Community Mental Health Team Service Specification

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Brief Summary of Document:	This service specification provides the framework for the Community Mental Health Teams (CMHT) in Hywel Dda University Health Board. The service specification will describe the service aims, values and principles and standards.
Scope	This service specification covers all staff working within CMHTs within Hywel Dda University Health Board. This includes a range of professionals including nursing, medical, occupational therapists, occupational therapy technician, social workers and healthcare support workers. The teams provide a flexible, responsive and integrated service to mental health service users and their carers in the most appropriate setting. The CMHT will provide an assessment service to people with a range of mental health problems and Secondary Mental Health care for individuals who are relevant patients under the Mental Health Measure (MHM).

To be read in conjunction with:	HDUHB Lone Working Policy HDUHB Medicines Management Policy Community treatment order policy Leave of Absence Policy – S17 MHA 1983 Mental Health Measure 2010 Code of Practice Inter-agency Protocol – S136 MHA 1983, Mentally Disordered Persons Found in Public Places. MHA Code of Practice Welsh Health Care Standards

	NMC Standards for Documentation NICE Guidance Social Services and Wellbeing Act (2004) Transition Policy (from S-CAMHS to AMHS)

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1	New Procedure	

Glossary of terms

Term	Definition

Keywords	Community Mental Health, Secondary Care, CTP

Contents

1. Aim of the Service

To provide urgent or routine mental health assessment from the duty team and Care Coordinate Relevant Patients under the Mental Health (Wales) Measure 2010.

The provision of services must be centred on the needs of the individual and the support needs of their families and carers. The team must ensure that their rights to dignity and choice are respected at all times.
The service will offer secondary mental health care for relevant patients under the Mental Health (Wales) Measure 2010.

This service specification will guide CMHT staff to undertake their work within the context of the following policy guidance.

- Mental health Measure Wales (2010)
- National Service Framework
- NICE clinical guidelines
- Together for Mental Health WAG
- Policing and Crime Act (2017)
- MHA Code of Practice
- Social Service and Wellbeing Act 2014 (SSWB)
- Talk to Me 2 suicide and self-harm for Wales 2015 – 2019
- Co-occurring substance misuse
- Violence against Women, Domestic Abuse and Sexual Violence VAWDASV

The teams are required to meet Welsh Government CTP targets in relation to CMHT services.

Target 1 – All relevant patient have an up to date CTP	-	Target 90%
Target 2 – Patients assessed under part 3 of the Mental health Measure Wales to have a copy of assessment within 10 working days of completion of assessment	-	Target 100%

The Team works towards the following working practices and values;

- Working in partnership
- Respecting diversity
- Practising ethically
- Promoting recovery
- Identifying peoples strengths and needs
- Providing service user-centred care
- Promoting safety and positive risk taking
- Personal development and learning

2. Service Objectives

CMHT practitioners focus on providing a holistic assessment of mental health problems and helping people

recover from symptoms of mental distress and disability which can occur due to complex health and social care needs. This is managed through offering evidence time limited based interventions with clearly determined outcomes. This sometimes requires assertive approaches to support individuals. The interventions include:

- Mental Health Promotion
- Appropriate Medication and medication management.
- Ensuring physical health needs are addressed.
- Psychosocial interventions.
- Ensuring needs are met in relation to occupational functioning across social, leisure and productivity domains
- Referral to Welfare Benefit advisory services.
- Assistance in accessing suitable accommodation.
- Help in accessing local opportunities for work and education.
- Relapse prevention.
- Support and advice for carers and families.
- Information regarding Advocacy Services.

CMHT's are required to adhere to Welsh Government legislation, including the Welsh Measure, Social Services and Well-being ACT (2004). In order to provide effective health and social care packages that meet individual need and are outcome focussed. Working with service users within a model of care that aids recovery and enables them to return to their full potential in day to day life and, when appropriate, discharge from the secondary services.

3. Scope

This Procedure applies to the CMHT within Hywel Dda University Health board, mental health and learning Disability Directorate. They offer a multi-disciplinary service for individuals suffering with mental health problems. CMHT's form part of a whole system approach that is delivered in conjunction with inpatient, crisis, Local Primary Mental health support service (LPMHSS) and specialist mental health services.

The Team Leader is responsible for the day to day operation of the CMHT, for the delivery of the services it provides and to ensure the delivery of an effective clinical pathway for the individual service user through the efficient coordination of the constituent members of the CMHT.

All disciplines will contribute both professional and generic skills to their team. Each team member is professionally responsible for clients under their care and for recognising the limits of their own competence and job description. This includes the responsibility to seek appropriate supervision both

within the team and within their professional structure. The Community Mental Health Services Team Leader or Specialist Supervisor is responsible for the Audit, compliance and quality of CTP within services

4. Team Location and hours of operation

CMHT's core operational hours are between 9.00am – 5.00pm but this is subject to flexibility and is subject to change in line with Transforming Mental Health (TMH).

Access to CMHT's is based on alignment with GP Surgery within Hywel Dda UHB catchment area, however it may be prudent that individuals living closer to other CMHT base may be in these circumstances under the closer CMHT. This will need to be agreed by individual team managers. Each CMHT is aligned to a number of Primary Care Practices in a defined geographical locality. There are 8 CMHT's based across HDUHB area.

In exceptional circumstances it may be necessary for a person to be seen by a different CMHT and this would be agreed between individual team leaders.

North Carmarthenshire	Wellfield Resource Centre Carmarthen, 01267 236017
	Towy Valley, Llandovery 01550 777771
Ceredigion	Hafan Hedd, Newcastle Emlyn, 01239 710454
	Gorwelion, Aberystwyth 01970 615448
South Carmarthenshire	Brynmair Clinic 01554 772768 Swn-y-Gwynt Ammanford 01269 595473
Pembrokeshire	Bro Cerwyn Haverfordwest 01437 773157
	Havenway Pembroke Dock, 01437 774042

5. Relationships with other teams and agencies

Teams will maintain close working links with other services to promote continuity and consistency of care which can be provided to individuals and carers who use the service. This will include (and not be limited to) strong and effective links with:

- Crisis Resolution and Home Treatment Teams
- Mental Health Inpatient Units
- Substance Misuse Services
- Integrated Psychological Therapies Service
- Primary Care Services
- Local Authorities
- Integrated Autism Service
- Forensic Services
- Early Intervention Psychosis Team

- Perinatal Mental Health Services
- S-CAMHS

Effective links will be maintained through:

- Attendance at regular 'Business meeting' or similar MDT '
- Appropriate external attendance at Single point of referral screening meetings.
- By inviting appropriate teams to join CMHT MDT meeting.
- Attendance at regular inpatient MDT meetings or 'ward rounds'
- Working in line with statutory processes e.g. MAPPA, Safeguarding, MARAC Care and treatment planning meetings.

6. Operational procedures

6.1.1 Referral Pathway

All referrals are directed to the duty officer within the CMHT (See appendix 10) for referral pathway.
Referrals are to be in writing and sent via email to the CMHT.
Urgent referrals must be done via telephone with a written referral to follow (see Appendix 3).

The CMHT review all referrals and make an appropriate decision based on criteria and risk factors as detailed in UK Mental health triage Scale (see appendix 2). If appropriate an assessment appointment will be offered either as routine of urgent based on this scale.

Referral for assessment should be made to the CMHT if the following conditions apply:

- Severe mental disorder
- Complex mental disorder or severe psychological disturbance where significant risk is a factor.
- Mental disorder associated with significant and / or urgent risk
- Complex needs and significant deterioration of mental state

Referrals will be received from a person's GP, Advanced Nurse Practioner or a health or social care professional that has seen the person prior to referral. Under the Mental Health (Wales) Measure, people who have been in receipt of support from secondary care services (CMHT) and have been discharged within the last three years are able to self-refer directly under Part 3 of the Measure. They are entitled to request an assessment without the need to go via their GP following assessment a written outcome must be sent within 10 days. If following assessment, a continuing service is not offered by the CMHT the reasons for this will be explained to the person and will be recorded on the assessment. The GP and original referrer will be informed. This also applies to those that have previously been under the care of S-CAMHS and between 18 and 21 years of age.

Referral for outpatient clinic by a medic, pharmacist or nurse prescriber should be made if the following conditions apply:

Review of current psychotropic medication, prescribing in order to initiate psychotropic medication for patients with complex needs
Reviewing to reducing and stopping medication

Whilst it is not expected that individuals will require more than 3 appointments but this is at the discretion

of medic.

Consultant Psychiatrists provide medical leadership within the CMHTs, carry out mental health assessments, diagnosis and treatments within the teams. The skills, knowledge and experience of Consultant Psychiatrists will be used to best effect by concentrating on service users with the most complex needs, acting as a consultant to multi-disciplinary teams.

The medical team will have the ability to see patients that are not in secondary care for the purpose of support and advice to General Practitioner for a limited time which would usually be considered as 3 appointments. However there may be times that this needs to be extended at extenuating circumstances at discretion of the medical team.

Occupational Therapists provide interventions that maximise level of independence in occupational function across personal, domestic, social, leisure, work, education or training. Screening may be carried out to identify patients who would benefit from Occupational Therapy intervention as a primary area of concern, The skills, knowledge and experience of occupational therapists will be used to best effect by working mainly with those requiring interventions to maximise their occupational functioning.

6.1.2 Assessment

Following referral an appointment will be offered if appropriate. Appointment for assessment should be no more than 28 days from time of screening. CMHT appointment letters to patients need to include crisis and contingency details should the persons needs become more urgent. CMHT's can offer joint assessments if required. The Assessment will be a comprehensive assessment of the persons needs which may not be completed on the first contact.

An initial assessment will be completed in a timely manner.

The assessment will:

- Determine whether the service user has a mental health problem which will require further care or assessment from services.
- Determine the level of risk to self or others
- Determine if referral to an appropriate service is required of if advice is required and they can be referred back to the referrer.
- On completion of the assessment the GP and patient will receive a summary of the assessment and any plan identified.

The assessment will incorporate:

- Mental health history and history of involvement with services.
- The person's views and beliefs about current problems and needs.
- Personal history.
- Social circumstances.
- Pre-morbid personality.
- Physical / health issues.
- Current medication.
- Use of alcohol / non-prescribed drugs.
- Forensic history.
- Information from other sources.
- Belief / faith / cultural issues.
- Mental State - profile, general behaviour and appearance, rapport.
- Speech - form and content.
- Affect (as reported by the service user / observed by the interviewer).

- Thought process and content.
- Perception, Cognition – (concentration, memory, orientation), Insight.
- Risk Assessment inclusive of suicidal ideation and self-harm
- Person's expectations of service.
- Carer's expectations of service.
- Formulation: Synthesis of the significant factors, which have contributed to the development of the crisis.
- Guidance on the management of the crisis.
- Indicators for hospital admission.
- Psychological distress
- Risk to others due to mental illness / distress

6.1.3 Eligibility for Relevant Patient status and secondary care.

Decisions on whether someone should be accepted for services should always be based on their health and social care needs as a whole and not on diagnosis alone. However following an assessment of need, priority for services will be given as shown below:

- Needs support in multiple domains of the care and treatment plan directly relating to their mental health.

- Complex and severe mental disorder that is current in presentation

- Service users with severe, difficult to manage and persistent mental illness, such as schizophrenia, severe depression or bipolar disorder

- Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up

- Any disorder where there is significant risk of self-harm or harm to others (e.g. acute depression, anorexia, high levels of anxiety) where the level of support exceeds that which the primary care team can offer.

- Severe disorders of personality where there is a clear role identified for the community mental health team, and the service user is agreeable to engage with the service.

- An expectant mother with a history of mental ill health or perinatal/post-natal mental health issues, even where there may be lower or more moderate risks identified.

6.1.4 Accepted for Care Co-ordination

Where an individual is accepted for care co-ordination they will be managed under CTP. The Care co-ordinater will be allocated within 2 weeks and CTP commenced within 6 weeks. This will reflect all relevant domains of a Care & Treatment Plan with specific reference to:

- Engagement/ assertive engagement
- Crisis Management
- Medication management.
- Occupational functional performance
- Social support and practical help.
- Psycho-social interventions.
- Education on maintaining good mental health and recognizing signs of relapse.

- Crisis & Contingency Planning, including working with carers and families.

The above will be contained in a personalised CTP in line with the statutory requirements of the Mental Health (Wales) Measure 2010. Individuals who are receiving care from secondary mental health services must have a CTP. The CTP must outline the frequency of agreed contact and how to contact services in and out of hours. Patients should be provided with their care co-coordinators work mobile number with a facility to leave a message along with an alternative office based number in the event of any absence from work. Patients should clearly be explained that these numbers are non-urgent and how to seek more urgent support if needed.

Where possible in accordance with recovery principles. Patients and carers should always be given an estimated time frame for service, and the expectation would be that once a planned intervention from the assessment has been completed the person will be discharged from secondary services.

The CORE Assessment on Care Partner must be completed at a minimum of yearly intervals or when there has been a change in the individual's presentation.

Where indicated STORM discussion and safety plan to be completed.

When a patient is accepted for treatment as a "relevant patient" a Wales Applied Risk Research Network (WARRN) risk assessment is completed and appropriate management plan agreed with the MDT to manage any identified serious risks.

6.1.5 Referral and transfers

Referral pathway from other service to community mental health team and pathways for transfer please see appendix 9.

6.1.6. CMHT Duty System

A registered practitioner is available to receive new referrals in line with our agreed referral pathway (see appendix 10), to offer advice and guidance to other professionals. To offer an appointment and complete an assessment of urgent referrals. The duty system operates between the hours of 9 – 5pm Monday to Friday excluding bank holidays however will only accept urgent referrals for same day where assessment is able to commence before 4pm following this time urgent referrals will need to be forwarded to CRHTs. All referrals for assessment must be from GP, AMHP, or Mental health professional. This may include hospital Liaison in some area where patients are medically fit for discharge.

6.1.7. MDT Meetings

A weekly Multi- disciplinary meeting attended by a range of professionals. The meeting will review new referrals only if a decision is needed about the most suitable person to carry out an assessment would be. To feedback or discuss assessments undertaken where further care is required and decision on most appropriate service to meet individual needs is required. To identify patients within the CMHT that has had a change in presentation and further clinical decision making is required to support this person's care.

The team leader's role is to chair the meeting and ensure the effective running of the meeting including allocation of new referrals and service users taken on by the team. Clearly documenting outcomes of assessment and MDT discussions with rational of patients reviews and assessment documented on care partner

Following a comprehensive health and social care assessment and a risk assessment, if a continuing service is offered, the service user with receive a package of care based on the Wales Mental Health Measure (2010) CTP

The Mental Health (Wales) Measure (WAG 2010) places duties on Local Health Boards and Local Authorities to appoint an eligible care coordinator for someone for whom secondary care mental health services are being provided. The care coordinator must work with service user and service user providers to agree and achieve outcomes with a view to agreeing a care plan aimed at achieving those outcomes.

6.1.8 Physical Health Checks

Annual Physical Health check to be offered to patients in receipt of anti-psychotic medication or mood stabilisers as per NICE Guidelines. Compliance recorded in the patient's clinical record.

6.2.1 Supervision and caseload management

Lone working
All staff with in CMHT are to work in accordance with the health board's lone working policy.

Caseload supervision
Caseload supervision will be delivered by the clinical supervisor using the caseload management tool in conjunction with the caseload guidance. (see appendix -11 and appendix 12)

CMHT and individual caseloads will be regularly monitored and reviewed to ensure CMHT members are able to provide immediate effective care (without the use of waiting lists) for new referrals with severe mental health problems, and a flexible capacity to increase contact during crisis.

Staff absence
CMHT Managers to prioritise and ensure adequate coverage of service at times when staff are on leave or sickness absence via nominated individuals. Patients should be contacted with a new point of contact if care co-ordinator is on prolonged period of leave. Patient care must not be adversely affected due to staff deficits.

6.2.2 CARE CO-ORDINATION

Care Coordinators to demonstrate awareness of their role as per Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010

A care co-ordinator must be able to demonstrate skills in the following areas:

1. Comprehensive needs assessment
2. Risk assessment and management
3. Crisis planning and management
4. Assessing and responding to carers' needs
5. Care planning and review
6. Transfer of care or discharge

It would be expected that Care coordinators complete training that meets these core skills, to complete Mandatory training, WARRN and STORM Training.

6.2.3 Care and Treatment Planning (CTP)

The Care and Treatment Plan is the framework for care co-ordination and resource allocation within mental health and should be an effective, efficient and transparent process of care co-ordination and care delivery that encompasses all the relevant responsibilities of the NHS and the local authority.

Following a comprehensive assessment of the active, complex health and social care needs and a risk assessment all service users requiring a service will be allocated a named Care Co-coordinator. The Care Co-ordinator and relevant patient will work together, as far as possible, to construct a CTP. In keeping with the Mental Health Measure, carers' views are to be canvassed.

The Care Plan will include details of services required to meet need and manage the assessed risk, and Contingency Plans which will identify risk factors, early warning signs and actions to be taken in any crisis.

Where a patient has identified occupational functioning needs (which are secondary to reason for referral) and are not being care coordinated by an occupational therapist, an occupational therapist will offer a functional assessment, shared goal planning and interventions with the patient which will form part of the care and treatment plan..

When a patient has a CTP meeting, the care co-ordinator should ensure that a pre-CTP meeting is held with the patient to ensure patient has the required information, opportunity to invite carers or advocates, and raise any queries. (see appendix 15). The CTP meeting should follow a set format; see example agenda on appendix 14.

An integral part of the management process should be for the service user to accept responsibility for their own actions and associated risks supported by the Care Plan and the team's interventions based on the principles of positive risk management.

The service user, relevant carers (if agreed) and GP will receive a copy of the care plan and the risk management plan.

During any inpatient admission the service user will be allocated a named nurse on the ward who will work with the Care Co-coordinator to ensure needs, identified on the Care Plan are met.

If a person is not known to the Care co-ordinator but is already under CTP through being in other services, CRHT/Inpatient, the CMHT Team Leader will identify a care co-ordinator within 3 working days of notification in order that a safe transfer of responsibilities. Care co-ordinator have 2 weeks to complete CTP paperwork. If patient is new to mental health services the CTP should be completed in 6 weeks.

6.2.4. Support for Service Users in Hospital

Service users already subject to a CTP who require admission to an acute inpatient unit or a secure setting need the full support of community staff during the inpatient episode. Ensuring the service user and relevant carers receive appropriate support is seen as high priority by CMHT staff

Whilst an inpatient on an acute ward the Care Co-ordinator or designated representative from the community team, will ensure that contact is maintained with the service user their inpatient care team, regularly and also discuss progress with the Named Nurse and attend CTP reviews held in the inpatient unit.

The community Care Co-ordinator and the Named Nurse will ensure the multi-disciplinary team are advised of any issues that may affect progress towards discharge. In particular any housing, welfare benefits or family relationship and child care difficulties will be identified, discussed with the service user and the care team and addressed within the care plan

Inpatients discharged on CTP to the care of the CMHT a date, time and place for a follow-up community appointment within 3 working days of discharge will be arranged. This will be in accordance with best practice guidelines on the follow up after discharge from mental health in-patient units.

Any unplanned discharge from the Mental Health Unit occurs a pre-discharge CTP review will not have occurred. The CMHT Care Co-ordinator must arrange a full CTP review to take place within two weeks and contact within 7 days of the discharge if not on CRHT caseload.

Support for patients on section 17 leave

When a patient goes on extended Section 17 leave (more than 72hours) it is the responsibility of the care co-ordinator to review and update the WARRN risk assessment and CTP care plan to reflect the plan of care during this period of leave.

When using extended section 17 leave consideration may be given to allocating responsibility to a community RC. In all instances, the transferring RC should discuss and confirm the allocation with the receiving RC and inform the MHA administration team in writing using a Nomination of RC form that the allocation has taken place.

6.2.5 Disengagement and discharge

It is essential that the CMHT maintains a capacity to undertake new assessments and take on work with new users. The CMHT must therefore be proactive in considering when a service user is ready for discharge back to the Primary Care Team.

Within a Recovery Model of work the CMHT will assist the service user to maximise their potential for recovery and return to independence and discharge from the secondary services

Clear expectations should be jointly agreed with the service user at the time of coming into the CMHT and an understanding of specific pieces of work that are required and goals that need obtaining in order to support the identification of discharge.

Discharge planning will form an integral part of the service users Care Plan. Liaison with other involved agencies will take place early in any work undertaken to ensure continuity of care

At the point where it is considered the service user has recovered and no longer requires specialist secondary mental health services discharge back to the Primary Care Team should take place via the CTP process under Part 3 of the Welsh Mental Health Measure.

If this occurs any responsibilities held under Section 117 of the Mental Health Act should also be considered for discharge. Any funded placements that do not require secondary care but paid for by S117 will remain on S117 register kept jointly by the CMHT and Local Authority and reviewed annually until S117 responsibility has been discharged, S117 aftercare is not a reason to prevent discharge from secondary care services.

Prior to any discharge from the CMHT an aftercare plan will be agreed with the service user and this will include a contingency plan identifying risk factors, warning signs and actions to be taken in the event of any difficulty occurring after the discharge back to the GP takes place

Part 3 of the measure can be used when there is a deterioration of mental health and will allow for a consideration of an assessment should that persons mental state indicate this.

Disengagement – Should a service user refuse to engage with the CMHT or refuse to continue to accept services the situation will be discussed within a multi-disciplinary team meeting. Risks to self and others will be assessed and an action plan, dependent on risks and need, agreed prior to discharge. All reasonable attempts at engaging a service user in their care are made and attempt to identify the reason for disengagement. The decision and its rationale must be recorded in the patient's electronic record and the GP informed immediately.

If person not known to the service does not attend for an assessment appointment efforts should be made to contact the person and understand why they did not attend for assessment, professionals should use clinical judgement to identify what actions should be taken, discuss relevant information as part of MDT if required, ensure that GP, have been informed immediately and discuss with referrer.

Patients discharged from CTP and CMHT should always receive a discharge letter and CTP closure form completed and sent to their GP. Patients service users should be reminded of their right to request an assessment under part 3 of the welsh measure.

6.2.6 Transfer between care co-ordinators and CMHTs

The transfer of care co-ordination request will be made by the Care Coordinator via a referral on care partner, unless the individual concerned is subject to a Community Treatment Order where the Responsible Clinician should make the referral

The referral will be addressed to the Manager of the team requested to take over the individuals care and treatment. The referral will include.
Reason for transfer of care request.
An indication of which professional groups need to be involved with the individuals Care and treatment
A brief summary of the history of the client: including diagnosis, treatments/interventions undertaken in the past
A description of current care and treatment being undertaken, goals outlined in the care plan, social situation,
Commissioned care package and funding arrangements where appropriate

The accepting CMHT will liaise with the Care Coordinator or RC making the request, to arrange a CTP handover meeting.

6.2.7 Supporting Carers

Carers are in many situations fundamental to the success of home treatment for patient experiencing mental health distress. All regular and substantial carers will have needs and views recorded. They will be offered appropriate services including use of 3rd sector agencies and charities that are available. Carers will have a written care plan, which will be reviewed no less than once annually. Carers can be offered a formal carers assessment through the local authority.

Carers should be provided with written information that is pertinent to the patient's case for example – signs and symptoms/relapse indicators. Provide information on medication management as appropriate. Carers are to be included in crisis/contingency plans reviews, and invited to attend CTP reviews. Their views and opinions are to be recognised and recorded appropriately.

Where issues of risk are high and consultation and information sharing is refused, discussion should take place at an MDT meeting about this issue and the outcome documented.

6.2.8 Advocacy

Staff must ensure they are aware of how patients can access advocacy services, and provide patients with

the opportunity to access advocacy services in their local areas.

6.3 Record Keeping

The Record keeping policies and code of practice relevant to each profession to be read by staff understood and adhered to.

6.3.1 Safeguarding Adults at Risk

Staff have a statutory duty to report if they suspect an adult is at risk of harm to the safeguarding team. To assist with this decision-making process staff have access to a Safeguarding Flowchart for decision making and reporting. This will prompt staff on the appropriate action to take to report any concerns raised by patients. All staff are expected to be up to date with required level of safeguarding training.

6.3.2 Quality Assurance

The CMHT service is subject to monthly audit of clinical record keeping as required by Welsh Government as well as spot checks on documentation, process and management of the teams.

Supervision is key to improving staff skills knowledge and confidence as well as helping manage staff wellbeing.

CMHT team leaders are to ensure that all CMHT staff have read and understand the Service specification and that care to patients is being delivered according to the Service specification.

All staff are to know where to access the service specification electronically via intranet and paper version to refer to as required. http://howis.wales.nhs.uk/sitesplus/862/page/74797.

Staff to be fully aware of the complaints procedure

Learning lessons from incidents and complaints is key to improving quality and robust system to ensure sharing of learning and recording of staff understanding is vital. Teams should do this be recorded signing sheets and mandatory communication books.

It is important that use of 3rd sector agencies that the effectiveness of the intervention is monitored and recorded either whilst under secondary care services or not. This is to ensure effective evaluation of referrals and advice to other agencies.

Team Leaders should conduct audits into discharges from secondary care services, looking at quality of care received, post discharge care in place, and timeliness of discharge.

6.3.3. Team Safety & Managing Clinical Risk

Individuals, whose behaviour is likely to put the safety of others at risk, should attend the CMHT base, to reduce risk. Hywel Dda have a zero tolerance to assault, verbal abuse, sexual abuse, and other behaviours deemed as intimidating and anti-social such as Stalking. The health board will consider prosecution where indicated.

A decision to exclude an individual from the CMHT base can only be made after a full discussion is held by the CMHT. This should be recorded. The patient must be informed in writing of any such decision.

The right to appeal should be made via the HDUHB complaints procedure.

Team members should comply with the HDUHB 'Lone Worker Policy', have access to mobile telephones

and be able to raise any concerns about lone visiting with their Operational manager or at the regular multidisciplinary Team meetings.

All patients should have been assessed for risks with conveyance included in their individual risk assessments.

Information regarding the whereabouts in the community and contact details of all staff will be kept by the team. Appropriate and comprehensive risk assessment will be used to maintain safety and also ensure treatment is not withdrawn inappropriately. The HDUHB operates a zero tolerance policy ('Prevention & Management of Violence of Aggression Policy') regarding racial, physical or verbal abuse towards its staff.

6.3.4. Training & Development.

Training and development will reflect the needs of the H D UHB and of the individual, as described in their personal development plan develop as part of the Knowledge & Skills Framework, to include their profession specific needs. The HDUHB recognises that Continuing Professional Development is a key element of ensuring the delivery of the highest possible quality of service. Role development and scope of practice is also increasingly relevant to the provision of staff training and supervision. All staff will be appraised annually via the KSF, with a six-month review. Where there is only one member of a discipline in a team, professional support and supervision must be provided. All new staff will attend an induction programme.

Induction programmes will be prepared for all staff to include reference to the appropriate policies and procedures such as delivering care via a Care and Treatment Plan and Risk Management. Staff will attend statutory/mandatory training sessions appropriate to their individual professional status and including Fire, Health and Safety, Assessment and Management of Risk, Cultural Awareness, and Breakaway. Training will also focus on the development of psychotherapeutic competences integral to the care delivery of all staff.

The CMHT will have annual team away days for the purpose of reviewing activities, policies and team building.

Training and Education to meet statutory and best practice requirements

All Mandatory Training including basic life support and defibrillator training.
First Aid training.
WARRN - Wales Applied Risk Research Network Training
STORM – Skills Based Training of Risk Management for suicide prevention and self-harm
Co-occurring Mental Health Substance Misuse Training
Relapse prevention training.
Solution focus Therapy
Recovery Principles

6.3.5 Medical devices policy
A full audit must be maintained of all medical devices and ensure maintenance and calibration of all devices. First aid kits to be maintained and in date.

All medical devices will be maintained internally by the EBME/Clinical Engineering department wo will service and calibrate in house for the health board and enter on to a register of equipment in each area.

If unable to service or calibrate the equipment they will send off to outside contracts to service/calibrate

6.3.6 Medication management Any medication prescribed at the time for Mental Health is clearly explained as to its purpose and any side effects to the patient and the patients family/carers as appropriate A leaflet describing commonly used medications that will inform of any expected outcomes/side effects to be give out as appropriate.

Medication adjustments will be addressed by the Psychiatrist or the GP. Any patient in receipt of depot medication that is not under secondary mental health care must have an appropriate risk sharing within the team.

The Pharmacist Gwen Hughes attends weekly MDT and offers advice around medications. They will also do medication history for those patients deemed to be complex and resistant to treatment. They also give advice to GP's around medication and in particular those patients not being taken on by CMHT.

The clozapine clinics are attended by the pharmacist who actively reviews each patient monthly with nursing staff in the clinic. they assists in the physical monitoring and oversees the ordering of the clozapine which is dispensed within the clinic and will also register new patients deemed appropriate to commence on clozapine.

With patients commencing on clozapine the pharmacist will work with the team to ensure regular bloods are taken. The bloods are analysed by the POCHI machine within CMHT so bloods are taken on site by nursing staff

In some instances it may be that a patient in receipt of depot medication that no longer requires secondary mental health care will be illegible for discharge from CTP but continue to receive medication from the CMHT under primary care remit where this is unable to facilitated by the persons GP. In such instances it will be necessary to complete a WARRN risk assessment minimum of yearly or as and when risks have changed.

6.3.7 Putting things Right

All CMHTs should display a copy of the Putting things right complaint procedure and have up to date knowledge of this. To be able to advise patients and carers appropriately of the procedure.

6.3.8 Equality Impact assessment

Hywel Dda University Health Board is committed to providing an environment where all staff, service users and carers enjoy equality of opportunity.

The HDUHB works to eliminate all forms of discrimination and recognises that this requires, not only a commitment to remove discrimination, but also action through positive policies to redress inequalities.

Providing equality of opportunity means understanding and appreciating the diversity of our staff, service users & carers and ensuring a supportive environment free from harassment. Because of this HDUHB actively encourages its staff to challenge discrimination and promote equality of opportunity for all.

7.0 References

- Mental Health (Wales) Measure 2010, Welsh Government.
- Mental Health Policy Implementation Guide: Dual Diagnosis – Good Practice Guide, May 2002.

- The Role of Community Mental Health Teams in Delivering Community Mental Health Services Interim Policy Implementation Guidance and Standards, Welsh Government, 2010.

Appendices

1. **Links with the Crisis Resolution and Home Treatment Team**
2. **UK Mental Health Triage Scale**
3. **Emergency / Urgent Referral Information Collection form.**
4. **Homeless people and non residence**
5. **Flow chart for Disengagement from Care and Treatment Planning**
6. **Flow chart for Disengagement prior to CTP Assessment**
7. **CTP Review Meeting Agenda**
8. **Care and Treatment Plan Review Pre-Review Checklist**
9. **Care and Treatment Plan Review Post-Review Checklist**
10. **Transfer between Mental Health Services and CMHT**
11. **CMHT Referrals**
12. **Caseload Management RAG Tool**
13. **Community Caseload Supervision Tool and Secondary Care Criteria**
14. **Record of Supervision**

Appendix 1 - Links with the Crisis Resolution and Home Treatment Team

The CRHTT provides intensive home treatment to service users that would otherwise require admission. The CRHTT will provide an alternative to admission where safe and appropriate, in a flexible and responsive manner, in the most appropriate setting.

The CRHTT will promote continuity and consistency of care and intervention for service users and carers, offering a range of approaches and skills.

A service user would be referred to the CRHT if it is clear that admission is required to continue to safely manage risks. Any individual referral passed to the Crisis Team must have been assessed face to face by a mental health professional during the previous 24 hour period.

The CMHT will provide clear plan in managing the service user through the crisis. With explanation of appropriate intervention with particular consideration to issues relating to risk assessment,

The CRHTT will make a decision on the appropriateness of the referral based on the information given. The outcome of the assessment will be fully discussed with the referrer and the Responsible Clinician, and a joint plan agreed upon.

Service users receiving home treatment also need the full support of community staff during the home treatment episode. The Care Coordinator retains responsibility throughout the home treatment spell and will undertake to liaise weekly with a CRHT

Appendix 2 – UK Mental health Triage Scale

Triage Code /description	Response type/ time to face-toface contact	Typical Presentations	Mental Health Service Action/ Response	Additional actions to be considered
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

Appendix 3

Emergency / Urgent Referral Information Collection form

Guidance for duty workers taking emergency/urgent referral information

Patient Information Required	
Name:	
Date of Birth:	
Address:	
Telephone number(s): **MAKE SURE CURRENT NUMBERS**	
Clinical details: Including current medication.	
Previous Mental Health Contact:	
Physical Status:	
Available support:	
Carer Responsibility	

Indicators of Urgent Risks	
Information Required	**Specifics to Consider**
Stated intent to harm / kill self	
Stated intent to harm others	
CLEAR plan or preparation	
Recent attempt	
Previous attempts	
Triggers for these thoughts	
Family History	
Recent psychiatric hospital stay	
Current available support	
Evidence of self neglect	
Protective Factors	
Known forensic history:	
Any practice concerns re: aggression:	
Known drug / alcohol misuse:	
Is client currently under the influence?	

Practicalities
Is the patient willing to be seen? Where is patient now, who with, able to get to us if needed? How will the appointment time be communicated to them? Are they willing for relatives to be contacted? How will they get to the CMHT for their assessment / is it safe?

What action needs to be taken if the patient cannot be contacted and we are unable to get back to the referrer e.g. surgery closed e.g. police welfare check?

Referrer Contact Name:	**Telephone No:**
GP details if not known (and if referrer not GP)	

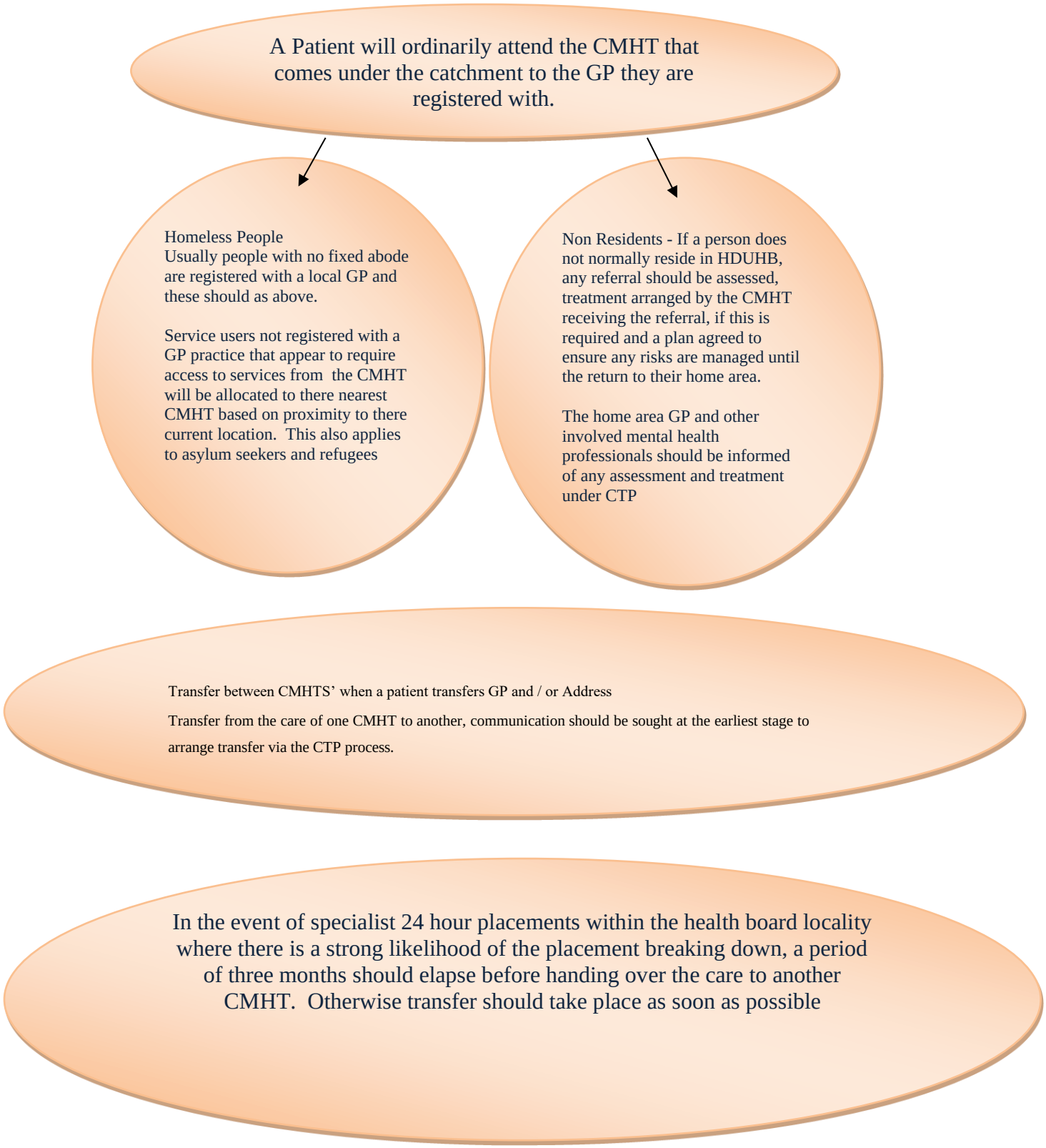
Time of referral

Outcome of referral

Signed: _____ Date: _____

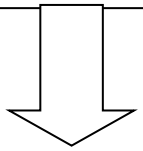
Print: _____

Appendix 4 - Homeless people and non residence



Appendix 5 - Flow Chart for Disengagement from Care and Treatment Planning

Client Disengaging or refraining from contact with mental health services
The Care Co-ordinator will use the following process



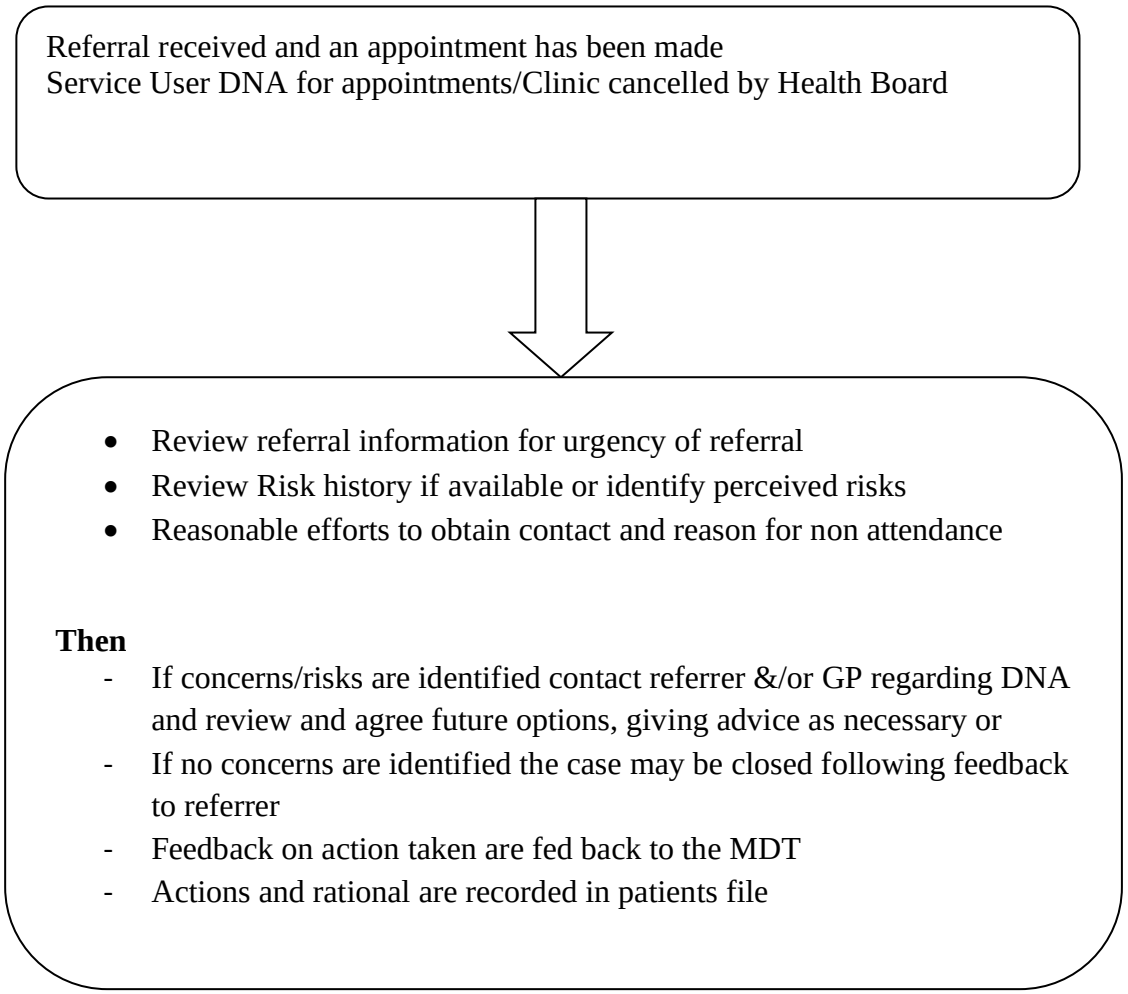
Review:-

- Nature of illness and current problems
- Determine any history and potential future risks if contact is lost with service
- Determine reasons for disengagement/non contact with service

Then Follow One of these Options

Option A **CTP Review Demonstrates need for ongoing support**	**Option B** **CTP review demonstrates no further need for ongoing support**
• Discuss and agree actions with key staff/MDT with the aim of maintaining minimal contact with most appropriate team member • Review and Amend care plan to highlight the agreed level of contact/need/action • Refer to and act upon crisis management plan • Ensure all agencies/disciplines involved in care receive the CTP Care Plan and Review to ensure they are aware of decisions made • Consider a Mental Health Assessment with a view to Compulsory Admission • Agree to review within MDT on a regular basis and record all plans and actions undertaken	• Discuss and agree actions with key staff/MDT – reduce level of support or discharge (particularly if no significant risks identified) • Review and amend care plan to highlight the goals achieved and those needing further progress • Inform all carers/family/advocate as agreed in care plan • Inform GP and send copy of updated care plan, CTP Review and Discharge Letter for MHM Part 3 • Make detailed notes in service user file including updated care plan • Provide Service user with completed care plan of progress and needs not achieved, a copy of the CTP review and Discharge letter for MHM Part 3

Appendix 6 - Flow chart for Disengagement prior to CTP Assessment



Appendix 7

CTP REVIEW MEETING

AGENDA

Segments	**Timing**
General health check with Health Care Assistant	*15mins*
Mental State Examination with Consultant	*15mins*
CTP Review	*30mins*

1. **People present and apologies**
2. **Purpose of the CPA review meeting**
3. **Review of the agenda set prior to the CPA review**
4. **Review of risk assessment – including safeguarding children procedures if applicable, driving**
5. **Review of the care and treatment plan – its co-ordination and anticipated outcomes**
6. **Any unmet needs identified, documented and reported**
7. **Note carer's perspective (if applicable)**
8. **Note concerns or disagreements**
9. **Summarise agreed actions**
10. **Date of next CPA review meeting agreed**

Appendix 8

CARE AND TREATMENT PLAN REVIEW
PRE-REVIEW CHECKLIST

Care Co-ordinator Duties	Completed
Reminder letter sent to the service user with the date for forthcoming CPA review four weeks prior to review – date as set in previous review meeting if applicable.	Date:
With the agreed consent of the service user, initial notification of CTP review letter circulated to those involved in the care of the individual. Four weeks prior to review to allow time for reports/feedback to be gathered.	Date:
Meeting between the care co-ordinator and service user two weeks prior to CTP review to set the agenda for CTP review. To agree attendees (carer, health & social care professionals, support staff, voluntary agencies, advocates), review the care plan and the wishes of the service user.	Date:
Details of current prescribed medication requested and recorded or copy of the service users repeat prescription obtained.	
Date and outcome of last known physical health check confirmed.	

Care Co-ordinator: *(Print name)* …… *(Signature)* …….
Date: *……..*

Health Check	Record	Date	Signed
Weight			
Height			
BMI			
Blood Pressure			

Appendix 9

CARE AND TREATMENT PLAN REVIEW
POST-REVIEW CHECKLIST

Documentation revised and updated following the CTP review – care and treatment plan, risk assessment, crisis and contingency plan.	
Proposed date of the next CTP review agreed and set out in the review summary.	
Review summary circulated to those involved in delivering the care with the consent of the service user.	
Trigger to prompt CTP review. (*If requested, by whom? ……*)	Admission ☐ Discharge ☐ Routine ☐ Emergency ☐ Request ☐

Care Co-ordinator: *(Print name)* …… *(Signature)* …….
Date: ……..

Appendix 10 - Transfer between Mental health Services and CMHT

CAMHS Referrals

Referrals for service users under the age of 18 must be referred to the community adolescent mental health. People in the care of CAMHS who are likely to needs ongoing care from the adult CMHT should be subject to robust handover processes to ensure effective transfer to adult mental health services. If a service user first presents at the age of 17 and 6 months they should be taken on by and adult CMHT directly rather than waiting until they are 18.

For patients already under CAMHS the transition policy should be followed

Co-occurring Alcohol/ Substance use

Service users with co-occurring alcohol/substance misuse problems are defined as those with severe mental illness and drug and/or alcohol problems. This group are likely to meet the eligibility criteria for services from a CMHT. Such individuals should be referred as necessary by CMHT's to Community Drug and Alcohol Services for joint working to provide expert advice and specific treatment packages.

Teams should operate with some flexibility in the interests of the service user. Guidance should be sought from the Interagency Protocol for Mental Health and Substance Misuse as to which agency takes the lead role in care coordination and treatment. Each CMHT's should have an identified link worker for alcohol and substance misuse to provide advice and support to other team members for this client group.

Learning Disability

Having a learning disability should not act as a barrier to acceptance by the CNHT as long as the CMHT is best placed to meet the individuals need. In cases where this is not immediately clear, assessments should be carried out jointly representatives of both CMHTs and Learning Disability Services
CTP process should be followed and there needs to be an identification of the most appropriate lead agency based on the primary need of the individual

OLDER ADULT SERVICES

Service users who are receiving mental health services from the CMHT will continue to until such a time as their needs are assessed as having changed, or where mental health is being impacted by social, physical or psychological aspects of ageing may, whatever their age, have their needs better met by older adult services

New presentation of a person with functional mental illness over the age of 70 or people that has been closed to the CMHT for a period of time should be referred to Mental Health Services for Older People. The needs of older adults with functional mental illness and/or organic disease and their associated physical and social issues are often distinct from younger people.

People suffering from an established primary progressive dementia related illness (including alcohol related) of any age with behavioural and psychological symptoms of dementia should be referred to Mental Health Services for Older People.

Transition of care to Mental Health Services for Older People will then be planned via the CTP

Appendix - 11

CMHT REFERALS

The Duty Worker will ask the referrer to go through a series of questions using the attached information gathering form (appendix 2). Decision based on criteria and risk factors as detailed in the referral classification scale (appendix 2).

Useful Referral Information:

Reasons for a referral and why now?

Any significant life events.

Working diagnosis and treatments already tried.

Previous psychiatric history.

Relevant personal and family history.

History of risk to self and others including forensic history.

Existing support networks already in place.

Carer details

Co-existing medical conditions

Emergency _ within 4 Hours
On receipt of complex or urgent new referrals, the duty worker will seek advice from a psychiatrist in the team or the Team Leader. It would be consider prudent to complete assessments jointly with crisis teams.

Urgent – Within 48 Hours
Should be seen and assessed within a maximum of 48 hours. An urgent referral an agreed appointment must be made between the GP, the client and the duty worker. Only by mutual agreement after discussion an appointment could be offered outside of the 48 hour period based on the agreed level of risk.

Routine with in 4 weeks
Non Urgent requests for assessments that are not deemed to be emergency or urgent who are deemed to meet the eligibility for access to the CMHT will be offered an assessment by an appropriate team member following initial screening by the MDT within a target of four weeks. A letter will be sent to the service user asking them to contact the CMHT within two weeks of referral asking them to arrange a mutually agreeable appointment.

Appendix – 12 – caseload management RAG tool

SCORE	RISK	RELAPSES & ADMISSIONS	NEEDS, SYMPTOMS & FUNCTIONING	SUPPORT& INPUT	ENGAGEMENT & COMPLIANCE	REQUIRED CONTACT
5	**CURRENT** high and Imminent apparent risk AND a danger to self / others / from others **HISTORY** of high risk behaviour	**RELAPSE =**3 or more in last 2 years OR very prolonged episode **ADMISSIONS=** more than 6 months as an inpatient in last 2 years OR more than 2 in-patient admissions in the last 2 years	**NEEDS** =multiple **SYMPTOMS** = severe **IMPAIRMENT OF FUNCTIONING =** high chaotic lifestyle co-existing substance use problem OR co morbidity	**SUPPORT PACKAGE** = high **INPUT** = 4 or more services / agencies Possible involvement with criminal justice system	**ENGAGEMENT** = difficult AND **COMPLIANCE** = well known problems	**APPOINTMENTS=** more than two per week early follow-up on non attendance is required
4	**CURRENT** high apparent risk but with no immediate risk to self / others / from others **HISTORY** of high risk behaviour is likely	**RELAPSE** =1–2 in last 2 years) OR prolonged Episode **ADMISSIONS=** more than three 3 months as an inpatient in last 2 years	**NEEDS** =multiple AND **IMPAIRMENT OF FUNCTIONING =** significant may have a coexisting substance use problem OR comorbidity	**SUPPORT PACKAGE** = medium **INPUT** = 3 services / agencies	**ENGAGEMENT** = requires active encouragement to engage & comply **COMPLIANCE** = problems are clearly evident at times of relapse	**APPOINTMENTS=** 2 per week early follow-up on non attendance is required
3	**CURRENT** medium or significant risk, which is manageable **HISTORY** of moderate to high risk behaviour possible	**RELAPSE=** 3 or more in last 5 years **ADMISSIONS** =has been admitted as an in-patient in the last 5 years	**NEEDS** =more complex **IMPAIRMENT OF FUNCTIONING =** some may require further assessment and information gathering	**SUPPORT PACKAGE** = medium to low **INPUT** = 2 services / agencies OR at least 3 disciplines **SUPPORT FROM FAMILY / CARERS / FRIENDS** = low to moderate	**ENGAGEMENT** = good to moderate **COMPLIANCE** = usually good to moderate, may show poor compliance at times of relapse / periods of heightened stress	**APPOINTMENTS=** weekly may require follow-up on nonattendance
2	**CURRENT** low apparent risk, which is manageable. No special precautions required	**RELAPSE=** 1–2 in last 5 years **ADMISSIONS** = none in last 5 years	**NEEDS** =less complex problems have a minimal impact on daily activities	**INPUT** = 1–2 disciplines **SUPPORT FROM FAMILY / CARERS / FRIENDS** = moderate	**ENGAGEMENT** = engages well with service **COMPLIANCE** = good to moderate compliance	**APPOINTMENTS=** 2/52 or 3/52 intervals
1	**CURRENT** very low risk, no special precautions required	long periods of being well may be a single episode **ADMISSIONS** = none	high level of functioning or independence AND problems do not interfere with daily activities	**INPUT** = 1 Discipline **SUPPORT FROM FAMILY / CARERS / FRIENDS** = high	Engages well with service AND shows good compliance (concordant) actively uses self help skills	**APPOINTMENTS=** at monthly intervals, or less often

Appendix 13 -

Community Caseload Supervision Tool and Secondary Care Criteria

Criteria

Service eligibility

The selection criteria for the above Service are applicable to:

- All adults irrespective of gender, age (18 years or over), ethnicity, sexuality, culture or physical abilities
- People who have substantial and complex mental health needs which cannot be met by primary care, the IAPT Service or other community services.

Selection criteria:

The CMHT will accept referrals for service users with substantial and complex mental health needs which include:

- Significant cognitive, emotional and behavioural problems associated with a mental health diagnosis.

The individual is likely to present predominantly with/as:

- Psychosis, such as schizophrenia or bi-polar disorder.
- Severe depressive disorder where the levels of risk/complexity/engagement require treatment by a specialist mental health service.
- Severe disorders of personality where there is a clear role identified for the community mental health team, and the service user is agreeable to engage with the service.
- Longer term severe disorders which are characterised by poor treatment adherence and increased levels of risk/vulnerability which cannot be managed solely by primary care.
- Dual diagnosis of mental illness and substance misuse where the mental illness is the primary need, severe and complex in nature.
- Co-morbid mental illness in service users with a neurodevelopmental disorder for treatment of the mental disorder where this is the primary issue.
- Complex presentations associated with severe mental illness, which impacts a significant risk of self-harm, harm to others, risk of harm from others or serious self-neglect.
- An expectant mother with a history of mental ill health or perinatal/post-natal mental health issues, even where there may be lower or more moderate risks identified.

Guidelines for Caseload Supervision

Do the needs of the individual meet the service eligibility criteria

Check the standard of written entries on Care Partner and current CTP

Is the individual subject to a CTO or S117

Diagnosis and/or assessment of need

Referred when, frequency of visits and duration

What interventions are being provided, could any of these be provided by support staff or third sector, helpline services etc...

When last unwell, what risks are preventing discharge
Can discharge be facilitated using contingency arrangements, CRT alongside part 3 of the Measure

Where living, what support from family, carers, staff and others (especially if in a residential placement)

What needs to happen to facilitate discharge?

Use in conjunction with Caseload colour coded

Appendix 14 – record of supervision

Date:
Name: Name of Supervisor:
Managerial & Clinical Work:
Professional & Service Development:
Action Plan (including dates for completion):
Signature of Supervisor: Print Name: Signature of Supervisee: Print Name:
Date & time of next Supervision:

- Area of practice that needs to be addressed by manager

<table>
<tr><td colspan="2">CASELOAD BASED SUPERVISION</td><td>Date:</td></tr>
<tr><td colspan="2">Care Co-ordinator:</td><td>Supervisors:</td></tr>
<tr><td colspan="3">Number on caseload:</td></tr>
<tr><td>Red: 5</td><td></td><td rowspan="3">Comments:</td></tr>
<tr><td>Amber:3/4</td><td></td></tr>
<tr><td>Green:1/2</td><td></td></tr>
<tr><td colspan="3">The case load guidance tool ,should be used when discussing all patients</td></tr>
<tr><td colspan="3">Patient discussed:

Standard of documentation:</td></tr>
<tr><td colspan="3">Action plan:</td></tr>
<tr><td colspan="3">Patient discussed:

Standard of documentation:</td></tr>
<tr><td colspan="3">Action Plan:</td></tr>
<tr><td colspan="3">Patient discussed:

Standard of documentation:</td></tr>
</table>

HYWEL DDA UNIVERSITY HEALTH BOARD

Appendix 15 – Community Mental Health Team Referral Form

GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Community Mental Health Team Referral Form

Urgent (why urgent if required) .....

Routine (why is routine required).....

Name:

Male/Female:

Address:

Post Code:
Telephone number:-
Mobile number:-

DOB:

Next of kin:
Telephone number:-

Does the client agree to this referral: YES/NO

Referrer information

Name: **Designation:**
Address: **Telephone number:**

GP:
Address:
Other professionals/agencies involved (e.g probation, voluntary agencies etc):

Name of professionals involved:-

Presenting problems/reason for referral:

How do these problems affect the person's life?

Date that the GP reviewed the patient:-

Any communication needs?

Mental Health History:

Medical history:-

Current medication:-

Any suicidal intentions-

Past self harm /suicidal feelings (including any recent attempts)-

Any evidence of plans or preparations disclosed, regarding suicide?

Current view of risk of harm:-

Current Sources of support: (Family/Social Network/Services etc)

Did they attend the GP appointment with the patient?

Can they attend any further appointments with the patient, to support and give the carer's perspective?

Any other potential risks to self/other/staff?

Any further relevant information

Signed..... Date.....

Office use:

Date received:

Team Manager signature:.....Date allocated: .....