Adult Community Mental Health Operational Policy

Lead Manager:	Caroline Paterson, Steven McCulloch
Responsible Director:	Martin Culshaw, Lorraine Cribbin
Approved by:	NHSGGC Mental Health Clinical and Care Governance Group
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2. Introduction

This Policy has been developed by the Community Mental Health Team (CMHT) Short Life Working Group (SLWG) on behalf of the Effective and Efficient Community Health Services Steering Group. The policy sites standards set out in the Accreditation for Community Mental Health Services (ACOMHS) Royal College of Psychiatrists' Centre for Quality Improvement (CCQI 329, 2020). Acomhs-second edition-standards-2020 and the University of Manchester's National Confidential Enquiry into Suicide and Safety in Mental Health (NCIS) Safer services toolkit. NCISH Self-Audit Toolkit 2022 Final updated to inc NICE self-harm guidelines 21092000. The undertaking was to update the 2016 CMHT operational Framework with the specific purpose of reflecting how teams are currently working and reflect any changes in practice.

Community Mental Health Teams are multi-disciplinary, secondary care service providing integrated care to patients who experience mental health difficulties and benefit from treatment and support in recovery. The use of the term "patient" throughout this policy refers to patient, client, resident, or service user. CMHTs provide specialist assessment, formulation, and treatment of moderate to severe mental illness and mental disorder, whose needs are characterised by complexity and risk.

3. Scope

This policy and practice guidance is applicable to all NHS Greater Glasgow and Clyde Mental Health Services. The guidance in this policy will be implemented by all staff employed by NHS GG&C in Adult Community Mental Health Teams.

4. Aim

The aim is to provide high quality care to improve people's mental health and well- being through working in partnership with all contributors to support recovery in a safe, effective and person-centered way. Since community mental health teams/services differ in their configuration and practice, dependent on locality this policy focuses on the function of teams to make them as widely accessible as possible.

5. Principles

The CMHT works to the following principles:

Collaboration – Working with patients, carers, family, and partner organizations access into and towards discharge from the service as safely, quickly, and effectively as possible.

Recovery – Enabling patients to live a meaningful life in the presence or absence of symptoms and providing education on relapse prevention.

Self-Management – Enabling and empowering individuals to successfully manage their illness/condition through education, intervention, and guidance.

Positive Risk Taking – Involving shared decision making, personalized care, and reducing risk through effective risk management within realistic expectations and in collaboration with all involved.

Trauma informed – Recognizing the impact of traumatic experiences on individuals and providing an appropriate response to care.

Interagency collaboration – Recognizing interagency working in collaboration with other disciplines, partners and third sector agencies including care pathways between organizations.

Holistic and whole person approach – Recognize wider social determinants of health and impact on individual's mental health. Adopt a "No wrong door" approach to patient care.
This means that **patients can access our network of services and be linked to the appropriate service regardless of where they enter the system**, providing a timely service response to both patient and referrer.

Service Delivery – Ensure the Right Care, in the Right Place, at the Right Time.

6. CMHT Service Standards

Community Mental Health Teams will:

Provide accessible and understandable information on who services are for, what is provided and referral routes. When seeking care, the patient will be supported to get the appropriate help regardless of point of contact.

Teams will provide estimated waiting times after referral, with regular updates if wait is longer than this. Information on other available supports (if available), should be provided during this waiting period.
Patients, carers, and families will be treated with kindness, compassion, dignity respect and consideration of needs and circumstances.

Patients will be supported within a timescale that reflects need.
Those most in need will be prioritized. Criteria used to assess need will be detailed. Teams will publish information in clear / accessible formats affirming who services are for what is provided, and referral routes, including contact information. Location of services, opening hours, plus how to contact out of hours/emergency care.

Team information should be widely available / easily found in people's preferred languages, in culturally sensitive formats, and understanding of the possible impact of trauma on people accessing services.

Teams ought to provide information on how mental services work together and with other agencies and organizations. Provide information on other sources of support while people are waiting, including organizations, which support people from different social, economic, cultural, and ethnic backgrounds.

Teams will have systems that accurately measure waiting times for assessment and treatment, are accessible to everyone, are recorded and regularly reported through Clinical and Care Governance structures. Supervision will be delivered on an ongoing basis as per relevant standards and policies to underpin safe practice and support the MDT.

Teams will provide multi-disciplinary, holistic, person centered, recovery orientated and trauma informed care while monitoring mental state and risk. Staff will work collaboratively with individuals to develop a formulation and /or establish a diagnosis and a care plan, this is discussed within the MDT and should be incorporated into the relevant ICD10 10/ICD 11 coding on electronic records.

The mechanisms for coding on electronic records should be followed and updated as regularly as possible following reviews. Coding mechanism include options for updating conditions that resolve with time and interventions vs longer term severe and enduring disorders. For certain cohorts of patients, diagnosis is not always clear, however these patients can and should still be coded.

Accurate diagnostic coding, formulation and risk stratification is fundamental to helping define where a patient's needs will lie and when patients can be moved positively to downgraded strata towards recovery.

Risk stratification, patient-initiated follow-up (PIFU) and discharge from CMHTs are tools that can be utilized to facilitate CMHT flow when and if relevant to the patient's needs.
Guidance Document for Emis Template for patient risk stratification

CMHTs to have appropriate information to promote and encourage carers and family involvement and provide support to carers in line with legislation on consent, confidentiality, and information sharing.

Provide brief evidence based psychosocial interventions to reduce distress, decrease potential for immediate harm and aid resolution of acute social or interpersonal crisis.

Support improvement in functioning, where this is an identified need, through the development of goals informed by assessment of how an individual's function is impacted by their health, circumstances, and environment. Goals will focus on interventions to maximize recovery and stabilization through early re-establishment of previous habits, routines, and behaviors in, leisure and social participation.

Patients will have their goals and preferences considered as part of their care and treatment plan.

- To be involved in decisions about care and treatment as fully aspossible
- To have their carers or supports involved in their care if they wish
- To be supported in developing a staying wellplan.

6.1 CMHT Service hours of operation

Community Mental Health Teams have public operating hours across NHS GGC of Monday to Friday 9-5pm excluding public holidays.

The Crisis Services/IHTT operates during the following hours:

Monday-Friday: 9-8pm; Saturday, Sunday, and Public Holidays 9-5pm. Outwith these hours the Mental Health Assessment Units (MHAU) are available for profession-to-profession referrals for patients presenting in mental health distress or crisis.

The following can refer directly to MHAU: Emergency Departments, Police Scotland, British Transport Police, Scottish Ambulance Service, GP Surgeries, GP out of Hours Service, NHS 24/Mental Health HUB, and Compassionate Distress Response Service (CDRS) Other Distress services in HSCP and Emergency Social Work Services.

6.2 Referral

Referral to the CMHT should be considered for patients with unknown or established moderate to severe mental illness and mental disorder. Referrals are accepted from Primary Care Services, Inpatient Services, Liaison Services, Alcohol Drug Recovery Services (ADRS), Children & Adolescent Mental Health Service (CAMHS), Mental Health Assessment Unit (MHAU), Adult Eating Disorder Service (AEDS) and Esteem. This list may vary depending on locality/area.

Referrals may include requests in relation to statutory and mandatory requirements provided by Consultant Psychiatrists and Mental Health Officers to facilitate the Mental Health (Scotland) Care & Treatment Act 2015, Adults with Incapacity (Scotland) Act 2000 and Adult Support & Protection act (Scotland) 2007. It should be noted that there is variance in access to MHO officers and this is achieved either through team members or through separate MHO teams.

Referrals should be made using the appropriate routes identified. The referral process will be completed via either a SCI Gateway referral, created by medical records and added to inbound folder on EMIS, or a referral using the Duty, Tasking System (Internal Only); if utilized in your locality then staff must have awareness and training in this process.

Referrals are also accepted via letter from individuals (e.g., social work, transfer of care from another health board) who do not have access to EMIS or SCI gateway system. These letters are uploaded and sent to medical records for processing, applying the same process as internal referral forms can also be completed for NHS GGC services.

The referral information should include demographic information.

- Presenting problem(s) including description of duration and severity.
- Brief mental and physical health history
- Current working diagnosis where known.
- Impact on psychosocial functioning
- Summary of relevant vulnerability/risk factors
- Alcohol or substance use/misuse e.g., including street procured, over the counter, prescribed
- Care and treatment offered to patient to date and response to treatment (if known)
- Expected outcome of CMHT involvement
- History of Violence & Aggression
- Forensic History (if known)
- Current support network
- Patient consent to referral to CMHT
- Patient expectations
- Referrer expectations
- Carer/Family view
- Legal Status/Any relevant legal orders.

6.3 Referral Processes

Referral Screening:

All referrals will be screened daily by CMHT staff. Where it is identified from information received that an individual's needs would be more appropriately met by an alternative service, the referral will be forwarded to the appropriate service and this decision will be communicated to the referrer the patient and the GP.

New Patients to CMHT, if a patient is previously known to CMHT then staff will open a new episode to continue care.

For patients currently open to CMHT and a new or supplementary referral is received, this requires a written communication from the CMHT to the referring agent and the patient's GP informing them of the patient's status. All written information should be recorded on EMIS.

6.4 Category of referral response time by CMHT

Same Day Urgent:

CMHTs are open to the Public: Between the hours of 9 am and 5 pm. if any open/current patient open/current requires emergency support/assessment, presenting with immediate risk of self-harm and / or active plans of suicide or acute distress due to psychiatric illness the duty practitioner will offer an appointment that is deemed a place of safety on the same day for an immediate assessment. If this is not possible then the duty practitioner will initiate a process of gathering more information and determine risk.

There may be various outcomes:

- Could be appointed to their key- worker
- A duty appointment/assessment
- An appointment with a medical member of staff
- Referral onto Crisis or 999.

This may include a situation where the patient is deemed suitable for admission to hospital. (Refer to Psychiatric Emergency Plan 2023)

Any Emergency referrals for same day assessment that are not open to CMHT should follow the Unscheduled Care pathway and be assessed at the Mental Health Assessment Unit (MHAU).

5 Day Urgent:

During the screening process all referrals marked urgent will be reviewed, where immediacy is not present, and the referrer is satisfied that the patient requires an intervention within the next few days. The patient will be offered an assessment within five working days from receipt of referral.

Patients discharged from inpatient services to the CMHT will have follow up within 7 days of discharge, this includes contacts with Liaison Psychiatry.

National Confidential Inquiry into Suicide and Safety in Mental Health – toolkit for specialist Mental Health services and Primary Care

It is probable that additional information gathering will take place, and ongoing proactive communication with GPs will be valuable and constructive.

Routine:

During the screening process, all referrals marked routine will be reviewed and assessment appointments will be generated within twenty-eight working days from receipt of referral.

Accreditation for Community Mental Health Services (ACOMHS)

If the referral is reviewed at screening and there is a requirement to upgrade to urgent this will also be actioned within 5 working days and the referrer & or GP will be notified.

Outcomes of Referral Process:

If a referral is deemed not suitable for secondary care services and is progressed or passed on to Primary Care Mental Health, or another Mental Health Service, recommending that the referral be considered, then all decisions and actions will be recorded on EMIS, and the outcomes communicated to the referrer and/or GP.

When a referral has been screened and reviewed by the MDT and deemed **NOT** suitable for our services, a letter will be sent to the referrer and GP instructing that the referral has been rejected and provide a rationale based on the decision made. This outcome will also be documented on EMIS.

7. Assessment Processes

The assessment tools used within the Community Mental Health Team are the Initial Assessment Tool (IAT) and the Brief Assessment Tool (BAT); both tools are embedded within EMIS. These tools provide a full overview of all presenting problems, care needs and treatment goals to enable the clinician to formulate a plan using a holistic approach to person centered care.

7.1 Initial Assessment

The Initial Assessment Tool (IAT) will be utilized for all new referrals. Patients will have a full IAT completed as part of the assessment process. The tool is designed to be used by all professional groups undertaking initial assessments.

The tool is a dynamic document and, depending on the patient's difficulties, service setting and other circumstances, might require to be completed over more than one contact. It is important that the tool is updated with the outcome of any Multi- Disciplinary Team discussions that have been undertaken and a treatment plan agreed. All record keeping will be as per NHSGG&C Professional Standards for Record Keeping and Documentation (2020).

All Initial assessments require an accompanying completed CRAFT and Mental Health Risk Stratification rating.

7.2 Brief Assessment Tool

The Brief Assessment Tool (BAT) is used for all urgent and emergency referrals.

During the assessment, process staff will collate information from the patient that will include a history of any known illness, presenting problems, family history, sensitive routine enquiry, veteran's status, substance misuse and any forensic history. Following the collection of information staff will complete the Clinical Risk Assessment for Teams (CRAFT) documentation.

The assessment and management of risk is an integral part of the assessment documentation and is an on-going process with constant consideration to Adult Support and Protection and Child Protection. All patients will have a current completed CRAFT risk assessment and associated risk management plan.

MHS 07 - Clinical Risk Screening and Management Policy

Risk assessments and management plans will be routinely reviewed at MDT.

Reviews will be recorded on the Community MDT Template on EMIS, to evidence that CRAFT has been considered and discussed (the frequency of MDT reviews will be outlined in the risk management plan and will occur as a minimum annually. Out with these times risk assessments will be updated at points of transition. These include any change to presentation or risk management plan, transfer of care and on discharge from a service.

All information relating to risk assessment and risk management plans will be recorded in the patient's EMIS record. Complying with policy, information relating to the patient's risk assessment and management plan will be communicated in a timely, concise, and effective manner to all those concerned in providing care, including external agencies where appropriate.

7.3 Family Carer Involvement

In relation to the Carers (Scotland) Act 2016, it is the organisation's duty to involve family/carers in the patient's journey. During the assessment process, staff must ascertain if the patient provides consent to having family/carers involved. If consent is obtained, then this must be clearly documented within the assessment paperwork.

The data field within patient registration (Family/Relationship Links) on EMIS covering consent to share information and this should be clearly visible in the notes. If a patient does not give consent and does not want family/carer involvement, then this also must be clearly documented within the assessment paperwork to ensure no information is shared. All EMIS alerts should be dated to aid ease of review. This does not preclude staff from **listening and heeding concerns from family/carers raised and documented in the Electronic Patient Record.**

Data field within patient registration (Family/Relationship Links) on EMIS covering consent to share information. Consent Status can change and should be considered at each patient contact, if consent status changes the staff member must inform the family/carer of decision and ensure that appropriate documentation is completed. Data field within patient registration (Family/Relationship Links) on EMIS covering consent to share information.

Carers are entitled to assessment of needs and support plan. This may be done by third party organization i.e., carers centers or social work in integrated teams.

7.4 Assessment Feedback/Allocation/MDT

Following completion of an assessment, information should be shared at assessment feedback sessions which take place minimally once per week. Feedback sessions will be facilitated by senior staff members from either medical, nursing, psychology, occupational therapy, and social work (integrated teams). All professions should have representation at the feedback meetings. Formulations from initial assessments, team assessments and assessments requiring multidisciplinary input, will be presented, and discussed. Reviews should be clearly documented on EMIS, including risk, primary concern and analysis plus MDT agreed plan.

Administrative support to be provided for allocations meeting to record outcomes on EMIS and allocate to appropriate discipline.

If following initial assessment, the patient is allocated to a different discipline then a profession specific assessment may be required. The assessment and a plan for the delivery of treatment interventions and expected outcomes should be completed within 4 weeks. The outcome of the assessment is discussed, and the plan of care will be agreed and shared with the patient and their carer (with consent). A copy of the assessment summary will be sent to the referrer and or GP, within 2 weeks following completion of the assessment.

8. Core Functions

CMHTs within NHSGGC will comprise of staff qualified in a range of disciplines including Nursing, Psychology, Medicine, Occupational Therapy, Social Workers, Pharmacy, Peer Support Workers, and Business Support.

A competency-based approach will be taken by all staff to ensure that clinical interventions can be delivered safely, and core values are upheld to ensure caring: compassionate, person-centered, recovery focused, engagement, listening, shared understanding; containment and optimism are the qualities encouraged and demonstrated by all staff.

The CMHT embraces a trauma informed approach and all staff are encouraged to be psychologically minded, which will be supported through training and the delivery of this will be routinely monitored through supervision arrangements. The aim of all support provided is to assist the individual in their recovery – if not to full health, then to the point of enjoying the best possible quality of life and the ability to self-manage.

A person centered care plan will be written with the patient to include the treatment and interventions to meet the patient's needs; the staff involved; the frequency of appointments; where possible an estimated length of treatment; the aim of the treatment. Person Centered Care plans will include risk assessment and risk management plans, identifying sources of support if in crisis and if treatment is needed outside of office hours and requires access to unscheduled care services. There may be exception in care plans for social work as a completed single shared (or community care) assessments and support plan, as recording is held on separate system.

Where practicable, an MDT positive risk management process will take place, which encourages and supports people to achieve personal change or growth. Secondary care mental health service works with patients with complex ongoing psychological needs potentially with a number of risk factors this could include a spectrum from vulnerability, risk of self-harm behaviors, harming others, and suicide. The service will work in accordance with relevant clinical guidance and evidence-based practice. MHS 41 - Suicide Reduction Guidance

Owing to the multi-disciplinary structure of the CMHT the support provided could involve a range of different approaches including:

- Medical Support
- Support the individual to improve the way they view themselves and how to deal with stressful situations
- Supporting the individual to access other agencies in order to receive the tailored support needed
- Peer support
- Short-term circumscribed work if the individual's needs can be met by time-limited interventions.
- For a small number of individuals who have significant difficulty in engaging with services, an assertive outreach approach can be adopted
- Physical health monitoring as stipulated by patient's main diagnoses, prescribed medications, and any co-morbid medical conditions. For further guidance on the agreed split responsibilities between primary and secondary care for psychotropic medication, please refer to the NHS GG&C Primary Care Psychotropic good practice guidance (2023) Primary Care Psychotropic Good Practice Guide

- Support with employability, with appropriate application of AHP health and work report
- Support to look at day to day activities and functioning
- Psychological evidence-based interventions - www.matrix.nhs.scot
- Social Work: provision of community care assessments, carers assessment, support plans, provision of formal support services through the Social Care (Self-directed Support) (Scotland) Act 2013, inquiries into vulnerable adults under both the Adult Support and Protection (Scotland) Act 2007 (ASP) and Adults with Incapacity (Scotland) Act and provision of care for destitution under the Social Work (Scotland) Act 1989.

Treatment provision may vary across localities.

Where group interventions are available for a particular condition, these may be offered in the first instance. All patients referred for group interventions will meet the criteria for treatment from secondary care mental health services.

The CMHT will also work with other parts of the community to jointly produce programmes and educational packages to promote self-management:

- Residential and nursing homes
- Day or voluntary services
- Primary Care Services, e.g. Community Link Workers
- Partner Agencies
- Social Services

The CMHT supports the individual's recovery journey and wellbeing by offering a range of groups and resources to support fulfilling their potential. These courses are linked to your local resources.

The aim is always to work towards discharge from secondary-level care with ongoing recovery. It is recognized that there will be certain cohorts of patients in CMHTs where long term support and treatment is appropriate, which will be provided in line with ongoing clinical review and need.

In line with a recovery approach, there will be no assumption of a life-long intervention from the secondary care mental health service.

8.1 Digital Services.

Mental health services now utilise a range of effective and efficient options of delivering care including telephone consultations, video conferencing using the NHS Attend Anywhere (Near Me) system and therapeutic groups, which have been provided predominately via MS Teams. These approaches should be applied if clinically appropriate, provide an opportunity for services to adapt and support more flexible ways of delivering services as well as patient choice on how they would like to receive services.

Link to VPM Guidance

8.2 Medicine Processes

The use of medication is an important therapeutic intervention in the care of many patients on the caseload of a CMHT. Activities in relation to medication use within CMHTs include but are not limited to.

- Prescribing
- Side effect monitoring and management
- Patient concordance and education
- Depot and long-acting antipsychotic injections
- Clozapine
- Safe and secure handling of medicines
- Incident management

8.3 Prescribing

Medication prescribing within CMHTs will be undertaken by medical staff and non-medical prescribers. All prescribing activity will comply with mental health services and GGC policies, systems, and guidelines Medicines Companion (nhsggc.org.uk).

Side effect monitoring and management

CMHTs will develop local systems and protocols to support the on-going assessment, monitoring and management of patients under their care prescribed psychotropic drugs.

8.3.1 Only prescribe and continue psychotropic drugs where there is a clear indication, evidence base and benefit to the patient.

8.3.2 Support GPs by ensuring that our clinical and discharge letters (especially at points of transition or change in risks or presentation) contain clear and detailed advice on the following:

- Diagnosis and reason for ongoing prescription
- For unlicensed indications, a clear evidence-based rationale
- What adjustments to the dose would be appropriate to try if necessary?
- Actions to consider if medication needs changed or stopped due to side effects or compliance
- Is it a case of just monitoring the patient's mental state or should an alternative treatment be considered?
- Should it trigger re-referral or a telephone/email discussion with a secondary care colleague?
- CMHTs will develop local systems and protocols to support interventions that improve concordance with prescribed medication and support the educational needs of patients with regards to oral medication, depot, and long-acting antipsychotic injections. This can be considered via the following practical steps:
- Formally assessing compliance and identifying appropriate strategies to improve concordance.
- Supporting patients to access blister packs via their local pharmacies when appropriate. Please note blister packs per se do not guarantee improved compliance. It should also

be noted that community pharmacies have limited capacity to provide blister packs. Other approaches to improving concordance (education, medicines charts, prompting) should be attempted before requesting blister packs.

- Establishing good communication with local pharmacies so that patients who default from collecting prescriptions are picked up at an earlier date.

Depot and long-acting antipsychotic injections are commonly prescribed and administered within CMHTs, either in dedicated clinics or in patients' homes. CMHTs will have SOPs to support the safe prescribing and administration of depot and long-acting antipsychotic injections. The standards described in the MHS depot good practice statement.

MHS 30 – Good Practice Statement Depot and Long Lasting Antipsychotic Injections

8.4 Communication with GPs

Please refer to the NHS GG&C - Supply of Medicines Following Specialist Review Additional Guidance for Mental Health, approved by Prescribing Management Group (Mental Health) August 2020.

Up to date information about prescribed psychotropics and specific instructions or requests, should be communicated to GPs via clinical requests in accordance with the above guidance, which also includes template letters for reference. All GP practices within NHS GGC have access to secure NHS.Scot addresses used to send patient identifiable information. Electronic documents will be created using the document management system, Winvoice Pro, and will be delivered electronically to GP practices.

- For anything urgent (i.e., needed the same day) the Mental Health prescriber should phone the GP, discuss the request, and obtain their agreement to issue an urgent prescription.
- Everything else will be classed as non-urgent and patients should be told that it will be at least 48 hours from the time the GP receives the request before any prescription will be ready to collect.

Restrictions on dispensing arrangements: For some patients with complex needs who have acute or chronic high risks of overdose or stockpiling psychotropics, aside from regular rationalization of prescribing, dispensing arrangements can be restricted by the prescriber. For example, daily dispensed or twice weekly dispensed. This can be tailored over time to changing presentations. Direct reference should be made in the communication to GPs following overdoses or stockpiling risks, with regards to prescription of further medication and any limits on what this should be and the frequency of the prescription, patient concordance, and education.

8.5 Clozapine prescribing and monitoring.

The safe prescribing and monitoring of clozapine treatment is a key responsibility of all adult CMHTs. Prescribing will be the responsibility of the RMO, and monitoring will be undertaken in clozapine clinics. Each clinic will have a set of appropriate SOPs describing local systems and processes, which will meet the MHS Clozapine Service Standards.

MHS MRG 03.1 - Clozapine Service Standards

Clinics, though hosted in adult CMHTs, will have a geographic remit to support clozapine patient in their catchment area regardless of mental health specialty.

8.6 Safe & Secure Handling of Medicines

All CMHTs will order, store, and safely manage medicines in accordance with the relevant GGC policies and procedures. GGC Medicines: SSHM Policy

8.7 Incident management

All medication related incidents will be reported and investigated as required by the GGC Incident Policy and guidance provided that all incidents including near misses will be recorded on Datix.

8.8 Care Programme Approach

For some patients, care will be arranged and managed through the specific guidance and standards as outlined in the Care Programme Approach (CPA): MHS 45 - Care Programme Approach Guidance

CPA is a package of care used in secondary mental health services. Service users will have a care plan, and this will be coordinated through CPA Coordinator. All Service Users under CPA must also have a crisis plan.

CPA aims to support recovery in mental health that focuses on patient's goals, strengths, support needs and difficulties. Arrangements for review, including review date or any triggers for review (e.g., expected legislation).

8.9 Patient Initiated Follow Up (PIFU)

As part of the follow up pathway within CMHTs, all clinicians are responsible for considering whether any of their patients on their caseload are suitable to be placed on the Patient Initiated Follow Up (PIFU) pathway. This involves having a shared decision-making conversation with the patient explaining the options, risks, and benefits. The patient has the option to decline to move to the PIFU pathway if it does not meet their individual needs or circumstances.

Further guidance on the process to be followed when placing a patient on PIFU including how to review patients can be found here: PIFU Guidance for Staff

8.10 Service and Patient Risk Stratification

Patient stratification is routine practice for all disciplines; it helps to identify those with greatest risks and needs, promoting prevention and early intervention care. It is the role and responsibility of the patient's lead/key worker to complete, review and update the patient's status as necessary following each contact.

Low risk patients indicate readiness for discharge, PIFU or may have a short-term treatment plan in place.

Guidance Document for EMIS template for patient risk stratification

9. Duty

Each CMHT will provide a Duty service from 9am – 5pm Monday to Friday (excluding public holidays). This service will be provided by a named qualified member of staff (Duty Person) within the CMHT who can access to the Team Lead or Senior Practitioner for advice, support and decision-making. Each team will be responsible for assuring a support structure is available. In integrated teams, social work have a separate duty system to deal with safeguarding issues.

The Duty Person is available:

- For existing patients who cannot reach their lead professional or care coordinator and have an urgent mental health need
- To offer advice and information to other agencies
- To discuss and respond to telephone referrals
- To screen all referrals for urgency and information to complete an appropriate level of screening and risk assessment
- To assess emergency referrals, open to CMHT's presenting to duty
- To review information / communications from Unscheduled Care Services
- Review out of hours tasks daily and determine appropriate action required e.g., desk duty to follow up / for information / pass to allocated work to take forward.

The Duty Person will provide a safe timely response to changing risk and consideration of stepped-up care. This may include allocation of appointment to attend same day or home visit when:

- There is significant change in the patient's circumstances
- Known 'risk triggers' are activated
- There are safeguarding children and / or adult support and protection issues or concerns
- A duty diary will be utilized to capture activity, staff undertake tasking on Emis.

10. <u>Discharge Planning/Transfer of Care</u>

Consideration and planning for discharge are an integral part of ongoing care planning. Discharge from the CMHT will be arranged following the implementation of a plan of care and following discussion with the patient, and where appropriate, carers / other professionals / agencies involved in their care. All patients will have advance notice of an intention to discharge/transfer and be provided with clear information in relation to any future access to services.

Prior to discharge, it is essential that risk assessments are updated as per policy (MHS 07 Clinical Risk Policy) and in relation to the Mental Health (Care and Treatment) Act 2003, Adult Support and Protection Act 2007 and Child Protection issues. The outcome of these assessments must be recorded within the integrated health record and shared as appropriate with agencies involved in the patients care.

A written discharge summary will be provided to the GP within 2 weeks of discharge. Information provided to the patient at discharge will include:

- A summary of interventions provided
- The effectiveness of those interventions

- Recommendations for the ongoing or future treatment (including medication)
- Identified triggers and / or an indication of the early warning signs of future deterioration of the individual's mental health
- Arrangements for referral back to CMHT if required
- The patient's views on discharge
- Note if any educational or resources materials have been provided.

The discharge summary will be filed in the patient's health record stored on EMIS, and for social care either Care First or Eclipse.

Appendix

Mental Health Services Interfaces with Services and Teams

Service Principles: Points of Interface:

Both the NHS GGC Service Specification for Mental Health Services in the Community (2016) and the CMHT Operational Framework (2016) describe in detail the principles that underpin the operation and function of Mental Health Services the service. For points of interface, the relevant principles can be summarized as:

- Patients will receive appropriate treatment with a minimum of delay with "easy in - easy out" access to and discharge from the service.
- CMHTs will provide the "minimum effective intervention" in a "stepped care" model.
- The CMHT will work flexibly to engage patients; family and carers in the delivery of services that are patient user focused and seek to include patients and carer representatives in the planning and review of care plans.
- CMHT staff will practice within a core set of values which are based on a safe, effective and person centered approach to care and service delivery.
- Quality care depends not only on the overt, measurable aspects of service delivery (medicines prescribed, visits completed), but also on less tangible qualities such as engagement and compassion, good customer care and meaningful therapeutic relationships.
- All staff working in CMHTs will comply with the NHS Scotland Code of Practice on Protecting Patient Confidentiality, the Data Protection Act (1998) and Caldicott guidance. Information will be managed and shared in accordance with NHSGGC Information Sharing Protocol.
- CMHTs will work with a range of services and partnership working is actively promoted as a mechanism for improving health and social care outcomes for patients.

In relation to specific interface situations, CMHT staff practice will be underpinned by principles of professional collaboration, proactive communication, and coordination of care. In doing so, CMHT staff will aim to minimize delay, duplication, unnecessary assessments and facilitate access to appropriate services for patients.

All services will have mutually defined boundaries with no gaps in delivery of patient care. Access between Core Mental Health Services is by transfer rather than referral, and agreement that between Core Mental Health Services it is the responsibility of the transferring team to facilitate appropriate sharing of information to ensure the transfer is clinically appropriate and meets the eligibility criteria for the receiving service.

Crisis Services/IHTT

Crisis Services provide a comprehensive mental health service whose first goal is to provide mental health care, treatment, and support as a credible alternative to hospital admission or prolonged inpatient care. The service delivers a safe alternative to hospital care, promoting emotional strength and reducing the impact of mental health crisis through intervention, education, prevention, and community collaboration.

The Crisis Service whose core functions are to:

- Offer short term intensive community-based treatment as a credible alternative to hospital admission.

- Manage all requests for access to inpatient care and provide assessment of suitability for home treatment as an alternative admission.

- Work in collaboration with Acute Inpatient Mental Health Service to facilitate and support patients on pass and discharges from hospital for individuals that home treatment is deemed to be appropriate for.

MHS – Glasgow City Crisis Service – Standard Operating Procedures

Perinatal Mental Health (PMHS)

PMHS provide services to pregnant and postnatal women, their babies, and families from Monday to Friday 9-5pm. The service provides a high level of support for patients and facilitates early discharge from the Mother & Baby Unit (MBU). Where it is necessary to involve the PMHS the CMHT where possible, will instigate a referral for a joint assessment to ensure a quick outcome that supports continuity of care, good communication and the provision/availability of specialist advice from the referring service. If a first presentation is made via the CMHT and appears appropriate for the PMHS, the CMHT will liaise with PMHS on identification of roles and responsibilities for ongoing care.

MHS 49 - Perinatal Mental Health Service Operational Policy

Early Intervention Psychosis (Esteem)

Esteem, first episode psychosis service works based on assertive outreach principles and will usually be expected to manage care, joint assessment would occur to ensure continuity of care, good communication and the provision/availability of specialist advice from the referring service.

MHS 10 - Early Intervention Psychosis

Complex Needs Service

The Complex Needs Service provides direct access to homeless/complex needs people and provides assessment and treatment for mental health problems within this population. Many people are difficult to engage with due to their chaotic and often transient lifestyles. The service operates on a pro-active assertive outreach basis. Homeless people's mental health problems are often complex and there is a high level of co-morbidity within this group. The service operates between the hours of Monday to Friday 9-5 pm.

Forensic Mental Health

The Directorate of Forensic Mental Health provides a range of services, including in-patient services at Leverndale Hospital and Rowanbank clinic at Stobhill.

Rowanbank Clinic provides dedicated admission beds for people requiring a level of security greater than that currently provided within adult admission wards and IPCUs.

The Forensic Directorate also provides an out-patient and community service for those people continuing to require the input of a Forensic Psychiatrist, which may or may not include input from the rest of the multi-disciplinary team. However, this service only operates between the hours of Monday to Friday 9-5pm. All out-patients who have a CPN attached to their care will have relapse plans indicating. The CMHT interface with the Forensic Service will predominately concern the Transfer of patients from one service to the other.

MHS 09 - Adult Mental Health and Forensic Services Shared Guidance and Specification for Interface Working

Adult Mental Health Liaison Service (AMHLS)

AMHLS provides a service to people within the acute hospital setting. The service provides specialist mental health assessment for patients presenting at Emergency Departments, admitted into acute beds following an episode of Self Harm and for complex physical and mental health concerns.

AMHLS operational hours are Monday to Friday 9-8pm, Saturday, Sunday, and Public Holidays 9-5pm.

MHS 62 - Adult Mental Health Liaison Service SOP Mental Health Assessment Units (MHAU)

Mental Health Assessment Unit (MHAU)

The MHAU is a specialist service, which provides an assessment, diagnosis and management to patients who are presenting in mental health crisis/distress and would have sought assistance through self-presenting at an Emergency Department or accessed assistance via Police Scotland or Scottish Ambulance Service.

MHAU offer one point of access 24/7 for emergency same day profession-to-profession mental health assessment. The service aims to provide patients with a full psychiatric evaluation including mental health risk assessment with appropriate treatment and follow-up arrangements.

Mental Health Assessment Unit (MHAU) SOP outwith these hours access for same day emergency mental health assessment for patient presenting at Emergency Departments would be via the Mental Health Assessment Units.

MHS 60 - Mental Health Assessment Unit (MHAU) SOP

Alcohol Drugs & Recovery Service (ADRS)

ADRS are integrated services comprising of social care staff, RGN, RMN nursing staff, psychology, occupational therapy, and medical staff. The service operates Monday to Friday 9-5pm covering Glasgow City, Clyde, East Dunbartonshire, West Dunbartonshire, and East Renfrewshire.

The service is targeted at people with problems with alcohol and illicit drug use with mild to moderate mental health needs. On occasion, there will be people who present with acute mental health problems such as suicidal ideation, cognitive impairment, and psychosis.
ADRS deal with delirium as medical emergencies.

There may be occasions where joint working with the CMHT is required and the provision of a joint package of care to prevent deterioration in Mental Health and hospital admission.

It is expected that the RMN within the ADRS would ensure that a comprehensive drug, alcohol, and mental health assessment is provided to the CMHT on request for joint working. This is to ensure that interventions are initiated based on efficient communication, which identifies and addresses the needs of the person.

MHS 03 - Adult Mental Health – ADRS Interface Policy

Acute Psychology Services

Acute psychologists work within acute hospitals providing psychological assessment, formulation and therapy across several ring-fenced specialties such as cardiac rehabilitation, chronic pain service, specialist weight management service, cystic fibrosis and neurology services, to name a few. Depending on the service, they can provide psychological practice within inpatient, outpatient and home settings.

Access to psychological practice within this setting is not defined by a mental health presentation or diagnosis per se, but by the need for specialist psychological opinion or intervention in relation to, and as a direct result of physical health presentations. This may include pre-operative assessments, neuropsychological assessments, adjustment work and working with depression or anxiety that has occurred as a direct response to illness, its treatments and consequences. In some cases, it may include working with people with premorbid mental health presentations, but the focus of the work will be delivered in the context of their current physical health presentation and not on their pre-existing mental health difficulties.

Psychology staff working in this field are usually embedded within the physical health speciality multidisciplinary care teams and are most often the only team member with specific mental health training. As such, it can be the case that it is appropriate and necessary for acute psychologists to provide therapy to patients who are concurrently attending their local CMHT, and in some cases to seek access to a local CMHT when the assessed difficulties are independent of the patient's physical health difficulties or when significant risk has been identified.

Glasgow Psychological Trauma Services (GPTS)

GPTS provide a service from Monday to Friday 9-5pm. The teams sit at Tier 3 in the mental health network, are Psychology led and are aimed at people with moderate to severe mental health problems who are suffering psychological/psychiatric problems

because of complex traumatic events. The teams provide consultation, training and shared assessment to staff working with these clients. The teams also provide therapy to clients who are often concurrently attending their local CMHT and may have a history of in-patient admission.

GPTS work closely with CMHT's. There are no psychiatrists in GPTS and in the event of a psychiatric emergency; there will be a need to link in with existing provision through the CMHT/Crisis Service structure.

Older Adult Mental Health:

Older Adult Mental Health Services are predominately for patients over the age of 65. The predominate interface between Adult and Older Adult community services will be Transfer of care between services. Continuity of care should take precedence over automatic referral to Older Adult Services for physically well people without dementia over the age of 65 years.

The guidance outlines the principles for management of people with enduring mental illness who have reached or are over the age of 65, and of people under the age 65 who develop significant cognitive impairment, particularly dementia.

MHS 27 - Guidance for the transfer of Graduate patients from Adult to Older Adult services