Kent and Medway
NHS and Social Care Partnership Trust

The day in the life of a KMPT Community Mental Health Team

A Guide

CONTENTS

1 INTRODUCTION

The pack aims to provide consistency across Community Mental Health Teams (CMHTs). The pack provides standardised documents which support the operational practices of the CMHTs.

It is an expectation that all CMHT staff should familiarize themselves with this document as it illustrates the how the CMHT functions on a day to day basis.

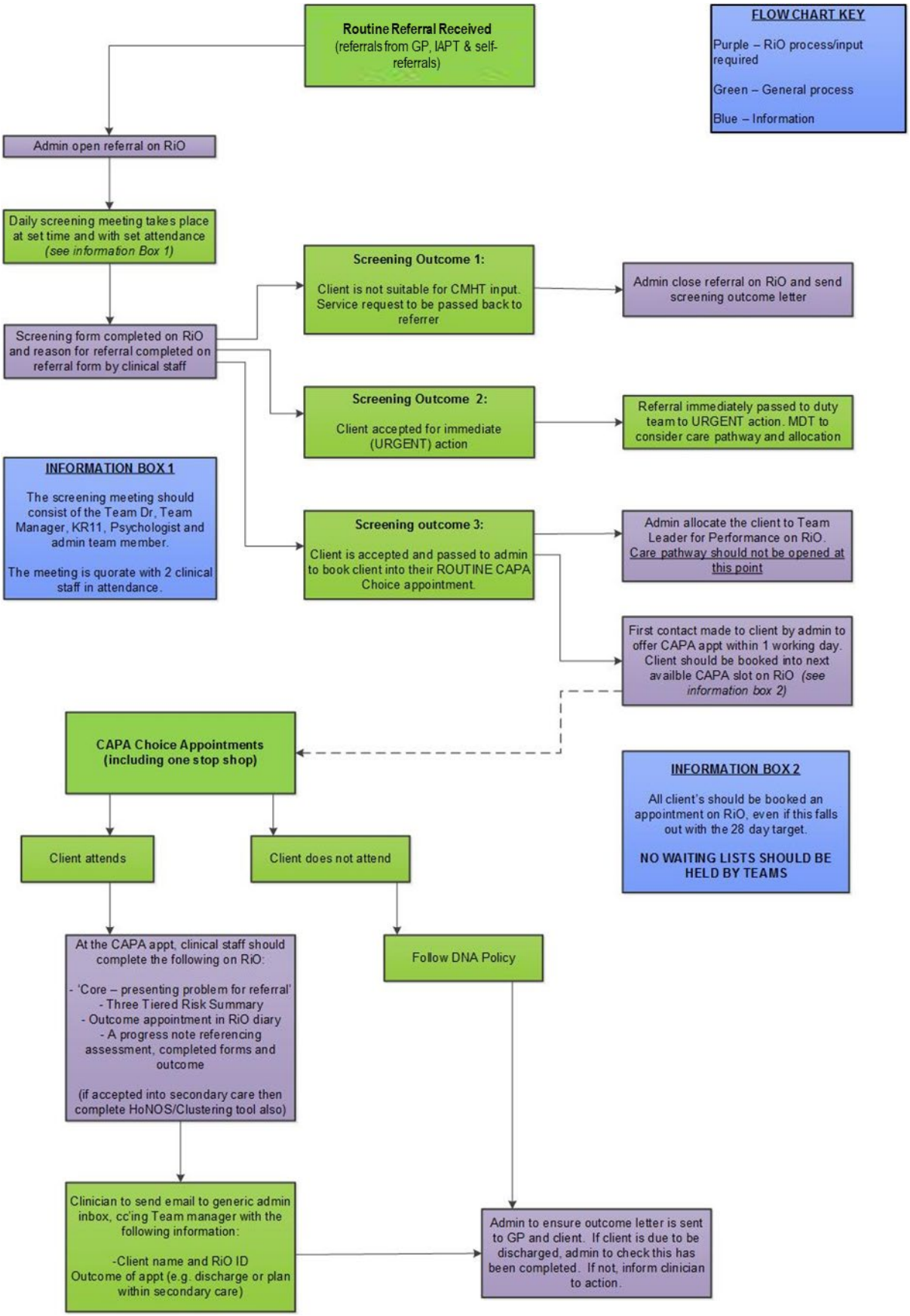
This document should also form part of new staff's induction. Where there is a requirement for local adaptations this will need to be passed through the Care Groups Governance process for agreement.

All staff need to read this pack alongside the CMHT operational policy and any other related policy.

2 CMHT STAFF MEETINGS

Frequency	Title	Purpose	Duration	Attendance	Terms reference
Daily	Red Board Meeting	Manage High Risk Individuals	Max 45 mins	MDT Representation	Appendix i
Weekly	Business/ Clinical Team meeting	Review & Action of operational decisions & issues	Max ½ day	MDT Representation	Appendix ii
Monthly	Clinical Risk Forum	Multi-professional, clinical review of high risk cases which contribute towards robust care planning, community safety and local risk management.	2 hours	• Consultant Psychiatrist • Consultant Psychologist or Senior Psychologist • Team Manager • Lead HCP • Other staff involved in the care of the high risk service user • Administrator Representative of partner agencies • Locality Manager	Appendix iii
Monthly	Caseload Clinics	Interactive meeting, where clinicians discuss their caseloads	1 hour per clinician (can form part of supervision)	Team Managers & Clinicians	N/A
Monthly	Reflective Practice	To improve practice through reflection on clinical and team practices	1 – 1.5 hours	MDT	N/A
6 monthly	Team away	Structured team away day to celebrate successes in the team, share learning, CPD and develop innovation.	A Full day	The whole Team	N/A

3 INITIAL ASSESSMENT SOP AND FLOW CHART



Following the assessment if the patient has been rated RED harm to self or others, the assessor must discuss the patient with the team manager/their line manager/ a senior clinician and immediate/same day action must be taken and the rationale for the clinical decision taken recorded in the patient's clinical notes. This may include:

- Psychiatric review; or
- Transition to CRHT for gate keeping assessment for either admission to an acute psychiatric bed or home treatment; or
- Allocation for care co-ordination; or
- Adding the patient to the agenda for the next day's RED board meeting, which is held every morning; or
- A combination of the above.

4 ACTIVE REVIEW

Active Review Standard Operating

Non-CPA clients waiting to be offered a service following assessment will be placed on the Active Review Process

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The Active Review Process consists of a Band 6/7 Lead, a Band 5 or an STR worker. There is also allocated admin support

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Clients on Active review will receive the following:

-Letter informing them or the process and giving the date and time of first telephone contact.

-A plan of contact can then be agreed during the phone call i.e. fortnightly, monthly calls which will be reflected in the PSP

- Safety Plan
- clients will be added to the correct Intervention tab on RiO

→ If risk changes and concerns are raised during telephone contacts, the client will be discussed at the daily RED Board Meeting

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If telephone contact is not achieved, the DNA Policy should be followed

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All clients on Active Review should be reviewed by the MDT on a 3 monthly basis

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If a client remains on Active Review for 6 months, they should be seen and their risk assessment and care plan updated

↓

Once a client begins to receive the Service they have been waiting for, they should be moved to the caseload of the HCP working with them

5 CPA

Those people with complex needs or need support from a number of services or are most at risk, are all subject to CPA Pathway. Other people with more straightforward support needs will not require the CPA Pathway but will still receive time limited support from the CMHT through the non–CPA Pathway.

Those considered requiring CPA care will have a severe mental illness (including personality disorder) with high degree of clinical complexity and one or more of the following:

- Current or potential risk(s), including:
  - Suicide, self-harm, harm to others (including history of offending)
  - Relapse history requiring urgent response
  - Self-neglect/non concordance with treatment plan
  - Vulnerable adult; adult/child protection e.g.
    - Exploitation e.g. financial/sexual
    - Financial difficulties related to mental illness
    - Disinhibition
    - Physical/emotional abuse
    - Cognitive impairment
    - Child protection issues

- Current or significant history of severe distress/instability or disengagement
- Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability
- Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
- Currently/recently detained under Mental Health Act or referred to crisis/home treatment team
- Significant reliance on carer(s) or has own significant caring responsibilities

- Experiencing disadvantage or difficulty as a result of:
  - Parenting responsibilities
  - Physical health problems/disability
  - Unsettled accommodation/housing issues
  - Employment issues when mentally ill
  - Significant impairment of function due to mental illness
  - Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues.

- The needs of person from the key groups below should be fully explored to make sure that the range of their needs are examined, understood and addressed when deciding their need for support under CPA. The default position for people with high levels of need and risk would normally be care provision under CPA unless a thorough assessment of need and risk shows otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in care records.
  - **Key Groups:**
    - Who have parenting responsibilities
    - Who have significant caring responsibilities
    - With duel diagnosis (substance misuse)
    - With a history of violence or self-harm
    - Who are in unsettled accommodation

6 NON CPA

For people who do not require care under CPA but have needs that are best supported by specialist mental health services they will be accepted onto caseload, often for a short period of up to six months.

Their needs are described as being more straightforward and less complex

- Present with low risks to self or others but are likely to respond to short term treatment
- Likely to require short term clinical treatment such as initial interventions
- Have a long term mental health issue, are stable in presentation but require a level of on-going monitoring to ensure mental health stability is maintained
- Step down from CPA, in the process of recovery, likely to be transferred back to their GP

Documentation requirements:

- Clinical progress notes
- Care plan - the care plan is in the form of a Personal Support Plan that goes to the person. This should include a clear understanding of how care and interventions will be carried out, by whom, and must be developed in collaboration with the person being treated. A copy is provided to the person in all cases, unless in very rare occasions when the decision not to share must be agreed by all involved and the rationale clearly documented on RiO. It should be updated to reflect changes, or otherwise on a six monthly basis. A brief guide can be found in appendix
- Risk assessment – completed at initial assessment and updated thereafter if there is a change in risk circumstances, or otherwise on an annual basis
- HoNOS / Cluster – at initial assessment then as required and at necessary time periods
- Physical health check if required
- RiO diary appointment and outcome
- Core assessment – at initial assessment and updated as required
- Review every 6-8 weeks

Important Note:

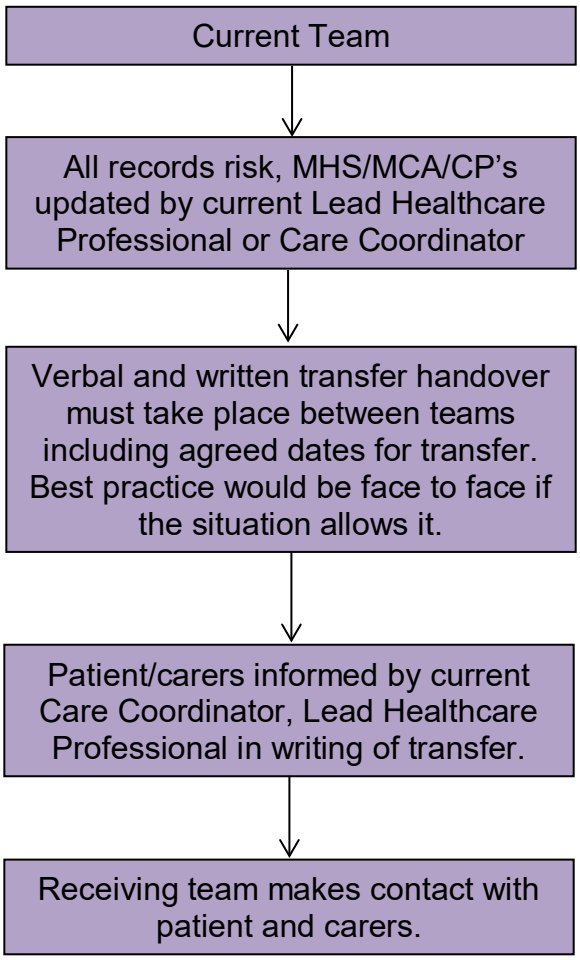
Whether CPA or non-CPA if clinical need or risk dictates, staff must ensure that a face to face appointment is offered. These face to face contacts must take priority when planning hybrid working, and staff who are working remotely, i.e. from work, are expected to carry out the face to face contact regardless of where they are working from.

People not requiring CPA care are not expected to require long term treatment. More frequent reviews are encouraged as part to the delivery of treatment interventions to ensure people only remain on team caseloads due to need. The named practitioner is expected to review their caseload in supervision at least once every three months to support good caseload management

7 DISCHARGE AND TRANSFER

Transfer and Discharge SOP

Transfer between Teams



4.3 (policy) Discharge for patients with a forensic history
* Any patients with forensic history who are being considered for discharge must be consulted by Kent Forensic Psychiatry Service.

4.5 (policy) Discharge of patients that move their address outside of Kent and Medway
* Patient must give consent. If patient has capacity but refuses then Team to use K&M Agency information sharing protocol. If patient lacks capacity MCA must occur and best interests considered.

8 PROTOCOL FOR THE TRANSFER OF CARE BETWEEN THE CMHTS AND THE INPATIENT REHABILIATION SERVICE

For full protocol see i-connect

Key extract:

3 PROCESS

3.1 When a service user is admitted to an inpatient rehabilitation bed and is accepted for a period of inpatient rehabilitation the following process will be followed to provide a seamless transfer of care to the Inpatient Rehabilitation Service and then back to the CMHT prior to discharge

3.1.1 A handover meeting take place at or around week 4 of the admission, where the decision regarding hand over of care including the Lead Health Care Professional (HCP) role will be agreed based on the therapeutic relationship, predicted length of stay, service user need and risks to engagement/therapeutic relationship

3.1.2 Once the handover meeting has taken place the CMHT will close the CMHT referral on Rio

3.1.3 Inpatient rehabilitation will provide a brief monthly report to the link worker for all service users in the service which will include the proposed discharge pathway and proposed discharge date (please see Appendix A for details)

3.1.4 Inpatient rehabilitation staff will notify the link worker and dial into the MDT meeting to escalate any concerns or risks especially if these may lead to the placement being compromised. The details of the MDT meetings will be provided by the link worker

3.1.5 The Lead HCP from the Inpatient Rehabilitation Service will notify the link work and CMHT administration team of the service user's proposed discharge date three months in advance and request reallocation of a Lead HCP in the CMHT

3.1.6 The CMHT Team Manager will arrange re-allocation of a care coordinator within 4 weeks

3.1.7 A handover meeting will take place at least 6 weeks prior to the proposed discharge date and care will transfer back to the CMHT

3.1.8 The Inpatient Rehabilitation referral will be closed on discharge from the service

4 KEY RESPONSIBILITIES

4.1 Community Mental Health Teams

4.1.1 Each CMHT will identify a link worker to provide a liaison role between the CMHT and the inpatient rehabilitation units

4.1.2 The Lead HCP or link worker will attend the handover meeting four weeks after the service user is admitted to the rehabilitation unit

4.1.3 Where concerns or risks are raised by the Inpatient Rehabilitation Service, the link worker will highlight these to the CMHT in the red board meeting and provide details of the MDT meeting to the Lead HCP in the Inpatient Rehabilitation so they can dial in to discuss it further

4.1.4 Following notification of the potential discharge date the Team Manager in the CMHT will allocate a lead HCP in the CMHT within four weeks; where possible consistency of the lead HCP will be prioritised

4.1.5 The identified lead HCP will attend the handover CPA meeting at least 6 weeks prior to the proposed discharge date

4.1.6 Where there is a change in the service user's admission status care will transfer back to the CMHT

4.2 Inpatient Rehabilitation Teams

4.2.1 The unit manager will be responsible for arranging the handover CPA Meeting four weeks after the service user is admitted to the unit

4.2.2 The unit manager will be responsible for identifying the Lead HCP from the substantive inpatient staff team

4.2.3 Following transfer of care the Lead HCP within the Inpatient Rehabilitation Service will take responsibility for all care plan review meetings CPA and placement paperwork (e.g. S117 NEL Form, CANFOR)

4.2.4 Following transfer of care, where and individual is held under a section of the Mental Health Act (typically section 3 or section 37) the lead HCP within the Inpatient Rehabilitation Service will complete a joint nursing and Social Circumstances Report for the MHA Tribunals for service users held under the Mental Health Act (please see Appendix B for the templates agreed by the Mental Health Act compliance Manager)

4.2.5 Inpatient rehabilitation staff will notify the link worker and dial into the CMHT MDT (patch) meeting to escalate any concerns or risks especially if these may lead to the placement being compromised. The details of the MDT meetings will be provided by the link worker

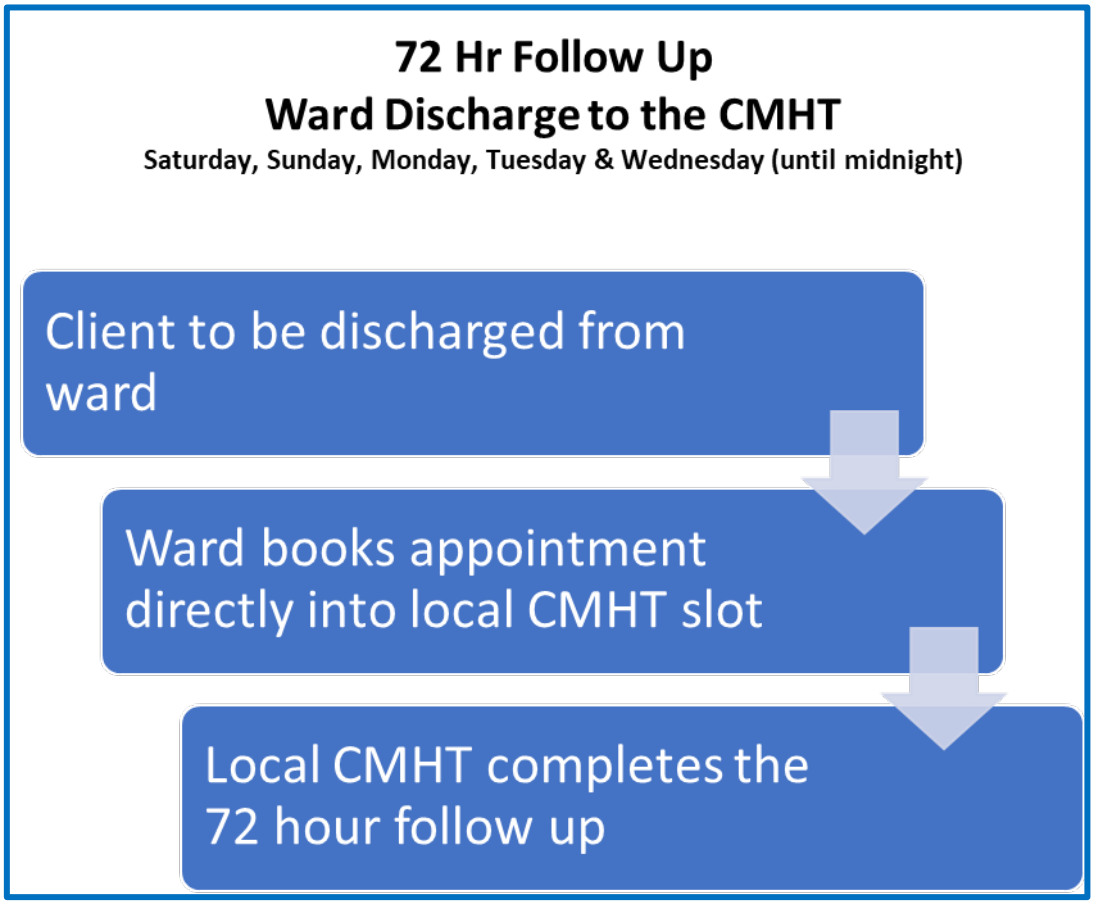
4.2.6 The lead HCP from the Inpatient Rehabilitation Service will notify the relevant CMHT of the service users proposed discharge date three months in advance by emailing the identified link worker and the CMHT 'admin inbox' (please see Appendix C for details)

4.2.7 Should a Lead HCP not be allocated in the CMHT within the specified timeframe this will be escalated via the Rehabilitation Service Manager to the CMHT and Specialist Heads of Service

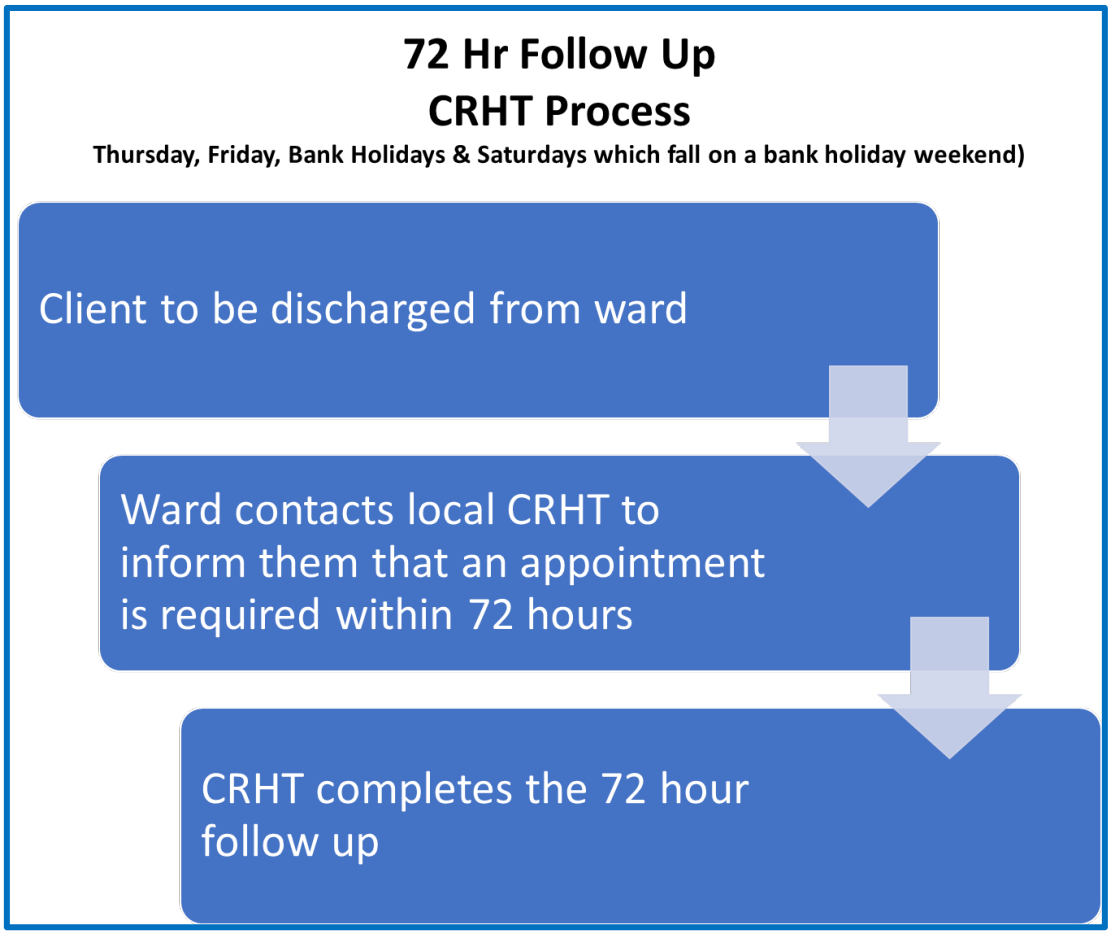
4.2.8 Once a Lead HCP has been identified in the CMHT, the Lead HCP from the Inpatient Rehabilitation Service will arrange a handover CPA at least 6 weeks before the proposed discharge date to transfer the service users care back to the CMHT

9 72 HOUR FOLLOW UP

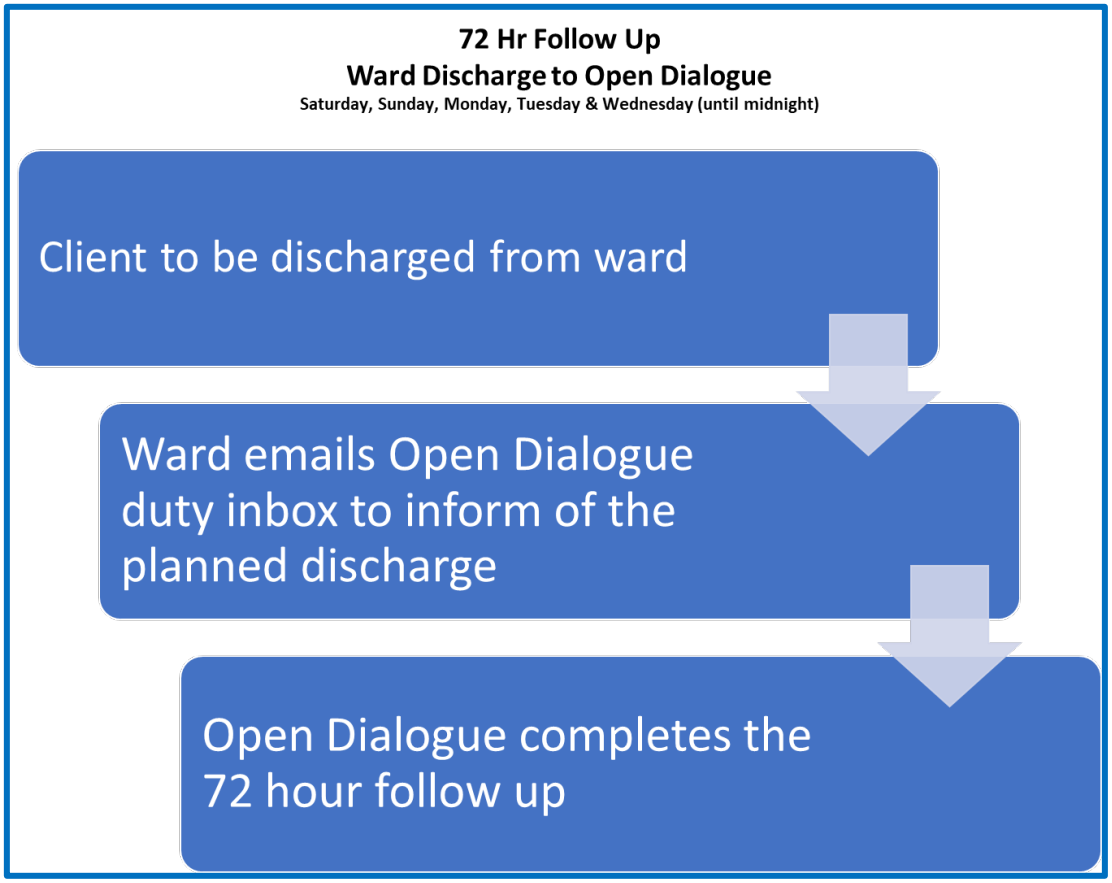
Flowchart – Ward to CMHT



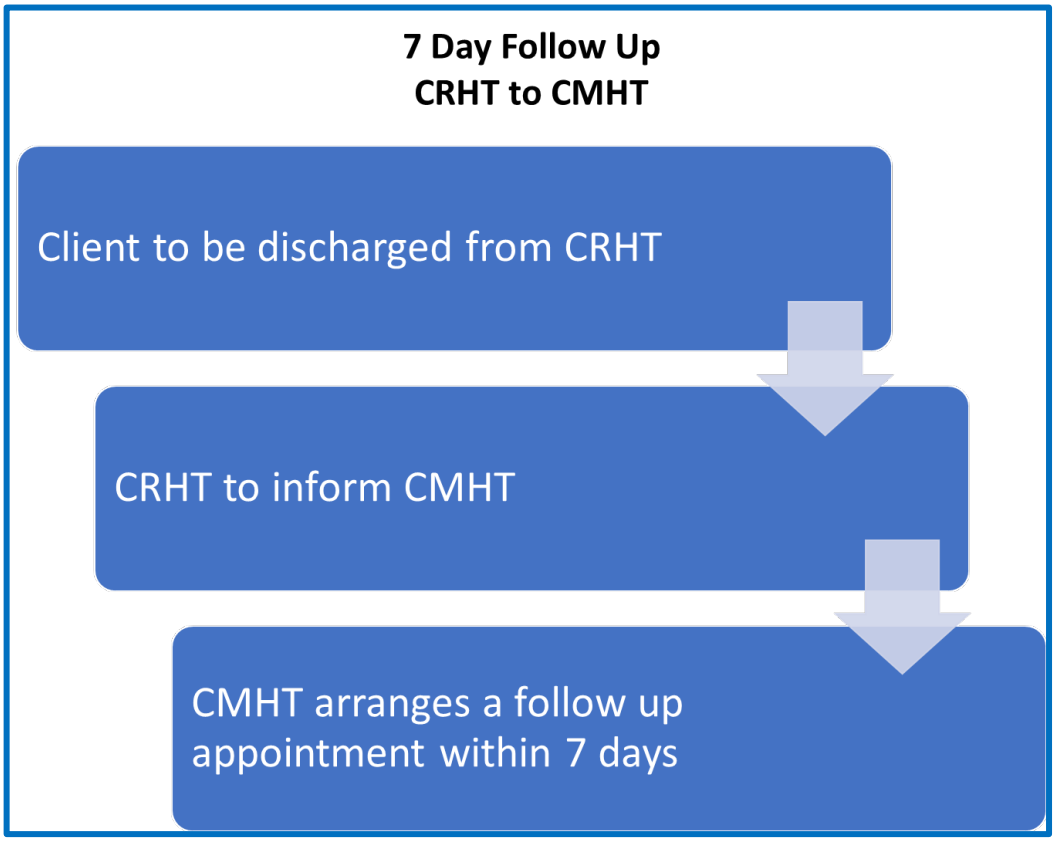
Flowchart – Ward to CRHT



Flowchart - Ward to Open Dialogue



Flowchart – CRHT to CMHT (7 day)



10 INTERFACE PROTOCOL – LIAISON PSYCHIATRY SERVICE TO CMHT PROCESS

Liaison Psychiatry and Community Mental Health Teams Interface Protocol for working and non-working age adults.

This protocol outlines the agreement between the Liaison Psychiatry Services and the Community Mental Health Teams (CMHT) for younger adults and Community Mental health services for older adults (CMHSOP) with regard to the process of how care will be passed from the Liaison service to the CMHT/CMHSOP for patients who are deemed eligible for secondary mental health services.

The CMHT/CMHSOP will see the patient for a follow up appointment within 72 Hours following discharge from the acute hospital. Liaison Staff will refer patients already known to CMHT/CMHSOP if patient remains admitted in Acute Hospital but has been discharged from Liaison caseload. Patients who are not known to the service will be referred to CMHT/CMHSOP after discharge from the acute hospital. The purpose of this initial meeting will be to review the initial assessment and to agree with the service user how any on-going identified needs will be met from within the community.

During office hours (Monday to Friday 9am to 5pm)

1. Liaison clinicians will telephone the relevant CMHT/CMHSOP and have a clinical discussion of the case with the duty worker. They will also email the correct team indicating the patient details, contact details and the immediacy of contact
2. As far as is possible, an appointment time will be identified, to be passed to the patient before discharge from Liaison services
3. Liaison will provide the patient with the CMHT/CMHSOP contact details, including the KMPT website details, the Mental Health Matters Helpline number and the single point of access number. Any information available regarding the patients mental health problem should also be shared.
4. Liaison will email the team and upload the Initial action plan to the CMHT/CMHSOP and General Practitioner (GP) The patient will receive a copy.

Out of office hours

1. Liaison will email and upload on RIO the discharge summary to the CMHT/CMHSOP, GP and any other relevant agencies involved. The patient will receive a copy
2. Liaison will provide the patient with the CMHT/CMHSOP contact details, including the KMPT website details, the Mental Health Matters Helpline number and the single point of access number. Any information available regarding the patients mental health problem should also be shared.

When the above information is received by the CMHT/CMHSOP, they will arrange to see the patient within the 72 Hrs

Community Mental Health Services for Older Persons (CMHSOP)

Patients being referred to CMHSOPS should be seen face to face within 72Hrs of being discharged from the Acute Hospital. This includes Functional and Complex Dementia presentations.

Routine Memory assessment requests should be discussed in the daily Triage meeting and a clinical decision made at that stage.

Additional information

CMHT/CMHSOP Lead health care professional (HCP) should advise the Liaison Service of patients under their care who are admitted to one of the 7 district general hospitals in Kent and Medway. This should highlight the type of support that might be required during the patient's admission.

Community mental health clinicians must only direct people on their caseload to attend A&E if they are physically unwell or injured requiring emergency medical intervention. Accident and Emergency is not a default alternative

for a mental health assessment by liaison with the absence of an emergency medical need that requires immediate attention.

Escalation

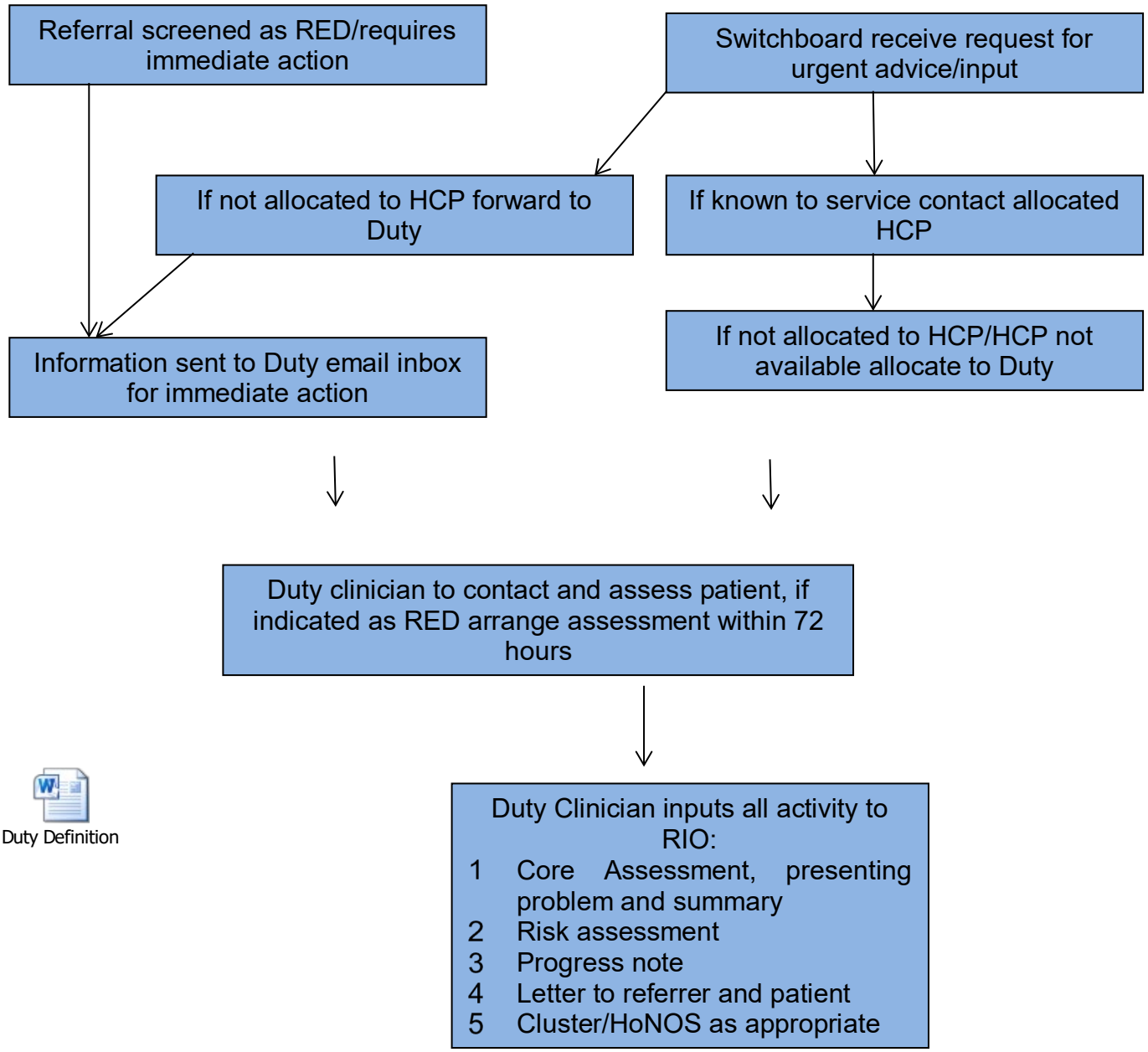
Any concerns in relation to the compliance with this protocol should be discussed between the relevant Liaison Team Manager and CMHT/CMHSOP Manager in real time.

Review

This protocol will be reviewed in January 2023

11 DUTY

Duty Flowchart



Duty Definition

12 CANCELLATION AND DNA

DNA PROCESS - Disengagement or difficult to contact

DNA Policy.pdf

The KMPT DNA Policy sets out how to manage DNAs in order to maximise resources without compromising safety and access to services and care.

When people disengage or become difficult to contact the named worker must always assess the impact for the individual. Review of risk assessment and care plan will inform further intervention. Professional judgement will dictate whether this is raised as a matter for serious concern using the risk management escalation process such as the RED board meeting

- Care plans MUST have a written contingency plan if there is an identified risk of disengagement.
- Care co-ordinators / practitioners must raise all instances of disengagement and failure to comply with essential treatment etc. at RED board meeting (for medium/high risk and/or for people on a CTO, or prescribed Clozapine or a depot medication) or team meetings when a positive action will be agreed and recorded on RiO.
- Where a home visit fails because the individual is not at home or there is no answer then a record of attempts to contact should be made. A plan of action to be recorded and concerns escalated appropriately.
- Staff must follow locally agreed protocols for pursuing welfare checks

Staff are expected to have read, understand and use the policy and procedure for managing patients who Do Not Attend and/or are unable to be contacted for full detail

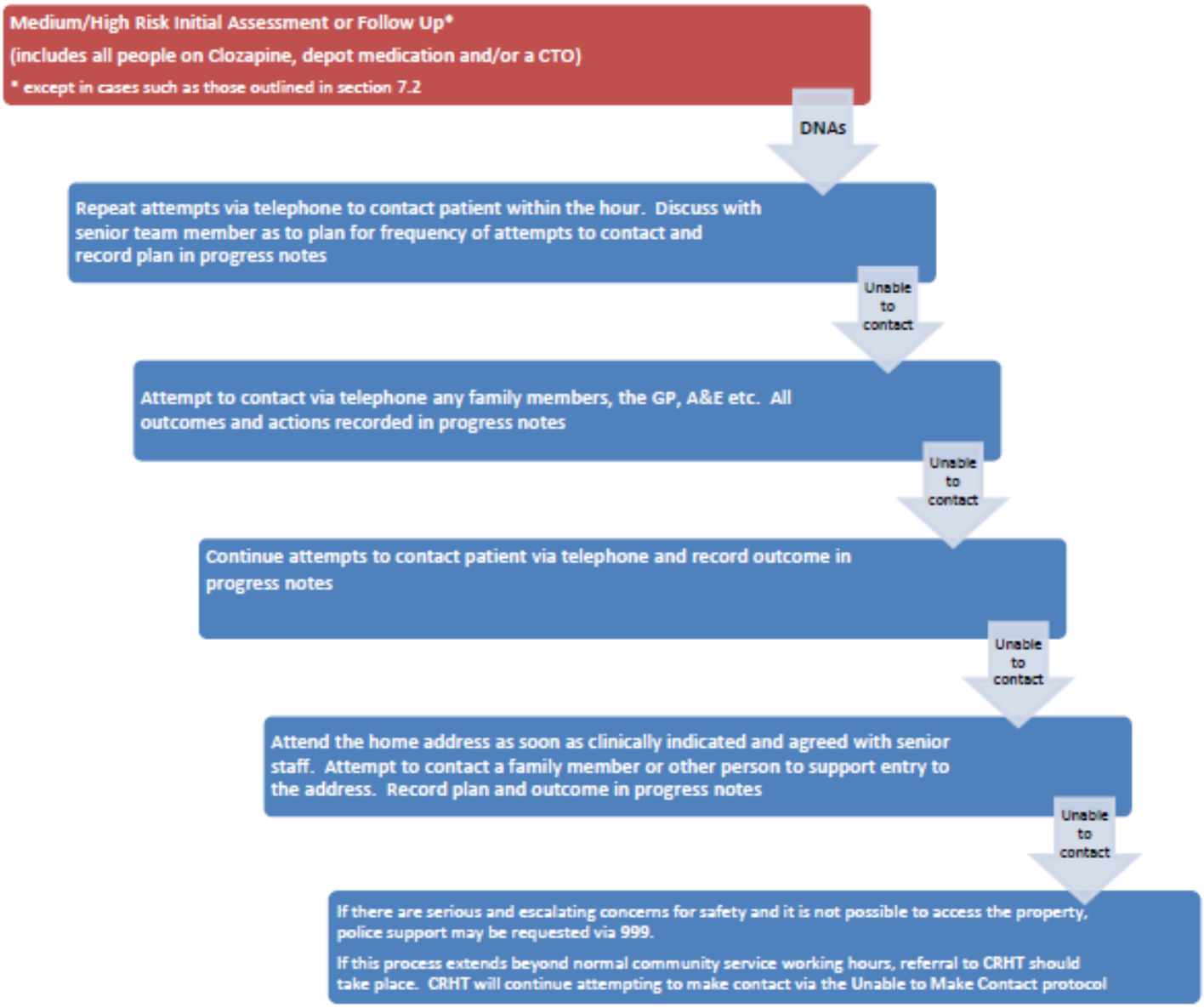
Important note:

Out of hours the CRHTT will accept referrals from CMHT where CMHT have been unable to make contact to assess and review the mental state of the person but significant risk factors are evident and meet the threshold for CRHTT involvement.

Low Risk

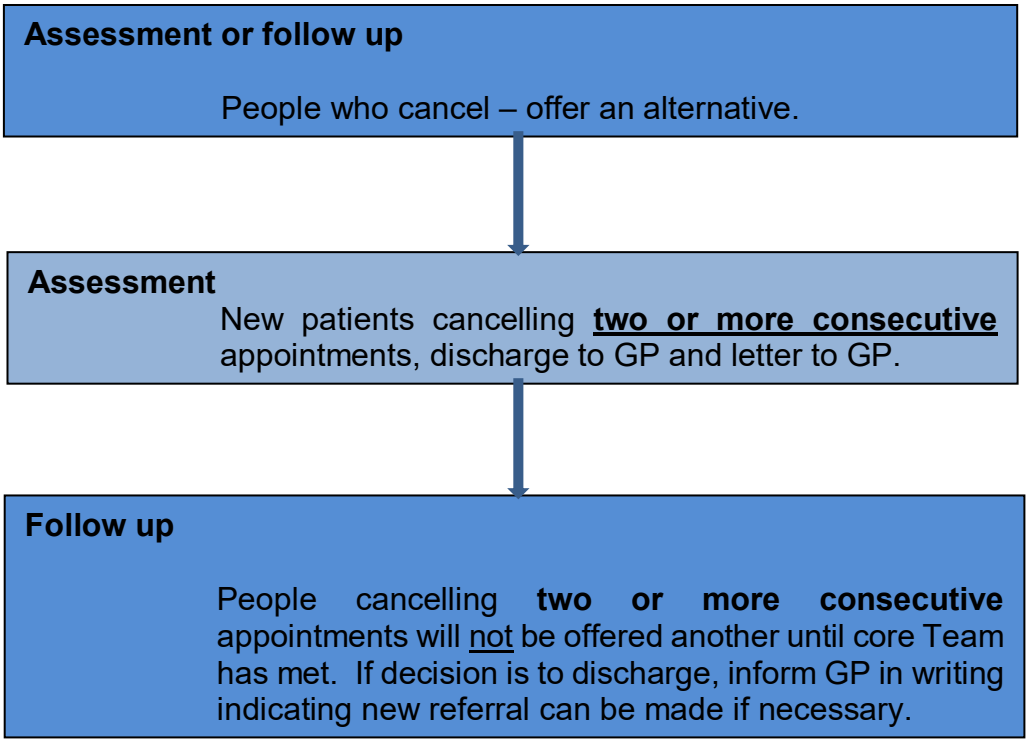

Low Risk Initial Assessment
(appointment agreed)
DNAs
Discussion with senior team member about situation and record decision in progress notes
If no extenuating circumstances, discharge back to GP/referrer including copy of letter to patient.
Offer follow up appointment letter if extenuating circumstances are present
Low Risk Initial Assessment
(appointment not agreed)
DNAs
Contact patient to arrange another appointment within 2 working days (record outcome in progress notes)
Unable to contact
If unable to contact patient, contact GP/referrer only if the level of risk is uncertain. If the GP/referrer clarifies a low risk, or if this is already evident, present the scenario to a senior team member and discharge back to GP/referrer including copy of letter to the patient. If any concerns or extenuating circumstances are identified, a folllow up appointment letter should be sent. Record decision in progress notes. If medium/high risk see relevant flow chart below
Low Risk Follow Up
DNAs
Review file to determine level of risk and need in order to form an opinion about offering another appointment. Either discharge or offer another appointment.
If x2 consecutive DNAs occur, discharge should occur unless there is a clear reason to offer another appointment
Discuss with senior team member and record decision in progress notes
Discharge back to GP/referrer including copy of letter to patient OR offer a follow up appointment letter

Medium/High Risk



Cancellation

Cancel appointment by patient



13 SICKNESS PROTOCOL

STAFF SICKNESS – PROTOCOL & COVER ARRANGEMENTS
From the Frist Day – Two Weeks (Short Term Sickness)
➢ Staff will report sickness at the beginning of the working day by 9:30 am at the latest. ➢ Staff will report sickness by way of a telephone call, and **speak** to the Team Manager. ➢ The Team Manager will advise Admin of sickness absence. ➢ Admin will update reception & duty staff, the whiteboard and electronic records. ➢ Staff **must not** report sickness by text, email or telephone message. ➢ Details of RIO diary commitments to be obtained and actions agreed. ➢ Staff will flag up any immediate concerns re: specific clients so a plan is agreed. ➢ The absent staff member will maintain contact with a Team Manager to ensure ongoing cover for diary commitments. ➢ If there is no appointment/no concern re: a client during this period, no contact will be made. If a client contacts the Service to speak to their care co-ordinator, s/he will be informed by Admin that the care co-ordinator is absent, and a message will be left for the care co-ordinator, or the client transferred to duty worker, for clinical contact.
From Two Weeks
➢ Letter sent to all clients, copied to GP, advising that the care co-ordinator is absent, with advice to contact duty if needed. ➢ Team Manager to ensure message slot is removed. ➢ Team Manager to ensure Admin staff contact IT helpdesk to arrange 'out of office' message on staff members email. ➢ **Admin** staff to review RIO diary of all clients on caseload, to identify any booked **CPA reviews/professional meetings** etc. List of appointments to be provided to locality senior/locality allocation meeting to identify cover as needed.
Two – Four Weeks
➢ Team Manager/Supervisor and Consultant Psychiatrist will review the care co-ordinator's caseload and RAG rate accordingly. ➢ Caseload distributed between staff, and allocated as additional worker/HCP in order to provide a named point of contact, and monitor needs and risk.
Two months+
➢ Team Manager/Supervisor and Consultant Psychiatrist to review caseload. ➢ All cases to be re-allocated.

14 PLANNED LEAVE PROCESS

Case Handover/ Case Update

Form to be completed by the care coordinator / Lead HCP prior to planned leave / absence, or when leaving the team permanently.

Step One: two months in advance of planned leave, care coordinator / Lead HCP complete the documentation below providing the required details for the whole caseload and share this with the Locality Manager and Team Managers

Step Two: Locality Manager and Team Managers work with the team to agree covering personnel per patient and document this on the documentation below

Step Three: Locality Manager or Team Manager to provide the updated documentation to the care coordinator / Lead HCP

Step Four: Care coordinator / Lead HCP to arrange handover meeting(s) with their covering colleagues in order to give a verbal handover of key information (this may repeat or supplement the information provided in the documentation below)

Step Five: Care coordinator to arrange a return handover meeting with their covering colleagues in advance of going on leave. This meeting will aim to take place within 14 days of their return (if not leaving the team permanently)

Step Six: Care coordinator writes to all patients providing them with the name and contact details of the covering member of staff

Form to be distributed to Locality Manager, Team Manager and duty.

Name of professional:

Date:

Dear Colleagues,

I will be away on annual leave from …… and will return to work on (complete if not leaving the team permanently)……

Please see below for my caseload updates

	Name of Service User and RiO Number	Case update of core issues including any risk / safeguarding issues, homelessness, interventions e.g. groups, psychology, STR, crisis team	Any upcoming appointments e.g. depot or CPAs / anything that needs to be done in my absence	Name of person covering	Send letter informing of absence (Y/N)
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15 DEPOT CLINIC

The '*Safe Administration and Monitoring of Intra Muscular Injection Medication*' policy must be read and understood by all staff working in or supporting depot clinics. To complement this policy, the '*Safe Administration and Monitoring of Intra Muscular Injection Medication within Community Settings Standard Operating Procedure*' must also be utilised by the same staff groups on a day to day basis to support the practical application of safe and consistent depot clinics.


IMI Administration Policy.pdf


IMI Administration SOP.pdf

APPENDIX A TERMS OF REFERENCE

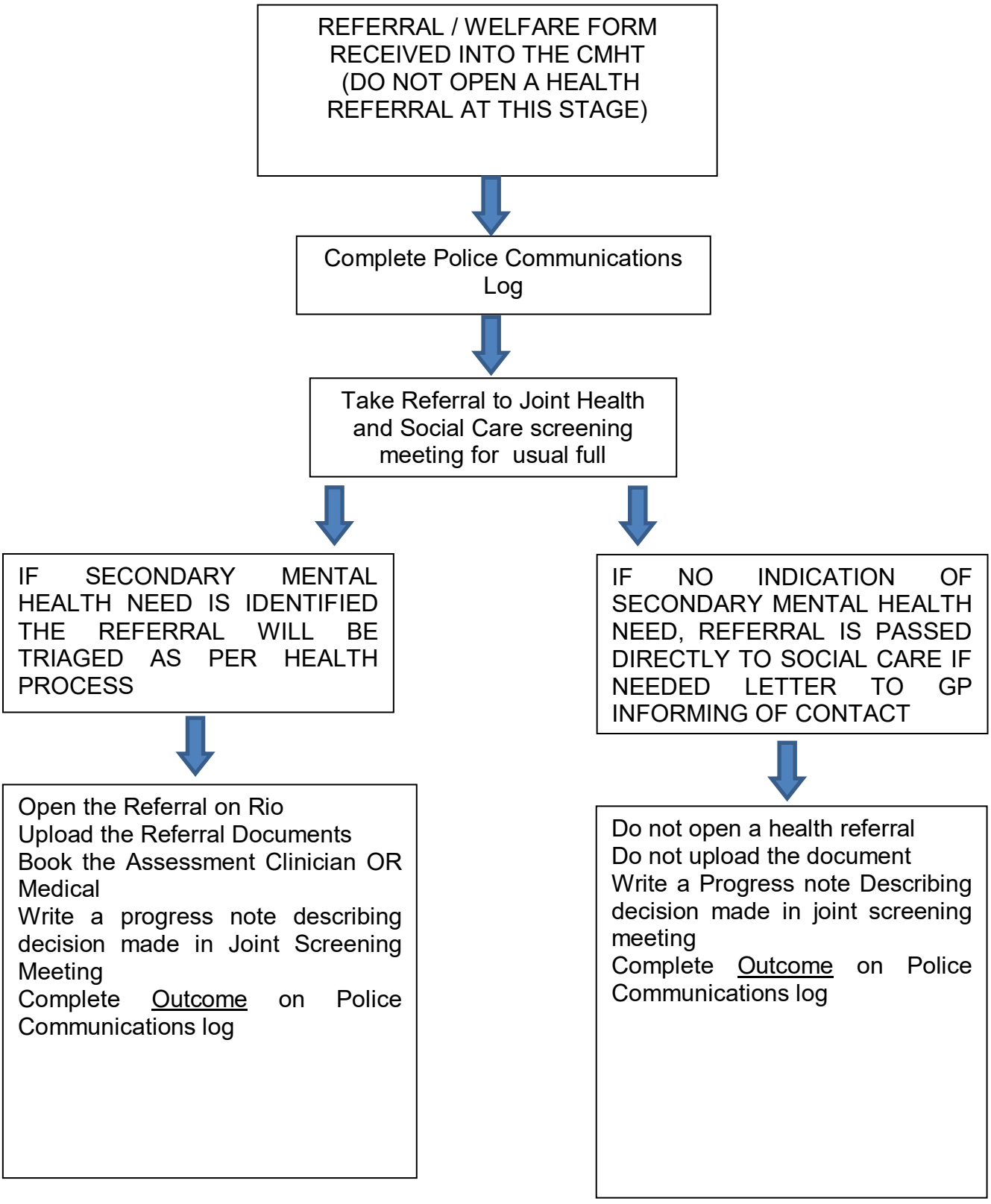
A	REDProcessGuidelinesKMPT.docx
B	Business Meeting Quality V2.docx Business Meeting Performance V2.doc Business Meeting Serious Incident V2. Business Meeting Patient Safety V2.do Business Meeting Anything Goes V1.d
C	Risk Forum

APPENDIX B STANDARDISED LETTERS

- All standardised letters are to be found on RiO
- These are accessed via clicking on the 'Clinical Documentation' tab and selecting the 'Editable Letters' link
- On every occasion that a letter needs to be written, the letter template will be pulled directly from RiO at that point in time. In no circumstances should the RiO template be saved to a local or shared drive and used from that source
- All letters will be written to the patient and copied to the GP (unless there are extenuating circumstances)
- Once a letter has been written it must be sent to the patient without delay. Letters should not be checked as routine by a Team Manager or equivalent

APPENDIX C HOW TO DEAL WITH COMMUNICATIONS RECEIVED FROM THE POLICE

When officers attend a call and there is a concern for someone who may be displaying Mental Health problems, they may complete a referral which they send to Social Services / Mental Health. This is for information and for Social Services/Mental Health to take necessary action, there is no expectation from the police of how services will respond and they confirm they are just sharing the information from a safeguarding point of view.



APPENDIX D POLICE COMMUNICATION LOG

Police Communications Log

Copy of Police Communications Log -

APPENDIX E PERSONAL SUPPORT PLAN BRIEF GUIDE

Personal Support Plan Brief Guide.pdf

APPENDIX III: AUTISTIC SPECTRUM CONDITIONS (ASC) AND ADHD REFERRAL PATHWAY STANDARD OPERATING PROCEDURE

AutismADHDSOPKMP T.CliG.190.01.docx

APPENDIX IV: RIO REQUIREMENTS

RiO Requirements (Clinician/Admin)	
DUTY	Staff member to complete presenting problem for referral in Core, and Risk, diary appointment should be recorded and outcome, and a progress note entered to reference assessment and plan. Open a cluster if coming in to service. If known to service, update anything which has changed in Core. Admin to complete assessment outcome letter see CRCG template in editable letters. Duty Team also carry out the 72 follow ups and follow the above process, including letter to the client with the outcome of the assessment.
REFERRALS RECEIVED	Urgent referrals which have previously been screened by SPoA will go direct to an assessment appointment, SPoA DNA's will go to the screening meeting, after being opened by admin. Admin will open all other referrals received to the team . They may come in via email or letter from GP or KCC. These will sit on the Team caseload awaiting screening. Any documents to be uploaded to the documents section in RiO by admin. Police referrals are discussed in the screening meeting, but are not opened or uploaded until a decision is made that the client will be taken on.
SCREENING	At the screening meeting the Screening page to be completed on RiO by clinician. Brief progress note to be entered referring to screening tool and with outcome. If a client is not taken in to Service the referral should be closed. Referral reason to be entered if this has not already been done. CRCG Signposting letter to be sent out by admin. If client is going to be offered an assessment the client is moved from Team Caseload to the caseload of the Performance Team Manager. Client is telephoned to arrange appointment, entered on Rio and letter sent out.
ASSESSMENT	Following assessment Core and Risk should be completed. Cluster should be completed following MDT meeting. Letter created from the Core and sent out by admin. Progress note is also completed by clinician which references the Core, and the appointment outcomed. If client is taken on under non-cpa pathway a pathway should be opened and client allocated to ART with an intervention tab opened, showing what they are waiting for. For example, Initial Interventions, Psychiatric Review, STEPPS or Psychology. A letter should be sent out to client with the Keep Safe Plan. Client should be moved from the Performance Team Manager to the ART Lead. Support calls should be made to clients on ART every 4 weeks. PCSP should be completed and sent to client after every contact. If client is going to be on CPA then they should be allocated a Care Coordinator and pathway opened. Care Plan should be completed and distributed. Every 6 months complete Risk Assessment and Care Plan and have a CPA review, or earlier if there is a change to their care need or risk.

HONOS & CLUSTERING

HoNOS & Clustering

HoNOS should be completed following assessment, as well as when there is a significant clinical change and on discharge. This is for all patients.

Cluster	Classification	Minimal Review interval
1	Common mental health problems (low severity)	12 weeks
2	Common mental health problems	15 weeks
3	Non-psychotic (moderate severity)	6 months
4	Non-psychotic (severe)	6 months
5	Non-psychotic (very severe)	4 weeks
6	Non-psychotic disorders of overvalued Ideas	6 months
7	Enduring non-psychotic disorders (high disability)	Annual
8	Non-psychotic chaotic and challenging disorders	Annual
9		
10	First episode in psychosis	Annual
11	Ongoing recurrent psychosis (low symptoms)	Annual
12	Ongoing or recurrent psychosis (high disability)	Annual
13	Ongoing or recurrent psychosis (high symptom and disability)	Annual
14	Psychotic crisis	4 weeks
15	Severe psychotic depression	4 weeks
16	Dual diagnosis (substance abuse and mental illness	6 months
17	Psychosis and affective disorder difficult to engage	6 months
18	Cognitive impairment (low need)	6 months

CONSENT

Clinician to record on RiO if consent is given by the patient to share information with specified people

Clinician or admin to record on RiO when consent is given by the patient to have a appointment via video (Lifesize or Attend Anywhere)

NOTICES	Complete and remember to remove where necessary
SAFEGUARDING	Complete safeguarding form on RiO, if a safeguarding alert has been raised, add to care plan and risk assessment as per Safeguarding policy.
EDITABLE LETTERS	**Editable Letters** – Staff should only use the CRCG templates on RiO. Letters to the GP should be sent via E-Correspondence. These Care Group Letters are : **CRCG Assessment Outcome Letter** – this is the letter following assessment, information captured from Core. **CRCG Cancellation letter** – Letter to be used if client or Trust cancels appointment, giving an alternative date. **CRCG Change of Care Coordinator** **CRCG CPA Invite** - appointment letter specifically for CPA's **CRCG DNA Letter** – transferring back to GP **CRCG Depo DNA Letter** – **CRCG First Assessment Letter** – Appointment letter for first appointment – following telephone contact arranging appointment **CRCG Signposting Letter** – Letter following screening where client is not taken on to Service **CRCG Transfer to GP** – Discharger letter for non CPA clients **CRCG II First Appointment letter** – **CRCG II First DNA letter** – offering another appointment **CRCG II Invite letter** – Introducing II to client enclosing preparation pack **CRCG II Second DNA Letter**- Option to discharge from CMHT or discharge from II **CRCG II Summary Letter**- End of all 4 sessions including forward plan **GP Letter** – to be used for doctor's clinic letters

Medication changes by doctors and NMP's	These should be clearly documented on RiO under progress notes and a letter sent to client copying in GP. These should always be signed by the prescriber or cross checked and counter signed by another clinician.
SCANNING & UPLOADING	All patient related documents to be scanned and uploaded using the naming convention – do not upload complaints.
PROGRESS NOTES	**Progress notes should include the following:** Setting and purpose of visit Who was present Mental health presentation Medication Care Planning Social and environmental issues Actions taken during visit Identified risks and needs Plan **Progress note for Depo clinics should include:** Mood & Mental Health Physical Health: Care Planning: Physical Observations: Risks and needs: Social Circumstances: GASS: Administered by: Chaperone: Consent: Drug:

Dosage:

Frequency

Route/Site:

Batch No:

Expiry Date:

Any additional actions:

Plan/Next Depot Due:

Progress note for Clozapine clients should include :

CPMS Number:

Chaperone:

Consent:

Comments:

Mental Health:

Physical Health:

Bloods taken today from: R/L arm:

Blood pressure**:** (weekly for 18 weeks, fortnightly for up to one year, then 4 weekly)

Pulse**:** (weekly for 18 weeks, fortnightly for up to one year, then 4 weekly)

Weight (including waist measurement and BMI): (baseline, weekly for 6 weeks, 3 monthly for 1 year, then annually).

Current dose of Clozapine daily:

Next appointment:

PATIENT RELATED OUTCOME MEASURES

Each intervention delivered has patient related outcome measures that need to be completed at the beginning and end of the intervention. These can be found under 'Outcome Measures' on RiO. The table below indicates which measure is required for each intervention and when. Please ensure that the ReQol-10 is always linked to the CMHT referral.

Intervention	Outcome Measure on RiO	Beginning of Intervention	Middle of Intervention	End of Intervention

	Entry/Exit into service	HoNos & Clustering	X	Update when clinical change has occurred	X
		ReQol-10	X	6 monthly time points by lead hcp	X
	Initial Interventions (ii)	GAD7	X		X
		PHQ9	X		X
		WAS	X		X
		ReQol-10			X (If discharging from service)
	Recovering Occupations Group	Group Outcome Measure	X		X
		MOHOST	X		X
	Individual OT	MOHOST	X		X
		ReQol-10			X (If discharging from service)
	CED Change	BEST	X		X
		ReQol-10			X (If discharging from service)
	STEPPS	CORE-34	X		X
		BEST	X		X
		WAS	X		X
		Zannarini-BPD	X		X
		ReQol-10			X (If discharging from service)
	CBT for Psychosis Group (CBTp)	CORE-34	X		X
		WAS	X		X
		CHOICE Short Form	X		X
		Self-esteem rating scale	X		X
		ReQol-10			X (If discharging from service)
	Individual Psychological Therapy	CORE-34	X		X
		ReQol-10			X (If discharging from service)
	Mentalisation Based Therapy (MBT Group)	CORE-34	X	X	X
		Zannarini-BPD	X	X	X
		SIPP-SV	X	X	X
		WAS	X	X	X
		ReQol-10			X (If discharging from service)
	Referral to Psychology:				

PSYCHOLOGY	Psychology referral is opened by admin on RiO. If accepted by psychology, patient will be offered a screening appointment. If not accepted by psychology, admin will close the referral. **Screening by Psychology** Booked as 'First appointment' in RiO diary. Patient will receive a 'Screening Outcome Letter'; cc to GP if patient has consented. If not accepted for treatment, admin will close the referral. **Psychological Treatment** Booked as 'Treatment' in RiO diary. Complete CORE-34 questionnaire in first treatment session. Patient receives a 'Psychological Treatment Plan' cc to GP if patient has consented. Clinician will open the intervention tab Input the CORE-34 as 'First Therapy Session', Transfer patient to clinician's caseload. HoNOS, clustering, care plans and risk assessment will be updated when required or when a change in the client's presentation determines so. **End of Psychological treatment and remain in CMHT** Patient will complete a CORE-34 outcome measure in penultimate session; clinician inputs this onto RiO under 'Outcome Measures' as 'Last Therapy Session' Patient will receive a 'Discharge Summary' cc to GP if patient has consented. Clinician updates clustering & HoNOS. Clinician closes the Intervention tab, closes the referral and removes from caseload. **End of Psychological treatment and discharge from Service** Patient will complete a CORE-34 outcome measure in penultimate session; clinician inputs this onto RiO under 'Outcome Measures' as 'Last Therapy Session' Patient will receive a 'Discharge Summary' cc to GP if patient has consented. Clinician updates clustering & HoNOS, then closes the cluster. Closes Intervention tabs. Closes the referral, removes from caseload and closes care spell. Requests admin close the CMHT referral.
DISCHARGES	Close referral, end care spell, close intervention tab & send letter to client cc GP