# Adult Mental Health Community Mental Health Team Standard Operating Procedure

**Version:** 2

## Summary:
Southern Health NHS Foundation Trust (SHFT) Adult Mental Health Service in partnership with other statutory agencies such as Local Authorities and Police services have developed a way of working together to provide a community care pathway within Hampshire and Southampton City.

## Keywords:
- Adult Mental Health
- Community Mental Health Team
- Community Care Pathway

## Target Audience:
Adult Mental Health Staff

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Adult Mental Health

STANDARD OPERATING PROCEDURE
Community Mental Health Team
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1. Introduction

Southern Health NHS Foundation Trust (SHFT) Adult Mental Health Service in partnership with other statutory agencies such as Local Authorities and Police services have developed a way of working together to provide a community care pathway within Hampshire and Southampton City.

2. Aim of the Service

- To promote and improve mental health and wellbeing.
- To promote independence, self-reliance and recovery
- To promote responsibility and citizenship
- To improve quality of life for patients, families and carers
- To assist individuals to remain within their communities and networks
- To work collaboratively with patients and their families
- To treat all individuals with dignity and respect

2.1 Objectives – which incorporate the WRAP model of Hope, Agency and Opportunity are:

- To provide person centred recovery focussed care
- To base care on the individuals strengths
- To provide the least intrusive and restrictive of care
- To encourage self-management and choice
- To work collaboratively with all individuals and agencies
- To utilise multi-disciplinary and multi-agency expertise
- To deliver evidence based interventions
- To apply positive risk management whilst maintaining safety

3. Service description

The Community Mental Health Team is available Monday to Friday 09:00 – 17.00hrs with some team bases opening at 08:30. All Community Mental Health Team’s offer planned shared care during weekday, weekends and bank holidays.

Community Mental Health Team is an umbrella term for a range of adult mental health community based functions and interventions that are delivered by a multi-professional team, consisting of nurses, occupational therapists, clinical psychologists, psychological therapists, psychiatrists, and health care support workers. The Community Mental Health Team provides a local single point of access for individuals who present with severe, complex and enduring mental health problems. The role of the Community Mental Health Team is to provide assessment and community-based interventions which is undertaken in partnership with referred individuals and focuses on individual needs, self-determination and recovery. To achieve this, the Community Mental Health Team works closely with other Southern Health services, acute services, Specialist Services, Primary Care services, local community networks and other agencies.

From 1st April 2016, the S75 agreement between Southern Health NHS Foundation Trust and Hampshire County Council Adult Services ceased and was replaced with a memorandum of understanding. In a number of areas the two respective organisations have continued to be co-located whilst in others they work from separate bases. HCC Adult
Services will be responsible for assessing social care needs under Section 9 of the Care Act 2014 and have developed a separate referral system with direct contact arrangements.

The Section 75 agreement remains in place within the Southampton area Adult Mental Health Teams and Southampton County Council and the teams continue to work and operate in an integrated way.

**South East Area**

Bordon & Petersfield Community Mental Health Team - Petersfield Hospital, Swan Street, Petersfield, Hants, GU32 3LB

Havant & Waterlooville Community Mental Health Team - Parkway Centre, 51 Leigh Road, Havant, Hampshire PO9 2BF

Fareham & Gosport Community Mental Health Team - Hewat Centre, Gosport War Memorial Hospital, Gosport, Hants PO12 3PW

**North Area**

Basingstoke Community Mental Health Team – Bridge Centre, Basingstoke

**West Area**

Winchester & Andover Community Mental Health Team – 68b Junction Road, Andover

Avalon House, Winchester

Eastleigh & Romsey Community Mental Health Team – Horsefair Mews, Romsey

Desborough House, Eastleigh

New Forest Community Mental Health Team – Waterford House, New Milton

Anchor House, Totton

**Southampton Area**

Southampton Central Community Mental Health Team - College Keep, Terminus Terrace

Southampton West Community Mental Health Team - Cannon House, Shirley

Southampton East Community Mental Health Team - Tom Rudd Unit, Moorgreen

### 3.1. Eligibility Criteria

Community Mental Health Team services are available to individuals who meet the criteria and have a severe, complex or enduring mental health disorder, plus one or more of the following associated needs. To provide healthcare interventions for individuals willing to engage for identified needs as outlined below.

- Poor response to previous mental health treatment in primary care
- History of violence or persistent offending.
- At significant risk of persistent self-harm or neglect
- Dual diagnosis of serious mental illness and substance misuse
- Mental health illness which mean that the individual is unable to carry on caring for a child, or the child may be at risk of harm
- Neurodegenerative disease with associated mood or psychotic disorder where needs are best met by Adult Mental Health Services.
- Assessed in IAPT services as needing a specialist mental health treatment
- Military veterans with severe and persistent mental health difficulties which are likely to be related to their service in the armed forces.
- 14 - 35 year old individuals who experience a first episode of psychosis, early intervention in psychosis will be referred to Early Intervention in Psychosis - Early Intervention in
Fast Access self-referral –  
**Patients can access directly within 6 months if identified as part of their discharge plan and agreed in Multidisciplinary Team GP & patient notified of same**

### 3.2. Exclusion criteria

This service is not appropriate for individuals with:

- Autistic spectrum disorder / Aspergers or ADHD, when not combined with a severe mental illness
- Mild to moderate anxiety and depressive disorders (Service provided by IAPT and Primary Care)
- Brain damage. Organic disorders including dementia, and early onset dementia, where Older persons Mental health service are best placed to provide care
- Anger control and violence without associated severe mental illness
- Somatic problems such as chronic fatigue syndrome, chronic pain in the absence of severe mental illness
- Disorders of sexual preference (e.g. paedophilia, fetishism) without associated severe mental illness
- Addictive behaviour (e.g. persistent drug or alcohol misuse or gambling) in the absence of severe mental illness
- Suicidal ideation with no intent and no history or diagnosis of mental illness

### 3.3 Key roles within the Multi-Disciplinary Team

Community Mental Health Team services are multi-disciplinary and share a common orientation promoting the principles of recovery. Each patient accepted onto the team caseload will be given a lead professional / care coordinator who will take the lead responsibility for their care. However, given the intensive nature of the team's work; a collaborative whole team approach is required with clinical responsibility shared across the team. The skill mix encourages the use of a diverse range of approaches, interventions and treatments.

The Multi-Disciplinary Team could consist of the following staff:

- Team Manager / Team Leader
- Consultant Psychiatrists and other medical staff
- Occupational Therapists
- Mental Health Nurses/Mental Health Practitioners
- Health Care Support Workers/Assistants
- Clinical Psychologists
- Psychotherapists
- Clinical Nurse Specialists
- Admin Support Staff

### 4. The Service User Journey (within the Community Mental Health Team pathway)

The Community Mental Health Team has simplified the operational process to make the pathway easier to follow for all users of the service. Patients must give consent for engagement and receipt of interventions and this must be recorded on RIO, whilst it is recognised that a number of individuals will receive treatments under the Mental Health Act or within an assertive outreach model of engagement. Consent is implied within RIO and the team indicate if contrary to this.
4.1. Referrals

Each Community Mental Health Team will have in place arrangements to allow for referrals to be accepted, processed and acted upon within the contractual agreed timescales.

There are a variety of referral routes including telephone, letters, emails and fax. Some urgent assessments to the Community Mental Health Team may be undertaken by the Acute Mental Health Team

Referrals are accepted from Primary Care and other health professionals and tertiary services as long as the individual lives within the catchment area of the team they are being referred to. Community Mental Health Teams do not accept self-referrals from individuals unless this has been previously agreed and part of a plan of care.

When an individual lives within the catchment area but has not yet registered with a local GP then the Community Mental Health Team must ensure this does not delay referral to adult mental health services and support the individual to register if that is required.

The referrals accepted for Community Mental Health Team assessment are those categorised as:-

**Soon referrals** - to be seen within 10 working days

**Routine referrals** - are to be seen within 7 weeks

**Urgent referrals** - those to be seen within 24 hours

For those referrals suspected of First Episode Psychosis if under the age of 35 years will be referred to the Early Intervention Team for assessment. For those over the age of 35 years will be assessed and allocated within 14 days

Should individuals who are referred be unable to attend the specified base for assessment then as part of the screening process a decision would be made as to whether it would be appropriate to arrange the assessment at another venue i.e. individuals home, GP practice.

All of these decisions are based on individual needs of the individual being referred into adult mental health services and things to take into account when offering a different venue for assessment could be mobility issues or unavailability of a carer to bring the individual to the assessment.

4.2. Screening

Community Mental Health Teams will have robust processes in place to ensure that all referrals are screened daily and within 4 hours of receipt if urgent. Routine referrals will be screened based on need by the members of the Multidisciplinary Team. Screening entails cross checking referrals with RIO, archived notes, and other services who may be involved in the individuals care. If further referral information is required to determine appropriate intervention the screener will contact the referrer.

If the referrer has referred the individual as being Urgent then the referral must be treated as such unless robust communication has occurred with the referrer who has agreed an alternative time scale. This must be documented on RIO. Downgrading of a referral from urgent cannot occur without agreement from the referrer. If the refer cannot be contacted a fax must be sent to them outlining the rationale to downgrade the referral to a SOON referral

The function of screening is to ensure the referred individual receives an assessment by the most appropriate service to meet their needs if the individual needs are best met by another service e.g. primary care (IAPT), Acute Mental Health Team, Eating Disorder service, then the screener based on referral information can refer the individual to the appropriate service.
following discussion with the relevant service and the original referrer will be informed by the Community Mental Health Team that this has taken place.

4.3. **Assessments**

A comprehensive mental health assessment will be undertaken by an appropriate member of the team within agreed timescales

**Urgent assessments** – contact will be made by telephone to arrange the assessment appointment within 24hrs. If a patient cannot be contacted by telephone the referrer will be made aware and alternative means of contact agreed

**Soon assessments** - if an individual cannot be contacted by telephone then an appointment will be posted with a provision that they can contact and rearrange if the date or time given is not suitable.

**Routine assessments** - contact will be made by letter to the patient requesting they contact the Community Mental Health Team so a suitable appointment can be arranged.

Community Mental Health Teams will ensure procedures are in place to discuss all assessments within the wider Multidisciplinary Team.

If an assessor determines that the referred individual presents as a risk to self or others that cannot be managed within the Community Mental Health Team then the individual will be referred to the Acute Mental Health Team.

It may be determined on assessment that the referred individual's needs are best met at IAPT step 2 or 3 interventions as per stepped care. The assessor will liaise with the IAPT service and in agreement arrange transfer to their services. The original referrer will be made aware of the transfer.

In cases where non statutory services are recommended, signposting and information sheets will be provided.

All assessments will be discussed in a multi-disciplinary meeting at least weekly and if it is considered appropriate a lead professional / Care Co-ordinator will be allocated to develop and co-ordinate the agreed plan of care Following allocation the lead professional / care co-ordinator will make contact with the service user within 10 working days.

Following assessment all individuals will be informed of outcome of assessment by telephone and a copy of the assessment with the outcome will be sent to the individual within 10 working days of the assessment. A copy of the letter will also be sent to the referrer within 10 working days informing them of the outcome of the assessment.

4.4. **Care Planning & Review**

“CPA and care planning are simple terms for describing the process of how services help people to assess their own needs, plan ways to meet them and check that they are being met” SHCP172 Care Planning & Care Programme Approach Standard Operating Procedure for Adult Mental Health Services will be adhered to.

4.5. **Risk Assessment and Management**

The individual risk assessment for each patient will be recorded in Part B of the risk assessment section of RIO. Once an individual is accepted on a CMHT caseload a combined Crisis and My Safety Plan is required to be completed for all patients with a diagnosis of Emotionally Unstable Personality Disorder and for all patients presenting with medium to high risk.
SH CP 27 Assessment & Management of Clinical Risk Policy. This policy describes the processes SHFT uses to ensure risks relating to the clinical presentation of patients and their care and support are assessed and managed. It should be read in conjunction with the Practice Guidance for Managing Clinical Risk Document (SHCP28) which supports the implementation of this policy.

4.6. Intervention and Support

Interventions provided are based on the needs of the individual patient and may include -

- Specialist psychiatric treatment of severe and enduring mental health disorders
- Formal specialist psychological therapies – in line with best practice guidelines and Trust clinical pathways, including Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT) and Cognitive Analytic Therapy (CAT) - Psychodynamic Psychotherapy and group work.
- Psychologically informed work – may be delivered by Multidisciplinary Team staff with support and supervision from psychological therapies to ensure necessary governance, e.g. Emotional Coping Skills (ECS), anxiety management, psychologically based practitioner clinics
- Practitioner clinics
- Care Coordination
- Medication management (neuroleptics, clozapine, monitoring and medication reviews)
- Relapse prevention, development of combined Crisis and My Safety plans to prevent relapse in collaboration with their families and social networks.
- Recovery focused work including use of Wellness Recovery Action Plans (WRAP), Recovery Star
- Allocated health professional will collaboratively agree with patient the appropriate frequency of contact with services and this will be recorded within their care record.
- Weekly liaison and contact with case load of patients within the acute inpatient setting
- Physical health monitoring in liaison with primary care
- Activities of daily living assessment may be undertaken by the Community Mental Health Team Occupational Therapist and the outcome will contribute to the overall plan of care where available.
- Review of health funded high cost placement
- As agreed with the individual patient involvement of their family and carers in their recovery journey
- Personal Health Budgets

4.7. Discharge

Recovery is the focus of all mental health interventions and discharge from services is planned in partnership with the individual at their initial assessment and reviewed regularly. Discharge is based on the individual completing a recovery focused intervention, or no longer benefitting from or accepting of interventions. Where appropriate families and carers will be involved in the discharge process in collaboration and agreement with the patient. All imminent discharges should be discussed with the Team Manager, Team Leader or at the Multidisciplinary Team meeting.

Prior to discharge, it is essential that the Section 117 Mental Health Act 1983 status of the Service User is reviewed and Local Authority staff should be involved.

A written discharge summary will be provided to both the individual and their GP within 10 days of discharge and much sooner in most cases.
Disengagement of individuals with ongoing mental health needs who are deemed at risk to self and others will not automatically be discharged from the Community Mental Health Team – please refer to the Clinical Disengagement / Did Not Attend Policy SH CP 97.

The discharge summary from an inpatient admission will include:

- A summary of interventions provided.
- The effectiveness of those interventions.
- All current Community Mental Health Team recommended medication doses; frequency and ongoing monitoring arrangements should be specified.
- 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
- Diagnosis/impression
- Arrangements for referral back to Mental Health services, including fast track if appropriate.

The Community Mental Health Team will discuss all current inpatients at the weekly Multidisciplinary Team Meeting. Appropriate follow up arrangements depending on individual Service User needs will be made prior to transfer/discharge from the Acute care Pathway.

4.8. Transfer

There are arrangements for transfers between the Community Mental Health Team and other Southern Health services. Transfers will be facilitated by liaison between the services or teams and RIO transfer mechanisms, including medication, funding and placement reviews if indicated.

Allocation to a Care Coordinator or lead professional will be determined based on identified need and will always take place within 48 hours of acceptance to the Community Mental Health Team.

The default position will be the Team Manager, Team Leader or designated deputy. The Care Plan / Care Programme Approach (CPA), will be collaboratively reviewed and revised by the allocated worker in the Community Mental Health Team 4 weeks after transfer, or sooner if indicated.

4.9. Managing students when in receipt of adult mental health services and whose care transitions between services.

Community Mental Health Teams across Southern Health offer care and treatment to a large number of students. This group of service users will often transition between teams and services during the academic year. Many students may reside during holiday and study periods outside the geographical boundary of our Trust or vice versa.

In order to ensure the service user receives the optimum level of care and treatment where a service user is open to two Trusts, communication between the teams is essential. It would not be practical at each transition to undertake a care planning meeting, although a telephone handover between the teams is expected ensuring current care planning and risk information is shared. The sharing of information between teams should be discussed with the service user so that they are aware that this is happening and consent to this.

It is accepted that there will be occasions where a service user is out of contact from the Community Mental Health Team for up to four months. A record should be made in the RIO progress note stating this and the anticipated return to the area when care and treatment interventions will resume. Consideration should also be given, based on need if the service user should be discharged from the service if they are returning to University or home for an extended period.
Where a service user is not open to another team, yet the service user is having long periods without contact due to residing outside the Trust boundary, the care coordinator should explore with the service user how to access crisis services during these times if required.

5. Support for Carers and Families

In addition to the needs of the patient, the Community Mental Health Team will also work with carers and families. The Community Mental Health Teams follow best practice guidelines for liaising with friends and family about the mental health services, as well as care of the individual patient. This allows the Community Mental Health Teams to establish links and support family members even when the patient declines involvement in their care. All individuals who provide care for a person on the team's caseload should be signposted to the agreed service that will provide an assessment of their own mental and physical health needs. The Carer's service is the responsibility of HCC/SCC. If an assessment is declined by the carer then the need for an assessment should be considered and offered at each care plan review and the outcome documented on RiO.

The Community Mental Health Team will ensure that carers are meaningfully engaged and involved in individual care planning and will also identify any opportunity where a carer is expressing a wish to become further involved in aspects of service design and delivery.

The sharing of sensitive information can be difficult but is often crucial to the wellbeing of both patient and carers. Often it is the carer or family who knows the person best and it is important that the Community Mental Health Team recognises these existing relationships and work with the family and carer to manage clinical situations appropriately. The wellbeing of the carer and risks to the individual can be greatly improved if they can be encouraged to be involved in the care provided.

The Mental Health Act 1983 and 2007 has set out various roles and responsibilities which relate to carers. When a service user is assessed using the Mental Health Act, the Nearest Relative has certain legal rights which all teams need to ensure are respected and adhered to. When treating a person under the Mental Health Act, family members and other carers should be proactively involved wherever possible.

6. Specialist Functions

6.1. Shared Care

Shared Care provides high levels of planned care to a proportion of Community Mental Health Team patients who are most in need. It is not a crisis response service and does not have the facility to provide urgent assessments. Patients meet the criteria for Shared Care if they require more intense clinical intervention, for a time limited period, than a Care Co-ordinator can reasonably give them within their normal working week, and the risks associated with their presentation are complex enough to raise significant concerns for themselves or others.

Teams have regular shared care meetings to discuss all service users on Shared care and can provide planned visits for those most in need. This can include those showing signs of relapse, increasing risk and facilitate early discharge with further joint working with Acute Mental Health Team.

Teams have an at least weekly shared care meeting and interventions which may include regular daily telephone contacts, increased visits during the week, planned weekend work, monitoring of medication, enhanced liaison with police, and other relevant agencies, and increased family intervention as agreed.
6.2. Psychological Therapies

Psychological therapies are an integrated component of the Community Mental Health Teams. Psychological therapies staff are responsible for ensuring the delivery and governance of psychological interventions in line with best practice guidelines and Trust clinical pathways. This includes formal specialist therapies, including CBT, DBT, CAT, psychodynamic and group work, as well as psychologically informed work that may be delivered by Multidisciplinary Team staff with support and supervision to ensure governance, e.g. ECS, anxiety management, psychologically based practitioner clinics.

Psychological Therapy is always time limited and the psychological therapist is expected to contract all interventions with the service users.

6.3. Safeguarding

Management of safeguarding concerns in Hampshire

All employees (including bank & agency staff), volunteers and contractors are required to adhere to the policies, procedure and guidelines of the Trust, including their roles and responsibilities under this policy. (Safeguarding Adults Policy SH CP 15.2 & Safeguarding Children Policy SH CP 56)

All staff should make sure that they have familiarised themselves with their local multi-agency safeguarding policy as the Southern Health policy is designed to complement rather than replace the multi-agency policies which define the local practice that must be followed, and the local responsibilities of Southern Health staff within multi-agency safeguarding practice.

Management of safeguarding concerns in Southampton

Safeguarding concern/alert received into the service:

1. Ensure a discussion is had with one of the Team Leaders or Senior Manager to carry out the initial screening of the safeguarding concern and triage in order to make a decision about the next step required.
2. The person raising the Safeguarding concern will need to complete an incident form on the Trust incident reporting system, Ulysses.
3. The Ulysses form triggers the Team Leader/Senior Manager to put this information on the team/service log for monitoring.

Triage the following steps will be required:

1. Request for further information
2. Information gathering
3. Decision about whether Section 42 Enquiry is needed/made.
4. Closure or enquiry
5. Immediate Safety Plan and/or planning meeting
6. In-depth enquiry
7. Planning

Documenting on RiO:

1. All Safeguarding concerns will now be documented in the section on RiO called Safeguarding.
2. Click onto safeguarding this will bring up the following.
3. Click onto docs: All safeguarding
4. Safeguarding Adults Referral will appear. Please use this document to record any safeguarding concerns. It helpfully supports the Trust to record details for the Three Point Test and supports our decision making for complex safeguarding concerns.

5. Lastly, there is a Safeguarding Adults referral Outcome that should now be used to document outcomes of concerns and more complex safeguarding issues that require the trust to hold a section 42 safeguarding meeting.

6. Please indicate on Rio in progress notes that a safeguarding concern has been raised and that the detail is in the section on Rio named Safeguarding.

Example template progress note:

EAST CMHT (INSERT YOUR JOB TITLE)
SAFEGUARDING CONCERN

7. Safeguarding concern has been raised; form has been completed and saved in the Safeguarding section of RiO.

8. The escalation process will be through the Southern Health Safeguarding Corporate Team, please refer to the Intranet for detail. Team Leaders and Senior staff will be available to discuss any safeguarding concerns and escalate issue should they arise.

9. From the 16th April 2018 the Safeguarding Adults Team (SAT) within Southampton City Council was no longer available. However we will remain integrated with the Southampton City Council through Social care connect on the following number:

Social care connect: 02380833003/ singlepointofaccess@southampton.gov.uk

7. Process and System of Governance

To ensure the effectiveness of Community Mental Health Team and the safety of all who receive services there are a number of governance measures in place over and above contractual, legislative and professional regulations.

7.1 Caseload Management

All staff within the Community Mental Health Team will receive regular clinical case management from a senior colleague e.g. monthly for full time staff and pro rota for part time staff.

Case management includes review of potential or existing clinical risks, reflective practice, caseload capacity, outcome measures and discharge planning.

Community Mental Health Team Managers must ensure that caseload management is undertaken as part of the overall management of the Community Mental Health Team.

7.2 Multidisciplinary Team Meetings and Shared Care Meetings

Multidisciplinary Teams are attended in the main by Consultant Psychiatrists, Assessment Practitioners, Care Coordinators, Psychological Therapists, and Health Care Support Workers. Team Manager, Team Leaders or deputy will chair the Multidisciplinary Team. Through discussion, support, and further investigation decisions and outcomes will be determined within the forum and recorded on RIO to ensure the aims and objectives of the service are maintained in the best interest of the referred individuals. The Community Mental Health Team may hold a weekly Shared Care Multidisciplinary Team meeting or the function is integrated into the Multidisciplinary Team. It is essential that the multidisciplinary approach is utilised for individuals requiring Shared Care. A database is maintained and updated at the agreed weekly meeting and agreed degree of intervention required maintaining patient safety and preventing further deterioration.
Individuals who are assessed as high risk that do not attend appointments will be discussed at the weekly Multidisciplinary Team meeting and practitioners will then follow the Clinical Disengagement policy and all actions recorded on RiO.

Each Community Mental Health Team will hold a monthly business meeting to ensure good communication among all team members to discuss the following:

- Team brief
- Quality issues and Key Performance issues
- Health and Safety and Security
- Learning from incidents/complaints/audit etc.
- What’s going well/what we can do differently
- Hotspots
- AOB

This meeting will need to maintain robust records, these will provide evidence of the work the teams are doing to ensure that the core business is appropriately monitored, reviewed and developed and the team are kept informed.

7.3 Leadership Meeting

To ensure key operational issues which affect the Community Mental Health Team performance and operational working are addressed, there will be a monthly meeting attended by senior team members including the Community Mental Health Team Manager, Consultant Psychiatrist, Team Leader, Lead Psychologist and Senior Administrator.

7.4 Supervision

The Community Mental Health Team Manager is responsible for ensuring that each team member receives management, clinical and professional supervision according to individual need and experience. Where this involves someone other than the line manager, this will be ratified by that manager.

The Community Mental Health Team place significant importance on supervision and have developed a supervision strategy. (Appendix 19)

The supervision process will inform the annual appraisal process, to ensure that staff professional training and development needs are addressed. This will include opportunities to access professional group supervision.

7.5 Training

All staff within the Community Mental Health Team is required to complete a yearly appraisal and undertake statutory and mandatory training that is monitored by the Trust’s Learning, Education, Appraisal Department (LEAD). Each staff member is responsible in ensuring they remain compliant with statutory and mandatory training.

Other training needs will be identified at the yearly appraisal, or sooner if required, to ensure staff have the relevant skills and knowledge to provide the appropriate evidence based interventions and meet service needs.

8. Research & Audit

Research and audit is undertaken to ensure the effectiveness and safety of our services and for services to be innovative in introducing new approaches. Research and audits are registered with the Trust to ensure they are carried out appropriately and within guidance.
Various audit models may be used but the Plan, Do, Study, Act is the most common. No research should be undertaken without the Trust’s permission and the individual’s informed consent.

9. Customer Care

We work with people to promote diversity and should an interpreter be required we are able to provide patients with one.

All staff, we will be:
- Respectful
- Approachable and easy to talk to
- Pleasant and friendly at all times
- Willing to listen and really hear
- Aware of individuals varying needs
- Dressed professionally

As an organisation, we commit to:
- Involve and inform patients and Carers/family about their care
- Wear name badges; introduce ourselves to the patient, family and Carers.
- Answer the telephone – all calls should be received by a live person or forwarded to someone else that can help
- Help individuals access the right care and the right person to contact
- Always protect individuals’ privacy and their confidential information
- Take action – if we see something that needs doing, we will never say, ‘it isn’t my job’
- Respond promptly to patients’ needs – put them first
- Listen to feedback – complaints and concerns are both welcomed

We will ensure to:
- Continue to improve our services by listening positively to patients and others concerns and suggestions
- Actively encourage people to comment about our services. Keep them informed about the progress of any complaints they may make
- Learn by our mistakes
- Offer ongoing support staff and ensure that their wellbeing is maintained

10. Confidentiality

The policy, **SH IG 46 Information Sharing Policy** outlines the principles of confidentiality, and establishes an interagency code of conduct with regard to the confidential management of service user information by Hampshire County Council Adult Services, Southampton City Adult Services and Southern Health NHS Foundation Trust. The policy applies to all service user information managed in all work undertaken by employees of the parties working in Southampton and Hampshire.

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

- All records, paper or electronic are kept within the guidelines of the Data Protection Act and are treated a confidential documents. Information is only shared on a ‘need to know’ basis with the service user’s permission and under the scrutiny of the Caldecott principles, unless the situation meets necessary risk requirements which would require those rights to be breached. **SH IG 47 Disclosure of Information to Police Procedure**
10.1 Access to Health and Personal Records Procedure

- This guidance has been written to assist all staff with a responsibility for dealing with requests for personal data from service users. SH IG 12 Access to Personal Clinical records Procedure.

10.2 Freedom of Information – Summary for Staff

- From 1 January 2005 the Freedom of Information Act 2000 (FOI) gives a general right of access to all types of recorded information held by the Trust. This Act gives rights to know whether or not information is held by the Trust, and if so, the right to have that information communicated to the applicant. SH NCP 52 Freedom of Information Policy

11. Concerns, Complaints and Compliments

Any complaints are initially passed to the Team Manager who will consider whether it is appropriate to locally resolve and respond formally in writing. Should it not be deemed appropriate or the complaint is deemed complex/serious other courses of action maybe required as detailed within the SHFT complaints procedure.

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

Should a Service User or carer wish to comment about the service they have received the Customer Care Team offers a means of resolving concerns of service users and carers at an early stage of the process.

12. Resolution of Disagreements

In principle all differences of opinion should be managed within the local teams. Where these disagreements occur across interfaces the local senior managers should try to seek resolution. If resolution cannot be sought then it should be referred to the Divisional Director and Clinical Service Director.

13. Untoward or Serious Incidents

All incidents to be managed using the following procedure SH NCP 17 Procedure for Reporting & Managing Incidents

14. CQC

The Team Manager will ensure that the Community Mental Health Team meets and maintains the requirements for CQC registration.

All staff are to be made aware of requirements and professional accountabilities.

15. Information Governance

All paper/electronic records must adhere to the Trust recording policies and in accordance with professional standards to provide an objective overview of all contacts and actions relating to the individual service user.
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 Caldecott principles, unless the situation meets necessary risk requirements which would require those rights to be breached.

Each team will have a range of standard letters to ensure effective, consistent communication with referrers, service users, carers and other services. Consent to share forms will be completed with all Service Users and RIO will be updated accordingly.

RIO is the primary method for recording clinical information, secondary paper files for each individual are also held and must be referred to by the Community Mental Health Team when accepting referral for individuals who are not known to the service or who have not been with the service for over 24 months.

List of items to be filed in secondary care records can be found in the RIO handbook. Standard letters for use in clinical practice can be found in the editable letters section of RIO these can be adapted for local use and new templates requested from the RIO team.

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

All Care Plans, Crisis Plans and Risk Assessments are to be recorded on RIO in line with Trust policy. 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 individual’s permission and under the scrutiny of the Caldecott principles, unless the situation meets necessary risk requirements which would require those rights to be breached.

16. Health and Safety

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

16.1 Lone Working

This policy is designed to reflect good practice in relation to the protection of lone workers. The term ‘Lone Worker’ is used in the policy to describe a wide variety of staff who work, either regularly or occasionally, on their own, without access to immediate support from work colleagues, managers or others. This could be inside a hospital or similar environment, or in a community setting; there is no single definition that encompasses those who may face lone working situations and, therefore, increased risk to their security and safety. **SH NCP 24 Lone Working Procedure**

16.2 Policy for the Positive Prevention and Management of Violence and Aggressive incidents

Incidents of violence and aggression are a recognised risk when working in a healthcare environment; however, such incidents are unacceptable whatever form they take and whatever reasons are given for the persons actions.

The Trust accepts that the prevention of violence and aggression towards staff requires a high level of management commitment, professional competence and adequate resources. Furthermore, it recognises that actual or threatened violence and aggression towards staff can be very frightening and / or traumatic. The Trust recognises that the nature of being a
Mental Health, Learning Disabilities and Social Care Trust, will mean caring for Service Users who at times exhibit challenging behaviours and/or display behaviours which can be aggressive and/or violent. As such, The Trust will provide appropriate training to meet the diverse needs of our workforce in line with all national guidelines. SH NCP 74 Management of Violence and Aggression Procedure

17. Business Continuity

A folder is to be held within each team base describing their business continuity plan for that team/unit and an area process will be in place to raise issues.