provision** Where a service user's needs would be better met by an alternative provision, transitions should be made following the respective referral process for that service. **Further assessment, input and intervention within CMHWS** Allocation of the most appropriate member of the CMHWS to support individuals' needs as informed by their DIALOG+ care plan provision. They will remain in this pathway until their needs have been sufficiently met. **Transition to other Mental Health Team** Onward referral / request for assessment by a specialist or crisis services where specialist or more complex interventions / treatments are better met or supplemented by another Mental Health Team. Transitions should be made in line with the respective teams' referral process.

6 Interventions

The CMHWS promotes recovery and when agreeing which interventions / input is appropriate, views of service users and their support network should be included. Consideration will be given to what interventions have been previously explored and whether they were effective.

The range of interventions deliverable within the CMHWS seek to address a range of bio psycho-social factors that impact the wider determinants of mental health and enhance psychological resilience.

The CMHWS will offer a range of psychological, social or pharmacological interventions in accordance with people's presenting needs and/or diagnosis. Interventions agreed should be needs led and dependant on the complexity of individual needs.

Evidence-based treatments and interventions will be delivered in line with NICE guidelines to achieve effective clinical outcomes and ensure compliance against national standards.

Through the continued development of the community transformation programme the intervention offer will be explored and enhanced.

6.1 NMHP Interventions

The majority of individuals accessing the NMHP will present with less complex mental health support needs that will be met with time-limited interventions. Interventions available within the NMHP will include one of or a combination of the following (list is not exhaustive):

- Advice and signposting
- Guided self help
- Psychoeducation
- Psychologically informed interventions
- Solution focussed interventions
- Problem solving and goal setting
- Community asset navigation
- Medication management, support and advice

6.2 CMHP Interventions

The majority of people with complex needs will be supported within the CMHP, will have diagnosis including psychosis, bipolar disorder, severe depression, complex post-traumatic stress disorder or people with complex mental health difficulties who are diagnosed with a personality disorder.

Individuals with complex needs will be supported to live well in the community, with the support of longerterm and ongoing interventions to support people to maintain and stabilise their mental health condition. Interventions available within the CMHP will include one of or a combination of the following (list is not exhaustive):

- Allocation of a key worker
- Cognitive Behavioural Therapy (CBT)
- Solution focussed interventions
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Psychoeducation
- Moderate to high complexity psychological interventions
- Problem solving and goal setting
- Community asset navigation
- Medication management, support and advice

- Identification of occupational, functional and social skills with agreed outcomes
- Continued assessment of clinical risk with accompanying safety plan
- Structured Clinical Management
- Care management including safety planning, relapse prevention etc.

7 Care Planning

7.1 DIALOG+

Care plans should be recovery focused, holistic and include interventions that are needs based, with consideration of broader bio-psychosocial support needs. Care Plans should be developed collaboratively between the service user and key practitioner involved in the service user's care. Where possible and appropriate, this should also include involvement of the service uses' carers and family members.

DIALOG+ will be used within the CMHWS to support the revised care planning approach in line with the National Community Mental Health Transformation Plan and the BSMHFT C01 Care Management and CPA / Care Support policy (ratified April 2023). DIALOG+ care plans will be regularly evaluated throughout the service users' journey to ensure that their care is personalised, meaningful and needs led.

DIALOG+ care plans are made up of:

1. The DIALOG scale
2. DIALOG+ action plan
3. DIALOG+ safety plan

It is expected that input into the plan of care may be provided by a range of professionals and services particularly when specialist interventions are required.

Key workers will be identified as the practitioners best suited to deliver an intervention. Multiple key workers may be involved in an individual's care during the same episode of care. Further changes to the existing CPA pathway and transition to 'key worker arrangements' will be revised and reflected within this document and Trust policy accordingly when further National guidance is received.

Any Advance Statements or Advance Decisions should be made clear in the care plan. All people under the care of Mental Health Services should be asked if they have any Advance Statements or Advance Decisions. These should be documented within the electronic patient record and taken into account when necessary.

7.2 Safety, Crisis, and Contingency Planning

Service users' safety plan should detail early warning signs, how they can access care in a crisis and expected interventions. Safety plans should be carefully worked through with service users and carers to enable them to take responsibility for steps that they will take to manage their own mental health.

Service users' crisis care will be managed by the CMHWS, where appropriate, and responses will be in accordance with service user's safety plan and advance directives.

Referrals will be made to the Crisis Resolution Home Treatment Team where risk is assessed to be beyond a level that can be safely managed by the CMHWS and where inpatient acute care may be indicated (see section for Step up from CMHWS to Crisis Resolution Home Treatment for process).

7.3 Carers Involvement

Carers should be involved in a person's care where possible. The keyworker responsible for the service user's care should:

- Be aware who the main carers are, what the relationship is with the person, and how to contact them.
- Communicate with carer/s as far as possible and be aware of the carer's needs and increased risks of mental health issues of families and carers.
- Recognise the roles that carers have as partners in care.

- Make sure the carer knows how to contact the service users' key worker
- Carer's role should be included in the service users care plan
- Be tactful where service users do not accept involvement of their families but recognise that conflict should not be a barrier to carer involvement.
- Provide education and information about mental health problems and treatment.
- Signpost to appropriate carers support provisions
- All carers will be informed of their right to a carer's assessment of their needs. Carers who provide regular and substantial care for a person should be identified and be offered a carers assessment. This should be repeated on an annual basis if they so wish. They should have their own written care plan if this is indicated.
- Carer's assessment and care plans should be carried out as per BSMHFT care records documentation guidelines with all sections completed. Needs of young carers and dependent children who act as carers require regular and careful attention.

7.4 Outcome Measures

Through the development of the Community Transformation Programme; DIALOG, Recovering Quality of Life (ReQoL) and Goal Based Outcomes (GBO) will be implemented (following confirmation from national guidance which will inform local use) as the patient rated outcome measures (PROMS) to be used within the CMHWS as various stages of someone's journey.

HoNoS (Health of the Nation Outcome Scale) will be used as the Clinician Rated Outcome Measure (CROM). Whilst HoNoS may be used within the CMHWS, as appropriate, it will be primarily used within the CMHP.

Local patient satisfaction surveys, national patient survey and key performance indicators will also be utilised to understand patient experience as appropriate.

8 Care Management Arrangements

8.1 NMHP Arrangements

Care and transition planning should focus on the service user and review whether their presenting needs have been met. Transitions should include a follow up plan with the GP and relevant community services and include advice and information on the re-referral process to NMHP, crisis numbers and support lines.

Transition from the NMHP occurs for many reasons, including but not limited to:

- When goals and outcomes of the clinical care plan have been met by NMHP
- Non-attendance and/or poor engagement or where individuals have declined and there are no immediate safety concerns.
- If individuals are not benefitting from the NMHP or there is a significant change in their presentation that requires their needs to be better met by another provision or team, following MAT discussion. • If circumstances change (e.g. move out of area)

8.2 CMHP Arrangements

Within the current care planning framework, service users supported by the CMHP are allocated on either a CPA or Care Support level as per the Trusts' current Care Programme Approach.

8.2.1 Care Coordination

Individuals on the CPA care level will be allocated a care coordinator who will provide a consistent point of contact, however it is not expected that they solely deliver all components of an individual's care. Care coordinators are professional members of staff (who are registered with their appropriate governing body) who oversee and monitor the care of the service user whilst under CPA.

The key responsibility of the care co-ordinator is to proactively oversee and direct a service users care pathway, keeping all service providers on track, co-ordinating and managing the plan of care in partnership with the individual, their carers and relevant professionals involved in their care, to promote recovery, choice and hope.

Care co-ordination has two key functions:

- Establishing and sustaining a professional relationship with the service user and significant others, based on regular contact.
- Co-ordinating, monitoring and recording the assessment, planning, delivery and review of care, including risk.

8.2.2 Care Co-ordinator criteria

Care coordination requests are for service users who have a severe and enduring mental health problem along with a high degree of clinical complexity that is classifiable under ICD10 and can respond to a combination of pharmacological and/or psychological therapies and/or behavioural and practical interventions, AND in addition, the presence of one or more of the following:

- Suicide – frequent suicidal thoughts/ recent attempt / intent & plan
- Self-harm that results in a high risk to persons physical safety
- Risk of physical safety to others due to the mental health condition
- Self-neglect that results in a high risk to persons physical safety
- Significant harm to children and whereby mental health condition impacts on ability to adequately care for the child.
- Significant risk of harm from others, abuse or exploitation from other individuals or society
- Current inpatient or subject to Supervised Community Treatment Order or Guardianship under section 7 of the mental health act.
- 'Trio of vulnerability' – Mental Health Problem, Domestic Violence & Substance Misuse
- Disabling problems with thinking / behaviour that has a significant impact on person's ability to function within the community causing vulnerability and a high risk to self.

NB: The above list is not exhaustive and should not be considered as a blanket rule to allocate to either CPA or Care Support. Each case should be considered based on its own merits and agreed within MDT.

8.2.3 Care Coordinator Caseload

Each care coordinator will hold a caseload of 30 service users who are on CPA, however dependant on complexity that is being held caseload numbers will vary. This will need to be adjusted for professionals who work part-time and needs to be weighted with consideration against other clinical duties and the complexity of the service users who exist on the caseload.

8.2.4 CPA Care Management Standards

- Where a service user has been assessed as needing CPA, the care co-ordinator will be a registered professional experienced in mental health work with the appropriate skills to perform the core functions of the role.
- Care coordinators are not a substitute for other services / interventions that are not available.
- If the referrer is aware prior to making a request for a care coordinator that the service user will need a referral to a specific service, (i.e. making a safeguarding referral, referring to DBT) then this is the responsibility of the referrer and not of the care coordinator once allocated.
- Once the need for care under CPA has been established, a care co-ordinator should be allocated within seven days. If a care co-ordinator cannot be allocated within this time, then an incident form should be completed via Eclipse and the rationale for this to be explained. It should then be escalated through the line management structure.
- Care co-ordination should facilitate access and support for service users to benefit from the full range of health and community support needed including physical health, housing, education, work skills, training, employment, voluntary work, leisure activities and welfare benefits.
- As a minimum, it is expected that service users on CPA will have face-to-face contact with a member of their care team, or another mental health team if directly under their care, at least every four weeks. Where circumstances do not allow for this or where the service user has expressed a

preference for less frequent contact this should be recorded in the care plan. This may also apply where the needs of the service user change, progressing towards step down to care support.

- As a minimum, service users on CPA must have a face-to-face appointment with a senior psychiatrist once every six months or sooner if clinically required.
- The care co-ordinator will retain their role at all points of the care pathway (including in patient admission, care under home treatment, and in line with prison pathway guidelines), providing input at key planning meetings (including admission, discharge and CPA review) and maintaining contact with the service user at a frequency defined in the care plan for each individual.

8.2.5 Clinical Reviews (currently referred to as CPA Reviews)

Service users will be invited to regular on-going reviews with their key worker to monitor progress and the outcomes of the care and treatment plan being implemented. Other professionals or agencies involved in their care and where appropriate their families and carers will be invited to attend the service users' clinical review meeting.

Reviews must be held annually as a minimum. Reviews ensure progress towards the recovery objectives of the service user, in line with their clinical need and care plan. The review should consider whether the ongoing involvement of the CMHP is appropriate or whether on-going support could be appropriately provided through the NMHP, third sector services or another specialist service.

In preparation for the review, the care co-ordinator should review and update the assessment summary (where there is no significant change or it has not been updated within the last twelve months) and appropriate risk assessment. All professionals involved (including tertiary services) should provide an evaluation for the interventions they are responsible for delivering in the appropriate section of the DIALOG+ care plan.

Where it is not possible to convene a single meeting of all involved, the review may comprise of a series of conversations and/or reports, co-ordinated by the care co-ordinator. In these cases, the care co-ordinator should complete the process by recording all decisions made in the CPA review section on Rio.

This will support the team to manage caseloads and ensure effective use of resources. Clinical reviews will include a review of the following:

- Risk assessment
- Care plan including crisis management plan (Care plans should be reviewed and updated at a frequency determined by need, but at least annually)
- Carers' needs
- Advance directives / statements
- Transition planning
- Clinical Outcomes

8.2.6 Outpatient Clinics

The management of outpatient clinics will be overseen by the Consultant Psychiatrist in conjunction with the CMHP team / hub manager. It is expected that team DNA rates will be managed effectively, and teams should aim for a DNA rate of no more than 11%.

Consultant Psychiatrists will hold a caseload of up to 250 complex and/or high need service users. The consultant will provide supervision to a Middle Grade doctor who will hold a caseload of up to 300 service users. The team Associate Nurse Prescriber (ANP) will hold caseload of up to 200 service users.

It is expected that the caseload will not exceed the above therapeutic thresholds. Teams will need to ensure robust caseload management (using the directorates agreed review criteria - stratification) and review of care on a regular basis to ensure appropriate flow through the team. Twice yearly clinical reviews should be conducted for those on the caseload as a minimum.

The ANP and medical team will be available for clinical advice to NMHP & GPs within their catchment area as and when required. All staff are required to ensure timely response to service user enquiries, either directly or through a nominated delegate.

Following each appointment, the relevant clinical documentation needs to be reviewed and, where appropriate, updated (namely DIALOG+ care plan and the level 1 risk screening tool).

9 Caseload Review and Transition

The Caseload Review and Transition process enables proactive reviews of CMHP care support caseloads to ensure that individuals' needs are supported at the most suitable part of the CMHWS.

Service users are identified for review through the application of a clinical algorithm which identifies those most likely to be suitable for the Primary Care pathway based on a range of information contained within the clinical record. The service users identified are then reviewed via a two-part process; desktop review and face-to-face reviews as described below. This process continues to be developed and modified to support on-going caseload reviews to support transition.

9.1 Desktop review

Desktop reviews are undertaken by senior clinicians within the CMHP, who carry out a thorough review of the clinical record according to predetermined criteria. The clinician arrives at a formulated opinion regarding where the service user's needs may best be met.

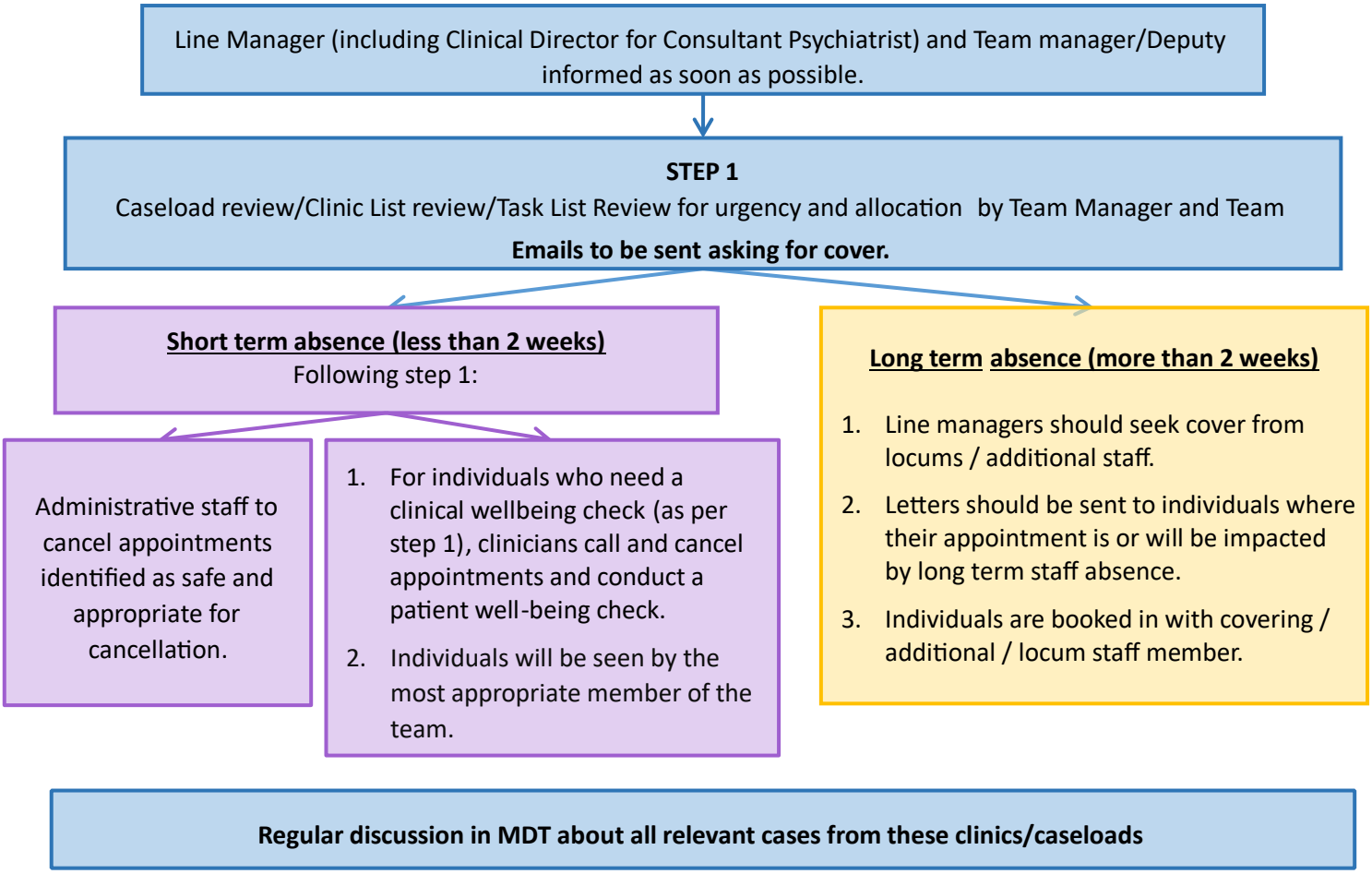
9.2 Face-to-face reviews

Service users are invited to attend a face-to-face appointment, providing an opportunity for an in-depth assessment and discussion between the service user and a senior clinician from the service users' CMHP.

Following this discussion, the anticipated outcomes will be step care down to GP, step down to NMHP or continue care with CMHP.

10 Caseload management in the event of sickness absence: CMHP

Where a member of the team within the CMHP is absent due to sickness (prior to or during the shift), the following process should be followed:



11 CMHP Duty System 09:00 – 17:00 and Extended duty provision (evenings and weekends)

11.1 CMHP Duty Provision

CMHP duty clinicians operate between the hours of 09:00 – 17:00 Monday to Friday for service users, and others involved in their care, who require support and advice in times of greater need.

Out of hours, service users, and others involved in their care, can contact the extended hours duty line (between 17:00 and 21:00 Monday to Friday and 09:00-21:00 weekends and bank holidays) to access support that addresses individual needs from the most appropriate pathway.

Teams will ensure that there is daily cover from a member of the senior medical team to support with managing crisis assessments/screenings that arise via the duty or assessment team during the day.

The duty clinicians and function will be in place to:

- Provide appropriate interventions/support/advice for service users who attend or call the CMHP outside of the allocated appointment slots, where there is a greater need and duty is the most appropriate service to do this.
- To ensure effective liaison with other teams/services, relatives and carers taking into account clinical risk and presentation.
- The duty clinician will maintain clear, robust and effective record keeping and handover procedures.

See Appendix 1: CMHT Duty Standards

11.2 Communication Arrangement for Specialist Teams Contacting CMHP Duty

CLINICAL CONSULTATION

Specialist Teams may need advice & expertise of CMHP clinicians for some service users during their access to respective teams.

Specialist teams:

- Will contact the lead clinician via email or the main CMHP and request a call back if no one is available
- If agreed MDT input is needed, then Team Manager / Clinical Leads to be informed via email so that it can be added to the MDT list and specialist team representative can be invited to attend.

MDT REQUESTS

e.g. request for medical review to be brought forward, medication advice or person's circumstance has changed which may increase risk of relapse then:

- Email entitled: FEEDBACK TO OR REQUEST FOR MDT will to be sent to Lead Clinician / Care Coordinator, team email and team manager and clinical lead who will ensure the feedback/ updates are discussed in the next MDT for patient.
- If any issues/concerns, then these staff will liaise with MOT staff directly and review/amend care or treatment plans as needed.
- Rio record will be updated by CMHT following MDT.

REQUEST FOR DUTY CONTACT

Colleagues from specialist teams will request duty contact from CMHP if they are alerted to change in the persons presentation by email/call with service user or within an appointment e.g. early signs which could lead to relapse / risk.

Specialist teams will:

- Contact and speak with service user first.
- Provide a clear rationale and request to the duty team and recorded on Rio progress note.
- CMHP will retain oversight should further immediate/urgent intervention be needed.
- This request should be made by direct email to duty team with a read receipt.
- Rio record will be updated by duty team and the specialist team can view the outcome of contact on Rio.

CRISIS / HOME TREATMENT

Where a member of the specialist team has risk assessed a service user and thinks that crisis intervention / home treatment is needed a direct referral should be made.

- Referrals to HTT made via phone call.
- Lead clinician for CMHT to be emailed following this.

In any case of discrepancies in clinical decision making the CMHP and specialist team clinical lead or team manager should liaise to discuss the case together and agree a plan.

12 Multi-Disciplinary Team Working

Multidisciplinary and multi-agency team between the range of practitioners working across the CMHWS is essential to the delivery of an integrated service user pathway to effectively meet the bio-psychosocial support needs of those experiencing mental health difficulties in the community.

Colleagues will need to work collaboratively with the range of professional disciplines working within the CMHWS and partners from other services involved within an individual's care.

12.1 Neighbourhood Multi Agency Team Meeting (MAT)

The locality-based Neighbourhood Multi Agency Team meeting brings together relevant partners across the CMHWS to explore and identify appropriate pathways, plans of care and interventions.

Where an individuals' needs are not clearly met by either pathway within the CMHWS or contracted VCFSE provisions, the MAT will facilitate discussions regarding:

- Potential interventions or support where previous arrangements have not proved effective
- Complex cases requiring MAT members advice and/or input including consideration of step up
- Complex safeguarding matters
- Missed appointments, Did Not Attend, barriers to engagement (where there are significant concerns)
- Transition from CMHP (where the case is complex)

Locality based MAT meetings will occur fortnightly and will be represented by the core membership identified with the MAT terms of reference.

Where it isn't possible to agree a resolution following a MAT discussion, escalation should be made to the respective Clinical Services Manager and Clinical Director to broaden the discussion.

12.2 CMHP Multidisciplinary Team (MDT) Meetings

As outlined in the CPA and Care Support Policy, the MDT review is a formal review comprising of a multidisciplinary discussion and may be called by any member of the care team including the service user or carer.

This will usually be where need, circumstance or risk has changed, the purpose being to review the plan of care with a view to confirming existing actions or making appropriate adjustments to the care plan. This should be recorded using the MDT review form.

Weekly MDT meetings support the on-going management of service users and are a platform for MDT discussion and feedback regarding the management of complex cases, DNA's, patients who repeatedly cancel appointments and any complex discharges.

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

- Discussion of any complex initial assessments that will benefit from the advice offered by the MDT
- Discussion of existing cases of concern that will benefit from the advice offered by the MDT
- Discussion of repeated DNAs and cancellations and next steps
- Feedback on service users open to CMHP who are currently on CRHT team caseloads and inpatient units
- Discussion of discharges and those suitable for rapid re-access. Routine discharges do not need to be brought to this meeting
- Discussion regarding referrals and compliance with National First Episode Psychosis (FEP) guidelines
- Discussion of transfers into the team
- Review of any "high" blood results (Clozapine, Lithium etc)
- Review of any physical health concerns

12.2.1 CMHP MDT Guiding Principles

As a minimum the MDT must:

- Be held on a weekly basis and attended by the Consultant Psychiatrist, Team Manager / Clinical Lead and Psychological Services, as a minimum.
- All other professionals should be invited and able to attend the MDT (e.g. AHPs, Psychological Practitioners, IPS workers).
- The opinions of all who attend are to be respected and the written documentation should be reflective of the MDT discussion.
- At each MDT a decision needs to be made as to who will be recording the minutes of the MDT and who will be completing the clinical documentation on Rio (MDT Part B). If the agreed member of staff is non-clinical then arrangements must be made to ensure that clinical oversight is available and accessible.
- Following the MDT discussion, a clear description of what was discussed during the MDT review, the decisions / actions to be taken and who is responsible for undertaking the actions and by which date they need to be completed by are clearly recorded in the MDT Part B form on Rio.
- Where applicable, the risk assessment and care plan should be updated following the outcome of the MDT discussion and relevant individuals should be made aware of the plan.
- A clear mechanism needs to be put in place to ensure that actions agreed in the MDT are followed up (e.g. action tracker to be reviewed in subsequent MDTs). The actions should be SMART and have an end date.

13 Management of DNA and Repeated Service User Cancellations

There will be instances where individuals DNA or repeatedly cancel or miss their appointment for their initial or follow up contact (Referrals and Appointments Policy).

The risk associated with an individuals' DNA or repeated cancellation should be considered on a case-by-case basis and practitioners should progress through the relevant escalation processes outlines below.

Colleagues within the CMHWS will proactively manage the number of service users who do not attend, and every effort will be made to ensure service users are able to attend their appointments.

All attempts to contact the service user and decisions made should be clearly documented in the individuals' notes on Rio, with a clear explanation of the decision-making process by the respective pathway team.

13.1 NMHP process

Service users who persistently DNA or cancel appointments should be discussed, on a case-by-case basis, in the NMHP MDT or MAT meeting as appropriate. The response to a DNA or repeated cancellations from an existing service user will depend on the circumstances.

MDT discussions will generate the following possible actions (decisions to discharge should be captured on GP notes or discussed with referrer where required):

SERVICE USERS WITHOUT COMPLEX NEEDS AND/OR LOW RISK	Consider closing episode with NMHP with advice and self-help information * Provide the service user with advice and information on the re-access process to NMHP, crisis numbers and support lines.
	Contact with the service user to discuss whether another appointment is

	required (consider contact methods such as phone, text message, email)
SERVICE USERS **WITH COMPLEX NEEDS AND** **POSSIBLE** Discharge dependant on the outcomes of the re: service user's needs and risks. NMHP MDT/MAT discussion **ASSOCIATED RISK**	*Offer another appointment as appropriate *Provide the service user with advice and information on the re-access process for NMHP, crisis numbers and support lines.

13.2 CMHP process

The following principles are to be followed by the CMHP:

- Reminders are to be sent to the service user within 48 hours leading up to their appointment. This can be completed via text message, telephone call or email (if the service user has previously consented to being contacted via these methods).
- Service user demographics (i.e. address, telephone number, email address and registered GP) should be checked at each visit. This ensures that the service user and the GP receive the correct correspondence and that community staff visit the correct address.
- Ensure that following the above, the Communications Preference form is completed on Rio.
- Ensure that appointments are made at a convenient time for both the service user and the team.
- Where possible, depot / blood clinic and out-patient appointments should be aligned. This minimises the number of times a service user has to attend the Trust site.
- Identify those service users who repeatedly DNA, check NHS Spine Portal to ensure we have correct details, and give consideration to other forms of engagement. Do not routinely book appointments for them and discuss in MDT to determine if their level of need is appropriate for the CMHP, or if the CMHP is able to meet this need.
- If a service user does not attend, the clinician should contact the service user during the appointment slot to see if they can speak to them and ascertain the reason for non-attendance and agree a plan moving forward.
- A DNA should be recorded when the service user does not attend and has not given advance notice. Where they notify us in advance (including on the day) the appointment should be cancelled.
- The outcome of the out-patient appointment should be completed within 24 hours of the scheduled time.
- The outcome of community appointments should be completed on the same day where possible, an in all cases within 4 working days.

13.2.1 New patient DNAs

Where the practitioner has not been able to contact the service user, and the appointment was deemed 'urgent', then the practitioner should discuss the DNA with either the Consultant or Team Manager / Clinical Lead to agree upon a plan on the same day as the scheduled appointment.

Where the practitioner has not been able to contact the service user, and the appointment was deemed 'routine', then this is to be discussed in the next MDT meeting whereby an appropriate plan can be developed.

Where service users DNAs their first appointment, consideration needs to be given to what action should be taken based on the referral and available information. This will involve a meaningful dialogue with the referrer, where possible.

13.2.2 Existing patient DNAs

Repeated and complex DNAs should be discussed in the MDT. Responses to a DNA or repeated cancellations from an existing service user will depend on the circumstances.

13.2.3 Repeated Service User Cancellations

It is understandable, and accepted, that service users will need to cancel their appointments on occasion due to several factors (e.g. illness, childcare issues, work commitments, conflicting appointments, etc).

If a service user cancels two appointments consecutively, and the CMHP has followed the principles outlined above in sections, then Referrals and Appointments Policy should be followed (process for DNA pages 7-9).

13.2.4 CMHP DNA Outcomes

In all cases cited above, relevant parties involved in the individuals' care should be advised of the service user DNA or cancellation. All decisions made should be clearly and fully documented using the MDT form in the service users Rio records with an explanation of the decision-making process taken by the MDT.

Outcome of the discussion needs to be communicated to the service user and other professionals, as appropriate, involved in their care. MDT discussion about the DNA or cancellation will generate the following possible actions:

SERVICE USERS	
WITHOUT COMPLEX NEEDS AND LOW RISK	Step care down to GP care depending on identified need with information re: re-accessing CMHWS service
SERVICE USERS WITH COMPLEX NEEDS AND POSSIBLE ASSOCIATED RISK	Contact with the service user via phone or preferred communication method to determine whether another appointment is required. Assertive follow up - home visit should be considered by the MDT and if home visit is not indicated the reason for this should be clearly documented. Following MDT discussion, transfer service user to GP care (or NHMP where appropriate) depending on identified need and risk.

13.2.5 DNA for Depot / Clozapine Blood Clinic:

In the event that an individual does not attend their scheduled appointment to for a depot or clozapine blood clinic, the following process should be adhered to:

If not able to make telephone contact, send an Accurx requesting contact with the team/offering another appointment

<u>If patient is unable to be contacted via telephone/Accurx or does not respond.</u>

Discuss at following day's morning meeting (document discussion and plan on patient's notes). This process should be supported by the wider team, and not rely on clinic nurses alone.

1. Allocate someone to follow up that day (continued attempts to contact, home visit, etc)
2. Agree in the team at what point to clinically escalate to a medic/prescriber (based on prescribing guidance, knowledge of patient, SMI diagnosis and level of risk).

For those with an SMI diagnosis and an established risk history, contact with next of kin and/or a home visit should be attempted within 72hrs if no contact with service user has been possible:

4. The above should be discussed with the Prescriber/Consultant/Duty Doctor (where applicable) at the earliest opportunity and does **not** need to wait for an MDT discussion.
5. A list should be kept of anyone who Did Not Attend their appointment. If the above process has been followed and unsuccessful in re-establishing contact with the patient (and ultimately treatment), this should be discussed within the MDT/at minimum weekly.

If this assertive approach to follow up has not been successful and there is sufficient evidence that the defaulting of treatment and engagement is increasing risk and causing relapse in mental state, then escalation to Crisis Resolution Home Treatment team should be considered.

13.2.6 DNA of Appointments for Transfer of Care

If the service user does not attend the initial assessment with the receiving team, attempts should be made to contact the service user during the allocated appointment slot.

If contact with the service user is not successful, then the transferring team are to be made aware on the same day, who will then be responsible for follow up. If the service user DNA the second appointment offered, the referring team and the transferring team are to discuss and agree on the appropriate outcome.

If the decision is made to discharge, it must be agreed by both the referring and receiving team. There should be consideration of the increased risk factors associated with people transitioning between teams.

14 Interface and Joint Working Arrangements with VCFSE

In keeping with the locality place-based service model, links will be established with local community organisations supporting mental health and wellbeing and bio-psychosocial needs to meet population need. Where required, service users can access both NMHP and VCFSE service provisions simultaneously.

Partnership working with VCFSE partners and local community assets will be required for a large number of individuals who are supported by the NMHP to support access to VCFSE provisions and. Contracted partners within the CMHWS include (not exhaustive):

- Change, Live, Grow (CGL)
- Birmingham Mind
- Shaw Trust Individual Placement Support (IPS)

15 Transitions, Interface and Joint Working Arrangements with other Clinical Teams

15.1 CMHWS Step Up and Step Down

15.1.1 Step down to GP

When a service users care is transferred to GP, DIALOG+ GP letters need to indicate:

- Current treatment
- Any advice / follow up actions for the GP
- Relapse signatures
- Safety plan
- Any physical health update as appropriate
- Procedures for re-access through NMHP

15.1.2 Step down to NMHP

Individuals will be stepped down to the NMHP where their needs have been met by the CMHP, as determined by their DIALOG+ care plan, the complexity of their needs have decreased and there are no identified imminent risk management issues identified.

Decision to step down care to NMHP should follow an MDT or clinician-to-clinician discussion with an agreed support need.

15.1.3 Step up to CMHP

Where the complexity of individuals needs is identified as complex or increases from less complex to complex, their care should be stepped up to the CMHP, following initial assessment by the NMHP.

Prior to stepping up care to the CMHP, the relevant care record documentation; DIALOG+ care plan and Level 1 risk screening and should be updated and is accompanied by a discussion as appropriate or where further clarification is required.

Assessments for cases transferred into the CMHP will be discussed at the daily CMHP allocation meeting. Members of the daily allocation meeting will decide on the practitioner best suited to meet the service user's needs.

15.2 Internal Transfers between CMHP teams

Internal BSMHFT transfers between CMHP to CMHP teams should be completed within 3 months of request being made as per process outlines in Appendix 2.

15.3 Transitions / transfer for young adults entering CMHP adult pathway

Arrangements to transfer the management of care for young adults, aged 24.5 years in Birmingham and 17.5 years in Solihull, with complex needs will be facilitated between the respective teams (see Admission, Transfer, Discharge and Follow Up Policy)

Upon receipt of the transfer request, an MDT discussion will take place to consider the needs of the young adult allocated them to the most appropriate pathway within the CMHWS.

15.4 Transfers from Out of Area Mental Health Teams

As part of the transfer process for referrals received by CMHP from Out of Area (OOA) mental health placements, CMHP should ensure that all collateral history, relevant information and discussions are undertaken with the external mental provider.

See Admission, Transfer, Discharge and Follow Up Policy

15.5 Step Up from CMHWS to Specialist / Crisis Teams

Colleagues within the CMHWS should maintain good working relationships with other teams both internally and externally, to enable integrated working and effective joint working arrangements. Practitioners will refer individuals to other functional teams when the level of need has altered, and the service user has been assessed to require a level of care management outside of the CMHWS remit.

Where it is identified that a service users care would either be supplemented or better met by another specialist care provision, transitions should be made following the respective team's referral process.

For more complex cases where all interventions have proven to make little or no significant improvements in outcomes for the service user, a professionals meeting should be convened to discuss on-going management and transition from CMHWS.

Prior to transitioning a service user from the CMHWS to another clinical team, their risk screening tool and DIALOG+ care plan should be reviewed and updated prior to completing a transition to another team.

Individuals may also be referred to specialist services where shared care arrangements are thought to be necessary. This may include the following Trust services (list not exhaustive):

- Eating disorders service.

- Psychotherapy service
- Perinatal service
- Personality and complex trauma pathway
- Neuropsychiatry service
- Deaf service
- Forensic service
- Meriden
- Assertive Outreach / Intensive Community Rehabilitation Team
- Steps to Recovery
- ADHD
- Early Intervention Services

15.6 Transitions between CMHWS and CRHT

15.6.1 Step up from CMHWS and CRHT Team

If a service users' acuity increases beyond the threshold of the CMHWS the service user will be assessed (where possible) and referred to their local CRHT team, in line with the Standard Operational Procedure.

As per the BSOL Integrated Mental Health Pathway Map (Intervention Codes 2/3) and in line with Triage Codes B and C of the UK Mental Health Triage Scale, typical presentations which require CRHT input include:

Risk	Typical Presentations
High risk of harm to self or others and/or high distress, especially in absence of capable supports. Urgent mental health contact and response Within 24 hours.	• Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent • Rapidly increasing symptoms of psychosis and/or severe mood disorder • Wandering at night • Vulnerable isolation or abuse • Overt/unprovoked aggression in care home or hospital ward setting • High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control
Very high risk of imminent harm to self or to others. Very urgent mental health response Within 4 hours.	• Acute suicidal ideation or risk of harm to others with clear plan or means • Ongoing history of self-harm or aggression with intent • Very high-risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control • Urgent assessment under Mental Health Act • Initial service response to A&E and 'front of hospital' ward areas

Referrals to CRHT team can be made by registered clinicians working at Band 6 or above. All transitions to the CRHT team should, where reasonably possible, be seen by a senior medic. Where this is not possible, the assessing clinician needs to have a discussion with a senior clinician within the CMHWS prior to referral. The CRHT will hold complete medical responsibility until the service user is transitioned back to the CMHWS.

If direct contact with the service user and the CMHWS has not been possible due to non-engagement, the CMHWS is to ensure that there is a plan for escalation documented in the Rio progress notes should the CRHT team also be unable to contact the service user.

The risk associated with a referral to the CRHT should be considered throughout and clinicians should progress through the escalation process as they deem appropriate. The Level 1 Risk Screening Tool and DIALOG+ care plan should be updated prior to referral and will include a clear rationale for referral and a 5point management plan. If the documentation is not able to be completed at the point of referral, then a timeframe for completion is to be agreed upon by both CMHWS and CRHT.

A qualified, registered clinician-to-clinician conversation must take place in which receipt of the referral and its urgency are acknowledged. The names of the clinicians involved in this conversation must be documented on Rio by both parties.

When any service user receives treatment from CRHT team, the care coordinator (where allocated) will continue to provide face-to-face contact at a regular interval during CRHT team episode. If there are exceptions, then they should be recorded in the notes. As appropriate, the care coordinator or nominated person will maintain contact with the service users' family / carers.

Where it is recognised that a crisis is likely to occur for service users supported by the CMHP, the host CMHP will be expected to work with CRHT team to develop a joint care plan with clearly identified roles for both teams and the point at which the respective roles will be enacted.

Where possible, link workers from CMHWS will attend the CRHT team MDT to support transition of service users between both teams.

15.6.2 Step down from CRHT Team to CMHWS

Prior to step down from the CRHT should ensure that:

- The MDT team have agreed that the service user is suitable for discharge from CRHT services.
- There is good understanding by the service user, their family, carers, and relevant others of why the crisis occurred and how it may be avoided in the future.
- Coping strategies have been explored with the service user and family/carer.
- A relapse prevention plan is in place.
- Service users and their family/carers have had opportunity to provide feedback and express their views about the services to help us improve.
- The decision to step down care from the CRHT should be made through consultation between the relevant clinical teams, the Care Coordinator (where one is allocated), the service user, and carer.
- CRHT will actively review the service user's CPA/Care Support and make recommendations for ongoing care. This will be documented in the service user's care record.
- There will be a full and complete handover, and all relevant documents, letters to GPs and care records will be completed in accordance with Trust policies.
- Clinician to clinician conversations between CRHT team and the service providing ongoing care should take place to support this handover process.
- Where appropriate, joint visits should be utilised to ensure the safe transition of the service user between services and to provide the opportunity to build relationships with service users.
- Clear discharge plan needs to be given to the patient & other relevant parties within 48 hours of discharge. Plan should include: ○ Ongoing care in the community/aftercare arrangements.
    - There should not be assumptions that a service user is automatically referred back to the service they were referred to CRHT from. Instead, ongoing care should be an active referral, to a broad range of available services, and have a clear rationale for how this will support ongoing care.
    - Crisis and contingency arrangements including details of who to contact ○ Medication, including monitoring arrangements
    - When, where and who will follow up with the patient as appropriate

15.6.3 CMHWS contact following step down from CRHT

All service users stepped down from CRHT team to CMHWS must be contacted within two weeks of the transition by the most appropriate member of the CMHWS clinical team.

For service users stepped down to CMHP, they must be seen face to face within the two-week transition period.

For service users stepped down to NMHP, contact will be made within the two-week transition period via the method agreed in the MDT discussion prior to discharge.

To ensure service users transitioned from CRHT to CMHWS are appropriately contacted within two weeks, senior medical staff are to have specific appointments designated for this purpose, where appropriate. Appointment slots are to be protected for CRHT transitions and the number of appointments made available is to be determined based upon local need.

If the service user DNA their appointment, or there are concerns regarding their mental health and associated risk, then is to be escalated on the same day to the Consultant, Team Manager or Clinical Lead so that an appropriate management plan can be formulated.

15.6.4 Care Coordination

See CRHT team SOP and Care Management & CPA/Care Support Policy for care coordination arrangements for service users who are under the care of CRHT team who require on-going support on CPA.

15.6.5 Transition from CRHT to CMHP for people with a diagnosis of personality disorder.

Guidance regarding transition from CRHT to CMHP is already outlined in the BSMHFT Personality Disorder Care Pathway: Clinical Guidance. Transitions between care teams can be a time of increased risk and anxiety for any service user, but particularly for individuals where relationship difficulties can be a key part of their experience. Therefore, guidelines have been developed for transitions between CRHT and CMHP for people who have a diagnosis of personality disorder (Appendix 3)

15.6.6 Differing Clinical Opinions Between Teams

For either transition to, or transition from the CRHT team, if there is a differing clinical opinion between the teams as to the most appropriate pathway for the service user, then the following is to be undertaken:

- A clinical discussion is to take place between both parties where the rationale for the disagreement is outlined and each party attempts to seek a mutually agreed resolution. This may include a 72 hour period of assessment by CRHT, if there is a concern about risk or that the patient is in crisis. ○ Where this is not possible, it should be escalated to the team managers for both the CRHT and the relevant pathway of the CMHWS. The team managers will then have a discussion and attempt to resolve the matter.
- If the team managers are unable to seek a resolution, then it is to be escalated to the Clinical Services Manager and Consultant Psychiatrist for both the CRHT team and CMHP.

15.6.7 Recall of service user on CTO

If the CMHP decides that a service user on a CTO needs to be recalled to hospital (including outpatients), the respective Responsible Clinician (RC) within the CMHP should transfer the RC responsibility immediately to the Consultant in CRHT. An urgent assessment will be carried out by the CRHT and if it is deemed that the service user needs immediate hospitalisation, the consultant in CRHT will complete the CTO recall form.

15.7 Step down from inpatient settings to CMHP

On rare occasions that service users are discharged from an acute inpatient mental health admission directly to the CMHP and not the CRHT team, they should be followed up within two days in person.

In exceptional circumstances, telephone contact may be made where face-to-face contact is not possible or where agreement has been reached between the team and the service user due to a specific situation. Telephone contact must be with the service users themselves.

Where the two day follow up cannot be completed directly with the service user, the exceptions form on Rio must be completed.

15.8 Transitions with Assertive Outreach Teams (AOT)

Referrals to AOT are allocated by address, not GP practice. The referral criteria, and the referral process, as outlined in the AOT Operational Framework are to be followed.

Transition from AOT to the CMHWS should be agreed by both teams. As a minimum the service user should be stable in mental health and clinical risk is adequately managed, reasonably well engaged with AOT, has stable accommodation and that these factors can be maintained by the CMHWS.

15.9 Steps to Recovery Inpatient and Community Rehabilitation

Steps to Recovery Inpatient and Community Rehabilitation services consists of Community Rehabilitation Wards (Grove Avenue, Hertford House, Forward House, and Rookery Gardens), High Dependency Unit (Endeavour Court), Complex Care Units (Dan Mooney House, and David Bromley House), and Intensive Community Rehabilitation Team (ICRT).

Referrals for rehabilitation involvement are often received due to the following issues:

- A pattern of persistently poor engagement (particular with regard to active participation with care) despite community service follow up and support.
- Dual diagnosis (problematic substance use)
- A repeated pattern of admission to acute psychiatric units / psychiatric intensive care Units
- Previously detained under The Mental Health Act 1983
- Failed use of a Community Treatment Order

Referrals will be received from Acute Inpatient services, Secure services, BSMHFT community teams, Prison Health Care, EIS for Solihull and from our commissioners for Birmingham out of area patients. All referrals from forensics services will be reviewed by the Clinical Director and other senior clinical staff before a decision is agreed to offer a service.

For all the rehabilitation services there is a single point of referral via the S2R Referral form on Rio. This referral will detail the rehabilitation needs including risk behaviours, indicate the potential rehabilitation interventions required along with the possible service type.

Referred service users will be typically assessed within a maximum of seven working days of the referral being received by the assessor with the decision being reviewed by the Responsible Clinician (RC) linked to the assessor's team. Issues with the timeframe for assessment will be discussed with the referring team. All assessments should be made with the involvement of the service user and the service user's care coordinator, where available.

The outcome will be communicated to the referrer and documented on RIO in the assessment section of the referral form. Where assessments have been accepted for admission to the inpatient rehabilitation service the assessor will then place the service user on the Steps to Recovery waiting list for the next appropriate vacancy in the referral management system on Rio.

All service users under the care of Steps to Recovery Inpatient and Community Rehabilitation services are subject to CPA and need an allocated care coordinator from the CMHP.

15.10 Transitions with Forensic Services

Regular ICCR and Secure care interface meetings will be held to discuss cases ready for transition, pathway interface issues, clinical support, advice, and guidance.

The CMHP Clinical Director and Clinical Service Managers should be notified of all referrals from secure care / FIRST/ Reach Out or the prison service for review and discussion before being accepted into the CMHWS.

Process for managing referrals from forensic teams into CMHP to be included following pending approval of the process via Community CGC.

15.11 Service users who are detained in prison whilst open to a CMHP

Where a service user engaged with secondary mental health services is detained in prison, the care coordinator/lead clinician must retain their role and make every effort to maintain contact with the service user through liaison with prison based staff in order to facilitate continuity of care, including if the service user is transferred to another prison. This is essential at the time of release from prison.

Once the care co-ordinator/lead clinician is made aware that a service user has been detained in prison, they must contact the prison mental health team and make available the most recent assessment, risk assessment and care plan.

Where a service user is detained for a prolonged period of time, the care co-ordinator/lead clinician must be involved with a review of the persons care as part of MDT discussion. Further actions, on a case-by-case basis, will be subject to MDT discussion between relevant CMHT and the prison mental health team; this may involve a formal meeting or an exchange of reports.

16 Escalation Process: Clinical Decision Making

In instances where there are discrepancies in clinical decision making:

1. Initial verbal discussion between the clinicians involved should take place
2. Consider whether a wider MDT discussion is required
3. Escalate to Clinical Service Manager / Clinical Director if an urgent decision is required or a resolution cannot be reached following the above

17 Equality, Diversity and Inclusion

Reducing health inequalities and ensuring considerations related to equality and diversity for service users and carers are essential to tailoring care accordingly for individuals accessing the CMHWS.

All staff have a duty not to discriminate any colleagues, service users, carers and third parties related to protected characteristics and should ensure that they adhere to the BSMHFT Equality, Inclusion and Human Rights Policy.

Specific consideration of reasonable adjustments or alternative engagement methods should be given to those with any learning disabilities, neuro-divergent conditions, cultural, religious or ethnicity related practices which affect compliance with treatment, disadvantages experienced by older adults and gender issues including the needs of transgendered and non-binary service users.

Staff have a responsibility to challenge any discrimination they may witness and report back in accordance with the Equality, Inclusion and Human Rights Policy.

18 Learning Disability and/or Autism Spectrum Condition

It is estimated that 40% of people with a learning disability experience mental health problems (Mental health problems in people with learning disabilities: prevention, assessment and management) and research suggests autistic people may be more likely to experience depression than non-autistic people (Depression (autism.org.uk). People with a learning disability and autistic people who are feeling overwhelmed may present with behaviours that challenge, such as hurting other people, hurting themselves or damaging property. Do not assume that this is an indication of mental illness and do your best to work with the person who is unwell, their carer or family member to find out how best to keep them calm and relaxed.

The following key points should be considered when assessing and treating a patient with a learning disability or autistic person:

- Be aware of diagnostic overshadowing
- Pay attention to healthcare passports
- Ensure that clinical decisions around care and access to treatment are made on an individual basis
- Make reasonable adjustments
- Communicate with and try to understand the person you are caring for
- People with a learning disability and autistic people should be assumed to have capacity in line with the principles of the Mental Capacity Act.
- Ask for specialist support and advice if necessary
- All staff within the CMHWS are to complete the Oliver McGowan Training on Learning Disability and Autism, which can be accessed via individual staff member's training traffic light.

The national Transforming Care programme aims to improve the lives of children, young people and adults with a learning disability and/or autism who display behaviours that challenge, including those with a mental health condition. The programme has three key aims:

- To improve quality of care for people with a learning disability and/or autism
- To improve quality of life for people with a learning disability and/or autism
- To enhance community capacity, thus reducing inappropriate hospital admissions and length of stay

In line with these aims, the CMHWS will support people with a learning disability and/or autism, making reasonable adjustments where necessary and will access specialist multi-disciplinary support as appropriate. BSMHFTs processes in relation to Transforming Care are currently in development and this operating framework will be updated once this work has been completed and agreed.

18.1 Confirmation of diagnosis

If a service user, or their family / carer, informs the CMHWS that they have a diagnosis of learning disability or Autism Spectrum Disorder/Autistic Spectrum Condition then further details are to be gathered, including where they received their diagnosis, when they received their diagnosis and any reasonable adjustments that are required to support them in accessing and receiving care.

The CMHWs, with consent from the service user, will need to liaise with the GP to confirm the diagnosis and that the service user is on the Learning Disabilities/Autism register (held by the GP).

The NHS Spine Portal should also be viewed to see whether there is a reasonable adjustment flag recorded (Reasonable Adjustment Flag - NHS Digital).

18.2 Reasonable adjustments

It is a legal requirement to make reasonable adjustments to care for people with a disability under the Equality Act (2010). Getting the reasonable adjustments right is important to help you make the correct diagnostic and treatment decisions for an individual. You can ask the person and their carer or family member what reasonable adjustments should be made. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need.

The acronym T.E.A.C.H. is a way of learning and remembering how to make reasonable adjustments, with the first letter of a key word to think about when supporting someone to access healthcare:

Time: This might be offering a double appointment with the GP or an early morning appointment when the waiting room is quieter

Environment: This might mean the dentist visiting at home or the operating theatre nurses meeting the individual in casual clothes rather than in gowns and masks

Attitude: This means treating everyone with dignity and respect and as an individual

Communication: This means using accessible information to ensure it can be understood, e.g. easy read leaflets, pictures, symbols or sign language

Help: This means listening to others (family carers/supporters) and knowing where to get specialist help when needed (community learning disability nurse, acute liaison nurse, social worker, safeguarding)

Examples of reasonable adjustments which can be made include:

- Arranging the first or the last appointment of the day,
- Arranging a double appointment,
- Using tools such as pictures or images to support communication,
- Communicating via technology, such as a tablet or telephone,
- Providing information in other formats, such as easy read or braille

Reasonable adjustments should be recorded on Rio under Alerts and is identifiable by the following symbol: 

18.3 Dynamic Support Register (DSR)

The DSR enables systems to identify adults, children and young people with increasing and/or complex health and care needs who may require extra support, care and treatment in the community as a safe and effective alternative to admission to a mental health hospital.

It is the responsibility of the CMHWS to ensure that an individual, who is being supported by the service, is added to the DSR when clinically indicated.

18.4 Care (Education) and Treatment Reviews (CTR / CETR)

Care (Education) and Treatment Reviews (C(E)TRs) are part of NHS England's commitment to transforming services for people of all ages with a learning disability and autistic people. C(E)TRs are for people who have been admitted to a mental health hospital or for people who are at risk of admission. They are undertaken by commissioners to ensure that people are only admitted to hospital when absolutely necessary and for the minimum amount of time possible. Care and Treatment Reviews (CTRs) are for adults and C(E)TRs are for children and young people.

C(E)TRs are carried out by an independent panel of people. Many people are involved in supporting a person through their Care and Treatment Review (CTR) including commissioners, CTR panel members, family carers, providers and other professionals.

The CMHWS are to request a C(E)TR at the point of referral to the CRHT.

18.5 Local Area Emergency Protocol (LAEP)

In circumstances where an admission is unplanned, urgent or someone is in 'crisis' it is recognised that a C(E)TR may be, on a practical level, very difficult to set up due to short time scales, level of risk and the need for urgent action.

The aim of the local area emergency protocol (LAEP) is to provide the commissioner with a set of prompts and questions both to prevent people with a learning disability or autistic people from being admitted unnecessarily to a mental health hospital; and where there is a clearly supported clinical indication for admission to ensure that the intended outcomes and timescales are clear.

It is also intended to help identify barriers to supporting a person to remain in the community and to make clear and constructive recommendations as to how these barriers could be overcome by working together and using resources creatively.

It is important to note that the LAEP does not replace the community C(E)TR and should only be used by exception. Where a community C(E)TR has not taken place, the pathway for a post-admission C(E)TR must be followed.

If an individual is at risk of admission and does not have a care pathway, they should be allocated a care coordinator to follow-up the agreed care plan. For an individual under 25, this may trigger a review of their Education, Health and Care Plan (EHP). The revised care plan will require regular review by those involved in the person's care to ascertain its effectiveness and quality. Should an individual be admitted following a LAEP meeting, a full C(E)TR will need to take place within 20 working days for adults.

19 Safeguarding Children and Vulnerable Adults

Clinicians are reminded to 'Think Family' to help improve the lives of service users, their children and families. The Trust Safeguarding Team are working to embed the Trust Think Family approach across all clinical services. This approach means that clinical staff will identify, consider and respond to the needs of all family members. It means that we 'dig deeper' or 'Look Closer' with our service users to ensure that we understand key relationships and concerns in their lives. Responding to needs that are identified could include seeking advice from the safeguarding team, signposting or referring to other agencies or offering the relevant mental health support.

The Trust Think Family approach ensures that we work in partnership with our service users and their families in the delivery of their care and as part of a much wider support network of agencies and avenues of support to meet the needs of the whole family. The Trust Think Family approach aims to ensure that our service users and their family's lives are understood, their wellbeing is promoted and, most importantly that they are safeguarded from abuse and neglect.

This approach means that anybody who works with children or adults in any role will be working holistically and identifying needs that any family member may have and getting them the right support. This will be done by practitioners coordinating their efforts with other family members' workers, sharing information and becoming part of a "team around the family."

For more information see the Safeguarding Hub Safeguarding - Safeguarding (sharepoint.com) and see the BSMHFT SG Policies R&S 26 "Safeguarding adults" and R&S 34 "Safeguarding Children and young people".

20 CMHWS Governance Arrangements

20.1 Record Keeping

Rio is the primary system that will be used for patient record keeping. Record keeping should be commensurate with BSMHFT Care Records policy (C12) and Care Management and CPA policy (C01), which should be adhered to at all times.

It is essential that each contact is documented and communicated to relevant team members. Whenever there is a change in the service user's contact details and/or clinical presentation, all core documentation must reflect this.

Your care connected is an information sharing protocol established within BSMHFT Sustainability Transformation Programme – care records from other sectors such as Primary Care may be available to access via Rio after practitioners have undertaken the appropriate training.

20.1.1 Core NMHP Clinical Documentation

Clinical documentation will be completed on Rio as the primary EPR system. Due to nature of the NMHP, some brief notes and outcomes of contacts will be captured on the GP EPR system by NMHP practitioners.

Within the NMHP, core documentation that will be completed on Rio (as applicable) will be:

- DIALOG+ care plan
- Level 1 risk screening (where a referral to CMHP is completed or where significant risk is identified)
- MDT form (part B) where a MAT meeting discussion has taken place

20.1.2 Core CMHP Clinical Documentation

Within the CMHP, core documentation that will be completed on Rio (as applicable) will be:

- Assessment Summary
- Risk Screening Level 1
- HoNoS and Care Cluster
- DIALOG+ Care Plan
- Advance Statement
- CPA review documentation as required
- Where discussed in MDT, completion of MDT form.

20.2 Prescribing Arrangements and Medication Management

All staff within the CMHWS with prescribing responsibilities are required to adhere to the respective Trust Medicines Code Policy and the Trust policies and procedures in relation to prescribing and prescribing supervision arrangements.

Dependant on individual's' diagnosis and treatment plan, medications may be prescribed with restrictions imposed by the Medicines and Healthcare Products Regulatory Authority, that present limitations as to who can prescribe specific medications such as clozapine; an antipsychotic for treatment resistant schizophrenia. In such cases, colleagues are required to follow relevant Trust guidelines such as the Use of Clozapine Guidelines to support the initiation, monitoring and management outlined by the Trust pharmacy team.

20.3 Risk and Incident Management

20.3.1 Clinical risk management

All members of the CMHWS will be required to follow the Clinical Risk Assessment and Management policy, to ensure a consistent approach that attempts to balance clinical responsibility, lifestyle choices and therapeutic risk management.

Identified clinical risk should be recorded within Rio and the safety of the service user and those around them should be discussed as an integral part of regular caseload management discussions. Concerns about appropriate management of clinical risk should be escalated to the Clinical Leads or Team/Hub Manager and Consultant Psychiatrist with a plan to discuss and resolve at the earliest opportunity.

20.3.2 Incident reporting / management

If an untoward or serious incident occurs, incidents should be recorded on eclipse as per the BSMHFT incident management policy and the policy must be followed. For those staff who work on non-BSMHFT sites (e.g. NMHP practitioners based in GP surgeries), they must also follow the local policies and reporting processes for that service / organisation.

BSMHFT operates a zero-tolerance policy for violent or abusive behaviour. It is expected that team managers and senior clinicians will address issues and reinforce this policy as and when issues arise. The BSMHFT Management of unacceptable behaviour policy outlines how such behaviours should be managed.

20.4 Lone working arrangements

Practitioners working within the CMHWS will adopt lone working practices, unless presenting risk determines otherwise, and are required to follow the BSMHFT Lone Working policy. Staff must utilise the personal protective equipment supplied by BSMHFT (e.g. Peoplesafe device), where applicable.

The lone working policy outlines that where teams are undertaking visits to community locations and the homes of service users, the risks of undertaking these visits should be regularly reviewed by the team.

Where significant risks are identified, a risk mitigation plan should be established and, where there is a history of violence from a service user and/or the location is high risk, consideration should be given as to whether visits can take place at an alternative location e.g., a Trust premises.

If a staff member still has concerns about their safety, despite risk mitigation plans being created and enacted, concerns should be escalated to their Team Manager or Clinical Service Manager (in hours) or to the On Call Manager (out of hours).

21 Relevant Documents

- BSMHFT Accessible Information and Communication for Service Users and Carers Policy (C32, August 2019)
- BSMHFT Admission, Transfer, Discharge and Follow Up Policy (C51, August 2022)
- BSMHFT Advance Statements and Advance Decisions Policy (MHL03, April 2019)
- BSMHFT Care Management & CPA/Care Support Policy (C01, April 2019)
- BSMHFT Care Records Management Policy (C12, April 2019)

- BSMHFT Referrals and appointments Policy (C11, January 2023)
- BSMHFT Lone Working Policy (RS04, July 2019)
- BSMHFT Missing Patient Policy (C37, March 2017)
- BSMHFT Safeguarding Adults Policy (R&S 26, August 2018)

22 Appendices

22.1 Appendix 1: CMHT Duty Standards

CMHT Duty Standards

Reason for call needs to be understood upon receipt of initial contact (e.g., request for medication, enquiry regarding appointment, request for supporting letter, worsening of mental health, etc) by admin staff so that it can be appropriately signposted to the correct pathway. On those occasions where the service user declines to give the reason, please explain that without this information we can not appropriately signpost or triage for urgency. If they continue to decline, then call will have to be put through to duty for further triage and redirecting, if appropriate.

Services, including those outside of CMHTs, are not to advise or inform service users to routinely 'walk in' to see Duty and should instead be encouraged to call in the first instance. If this continuously and persistently happens, then please escalate to the team / hub manager so that plans can be put in place to address / mitigate this.

All patients who attend community hubs without an appointment will be initially welcomed by reception. If it is for routine enquiries (as listed below) then the appropriate clinician is to be contacted to deal with the patient's needs. If the patient's concern is related to their current mental health and the issue cannot wait until their next planned appointment, the duty clinician should be contacted to triage.

Duty should attempt to resolve the issue on the initial call (where follow up or further advice from other professionals is not required) and they should not routinely be booking patients in face to face, unless it is felt that onwards referral is required e.g., home treatment.

Any calls received by admin where the service user is distressed ++ or expressing suicidal thoughts, a phone call should be made directly to Duty to inform them.

Where we receive an internal call (from BSMHFT) who request to speak with duty or a call from emergency services who are currently with or on their way to a service user, then this call should be put directly through to the duty clinician, or the direct extension number should be given.

All service users will be contacted by telephone within 48 hours (two working days) for routine and same day for those who are expressing clinical risk (e.g., suicidal, aggressive / violent behaviour, significant self neglect). There is an expectation that Duty will not be asked to see service users by other mental health professionals who have seen the patient in the last 72 hours, unless there is a change in their presentation / risk or a clear rationale is provided. The function of duty is to provide crisis support to those who are known and open to the CMHT to enable further assessment and appropriate planning (e.g. refer to ANP / medic for medication changes, refer to HT, etc).

Unless there is a suspected overdose or a physical health concern, requiring immediate medical assistance, we do not advise to call an ambulance or direct service users to A&E. If there is an immediate risk of harm to self or others we should contact the emergency services to request urgent attendance. Where emergency services need to be called, or service users are directed to attend A&E, an incident form must be completed via Eclipse and the CMHT clinician should phone Liaison Psychiatry to advise of potential referral. A follow up plan for CMHT must be recorded in the progress notes so as to assist Liaison Psychiatry / Urgent Care Clinicians with formulating an appropriate plan.

Duty will operate from 09:00 – 17:00 however protected time will be given from 16:30 onwards to allow for completion of the daily tasks and to effectively triage the remaining calls. If any of the remaining calls are

urgent, including any calls from 16:30 onwards, then it is expected that Duty will triage this and either make plans for the service user to be contacted first thing the following morning or to signpost appropriately to an alternative service. This triage may include contacting the service user directly to ascertain the most appropriate and clinically safe plan.

Duty (including those on 'back up') needs to be on site and not having routine appointments booked into their diaries. Where this is not possible (e.g. occasional remote support owing to staffing pressures, COVID+ but fit to work, etc), then the team / hub manager is to be made aware. Duty working remotely should be the exception and not the rule.

All calls to be recorded in Rio diary as Duty contact, not planned or unplanned contact.

For all contacts, the duty clinician needs to ensure that the lead clinician / care coordinator has been informed, even if there is no further action nor follow-up required at that time. Any increase in duty contact should be escalated for discussion in MDT.

There needs to be a standardised approach of recording duty contacts in the progress notes. Therefore, the use of SBAR (Situation, Background, Assessment, Recommendation) will be used by all clinicians undertaking this role (including those who support the extended CMHT duty line).

Escalation process – allocated senior clinician to make contact with Duty halfway through the working day to review resources and volume of calls that are outstanding. If demand exceeds capacity, then a robust plan is to be put in place at this time. If robust plan is not possible then to be escalated to the Team / Hub Manager.

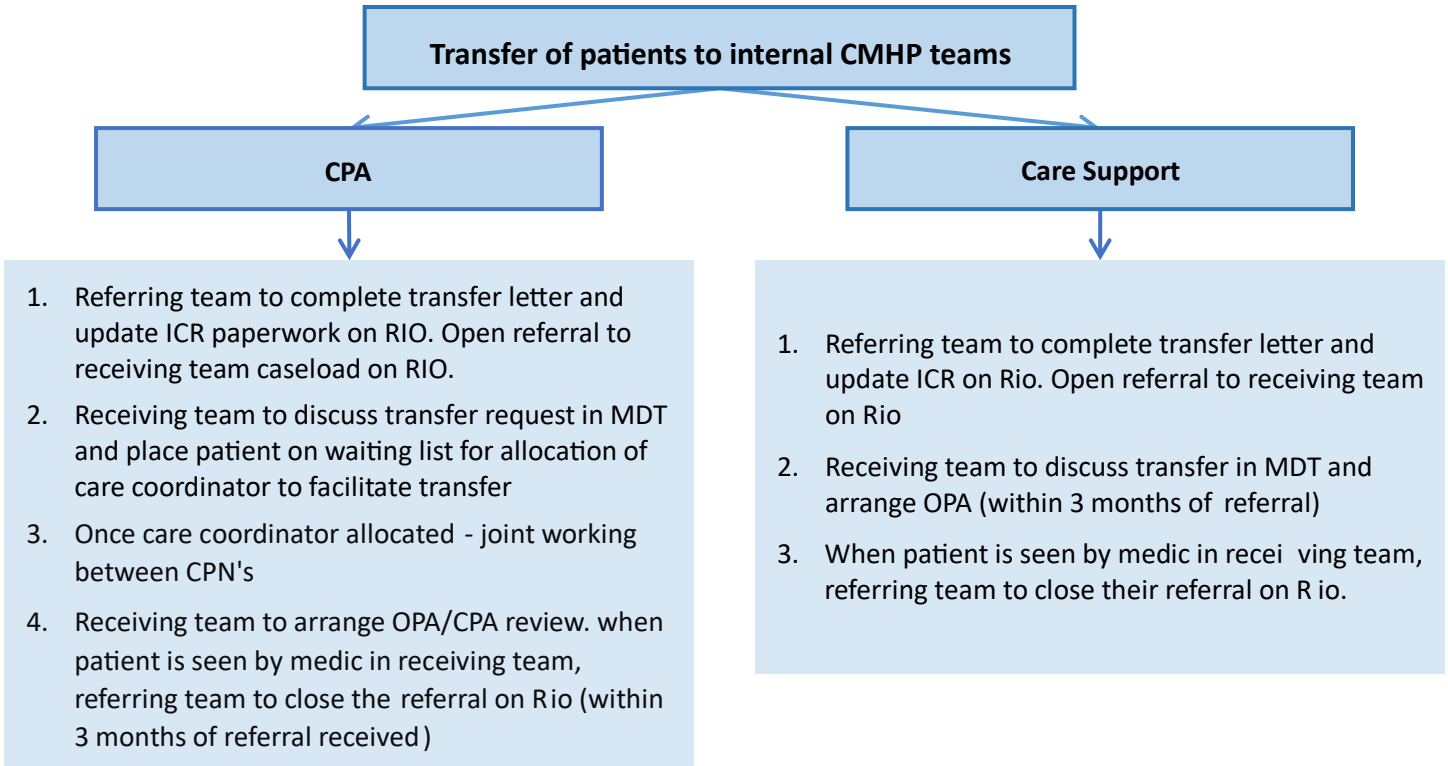
Please find below a list of routine enquiries that are not to be passed to Duty. Please note that this list is not exhaustive and is for guidance only:

- Medication queries, requests for prescription should be signposted to medical secretaries, lead clinicians or the allocated care co-ordinator.
- Requests for changes to appointments (e.g., cancellation, to be brought forward, etc) should be signposted to medical secretaries, lead clinicians or the allocated care co-ordinator.
- Query about diagnosis, current prescribed medication, letter from last OPA, etc should be signposted to medical secretaries, lead clinicians or the allocated care co-ordinator.
- Raising complaints / concerns should be signposted to the team manager / clinical leads.
- PIP forms / DVLA forms / Supporting letters should be signposted to medical secretaries, lead clinicians or the allocated care co-ordinator.
- Any service user under CPA should be signposted to the care coordinator in first instance.
- Actions from MDT should be assigned to the most appropriate team member. These are not to be given to Duty unless Duty has requested that it be brought to MDT.
- Gathering of collateral information from routine appointments should be made by the clinician undertaking the appointment or by appropriate admin support.
- Service users who have had their routine appointments cancelled with short notice. Duty is not a substitute for planned appointments. If duty is asked to call then this must be due to a clinical rationale and not to fill a gap in the service.
- It is not the responsibility of Duty to issue pre-ordered / requested FP10s or TTOs. The responsibility for this sits with the allocated clinician.

22.2 Appendix 2: Transfer Process – Internal CMHP to CMHP

1. Referring team will open referral to receiving CMHT based on GP and email will be forwarded to receiving team email address and copy to team manager to advise referral has been open for transfer with transfer letter as attachment. Progress note entry will be completed to reflect this on RIO. Please do not send transfer letters in post.
2. **CPA patients** – agreed timeframe for transfer within **3 months of referral**. This would include allocation of CPN to complete joint working and medical OPA for transfer to be completed. Where patients DNA their medical OPA appointment offered then escalation process for further discussion and plan between teams.
3. **Care Support patients** – agreed timeframe for transfer within **3 months of referral**. Where patients DNA the appointment/s offered then escalation process for further discussion and plan between teams.
4. All OPA offered must be shared with referring team in order for patient to be offered relevant support needed to ensure smooth transition of care and attendance at appointments.

NB: Please ensure all relevant ICR documentation is completed and up to date prior to transfer request being made as this may potentially cause delays in transfer. Also note 'period of stability in mental state' is not an essential criteria for transfer.



22.3 Appendix 3: Transition from CRHT to CMHP for people with a diagnosis of personality disorder.

The importance of these clinical guidelines when considering transfers of care are as follows:

- Transitions between care teams can be a time of increased risk and anxiety for any service user, but particularly for individuals where relationship difficulties can be a key part of their experience.
- Service users will hopefully form attachments with practitioners and services at a time when support is crucial to their well-being therefore the ending of these need to be considered in a way that limits the disruption to recovery.
- Transitions between teams is an opportunity to work through challenging times, distressing emotions and can help to teach service users about the natural course of relationships. Times of transition are going to cause difficult emotions for the service user and this is an opportunity to sit with the emotions and work through them without avoiding. Although difficult for clinicians, this could be seen as a therapeutic opportunity.
- With people who can experience extremely high levels of mental distress/anguish, the thought of being left alone with this causes additional stress and worry.
- Any change to arrangements is likely to cause anxiety and a sense of isolation and loneliness. It may also cause thoughts of abandonment and hopelessness.
- Self-harm and suicide attempts often occur at times of change and increased distress and therefore are likely to be more prevalent at transition points.
- The pressure on boundaries of relationships and services can increase at transition. Working together as a whole pathway will improve these transition points. Transitions can be stressful for staff too and boundaries will aid a better relationship with the service user.
- Being able to helpfully navigate a transition between services is a crucial part of our role.

For all these reasons, transitions need to be carefully considered. Transitions need to be managed with honesty, clarity, transparency and sensitivity with the aim of avoiding re-traumatisation. It is acknowledged that services may be impacted by staffing and logistical pressures which may make following these guidelines more difficult however, this should also be dealt with in a similar transparency so that services users can learn about boundaries and expectations.

Guidance regarding transition from CRHT to CMHP is already outlined in the BSMHFT Personality Disorder Care Pathway: Clinical Guidance and the following will summarise and expand on this guidance. The transition/discharge protocols as set out in the HHT SOP are equally relevant for this client group and should also be followed.

Transition to CRHT from CMHP:

When referring to a CRHT, the goals / aims of the episode of care with the team should be clear at the point of referral, documented and be clearly communicated and agreed with the service user. If there is no improvement or progress on the difficulties identified at referral in a short time frame, for example, a week, then the home treatment team should consider working towards a transition plan back to CMHP .

If referring to CRHT to access another service, for example, respite / crisis house / day service, it is important the service user is supported with their expectations until there is certainty that the service would be available for the service user. If a service is not available and the service user was expecting to access it, assume this will cause feelings of rejection, abandonment and / or hopelessness. Discussing the understandable disappointment and having an alternative plan is important.

If a person has a care coordinator or is actively seeing a psychological therapist in the CMHP , they should continue to offer face to face contacts at regular intervals during the CRHT episode. If there are exceptions, the rationale should be discussed with CRHT, recorded in the notes and any change to their usual CMHP 's care should be explained to the service user by their care coordinator/psychological therapist. Integrating

services is important to establish clear pathways for transitions between services and agencies, and facilitating well organised services, care and support.

The CRHT / CMHP must ensure they work within a 'whole system' approach and therefore need to ensure they establish good and effective working relationships with the other team to provide an integrated service. This would include holding regular interface meetings, ensuring the direct handover of care and ensuring joint working protocols are in place.

It is important that contact with the service users' family is also maintained through the crisis episode by the CMHP.

Transition back to CMHP from CRHT:

The decision to transfer care should be made through consultation between all relevant clinicians involved, the service user and carer. This consultation should also include consideration for other relevant life circumstances for example the ending of other key relationships and these should be discussed with transparency. Attempts to do this need to be documented accordingly. This transition may feel difficult for a service user, regardless of whether they have engaged with the service or not. Discussing their concerns about transition will be important and validating their feelings about it. Working closely with their CMHP should help support them in this period of change.

Discuss a transfer of care in advance and develop a structured and phased plan acceptable to the service user, that gives them a greater sense of control and reduces associated anxiety.

A clear individualised transition plan should then be followed which has been agreed between teams and the service user. If the plan needs to change at any point it will be important to involve the service user and ensure they feel heard and supported, as unexpected change at a time of transition may lead to a service user feeling more anxious.

Joint visits must be utilised to ensure the safe transition of the service user between services and to provide the opportunity to build or re-establish relationships with service users.

It will be important to ensure there is good, shared understanding with the service user, their family, carers, and relevant others of why the crisis occurred, for example chronic social factors, and how it may be managed in the future. Feeling overwhelmed by emotions can lead people to feeling they have no ways to manage on their own, but this understanding and a good crisis plan can help. Although our aim should be that a crisis plan is in place that is co-produced with the service user and their support network (where appropriate), it is important to recognise that this may not be possible. It is important the development and reviewing of a crisis plan is continually considered.