Older Peoples Community Mental Health Service Specification

Service Specification information

Service Specification number:

Enter Service Specification number:

Classification:
Corporate/Employment/Clinical/Financial (*please delete as relevant)*

Supersedes:
Please detail

Version number:
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Approval information

Approved by:
Complete

Date of approval:
Enter approval date

Date made active:
Enter date made active (completion by Service Specification team)

Review date:
Enter review date (normally three years from approval date)

Summary of document:
This service specification provides the framework for the Older Peoples Community Mental Health service within Hywel Dda University Health Board. The service specification will describe the service aims, values, principles, standards, and processes. It will function as an instructional guide to ensure service delivery and operations are carried out to an agreed set of processes and standards.

Scope:
This service specification covers all staff working within Older Peoples Community Mental Health service with Hywel Dda University Health Board. This includes a range of professionals including Nursing, Medical, Occupational Therapists, Occupational Therapy Support Worker, Psychologist and Support Workers. The teams provide a flexible and responsive service to mental health service users and their carers in the most appropriate setting. The service delivers assessment, diagnosis and treatment for people with a range of mental health problems (Including Dementia) in a variety of settings for individuals who are Relevant Patients under the Mental Health (Wales) Measure 2010 (MHM).

To be read in conjunction with:

All documents can be found via the Health Board: All Health Board Policies, Procedures and Guidelines (sharepoint.com) - Opens in a new tab

Policy	Document Name
836	All Wales Information Governance Policy - opens in a new tab
415	Clinical Supervision Policy -opens in a new tab
902	Supervision Procedure for Nurses and Practitioners in the Mental Health/Learnng Disability Directorate - opens in a new tab
868	All Wales Safeguarding Procedures - opens in a new tab
1122	Corporate Governance - 1122-Mental Health Single Point of ContactService Spec.pdf - All Documents (sharepoint.com) - opens in a new tab
389	Expenses Policy - opens in a new tab
370	Discharge & Transfer of Care - Adults Policy - opens in a new tab
311	Domestic Abuse and Sexual Violence Workplace Policy - opens in a new tab
133	Equality, Diversity, and Inclusion Policy - opens in a new tab
170	Lone Worker Policy - opens in a new tab
268	Medicines Policy Acute, Mental Health learning Disabilities and Community services- opens in a new tab
013	Management of NICE and other National Guidance Policy opens in a new tab
843	Reducing Restrictive Practice Policy- opens in a new tab
395	Section 136-Mental Health Act, 1983 Mentally Disordered Persons found in Public Places -opens in a new tab
731	Section 17-Leave of Absence Policy opens in a new tab
688	Section 117 After-Care Procedure Mental Health Act 1983 - opens in a new tab
214	The Provision and Access to the Independent Mental Health Advocacy (IMHA) Service Policy - opens in a new tab

494 All Wales Email Use Policy- opens in a new tab

248 Standards of Behaviour Policy - opens in a new tab

488 ALL WALES Upholding Professional Standards in Wales (Medical and Dental Staff) -opens in a new tab

195 Clinical Record Keeping Policy - opens in a new tab

141 Independent Mental Capacity Advocacy Service Policy -opens in a new tab

N/A Concerns investigation and management -opens in a new tab

N/A The National Framework for Implementation in Wales -opens in a new tab

1101 Clinical Supervison - opens in a new tab

1138 Security Management Policy - opens in a new tab

Co-occurring Mental Health and Substance Misuse Framework - opens in a new tab

Patient information:
Include links to **Patient Information Library** - opens in a new tab

Owning group: Mental Health & Learning Disabilities Written Control Documentation Group

30th January 2024

Date signed off by owning group

Executive Director job title:
Andrew Carruthers, Director of Operations

Reviews and updates:

V0.3 Initial Draft Service Specification development – 29.08.23

V0.4 Amendments following Global consultation exercise – 6.10.23

Keywords
Community Mental Health Team Service Specification

Glossary of terms

OP-CMHS	Older Peoples Community Mental Health Service
CMHT	Community Mental Health Team
MDT	Multi-disciplinary meeting
CTP	Care and Treatment Plan
SPOR	Single Point of Referral
WPAS	Welsh Patient Administration System
CDAT	Community Drug and Alcohol Team
DDAS	Dyfed Drug and Alcohol Service
MAS	Memory Assessment Service
LPMHS	Local Primary Mental Health Service
PICU	Psychiatric Intensive Care Unit
MH	Mental Health
LD	Learning Disability
SW	Support Worker
MH&LD	Mental Health & Learning Disability
OP	Older Peoples
Donee	Someone appointed under the Mental Capacity Act 2005 who has the legal right to make decisions within the scope of their authority on behalf of the person who made the power of attorney. Also known as a ‘donee’ of lasting power of attorney
JDT	Journey Through Dementia
OT	Occupational Therapy

Contents

What Is an Older Adult Mental Health Service:

There are multiple risk factors for mental health problems at any point in a person's life. Older people in later life experience complex social, psychological, and physical factors that influence the pattern, cause, diagnosis, treatment and prognosis of their mental health.

Older people experience stressors that are more common in later life such as a significant ongoing loss in capacities and a decline in functional ability. Older people often experience reduced mobility, chronic pain, frailty* or other long-term health conditions, for which they may require increasing levels of support, and often, some form of long-term care. In addition, older people are more likely to experience events such as bereavement, or a drop in socioeconomic status with retirement. All of these factors can result in isolation, loneliness and/or psychological stress and distress in later life.

*Frailty is a state of vulnerability, which renders the individual unable to resist external stressors *(physical, psychological, social and environmental)* resulting in the increased risk of adverse outcomes. Clegg A. et al (2013)

Therefore, Older People Community Mental Health Service are concerned with the care and treatment of people with complex mixtures of psychological, cognitive, functional, behavioural, physical and social risk usually related to mental disorder and frailty experienced in later life.

Service provision is, given the breadth of holistic needs in later life, inevitably through an integrated 'shared stepped care' approach, working in partnership with primary care, acute hospitals, social care, third sector agencies and voluntary sectors as appropriate.

Care delivery is personalised with a focus on recovery, well-being, quality of life, and independence to prevent both escalations of mental ill health and care, whilst consistently facilitating alternatives to hospital admission and/or facilitating successful safe return to the least restrictive environment.

Who is the client cohort?

'Mental ill health in older people does not just mean dementia but also other disorders such as depression, anxiety, schizophrenia, suicidal feelings, personality disorder and substance misuse' JCPMH, 2013

The service provision will focus adults over the age of 70 years as a chronological indicator for people experiencing serious mental disorder manifest in later life. This is positive protective action, acceptable within the Equalities Act 2010, for the defined clinical cohort. Not an age cut-off that necessitates a transition of service for mental ill-health manifest prior to such an age. The age threshold is an indicative protective element of an essentially needs led service for the defined clinical cohort. When the needs of an individual aged under 70 years are best be met by the Older People's service, they will be accepted, following assessment and agreement from the Older Adult Mental Health Service clinicians. This indicative age threshold does not apply to people living with dementia.

"Chronological age cut-offs remain inseparable from certain services. They are used at both ends of life for administrative matters such as for leaving school or receiving a state pension or to enable population needs to be estimated and plans implemented. Age-related physiological and social factors affect illness in old age and may interact, requiring a distinct body of clinical knowledge and skills to permit optimum treatment…. Not all adolescents reach 'maturity' at the same chronological age, and not all older people age at the same rate" Hilton, 2015

All people in later life using Older People Community Mental Health Service will be experiencing significant mental disorder. Significance would be indicated by the nature and severity of the condition with inadequate front-line treatment responses evident at the point of referral.

Population Needs:

This service specification has been designed in supporting current demographic trends 2023 within the Hywel Dda University Health Board footprint. The Older People Community Mental Health Teams supports people who are defined as being:

1. First Presentation over the age of 70
2. Age related Frailty
3. Any Age Adult presenting with Dementia.

West Wales has a higher proportion of older people than average across Wales. The projected increase in those 85 and over is 28% by 2030, with local increase variation projected as follows: Carmarthenshire=25%; Ceredigion=26% and Pembrokeshire=33%. (Older people - West Wales Care Partnership (wwcp-data.org.uk)-(opens in a new tab)

People are living longer with increasingly complex issues, whilst wanting to remain in their own homes and live as independently as possible for as long as possible. COVID-19 has had a significant impact on the physical and mental wellbeing of older people, due to the following:

- Periods of social isolation
- Lack of access to health and care services
- Direct impact of contracting COVID-19.

Prevalence shows that in the upcoming decades life expectancy and inward migration of older people impacts an upward growth of the percentage of people 70 years plus in the region, therefore an expected increase within West Wales around the number of people living with dementia.-(opens in a new tab)

Dementia - West Wales Care Partnership (wwcp-data.org.uk) - (opens in a new tab). shows that older adults in the West Wales region have increasingly complex needs. There are an estimated 6,884 people over the age of 65 with dementia in West Wales, 1,322 in Ceredigion, 2,358 in Pembrokeshire, and 3,204 in Carmarthenshire. Projections show that there will be 10,897 people over the age of 65 with dementia in West Wales by 2035, 1,993 in Ceredigion, 3,831 in Pembrokeshire, and 5,073 in Carmarthenshire.

As part of the ongoing support in current care and support provisions the community mental health team will support in delivering as part of 'The Dementia Action Plan for Wales': (opens in a new tab)

Aims 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.

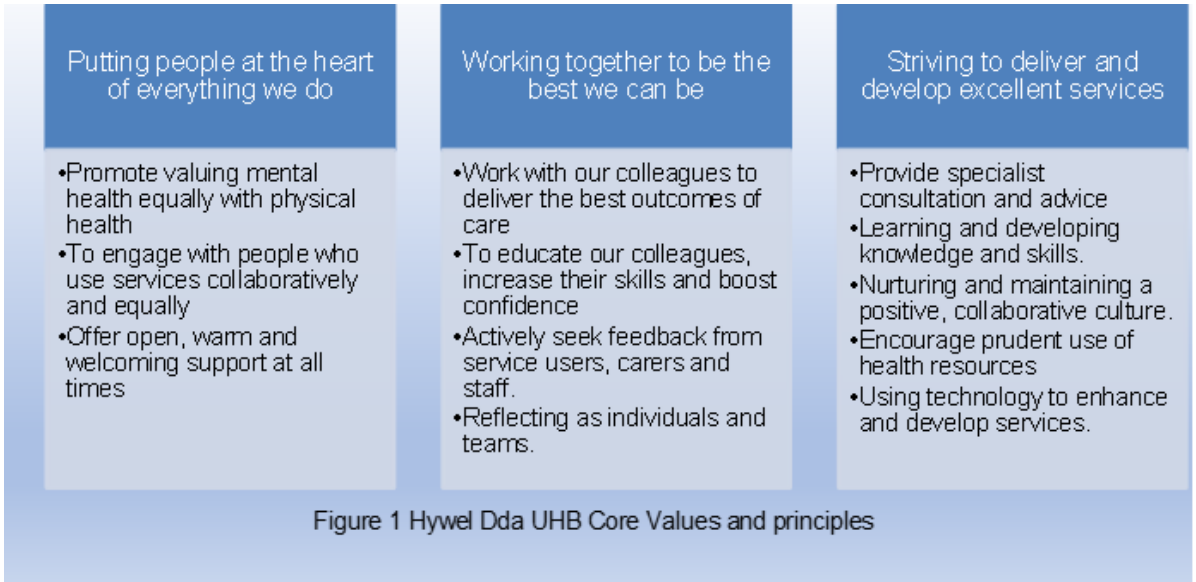


Figure 1 Hywel Dda UHB Core Values and principles

In alignment of Hywel Dda University Health Board (HDdUHB) core values and principles we have made a commitment to work collaboratively with service users, staff, carers, and key stakeholders to review and co-design a future model for Older Peoples Community Mental Health Service in alignment to deliver the following Mental Health (Wales) Measure 2010 (legislation.gov.uk) - (opens in a new tab)

- **Part 2** gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.
- **Part 3** gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services within the 3 year time frame

Ensuring to review and reflect the guiding future vision for Community Mental Health Services (opens in a new tab) in Wales with following principles:

Compassion, dignity and respect
Person-centred care
Prevention and wellbeing – focus on keeping people well
Access and equality – no wrong door
Coproduction
Choice and respect
Quality and consistency
Outcomes-focus
Leadership and innovation

Service Scope:

The provision of services is centred on the needs of individual users, their families and carers. With the individual rights to dignity and choice being respected at all times.

OP Community Mental Health Services are located within the centre of communities and provide strong links to other services, both statutory and voluntary. The OP-CMHS will uphold the guiding principles in respect to Recovery.

'*That it is possible for each individual to achieve goals that enable the individual to live a fulfilling quality of life and living well life, despite serious mental illness and it is possible for someone to regain in time, a meaningful life'.*

Source: Living a Meaningful Life While Struggling with Mental Health: Challenging Aspects Regarding Personal Recovery Encountered in the Mental Health System - PMC (nih.gov) (opens in a new tab)

The team has a clear identity and ethos to ensure that the needs of individuals and their carers presenting with warning signs of new or increased psychiatric disturbance (Including Dementia) are supported appropriately based on the following principles:

- Working in partnership
- Respecting Diversity
- Practising Ethically
- Promoting Recovery
- Identifying people's strengths and needs
- Providing service user centred care
- Promoting safety and positive risk taking
- Personal development and learning
- Carers support

This service specification will guide OP-CMHT staff to undertake their work within the context of the following policy guidance. Can be found within Read In Conjunction & References:

OP-CMHT's form part of a whole system approach that is delivered in conjunction with Inpatient, Crisis (CRHT), 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 OP-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 OP-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 Older Peoples Community Mental Health Services Team Leader or Specialist Supervisor is responsible for the Audit, compliance, and quality of CTP within services.

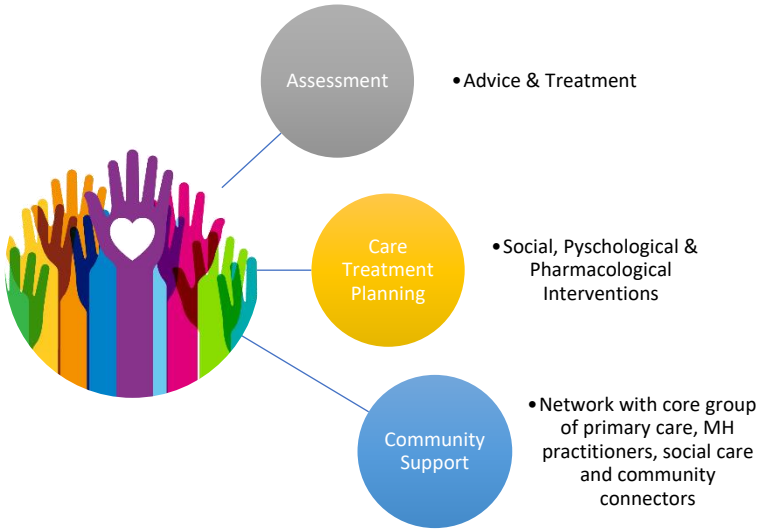
The teams are required to meet Welsh Government CTP targets in relation to OP-CMHT services.

Target 1	All relevant patient has an up-to-date CTP	90% Compliance
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	100% Compliance

Part 3 of the measure requires that; Local Health Boards and Local Authorities have arrangements in place to receive self-referrals from relevant patients discharged within the previous 3 years and to undertake assessments within 28 days. The regulation made under Part 3 requires that a copy of the

report be provided to the individual who was assessed no later than 10 working days after the conclusion of the assessment.

Function of OPCMHT:



OP-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:

1. Mental Health Promotion
2. Appropriate Medication and medication management.
3. Ensuring physical health needs are addressed.
4. Psychosocial interventions.
5. Ensuring needs are met in relation to occupational functioning across social, leisure and productivity domains.
6. Referral to Welfare Benefit advisory services.
7. Assistance in accessing suitable accommodation to meet their needs.
8. Relapse prevention.
9. Support and advice for carers and families.
10. Information regarding Advocacy Services.

OP-CMHT's are required to adhere to Welsh Government legislation, including the Social Services & Wellbeing (Wales) Act 2014 (opens in a new tab) 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.

Each OP-CMHT is aligned to a number of Primary Care Practices in a defined geographical locality. There are 4 OP-CMHT's based across HDUHB area.

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

The OPCMHTs within Hywel Dda University Health Board is composed of a multidisciplinary skill mix of medical staff (psychiatrists), nurses, healthcare support workers, Occupational Therapists, Occupational Therapy Support Worker, Psychologists and Business Administration.

Role of The Mental Health Practitioner, supported by Health Care Support Worker:

- Screening referrals as part of duty responsibility
- Comprehensive Mental Health and Risk Assessment in a timely manner
- Care Co-ordination under Part 2 of Wales Mental Health Measure alongside facilitation of Part 3
- Social and Psychological Interventions
- A focus on recovery, well-being, quality of life, and independence to prevent both escalations of mental ill health and care, whilst consistently facilitating alternatives to hospital admission and/or facilitating successful safe return to the least restrictive environment.
- Identifying and supporting the needs of carers

Role of Consultant Psychiatrists:

- Assessment, diagnosis, provide treatment recommendation and medication management.
- Exercise responsibilities of a Responsible Clinician in accordance with the Mental Health Act
- Provide teaching and support to MDT and junior doctors.
- Care Co-ordination under Part 2 of Wales Mental Health Measure alongside facilitation of Part 3
- A focus on recovery, well-being, quality of life, and independence to prevent both escalations of mental ill health and care, whilst consistently facilitating alternatives to hospital admission and/or facilitating successful safe return to the least restrictive environment.

Role of Occupational Therapists supported by Occupational Therapy Support Worker

- Inform the teams of specialist occupational therapy approaches and interventions. Specifically, where service users are demonstrating a significant change in occupational participation and functioning across personal and domestic activities of daily living, social, leisure and work, education, or training activities. Alongside their specialism occupational therapist will also deliver Comprehensive Mental Health and Risk Assessment in a timely manner and Care Co-ordination under Part 2 of Wales Mental Health Measure alongside facilitation of Part 3 to those patients primarily demonstrating a significant change in occupational participation and functioning across personal and domestic activities of daily living, social, leisure and work, education, or training activities.
- Occupational Therapy Support Workers help to deliver recovery focused interventions that maximise level of independence in occupational function across personal, domestic, social, leisure, work, education, or training activities.
- A focus on overcoming functional deficits as an aid to recovery, promoting well-being, quality of life, and independence to prevent both escalations of mental ill health and care, whilst consistently facilitating alternatives to hospital admission and/or facilitating successful safe return to the least restrictive environment.

Role of Psychologists:

- Work collaboratively with psychology, multidisciplinary and senior management team colleagues to achieve effective practice-based and evidence-based psychological service development and psychological service provision to older people and their families and carers in Hywel Dda.
- Take a flexible and adaptable approach to service development and delivery.
- Contribute to strategic developments impacting psychology and wider Older Adult services initiatives.
- Disseminate knowledge and contribute to the development of other services and individual staff.
- Develop opportunities for supervision experience reaching beyond just the Psychology department; our Psychologists can supervise nurses, OTs, Psychiatrists and Health Care Support Workers in the provision of psychologically informed working, where requested and appropriate.
- Develop and monitor training, supervision, and evaluation frameworks to enhance psychologically informed workforce and psychologically informed older adult services.
- Carry out research, contribute to the evidence base and use research skills in the audit and evaluation of services.
- In clinical work, provide specialist needs-led and evidence-based approaches to assessments (including cognitive assessments), formulations and treatments for individuals and carers where patients present with the full range, severity, and complexity of mental health problems (including stress and distress in dementia).
- Highly provide specialist consultation, advice, training and supervision on psychologically informed approaches across all older adult's services pathways (including psychological approaches to complex risk prevention, assessment and management).
- Our Psychology team have an important role to play in the assessment, formulation, and treatment of functional mental illness and/ or stress and distress in dementia, in older people, both directly, with the patient, and by supporting nursing staff and/ or carers to deliver therapy.

- Focus approaches on recovery that embraces diversity and is equitable across the three counties.
- A focus on recovery, well-being, quality of life, and independence; working to support the prevention and amelioration of mental ill health and reducing and preventing escalation in care needs; collaborating with colleagues, service users and carers to achieve alternatives to hospital admission and successful safe return to least restrictive environments.
- Work closely with service user representatives and all relevant stakeholders to collectively shape the way our psychology services are developed and delivered.

Role of the Service Manager:

- To provide operational leadership, guidance, and direction to the Team leaders, Specialist Nurses, and the MDT.
- Ensure the delivery of a safe consistent and effective mental health service to the communities represented by the team.
- Contribute to service developments to ensure that evidence-based care is delivered efficiently.
- Provide assurance that services are being delivered as expected. Resolving professional differences which may occur.
- Ensures DATIX and feedback are managed within the time scales, ensuring any learning and improvements are implemented and shared within the service

Role of Administration support:

- **Organising and coordinating:**
    - Scheduling meetings, events, and workshops for the mental health community service.
    - Ensuring formal communication between team members and participants.

- **Managing resources:**
    - Keeping track of available resources, such as funding, materials, and equipment.
    - Procuring necessary supplies for workshops and events.

- **Supporting staff:**
    - Assisting in the recruitment and training of volunteers.
    - Providing guidance and support to volunteers during their service.
    - Ongoing support to cross cover colleagues in managing effective workload.

- **Data management:**
    - Maintaining accurate records of participants and their progress.
    - Ensuring the confidentiality and security of sensitive information.

- **Promoting the service:**
    - Collaborating with marketing or outreach teams to raise awareness about the mental health community service.

- **Liaising with stakeholders:**
    - Building and maintaining relationships with other mental health organisations, local authorities, and community partners.

    - Collaborating with relevant agencies to expand the service reach.

- **Handling administrative tasks:**
    - Managing paperwork, such as participant forms, consent, and evaluations.
    - Keeping track of service metrics and preparing reports for evaluation.

- **Monitoring and Evaluating:**
    - Regularly assessing the service's impact and effectiveness.
    - Identifying areas for improvement and proposing appropriate changes.

- **Crisis Intervention:**
    - Being prepared to respond to any mental health crisis that may arise during service events or interactions.
    - Knowing when and how to seek professional help for individuals in need.

Role of Pharmacists:

There is a dedicated Mental Health and Learning Disability (MH&LD) pharmacy department based in Glangwili Hospital. This team comprises of specialist mental health pharmacist, technicians, and support workers. They deliver a service throughout the Health Board. The specialist mental health pharmacist will provide a service to the CMHT which include.

- They can advise on any medication queries the team have with current patients or any recommendations to be made following a screening by the team.
- To provide a point of contact to all OA-CMHT with regards to any medication queries
- Pharmacists can be requested to attend OPA or CTP reviews by the Care Coordinator when required with a medic, either in person or via Microsoft Teams if needed for medication advice.
- To offer advice to GPs with regards to medication, in particular psychotropic medication. This can be done via the telephone: 01267 227367 or email MentalHealthPharmacy.Account@wales.nhs.uk
- The OP CMHT can also liaise with the mental health pharmacy team for any medication management issues outside the weekly CMHT meetings via the above contact telephone number or email address. (Medicines Policy) opens in a new tab
- To ensure that the CMHT have adequate supply of depot medications for their depot clinics.

Multi-Disciplinary Team Meetings:

Purpose:

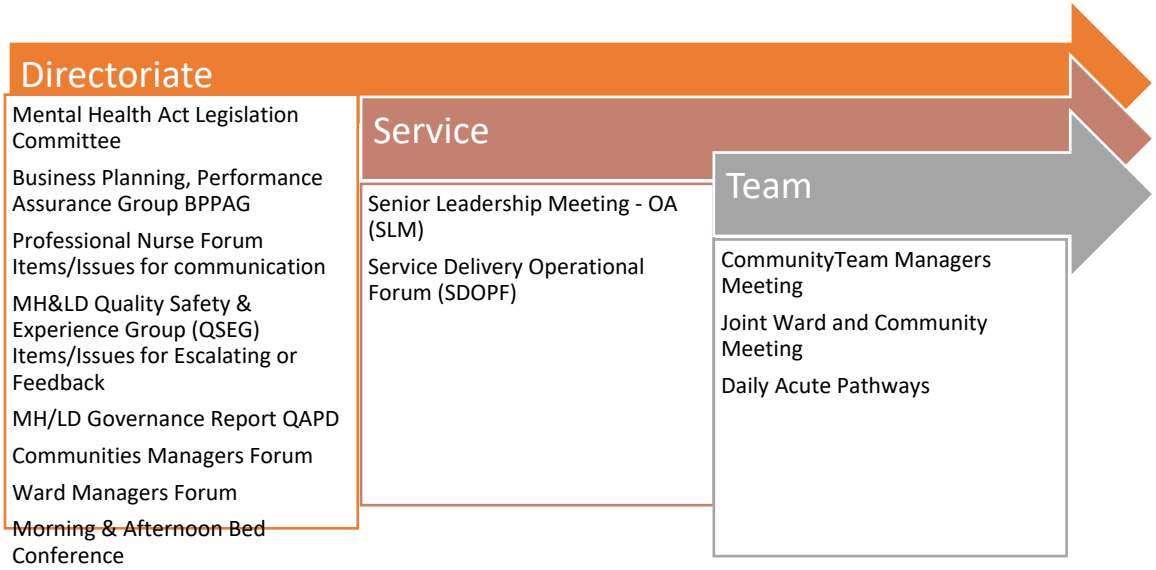
A weekly multi-disciplinary meeting attended by CMHT professionals to undertake the following.

- Presentation of new referrals following the completion of Initial Comprehensive Assessment Tool (CAT) (within 14 working days of allocation), appropriate assessment tools/scales and PROMS to support the decision on most appropriate service to meet the individual needs.
- Agreement on patient's relevancy under the Mental Health (Wales) Measure 2010 (legislation.gov.uk) (opens in new tab)
- Feedback and Formulate treatment and/or interventions following OPA/OPC
- Inter CMHT Assessment (OT/MEDIC/MHP/PSYCHOLOGY)
- Onward referral e.g., DWB/CRHT/AC/AS/ ADMIRAL
- Transfer of Care Co-ordinator
- Transfer to other MH team/service e.g., Adult CMHT
- Discharge agreement.
- Discuss the recovery pathway of all patients registered to the CMHT using caseload weighting tool. (Including those within our MH and DGH's inpatient wards):
    - Red 4 = weekly
    - Amber 3 = alternate weeks
    - Green 2 = alternate weeks
    - Green 1 = monthly
- Discuss pending Inpatient discharge planning arrangements.

A designated chairperson role (usually the team leader) is to chair the meeting and ensure the effective running of the meeting adhering to a standard agenda, 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. The minutes and action log are to be stored in the OA CMHT shared drive.

TermsOfReference_CMHTMDT_Draft.docx (opens in a new tab)

Daily Directorate Clinical Governance Meetings:



A presence of practitioners from Older People Community Mental Health at the following key directorate meetings plays a crucial role in ensuring comprehensive and effective care for older adults with several key components:

1. Facilitation of Interdisciplinary Collaboration
2. Care Coordination and Case Management
3. Resource Allocation and Prioritization
4. Risk Assessment and Management
5. Quality Improvement Initiatives
6. Training and Professional Development
7. Legal and Ethical Considerations

Service Description:

OP-CMHT is a Secondary Specialist Multi-Disciplinary team supporting new or increased psychiatric disturbance of older people providing, **Assessment**, **Care** and **Treatment.**

This includes the patient, family and carers, whose age-related mental health needs, or dementia, due to complexity and risk, cannot be fully addressed by their GP and/or other primary care support services.

NB Assessment will only very rarely be declined, and the individual referred will become "known" to the service, but this does not mean Care Coordination and/or Care and Treatment Plans will be deemed as required under the Mental Health (Wales) Measure 2010 (legislation.gov.uk) and may result in support, advice and/or sign posting. Being "known" to the service does not mean that the case or person is perpetually open to or in receipt of secondary specialist service intervention.

The service meets the needs of services users who have:

- Depression moderate to severe
- Generalised Anxiety disorder moderate – severe
- Bipolar Affective disorder moderate – severe
- Psychosis - First episode/late onset
- Psychosis - on-going/recurrent symptoms/high relapse risk, moderate - severe needs
- Obsessive Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Specific/Social phobia
- Eating disorders (in conjunction with specialist eating disorders service where necessary)
- Personality disorder co-existing with the above diagnosis and / or personality disorder that causes significant distress or risk to the Service User or others and where there may be a benefit from specialist expertise.
- Organic mental health disorders: dementia (any age) with moderate to severe behavioural and psychological symptoms and associated moderate to severe risks to self or others &/or severe self-neglect.

If a person presents with the following: * Note this list would **not** be accepted via the Older Adult CMHT

- Minor/mild/low severity – depression/anxiety *(Refer to Local Primary Mental Health Support Service)*
- Primary substance misuse ***unless*** comorbidity alongside age related mental health disorder. *(Refer to Co-occurring Mental Health and Substance Misuse Framework) (opens in a new tab)*
- Learning disabilities ***unless*** it occurs within/alongside age related mental health disorder. (*Mental Health and Learning Disabilities - Home (sharepoint.com) (opens in a new tab)*

- Presentation changes as a result of likely/ confirmed Delirium and/or other reversible medical conditions not excluded prior to referral (i.e., via physical health screening and review) (*Delirium: prevention, diagnosis and management in hospital and long-term care) (opens in a new)*
- Normal grief reaction (*Bereavement Support Services) (opens in a new tab)*
- Social need/assessment only (no age-related mental health disorder (as above) Social Services and Wellbeing (Wales) Act 2014 (opens in a new tab)
- Cognitive changes associated with severe and enduring psychosis and or other long term psychiatric or medical conditions. (Alzheimer's Society) (opens in a new tab)
- Advanced dementia with low level risks and/or end of life care
- Acute traumatic or acquired brain injury. (Neurological rehabilitation service (opens in a new tab) / Community Neurorehabilitation Service - Swansea Bay University Health Board (nhs.wales) (opens in a new tab)
- Chronic traumatic or acquired brain injury unless historically stable but with recent change suggestive of age-related frailty. (Headway - the brain injury association | Headway) (opens in a new tab)

Priority for assessment (taken within the above criteria) are where one or more of the following criteria exists: (*Appendix 2: Mental Health Triage Scale*

- The individual is at risk of abuse from another party.
- The individual poses a risk to others.
- Impaired ability to function effectively and safely within the community without assistance.
- Changes in behaviour manifest as stress or distress, which may lead to a breakdown in the integrity of their current social situation, community tenure and/or risk of unnecessary escalations in care
- Self-neglect and/or neglect of the home
- Any self-harming behaviour
- Persistent somatic complaints without organic basis
- Increased use of alcohol or other drugs, including persistent requests for hypnotic medication
- Exhaustion of carers
- Repeated complaints by neighbours or the police

Referrals will be received from a person's GP, Advanced Nurse Practitoner or a health or social care professional that has seen the person prior to referral. Under the Mental Health (Wales) Measure 2010 (legislation.gov.uk), people who have been in receipt of support from secondary care services (OP-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 OP-CMHT the reasons for this will be explained to the person and/or their carer will be recorded on the assessment. The GP and original referrer will be informed.

OP CMHT Duty System:

A mental health practitioner is available to receive new referrals, to offer advice and guidance to other professionals Mental Health Single Point of Contact 111/2 - MH Single Point of Contact (111 Option 2) (opens in a new tab) available 24/7.

To offer an appointment and complete an assessment of urgent and non 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 16.00pm following this time urgent referrals will be screened by the OA CMHT and if same day assessment/intervention is required it will be forwarded to CRHT (opens in a new tab) if assessment is required out of hours. All referrals for assessment must be from GP, AMHP, or Mental health professional. This may include hospital Liaison in some areas where patients are medically fit for discharge.

Referring into OA CMHT:
Individuals referred to the OPCMHT must have had a consultation with the **referrer** in the **previous 48 hours.** This can be virtual, email, face to face or by telephone using the following contact points:

Location	Opening Hours	Contact Information
Ceredigion	**09:00-17:00** **(Mon-Fri)** **Excluding** **Bank Holidays**	SPOC Ceredigion: 01970 635844 Email: **CeredigionOACMHT.HDD@wales.nhs.uk**
North Carmarthenshire	**09:00-17:00** **(Mon-Fri)** **Excluding** **Bank Holidays**	SPOC North Carmarthenshire: 01267 674042 Email:**NorthCarmsOACMHT.HDD@wales.nhs.uk**
Pembrokeshire	**09:00-17:00** **(Mon-Fri)** **Excluding** **Bank Holidays**	SPOC Pembrokeshire 01437 773219 Email: **PembsOACMHT.HDD@wales.nhs.uk**
South Carmarthenshire	**09:00-17:00** **(Mon-Fri)** **Excluding** **Bank Holidays**	SPOC South Carmarthen 01554 779211 / 01554 779311 Email: **SouthCarmsOACMHT.HDD@wales.nhs.uk**
Out Of Hours	**17:00-08:30** **(Mon-Sun)**	First Point Contact: 111/2 MH Single Point of Access **Or** Access provided in all District General Hospitals with an all-age MH&LD Liaison support.

Urgent Referrals to OPCMHT Require Referee to make telephone contact to the duty manager before **15:00 for discussion.**

Accepting as part of a Section 136:

This section should be read in conjunction with the Inter-agency Protocol for Section 136 - Mentally Disordered Persons found in Public Places - Mental Health Act 1983 - opens in a new tab

Wherever a police officer encounters an individual who appears to warrant the provision of Section 136 of the Mental Health Act, they should first attempt to contact an appropriate mental health professional to seek advice, if practicable. In hours this will be via the Duty Service Manager and Out of Hours via the Clinical Co-ordinator. If detention under Section 136 is required, the Mental Health Practitioner will advise which place of safety to be used. Where admission to hospital is indicated, following the mental health act assessment it is the responsibility of the assessing medical practitioner to identify an inpatient bed for the patient, assisted by the Bed Conference or Out of Hours Co-Ordinator.

The AMHP is responsible for arranging the transportation of the patient to the identified admission bed. The Bed Conference or Out of Hours will support this process using St Johns Ambulance.

Referral Screening:

Referral is screened using the Mental Health Triage Scale and is conducted alongside the needs of the person and/or carer/family:

Triage Code/description	Response type/time to face-to-face contact
A **Emergency**	**IMMEDIATE REFERRAL** **Emergency service response**
B **Very high risk of imminent harm to self or to others**	**WITHIN 4 HOURS** **Very urgent mental health response Pt to attend A&E or refer to Crisis team.**
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 by CMHT for face-to-face assessment.**
D **Moderate risk of harm and/or significant distress.**	**WITHIN 72 HOURS** **Semi-urgent mental health response.**
E	**WITHIN 4 WEEKS** **Non-urgent mental health response.**

Low risk of harm in short term or moderate risk with good support/ stabilising factors.	

Once a decision is reached jointly the following occurs:

A. **Allocate** referrals that require an assessment by OPCMHT with a nurse, Occupational Therapist, Psychology, Psychiatrist, or any joint assessment required to include urgency of response.
B. **Redirection** and or **Signposted** to the most appropriate service.
C. **Not Accepted** back to referrer.

Screening Communication:

A. & C. Outcome of screening to be communicated back to the referrer via approved outcome screening letter to GP.
B. Outcome of screening to be communicated back to person, family, or carer via approved Appendix 6 - Older Adult CMHT Leaflet - opens in a new tab

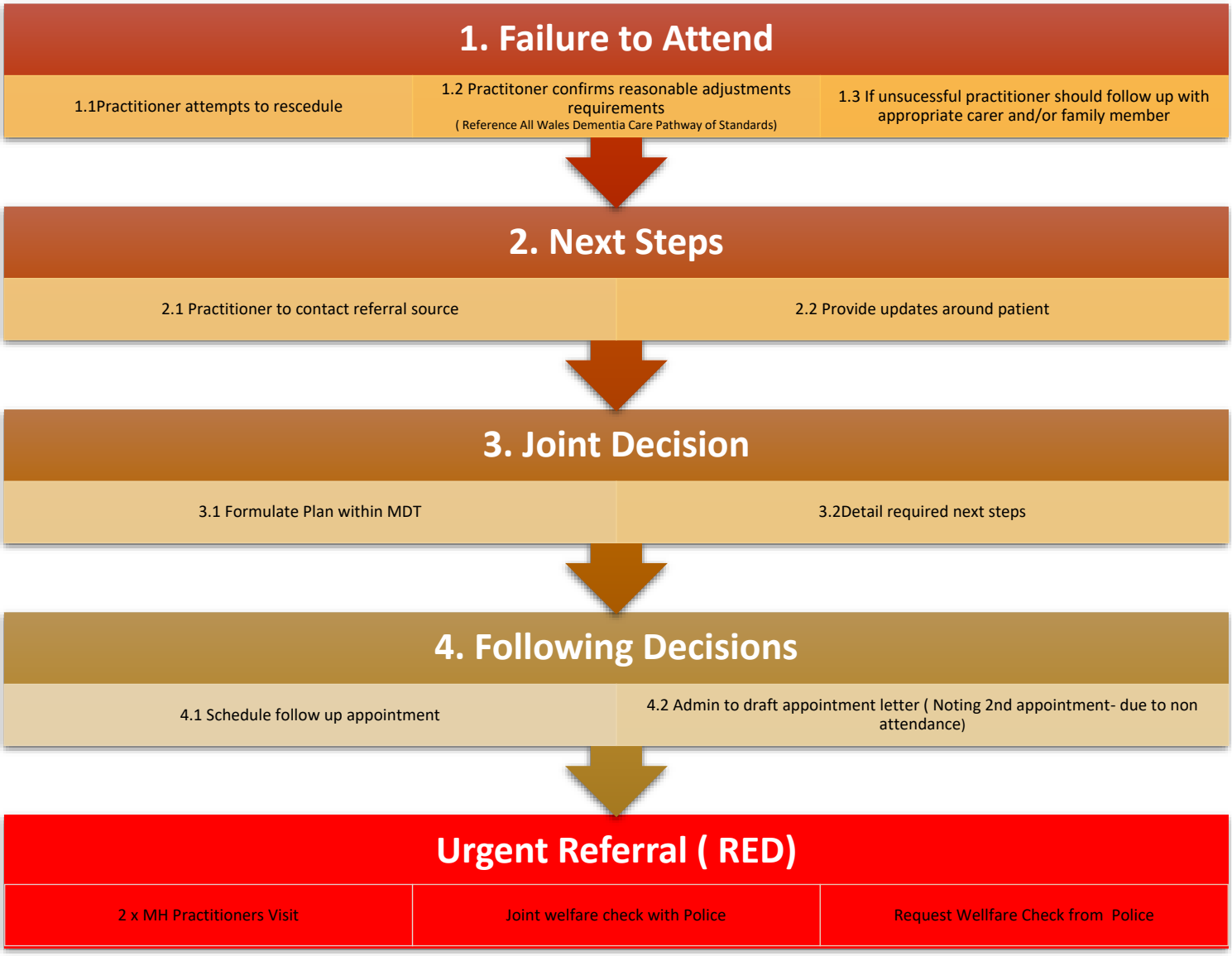
The Screening process should be completed same day, any issues should be escalated through Clinical and Governance structures. E.g., Daily Acute Pathways Meeting and Directorate daily bed conference.

Scheduling Appointments:

Referral approved; patient appointment required to be scheduled by administrative support. Once booked administrative support will ensure the timely update of the following:

1. Patient Appointment
2. Referrer
3. Care Partner
4. WPAS
5. MDT Template
6. OPCMHT Matrix

Failure to attend appointments protocol:



On receipt of referral. Please refer to the following Caseload Weighting Tool in accordance with the below tasks:

- If telephone contact is unsuccessful, a written attempt to contact the patient will be made in order to arrange an initial appointment if routine assessment.
- When attempting to contact a patient, if there is **no** answer, a brief message is to be left on a mobile phone, if possible, leaving the OACMHT number and explaining that it is regarding booking an appointment. Messages **should not** be left on landlines without permission from the patient.

Referral for routine outpatient/community 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 OP-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.

Service Level Risks

- Service level risks are risks which affect a service.
- The Head of Service/Departmental Manager is responsible for approving the inclusion and closure of operational risks on to the service risk register, as well as highlighting risks to the relevant Executive Director (or Director/General Manager for the Operations Directorate) for possible escalation or request for acceptance of risk above UHB tolerance
- The relevant Executive Director (or Director/General Manager for the Operations Directorate) is responsible for approving service level risks being escalated to directorate Level.
- The Executive Risk Owner is responsible for agreeing acceptance of service level risks above UHB tolerance and reporting this decision to the Executive Team, as well as presenting any service level risks to the Executive Team for approval for inclusion on to the CRR

Clinical Risk Assessment and Management:

“Effectively managing risk becomes an essential aspect of providing optimal care to individuals in distress. This dedicated approach involves a thorough examination of potential risks and the implementation of robust strategies to mitigate them. By equipping ourselves with the knowledge and skills to identify, assess, and respond to risks promptly, we can foster a safe and supportive crisis intervention environment for our patients and fellow team members. The Royal College of Psychiatrist (opens in a new tab) defines the following principles for managing risk:

1. A clinician, having identified a risk of dangerous behaviour, has a responsibility to take action with a view to ensuring that risk is reduced and managed effectively.
2. A management plan should seek to change the balance between risk and safety.
3. The clinician should aim to make the patient feel safer and less distressed.
4. Sensitive use of empathy and compassion should allow the patient to feel understood and, potentially, more contained.

Assessment of Co-occurring physical co-morbidities and current medications is essential to assessing risk in older people. For example, chronic physical illness and pain can be associated with suicidal behaviour. Confusion associated with organic brain conditions such as dementia may place an elderly patient at physical risk, including risk of falls, because of disorganised, impulsive, or disinhibited behaviour. Certain medications (for example cortisone) can cause side effects, including delirium, in an older person.”

A primary function of secondary care practitioners is to undertake clinical assessments in varying contexts. Clinical assessments are multidimensional in approach with information gathered from many sources, including the service-user’s opinions and other interested parties such as family.

Through the clinical assessment process, Practitioners develop an understanding of the individual to identify needs which can be supported and risks which can be managed. This helps effective person-centred care to be planned for each service user. The assessment of a person's needs, vulnerabilities, and safety should be a part of every assessment and that 'risk' should not be used to determine care management in isolation of other factors.

All staff should use their clinical judgement when assessing someone who has a risk of harm, whether to themselves or others, and in the event, they are concerned about the person and their safety, should conduct a risk formulation using the WARRN Tool to place the person's safety considerations in context with their strengths and difficulties. Risk formulation is a collaborative process between the person and a mental health professional that aims to summarise the person's current risks and difficulties and understand why they are happening in order to inform a treatment plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources. Risk assessment should take into account that risk is dynamic and, where possible, specify key risk indicators which would trigger a review of risk management plans. Risk formulation brings together an understanding of personality, history, mental state, environment, potential causes and protective factors, or changes in any of these.

It should aim to answer the following questions:

• What is the nature of the risk?

• What is the probability of the risk occurring?

• How imminently might the risk occur?

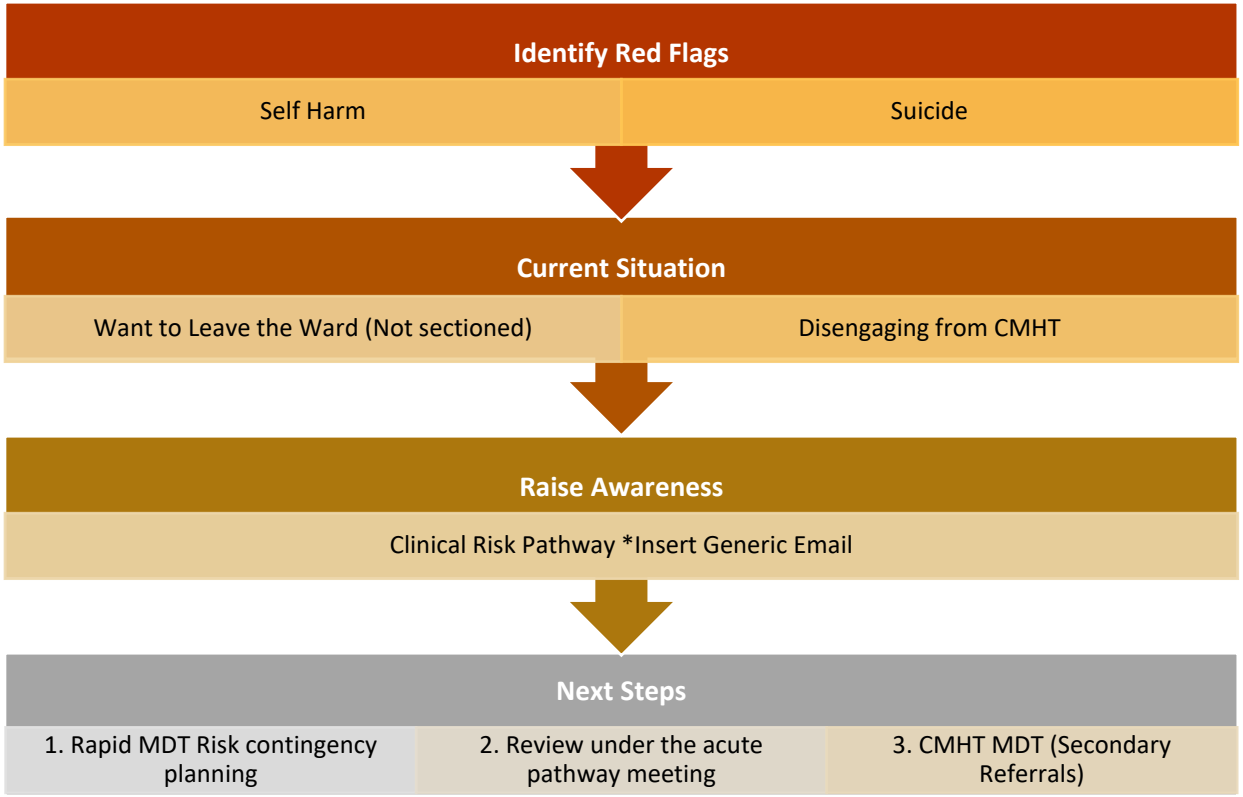
• What is the likely severity if the risk does occur?

• What are the key risk indicators or risk reducing factors?

The purpose of any risk assessment process is to enable a risk management plan to be developed. Risk management plans should consider how risk can be safely managed which may include options such as treatments, and control measures. Considerations should also be given to how the person has managed these feelings and risks in the past and what has been helpful to them previously in achieving a positive outcome.

Where indicated a person-centred safety plan should be completed. This is a written, prioritised list of coping strategies and/or sources of support that the person can use to help overcome a period of crisis. Components can include recognising warning signs, listing coping strategies, involving friends and family members, contacting mental health services, and limiting access to self-harm methods, which are to be referenced in the Care and Treatment Plan. Where appropriate and with the person's consent, sharing information including risks, management plan and contact numbers with key individuals which may include family / Carers.

Clinical Risk Flow Chart:



Assessment:

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

An assessment can take place in a range of settings including:

A. Where a person resides
B. Outpatient Clinic
C. Community premises

When identifying new patients within OP-CMHT ensure guidance followed under the Health Board Lone Worker Policy – opens in a new tab

Using the following MH&LD Directorate wide Comprehensive Assessment Tool (CAT) and appropriate assessment scales and outcome tools to inform formulation.

All assessments undertaken by the OPCMHT will identify the following:

1. Determine the level of risk to self or others.
2. Determine the needs and wishes of both patient and carer.
3. Determine what immediate action is required.
4. Determine whether the service user needs require admission to an acute Inpatient Ward
5. Determine if the service user requires a further period of assessment by OPCMHT.
6. Determine the need for further joint assessment e.g.
    A. Substance misuse practitioner
    B. Social Workers: Social services and wellbeing act - opens in a new tab
7. Determine if the person needs to be signposted/ referred to an alternative service.
8. Determine if the person requires further input by the OPCMHT or discharge back to the referrer.
9. Determine relevancy under the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010. – opens in a new tab
10. Determine continuing healthcare eligibility (CHC & NFC)

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

On completion of the assessment the GP and patient will receive a summary of the assessment and any plan identified.

Following Assessment: **Appendix 4: OA CMHT Operational Process Flow:**

1. Present assessment as part of weekly clinical governance at the MDT team meeting
2. Formulation agreement.
3. After a maximum of **14 working days** agree relevancy in-line with the outcomes listed above and Implement **Care Treatment Planning. Flow Chart INCLUDE** OPCMHT_CareTreatmentPlanning_Flow Chart_Final_March23.docx (sharepoint.com)
4. The outcome of the assessment and the agreement of MDT will be communicated to the referrer and relevant others in writing and a copy scanned to the patient's electronic clinical record (Care Partner).

****NB*** **"**A relevant patient is defined in the Measure as an individual for whom a mental health service provider is responsible for providing a secondary mental health service. This is irrespective of whether the individual is cooperating with the provision of such services." Ref: Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010

Referral and transfers:
Upon agreement of transfer of care team leader will identify a care co-ordinator within **3 working days** of notification in order that a safe transfer of responsibilities. Care co-ordinators have **2 weeks** to complete CTP paperwork. If patient is new to mental health services, the CTP should be completed in **6 weeks**.

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:

1. Needs support in multiple domains of the care and treatment plan directly relating to their mental health.
2. Complex and severe mental disorder that is current in presentation.
3. Service users with severe, difficult to manage and persistent mental illness, such as schizophrenia, severe depression, or bipolar disorder.
4. Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up
5. 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.
6. 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.

The code of practice part 2 and 3 states that in every case the relevant mental health service provider may only appoint a care coordinator who is eligible to be appointed; eligibility criteria are set out in the Part 2 Regulations. Under these Regulations, a person is only eligible to be appointed if that person:

- Meets one or more of the professional requirements (see paragraph below); and,
  demonstrates to the satisfaction of the appointing organisation that he or she has appropriate experience, skills or training, or appropriate combination of experience, skills, and training to undertake the functions of a care coordinator.

The professional requirements are that the potential care coordinator is:

- Qualified social worker (registered with either the Care Council for Wales or the General Social Care Council).
- A first or second level mental health or learning disabilities nurse (registered in Sub-part 1 or Sub-part 2 of the Register)
- An occupational therapist (registered in Part 6 of the Register)
- A practitioner psychologist (registered in Part 14 of the Register)
- A registered medical practitioner
- A dietician (registered in Part 4 of the Register)
- A physiotherapist (registered in Part 9 of the Register)
- A speech and language therapist (registered in under Part 12 of the Register)

Ref: Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 (opens in a new tab)

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:

- Comprehensive needs assessment
- Risk assessment and management
- Crisis planning and management.
- Assessing and responding to carers' needs
- Care planning and review
- Transfer of care or discharge

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

Co-occurring Mental Health and Alcohol/Substance Use

Service users with co-occurring alcohol/substance use problems are defined as those with severe mental illness and drug and/or alcohol problems. This group are likely to meet the eligibility criteria Care Coordination.

It is acknowledged that service users may often present particular risks to themselves or others and require robust Care Co-ordination. Those with a co-occurring diagnosis as defined will be the primary responsibility of the mental health services. Such individuals should be referred as necessary to Community Drug and Alcohol Services for expert advice or a specific treatment package.

Community Drug and Alcohol Services will also give advice as necessary to those providing medically assisted withdrawal programmes to service users with co-occurring diagnosis. Regular communication with CDAT and DDAS should be maintained through regular meetings and attendance at MDT meetings.

In order to ensure that a collaborative approach is being delivered within local services, a Local Cooccurring Mental Health, and Substance Misuse Framework has been jointly produced and agreed Corporate Governance - 1173 Hywel Dda Co-occurring Mental Health and Substance Misuse Framework.pdf - All Documents (sharepoint.com)

Hywel Dda Co-occurring Mental Health & Substance Misuse Framework (opens in a new tab).

Co-occurring Mental Health and Substance Misuse Practitioner
Service users with Co-occurring Mental Health and Substance Misuse problems, often find it hard to access treatment, remain engaged in treatment and have worse overall outcomes. The role of the cooccurring mental health and substance misuse practitioner is to work with individuals who meet the criteria for secondary mental health services and require a CTP and also have substance misuse concerns. To provide support and advice to both teams in working with substance misuse and mental illness, as well as providing strong communication links and a shared joined up approach to working with these individuals.

Accepted for Care Co-ordination

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

1. Engagement/ assertive engagement
2. Crisis Management
3. Medication management.
4. Occupational functional performance
5. Social support and practical help.
6. Psycho-social interventions.
7. Education on maintaining good mental health and recognising signs of relapse.
8. Crisis & Contingency Planning, including working with carers and families.

"The role of the care coordinator is a distinct one within the care and treatment planning process, which may overlap with some areas of professional practice but also has its own distinct responsibilities. There may be many people involved in a relevant patient's care in secondary mental health services but there will be only one care coordinator acting for a relevant patient at any one time."

Ref: Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 (opens in a new tab)

The care coordinator is responsible for the following:

- Working collaboratively with the relevant patient and the relevant patient's mental health service providers with a view to agreeing the outcomes which the provision of mental health services are designed to achieve;
- Ensuring that a care and treatment plan is developed and written.
- Ensuring care and treatment plans are reviewed and revised.
- Keeping in touch with the relevant patient. The care coordinator may also choose to keep in touch with family and carers where appropriate or necessary.

Care coordinators are the principal source of information for the relevant patient and are responsible for seeking their active involvement and engagement in the care planning process. They also have a significant role in managing relationships with a wider range of partners in the care and treatment process. The care coordinator may also deliver certain components of the care and treatment plan themselves.

OPCMHT_CareTreatmentPlanning_Flow Chart_Final_March23.docx

(opens in a new tab)

Care and Treatment Planning:

The following steps should be followed in conjunction when detailing the care and treatment plan:

- Care coordinator to **Co-produce** with patient, carer, family and/or significant other subject to agreement and consent put into writing a care and treatment plan for a relevant patient.
- **Ensure** Outcome measures are identified and initiated with patient with patient, carer, family and/or significant other.
- **Consider** where there are high levels of risk on completion of the CAT assessment for a WARRN / STORM to be completed.
- **Ensure** Care and Treatment plans are recorded via the Health Board approved patient recording system- Care Partner.(opens in a new tab)

The Care and Treatment plan will consider the following domains of a Care & Treatment Plan with specific reference to:

1. Finance and money
2. Accommodation
3. Personal care and physical wellbeing
4. Education and training
5. Work and Occupation
6. Parenting or caring responsibilities
7. Social, Cultural and Spiritual
8. Medical and other forms of treatment including psychological intervention.

“Whilst there is no requirement for a care and treatment plan to record outcomes against each of these potential areas for intervention, it is likely that, outcomes would arise in more than one of these areas. It is also the case that care coordinators are not limited to recording outcomes only in relation to these 8 areas. Outcomes in additional areas may be recorded where identified, such as sensory or communication needs. It is also possible to record outcomes where the relevant patient is taking responsibility for the action.”

“Part 2 Regulations set out a standard format for care and treatment plans which includes sections to record the thoughts feelings or behaviours that may indicate when a relevant patient is becoming more unwell and may require extra help or support (sometimes referred to as ‘relapse signatures’) and also the actions that ought to be taken should this happen (sometimes referred to as a ‘crisis plan’).”

“The purpose of recording these is to try and prevent circumstances escalating into a crisis by detailing the arrangements or strategies that may have worked well in the past for the relevant patient.”

Ref: Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010
(opens in a new tab)

Copies of Care and Treatment Planning:
Care coordinator takes all practicable steps to ensure a copy of the care and treatment plan is provided to those involved in the persons provision of care which include.

a. the relevant patient, unless they do not wish to receive a copy, or the provision of a copy (or part of it) is likely to cause serious harm to the physical or mental health or condition of the relevant patient.
b. all carers of the relevant patient (including adult placement carers) unless they do not wish to receive a copy.
c. the relevant patient’s general practitioner.
d. the mental health service provider(s) and voluntary organisations who provide mental health services to the relevant patient.
e. the relevant patient’s guardian and responsible local social services authority (within the meaning of the Mental Health Act 1983).
f. an independent mental capacity advocate who has been appointed for the relevant patient.
g. the managing authority and supervisory body where the relevant patient is subject to urgent or standard authorisations under the Deprivation of Liberty Safeguards of the Mental Capacity Act 2005, together with any ‘relevant persons representative’, under those provisions.

Monitoring and Reviewing Care and Treatment Plans:

“Part 2 of the Measure, and the associated Regulations, place duties on care coordinators to review and revise care and treatment plans which have been developed to meet the needs of relevant patients. The Part 2 Regulations set out when and how frequently a plan must be reviewed, and if necessary revised, as well as who may request a review.”

Ref: Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010

(opens in a new tab)

The process of monitoring the implementation of the care and treatment plan should therefore include:

a. ongoing assessment of the relevant patient’s mental health related needs along with the nature and degree of need and risk they are currently presenting.
b. ensuring the delivery of the care and treatment specified in the plan.
c. that the outcomes specified within the care and treatment plan continue to be suitable and minimise any risks posed.

CTP Review:
All reviews should consider the following:

a. any monitoring information which has been gathered since the care and treatment plan was first established, or since its revision at a previous review.
b. Where amendment is required, consideration should be given to all aspects of care and treatment and not simply a revision of those components that were included in the initial plan.
c. Any member of the care and treatment planning team can request that a review take place.

Informal Reviews:

d. Where changes require only minor amendment of the care and treatment plan, the care coordinator may use their discretion to revise the plan in consultation with the relevant patient, without a formal review considering the need and risk they are currently presenting.

Formal Review

e. Where amendments are more significant, the change of circumstances should trigger a formal review through which the care and treatment plan should be amended including ensuring the degree of need and risk they are currently presenting.

Triggers to prompt review:

The Part 2 Regulations require that a review must be held, as a minimum,

a. at least once in any twelve-month period.

However, reviews should be needs-led, and should be held as frequently as required.

For further triggers please review Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010 ***(Chapter 6)*** *(opens in a new tab)*

A formal and clear record should be made of each review, including:

a. any changes to the care and treatment plan, together with any updates to assessments (including risk- WARRN and/or STORM).
b. an agreed care and treatment plan should be produced within 2 weeks of the review.

A review may be undertaken in a meeting involving a number of members of the care team and other interested persons. Equally such a review may only include the relevant patient and care coordinator, if the care coordinator considers that there is no requirement to involve other health and social care professionals. It is advised that the relevant patient should be informed prior to the meeting that a review is taking place so that the process is open and understood. This information sharing should be recorded via Health Board approved patient recording system- Care Partner. (opens in a new tab)

CTP Review Guidance:

Formal CTP Guidance

1. A date, time and venue **must** be agreed with adequate notice for all attendees with an agreed period allocated for the review.
2. A chairperson will be **agreed** who will ask attendees to introduce themselves.
3. CTP domains will be updated to **identify** achievement of outcomes or **identify** the need for additional support.

4. If there has been any **change** in relation to risk this can be incorporated into the review however the WARRN **must** have been updated at that time.
5. Details of the meeting discussion will be **recorded** on the CTP Review documentation.
6. Relapse indicators and CTP contingency plans must be **reviewed** and **updated** as required. This will be **shared** and **agreed** with the patient and the patient given a copy.

Support for Service Users in Hospital

Care Co-ordination: Inpatient Services

For patients under care co-ordination on admission:
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 OP-CMHT staff.

Discharge planning should commence at the point of admission, if not before as part of a joint discussion with the Care Coordinator. During any inpatient admission, the service user will be allocated a named nurse on the ward who will work with the Care Co-Ordinator to ensure needs identified on the Care Plan are met.

The Care Co-Ordinator will:

- maintain a minimum of weekly contact with their patient whilst in hospital.
- work collaboratively with the service user and inpatient staff to devise a care and treatment plan.
- Attend relevant meetings e.g. Ward rounds, Professional MDT's, CTP reviews, Discharge planning meeting and Best interest meetings.

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/placement, welfare benefits/funding, family/carer relationship and/or Care provider difficulties, they will be discussed with the service user and/or carer and the care team and addressed within the care plan.

For those inpatients not under care co-ordination on admission:

When patients are admitted to inpatient wards, they meet the criteria for a Care and Treatment Plan as a 'relevant patient.'

• Patient to be discussed with relevant CMHT team leader at the Daily Acute Pathway meeting with a view to allocate a Community Care Co-ordinator within 7 days.

• Community care Co-ordinator to meet with patient within 7 days of allocation.

• Care Co-ordinator to work collaboratively with patient and inpatient staff to devise a care and

treatment plan.

In accordance with the recommendations form the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) National Suicide & Homicide Inquiry, following discharge from In-Patient services to the community, a follow up review within 72 hours will be undertaken by the CRHT, or by the existing Care Co-Ordinator, if the individual is under the care of secondary care Mental Health Services; this will be agreed during the discharge planning meeting. The patient and carer are informed of the follow up appointment and onward plan before discharge from inpatient service

Any unplanned discharge from the Mental Health Unit occurs, a pre-discharge CTP review will not have occurred. The OP-CMHT Care Co-ordinator must arrange a face-to-face review within 3 days and a full CTP review to take place within two weeks if not on CRHT caseload. If identified as a red flag (Self Harm / Suicide) please *Ref Clinical Risk:*

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.

For those patients who are transferring from hospital to a Community Treatment Order, it is the responsibility of the care coordinator to update the CTP to reflect the conditions of the CTO. 625 - CTO Policy - opens in a new tab

Interventions:

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.

1. Investigations re: Dementia diagnosis
2. JTD
3. START
4. Psychological Interventions
5. Occupational Therapy

Further information on access to interventions can be referenced here*:* Appendix 1: Pathways:

Third Sectors:

The voluntary and community organisations have a crucial role in supporting and sustaining individuals and families/carers mental and physical health recovery. Some of these organisations are mental health specific, and some have a generic community role such as Community Connectors.

There is a wide range of services and activities provided by such organisations across West Wales and it is important that teams ensure they keep up to date with such services and refer into these services as appropriate. These services and activities are available for all age groups and in different areas of West Wales. In some cases, these organisations are best placed to provide the care and support, with help from OP Community Mental Health Teams.

Information on these services can be found via the West Wales Action for Mental Health (WWAMH)

Directories on: http://www.wwamh.org.uk and via DEWIS www.dewis.wales and Info Engine

https://en.infoengine.cymru.

The mental health services provided by Hywel Dda UHB must work in partnership with these organisations and where organisations are providing significant mental health care they should be included in Care and Treatment Plans (CTP), attend CTP reviews and other aspects of Care Coordination where indicated.

There is a reciprocal collaborating relationship between these organisations and Hywel Dda UHB services to provide quality care and support for people with mental health needs and their families. There is information sharing between these organisations in order to provide this care and to ensure risk management and positive risk taking to support recovery.

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 can be offered a formal carers assessment through the local authority.

OP-CMHT staff are expected to support Carers by:

- Sharing information about the person they are caring for including Risks, management plans and contact information.
- Providing Carers with written information that is pertinent to the service users case for example signs and symptoms of their diagnosis.
- 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.
- Engage with supporting service i.e Admiral service- *Reference Admiral Service Specification *Under review*
- Raising awareness Information and Support Available for Carers Externally (opens in a new tab)
- Where issues of risk are high and consultation and information sharing is refused, discussion should take place at an MDT and Acute Pathway meeting about this issue and the outcome documented.

Discharge.

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

Clear expectations should be jointly agreed with the service user and/or carer at the time of coming into the OP-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 OP-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 OP-CMHT an aftercare plan will be agreed with the service user, and this will include a contingency plan identifying risk factor, 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 person's mental state indicate this.

Measuring Success:

OPCMHT to ensure the following data collection is managed and monitored:

Operational Key Performance Indicators:

In effectively ensuring delivery each locality should be monitoring the following KPI measures and recording using the **CMHT Matrix daily**:

Measure	System	Who
Referral numbers (Pathway & Team totals week/month/year)	Welsh Admin Portal CMHT Matrix	CMHT Admin

Referral to Assessment Demands (4hrs - 72hrs – 28days)	CMHT Matrix	CMHT Admin & Team Leader
Caseload Weighting (Including S117) (Pathway & Team totals week/month/year	Caseload weighting tool CMHT Matrix	MH Practitioners (CWT) CMHT Admin
Functional & Dementia caseload numbers (Pathway & Team totals month/year)	CMHT Matrix	CMHT Admin
Contact Rates (frequency & duration week/month/year)	Care Partner	MH Practitioners
Third Sector Referrals (Age Cymru & Alzheimer's Society month/year)	CMHT MDT Template CMHT Matrix	CMHT Admin
On-ward referrals	CMHT MDT Template CMHT Matrix	CMHT Admin
Step-down numbers (Pathway & Team totals week/month/year)	CMHT MDT Template CMHT Matrix	CMHT Admin
Outcome Measures (Prems/Proms)	Care Partner CMHT Matrix	MH Practitioners CMHT Admin
Target 1 **All relevant patient has an up-to-date CTP- Part 2** 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**	Care Partner (Evidenced) CTP Audit Tool CMHT Matrix	MH Practitioners Team Leader CMHT Admin

Governance:

Information governance – record keeping policies /IT policies (see https://hduhb.nhs.wales/about-us/governance-arrangements/policies-and-written-control-documents/): (opens in a new tab)

Dignity and Equality of Access:
In producing a care and treatment plan, due regard shall be given to a relevant patient's specific needs. Needs arising from a relevant patient's race, gender, religion, sexuality, age, or disability should be specifically considered. Relevant patients should not be disadvantaged in their involvement or experience of care and treatment planning as a consequence of these facets.

Clear communication in terms of language and culture is essential to ensure relevant patients and carers are truly involved and receive the best possible care and treatment. In Wales, this also means all possible steps should be taken to ensure that bilingual (Welsh and English) services are available.

Collaboration 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):

- Community Mental Health Centres to enable access to the Intensive Home Assessment & Treatment Team
- Mental Health Inpatient Units
- Substance Misuse Services-CDAT and DDAS
- General Hospital Teams, including Accident and Emergency (A&E) / Minor Injuries Unit (MIU) and Acute Medical Admissions Unit (AMAU) /Clinical Decisions Unit (CDU)
- Local Primary Mental Health Services and Integrated Psychological Therapies Service
- Police
- Forensic Mental health Team
- Welsh Ambulance Service trust
- Dyfed Powys Police Vulnerability Hub
- Locality Authority
- Local Third Sector Providers
- Mental Health & Learning Disabilities Liaison
- Mental Health Act Administration Team
- Mental Health Single Point of Contact via 111 option 2
- Out of Hours Clinical Co-ordinators
- Statutory processes e.g., MAPPA, Safeguarding
- Dementia Wellbeing Service (DWS) Under review

Ref: ***Appendix 1: Pathways:***

Mental Health Single Point of Contact; 111 Option 2

The Mental Health Single Point of Contact (MH SPOC) operates 24/7 within the Mental Health and Learning Disabilities Directorate of Hywel Dda University Health Board. It is a well-being and mental

health telephone triage service which can be accessed via the national 111 call line and selecting Option 2. Callers can self-refer, or calls can come from family, friends, carers.

It is an open access, all-age service and is open to anyone experiencing mental health crisis residing within the Health Board footprint of Ceredigion, Carmarthenshire, and Pembrokeshire. This includes anyone visiting the area, including those who may be homeless or living in temporary accommodation.

Using a recognised triage tool and compassionate focused interventions. Mental Health Practitioners will assess the mental health needs of the individual and escalate as appropriate. They will connect individuals to the most appropriate mental health and well-being provision to meet their needs in a timely manner, including those with common mental health problems and those with more complex, acute, and high-risk presentations.

The triaging of urgent mental health requests for help, will ensure that service users, carers and referrers receive an efficient and timely response when accessing mental health services or needing advice, support, and signposting.

The Single Point of Contact (SPOC) team have agreed pathways into all the areas within the Mental Health & Learning Disabilities Directorate.
Professionals seeking advice and guidance can access the service by identifying themselves during the call, ensuring they are directed to the appropriate person for support.

Managing and maintaining effective relationships:

How are we doing this?

- Regular liaison regarding referrals, assessment, and treatment with team members of CRHTs, CMHTs and other mental health services as appropriate.
- Working in line with statutory processes e.g. MAPPA, Safeguarding
- Link working in Primary care (G.P.)
- Attendance at CMHT Multi-disciplinary meetings
- Attending GP cluster meetings.
- Liaising with the Primary Care Locality Development Managers.
- Attendance at Monthly Community manager forum
- Attendance at monthly joint ward and Community Managers Forum
- Team Leader attendance at monthly Service Delivery and Operational Performance Forum
- Daily attendance at once daily APM and twice daily Directorate Bed Conference
- Attendance at regular Inpatient 'Ward Rounds' or MDT reviews
- Attendance at weekly Community Mental Health Team meetings

GP Link Working

Each OP-CMHT will identify individuals to link work with GP practices in their area. The key purpose of Link Working is to provide support, education and problem-solving for the primary health care team. This entails advising GPs with assessments and management of common mental health problems and acting as a signpost for patients to other services which may benefit them. They ensure people access the best route into a service.

Complaints/incidents:
Putting Things Right' Management and Resolution of Concerns Policy (Incidents, Complaints and Claims) (*PDF, 533Kb*) (opens in a new tab)

Workforce:

Staffing Structure: Older Adult Mental Health - opens in a new tab

Lone working

All staff with in CMHT are to work in accordance with the health board's Lone Working Policy- To be read in conjunction with:

Caseload supervision
Caseload supervision will be delivered by the clinical/managerial supervisor using the caseload management tool (Appendix 5: Supervision & Caseload Management Tool)

CMHT and individual caseloads will be regularly monitored and reviewed to ensure OP-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- To be read in conjunction with:

Staff absence
OP- 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.
Workforce Policies:
Access to all workforce related information including policies, occupational health, learning and development and more can be referenced via the Health board Intranet page: Working for Us - Home (sharepoint.com) (opens in anew tab)

All key policies can be found here: Policies and written control documents - Hywel Dda University Health Board (NHS. Wales) (opens in anew tab)
Detailing all major employment policy including but not limited too:

- NHS Wales Managing Attendance at Work Policy (opens in a new tab)
- All Wales Email Use (opens in a new tab)
- Standards of Behaviour (opens in a new tab)

- Travel Claim (opens in a new tab)
- Staff Psychological Wellbeing (opens in a new tab)

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. *Ref Policy 141 To be read in conjunction with:*

Record Keeping

The Record keeping policies and code of practice relevant to each profession to be read by staff understood and adhered to. *Ref Policy 791 To be read in conjunction with:*

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.

Ref: Safeguarding (sharepoint.com) (opens in a new tab)

Quality Assurance

- The OP-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.
- OP- 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.
- Staff to be fully aware of the complaint's 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.
- 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.

Team Safety & Managing Clinical Risk

- Individuals, whose behaviour is likely to put the safety of others at risk, should attend the OP- 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 OP-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 (To be read in conjunction with:) regarding racial, physical or verbal abuse towards its staff.

Training & Development.

Training and development will reflect the needs of the HDUHB 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.

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

- Mental Health Act training

Reference Health Board Organisation Development: Organisational Development - Home (sharepoint.com) (opens in a new tab) / Clinical Career Pathways (sharepoint.com) (opens in a new tab)

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

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 Mental Health Pharmacist 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 GPs around medication and in particular those patients not being taken on by OP-CMHT.

Ref: Function of OP-CMHT: / Medicines Management, Controlled Drugs, Antibiotics, Pharmacy, Acute Pain Policies, Procedures and Guidelines (sharepoint.com) (opens in a new tab)

Putting things Right

All OP-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.

Ref: Concerns investigation and management (sharepoint.com) (opens in a new tab)

Equality Impact assessment

An Equality Impact Assessment (EQIA) on the proposed procedure revision has been undertaken to assist the Health Board in discharging its Public Sector Equality Duty under the Equality Act 2010.

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

The EQIA has assessed and required changes that will affect services users or workforce in delivering best practice around Community Mental Health within Older People.

The proposed revision will not have an adverse effect on protected characteristics highlighting minimal to no impact on delivery of this procedure revision.

Staff delivering this procedure will benefit from the revisions to the procedure ensuring alignment of any further/future updates in accordance with The MHA Code of Practice staff will continue to have access to training and resources to support them in their roles with the procedure identifying clear roles and responsibilities.

Service user will benefit in ensuring the procedure to current guidelines whereby the procedure sets out to maintain the following:

1. Maintain the safety and wellbeing of the patient.
2. Provides care and support to the patient who require ongoing support within the community.
3. Provides a suitable environment for the use maintaining the dignity of the patient.
4. Provide a consistent approach to the use/delivery of Community Mental Health

References:

Supporting Strategies:

1. WWCP-Dementia-Strategy-Final-Issued.pptx (live.com) (opens in a new tab)
2. dementia-action-plan-for-wales.pdf (gov.wales) (opens in a new tab)
3. Adult Community Mental Health Services in Wales (opens in a new tab)
4. Social Services and well-being Wales ACT 2014 (opens in a new tab)
5. NICE | The National Institute for Health and Care Excellence (opens in a new tab)

Supporting Specifications:

1. 1122-Mental Health Single Point of Contact 1122 (opens in a new tab)
2. CMHC Service Spec (Awaiting to be Ratified)
3. Memory Assessment Service Specification (opens in a new tab)
4. Co Occurring (Awaiting to be Ratified)
5. Dementia Wellbeing Service Specification (Awaiting to be Ratified)
6. Older Adult Mental Health Inpatient Areas Service Operating Procedure (opens in a new tab)
7. Local Primary Mental health support service (Awaiting to be Ratified)

Supporting Legislation:

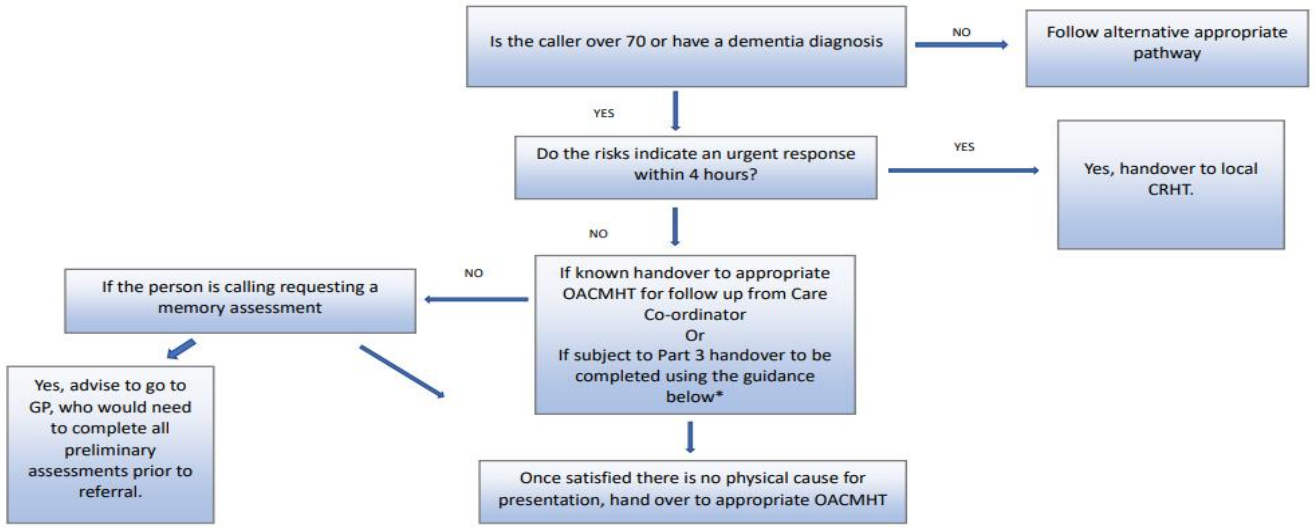
1. NICE Guidance within Hywel Dda (sharepoint.com) (opens in a new tab)
2. Mental Health (Wales) Measure 2010 (legislation.gov.uk) (opens in a new tab)
3. Violence Against Women, Domestic Abuse & Sexual Violence (VAWDASV) (opens in a new tab)
4. Mental Health Act Code of Practice for Wales (opens in a new tab)
5. Mental Health Act 2007

Appendix:

Appendix 1: Pathways:

Handover Pathway

Older Adult Community Mental Health Team (OAMHT) & Memory Assessment (MAS)



Carmarthenshire
Carmarthen – 01267 674042
Llanelli – 01554 779311

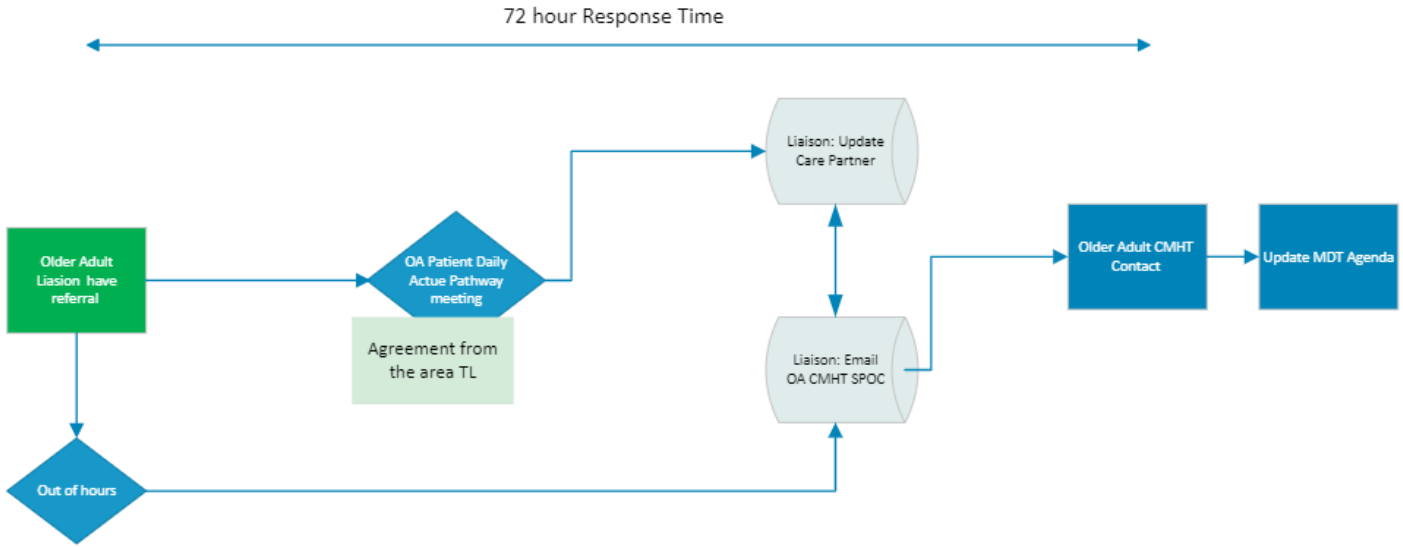
Pembrokeshire
01437 773219

Ceredigion
Ceredigion.OlderAdultMHTeam.HDD@wales.nhs.uk

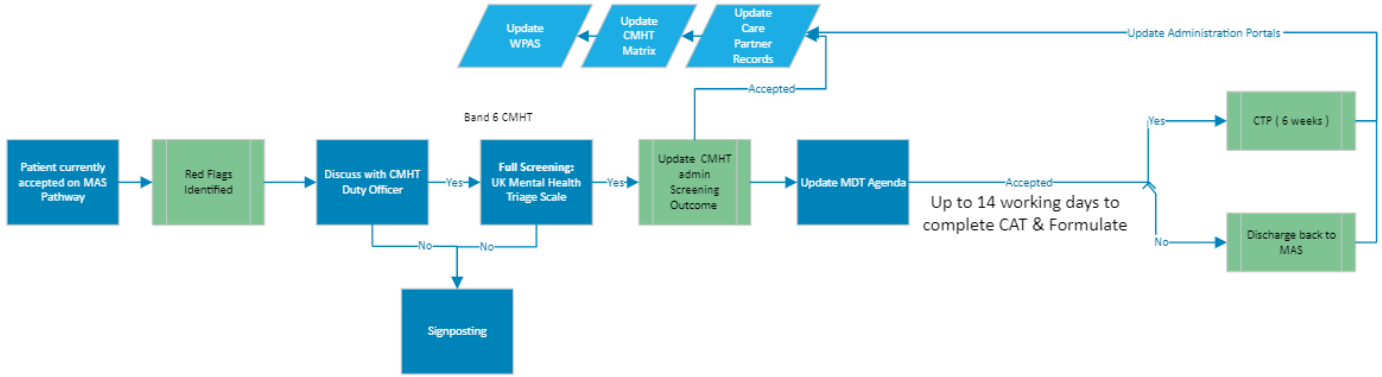
*Mental Health Measure – if previously known to Mental Health Services and under CTP within the last 3 years.

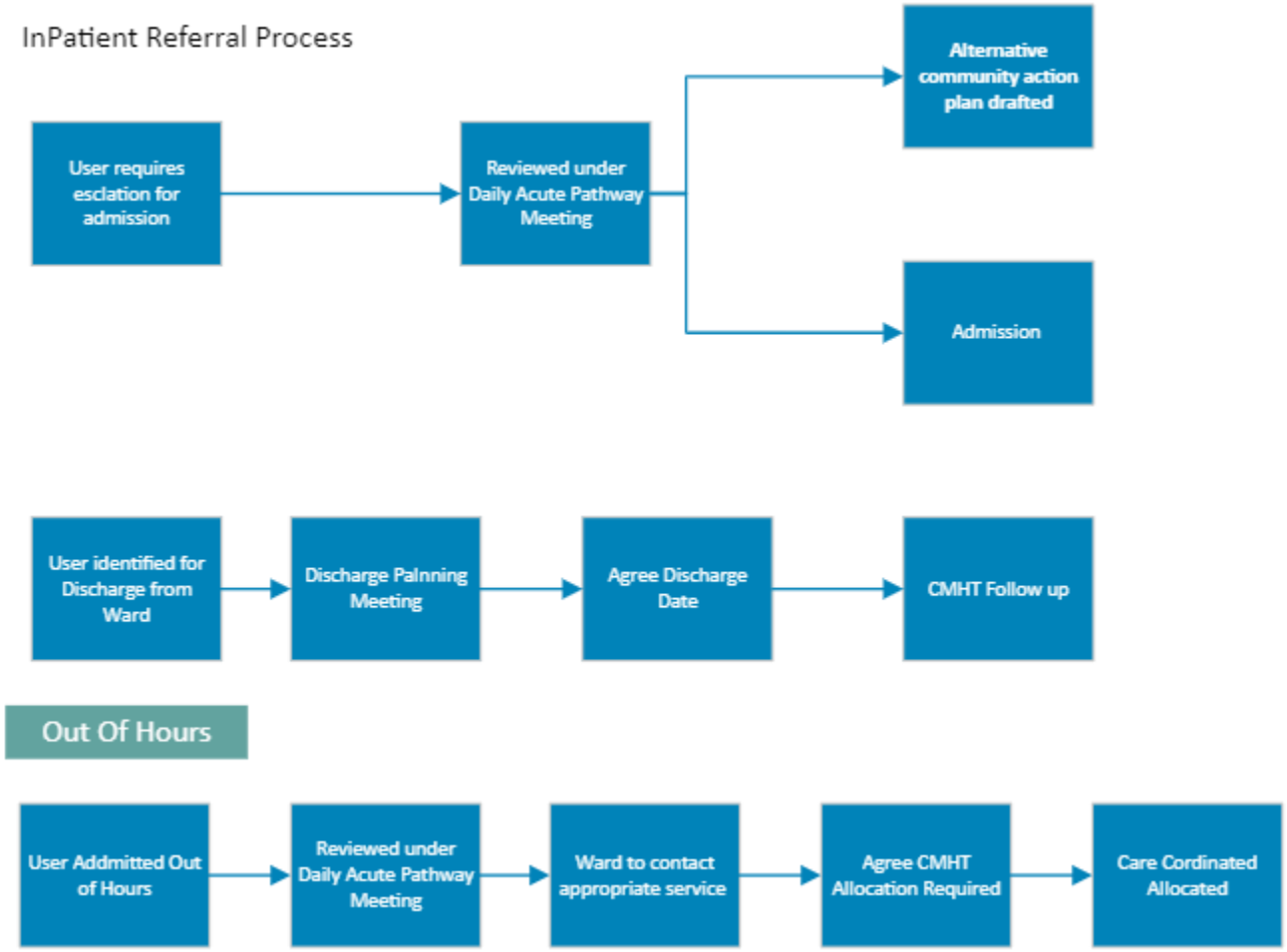
The handover should ensure that response times for a person to be seen is documented within the risk formulation. Where such response times are included it is expected that these should, at a minimum, match the usual standards for community mental health teams – namely that emergency referrals are to be seen within 4 hours of request, urgent referrals within 48 hours of request, and all other referrals within 28 days of request.

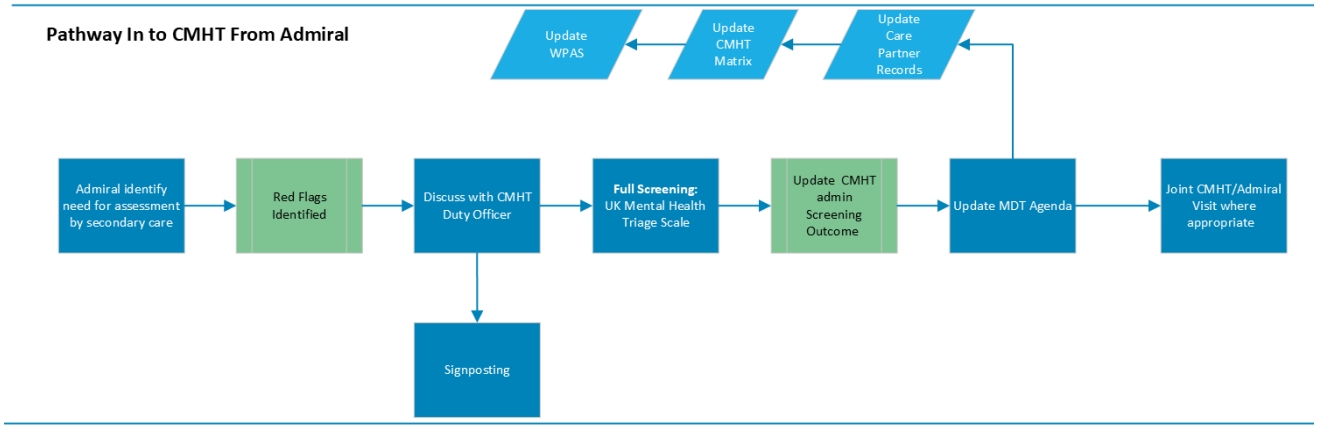
Liasion Referral Process

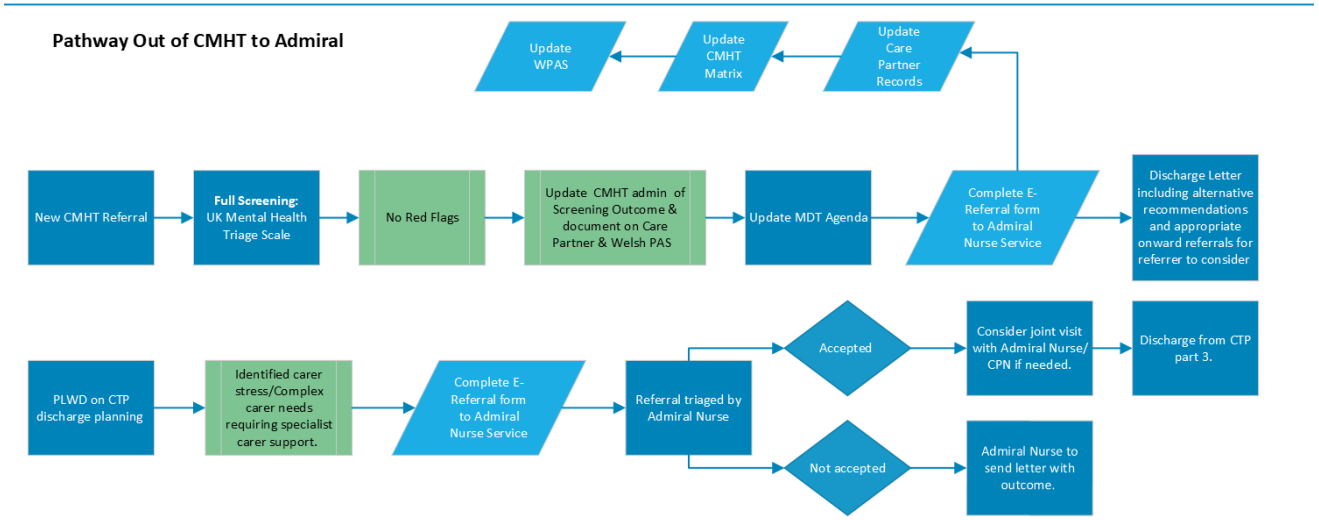


DDS Referral Process




InPatient Referral Process
User requires esclation for admission
Reviewed under Daily Acute Pathway Meeting
Alternative community action plan drafted
Admission
User identified for Discharge from Ward
Discharge Palnning Meeting
Agree Discharge Date
CMHT Follow up
Out Of Hours
User Addmitted Out of Hours
Reviewed under Daily Acute Pathway Meeting
Ward to contact appropriate service
Agree CMHT Allocation Required
Care Cordinated Allocated





Note some pathway descriptions are currently under revision and will require updated versions to be linked with OACMHT Service Specification.

Appendix 2: Mental Health Triage Scale:

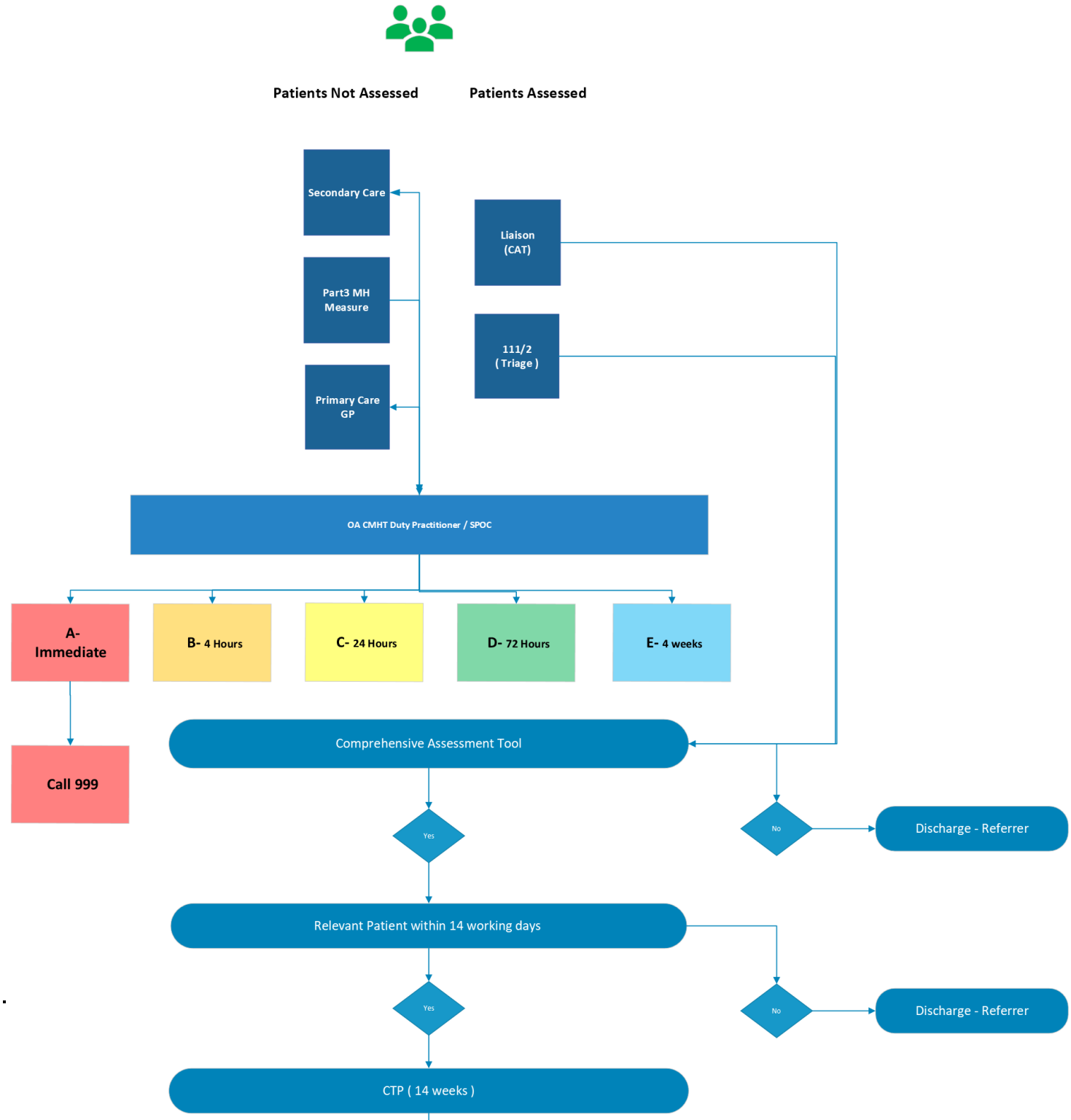
UK Mental Health Triage Scale				
Triage Code /description	**Response type/ time to face-to-face contact**	**Typical presentations**	**Mental health service action/response**	**Additional actions to be considered**
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering 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

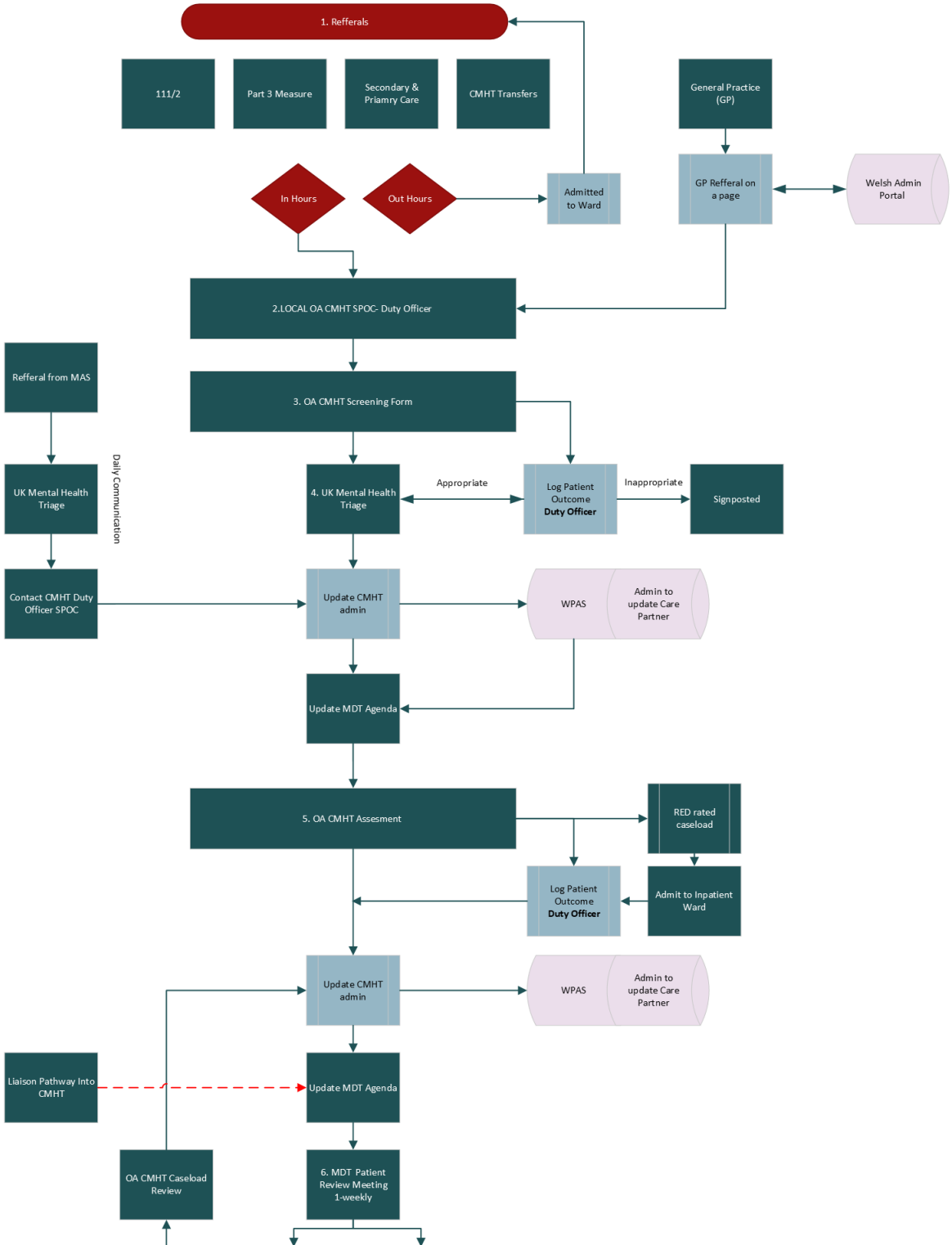
F **Referral not requiring face-to-face response from mental health**	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support** **Advice to contact other provider and/or phone 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

Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). *International Journal of Mental Health Nursing.*

Appendix 3: OA Community Mental Health Pathway:


Patients Not Assessed
Patients Assessed
Secondary Care
Part3 MH Measure
Primary Care GP
Liaison (CAT)
111/2 (Triage)
OA CMHT Duty Practitioner / SPOC
A- Immediate
B- 4 Hours
C- 24 Hours
D- 72 Hours
E- 4 weeks
Call 999
Comprehensive Assessment Tool
Yes
No
Discharge - Referrer
Relevant Patient within 14 working days
Yes
No
Discharge - Referrer
CTP (14 weeks)

Ap



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Appendix 5: Supervision & Caseload Management Tool:

Supervision & Caseload

Management

Management Supervision Overview

Staff Name / Pin Registration number :	
Profession/Banding:	
Contracted Hours per Week:	
MC Registration renewal date:	
Mandatory Training compliance:	
PADR renewal date:	
NMC Revalidation date:	
Annual Leave entitlement: How many hours left to book: Any purchased leave:	
Sickness Management: Any periods of Sickness/dates Sickness Trigger Occupation Health Involvement/Referral Staff wellbeing	Discussion: PLAN:

Caseload Management Profile Overview:

Geographical area you cover:	
GP surgeries you cover:	*(NB sate if MDT's in place and attended)*
Care homes you cover:	*(NB: please provider performance issues)*
Total number on CTP Caseload:	

Total number <u>NON</u> CTP Caseload:	
Number of Datix completed:	*(Narrative)*
Number of Safeguarding referrals completed:	*(Narrative)*
Number of patients admitted to Inpatient unit since last supervision session:	
Number of patients discharged from CTP since last supervision session: ***(NB: please include unit numbers)***	
Review/discussion of 2 Duty referrals with line manager ***(include unit number)***	*e.g. MH Triage tool algorithm followed? Agreed activities headings used in C/P & MDT template? Communication had with Pt and carer?, Communicated triage outcome to referrer?*

<u>NB: Using the caseload weighting tool (BELOW) please score you caseload prior to supervision session</u>

Score	Risk	Needs, Symptoms and Functioning	Support & Input	Required Contact
4	CURRENT / HIGH PROBABILITY/ SEVERITY Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or Verbal and Physical aggression. Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control	Issues may include non-compliance; vulnerability; risk; sensory/physical impairment; isolation; self-harm; dual diagnosis; significant carers' needs; Safeguarding concerns.	Multiple interventions; multi-agency input; frequent consultation/review; Communication required with other services to manage the care need and risk. Less stable case; hospital admission possible;	Daily or multiple times a week You provide intensive home or community based treatment/care, daily or several times per week
3	CURRENT HIGH but NO IMMINENCE 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 Significant patient / carer distress associated with serious mental illness and/ or dementia. Isolation / failing carer or known situation requiring priority intervention or assessment	High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control. Overt / unprovoked aggression in care home or hospital wards setting. Wandering (community) Vulnerable isolation or abuse. Risk of potential breakdown in carer support.	May require support with non-compliance. May require inpatient treatment or crisis intervention. May require emergency respite or support as the carers may require significant support/input. May require support due to poor housing environment and significant environmental concerns and/or issues.	Weekly visits

2	LOW /NON IMMINENT/MEDIUM SEVERITY The service user is likely to be: In a relatively stable condition Compliant with treatment and care May use other parts of the service (e.g. day care; drop in).	They require regular support/monitoring in order to remain stable. They may remain vulnerable to occasional relapses; Regular monitoring of care package; Medication monitoring and management;	Moderate Interventions to support service user's and/or carer's change in circumstances, e.g. Rehabilitation/skills training (e.g. activities of daily living); Medication review Beginning to discuss Discharge Planning.	Once every 2/3 weeks
1	LOW/NON IMMINENT /LOW SEVERITY No further special precautions required. No requirement for regular specialist support and advice.	Likely to be receiving 24 hour care and support in a care environment.	Input likely to be requested by the family and/or care environment due to a change in presentation.	3-6 monthly or as requested. Patients on S117 Case closure indicated.

Prediscussion CTP weight load: -

RED CATEGORY R RED =4	AMBER CATEGORY A AMBER=3	GREEN CATEGORY G GREEN =2	GREEN CATEGORY G GREEN =1	TOTAL

PT Unit No & Initials.	CTP Completed Y/N OR N/A *(as per flow chart)*	S117 Y/N OR N/A	S117 Review date or N/A	Comprehensive Assessment Y/N:	WARRN Completed: Y/N or N/A *(as per flow chart)*	CTP Review completed: Y/N or N/A *(as per flow chart)*	Outcome measures tools used. Y/N	CTP caseload weighting Score: R RED =4 A AMBER=3 G GREEN =2 G GREEN =1	Discussion and plan with supervisor:
Joe blogs	y	n/a	n/a	y	N/A	n/a	Y ReQuel	A =3	Move to Green 2 and plan for CTP review and discharge, part 3, as care package in place and medication titrated to therapeutic dose.

Post discussion CTP weight load: -

RED CATEGORY **R RED =4**	**AMBER CATEGORY** **A AMBER=3**	**GREEN CATEGORY** **G GREEN =2**	**GREEN CATEGORY** **G GREEN =1**	**TOTAL**

Employee Signature:-.....Date:-.....

Managers Signature:-.....Date:-.....

Date of next Supervision:-.....

Other Activity: To be completed when required and at the Manager's discretion

(Please record additional activities in hours per month)

Description of Activity	Time Spent *(Hours per month)*	
Team		
Management		
Ward Rounds		
Other:		
		Total:
Clinical / Practice Governance:		
Meetings		
Supervision / Caseload Management Supervision		
Other :		
		Total:
Administration:		
Clinical		
Travel:		
Average hours per month excluding travel to work:		
Mileage:		

Education & Training		
Mentoring Students *(Average hours per month spent mentoring students)*		
Organising & Leading Education or Training		
Attending CPD *(Workshops, Courses, Conferences etc)*		**Total:**

Appendix 6: Older Adult CMHT Leaflet

Mental Health and Learning Disabilities - OA-Leaflet.pdf - All Documents (sharepoint.com) – (opens in a new tab)