Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
HULL INTEGRATED COMMUNITY MENTAL HEALTH TEAM AND PRIMARY CARE MENTAL HEALTH NETWORKS

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Sept 2017*	*Complete review of all processes*
2.0	*Nov 2019*	*Improvements and changes to working of CMHT and review required of document. Updates required for some areas.*
3.0	*Jan 2020*	*Improvements and changes required to reflect focused work on priorities and waiting lists.*
4.0	*Oct 2020*	*Improvements and changes following a patient incident and learning.*
5.0	*Sept 2021*	*Updated Waiting List SOP and addition of appendix 5 Specialist Community Forensics Team*
6.0	*August 2022*	*Integration of PCMHN SOP and process updates. Update to MHLT Waiting List SOP. Inclusion of Social Care flowchart/pathway. Approved by MH Division Practice Network (03.08.2022)*
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		patients with a history of harm to others. Evidence of the work with the FOLS team – 4.10 *7 – Addiitonal methods o monitoring compliance with medication to mitigate the risks of non-concordancewith treatment plans for patients with a history of non compliance and who are at risk of relapse – 4.3.5* *Clairfy role of the Hull CMHT consultant psychiatrist and when medical review of a service users care should be sought, including timescale for review when discharged from CTO– 4.3.5* *SI 2021-18031* *2b – A joint clinical review between CMHT and HBTT should be agreed* *2c – A notification fo the discahrge letter to be sent from HBTT to CMHT* *2e - Once someone has been allocated as Care Co-ordinator and the patient is open to HBTT, they should have weekly contact with HBTT to ensure they are kept updated of a patient's progress.* *All located across – 4.2.2, 4.4.2* *SI 2021-20921* *13a – CMHT SOP to include pathway or treatment from community to inpatient to prompt staff to infrom patients about what's offered within inpatient services – 4.4.2* *Approved by MH Division Practice Network (6 December 2023)*
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1. INTRODUCTION

The Hull Integrated Community Mental Health Team (CMHT) and Primary Care Mental Health Networks (PCMHN) Standard Operating Procedure (SOP) aims to support the delivery of care for community-based patients. Humber Teaching NHS Foundation Trust (HTFT) and Hull City Council (HCC) provide in collaboration and integration, a joint health and social care service to individuals with a Serious Mental Illness (SMI). SMI is a smaller and more severe subset of mental health problems defined as; one or more mental, behavioural, or emotional disorder(s) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (NIMH).

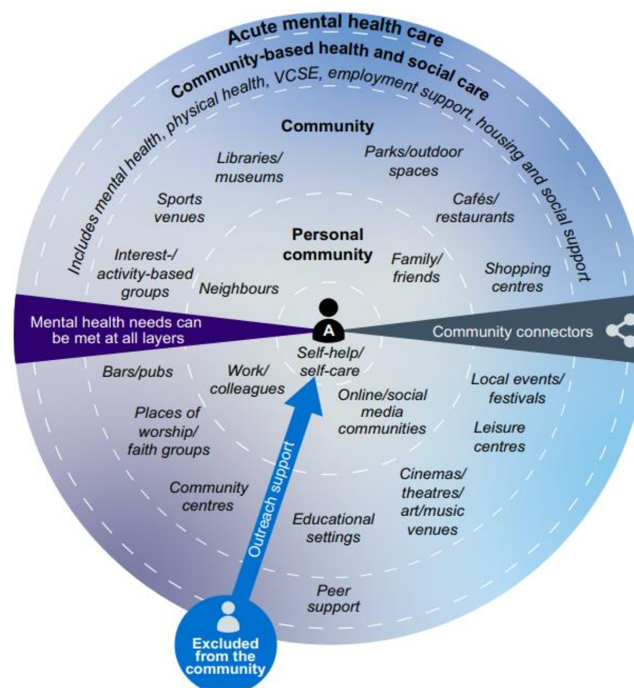
This document aims to provide operational procedures for the safe and effective day to day running of the service, ensuring equity across locality, and puts collaboration with the patient and their family at its heart.

The Community Mental Health Framework for Adults and Older Adults (2019), sets out the ambitious transformation of community mental health care with the objectives of:

- Delivering care in a place-based way
- Tackling health inequality
- Utilising the power of communities
- Reducing barriers and variations in care
- Improving access to appropriate care
- An ease of moving between services as required

This document aims to support the delivery of these objectives, alongside other implementation initiatives including the replacement to Care Programme Approach (CPA), the Four Week Wait (4WW) to treatment guidelines and integration of additional Patient Recorded Outcomes Measures (PROMs) into the patient journey.

The importance of a collaborative health and social care integrated model is demonstrated in the figure below, taken from the Community Mental Health Framework for Adults and Older Adults (2019).



This shows how mental health needs can be met by many layers, from the personal resources of the individual to their local community of friends, family and networks, up to acute level mental

health care. The person moves between their layers of support depending upon their needs at the time, and as a community mental health provider, the aim is to provide care and support when required, and to also link individuals into community support which will help with their recovery and long-term wellbeing, helping to keep people well for longer.

The British Medical Association (2014), Closing the Gap (2014) and The Kings Fund (2016) suggests that integration with Primary Care can play an important role in ensuring that people with mental health problems receive equitable access to care across the system and that building relationships with Primary Care is a crucial component to build a closer connection between mental and physical health. Implementing a new service model will be an effective way of supporting the large number of people presenting with mental health needs, often alongside a mixture of physical illness, substance abuse problems and complex social circumstances.

The teams are underpinned by the requirements, responsibilities and principles of The Care Act 2014, and the introduction of a care and support system aimed at being clearer, fairer and fit for the future. The focus is on people's wellbeing, and on supporting them to live independently for as long as possible. Existing policy objectives around prevention, early intervention and personalisation have been consolidated, and new statutory responsibilities around individual well-being, prevention, information and advice, advocacy and carers will inform the structures process and practice in the team.

The Accreditation for Community Mental Health Services (ACOMHS) Standards for Adult Community Mental Health Services (2015) embraces the diversity represented by the range of community mental health services and is designed to be applicable to all adult community mental health services. ACOMHS facilitates quality improvement and supports teams to achieve accreditation.

ACOMHS standards refer to three categories:

- Type 1: criteria relating to patient safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and treatment
- Type 2: criteria that a service would be expected to meet
- Type 3: criteria that is desirable for a service to meet, or criteria that are not the direct responsibility of the service.

The overarching principles of the ACOMHS Standards have been used within the aims and objectives of the service. The suggested Standards have been utilised within the setting of this standard operating procedure.

The integrated nature of the community mental health services in Hull provides increased flexibility to meet the needs of our local populations and reduce the need for internal referrals between services, with a reduction in patients having to have unnecessary assessments when moving between primary and secondary care mental health services.

This SOP aims to support the service to meet the health and social needs of individuals with mental health problems, and their families, to improve their lives and to enable their personal recovery. This will be achieved by a multidisciplinary, community-based model of service, with a clear aim of working closer with other agencies and partners including Voluntary, Community and Social Enterprise (VCSE). It is fully integrated with health and social care staff and delivered as part of a whole system of community mental health care.

The key aims of the service are:

- The team will work with patients whose needs arise from a common and mild to moderate or moderate to severe, mental health difficulty. The CMHT/PCMHN will be a needs led, recovery focussed, intervention and treatment service and therefore is not limited by specific diagnostic criteria.

- The clinical team will strive toward the achievement of clinical excellence, patient safety and regulatory assurance
- Provide a multi-disciplinary service, which will provide timely bio, psycho-social assessment, diagnosis, and intervention for people with complex mental health difficulties
    a. Patients can be stepped up/down between the primary/secondary care elements of the team as their needs change to ensure we provide the most effective and appropriate service for them
    b. With this approach, patients only 'step up' to more intensive/specialist services if it is considered the right thing to do clinically
- Provide a person-centred approach that advises on appropriate treatment, information, care and support and empowers people with complex mental health difficulties and their carers to make informed decisions about care which helps maximise quality of life
- Provide family inclusive interventions
- Provide advanced assessment & treatment interventions based on the analysis and formulation of the individual presentation and diagnosis. Interventions will follow local care pathways and evidence-based practice.
- Provide expert risk formulation and robust risk management plans that are person centred and family inclusive. Promote therapeutic risk taking as part of a recovery-focussed approach.
- Provide intensive case management of patients with severe mental illness(SMI)/complex mental health problems who are deemed high risk and have significant safety issues who may also have Mental Health Act or Ministry of Justice restrictions or be managed under the Multi-Agency Public Protection Arrangements
- Understand and work in partnership with all local resources relevant to the patient group and to promote effective interagency working. This will include commissioning services through individual/personal budgets, promoting access to the Recovery College, working with relevant dedicated focus services in HTFT and externally provided, and working with a range of third sector providers.
- Provide effective assessment and care management and access to social care services, in line with the requirements of the Care Act (2014), through personalisation and self-directed support, promoting choice and control
- Use a range of approved outcome measures, review patient feedback and promote positive patient experience. To ensure systems are in place to monitor quality of the services.
- The service will aim to promote recovery and support the maintenance of a person's wellbeing and preventing future crisis, by making sure people are referred to appropriate services in a timely manner
- Reduce the reliance on institutionalised care and empower people to live independently, emphasising the least restrictive option. Enabling the patient to be cared for at home or within their community.
- Improve the physical health of patients to reduce premature mortality in people with severe mental health problems
- Work in partnership with GP and Primary Care, to develop a seamless service
- Continually review the development of service specifications, business plans and service level agreements with patients, commissioners and other providers to ensure responsive, flexible, cost-effective quality service within a culture of competing priorities
- Offer patients, their carers and families the opportunity to take part in research studies they may be eligible for

The key objectives of the service are:

- Ensure the service emphasis is on inclusion rather than exclusion criteria.
- Ensure that the practice of team members is Recovery focused and aligned to Trauma Informed care

- Facilitate ease of access to an integrated service using a streamlined and responsive referral pathway
- Focus on the needs of patients, their carers and families as opposed to an emphasis on exclusion. For example, self-harm, substance misuse, social background, criminal history, learning disability, neurodiversity or personality disorder are not barriers to acceptance by the service.
- Ensure the service is readily accessible and meets the range of needs of the patient group
- Provide appropriate evidence-based interventions in line with national guidelines and treatment pathways
- Ensure patients and, if required, their carers have appropriate information that allows them to manage their care more effectively along the pathway and understand how to access other assistance
- Ensure patients and, if required, their carers are supported to access local sources of advice and community support through social care and the voluntary sector
- Ensure that services are responsive to the needs of patients whose partners / family members are also in receipt of mental health services
- Engage patients in decisions about the care options available to them, including the development of Personal Care Plans and Personal Budgets
- Ensure continuity of care across the pathway and integration with other health and social care providers
- Ensure the service is delivered in a considered, timely and co-ordinated manner
- Ensure patients, carers and families are informed about research available to them

2. SCOPE

The Humber Teaching NHS Foundation Trust and Hull City Council provide an integrated health and social care community mental health service. This SOP covers the community mental health teams in Hull offered in collaboration by the providers. The scope of the SOP aims to address the following:

The teams are based on the following underpinning principles:

- Prevention and personalised support for all.
- Recovery focused principles aim to ensure better patient outcomes and improved patient safety so enabling patients to reach their potential and live well in their community.
- Right Care, Right Quality, Right Place, Right Time
- Clinically Led – Operationally Managed
- We aim to be recognised as a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff. We want to be a trusted provider of local healthcare and a great place to work. We want to be a valued partner with a problem-solving approach.

The fundamental standards of the Care Quality Commission, including the five key questions:

1. Are they safe? - People are protected from abuse and avoidable harm
2. Are they effective? - People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
3. Are they caring? - Staff involve and treat people with compassion, kindness, dignity and respect
4. Are they responsive to people’s needs? – our services are organised so that they meet people's needs

5. Are they well-led? - Leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture

The service is for individuals who are 18 years of age or older; in some cases, CMHT/PCMHN support may commence for individuals prior to their 18th birthday who are in the process of transitioning from Child and Adolescent Mental Health Services (CAMHS), in line with the Trust's CAMHS transition guidelines. Furthermore, transitions to and from adult and older adult community mental health service will be on a need-led basis, with CMHT working with no upper age limit for active cases, but new referrals for anyone over the age of 65 will first go to Older Peoples Mental Health Services and then transfer will be considered if appropriate. There is no upper age limit for PCMHN for both active cases or new referrals from GP.

The Care Act 2014 places a duty on the Local Authority to offer an Adult Care and Support Assessment where it appears that an adult may have needs and to promote wellbeing and independence. The eligibility threshold for adults with care and support needs is set out in the Care and Support (Eligibility Criteria) Regulations 2014.

In Hull, there is one CMHT which operates with two bases, split as Hull East and Hull West & Central, based at the Grange and the Waterloo Centre respectively. The PCMHN is fully integrated into the community mental health service and enables the CMHT and PCMHN to work collaboratively to provide different levels of intervention. Mental Health Services in Hull are commissioned to provide services to residents within the boundary of Hull City Local Authority and registered with a Hull GP Practice.

Each locality team will be aligned to designated GP practices within the areas. Overlap can occur as teams will be mindful of the service user's address.

This SOP should be used to support the day-to-day delivery of safe and effective care for all substantive, bank or agency team members and students who are working alongside team member. This SOP is aimed at individuals working on behalf of HTFT and HCC.
The following list of professionals in not exhaustive but cover general staff groups the SOP should support the practice of, within the area of CMHT/PCMHN:

- Leadership and Management team
- Administrative team
- Social Workers/Social care staff
- Medical team
- Nursing team
- Occupational Therapy team
- Psychological Therapies team
- Pharmacy team
- VCSE team
- Peer support workers

These individuals may be employed by HTFT or the VCSE sector. Individuals will cover a range of bandings and this SOP is for those from band 2 to band 8a, depending on their function within the team. Additionally, other staff members who are providing care may not be on an Agenda for Change contract and therefore will not be banded.

3. DUTIES AND RESPONSIBILITIES

The teams are managed through a single integrated management structure and comprises a variety of disciplines across both primary and secondary care mental health service provision.

The Trust is committed to the value of leadership, recognising the significance of leadership in all care settings. This is reiterated in recent reports into the failings of various health systems (Francis, 2013, Berwick 2013) and has resulted in calls for more effective leadership. See mental health brochure for more details on roles as this list is no exhaustive.

Service managers – The service manager is the budget holder and responsible for the service meeting their performance indicators. The service manager holds ultimate responsibility for the operation of the service, working closely with the team manager to facilitate and enable this. The service manager will report directly to the general manager of the division.

Senior clinical leads – The senior clinical lead works closely with the service manager to ensure the service area is meeting the aims and objectives of the service, providing high quality, safe and effective care to the population. The senior clinical lead will work directly with the clinical leads to deliver the service and will report to the divisional clinical lead.

Team managers, clinical leads & advanced practitioners in social work – Responsible for the day to day operational and clinical management of the CMHT/PCMHN. The Clinical Leads/Advanced Practitioners in Social Work and Team Leaders have different roles and responsibilities but will be jointly liable for the accountability and assurance of the service. It is important that the line management structure has clear lines of accountability within the service, and it is essential they work alongside each other to achieve the aims and objectives of the service, with the clinical lead focussing on clinical delivery, effectiveness and safety, and the team manager focussing on the wellbeing of the workforce and team performance.

Administrative team – The administration team provides administrative and clerical support to the team and is often the first point of contact for patients and family when contacting the service. The admin team will be responsible for the data quality and caseload management on the electronic patient record, in conjunction with the team managers, clinical leads and service managers.

Consultant psychiatrist/medical team - The consultant psychiatrist does not carry their own caseload of patients and have clinical oversight for the patients open to the team. The role of the consultant psychiatrist in the CMHT/PCMHN is to provide clinical leadership and expertise from a clinical medical perspective. Duties include, but not exclusively:

- Involvement in the team MDT discussion about patients who are open to the team and input into their individual plans of care
- Involvement in the discharge discussions for any patient open to the team
- Review of medications or to provide medical consultation on individuals accessing the teams, providing urgent appointments where required for relapse prevention or crisis mitigation
- To provide clinical involvement with CTO requirements, ministry of justice requirements, Court reports and other relevant legislation and to ensure a 3 month Consultant follow up appointment is made with the patient following discharge of CTO.
- To provide care with colleagues in partner agencies in line with Trust Shared care protocols i.e. General Practitioners

Registered nursing team – Registered nurses provide a key worker role, in promoting and delivering evidence-based care for service users with mental health conditions within CMHT/PCMHN. The nursing team will follow their code of conduct and professional remit to provide well-coordinated care and therapeutic interventions based upon a collaborative and individual care plan.

The nurse associate (NA) role is relatively new in the nursing field. The role is able to offer nursing interventions but under a more closely monitored and role boundary approach. As the team develops it is envisaged that this role will also develop, in terms of the interventions offered.

Social workers - Social workers place a strong focus on prevention and early intervention using a strength-based approach that considers all aspects of a person's life using the principles of the Care Act (2014) and supporting people's choice, control and human rights. Social workers are experts in the application of relevant legislation and have statutory responsibilities in relation to the Mental Health Act 1983, Mental Capacity Act 2005, Care Act 2014, Human Rights Act 1998 and safeguarding. Social workers are integral to multi-disciplinary teams and provide a range of interventions to support people to achieve sustainable recovery, through effective discharge pathways, where they have independence and their discharge from services is long term.
Social workers should refer to the Hull APP for guidance and procedures relevant to their work and the ASC operating manual below.

Psychology/psychological intervention team – The psychology and psychological intervention team include practitioner psychologists, assistant psychologists clinical associate psychologists, family therapists and family interventions practitioners, who are responsible for providing psychological interventions for people accessing CMHT/PCMHN, balancing evidence-based practice and practice-based evidence to ensure intervention delivered is appropriate to the specific individual and family. They will also provide psychological intervention groups as part of their core function within the community service.

Approved Mental Health Professionals (AMHP) - AMHP's are mental health professionals who are approved by the Local Authority to carry out certain duties under the Mental Health Act.
They may be:

- Social Workers,
- Nurses,
- Occupational Therapists,
- Psychologists.

Please refer to the AMHP Agreement in relation an AMHP's commitment to the AMHP Service and in relation to Training and Approval.

Also refer to National workforce plan for approved mental health professionals (AMHPs) (publishing.service.gov.uk) which also contains the National AMHP Service Standards.

Non-Medical Prescribers (NMP) – NMPs are individuals with a core profession who have completed additional training in the area of medicines prescribing. NMPs can provide additional medicines review resources into teams, within their scope of practice and competence. All NMPs are governed by local NMP policy and SOP.

Pharmacists/pharmacy technicians - Pharmacy support within the CMHT/PCMHN is a developing role to support with safe and effective use of medicines and a key role in ensuring appropriate medicines use and addressing needs of polypharmacy and inappropriate medicines use.

Occupational Therapist and Occupational Therapy Team – Occupational Therapists (OT) are able to operate autonomously, demonstrating the use of standardised assessments and outcome measures. Occupational Therapists and the OT team assess, plan, implement, and evaluate treatment plans, with an aim to increase patients' productivity, self-care and independence. Work with patients through a shared-decision making approach to plan realistic, outcomes-focused goals. As a profession, OT work holistically using a person-centred approach in partnership with the multi-disciplinary team.

Mental Health Wellbeing Coaches (MHWBC) - The role of the MHWBC is a hybrid role taking elements of a health trainer along with building community links to address and focus on the mental health and wellbeing needs of patients, whilst using the recovery star to support the intervention. The role will support individuals to move from 'surviving to thriving' through non-clinical interventions.

Support, Time and Recovery (STR) worker – STR workers support and provide interventions to individuals under the guidance of a registered clinician. STR workers take an active and lead role in facilitation of the groups programme in CMHT/PCMHN.

Peer Support Workers - Peer Support Workers provide support, encouragement and signposting based on their lived and learned experience. Their role is to establish the Mental Health recovery needs of the individual they are working with to enable them to continue on their recovery path to become an integrated member of the community. They will provide this support on an individual centred basis. They are not there to provide clinical care as they are not clinicians

4. PROCEDURES

This is detailed instruction which must be followed, or steps which must be taken to implement the document.

All processes detailed in this section should be considered within the scope of trauma informed principles, alongside the ongoing work within HTFT to integrate further trauma informed ways of working.

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being. The working definition of trauma informed practice is:
"Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development." (Office for Health Improvement and Disparities. 2002. Working Definition of Trauma Informed Practice. Gov.UK)

The principles of trauma informed practice are:

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment
- Cultural consideration

Practitioners should be aware of the personal and wider societal effects of trauma, focus on accessibility of services and aim to present re-traumatisation by being sensitive to the needs of the person.

4.1. Team structure, purpose and inclusion

The aim of the teams is to provide a seamless, integrated health and social care, community mental health service. Community mental health services have different levels of intervention, providing a range of treatment options at primary and secondary care level. Community services in Hull are fully integrated. The community mental health services covered within this SOP are part of a wider offering of mental health care in the locality, including via other statutory providers, NHS Talking Therapies, specialist mental health services, third sector and VCSE.

This SOP relates to a service which provides interventions and support to individuals with a Serious Mental Illness (SMI). SMI is a smaller and more severe subset of mental health problems with SMI defined as; one or more mental, behavioural, or emotional disorder(s) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (NIMH).

For individuals to be eligible for interventions and care via the community mental health services, they should demonstrate needs which are covered by the definition above and needs which are not best met by other providers. For example, and individual may have a history of SMI, but be seeking talking therapy for a co-occurring anxiety problem without complex needs which would be eligible for care via NHS Talking Therapies. Furthermore, an individual may have a history of SMI, but the problem they are seeing support for is for substance misuse without a core mental health element or complex need, therefore their needs are best met by the local substance misuse agency.

The patient should be registered with a local GP or live and have ties to the local area, to be eligible for support with the local team. However, there may be times when a patient is not registered or living in the local area but remains under the service for social care needs as they have Section 117 entitlement or eligible needs under the Care Act 2014. Additionally, the patient may be accessing a specialist placement out of the local area, where the continued provision of community mental health service is required from the team.

The community mental health service will not hold an exhaustive list of inclusion or exclusion criteria, however each referral will be considered on its own basis, taking into account current presentation, historical information, the patients' wishes and risk assessment. Local community mental health services are often best placed to know what services are in the local area to meet the needs of the population, using best evidence to support with decision making.

The service offers two degrees of intervention, both at primary and secondary levels. Both levels of service are designed and commissioned for those individuals who display having a serious mental illness (SMI) or complex mental health problem, the difference in which level is more appropriate to meet the needs of the patient links more into their individual and identified needs, the complexity of the needs and presentation, and the risk associated with this.

- The primary care level would usually be more appropriate for those individuals who have less complex presentation, have a lower level of risk and have limited identified needs which can be treated consecutively rather than concurrently. Furthermore, the level of engagement of someone accessing the primary care level intervention needs to be demonstrated as the team is unable to provide an assertive outreach approach. The PCMHN provides short term and brief interventions over approximately 12 sessions in a 3-month time frame.
- The secondary care level would usually be more appropriate for those individuals who have more complex presentations with interplay between different issues, moderate to more severe risks, and those who have multiple needs which require concurrent interventions and a wrap around service. The secondary care level can provide a more assertive approach over a longer period of care.
- Both levels of service require the identification of needs which can be best met by the team and not best met by another, more appropriate agency.

The service will operate in the main Monday to Friday between 9 am and 5 pm. Outside of these hours, patients can be supported by the Mental Health Crisis Intervention Team (MHCIT). A service offer brochure is available on the intranet and internet for patients and carers clearly outlining the Trust's community mental health service offer. This is suitable for individuals with learning disabilities, sensory impairments and is available in different languages.

All bases have their own contact details and email address, including staff having their own smartphone for work use.

4.2. Referral into the service

Referrals into the community mental health services may come from several pathways. Referrals may be received by the primary or secondary care intervention teams (PCMHN/CMHT), however ***this should not pose a barrier to treatment and patients care should step up or step down through the intervention level as per their presentation, risk and care needs, without the need for additional assessment or unnecessary delays to their care.***

Processes for new referrals:

- Admin team to accept all new referrals within 1 working day, and add onto access plan 'Referral Received Awaiting Allocation'. This access plan will act as a holding area until clinical review has taken place, and the access plan will automatically breach within 7 days.
- Clinical team to review all new referrals to the service on a daily basis, held on the access plan 'Referral Received Awaiting Allocation' and document on an MDT clinical note, the outcome from the referral discussion. **Needs and risks of/to the patient should always be considered at this point in the referral discussion, with priority of allocation being based upon these factors.** This process should be completed alongside the admin team to confirm the system changes immediately where possible, or if unavailable, a clear task list provided to the admin team for completion within 2 working days.
- Referrals which are reviewed as not needing any further input from the Community Mental Health Service will follow the pathway indicated in section 4.2.1
- Referrals which are reviewed as needing treatment from the Community Mental Health Service will be allocated directly to a clinicians caseload or be placed on a different or additional intervention access plan which include:
    - Waiting for next SIP (supportive intervention programme) group
    - Waiting for next SCM (structured clinical management) group
    - Waiting for next trauma stabilisation group
    - Waiting for psychology/psychological intervention
    - Waiting for medication review

  All these access plans are set to breach after 4 weeks. The patient may remain on awaiting allocation and another access plan depending upon identified needs.
- Patients should be informed of the status of their referral and what they may be waiting for in writing and should be provided with appropriate safety netting should their needs change or require urgent care and support. A link to the MH brochure is on this letter and the brochure provides further information about the services available.
- The senior administrator (band 3) will check the team baseboard a minimum of twice weekly to resolve any issues and/or escalate any concerns to the clinical team/team manager
- All access plans will be reviewed a minimum of weekly by the senior administrator (band 3) with all breaches escalated to the clinical lead/team manager

4.2.1. Referrals from initial mental health assessment

The majority of referrals received into the community mental health services come via the Mental Health Triage and Assessment Team (MHTAT), Mental Health Liaison Service (MHLS) and Mental Health Crisis Intervention Team (MHCIT). The MHTAT service is a routine triage and assessment service, whereas MHLS and MHCIT are unplanned services who respond more urgently to patient needs. The Complex Emotional Needs Service (CENS) also complete initial mental health assessments for care leavers and although this accounts for a smaller number of referrals into the service compared to the other services, this pathway of assessment should be included within this referral route. It should be acknowledged an assessment is a-snapshot of information in the context of the time and place the assessment happens, therefore the assessment may be more about understanding needs and risk to inform the treatment plan, rather than the full history and presentation of the patient being comprehensively assessed an understood at this initial stage.

All three services will complete a collaborative and holistic assessment of mental health needs and consider what support is required for individuals to meet their needs. Consideration will be given by the assessing clinicians for services who may be best placed to meet the needs of the patient which are outside the community mental health service. If the patient is presenting with an SMI and

complex needs of which there is a core mental health element, which require community mental health services, they can refer to the local community mental health service via the following procedure. This revised pathway puts more emphasis on collaborative working between the referring and receiving teams and also on collaboration with the patient to review their needs prior to alteration of the agreed outcome from assessment.

- The assessors identify needs through the assessment which are not best met via another service and require intervention through the community mental health service. Specific interventions should not be offered to the patient at the assessment stage, but should focus on need and why the community mental health service is best placed to meet this need.
- The patient is consenting and agreeable to a referral to the community mental health service
- The assessor has considered historical information, treatment and engagement within service
- Up to date and relevant documentation is completed by the assessor including the; initial mental health assessment, FACE risk, mental health clustering tool, AUDIT, DAST, ReQoL and other tools identified as appropriate at the assessment stage. If the documentation is not completed or to an acceptable and defensible standard, the receiving team may decline the referral until this has been addressed.
- An electronic referral will be made via the electronic patient record to the receiving team
- The receiving team will review the assessment documentation within their MDT and consider what pathway the patient should be placed on according to their needs identified. This discussion and outcome should be captured on the patient record on the CMHT MDT clinical note, to accurately recount the decision-making process and rationale for such.
- If the receiving team agrees with the outcome/plan of the assessment, the referral is accepted and allocated to the right pathway
- If the receiving team does not agree with the plan/outcome of the assessment and wishes to redirect to a more appropriate service, this must be completed in consultation with the patient and outcome shared with the referrer to support learning. Please see 4.13 for consideration of the interface with external agencies.

If a patient comes to the attention of the MHCIT/MHLS or MHTAT within 12 weeks of discharge from the community mental health services, a full assessment may not be required, but a review of the needs and update of the risk assessment, mental health cluster tool and ReQoL may be sufficient to support a referral back to the team. It should always remain at the discretion of the assessing clinician if a full assessment is required based on the change in needs and presentation since last engagement, however outside of 12 weeks the episode of care should be treated as new and complete assessment should be completed.

The local community mental health teams are completing routine referral screening for MHTAT, which may yield an outcome of the team agreeing to open a referral without the need for initial assessment taking place. This should be completed at the discretion of the team, but would be considered good practice for people who have been recently discharged whose needs remain largely the same as the previous care episode, or where the team is best placed to offer intervention/signposting and going through an assessment is deemed unnecessary or causing delays to care. As per the MHTAT SOP, the clinical team needs to provide a rationale for taking someone into the care of the service, or not, at this time, which will then be recorded on the patient's clinical record by the MHTAT admin team.

4.2.2. Referrals from inpatient services/home based treatment (HBT)

Patients may be admitted to inpatient services or offered home based treatment following an assessment and may not be currently receiving care from the community mental health service. During this period of care, the acute care team will consider if a referral to the community mental health service is required.

In Hull, the community mental health services have a discharge liaison nurse who will work closely with the inpatient services and home-based treatment team to discuss and identify appropriate referrals for community mental health intervention. They will attend appropriate meetings regarding the patient's care and discharge plans and be the main point of contact for the acute services until the patient is discharged. The discharge liaison nurse will accept patients onto their caseload during the inpatient/HBT period of care and make appropriate arrangements for discharge alongside the ward and the community mental health team.
When considering step down to CMHT from HBT and during HBT intervention for a patient open to the CMHT, the following good practice elements should be followed (this may be completed by the allocated care coordinator or discharge liaison nurse):

- Regular contact between the HBT team and CMHT should occur to ensure services are up to date with the patient progress
- A joint clinical handover meeting should be agreed with the patient
- HBT should distribute their discharge letter to the CMHT

In the absence of the discharge liaison nurse, the referrals from inpatient and HBT services will be managed as below.

The inpatient and HBT services will contact the team to discuss a potential referral, where the internal transfer form will be completed to capture this discussion by the referring clinician. If the referral is accepted, an electronic referral should be made to the receiving team via the electronic patient record. Once received, the receiving community mental health service should complete acceptance and allocation within 2 working days.

Due to the recent acute mental health needs of this group of patients and the heightened risks they may continue to present with, referrals to the community mental health service from acute services should be prioritised for allocation to the individual who will be providing their main intervention. This should be completed within 2 working days of the referral being made and should be either the discharge liaison nurse or their longer term key worker.

If a referral is declined from to community mental health services, this should be clearly documented in the patient notes including the rationale for the decision making. If there continues to be disagreement regarding the referral, this should be escalated to the clinical leads initially and then further to the modern matron/senior clinical lead.

The 3 day follow up is a vital component of discharge planning, which is in response to increased risk following discharge from inpatient services. Responsibility for completion of the 3 day follow up should be carefully considered if the patient is unknown to community mental health services and engagement may be improved if the inpatient team held responsibility of this. A clear plan for achievement of the 3 day follow up should be agreed with the patient at the discharge planning stage, including additional plans and contact details including next of kin, should there be issues in completion. Careful consideration for the way in which the follow up is completed should occur, including virtual, telephone and face to face, with a clear rationale evidenced in the clinical records for this choice. Escalation of a follow up which appears likely to breach should be made to the clinical lead and an ad-hoc MDT discussion should be organised to determine the level of response required from the service. All decisions regarding follow up should be recorded on the patients clinical record.

4.2.3. Transfers from internal CMHT and other HTFT teams

Transfers from other internal teams and between local community mental health services will be expected. Internal transfers should be from other community mental health services due to the patient moving areas or reaching the end point of intervention in the case of Early Intervention in Psychosis, should not cause a delay or break in their treatment. The referring team should contact the appropriate community mental health service to discuss the transition of care and complete an internal transfer form to support the discussion and decision making. The receiving team withhold the option to consider alternative services/agencies which are more appropriate to meet the patients' needs and use their local knowledge to support with alternative care plans which may be

more appropriate. Should the two teams disagree about appropriate care, escalation should occur to the clinical leads and then senior clinical leads as required.

For transfer of care to take place, the referring team should be able to clearly demonstrate a continued need for community mental health service, have an up to date care plan, FACE risk, mental health clustering tool and patient recorded outcome measures.

The referring team should inform the receiving community mental health service as soon as possible so the transition of care can be appropriately planned, with a period of shared care agreed upon in the best interest of the patient and completion of interventions. Patients should be allocated directly to their new clinican, without re-entering a waiting list. There should be no set time frame on transition as this should be tailored to individual need, but this would be expected to be completed in most cases within 3 months.

Where someone is in receipt of a care package, the original team may retain responsibility for reviewing the care package or 117 entitlement, but the healthcare provision is transferred to the new team. This aspect should not delay the transition of healthcare but should be clearly identified in the transition process who has the responsibility for what aspects of the patient's care plan.

4.2.4. Transfers from external mental health providers

If an external community mental health provider is seeking to transfer care to the local community mental health services, the referral should not go via an initial assessment service such as MHTAT. Referrals from these services should be made directly to the local community mental health service and a transfer of care organised between the teams in the best interest of the patient.

For transfer of care to take place, the referring team should be able to clearly demonstrate a continued need for community mental health service. Should the two teams disagree about appropriate care, escalation should occur to the clinical leads and then senior clinical leads as required.

If a transfer of care is agreed from an out of area provider, the patient may be unknown to local mental health services, therefore will require registering onto the system, new care plan, FACE risk and mental health clustering tool be completed by the receiving team within 4 weeks. The receiving team should request and upload relevant information from the previous team onto the system for historical accuracy.

4.2.5. Referrals from GP to PCMHN

GPs are able to refer directly to the PCMHN via bookable eRS slots in Hull.

GPs can directly access mental health wellbeing coaches and clinical leads within their PCMHN, aligned to the PCN. The MHWBC or clinical lead will arrange the first appointment and determine if their/PCMHN intervention is appropriate, or if they are to step up into the CMHT or signpost into other services.

The MHWBC will continue to record their interventions on SystmOne if they take the patient onto their caseload to complete their intervention, following their initial appointment. If the MHWBC feels their intervention is not appropriate for the patient's needs or they are presenting with complex needs or concerns around risk, this will be escalated either to the PCMHN Point of Contact, the MDT, or in supervision. Any urgent cases to discuss and escalate the care of should be completed on the same day with the Point of Contact, who is a PCMHN Clinical Lead.

The initial contact by the clinical lead is recorded on SystmOne and the clinical lead will complete an initial mental health assessment to determine the needs of the patient. At the initial assessment stage, this does not include a cluster or FACE risk completion. Following their assessment, the clinical lead will open the patients on Lorenzo and create a referral to the CMHT, which will then be allocated to a PCMHN worker or stepped up into CMHT, if the patient is to be offered a period of

care. At this point, the clinical lead or other worker will complete a risk assessment and cluster. If the clinical lead signposts on to another service, they will be responsible for completing this task (please see 4.13 for consideration).

4.3. Treatment in the service

If a referral is appropriate for intervention via the community mental health service, the patient will be allocated a team member to work with as soon as possible, in their allocated care pathway or remain on an access plan until this intervention is deliverable. Treatment in the service should always be collaborative, patient centred, involving the family, non-judgemental and trauma informed.

Evidence supports how appropriate interventions delivered as soon as possible enable the best outcomes. The organisation is committed to the four week wait to treatment, therefore an individual should be engaged in their treatment within 4 weeks of the referral to the service, with either a social or psychological intervention started, or a comprehensive collaborative care plan completed with the appropriate SNOMED code to stop the clock.

Treatment should be provided by the most appropriate clinician for the intervention required either at primary or secondary care level, with adequate levels of supervision.

Primary care level intervention – The PCMHN model is to provide proactive and preventative mental health support and care to people who have a serious mental illness (SMI)/complex mental health problem. The care needs of the patient's accessing this support should be defined, have lower levels of complexity with low to moderate levels of risk. The PCMHN will provide intervention for 3 months for the identified care need and look to step into other community resources which can support the patient in their community longer term. The aim of the PCMHN is to work into primary care, providing interventions for those with reduced levels of need, providing lower level interventions for a higher number of people.

Secondary care level intervention – The CMHT model is to provide an intervention for individuals with a serious mental illness, who present with complex and multiple needs who require more wrap around care. Individuals accessing CMHT will likely have moderate to high levels of risk and require a longer period of intervention from multiple professionals. The aim of the CMHT should be to treat identified needs, providing episodic care to empower the patient to live as functionally and independently as possible, rather than life-long care.

In both levels of intervention, the clinical leads will provide clinical oversight and recommendations of which level of intervention a person will require from their identified needs and risk. Allocation of intervention level should always be based upon their presenting problem and what their goals of treatment are.

4.3.1. Initial allocation

Allocation priority

Allocation to a clinician should not be purely based on a 'first come, first served' basis, but may be prioritised for people who are experiencing a higher level of need or risk, or have recently experienced acute mental health problems, or have been in mental health crisis. The clinical team should use the MDT to support, where required, with decisions regarding allocation priority. If there are operational concerns which affect the ability to allocate treatment to a patient in the timescales identified within this document, they should be immediately escalated to the service manager and senior clinical lead.

Priority allocation should occur for any patients being discharged from an inpatient ward and should be completed in 2 working days.

Supportive intervention contacts

Treatment should never be unnecessarily delayed and should commence as soon as possible. If a patient cannot be allocated for treatment initially, they should be allocated to a registered clinician

within 5 working days of the review of referral, for commencement of supportive intervention contacts. The clinician will complete a collaborative care plan and arrange the care and support required with the patient, prior to treatment commencement, at a minimum of a contact every 4 weeks, up to weekly. This contact can be completed by the registered clinician or an unregistered clinician with appropriate supervision and guidance from a registered staff member. The registered clinician should agree appropriate review points during this phase of treatment with the patient but should be completed at a minimum of every 4 weeks. The care plan should be shared with the patient and family and include appropriate safety netting information to support the patient and family with any deterioration in their mental health or possible crisis.

Additionally, should the needs of the patient change whilst awaiting treatment intervention, the registered clinician will urgently review the needs and the risks of the patient and based upon clinical priority either expedite the allocation to treatment or arrange acute care. Prioritisation must be in response to the level of presenting need and risk. Conversely, should the needs and risks of the patient decrease, formal review of this should take place, with appropriate plans to meet the needs put in place. The reviewing clinician should use the MDT where needed to support with any decisions about escalation or reduction in care required, documenting clearly in the patient record the rationale for the decision to change priority status of the care and updating the core documentation i.e. FACE risk and care plan.

New allocation task list

Within the first 4 weeks of a referral being accepted by the team, the following should be completed:

- Review of assessment information and any unidentified or unmet needs
- A review and if required, update of the FACE risk assessment
- A collaborative and comprehensive care plan
- Completion of patient recorded outcomes measure baselines
- Long term goals and routes out of service/discharge planning
- Agree a frequency of contact, safety plan and review of the needs of the family/carer with appropriate signposting/onward referral
- Review and update of the next of kin/support network contacts and patient protected characteristic information
- Identification and collaboration with external agencies/other providers the patient may be working should commence at this stage and be further developed in care planning stages

4.3.2. Caseload

In terms of care co-ordination responsibilities, staff will generally carry an average caseload of 30 and above (based on capacity, productivity information linked to roles and job planning), which may indicate a higher or lower number on caseload. Caseload sizes, however, should not be based purely on a number, but consideration given for additional roles such as AMHP/NMP, complexity of cases and any other additional duties the staff member has such as running groups, supervision, statutory work on behalf of the local authority and mentoring. Regular clinical and professional supervision should aim to identify those people on caseload who are appropriate to transfer following treatment being completed or the patient disengaging, people who require additional support or different intervention, and identify the capacity each patient needs, which will help determine case allocation.

The care coordinator/key worker/case manager will be responsible for (but not limited to) the oversight of the patient's care journey in service, identifying, with the support of the MDT, other interventions which may be appropriate, making onward referrals, and ensuring care plans, FACE risk assessments, mental health clusters and other appropriate documentation remains up to date and relevant at all times. The allocated worker should also ensure contact is made directly with the patient monthly, at the very minimum, and regular contact with family/carers is made as per arrangements with the patient.

The allocated worker should have an awareness of all other services the patient may be working with and therefore proactive engagement with these services to support integrated care planning is a high priority. Please see 4.13 for consideration of the interface with external agencies.

Reallocation of cases – if the main allocated worker of the patient is absent from work due to sickness for 14 calendar days or more, the patients on this caseload will be reallocated to other team members to continue providing the care plan and prevent a break in treatment. If the absence is short term, up to 14 days, the patients on the caseload will be notified of the absence, either via direct telephone contact or letter, alongside the routes into the team for support whilst their worker is unavailable.

Upon an allocated worker handing in their notice to leave the team, they will be required to review each of their cases and determine who requires reallocation to another worker, which will be discussed with the clinical lead. Where possible, all reallocations via this mechanism should be completed 'warm' and a direct transfer from one worker to another, with the update of care plan and other relevant paperwork to be completed in collaboration with the patient and family.

The patient will be reallocated as soon as possible and in the interim, safety planning measures must be put in place to ensure appropriate escalation of care is planned for.

Planned absence of 14 calendar days or more will be discussed directly with the clinical lead for consideration of reallocation on a case by case basis.

Cancellation of appointments
If it becomes necessary to cancel a patient's appointment for any intervention under the community team (ie medical appointment, psychology appointment, key worker appointment), the patient should be contacted as soon as possible, notifying them of the cancellation.
If this is a short notice cancellation, within 14 days, the patient must be contacted by telephone. If the appointment is over 14 days away and is routine in priority, the patient can be notified via letter if appropriate.
Where possible, a further appointment should be booked at the time of the cancellation.
If it is a short notice cancellation, an option for the patient to discuss any concerns with the duty clinician should be offered.
Staff cancellation should not be included within the disengagement/did not attend (DNA) consideration.

4.3.3. Ongoing CPA/care planning/documentation standards

<u>CPA</u>

As per national standards all community mental health service patients will be offered an annual review of their care if they are managed under the provision of the Care Programme Approach (CPA). Care co-ordinators are expected to empower the patient to be fully involved in care planning and also to prepare for the review of their care and intervention plan. The allocated worker will be responsible for maintaining an up-to-date caseload and appropriate and timely review of documentation, in collaboration with the patient, family and other professionals involved. The allocated worker should have an awareness of all other services the patient may be working with and therefore proactive engagement with these services to support integrated care planning is a high priority. Please see 4.13 for consideration of the interface with external agencies.

The patient will have access to independent advocates to provide information, advice and support, including assistance with advance statements and CPA Reviews. Outcome of CPA Reviews will be discussed with all parties, recorded and circulated to the GP.

At the time of publication of this SOP, the Care Programme Approach (CPA) remains the framework used in the community mental health service and wider organisation to review and plan appropriate care for this on the secondary care caseload. Not all patients on the caseload of the community mental health services, receiving secondary care level interventions are required to be

monitored on CPA, however those who are and are not held on CPA should be regularly reviewed in line with the CPA standards SOP/policy.

Further CPA guidance and assurance this is completed at a minimum of annually is located in appendix one.

Please see CPA policy for further information

The organisation is making steps to move away from CPA and towards person centred care planning, under the community mental health framework initiative. This move will be one of the most significant policy changes to occur in mental health in recent times and aims to ensure holistic needs and met in collaboration with the patient and their family. Outside of the minimum expectation for CPA review annually, CPA review should also take place when clinically indicated through step up or step down in care provision.

Care planning and FACE risk
Furthermore, care plan and FACE risk review should take place at all transitions in care, annually (minimum standard) and when the patient and family may request this.

The care plan is the foundation to provide a narrative as to what the patient wants to address, what this will look like and how they will get there, therefore this document must be up to date and relevant to the patient and the community setting, with an associated relevant safety plan in the event of a crisis. The care plan should be co-produced and a copy of this should always be offered to the patient, as it is their care plan. A copy of the care plan should also be shared with key individuals involved in the person's care, with their consent.

The allocated worker should have an awareness of all other services the patient may be working with and therefore proactive engagement with these services to support integrated care planning is a high priority. Please see 4.13 for consideration of the interface with external agencies.

Additionally, the FACE risk provides a comprehensive review of actual and possible risk to self (patient) and to others, and therefore is a key document to ensure the appropriate provision of care in both planned and unplanned care settings.

Clinical records
A contemporaneous record of the interactions with the patient, family and key professionals is paramount in ensuring safe and effective care, therefore all records should be made in line with the trust defensible documentations standards. A clinical contact is required for all activity completed on behalf or with the patient, as well as adding appropriate SNOMED codes for the interventions delivered.
All MDT discussions, whether these are conducted in the formal MDT meeting or another clinical meeting, should be recorded on the CMHT MDT clinical note template on the patient record.

Updates to general details
Protected characteristics and next of kin/support network contacts should be routinely checked and updated on the patient record at every care plan/CPA review point.

4.3.4. Social work & AMHP

Social Workers
Social Workers place a strong focus on prevention and early intervention using a strength-based approach that considers all aspects of a person's life using the principles of the Care Act and supporting people's choice, control and human rights. Social workers are experts in the application of relevant legislation and have statutory responsibilities in relation to the Mental Health Act 1983, Mental Capacity Act 2005, Care Act 2014 and Human Rights Act 1998 and safeguarding.
Social Workers are integral to multi-disciplinary teams and provide a range of interventions to support people to achieve sustainable recovery, through effective discharge pathways, where they have independence and their discharge from services is long term. As part of their work to assess,

arrange and review support packages funded by Hull City Council they are required to work to their operating model and record information on their operating system.

Some patients may be open to the team for social work only interventions and care package review. As good practice, for this group of patients the expectations would be monthly contact or less frequent with clear rationale provided, contact to be recorded on Lorenzo and Liquid Logic alongside all completed documentation including; Care Act Needs Assessment/Mental Capacity Act/Best Interests/Safeguarding/Care Plan/FACE Risk Assessment/Mental Health Clustering Tool and Patient Recorded Outcome Measures. All Social Workers should be allocated on both systems to the case to ensure effective governance, communication, and escalation of concerns.

Social workers should refer to the Hull APP for guidance.
Operating Model Operational Manuals – Hull Adult Social Care APPP (hullappp.co.uk)

Please see the Adult Social Care Interim Operating Manual, Section 117 aftercare practice procedures, and Flow Chart – decision making thresholds. These are available on the Hull CMHT shared v drives.

Approved Mental Health Professionals
AMHP's are Mental Health Professionals who are approved by the Local Authority to carry out certain duties under the Mental Health Act. They may be: Social Workers, Nurses, Occupational Therapists, Psychologists. Please refer to the AMHP Agreement in relation an AMHP's commitment to the AMHP Service and in relation to Training and Approval.

Please see AMHP agreement and AMHP agreement unplanned mental health. These are available on the Hull CMHT shared v drives.

Also refer to National workforce plan for approved mental health professionals (AMHPs) (publishing.service.gov.uk) which also contains the National AMHP Service Standards.

Please see appendix two for social work flow chart
Please see appendix three for Terms of Reference – Quality & Risk Forum
Please see Humber AMHP SOP

4.3.5. Medical

Psychiatry forms a vital and integral part of the community mental health service provision. Psychiatrists bring with them significant skills, knowledge and experience, which can support the patient's care plan and the team with management of the needs and risk. Psychiatrists may provide medication reviews for individuals who require this, though have a role which extends beyond this and should routinely be involved with complex case discussion and reviewing the needs of deteriorating patients.

Non-medical prescribers are a complementary role to support with the treatment initiation, change and cessation of medicinal products for people who have lower levels of complexity and do not require the expertise of the psychiatrist. NMPs are a vital part of the modernisation of community mental health services, enabling quicker access to medicines and as a resource to the wider service to support holistic needs management.

Pharmacists and pharmacy technicians are also key roles in the delivery of medical care, ensuring the safe and appropriate use of medicines. Pharmacy technicians can provide level 1 reviews of medications, which allow for the review of the efficacy, use and side effects of medications, including any barriers to adherence.

Medication/medical review can be sought by the team member at theirs or the patient's request and can be completed either in direct discussion with the consultant or NMP, during the MDT meeting, or via completion of the medication review request from and submitted for consideration by the consultant or NMP, via the clinical lead.

Good practice for medication/medical reviews should include:

- Patients who are on multiple medicinal therapies for their mental health.
- Patients who are on high dose antipsychotic prescribing.
- Patients who have several comorbid physical health conditions.
- Patients who are struggling with adherence to their medications.
- Patients who are experiencing undesirable adverse effects from their psychiatric medicines.
- Patients who are presenting with complex mental health problems and significant risks, who would benefit from psychiatric input.
- A review of patients who have been discharged from inpatient services within 6 weeks.
- An automatically triggered review for any patient discharged from CTO within a stipulated time frame or earlier.
- Any patient wishing to discuss their psychiatric medicines should be provided with the relevant information and pathway information.

For those patients who are accessing 'medication review only pathway', they will be held on the 'Waiting for Medication Review' access plan, until this intervention is complete and discharge has been organised, or they have been allocated another worker and intervention in the team. This access plan will be reviewed monthly by the senior administration (band 3) and any concerns escalated to the clinical lead/team manager.
It remains the responsibility of the Psychiatrist/NMP to determine the ongoing care for the patient when they are receiving a medication review only intervention. Therefore, any discussions regarding additional care, allocation or discharge must be made via the MDT meeting or in consultation with the clinical lead, to be initiated by the Psychiatrist/NMP.

Any medical review should include appropriate documentation completion including but not limited to HTFT standardised template clinic letter and treatment recommendation form. An outcome from the review should routinely be shared with the GP for their records and rationale for prescribing arrangements. Any significant medication changes should result in the community team providing adequate follow up, either via the prescriber, or via the team to monitor for efficacy and side effects, as this is best practice. A discharge to GP should only take place once all treatable needs have been identified and met where possible, and the effects of the medication have identified.

The patient should be provided with:

- Information on their differential diagnosis
- Information on their medicines
- Leaflets on their medicines from choice and medication
- Follow up timescales and plans
- Monitoring procedures and plans
- Safety planning and how to seek guidance from their prescriber and GP, or other sources if required, or when to seek urgent medical attention if experiencing hypersensitivity or allergy

Medicine adherence in patients with a mental health difficulty can be a significant problem; particularly in patients with severe mental illness (SMI) as they may have little insight into their illness and as a consequence often do not believe themselves to be ill. Other reasons for poor adherence are concurrent alcohol or drug abuse and/or a poor relationship between the healthcare professional and the patient. Clinicians working in the community should have discussions regularly with patients regarding their medication as determined by the patient risk factors if prescribed medication is be taken. For this approach to have the maximum effect it is vital clinicians involve service users/patients in their care and develop supportive, trusting relations with service users/patients. Any issues with treatment adherence, especially where adherence has been an issue previously steps should be taken to help the patients improve adherence and prevent relapse.

Please refer to the Safe and Secure Handling of Medicines Procedure

4.3.6. Psychological Therapies

The psychology therapies team within the Hull PCMHN and CMHT consists of different staff, with different roles. Currently the team consists of:

- Clinical or Practitioner Psychologists
- Assistant Psychologists
- Clinical Associate Psychologists (often referred to as CAPs)
- Psychological Therapists e.g., Cognitive Behavioural Therapists (CBT) and Eye Movement Desensitisation Reprocessing (EMDR) Therapists.
- Trainee Psychologists/Therapists
- Family Therapists
- Family Intervention Practitioners

Accessing the psychology provision in Hull CMHT involves the following steps:

1. Patient is allocated a care coordinator/key worker within the team.
2. The care coordinator/key worker builds a relationship with the patient and identifies that psychology work might be appropriate.
3. The care coordinator/key worker arranges a consultation with the psychological therapies team, either directly or via the weekly MDT meeting.
4. During the consultation, the psychological practitioner will consider options for psychological input including: intervention within the CMHT (e.g. Assistant Psychology, 1:1 therapy, groups), referral to external and specialist services (e.g. DBT, MBT, Humber Traumatic Stress Service).
5. If input from the CMHT psychological therapies team is indicated, a therapy/psychological intervention screening appointment is offered to the patient. This is a one-off assessment to gain a psychological understanding of the patient and their difficulties, as well as to assess suitability for intervention. Patient continues to access support from their care coordinator/key worker as usual until they start the intervention.
6. Upon commencement of psychological intervention, there should be communication between the member of the psychology team, the patient and the care coordinator/key worker to create a collaborative care plan, which reflects the degree of support required from the care coordinator going forward.
7. Some patients may be held on an access plan for 'Waiting for Psychology/Psychological Intervention'. On commencement of their intervention, this access plan should be ended and the patient allocated to the caseload of the clinician.
8. Patient completes the psychology intervention and is either discharged from the service (collaboratively with the care coordinator involved if allocated one), is discharged back to the care of the care coordinator, or is taken to MDT for further discussion of needs and appropriate interventions.

Accessing psychological provision in Hull PCMHN involves the following steps:

1. The requirement for psychological therapies/interventions will be explored within the MDT in discussion with a CAP
2. If the patient would benefit from intervention with a CAP, they will discuss the case suitability with their psychology supervisor to determine if this care would be appropriate
3. The CAP may arrange a note review, screening appointment or joint consultation with the involved clinician (if there is on assigned at the point of discussion) to ascertain the appropriateness for this intervention
4. The CAP will complete their intervention if agreed to by the patient, using appropriate modalities for the presenting needs
5. Once treatment is completed, the CAP will make recommendations for further care if needed and discuss this in supervision or MDT meeting. The patient may be discharged from service at this point, or transferred to another intervention/team.

6. The CAPs work to a 16 session model and they may require additional sessions to meaningfully complete a piece of work with the patient. In this situation, the case should be discussed with the clinical leads of the PCMHN and the psychology supervisor

It is the case that some patients are case managed by psychology staff presently, when there are no other needs requiring a care coordinator/key worker elsewhere in the service, at both primary and secondary care level. In this circumstance, psychology team members will continue to have access to other team members and duty to support with any additional needs which may arise.

If input from the psychological therapies team is not deemed appropriate, the psychologist/therapist may recommend resources and interventions that could be used by the care coordinator with the patient. Further consultations or support can be offered by the psychologist/therapist to aid this work or to reconsider accessing psychological therapies in the future.

At any stage in this process, if there is uncertainty about the most appropriate course of action, the case will be discussed within the psychological therapies team meeting. The outcome will then be communicated to the care coordinator.

Assessment proformas, tools, and outcome measures may be used on a case-by-case basis. These are uploaded to the patient record.

Interventions:
The Psychological therapies team provide both direct (with the patient) and indirect (with staff) interventions. Members of the team will provide some or all of these, dependent on role and experience. See below for more details about the difference in roles within the Psychological Therapies Team.

Direct	Therapy screening assessment Extended assessment and formulation Individual therapy Individual skills-based work Skills group Group therapy Neurocognitive assessment Family therapy and interventions
Indirect	Consultation Complex case discussions File review Supervision Formulation group Reflective practice group Staff team well-being work Training

Role/Band	Interventions delivered	Supervision arrangements
Clinical Psychologists Band 7/8a	Therapy screening assessment Extended assessment and formulation Individual therapy (model varies between clinician and client) Individual skills-based work Facilitation of groups Group therapy Neurocognitive assessment Consultation Supervision of others	Clinical Supervision from another Clinical Psychologist. Clinically responsible for own work.

	Facilitation of formulation group Facilitation of reflective practice group Staff team well-being work Staff training	
Therapists (e.g. EMDR, CBT) Band 7	Therapy screening assessment Extended assessment and formulation Individual therapy (model varies between clinician and client) Group work Consultation Staff training Supervision of others	Clinically responsible for own work.
Family intervention practitioner Band 6	Contribute to Family Therapy Family Interventions Supporting decision making and making recommendations for working with families Supporting Family Inclusive Practice Supervision (including Live supervision) Staff Training Consultation Joint working	Monthly Supervision with Family Therapist Monthly Family Interventions Supervision Group facilitated by Family Therapists Live supervision within Family Therapy Clinics by Family Therapists Clinically responsible for own practice.
Clinical Associate Psychologists (CAPs) Band 6	Therapy screening assessment Extended assessment and formulation Individual therapy (short term, focussed therapeutic work) Co-facilitation of skills group Consultation Facilitation of formulation group Staff training SCM Group	Weekly supervision with Clinical Psychologist. Supervisor holds clinical responsibility.
Assistant Psychologists Band 4	Individual skills-based work (low intensity, time-limited, manualised work) File reviews Neurocognitive assessments Supporting the running of groups Supporting the running of team-based groups (E.g. Formulation/Reflective Practice)	Weekly supervision with Clinical Psychologist. Supervisor holds clinical responsibility.

4.3.7. Occupational therapy

Occupational therapists advise patients, and their families or carers, on specialist equipment and organisations that can help with daily activities. Occupational therapists help patients to adapt to and manage their physical and mental health long-term conditions, through the teaching of coping strategies. OT's develop, implement and evaluate a seamless occupational therapy support service across the CMHT/PMHCN, working with community and secondary care where appropriate, and aimed at continuously improving standards of patient care and wider multi-disciplinary team working.

Access to the occupational therapy team is completed via discussion in the MDT if the discussion sits within the PCMHN level of the service. Although there is no current direct provision of OT within the PCMHN, the ambition is to grow this service via the OT resource within the integrated CMHT.

If the patient sits in the secondary care level of the service, this can be completed via completion of the OT referral form and forwarding on to OT email inbox.

4.3.8. Peer support work

Peer support workers offer an invaluable link for patients to work with someone who has lived experience. This can not only support their mental health and treatment generally but provides a vital support regarding social inclusion.

The peer support workers sit as part of the primary care level intervention and can be accessed via the PCMHN or through step down from the CMHT into the PCMHN.

When identifying a patient for possible peer support intervention, the following gold standard should be following as closely as possible:

- If the patient is new to the PCMHN, the clinical lead to identify possible intervention through the MDT in discussion with the peer support workers and the lead for this part of the service.
- Discussion for allocation to a peer support worker should be completed via discussion with the peer support worker manager.
- Once allocation is identified, the clinical lead or other allocated worker (if the patient has been working with another staff member) should arrange a joint appointment between the peer support worker, clinical lead/other staff member and the patient.
- A care plan should be completed in collaboration with the patient for the peer support work intervention.
- The peer support worker would carry out their intervention and report back through clinical supervision and the MDT on progress or escalation of any concerns.
- The case will be reviewed by the clinical lead providing the peer support workers clinical supervision and completion of further care plans, FACE risk reviews, PROMs and other documents will be completed.

4.3.9. Groups

The delivery and facilitation of groups are a key objective within the community mental health service. When delivered appropriately, they can provide additional capacity to the team as the intervention can be run for several people at once, and also provides a peer support element and other potential benefits to the patients who are accessing them.

It should be noted that group work is not for everyone, and the team may need to work with the person to recognise and manage any negative feelings and experiences associated with past group work. If the patient does not engage with this intervention of starts to disengage over time, the team should identify with the patient the reason for this and work collaboratively with them to overcome any concerns they have with this. If the patient choses not to take up the group offer, but this is the most appropriate care pathway for them, the reasons for not wishing to undertake a group intervention should be considered by the team and whether any alternative treatment can be provided.

Those awaiting group intervention will be held on one of three access plans, whether they are on caseload or not, including:

- Waiting for next SIP Group
- Waiting for next SCM Group
- Waiting for next trauma stabilisation group

On commencement of the group, the patient will be placed on the caseload of the group facilitator and taken off the access plan. If the group is the main intervention for the patient, the group facilitator should hold overall caseload responsibility whilst they are accessing this treatment pathway. If the group is alongside other care ongoing with someone else holding the case, the group facilitator should work alongside as a co-worker.

A review of the effectiveness of the group and ongoing care needs should be completed as standard for all group participants, with discussion in the MDT meeting for allocation of further care if required, or discharge from the service following treatment completion and review by a registered clinician or agreement within the MDT. Any discharge from non-attendance at the group should be undertaken as a direct review with the patient.

4.3.10. Duty

There will be a duty rota within each team to which two staff are allocated per day (1 duty worker and 1 shift co-ordinator). There will always be a qualified practitioner on duty. Duty is to be covered for either a one day period or a half day period. Staff must always complete their availability for duty cover. Whilst the rota is devised, the rostered duty worker is responsible to promptly notify the Team Manager if they cannot work their allocated duty session due to any unforeseen absence. The manager is responsible for ensuring that this duty is allocated to another worker. Individual staff are responsible for swapping the duty worker role in good time if they know in advance that they will be unable to fulfil the role on a specific day.

Role and responsibilities of the designated Duty Worker and Shift Co-ordinator

- It is the duty worker's responsibility to ensure that each member of staff communicates their safety at the end of the day via phone, as per lone working policy. The cut off time for phoning to confirm safety is 16.45 unless a prior arrangement has been made.
- The duty worker, at the end of the day will ensure that the building is safe to be left and is secure.
- The duty worker will manage clinical calls in the absence of the patient's designated worker in a timely fashion and follow up any actions and ensure any outstanding work is handed over to the next duty person.
- The Duty Worker will record all clinical contact in the clinical record and make the relevant care co-ordinator aware of any significant issues.
- The duty worker will be responsible for handover of specific clinical issues to Care Co-ordinators, Team Manager/Clinical Lead and ensure follow-up to the next day duty worker if appropriate.
- The duty worker must seek additional support/guidance/advice from the Shift Co-ordinator in the first instance if they require additional support or advice in this role.
- The Shift Co-ordinator will provide support to the Duty Worker to facilitate face to face contact with patients when necessary and will also support the management of the Lone Working Policy.

PCMHN Point of Contact (PoC)

The Hull PCMHN will provide a PoC via an assigned clinical lead daily. The PoC will manage a shared mailbox and be responsible for being the main contact person for all other network staff, or other team members who may need to discuss a matter pertaining to the network. The PoC will ensure they are available during the core hours of the service and are there to direct and support other team members as required. The PoC is not a replacement for duty and patients who are receiving primary care level interventions may need the support of duty still.

4.3.11. Escalation in care needs

Needs and risks very rarely remain static and therefore the clinical team, other professionals, patient, and family (where appropriate) should remain vigilant to changes and act accordingly.

'Red flags' and key risk indicators should be used to support identification of changes in clinical presentation and risk status, where these support real time understanding, formulation and onward planning on care. An exhaustive and up to date list of 'red flags' cannot be provided within this SOP, however relevant guidance can support the use of these in practice including NICE, NCISH, RCPSYCH and the use of emerging evidence in mental health research.

Risk and need does not fluctuate in just mental health, but also in a person's housing, finances, family situation, social support, physical health to name a few. Therefore, the clinical team should consider all areas of destabilisation in planning of escalation of care needs. Cases with increasing needs and risks should routinely be discussed in the MDT meeting and the outcome documented on the patient's records, with clear actions and plans/timescales for review. Clinical prioritisation may alter based upon escalation of care needs and should be based upon presenting needs and

risk, with clear rationale documented in the clinical record as to the actions taken or not taken in relation to increasing care needs.

See section 4.4 for further details on step up of care needs as required.

4.3.12. Physical health

Evidence identifies people with a serious mental illness (SMI) have higher rates of mortality than their general population counterparts. This is due to a combination of factors including (but not limited to) higher prevalence of tobacco use, substance use, the negative effects of medication and the exclusion from services to support health and wellbeing.

As such, it is of the upmost importance to identify unmet physical health needs and support the person to access the appropriate treatment in a timely manner, which befits the concern. All clinical staff, to varying degrees, have a responsibility in this area and to escalate concerns regarding physical health issues if they identify them.

SMI patients should be offered an annual review of their physical health to support with early identification of physical health needs. Community mental health services should ensure this has been completed and support the patient to be empowered to understand why this is important and to access it.

Furthermore, physical health checks should be completed by the team, under the advice of a prescriber, when initiating, stopping or changing medicines. The prescriber may also request additional physical health checks in the form of bloods and ECG from the GP when required.

If a patient presents with a potentially urgent or life-threatening physical health concern, this should be escalated to the appropriate agency including GP, urgent treatment centre or emergency services. If the clinician is unsure if there is an urgent or life-threatening need or they lack the skills and knowledge to make a judgement on this, they must urgently seek out advice from an appropriate clinician to support the decision making.

Should any plans or agreements be made with the patient or family regarding escalation of physical health concerns, an appropriate follow up plan should be put in place to ensure this has occurred.

Please see additional guidance on managing the deteriorating patient

4.4. Steps within the service

The community mental health services, following the community mental health transformation framework, now have tiers of service for offering different levels of intervention for people with primary level and secondary level needs. A patient should be able to transition between tiers of the service as per their clinical needs and risk status, without reassessment and with ease of access and no break in treatment. This is also true of individuals stepping across into similar services of stepping up and down in acute services.

4.4.1. Steps between primary and secondary care level interventions and out into other Humber services

- Step-down – towards the end of a specific piece of care, a patient led review will be completed and will inform the next step when a less intensive level of care is required,
    - E.g. HBT to community mental health services
    - E.g. Secondary care to Primary care element of community mental health services
    - E.g. Psypher to Primary care element of community mental health services
    - E.g. Community mental health services to PCN (GP service) or VCSE
- Step-up – when a patient has escalating needs in respect of their health problems

- E.g. – Primary/Secondary support following “Assessment intervention” to MHCIT
    - E.g. – Primary to Secondary support within the integrated community mental health services

- Step-across – this would reflect when a patient is sign posted to another service either within the community mental health services or to external services, but there is a specific piece of care interventions that is required

    - E.g. – community mental health services following “Assessment intervention” to “MHWBC intervention”
    - E.g. – community mental health services following “Assessment intervention” to VCSE or other external provision such as IAPT

- Step-out – once a period of brief intervention has been offered the expectation is that a patient can step-out of the community mental health services

    - In order to facilitate recovery the patient must have ease of access back to the community mental health services should their needs change significantly
    - Care can be reviewed with the patient and MDT at point of contact if accessing services again

4.4.2. Step up/step down to/from acute services

Interface with the Mental Health Crisis Intervention Team for CMHT

Where intensive care is required beyond the normal expected support from community mental health services, patients will be referred to the Mental Health Crisis Intervention Team (MHCIT). This service gatekeeps all inpatient beds and provides alternative acute care through Home Based Treatment (HBT), ensuring where feasible and safe to support patients and their family/carers to remain in the community. Prior to any discussion with the MHCIT for either HBT or inpatient admission, the community mental health service worker should gain consent for the this to occur and explain to the patient what a HBT or inpatient admission involves, including the offering of the service. This discussion should be realistic and explain all aspects of this intervention including practices which may appear restrictive including access to personal items and smokefree policy.

The MHCIT service will only accept referrals from the community mental health service where there has been contact with the patient by the team on the same day. All internal referrals need to be phoned though in the first instance where a clinical discussion will take place and the MHCIT completes an internal referral form. This dialogue with the Named Worker/Duty Worker is to ensure that the service is clear about identified needs/risks and the type of intervention/support required, only after the agreement that the referral is accepted by the MHCIT will it placed on Lorenzo.

All referrals to MHCIT will be reviewed and triaged by MHCIT who have their own process. MHCIT is not the service for weekend support; unless there are clear treatment requirements and not being provided care through MCHIT would lead to an admission. A telephone call to MHCIT to notify the potential contact by the service would be expected to ensure the team are aware and therefore facilitate a safe intervention.

Internal referrals are accepted directly and all paperwork should be completed and accessible, to include the following:

- Internal referral form (completed by MHCIT)
- Up to date FACE.(due to change in presentation and a different pathway is being considered)
- Up to date Care and Intervention plan to reflect the changes and requirements in care.
- Clinical note reflecting the clinical decision, reasons for referral, gatekeeping considerations and expectations + any other relevant clinical information.
- Up to date MHCT completed

At the time of assessment, permission should be sought from the patient as to what information can be shared and with whom and carers identified. MHCIT staff will also inform them of their right to confidentiality following the assessment process in line with HFT policies. Attempts should be made to involve carers where permission has been given. It will also be highlighted to the patient that where carers are involved MHCIT staff can accept information from the carers even if permission is not given to share information.

Please see the MHCIT and Bed Management SOP for further specific details on inclusion criteria and internal processes.

4.4.3. Step down to CMHT from HBT and acute service

When considering step down to CMHT from HBT and during HBT intervention for a patient open to the CMHT, the following good practice elements should be followed:

- Regular contact between the HBT team and CMHT should occur to ensure services are up to date with the patient progress
- A joint clinical handover meeting should be agreed with the patient
- HBT should distribute their discharge letter to the CMHT

Upon step down back to the community mental health service from acute service, and within the first 4 weeks of returning to the community, a review of the following should take place:

- A review and update of the FACE risk assessment
- A collaborative and comprehensive community-based care plan
- Completion of patient recorded outcome measures
- Long term goals and routes out of service/discharge planning
- Agree a frequency of contact, safety plan and review of the needs of the family/carer with appropriate signposting/onward referral
- A discussion with the psychiatrist and booking of follow up appointment if required

Interface with the Mental Health Crisis Intervention Team for PCMN

If a PCMHN patient presents in crisis, a referral can be sent to MHCIT by using their email address (hnf-tr.MHCIT@nhs.net). To ensure that the referral is appropriate this referral will come through the PCMHN Clinical Lead and follow the steps below:

- If a person presents in Crisis and is open to the PCMHN including Peer Support Workers and Health and Wellbeing Coaches, then they will escalate this to the appointed clinical lead. The Clinical Lead will provide the appropriate advice to manage the immediate situation/safety. The Clinical Lead will then take over responsibility (if required) of managing the situation to a safe and effective outcome. The clinician would then liaise with the appropriate service to transfer care to the most appropriate team. If the outcome was to refer to the MHCIT, the MHCIT referral form would be completed and sent to the email address above. At this point the person would be discussed in the PCMHN MDT to discuss their future care within PCMHN.

MHCIT are aware the PCMHN is a primary care service, therefore some patients will not have a Face risk assessment, clustering tool or initial mental health, unless they have come through secondary mental health service.

This agreement has been made with the MHCIT leadership team and relates to patients under PCMHN level, not CMHT.

4.5. Discharge from the service

Discharge from the community mental health service must be a planned process in collaboration with the patient and carer. Collaboration in this respect includes but is not limited to; timescales for discharge, onward care provision, relapse prevention planning, safety netting, and carer support. This should also take place with any agencies whom the care of the patient may be transferred to, or they are currently engaging with (please see 4.13 for further consideration).

When being discharged from service, patients will receive a letter and be offered a plan, which will indicate clear routes back into the service for that individual if needs be. Relapse prevention work will, at all times, seek to empower the individual and their family with the confidence and the skills to manage their mental health.

The Trust CPA Policy and Procedural Guidance (page 19) states that:

> Discharge from Mental Health Services
> Where it has been agreed at review that discharge from secondary care services is appropriate then this decision should be recorded on the appropriate documentation. The only criterion for discharge from the Trust is that the patient no longer needs support from any part of the Mental Health Services. Where the patient requests that care be discontinued against the advice of the MH care coordinator and/or multi-disciplinary team, then every effort must be made to develop/present a care plan that is acceptable to that individual. This could mean delivering only part of the original plan or making substantial modifications. (See also service users requesting self-discharge within Discharge/transfer Policy.) Where compromise cannot be reached, support should be offered to the patient and/or carer, and they should be given full details of how to contact the Mental Health Services for future reference.

The discharge of any patient from the community mental health services with a history of violent and aggressive behaviour towards others should be discussed and considered by the MDT prior to discharge and recorded in the clinical record and discharge paperwork.

Also care coordinators should ensure they notify the service user's GP and other services/agencies that the service user is either involved with or may come into contact with, as it may be that some individuals may quickly relapse in their mental health without the level of service they have been receiving previously. Consideration should also be given to arranging a VARM (Vulnerable Adult Risk Management) meeting if the individual is thought to be vulnerable. Withdrawal of a particular service or intervention should only take place with the agreement of the team following full discussion with those persons/agencies involved in the service user's care. Unilateral withdrawal of services or discharge from caseloads will be avoided at all times

This will be followed with every patient open to the team, including those on a waiting list, attending a group, on CPA or being case managed. This will support the safe discharge of patients and will allow for a full discussion about the most relevant way to progress for any individual by the full multidisciplinary team.

Discharge plans must include consideration of carer/family concerns especially where the carer/family member is also in receipt of mental health services. The discharge will also be discussed at the team MDT discussion where all clinical disciplines review ongoing care and cases. This includes representation of the team clinical leadership too, i.e.
Clinical Lead, Consultant Psychiatrist, Clinical Psychologist. The teams should also consider the Trust's MDT Care Planning Guidelines which indicate inclusion of dedicated focus services for specific presentations or issues (e.g. Complex Emotional Needs Service, Humber Adult Autism Diagnostic Service) in MDT discussion, where efforts to locally care plan have been unsuccessful.

Please see the MDT Care Planning Guidelines

If the patient and family do not agree with the discharge and plan, their views must be taken into consideration and presented in the MDT meeting. The patient and family should also be given the opportunity to meet with and discuss the discharge with the clinical lead of the service to informally manage the disagreement. Should disagreement still continue, escalation to the senior clinical lead would be appropriate. Discharge should always be based upon clinical information/evidence, NICE/care guideline and the needs of the patient.

Discharge paperwork and process should be completed by the allocated worker and should include:

- Updated FACE risk assessment
- Review of the Mental Health Clustering Tool
- Patient recorded outcome measures
- Relapse prevention and safety netting procedures, in a letter/care plan to the patient
- A letter to the GP/any other care provider following discussion and planning of the discharge
- Carers support in place for family
- Any onward referrals required to be made

4.6. Disengagement and DNA

Sometimes, patients will disengage from the support the team is providing. Should this be the case, the worker/team should consider the reason for this and what barriers may be in place to deter engagement. Where possible, understanding of the disengagement should be sought by directly discussing with the patient and family, or other professionals who may be involved. The ethos for managing disengagement should always be to consider how we can better engage with the patient, rather than how can they better engage with us. Consideration of a face to face appointment or a home visit must be considered and rationale documented as to why this has not been offered to patients who disengage to ensure this is not because of a deteriaoration in mental health.

The team will proactively follow up patients who have not attended an appointment or who are having difficulty engaging including the option of an unplanned home visit. Patients should not be discharged back to their GP simply because they have missed, cancelled or rearranged appointments, or missed a group session. Any decision to discharge should always be a clinical decision, based on the individual patient's best clinical interest and ratified through a minuted discussion at an MDT meeting. Discharge via disengagement should never be a punitive action. Please see 4.13 for consideration of the interface with external agencies.

The following steps to good practice will be adhered to in safely managing missed appointments, did not attends and no access visits.

- Recognising non-attendance. This may be non-attendance at clinic appointment or not available at a planned or urgent home visit.

- The individual recognising the non-attendance must take action. If this individual is a non-registered practitioner they must discuss the case with a supervisor and/ or clinical lead practitioner.

- Identify and take action to minimise risk to the patient and/or others, utilising appropriate clinical information to support the actions.

- If the patient is known all relevant information relating to risk should be used to formulate an action plan. This may involve existing care plans, contingency and crisis plans. This may also include formal approaches to assessment under the Mental Health Act 1983 or assistance/engagement with other agencies such as Approved Mental Health Professionals (AMHP).

- If the patient is not previously known to services or additional information may be required to formulate an action then the referrer/GP must be contacted to identify potential risks and to agree any actions.

- Following robust attempts at engaging with the patient and after agreement with the MDT, patients who do not attend (DNA) will be sent a letter inviting the person to contact the team within 14 days. The named worker or duty officer will document all action taken on the

patients electronic record. Where no action is considered to be necessary this should also be recorded with a clinical rationale as to how this has been concluded

- If no contact is made within the time frame a communication is required to the referring agent, the patient and the GP notifying them the patient is now discharged.

- If the patient is subject to a Community Treatment Order or Home Office Conditional Discharge arrangements the Responsible Clinician should be made aware at the earliest opportunity in line with the details of the after-care plan.

4.7. Agile working

All patient activity should be recorded on Lorenzo the Trust's Mental Health Clinical Record System or SystmOne if patient is only open to a Mental Health Wellbeing Coach for lifestyle support.

The community mental health services are working in an agile manner with staff will using laptops, smartphones and hot desking when required at base.

Wi-Fi is available at all Trust premises so staff are able to 'drop in' to use available desks to access Lorenzo and other applications rather than having to return to their office base to update the Electronic Patient Record (EPR) after they have seen patients. Additionally, the ability to access these applications from home is available and the Trust also has partnership arrangements with many other organisations, for example GP Practices thus enabling staff to use many locations across Hull.

4.8. Lone working

The safety of workers is paramount to the ability to provide an effective service. Staff frequently work alone in the community and face a variety of challenging situations. Team members should comply with the Trust lone working policy.
It is the duty worker's responsibility to ensure that each member of staff communicates their safety at the end of the day via phone, as per lone working policy. The cut off time for phoning to confirm safety is 16.45 unless a prior arrangement has been made. If no contact is made the duty worker needs actively contact the staff member by telephone initially to check safety. If they do not answer the phone then this is escalated to senior member of the team (Shift Co-ordinator or Team leader).

A decision will then be made to (via assessment of risk).

- Contact the last known address by telephone.
- 2 x members of staff to visit the address listed.
- If contact cannot still be established contact the police.
- Contact NOK.

The duty worker, at the end of the day will ensure that the building is safe to be left and is secure.

4.9. CAMHS transitions

Transition for young people approaching their 18th birthday will be managed in accordance with the relevant CAMHS Transitions Policy and Protocol. Referrals to the adult community mental health services in such cases will be accepted for young people aged 17 and half years old and above in accordance with good practice and opportunities for preparation and joint working.

The Children and Young People (CYP) services key worker will coordinate transition with the identified adult clinician with support from both team managers if required.

The CYP services clinician will be the lead professional in a young person's care until the age of 18 and take the lead in overseeing and co-ordinating the appropriate level of support needed within adult services. This may require a multi-agency approach to ensuring all aspects of care are recognised and supported. This remains the case even when an adult service is providing an

intervention prior to the age of 18 if the young person remains open to CYP services. A CPA review or other planning meeting, involving the young person, should take place as soon as possible, and this should document clearly the transition plan and the date upon which the adult services clinician becomes the lead professional instead of the CYP services clinician.

Please see the CAMHS transition policy and passport for further details

4.10. Forensic transitions

The community mental health service will support the appropriate step down from forensic services for those whom no longer require this level of care. The Humber and North Yorkshire Provider Collaborative provide a Single Point of Access for all referrals for forensic inpatient and community services in the area. The Humber Specialist Community Forensic Service (SCFT) works with people in community settings who have a needs which can only be met via forensic services, however these needs will not remain static and therefore transition to mainstream services will be required at some point within their care journey for most.

The SCFT provide a series of points in the care journey including, consultation, assessment, intervention and care coordination. If a patient is open to the community mental health service who may have needs of a forensic nature, the SCFT is available for consultation and support should the team wish to access this. Consultation should not purely be based on completion of a forensic risk assessment but should indicate the underlying need and advice which is being sought to work with the person. Furthermore, if the team are looking to discharge or move someone's care to another provider and the patient has forensic history, the SCFT can also provide consultation and discharge planning advice in this circumstance. The team can also provide advice on MAPPA and signposting where appropriate.

Transitions to mainstream services will be considered as soon as possible by the SCFT. Most patients will require transfer of responsible clinician and care coordinator, plus some will require an element of social supervision. A transition from SCFT to mainstream community mental health services should aim for the following principles:

- Transfer should commence 2 months prior to planned transfer date
- An internal transfer form should be completed by SCFt, a call placed to the community team to discuss the transfer and an electronic referral made if this is the agreed outcome
- If the patient has needs which require the ongoing input from the community mental health service, they should be allocated a care coordinator and responsible clinician
- If the patent does not appear to have needs which require the ongoing input from the community mental health team, this should be escalated to the clinical leads of the services to discuss and to the MDT. If this does not resolve the dispute, further escalation to the senior clinical leads may be required.
- The care coordinators should meet to discuss transfer arrangements and joint visits
- The responsible clinicians should meet to arrange handover
- A joint care plan should be developed with the patient to support the transition period
- Full transfer should take place on the agreed date

An interface meeting between community mental health and SCFT should be established to support joint working and transitions but should not supersede the elements of good practice for the transition as stated.

4.11. Older adults transitions

Where appropriate and in accordance with local commissioning arrangements and service configuration, transition into Older People Services for people around the age of 65 should be managed on a needs-led basis through CPA using established protocols to plan care and provide continuity.

Please see Older People's Mental Health and Working Age Adults transition SOP

4.12. Interface between the Community Mental Health Service and the Complex Emotional Needs Service (CENS)

Patients care co-ordinated by CENS do not require an open referral to be maintained to the CMHT.

If a patient who is open to CENS requires a medication review or other intervention provided by the CMHT that CENS are not commissioned or able to provide (for example CMHT psychology, occupational therapy), then a referral into the CMHT can be made directly by creating a referral to the relevant CMHT on Lorenzo, alongside the completion of a clinical note/letter detailing the request. After the identified request has been completed, the CMHT would then close the referral and direct them back to the referring service.

CENS will initially provide indirect support to the CMHT in working with patients. If CENS agree to assess a service-user, the CMHT remain the lead team with responsibility for all tasks e.g. FACE, care plan, follow-up, unplanned care liaison, until the point that CENS agree that they will take care co-ordination responsibility, if appropriate.

The responsibility for the social care packages of patients whose package pre-dates their referral to CENS will remain with the agency or team who initiated/completed that work, which may be the CMHT. If there is a subsequent change in need such that it is more clinically appropriate for a review/re-assessment to be undertaken by CENS social work provision, this should be discussed with the CENS clinical lead in the first instance by the CMHT social work lead to identify which is the most appropriate service. If a patient is open to CENS for care co-ordination and has no open referral to the CMHT and a social care need becomes evident, CENS will fulfil this need. Once the package is considered stable this should be transitioned to CMHT social workers or the local authority, as appropriate. In the unplanned event that CENS do not have social work provision, the CMHT social workers will facilitate the social care needs of CENS patients who would otherwise be eligible to be supported by the Hull CMHT.

4.13. Interface between CMHT and Humber Dialectical Behaviour Therapy (DBT)

Patients referred to DBT require an open referral to a CMHT during the initial group phase of treatment, and should be allocated to caseload of an worker. During this time, the CMHT remains responsible for tasks e.g. FACE, care plan, follow-up, unplanned care liaison, until the point that DBT agree that they will case manage the patient, if appropriate. This will typically not occur until at least 12 weeks into individual DBT. Discharge from the CMHT should not be initiated unilaterally for patients within DBT; this should be a joint decision between DBT and the CMHT, with any disagreements escalated via clinical leads.

If a patient who is case managed by DBT requires a medication review or other intervention provided by the CMHT that DBT are not commissioned or able to provide (e.g. occupational therapy), then a referral into the CMHT can be made directly by creating a referral to the relevant CMHT on Lorenzo, alongside the completion of a clinical note/letter detailing the request. After the identified request has been completed, the CMHT would then close the referral and direct them back to the referring service.

Humber DBT is a psychological therapy service and does not have a social work function. As such, social care needs for patients case managed by Humber DBT would be met via CMHT social workers or the local authority, following a referral from Humber DBT to the relevant agency.

4.14. Interface with external agencies – new referrals/in treatment/discharge

Where an individual's ongoing support or intervention plan is to be delivered by an external agency (whether that is an established relationship or a new referral), the discharging clinician is responsible for liaising with that service to ensure that the provision is clinically appropriate and available to meet the identified needs. This allows the clinician and patient to formulate an alternative plan, prior to discharge, if required. There may be circumstances under which there is a strong clinical rationale to facilitate the patient in managing their own care/self-referral, in those instances a rationale for not liaising with the external agency must be documented.

4.15. Clinical audit

Clinical audit is one of the components of clinical governance. The team participate in Trust wide audits where appropriate or required. Team managers/clinical leads are responsible for working with staff to ensure collection of the required information.

Case note record audits will be completed as part of ongoing supervision and other additional audits, such as audits of clinical supervision may be undertaken as appropriate as part of service evaluation. The sharing of any audits should be completed via the clinical lead to the team to support learning and development.

It is essential that teams incorporate the learning from serious incidents, complaints and audits into clinical practise. Team managers and clinical leads will oversee the application of learning outcomes in consultation with trust structures e.g. The Clinical Governance, Clinical Networks and Risk Management Team.

The use of clinical and operational reports is vital to ensure safety and quality of the service. The clinical lead, team manager and senior admin team will have responsibility to review and action several reports which include the following information (not exhaustive); waiting times for those on access plans, anyone not allocated to an access plan or caseload, date of last contact and date of last care plan, cluster, FACE risk and ReQoL.

These reports should be utilised on a 1:1 basis with staff members directly and also on a larger team scale to monitor general performance and quality on a twice weekly/weekly and monthly basis, depending on the report.

4.16. Incident reporting & escalation

The community mental health services and Humber organisation is committed to an open and just culture at work. An open and just culture is vital to ensure learning takes place, and to develop a safe and effective service. The organisation is currently rolling out the Patient Safety Incident Response Framework (PSIRF), with a focus on learning from patient safety incidents and no blame culture. An open and just culture is vital to ensuring a safe and effective service, a culture without the fear of reprisals or blame. Therefore, all staff are strongly encouraged to ensure they are aware of safety incident reporting procedures, the use of DATIX and their awareness of the risk register.

Escalation of issues is a very important part of activity management. Escalation ensures:

- Staff are supported with resolving issues
- Those with responsibility and accountability are aware and sited on the issue and given time and opportunity to assess and respond
- Upward escalation/assurance can be provided if needed
- Early escalation can avoid bigger issues from occurring
- Escalation allows for Service Improvement plans to be developed to avoid future issues from occurring

Escalation is a form of communication which ensures a right place, right time, right person culture. There are many instances that could and should prompt escalation though it is not possible to be entirely explicit in describing each event and escalation route as they will be unique. It is however possible to describe a set of guiding principles to help understand situations that require escalation and to who:

Guiding Principles / Escalation Triggers (not exhaustive)

Service Cover	Inability to perform essential elements of role/safety and wellbeing concerns.
Financial	Inability to apply solutions without incurring additional costs – budget holders would need to be included in issue and resolutions i.e. staff overtime, additional lists, additional equipment
Performance	Scenarios affecting the achievement of the expected activity performance i.e. treatment delays, allocation delays, cancellations, reporting, clinical rota etc.
Capacity	Early capacity escalations in line with fluctuations with demand and capacity, unexpected events impacting on expected capacity.
Incidents/Complaints	Events that may result in incident/complaints or receipt of incident/complaints that require escalation as unable to resolve effectively.
Reputational	Events that could cause reputational risk i.e. safety, security, mishaps/human error, poor quality, ethical – the majority of which is already covered in the above but there may be specific incidents that affect the internal or public collective view on our services.

Escalation Routes

Incident	Level	Who	When
Immediate member of team is aware of the issue, has assessed and is able to resolve without any impact as described above	Awareness	Immediate Line Manager & Next Immediate Line Manager	Following assessment – provide update to include issue, assessment and resolution, impact
Immediate member of the team is aware of the issue, has assessed and is unable to resolve without impact as described above	Escalation: For Action/Decision/Onward Escalation	Immediate Line Manager & Next Immediate Line Manager	Following assessment – provide update to include issue, assessment and resolution, impact

Escalation Priorities

Urgent	requires immediate attention (in order to avoid impact solution required in week). Should be escalated by phone call and followed up with email
Routine	requires attention (in order to avoid impact solution not required in week). Should be escalated by email and discussed in regular team meetings/catch ups.

Should any operational or clinical issues requiring escalation be identified by any team member, these should be escalated through appropriate structures including individual supervision, business meetings and MDTs. Patient safety concerns should routinely be escalated to the service manager and senior clinical lead.

Specific areas to consider for effective escalation (not exhaustive):

- All access plan breaches identified by the admin team as per section 4.2 should be routinely escalated to the clinical lead/team manager for action.
- All access plan breaches, and reallocation challenges should be routinely escalated to the service manager and senior clinical lead for awareness and possible action if remain unresolved.
- All staff are responsible for escalating breaches regarding CPA review and 3 day follow up to the clinical lead/team manager, who should in turn escalate to the service manager and senior clinical lead for awareness and the plan to action.
- Any impact on effective, safe and quality care delivery (including regular contact (min monthly), completion of mandatory documentation (care plan, CPA, FACE risk) or inability to offer planned intervention) with or without reputational risk should be escalated to the clinical lead/team manager and subsequently to the service manager and senior clinical lead.

Should any staff member feel unable to report concerns to their immediate supervisor, they should go to a more senior person to report their concerns, or utilise the 'Freedom to Speak Up' process/guardian to raise the issues.

4.17. Supervision

The Trust is committed to ensuring that all staff engages in supervision as part of their continuing development, organisational and professional accountability. Supervision is included in the terms and conditions of all posts and is a requirement of national standards within care quality commission quality standards and guidance from a range of professional regulatory bodies. The Trust supervision policy differentiates management, clinical & professional supervision and lays out recommended frequency of the various types of supervision.

Supervision is a key element in maintaining wellbeing at work and as such, it should be prioritised to ensure this, and safe and effective care delivery.

Supervision is an opportunity to discuss issues arising from patients on the staff members caseload and comes in several forms both informally and formally. Whether supervision is sought on an informal or formal basis, if any discussion is had with another clinician regarding a patient's care, this should always be documented on the patient record, alongside the outcome from the discussion. Furthermore, any discussion from MDT meetings, peer support, case formulation etc. should be documented on the patient records also. This information is vital to support a contemporaneous record of the patient's journey through services.

Managerial and clinical supervisors will routinely use available reports to monitor the activity of the staff member, last contacts with patients on caseload, 4 week wait to treatment targets and the review of key documentation (CPA, FACE risk, care plan). These reports should be utilised on a 1:1 basis with staff members directly to support supervision discussions and monitor quality of care.

Supervision is an opportunity for staff to explore issues at work which may be affecting their wellbeing and resources which may be able to help manage this, including a referral to occupational health, a stress at work assessment, a back care assessment, using VIVUP benefits, or accessing the resilience hub. All staff are strongly encouraged to engage with and complete their wellbeing at work passport.

4.18. Training and Development

Training and development will reflect local and national drivers including NICE guidance, the needs of the trust/local authority and individuals who use services. These development needs will be identified and reviewed in line with the Trust Appraisal Policy. All staff will be appraised annually as per the Trust Appraisal Policy.

The Trust recognises that continuing professional development is a key element of ensuring the delivery of evidence-based quality services. Role development and scope of practice is also increasingly relevant to the provision of staff training and supervision.

All staff will keep up to date with their individual statutory and mandatory training requirements either through e-learning or by attending relevant face to face or video conference based training sessions.

Team managers and clinical leads will facilitate staff and team development as required, liaising with the training and development department or Professional Lead Educator as appropriate. Training necessitates the absence from normal duties of the team. Cover arrangements will apply wherever possible and should be discussed in advance with the team. Full team training days will necessitate specific cover arrangements from other locality teams and will be decided well in advance in order to ensure service continuity

The Trust aims to provide the highest standards of pre-registration and post-registration training and development. Students from various disciplines are regularly attached to teams as part of their training. All such students will be advised of the operational policy of the teams and will understand the supervision arrangements within the team. All disciplines are required to provide practice supervision to students. Patients have the right to choose if students are present for their appointments.

4.19. Complaints and PALS

Issues and concerns will initially be dealt with at a local level to a satisfactory outcome.
Trust Complaints and PALs department will co-ordinate all complaints, concerns and compliments within the newly adopted integrated guidelines. All team members are responsible for adhering to the Trust complaints procedures and for ensuring that patients and carers know how they can complain or offer a compliment if they wish to do so.

Serious allegations and complaints which cannot be resolved informally will be dealt with according to the Trust complaints procedures, and concerned parties will be advised to contact the PAL's Team for support in the process.

A key part of the process of complaints is identifying themes and learning, to develop a safer and more effective service in the future. Outcomes from complaints will be routinely shared with the team in the business meeting, where reflection and discussion will be encouraged. The team manager will coordinate complaints and feedback to the clinical leads, service manager and senior clinical lead with outcomes.

4.20. Involvement of Patients and Carers

Patient and carer involvement is a high priority for the MHLT and the Trust. Patients should always be involved in the planning and provision of their care. Patients and their carers are given the opportunity to feed back about their experiences of using the service by the use of the Friends and Family Test (FFT) which is available in all team bases and offered to all patients using the community mental health services. Their feedback will be used to improve the service.

All care coordinators/named workers have a responsibility to offer Carer's assessments in line with the Care Act. These should be routinely offered at every review or sooner if circumstances change. The teams social care staff can complete carer's assessments or alternatively carers are supported to access local carer's services.

Anyone who considers themselves to be a carer and provides regular care, paid or unpaid is entitled to have a carer's assessment. This is an assessment of their own wellbeing and how caring has affected them. It does not matter whether or not you live with the person you support.

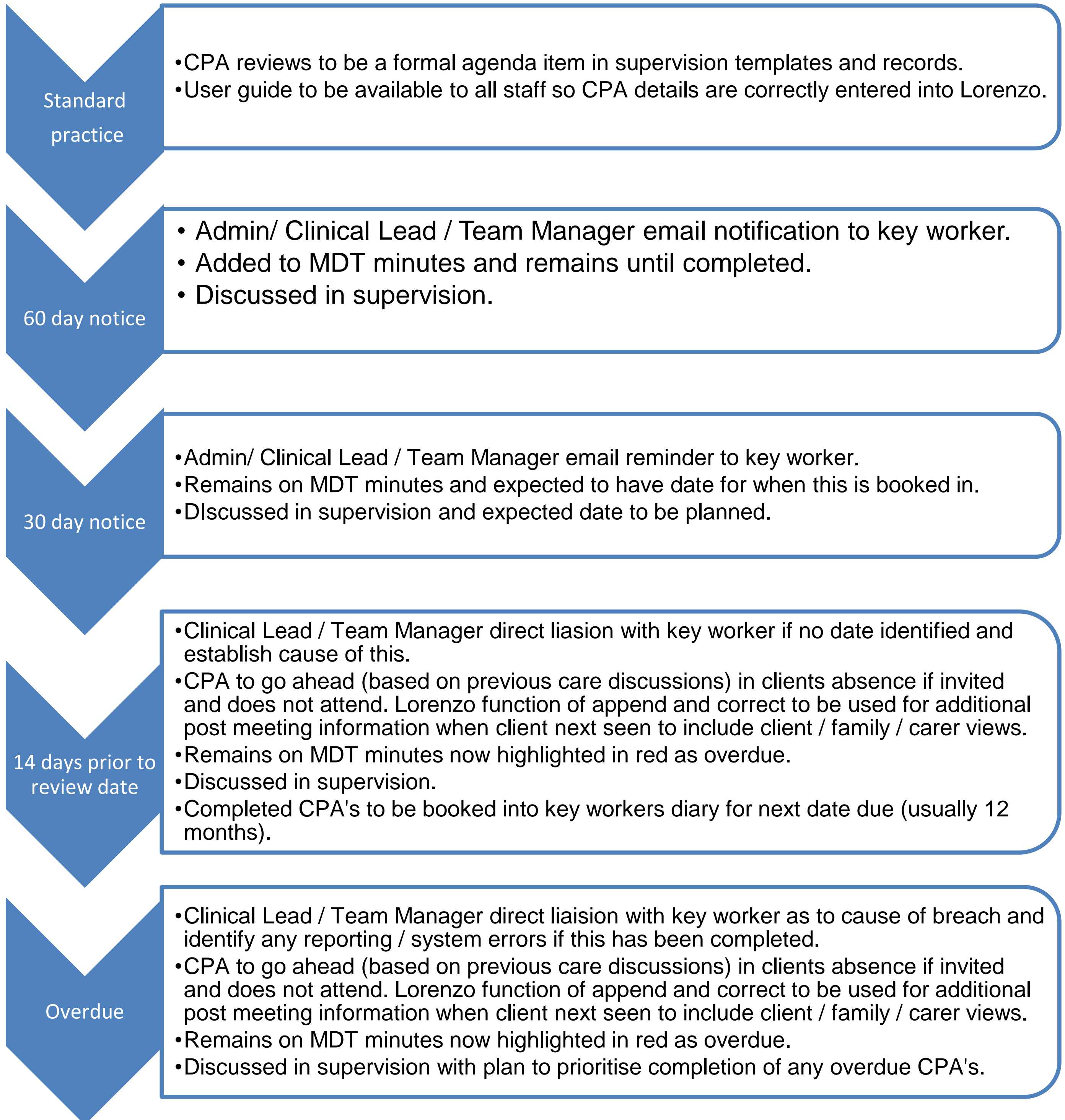
The service shares information about any Serious Incidents involving a patient with the patient and their carer's, in line with the Duty of Candour Agreement.
Family inclusive care coordination, family interventions & family therapy are integral components of the community mental health service.

5. REFERENCES

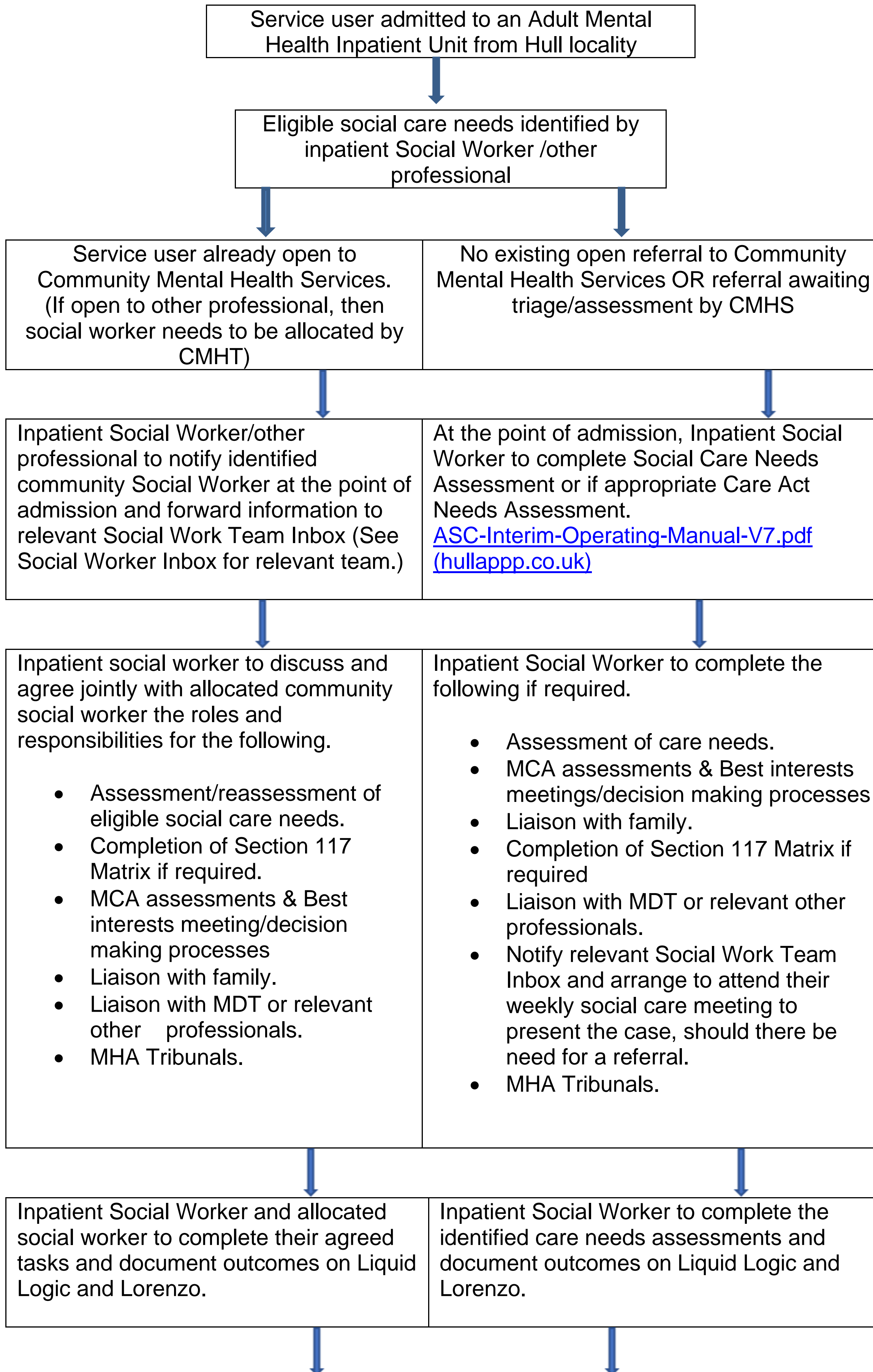
References to various trust policies are made throughout the document and can be found on the trust intranet page here: Policies, Procedures and SOPs (humber.nhs.uk)

NICE guidance is available here: Find guidance | NICE

Appendix 1: CPA Monitoring Process



Appendix 2: Social Work Flow Chart



Inpatient social worker to update nursing team via Daily Care/Clinical Review/CPA Meetings of agreed action plan, shared responsibilities, and outcomes of identified social care needs.

↓

Once the allocated social worker has completed their agreed tasks, they should notify the Inpatient Social Worker via their Duty Inbox. A Discharge CPA meeting will then be arranged.

↓

Where a package of care has been arranged through Hull City Council, a community social worker will need to be/remain allocated to ensure the package is reviewed as set out in the HCC ASC Operating Manual.

Transfer to a long-term team at Hull CC can be considered if the criteria set out in the manual is met – see Case Transfers.

Social Worker Team Inboxes.

hnf-tr.hullwestsocialcarereferrals@nhs.net - West Community Mental Health Team.

hnf-tr.eastsocialwork@nhs.net – East Community Mental Health Team.

hnf-tr.forensicsocialwork@nhs.net - Forensic Services.

hnf-tr.hmht@nhs.net – Homeless Mental Health Team.

hnf-tr.psyphersocialwork@nhs.net- PSYPHER (Psychosis Service for Young People in Hull and East Riding).

hnf-tr.inpatientsocialworkduty@nhs.net – Inpatient Social Work Team.

Appendix 3: Terms of Reference: Quality and Risk Forum (as of 2023)

Terms of Reference – Quality & Risk Forum

Purpose

To provide consistent, timely decision making to ensure that Adult Social Care (ASC) resources are fairly and equitably allocated to meet unmet eligible social care needs.
To approve final recommendations for guardianship orders as recommended by the AMPHS.
To ensure that all decisions are subject to a collective, transparent process where the rationale for the decision outcome is recorded and communicated to the appropriate professionals.
Decision records will be recorded in Liquid Logic on individual case records, which will ensure decision making is clear and robust.

Membership;
HOS ASC will be the Chair and overall decision maker
OPPL ASC (Chair of the JWF)
Service manager for operations ASC
Brokerage manager/deputy (maintains the action log/tracker)
Representative from the following partner agencies; CCG, Humber mental health, Humber LD services
Other attendance will be as required; commissioning manager/officer, legal representative, Civica and debt management, individual worker/manager

Objectives

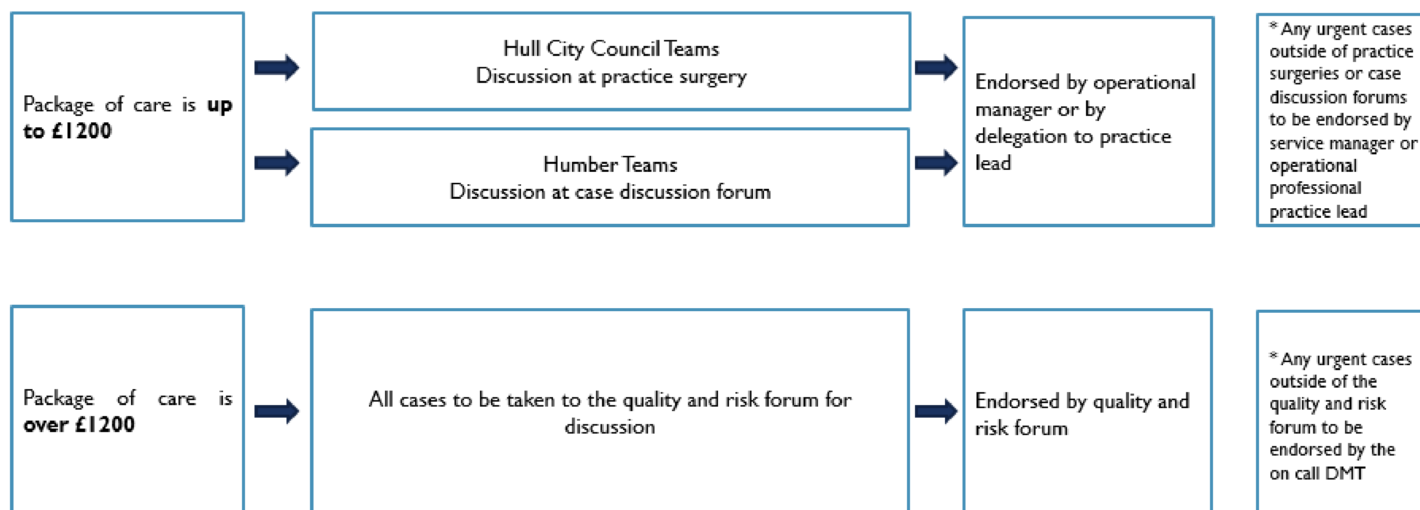
To demonstrate compliance with the legal frameworks for practice e.g. Care Act 2014, Mental Health Act & Mental Capacity Act.
To ensure the council adheres to the legal framework for commissioning. E.g. Fee rates and Dynamic Purchasing System (DPS).
To ensure packages of support agreed are least restrictive and give direction where packages are responding to risks and/or safeguarding concerns or recommendations.
To provide an accountable process; ensuring defensible decision making regarding the deployment of resources.
To agree care and support to meet people's assessed needs and funding streams e.g. ASC CHC, S117 (once these cases have been through the joint panels for CHC/117 funding process) regarding meeting people's needs and progressing disputes where disagreement remains and cannot be resolved using the agreed Protocols.
Identify any concerns regarding unmanaged risks and ensure appropriate action is taken.
Make decisions based on the recommendations of the practice surgery/case discussion forum for the allocation of resources to people with no entitlement to Adult Social Care support or recourse to public funds – informed by Human Rights assessment.
To address issues, remove barriers, ensure compliance or if required escalate non-compliance with Court of Protection (COP) directions, to responsible commissioning authority.

Process

Case workers MUST complete a practice surgery prompt sheet and send to Brokerage JWF box
The Social Work Practitioner will present the case at Q&R where possible, if not a representative of the team to present instead.
All guardianship recommendations regardless of cost will be considered directly at Quality and Risk, the responsible AMHP will be required to present.
Any requests for legal support for example, urgent COP work or transportation, procurement of a specialist assessment or litigation friend will need to be presented at Q&R, any decisions recorded on LL.
Decisions from Quality and Risk forum will be recorded on Liquid Logic and actions will be taken which will be fed-back to the individual worker and their operational manager if they were unable to attend to ensure they understand the decisions and actions required from quality and risk forum.
It is important that social work staff understand the rationale for decisions and feel confident in communicating these to people being supported, their families and carers. If either operational

managers or social care staff are not clear about decisions or outcome they will liaise with the deputy brokerage manager who is responsible for updating the tracker and decision records.

Decision Making Pathway and criteria



Criteria for cases for Quality and Risk forum

- If over £1200 per week.
- 10% above PB – (RAS)
- High Cost
- Risk management support required
- Safeguarding concerns
- Compliant outcome recommendation
- High levels of risk (unmanaged).
- Continued safeguarding issue
- Guardianship recommendation
- Court of protection issues
- Authorisation of court work/ statements on behalf of Hull cc

PLEASE NOTE
Urgent Agreement OR authorisations outside Quality and Risk forum on a Tuesday
Any decisions that are needed to be made outside the forum should be directed to whomever is on the DMT on call rota, the HOS for that service must also be informed. As a general rule this will be Brokerage approaching DMT as they will have the information and costings of care arrangements to make the decision.
A decision record must be recorded on Liquid Logic by the person seeking authorisation.

Accountability

Accountable to the Chief Executive Officer for paid Services, Deputy Chief Executive for Public Health and Public Protection and the Section 151 Officer.

Membership

The core membership is as follows:

Name	Title	Team
Angela Tew	Head of Personalisation and long-term care	Adult Social Care (ASC)
Cheryl Giles	Operational Professional Practice Lead	Adult Social Care (ASC)
	Service Manager for operations	Personalisation & Long-Term Support
Carolyn Hood	Deputy Brokerage Manager	Brokerage
Paul Sullivan		Humber L&D
Chris Denman	Head of NHS funded care	Hull CCG

Other attendees as required

- Adult Social Care (ASC) Lawyer
- Operation Manager
- Principal Social Worker / Occupational Therapist

Frequency

The meetings will take place on a weekly basis. (12 – 3pm)

Administration

The meeting will be supported by a Deputy from Brokerage who will manage the tracker and directly input decisions onto LL.

Review

To be reviewed annually

Reporting

Will report risks and concerns to the appropriate Head of Service (HoS)
Will identify any themes or general risks and direct to appropriate officer / forum eg. DMT
Will support the Quality Assurance Framework and audit process
Will ensure any issues/feedback regarding AMHPs is directed to the contract management for NHS Humber

TOR reviewed annually in May

Appendix 4: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: Hull Integrated Community Mental Health Team and Primary Care Mental Health Networks (SOP21-008)
2. EIA Reviewer (name, job title, base and contact details): Kyle McInnes, Senior Clinical Lead, Hull East CMHT - The Grange, kyle.mcinnes@nhs.net
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? SOP

Main Aims of the Document, Process or Service
The Hull Integrated Community Mental Health Team (CMHT) and Primary Care Mental Health Networks (PCMHN) Standard Operating Procedure (SOP) aims to support the delivery of care for community-based patients. Humber Teaching NHS Foundation Trust (HTFT) and Hull City Council (HCC) provide in collaboration and integration, a joint health and social care service to individuals with a Serious Mental Illness (SMI).
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. This procedural document is in relation to adults over the age of 18 and considers specific areas of need for people who are older. Additionally the procedures include contact with younger people to include their impact. Additional documents related to these groups have been referenced in the text as required.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not on those with a disability and procedures account for reasonable adjustments where required. Copies of relevant documentation can be made into accessible formats where required.
Sex	Men/Male Women/Female	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon sex.

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Marriage/Civil Partnership		Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon marriage/civil partnership
Pregnancy/ Maternity		Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon pregnancy/maternity.
Race	Colour Nationality Ethnic/national origins	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon race. Documents can be made accessible and translated into other languages if English is not a first language.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon religion or belief.
Sexual Orientation	Lesbian Gay men Bisexual	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon sexuality.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon gender reassignment.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The procedures listed in this document will have low impact on those with protected characteristics and will be adopted by the team members within the service area. Special attention should be ensured when applying procedures listed to groups with protected characteristics, especially the groups of race, sexual orientation, gender reassignment, sex, age and disability. Procedures are listed as a guideline to staff, but awareness of flexibility in procedure to ensure non-discriminatory practice should be observed.	
EIA Reviewer: Kyle McInnes	
Date completed: 19.12.2023	Signature: KMcInnes