Adult Mental Health Service Directorate
in partnership with
Hampshire County and Southampton City Councils

COMMUNITY MENTAL HEALTH TEAM
OPERATIONAL POLICY
Standards for Practice

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1. Introduction

1.1 Hampshire Partnership NHS Trust (HPT) Adult Mental Health Directorate in partnership with Hampshire County Council and Southampton City Council has developed an integrated model of working for community mental health services using the stepped care approach, first outlined in the NICE Depression Guidance (2004).

1.2 This adapted stepped care model approach is shown in Appendix 1. Most of the Directorate’s existing services are positioned within Step 3 and 4. This includes Community Mental Health team (CMHT) resources.

1.3 The purpose of this policy is to ensure that there are common standards of practice, language and operational systems by which all the CMHT’s function. This is an evolving policy and will be reviewed comprehensively six months post implementation.

1.4 The CMHT resource will be targeted specifically at Steps 3 and 4 of the Stepped Approach, i.e. those who are most unwell who require specialist mental health input, building robust interfaces between Primary Care mental health, Improving Access to Psychological Therapies (IAPT) projects and more specialist mental health services and provision.

1.5 This policy sets out the expected standards of service delivery, functions and operational processes in each CMHT within the Directorate to ensure the delivery of high quality community mental health interventions, and to promote recovery of people who experience mental health difficulties.

1.6 This is a public document and will be accessible to service users, carers and other stakeholders interested in the work of the CMHTs.

2. Values and Aims of the Service

The vision of Hampshire Partnership NHS Trust is to excel in enabling individuals with mental health needs and learning disabilities to achieve the best quality of life.

2.1 Underpinning the practice of the CMHT will be the following values identified within the ‘Ten Essential Shared Capabilities’ (2005):

- Working in partnership
- Respecting diversity
- Practicing ethically
- Challenging inequality
- Promoting recovery
- Identifying people’s needs and strengths
- Providing service user centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning

2.2 All CMHTs will work towards achieving the following outcomes for service users:
• Improved health and well-being
• Improved quality of life
• Choice and control
• Freedom from discrimination
• Personal dignity

3. **Customer Care Standards**

3.1 The Adult Mental Health Services Directorate has an agreed set of customer care standards. It is our aim to engage with and listen to our service users, carers and other stakeholders in order to be able to determine and deliver responsive, high quality, value for money, user focussed services.

3.2 We will ensure:

• All staff introduce themselves to service users and carers by name, explain their job role and address them in the manner of their choice

• Staff badges are worn and/or proof of their identity is shown when appropriate

• Service users are offered a choice of appointment times

• Staff arrive punctually for agreed appointments and give explanations for any delays

• Appointments are only cancelled by staff in exceptional circumstances

• The appointment time is protected and takes place in a private environment

• When answering the telephone staff give their name and the name of the service you have reached and redirect your call appropriately or take a message

• If we have not been able to answer your call, you can leave a message and we will call you back within one working day

• Staff will provide information about diagnoses, medication, the range of health and social care interventions and services provided by the team.

• Service user information maybe supplemented with written information, and/or advice as to where information can be obtained about services that maybe useful to you even if we don’t provide them ourselves e.g. libraries, websites, voluntary groups etc.

• When carrying out a needs assessment and creating a care plan, staff work in partnership with service users and where appropriate, their carers

• Service users are involved in the decisions being made about their care and treatment
• The service users right to confidentiality is respected and staff will ensure that they seek ‘permission to share’ information with others wherever possible.

• Service users receive copies of their assessment and care plan documentation

• All letters, emails and publications are in plain language and easy to understand

• Information and communication is provided in alternative formats or other languages when requested

3.3 We promise to:

• Continue to improve our services by listening positively to your concerns, suggestions and/or queries.

• Actively encourage you to comment about our services by providing you with our ‘We’re here to help’ leaflet.

• Keep you informed about the progress of any complaints you may need to make.

• Learn by our mistakes

4. Eligibility Criteria

4.1 In creating the eligibility criteria for CMHT services, consideration has been given to ‘Fair Access to Care Services’ and CMHT Policy Implementation Guidance (DOH 2002, revised).

4.2 The CMHT will provide services to people as specified in the partnership agreements.

4.3 Under Section 75 of the National Service Act 2006 for the provision of integrated mental health services in conjunction with Southampton City Council and Hampshire County Council. Those eligible for a service from CMHT are those individuals who require services provided at Steps 3 and 4 of the stepped care approach.

4.4 The service is designed primarily to meet the needs of people aged between 18 – 65 years of age and where there is a concern that the individual maybe suffering from a ‘psychiatric disorder’ or serious mental illness.

4.5 Psychiatric disorders can be defined as a wide range of conditions that include;

• An acute episode of mental illness which requires assessment and intervention

• Bipolar disorders

• Psychotic disorders – including schizophrenia, drug induced psychosis
• Depression which is resistant to treatment, recurrent or significantly impairs social functioning and where primary care interventions have been unsuccessful

• Severe anxiety disorders

• Severe emotional difficulties where mental health interventions are required to manage distress and/or risk

• Personality disorder

• Conditions requiring diagnosis/medical opinion of a Psychiatrist

• Specific disorders e.g. severe obsessive compulsive disorder, phobias, post traumatic stress disorder and anxiety spectrum disorders needing secondary care specialist interventions

• People seeking gender re-assignment who require a specialist mental health assessment

• People with a dual diagnosis i.e. substance misuse, learning disability, eating disorder, alongside where there is also evidence that the person has a serious mental illness

• People with a genetic and or neuro-degenerative disease and mental illness e.g. pre-senile dementia, Huntingtons, where the person’s needs are best met by Adult Mental Health Services (refer to HPT policy CP 73 March 2008).

4.6 The following exclusions apply:

• Ongoing treatment for people with Autistic spectrum disorder including Aspergers and adults with Attention-Deficit Hyperactivity Disorder (ADHD)

• Where the primary problem is substance misuse – either illicit, prescribed or non-prescribed medication or alcohol

• Those people who present predominantly with learning disability and have no evidence of serious mental illness

• Those people with Chronic Fatigues Syndrome if no evidence of mental illness

• Those people with acquired brain injury with no evidence of serious mental illness

4.7 People presenting with their first episode of mental illness in later life (e.g. over 65 years) will be referred to the Older Person’s Mental Health service (OPMH). However, in exceptional circumstances consideration should be given to individual needs and how these can best be met by secondary care mental health services. Therefore, transferring a person between CMHT and
Older Persons Mental Health services purely on the grounds of birth date is not always acceptable. (Refer to HPT Policy CP 73 March 2008).

4.8 Young people who present with mental health problems aged between 16/17 years will come to the attention of Children and Adolescent Mental Health services (CAMHS), in the first instance. (Refer to HPT Policy CP 72 November 2005).

4.9 The CMHT will work in partnership with the local Early Intervention in Psychosis Team (EIP) who accept referrals for young people aged between 14 – 35 years old in the early stages of a psychotic illness.

5. **The CMHT Service**

5.1 For most people of working age, the CMHT is likely to be the first point of contact with specialist mental health services. In line with the revised National Policy Implementation Guide (DOH 2002), the key functions of the CMHT can be grouped under five headings;

a. Assessment – all newly referred people will have their health and social care needs assessed by the CMHT. The level of this assessment will vary according to the presenting needs/problems.

b. Signposting, advice and guidance – people who are referred to the CMHT who do not require further intervention (as described below) to meet their assessed needs may benefit from further information about local/national resources or onward referral to a more appropriate service.

c. Brief interventions – will be provided within a maximum of 12 focused sessions or of duration up to a maximum of six months

d. Interventions for people with complex and acute mental health needs – people who have been assessed as having complex mental health needs are likely to require a range of services and interventions, in order to promote recovery and to prevent deterioration (likely to be in excess of 6 months).

e. Interventions for people with complex but stable mental health needs – people who have been assessed as having complex mental health needs who require some services and interventions to maintain an optimal level of health and social inclusion (likely to be in excess of 6 months).

6. **Access to Service**

6.1 The overall care pathway for services provided by the CMHT and other specialist mental health services are set out in Appendix 2.

6.2 The opening hours of the CMHT are generally from 9am – 5pm Monday to Friday (excluding bank holidays). For a list of CMHTs and their contact details refer to Appendix 3.

6.3 An out of hours crisis and advice line is available to all current service users and their carers (particulars of how this service is provided will vary across Localities).
6.4 The CMHT aims to deliver services in a suitable environment that is accessible to the individual (and their carers). This may include a team base, General Practitioner's surgery, the service user's home or other appropriate community settings.

6.5 Home visits may be appropriate when:

- A service user has significant mobility or transport problems
- The service user’s physical and social environment is a key part of their health and social care needs assessment
- There are concerns about safeguarding children or adults
- An assessment is required of the service user’s level of functioning in their home environment
- Delivering a particular intervention necessitates the service user being at home
- Carrying out duties under the Mental Health Act (1983)

6.6 Prior to any home visit being made, a judgement of the risks will be undertaken, taking into account the Lone Working policy and if necessary, a full risk assessment will be completed. Refer to HPT Policy NCP 43 May 2007.

6.7 When an assessment under the Mental Health Act is required outside of the CMHT’s opening hours these are undertaken by dedicated ‘out of hours’ teams. CMHTs will work very closely with Crisis Resolution and Home Treatment (CRHT) teams to seek alternatives to hospital admission and intervene where a crisis has occurred with the intention of identifying the least disruptive intervention for an individual.

7. **Equality and Social Inclusion**

7.1 The aim of the CMHT is to eliminate any inequalities/differential outcomes experienced as a result of:

- Race
- Disability
- Gender
- Age
- Religious belief or faith
- Sexual orientation

7.2 Individual needs arising as a result of any of the above will be actively addressed throughout the service user’s contact with the service.

7.3 All service users and carers will be provided with information in a manner which is relevant and accessible as part of the individual’s engagement with the CMHT service.
Formats will include:

- Leaflets in plain language
- Information in languages other than English
- Large print documents
- Information on DVD/CD or on audiotape

8. **Service Delivery**

This section sets out the day to day operations for the CMHT and the core clinical business which is based on the care process e.g. assessment, care plan, interventions and review. This is multi-disciplinary in nature to provide holistic provision for service users and carers.

8.1 **Membership**

The membership of the CMHT is likely to consist of:

- Consultant psychiatrist
- Staff grade/trainee psychiatrist
- Mental health nurses
- Occupational therapists
- Social workers
- Approved mental health professionals
- Psychologists
- Vocational advisers
- Support, time and recovery workers (STRs)
- Carer support workers
- Administrative staff

8.2 **Referrals**

Referrals can be made to the CMHT by letter, fax to a safe haven, telephone and NHS net email.

8.2.1 Referrals are accepted from the following sources:

- GPs and other primary care workers
- Local authority staff
- Police
- Housing associations
- And other statutory, non-statutory and third sector organisations
- Self referrals (as per section 47 NHSCCA 1990)

8.2.2 When the individual’s GP has not been involved in the referral or the service user has accessed the service via a Fast Track agreement, the CMHT will notify him/her of the referral.

8.2.3 If the individual is not registered with a GP, the CMHT staff will support the Service User to register as soon as possible.
8.2.4 There is an expectation that an initial assessment of the individual’s mental health needs will have taken place in Primary Care first. Inappropriate referrals will be recorded on the Directorate monitoring form Appendix 4.

8.2.5 Routine referrals are those where the risk is considered low or medium. An assessment will be undertaken within 7 weeks of receipt of the original referral.

8.3 **Urgent Referrals**

8.3.1 Urgent referrals are those where the service user and/or carer are in crisis and where the information collated from the referrer (and others) indicates a high level of risk is involved.

8.3.2 Urgent referrals will be screened within 2 hours of receipt by the CMHT.

8.3.3 Once the status of the referral has been confirmed as Urgent, arrangements will be made for an individual needs assessment to be undertaken within one working day (24 hours from the point of receiving the referral).

8.3.4 If an urgent referral to CRHT is anticipated following the first presentation of a service user to the CMHT there will be a requirement for a face to face interview to be carried out in accordance with CRHT Policy (section 8.1)

8.4 **Screening**

The process of screening requires the information received by the referrer to be checked to ascertain whether or not the individual being referred meets the eligibility criteria to received services from the CMHT. It may be necessary, at this stage to obtain further information from the referrer about the individual’s needs.

8.4.1 Screening of referrals should take place daily.

8.4.2 Where a referral is deemed inappropriate and does not meet the eligibility criteria for CMHT services this information will be communicated to the referrer and signposting to more appropriate interventions maybe necessary.

8.4.3 The level of all those referrals screened as being appropriate for CMHT involvement will be categorised at this point, as either;

- Urgent or;
- Routine

8.5 **Assessment**

An experienced mental health practitioner will undertake an assessment of the Individual’s health and social care needs using a standardised format.

8.5.1 Referrals from other HPT services will be accompanied by the service user’s needs assessment, risk assessment and other information, to minimise duplication.
8.5.2 The same standards of service are applicable to internal referrals from other Hampshire Partnership Trust services. Carers maybe referred to the relevant carers support worker for their own needs assessment.

8.5.3 The outcomes of the assessment will determine if the service user is offered brief intervention with a lead professional, care co-ordination, onward referrals to other specialist services or transfer back to primary care.

8.5.4 A copy of the assessment summary will be offered to the service user, their carer when appropriate and sent to the referrer within 10 days.

8.6 **Allocation**

All referrals for care co-ordinator allocation will be discussed at a multi-disciplinary team meeting and allocated to a named Care co-ordinator within one working day of the meeting.

8.6.1 Referrals from inpatient services will be allocated within 48 hours of receipt. Until allocation is made the CMHT Manager will undertake this role.

8.6.2 All workers will be assigned a colleague as a ‘buddy’, who will be available to their allocated service users when they are away on annual or sick leave. In some instances this maybe provided by the CMHT duty system.

8.7 **Management of Risk**

The assessment and management of risk is an integral part of the screening and assessment processes.

8.7.1 Risk Management is an ongoing process and will automatically be reviewed at:

- Care process reviews;
- When there is significant change in the Service Users circumstances;
- Known ‘risk triggers’ are activated;
- When there are safeguarding children and/or adult issues or domestic violence concerns (MAPPA/MARAC)\(^1\).

8.7.2 All information relating to risk assessment and management plans will be recorded in the service user’s case note records and on the HECS IT system.

8.7.3 Information relating to the individual’s risk screening, management plan and/or crisis plan will be communicated in a timely, concise and effective manner to all those concerned in providing care, including external agencies.

8.7.4 The principles of the Data Protection Act and Caldicott guidance will be adhered to as this information will be provided on a need to know basis.

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1 Refer to Trust Policies and inter-agency protocols on safe guarding adults and safe guarding children.
8.8 Care Planning

8.8.1 All service users will be offered a copy of their care plan. If they are subject to a CPA, service users are expected to agree and sign their care plan along with the allocated worker.

8.8.2 The CMHT will keep GPs informed in writing of any changes to an individual's care plan including medication changes. This will occur on a 6 monthly basis if there are no changes to the plan.

9. Interventions

9.1 Functions

CMHT resources will be organised to provide two discreet functions in addition to a Duty Service;

- Brief interventions – will be provided within 12 focused sessions or of duration up to a maximum of six months.

9.1.1 And provision of services for those service users with complex care needs.

- Interventions for people with complex and acute mental health needs – people who have been assessed as having complex mental health needs are likely to require a range of services and interventions, in order to promote recovery and to prevent deterioration (likely to be in excess of 6 months).

- Interventions for people with complex but stable mental health needs – people who have been assessed as having complex mental health needs who require some services and interventions to maintain an optimal level of health and social inclusion (likely to be in excess of 6 months).

9.1.2 Dependant upon the outcomes of the individual's needs assessment, the multi-disciplinary nature of the CMHT means that a service user will have access to a variety of service and interventions to meet their assessed needs, which include:

- Information and advice/signposting
- Evidence-based interventions
- Care co-ordination and care management (Refer to HPT policy CP18)
- Group work
- Wellness and recovery action planning (WRAP)
- Vocational advice
- Access to direct payments and self directed support
- Medical intervention and support
- Continuing healthcare
- Access to specialist psychological therapies
- Carers assessment and support
- Onward referral to a specialist or acute service
- Or transfer back to primary care

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9.2 **Practitioner-Led Clinics**

The practitioner-led clinic (including assessment clinics and brief interventions) focuses upon service users with complex and stable needs who are not yet ready to be referred back to primary care.

9.2.1 The Clinics are designed to enable Consultant Psychiatrists to have more time for those service users with higher, complex or more urgent levels of need and to extend the role of other professional groups such as nurses, social workers and occupational therapists. This is in line with the national policy guidance ‘New ways of working’ (2006).

9.2.2 It is anticipated that the majority of service users with complex and stable needs will have their care delivered via practitioner-led clinics.

9.3 **The Role of the Duty Service**

Each CMHT will provide a Duty service from 9am – 5pm Monday to Friday (excluding bank holidays).

9.3.1 This service will be provided by a named qualified member of staff within the CMHT and will have access to the Duty Manager/Team Manager or Senior Practitioner for advice, support and decision making.

9.3.2 The Duty officer is available:

- For existing clients who cannot reach their lead professional, care co-ordinator or buddy
- To provide a ‘buddy’ function for service users as appropriate
- To offer advice and information to other agencies
- To take telephone referrals
- To undertake urgent assessments as required

9.4 **Managing the Most Unwell**

Those defined as the ‘most unwell’ are service users who are acutely disturbed and vulnerable to serious deterioration in their mental state and who may or may not require admission to hospital. The CMHT will target the delivery of care to this group of people through the following actions which will be carried out on a weekly basis;

- Identify those who are **most** at risk (to either themselves or others)
- Consider the needs of those people identified
- Ensure all parts for the specialist mental health network (i.e. Crisis resolution and home treatment team, local inpatient provision etc.) are aware of the individuals who have been assessed by the CMHT as being **most** at risk.
9.4.1 Those Service Users who are identified as being most at risk will be reviewed on a regular basis. It is the responsibility of the CMHT Manager to ensure that there is a local reviewing system in place.

9.5 **Discharge**

Following the implementation of the care plan and in discussion with the service user and those involved, discharge from the CMHT will be arranged.

9.5.1 Prior to discharge it is essential that the Section 117 Mental Health Act 1983 status of the service users is checked and recorded.

9.5.2 A written discharge summary will be provided to both the Service User and their GP within 10 days of discharge.

9.5.3 The summary will include;

- A summary of interventions provided
- The effectiveness of those interventions
- Recommendations for the ongoing or future treatment (including medication);
- Identified triggers and/or an indication of the early warning signs of future deterioration of the individual’s mental health
- Arrangements for referral back to CMHT if required.

9.5.4 The discharge summary will be filed in the service user’s case notes and recorded on HECS (and any other relevant IT systems).

9.6 **Fast Track back into CMHT Services**

When a service user is transferred back to the care of their GP consideration will be given by the CMHT to any future care needs that the service user may have. This may include the need for the service user to be able to refer him or her self back to the CMHT if their mental health condition deteriorates significantly. This is known as a ‘fast track’ referral.

9.6.1 The agreement for fast track referral will be recorded on a discharge care plan as part of the discharge planning meeting.

9.6.2 The period for which the service user is be able to use the fast-track referral route back into the CMHT service will be defined prior to discharge, and will not exceed 6 months.

9.6.3 In the event of a fast-track referral back into the CMHT, the service user’s health and social care needs will be assessed within 7 working days to agree the future care plan.
10. **Working in Partnership**

10.1 Partnership working is actively promoted within the CMHT as a mechanism for improving health and social care outcomes for service users.

10.2 Partners may include:

- Service users and carers
- Primary care workers
- Other local authority staff
- Police and probation services
- Voluntary and third sector organisations and community groups
- Housing associations
- Liaison teams
- Link workers

10.3 The CMHT offers advice and support to colleagues within Primary Care Services through the provision of a link worker for each GP’s surgery within the Trust’s catchments.

10.4 Medical advice and information to GPs and Primary Care staff is made readily available and all enquiries will be responded to within 4 hours.

10.5 When Service users are assessed as having a dual diagnosis (predominantly mental illness combined with a learning disability, physical disability or misuse of substances) the CMHT will work in partnership with other specialist teams.

10.6 When the service user’s primary diagnosis relates to their mental health the CMHT will take responsibility for case management.

10.7 CMHTs will work in conjunction with other professionals and agencies to provide education and guidance about mental health issues.

11. **Engagement and Participation with Service Users and Carers**

11.1 The CMHT will work flexibly to engage service users and carers in delivery of services which are user focused and seek to include service user and carer representatives in the planning and review of care plans, offering choice wherever possible.

11.2 The CMHT will work flexibly in the time and location of appointments, choice of worker, offering second opinions and the overall approach to the individual needs of the service user/carers.

11.3 The views of service users and carers are central not only to making decisions affecting their own lives but in more general policy development and monitoring of services and this should be seen as an important function of engaging service users/carers.

11.4 Service users will not automatically be discharged from the CMHT for non-engagement if they have on-going mental health needs (refer to ‘Difficult to Engage’ Service Users policy – HPT policy CP29 August 2008).
11.5 A service user may choose to cease contact with the CMHT without full discharge arrangements having been made (refer to Non Attendance Policy (DNA) HPT Policy CP 28 August 2008). In this instance a closure plan/letter will be written to the service user, their GP and any others involved.

12. Management Arrangements

12.1 Workload Management

The CMHT manager is responsible for monitoring the team’s workload, ensuring that systems are in place for setting priorities for allocation and discharge and making certain that there is an equitable distribution of cases across team members\(^2\).

12.1.1 In fulfilling this function the following factors will be taken into consideration:

- The service’s eligibility criteria
- Prioritisation of those in greatest needs
- Team members individual caseloads and functions that they serve (i.e. brief intervention or complex acute/stable)
- Individual capacity
- Impact on discharge on service user and carer and primary care services
- AMHP duty commitment to a monthly rota

12.2 Supervision

The CMHT manager is responsible for ensuring that each team member receives management and professional supervision according to individual need and experience.

12.2.1 Supervision arrangements will be in line with HPT’s supervision policy (refer to HPT Policy NCP 14 – Sept 2003).

12.2.2 Each member of the CMHT will receive a minimum of monthly management supervision.

12.2.3 Notes from each supervision session will be recorded and signed by both the manager and a member of staff, with copies for both.

12.2.4 Team members will also be able to access advice and consultation through the CMHT clinical meetings and one to one meetings with senior professionals.

12.2.5 Each CMHT member will also receive a minimum of monthly clinical supervision by a senior member of the team or senior professional with recognised expert knowledge and experience in a given area and who is trained/experienced in delivering supervision.

12.3 Record Keeping and Confidentiality

All written records must adhere to the Trust/Local Authority recording policies and in accordance with professional standards to provide an objective overview of all contacts and actions relating to the individual service user.

As far as possible this should be within a single set of records for each person, to which all team members have access to enable cohesive case management.

12.3.1 All records, paper or electronic are kept within the guidelines of the data protection act and are treated as confidential documents. Information is only shared on a 'need to know' basis with the service user’s permission and under the scrutiny of the Caldicott principles, unless the situation meets necessary risk requirements which would require those rights to be breached.

12.4 The Multi-disciplinary Team

CMHT staff will have a range of skills which are described within the ‘Capable Practitioner’ (2001) and the ‘10 essential shared capabilities’. The specific role of each professional group will be in line with those set out in New Ways of working.

12.5 Clinical Team Meeting

The CMHT will hold a multi-disciplinary team meeting every week to discuss in-patients, the most unwell, new assessments, as necessary.

12.6 Leadership Meeting

To ensure key operational issues which affect CMHT performance and operational working are addressed there will be a monthly meeting attended by senior CMHT members including the CMHT manager, Consultant Psychiatrist, Advanced Practitioner and the lead administrator.

12.7 Business Meeting

To ensure good communication among all team members, regular business/team meetings will be held to discuss the following:

- Team brief
- Key performance issues
- Local issues
- Health and safety
- AOB
- These will be held at least monthly

13. Health and Safety

13.1 It is the responsibility of the CMHT manager to ensure that all staff attend relevant Health and Safety training as determined in the essential training programme or if identified by local risk assessment.

13.2 All CMHT staff must ensure that they are familiar with and conform to the Trust’s Health and Safety policy and procedures including the lone working policy, Fire safety, incident reporting, recording and reviewing.

14. Complaints and Compliments
14.1 All complaints are passed to the team manager who will investigate them and respond formally in writing. Should this not achieve a satisfactory outcome other courses of action maybe required as detailed within the Hampshire Partnership Trust/Local Authority complaints procedure.

14.2 Compliments will also be passed to the team manager and then be recognised formally within Team Meetings and Trust Bulletins.

14.3 Should a service user or carer wish to comment about the service they have received the Patient Advisory and Liaison Service (PALS) offers a means of resolving concerns of service users and carers at an early stage. Using PALS is an alternative to raising a formal complaint. CMHT staff should provide the service user and/or carer with a copy of the PALS leaflet - ‘We’re here to help’.

15. **Audit and Quality**

15.1 HPT has a robust audit cycle which enables quality of service delivery to be monitored and improved when necessary.

15.2 CMHT managers are expected to return caseload management data on a monthly basis (refer to section 10.1).

15.3 Activity data is captured and reported on as a requirement of the commissioning arrangements.

16. **Fulfilling the requirements of the Race Equality Impact Assessment**

An equality impact assessment has been completed for this policy.

17. **References/related policies/legal frameworks**

- National Service Framework for Adults of Working age (September 1999).
- Mental Health Policy Implementation Guide: Community Mental Health Teams (July 2002).
- Depression: Management of depression in primary and secondary care, National Institute of Clinical Excellence (NICE).
- The Capable Practitioner: A framework and list of the practitioner capabilities required to implement the National Service Framework for Mental Health, Sainsbury Centre for Mental Health (April 2001).
- The Ten Essential Shared Capabilities: A framework for whole mental health workforce, Sainsbury Centre for Mental Health, National Institute for Mental Health in England (NIMHE) and National Health Service University (NHSU).
• New Ways of Working in Mental Health, NIMHE (November 2006).
• The Mental Health Act 1983 and amendment 2007
• Care Programme Approach (LASSL (90) 11).
• Effective Care co-ordination (SSI/NHSE 1999)
• Children Act 1989
• Working together (DoH 1999)
• Every Child Matters (DfES 2004)
• No Secrets (DoH 2000)
Appendix 1

Community Mental Health Team Operational Policy

ADAPTED STEPPED APPROACH FOR CMHTs
(REFERENCE NICE DEPRESSION GUIDANCE)

December 2008
### Appendix 3

**Community Mental Health Team Operational Policy**

**CMHT CONTACT DETAILS**

<table>
<thead>
<tr>
<th>Locality</th>
<th>Address</th>
<th>Contact Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Hants</td>
<td><strong>Tadley CMHT</strong>&lt;br&gt;Mulford Hills Centre&lt;br&gt;37-39 Mulford Hills&lt;br&gt;Tadley&lt;br&gt;Hampshire&lt;br&gt;G26 3HX</td>
<td>0118 981 0033</td>
</tr>
<tr>
<td>North Hants</td>
<td><strong>Basingstoke CMHT</strong>&lt;br&gt;c/o Bridge Centre&lt;br&gt;New Road&lt;br&gt;Basingstoke&lt;br&gt;Hampshire&lt;br&gt;RG21 7RJ</td>
<td>01256 316300</td>
</tr>
<tr>
<td>North Hants</td>
<td><strong>Alton &amp; Borden CMHT</strong>&lt;br&gt;Elizabeth Dibben Centre&lt;br&gt;Pinehill Road&lt;br&gt;Borden&lt;br&gt;Hampshire&lt;br&gt;GU35 0BS</td>
<td>01420 488008</td>
</tr>
<tr>
<td>Mid Hants and Eastleigh</td>
<td><strong>Eastleigh CMHT</strong>&lt;br&gt;Desborough House&lt;br&gt;1 Desborough Road&lt;br&gt;Eastleigh&lt;br&gt;SO50 5NY</td>
<td>01962 825507</td>
</tr>
<tr>
<td>Mid Hants and Eastleigh</td>
<td><strong>Winchester CMHT</strong>&lt;br&gt;Connaught House&lt;br&gt;63b Romsey Road&lt;br&gt;Winchester&lt;br&gt;SO22 5DE</td>
<td>01962 825128</td>
</tr>
<tr>
<td>Mid Hants and Eastleigh</td>
<td><strong>Andover CMHT</strong>&lt;br&gt;68b Junction Road&lt;br&gt;Andover&lt;br&gt;SP10 3QX</td>
<td>01264 358180</td>
</tr>
<tr>
<td>Southampton</td>
<td><strong>Southampton East CMHT</strong>&lt;br&gt;Hawthorn Lodge, Moorgreen Hospital&lt;br&gt;Botley Road&lt;br&gt;West End&lt;br&gt;Southampton&lt;br&gt;SO30 3JB</td>
<td>02380 475130</td>
</tr>
<tr>
<td>Southampton</td>
<td><strong>Southampton Central CMHT</strong>&lt;br&gt;College Keep&lt;br&gt;4-12 Terminus Terrace&lt;br&gt;Southampton&lt;br&gt;SO14 3DT</td>
<td>02380 717204</td>
</tr>
<tr>
<td>Southampton</td>
<td><strong>Southampton West CMHT</strong>&lt;br&gt;Cannon House&lt;br&gt;6 Cannon House</td>
<td>02380 878040</td>
</tr>
<tr>
<td>Area</td>
<td>CMHT Name</td>
<td>Address 1</td>
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<tr>
<td>New Forest / TVS</td>
<td>New Forest East CMHT</td>
<td>Anchor House 67-69 Ringwood Road Totton</td>
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<tr>
<td>New Forest / TVS</td>
<td>New Forest West CMHT</td>
<td>Waterford House 142 Station Road New Milton BH25 6LP</td>
</tr>
<tr>
<td>New Forest / TVS</td>
<td>Romsey CMHT</td>
<td>5 Horsefair Mews Romsey SO51 8JG</td>
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<tr>
<td>Fareham &amp; Gosport</td>
<td>Fareham CMHT</td>
<td>Osborn Centre Osborn Road Fareham PO16 7ES</td>
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<tr>
<td>Fareham &amp; Gosport</td>
<td>Gosport CMHT</td>
<td>Hewatt House 89-91 Bury Road Gosport Hants BH25 3PR</td>
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<tr>
<td>East Hants</td>
<td>Havant &amp; Hayling CMHT</td>
<td>Park Way Centre Park Way Havant PO9 1HH</td>
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<tr>
<td>East Hants</td>
<td>Petersfield CMHT</td>
<td>Petersfield Community Hospital Swan Street Petersfield GU32 3LB</td>
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<tr>
<td>East Hants</td>
<td>Waterlooville CMHT</td>
<td>Park Way Centre Park Way Havant PO9 1HH</td>
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</tbody>
</table>
## LOG OF REFERRALS THAT ARE RETURNED TO GPs

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Referral / d.o.b.</th>
<th>G.P./Surgery</th>
<th>Reason for non-acceptance</th>
<th>Date and who discussed with G.P.</th>
<th>Date follow-up letter sent</th>
<th>Signposting / alternatives suggested</th>
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</table>
### Brief Guidelines for the completion of the Log

<table>
<thead>
<tr>
<th><strong>Date:</strong></th>
<th>The date of the receipt of the referral</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of referral / d.o.b.:</strong></td>
<td>This should include the name of the referral and the date of birth. Any other identifying codes used by the CMHT can also be entered</td>
</tr>
<tr>
<td><strong>G.P. / Surgery:</strong></td>
<td>This should include the name of the G.P. and the surgery.</td>
</tr>
<tr>
<td><strong>Reason for non-acceptance:</strong></td>
<td>This should give the detail of why the referral is deemed as ‘inappropriate’ for assessment by the CMHT</td>
</tr>
<tr>
<td><strong>Date &amp; who discussed with G.P.:</strong></td>
<td>It is expected that prior to any referral being sent back to the G.P. that there is direct contact made with the G.P. to discuss the decision. The date this discussion occurred should be entered and signed by the member of staff who has had the conversation.</td>
</tr>
<tr>
<td><strong>Date follow-up letter sent:</strong></td>
<td>It is expected that if a referral is sent back to a G.P. that, following a direct discussion with the G.P., a follow-up letter is sent detailing the agreed plan. The date of the letter should be entered.</td>
</tr>
<tr>
<td><strong>Signposting / alternative suggestions:</strong></td>
<td>Any signposting or suggestions of alternatives discussed with the G.P. should be entered here.</td>
</tr>
</tbody>
</table>