1. INTRODUCTION

1.1. East London and the City Mental Health NHS Trust (Tower Hamlets Locality) and London Borough of Tower Hamlets Social Services have made a commitment to integrated Community Mental Health Teams (CMHT’s). This is in order to provide a coherent and comprehensive community mental health service which will incorporate the best features of multi-disciplinary working.

1.2. This has been done in line with national policy and guidance\(^{(1-9)}\) and is intended to prevent the duplication of service provision. The teams will provide one gateway into community mental health services, to ensure ease of access. Both organisations are committed to ensuring equality of access for all clients.

1.3. The purpose of this policy is to provide an internal document for CMHT members which details policies and procedures, standards and expected ways of working. It defines the organisational parameters within which team members will operate. It will not define clinical or specialist interventions, as these are more appropriately dealt with in the domain of professional judgement and clinical practice.

2. PRINCIPLES

2.1. To enable people to maximise their potential by helping them build on their strengths and overcome potential barriers to social, economic, physical and psychological functioning.

2.2. That support or care should be designed to promote independence and empower an individual to make his or her own personal decisions and choices.

2.3. The care of people with mental health problems should be within the least restrictive environment compatible with their needs, and the needs of those around them.

2.4. That users of the service and their carers should be encouraged to take part in the planning and management of services, and to play an active part in the choice and design of their individual packages of care.

2.5. To ensure that people with severe and enduring mental health problems receive priority in the allocation of resources.

2.6. To enable people with severe and enduring mental illness to achieve as high a quality of life as possible by maximising their potential for independent living.

2.7. To make information about services easily available to users and carers, and presented in a range of relevant languages.

2.8. To enable users to access services that are culturally sensitive and anti-discriminatory.
2.9. To provide information, support and care in response to needs of carers, including young carers, of those with severe mental illness.

2.10. To work with other services in the statutory and voluntary sector in order to meet the needs of service users and their carers.

### 3. Service Objectives

**The team will seek to:**

3.1. Provide a timely and appropriate response to requests for help.

3.2. Provide a comprehensive assessment of a person’s needs which will, where appropriate, include members of the family and carers.

3.3. Develop a care plan with the service user, and their family or carers where appropriate, which is individually tailored to meet assessed health and social care needs.

3.4. Ensure services are delivered to meet assessed needs, through either the provision of a range of therapies and interventions delivered by the CMHT, or through the purchasing and co-ordination of other services.

3.5. Be sensitive to issues of ethnicity, sexual orientation, disability and gender in the assessment and care planning process, and offer services appropriate to local cultural and religious norms.

3.6. Monitor and regularly review individual care plans with full involvement of the service user, and family or carers where appropriate.

3.7. Maintain effective working relationships with other statutory services, and those in the independent sector, to deliver a high quality comprehensive mental health service to the local community.

3.8. Provide appropriate support for mutual/self help groups and voluntary sector services.

3.9. Promote a positive image of mental health within the community through high standards of professional practice.

### 4. Equal Opportunities Statement

4.1. The CMHT is committed to the principles of equal opportunities. The local population we serve is multi-cultural and the people who use our service have a wide range of needs. We aim to ensure that no person receives less favourable treatment on any grounds (e.g. religious or cultural beliefs, gender, ethnicity, sexual orientation, or disabilities) and will
actively seek to promote access to our services by people from the Black and Asian communities and other groups which may be disadvantaged.

4.2. We will not tolerate discrimination, harassment or abuse of any form, and complaints about any user or member of staff against other users or members of staff will be dealt with seriously and swiftly in all cases. We will not tolerate discrimination in service delivery and will monitor the care we offer to ensure equality of access to services for all users.

4.3. We will monitor our progress in equality of opportunity in the employment of team members.

5. BOROUGH PROFILE

5.1. The population of East London (covering the boroughs of Tower Hamlets, Newham, Hackney and the City) is characterised by its ethnic diversity, higher proportion of young people, numbers of refugees and asylum seekers and high levels of overcrowding and poverty. All of these factors contribute to disproportionately high levels of ill health amongst the residents of these boroughs.

5.2. Recent projected figures show the population of Tower Hamlets to be 177,000, of which approximately 112,500 are adults [see Appendix I for further breakdown]. The ethnic breakdown of the population of Tower Hamlets in 1997 showed that 60% are White, 26% are Bangladeshi, and 6% are from African and African-Caribbean background, with the remaining 8% from other ethnic populations. Pupil population studies showed that Tower Hamlets school population in 1998 was 54% Bangladeshi, 30% White, 8% Black African and Caribbean, with the remaining 8% from other ethnic populations.

5.3. Based on Department of Environment and Transport figures in June 1998, Tower Hamlets was shown to be amongst the six most deprived local authorities (along with Newham and Hackney). Tower Hamlets has a 13.6% unemployment rate, compared with an inner London average of 9.6% and a national average of 4.6%. 23,298 (14.5%) of the Tower Hamlets population has Long-Term Limiting Illness. Homelessness is over three times the national average, and overcrowding is shown to be the worst in the country, with 13% of households overcrowded (42% for the Bangladeshi population).

source: LBTH, 1999 (10)

5.4. Estimated figures in 2001 show that over 2,000 people within the borough are under the care of secondary specialist mental health services, with approximately half of these under the enhanced level of the Care Programme Approach. Mental Health Act activity in the year 2000 showed 384 episodes of detention for assessment or treatment (Sections 2, 3, 4, 35, 37 and 48). Bed occupancy for acute in-patient psychiatric beds is 120% as against a national average of 80%.

5.5. There exists a Directory of Mental Health Services for Tower Hamlets (11), including health and local authority services as well as other relevant services around mental health. It also includes more general information such as education, training and leisure facilities and
chapters, which are specifically for older people, parents and younger people. A similar directory is currently in production for services across East London.

6. **COMMUNITY MENTAL HEALTH TEAM COMPOSITION**

6.1. The Borough will be serviced by four joint Health and Social Services Community Mental Health Teams, two in the East Sector and two in the West. These are currently based around geographical localities, although will be in the future defined by General Practitioner (GP) clusters. This will be considered further in the Review of Community Mental Health Services due to take place in 2001 as required by the National Service Framework for Mental Health(7).

6.2. Within each team, a specialist Access and Assessment (referred to throughout this document as ‘Access’) function exists to receive referrals, to provide consultation, information and assessment, to engage in short-term work and, where appropriate, to assist in referring on to other statutory or voluntary agencies. There is also a Case Management function, which targets resources towards those with severe and enduring mental health problems. Assertive Outreach workers provide input for users who have more difficulty engaging with services. The teams also provide statutory mental health assessments under the Mental Health Act (1983).

6.3. All four CMHTs will have the following structure:

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**Figure 1**

- **Team Manager** (PO4 / SMP 20-18)
- **Senior Practitioner**
  - **Access**
- **Case Management**
  - **Senior Practitioner**

one from health background
one from social background
6.4. A single line management structure will operate across the Health and Social Services staff. The Team Manager will have overall managerial responsibility for the team and, in turn, be accountable to the respective Sector Manager.

6.5. The teams will comprise of mental health nurses, social workers, occupational therapists, psychologists, support workers, and team administrators. Medical staff, although not operationally accountable to the Team Manager, will be directly linked to the teams.

**Role of the Team Manager:**

6.6. The Team Managers will provide supervision and development for the Senior Practitioners, will be involved in the development of local services, will liaise with their Sector Manager, and will be responsible for the general development and day-to-day running of the teams. They will be responsible for budget management, administering the Care Management budget under the supervision of the respective Sector Manager. They will manage the recruitment process to ensure an appropriate skill mix exists within the team, and will liaise with the training department(s) to provide suitable training for staff. They will also have responsibility for investigating serious incidents and complaints.

**Role of Senior Practitioners:**

6.7. The Senior Practitioners will supervise a group of staff, operate duty systems and provide senior support, ensure a good quality of care delivery and ensure that policies and procedures are adhered to. They will also retain a small, specialised caseload and provide specialist advice. They will meet regularly with the Team Manager, and will be involved in the planning and development of the teams, including recruitment and training issues.

7. **TARGET CLIENT GROUP**

7.1. The integrated adult community mental health service is primarily established to respond to the needs of adults of working age living in Tower Hamlets experiencing severe mental health problems.

7.2. The guide for defining severe mental illness, as outlined in the East London & The City Care Programme Approach (CPA) Policy, and adopted from national policy is as follows:

<table>
<thead>
<tr>
<th><strong>Safety:</strong></th>
<th>History of significant violence, self-harm or self-neglect or at risk of exploitation due to mental illness.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Informal/Formal help:</strong></td>
<td>Need for intensive support in the community either from informal carers or from formal services e.g., more than one contact with specialist services per week, involvement of two or more agencies or subject to Section 117 of the Mental Health Act, supervised discharge or a restriction order.</td>
</tr>
<tr>
<td><strong>Diagnosis:</strong></td>
<td>Presence of a mental disorder including psychotic illness, severe neurotic disorder, personality disorder, dementia.</td>
</tr>
<tr>
<td><strong>Disability:</strong></td>
<td>Severely impaired ability to function effectively in the community to the extent at which the person may be at risk of serious self-neglect.</td>
</tr>
<tr>
<td><strong>Duration:</strong></td>
<td>Length of illness of greater than one year or likelihood of illness persisting, three or more admissions, or aggregate total of one year stay in past five years.</td>
</tr>
</tbody>
</table>

_N.B._ Not all of the above ‘conditions’ need to be met for a person to be regarded as severely mentally ill.
7.2.1. **For example:**

*a person who has a chronic illness but who has not been in regular contact with services might still be regarded as a severely mentally ill person; an individual who presents for the first time with florid symptoms should also be regarded as suffering from a severe mental illness; person with a very serious phobic disorder which was not necessarily chronic, but resulted in very considerable disabilities would also fall within this remit; and the person can be severely mentally ill without occasioning significant risk to their own safety or that of others.*

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**The target client group for the CMHT’s are:**

7.3. **Aged between 18 and 65, although flexibility will operate at either end of the age range in order to ensure that individuals receive the most appropriate service.**

7.4. **Living in Tower Hamlets. For those people who are currently street homeless, contact will be made with the Homeless Health in East London Project (HHELP) team to check if they are known, or of they will become involved. If the HHELP team will not become involved, homeless people will be taken by the teams on a rotational basis. People in homelessness accommodation, not being managed by HHELP will be dealt with on the basis of location of accommodation.**

7.5. **Having a severe mental illness as defined in the East London & The City CPA Policy [see 7.2]. The service will prioritise people with a severe and enduring mental illness.**

7.6. **Individuals with the following problems will be the primary responsibility of other services:**

- People whose primary problem relates to substance misuse.
- People whose primary problem relates to accommodation difficulties.
- People whose primary problem relates to learning difficulties.
- People who suffer from mental distress such as anxiety, phobias and depression as a reaction to life events, but who are able to access services themselves without intensive help. In these cases, referrals should be made directly to other mental health-related services, such as the counselling service.

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### 8. Referrals and Screening

8.1. **A single point of access to both health and social care will operate. The main point of access to the service is via the Community Mental Health Team’s Access staff who will process all new referrals to the service to determine the most appropriate service response. This will be according to the individual’s needs, severity of mental health problem, and anticipated length of service contact.**

8.2. **Referrals will be accepted from the A&E Liaison Service, Social Services Access Team, Emergency Duty Team, other sections within Social Services, in-patient services, GP’s,**
other Primary Care services, police, criminal justice agencies, voluntary agencies, members of the public (including carers), and other mental health services transferring care.

8.3. Self-referrals will be dealt with as any other referral, such that the Access worker will take information as part of the screening process, offering support and advice as appropriate [see also 8.5].

8.4. Referrals from GP’s will be either a referral to the team where the duty of care is with the GP and team, or referral to the team with an explicit request that the Consultant Psychiatrist is involved. If the involvement of the Consultant Psychiatrist is required later in the screening or assessment process, the GP will be asked to make a written referral to them.

8.5. For any non-GP referrals (including self-referrals), the Access staff will ensure that discussion occurs with the GP as part of the screening process.

8.6. For people who do not currently have a GP, they should be encouraged to register with one and, where appropriate, support will be given in this process.

**Referral information:**

8.7. The CMHT currently works Monday to Friday 9am to 5pm. Referrals can be made by post or fax, or can be telephoned through to the Access staff. Upon referral, the following information will be requested:

- Name, address, gender, DoB, ethnicity.
- Name of GP (if applicable).
- Reason for referral (the staff member should try to ascertain sensitively a brief history of why the referrer feels a service might be needed).
- Degree and type of risk.
- Any other services involved and previous interventions.
- Does the person being referred know?
- Level of intervention required (i.e. CMHT only, or CMHT and Consultant Psychiatrist)

8.8. Checks should be made on all new referrals for any information held in other relevant agencies. All referrals will be prioritised in terms of urgency and appropriateness. Where appropriate, referrers will be informed of the time of the appointment offered.

**Screening:**

8.9. People referred to the CMHT will undergo a screening process based on the information received from the referral to determine their eligibility for a full CPA assessment of their health and social care needs. The screening system will operate via Access workers. People who meet the criteria for assessment will be prioritised for allocation accordingly.

8.10. Requests for assessments will be prioritised by a Senior Practitioner (or Team Manager), who will subsequently co-ordinate the team response. Decisions made about whom will undertake the assessment will be influenced by what is known about the person referred, taking into account ethnicity and gender, and worker availability.
**Urgent Assessments:**

8.11. All requests for Mental Health Act Assessments are treated as urgent. Requests for these will be responded to within 4 hours. An ASW will be allocated within one working day to co-ordinate the assessment in a timely fashion. If the ASW on rota for that day is unable to undertake the assessment, the Team Manager or a Senior Practitioner will allocate the work to another ASW from within the team. Failing this, the Team Manager will contact the manager of the team on the emergency back-up rota for their assistance.

8.12. Situations which come under High Priority of the local authority priority levels (as indicated in the LBTH Care Management Procedures and the East London & The City CPA Policy) may also require a more immediate response. If the Access worker is unable to undertake the response, the Team Manager or a Senior Practitioner will allocate the work to the most appropriate team member. For known cases, the follow-up will be initially allocated to the care co-ordinator, depending on their availability.

**Screening Outcomes:**

8.13. After the screening process has been completed, the service options may include:

- Assessment and brief treatment (this would normally be no longer than 6 months, but flexibility will operate if the situation warrants).
- Assessment and follow-up by Case Management staff.
- Mental Health Act Assessment
- Provide one-off service (e.g. advice/support; freedom pass application)
- Referral onto other specialist mental health provider (e.g. Drug Dependency Unit; psychological treatment service).
- Referral to local voluntary agencies.
- Advice and support to the referrer, with recommendations on further action.

8.14. If the referral does not meet the criteria, the Team Manager will write to the referrer within 10 working days of receiving the referral. This letter will inform the referrer of the reason for non-acceptance, offering advice and appropriate alternatives if necessary. In the case of a self-referral being accepted for assessment, the GP will be informed.

8.15. If the referral is accepted, a letter will be sent within 10 working days to the person being referred, with a copy to the referrer, to inform them that the referral is receiving attention. If, in exceptional circumstances, a professional decision is made not to notify the person being referred, reasons for this must be clearly documented.

**Recording of Information:**

- The staff member receiving the referral will complete the Basic Data Information (CPA1) and Screening Information (CPA3) forms.
- The relevant part of the RAP form will be completed and processed.
- The staff member receiving the referral will also ensure that the referral and outcome is logged on to Mental Health Connection (MHC) and SWIFT.
9. **Assessment**

9.1. Assessments under the NHS & Community Care Act (1990)\(^{(13)}\) and the CPA\(^{(14,15)}\) will be carried out using the principles outlined in the East London & The City CPA Policy. The documentation used will be the CPA forms as agreed by health and social services in Tower Hamlets.

9.2. Following allocation by the Senior Practitioner, a full CPA assessment will be carried out in accordance with the East London & The City CPA Policy, ensuring the following areas are addressed:

- mental health care (including medication)
- any identified areas of risk
- physical health care
- accommodation
- activities of daily living (including self-care; domestic skills)
- employment / education / training / occupation
- finance / budgeting
- cultural and faith needs
- independence
- social networks
- therapeutic leisure activity
- history of previous violence and criminal record
- needs arising from co-morbidity
- service user skills and strengths
- service user views (including hopes and future plans)
- family / carer(s) views and issues (including young carer(s) / children)

9.3. The person carrying out the assessment will assume the role of care co-ordinator until the initial care planning meeting [see 10.4], and will have responsibility for co-ordinating the assessment process. This health and social care assessment provides the baseline which can be built on and used to prevent frequent request being made for the same information from service users and their carers. The care co-ordinator will arrange requests for further specialist assessments as necessary.

9.4. The service user will be as fully involved in the assessment process as possible, ensuring where possible their consent is sought with regards to sharing of information. The requirements of the Data Protection Act (1998)\(^{(16)}\) with regards to the storing and sharing of information will be fully met.

9.5. The service user’s family and carer(s) will be as fully involved in the assessment process as is appropriate. Where a carer is recognised as providing regular and substantial care for the person being offered an assessment, a full carer’s assessment will be carried out in accordance with the Carers [Recognition and Services] Act (1995)\(^{(17)}\) and the Carers and
Disabled Children Act (2000)(18-20). The CMHT staff member co-ordinating the CPA assessment should ensure that the carer has knowledge of their right to such an assessment.

9.6. All assessments will be discussed via the Senior Practitioners (or Team Manager) prior to the initial care planning meeting in order to make decisions regarding the most appropriate outcome of the assessment:

- Follow-up to occur within Access part of the team.
- Follow-up to occur within Case Management part of the team.
- Referral to other service.
- No services to be received.

9.7. Following the CPA assessment, if the person is not to receive any services, a letter will be sent to inform the referrer of the reason for non-acceptance, offering advice and appropriate alternatives if necessary.

9.8. If the person is to receive services, a level of CPA (standard or enhanced) will be allocated as defined in the East London & The City CPA Policy and an initial care planning meeting will be convened, inviting the service user, family/carer(s), and all relevant professionals. It is important, where possible, to include relevant members of both the Access and Case Management parts of the team where transfer is to occur.

9.9. If any concerns arise with regards to children or young people, a referral will be made to Children and Families Services.

Figure 4

Recording of Information:

- The CPA Assessment (CPA5) form will form the basis of the health and social care assessment. Any additional specialist assessments should be attached to this and filed in the notes. At an early stage in the assessment, a Permission to Share Information (CPA4) should be completed. If a carer’s assessment is indicated, the Carer Assessment Part 1: Information (CPA6a) and Carer Assessment Part 2: Summary (CPA6b) forms should be completed.
- The relevant sections of the RAP form should be completed and processed.
- Information should also be entered as necessary on to MHC and SWIFT.

10. Care Planning and Review

10.1. The East London & The City CPA Policy outlines a framework within which requirements of CPA and Care Management are met. The documentation used for care planning will be the CPA forms as agreed by health and social services in Tower Hamlets.

10.2. Following assessment, all service users, unless no follow-up is to occur from within mental health services, will have a written care plan which is devised with them in order to meet
their identified needs. This should focus on the user’s strengths and seek to promote their recovery. It should include interventions devised to meet each need, expected outcomes, person(s) responsible and expected timescales. The service user must be given full information about the care planning process and a copy of the agreed care plan. Every care plan should be ‘signed off’ by a Senior Practitioner or Team Manager.

10.3. Local authority priority levels (as set by the Team Manager or a Senior Practitioner) should be indicated on the care plan when accessing local authority care resources.

10.4. National policy\(^{(15)}\) states that all service users under the enhanced level of the CPA will have a crisis and contingency plan developed with them which will provide information for all agencies and the service user to minimise the likelihood of relapse occurring, along with an agreed 24-hour service response to crisis. It is considered good practice for service users under the standard level of CPA to have similar arrangements.

**Initial Care Planning Meeting**

10.5. Guidelines on preparing for, conducting, organising and chairing initial care planning meetings, along with responsibilities of the chairperson and a ‘meeting checklist’ are outlined in the East London & The City CPA Policy. The purpose of the initial care-planning meeting is to plan the care with the service user and not necessarily discuss the intricacies of treatment within that plan. Practices may differ regarding how meetings are conducted (i.e. the setting; who chairs; when service users / carers attend), but the following minimum standards must always be met:

- The professional delegated to co-ordinate the full assessment (or representative) reports on the needs identified
- The level (standard or enhanced) is reviewed and recorded
- A care co-ordinator is identified (not necessarily the same person who co-ordinated the assessment)
- The chair of the meeting ensures that minutes are taken
- The care plan is drawn up at the meeting (or as soon as possible after)
- **The next review meeting date is set** (DoH requirement)\(^{(15)}\)

10.6. If a decision has already been made following the screening process to transfer the case to the Case Management part of the team, then the care co-ordinator will be a member of that team. In these cases, further care planning and reviews will continue to occur within the Case Management part of the team until point of discharge or transfer to another service.

10.7. Where it has been agreed that the Access part of the team will continue to follow up the case, it is important that the ‘next review date’ is set within a six-month period, when a decision can be made to cease follow-up, or to transfer to the Case Management part of the team.

10.8. If the case is to be transferred at this point to the Case Management part of the team, this should be reflected in the care plan and documented clearly in the notes.

**Care Plan Reviews**
10.9. The care co-ordinator has responsibility to ensure that service users have regular reviews of their care. Guidelines on preparing for, conducting, organising and chairing care plan review meetings, along with responsibilities of the chairperson and a ‘meeting checklist’ are outlined in the East London & The City CPA Policy.

10.10. Review and evaluation of care planning should be regarded as ongoing processes. Frequency of reviews should reflect need and be based on professional and clinical judgement. At each review meeting the date of the next review must be set.

10.11. Discussions regarding transfer from Access to Case management must occur via the Senior Practitioners (or Team Manager), and arrangements should be made to ensure that transfer occurs as a part of the CPA process. Any transfer from Access to Case Management, which may as a result incur changes to care co-ordinator or to elements of the care plan, should be discussed in a CPA care plan review meeting, with the user as a central participant.

**Purchasing of Services:**

10.12. All care co-ordinators will have access to health and social care resources. As services develop, procedures for accessing local authority care resources may change. However, all care plans should be agreed by the Team Manager where budgetary requirements apply. The relevant procedures for accessing these budgets will be subsequently followed.

**Medication Management:**

10.13. Staff should ensure that users’ medication is reviewed regularly, and any side effects noted and reported to the prescribing doctor (or GP). Each service user on depot medication should have a depot care plan, and all nursing staff should follow the Trust’s policies and procedures for storing and administering medication, and standard for administration of medication issued by the UKCC. All care co-ordinators for users whom are receiving medication should be aware of the need to monitor the users’ medication usage.
Recording of Information:

- At all reviews, a Care Planning Record (CPA8) must be completed and filed in the notes. All key people involved in the person’s care, including the GP, the user and, where appropriate, the carer, should have a copy of the agreed CPA Care Plan (CPA9) given to them following an initial care planning meeting or a review. A CPA Contact and Crisis Sheet (CPA10) should be completed for all users under the enhanced level of CPA and circulated to all key people involved in the person’s care as a separate part of the care plan. A copy of this form will also be kept at A&E, and a copy must be sent to them via the CPA Office at St. Clements.

- The following forms should also be completed where necessary:
  - Legal Status Sheet (CPA7) – if MHA (1983) applies
  - Unmet Needs (CPA11) – copied to CMHT manager
  - Review of Care Plan (CPA12a) – can be used as a format for recording minutes of reviews
  - Review of Care Plan (CPA12b) – similarly, but for when the user is in a residential or specialist placement
  - Transfer of Care (CPA17) – for when key changes occur outside of reviews

- The following forms should be completed where Care Management requirements apply:
  - Application for the Provision of a Service / Item for a client (CPA13)
  - Costing of a Care Plan (CPA14)
  - Service Timetable (CPA15)
  - Individual Service Specification (CPA16)

- For each stage of care planning, service provision and review, the relevant part of the RAP form should be completed and processed.

- MHC and SWIFT should also be updated at each and every stage.

### 11. Transfer and Discharge

[see also Appendix IV - Patient Transfer Protocol; issued by NHSE / SSI (February 2001)]
11.1. Any key changes made to a care plan (such as transfer of care from Access to Case Management [see 10.11], transfer from one locality CMHT to another, transfer to another mental health service provider out of area, or discharge from secondary mental services) will usually arise following a CPA review meeting. Therefore, the process for transfer of care or discharge will be usually met under the CPA framework.

11.2. For changes made outside of reviews, it is important that information is communicated to all agencies involved, the service user, and carer where appropriate.

11.3. If a service user’s care is to be transferred outside of the Trust, a CPA meeting should be arranged by the care co-ordinator involving the receiving agencies to allow a formal handover of care responsibilities. It is expected that the Trust care team retain responsibility of care (including care co-ordinator role) until the receiving agencies agree to the transfer of care.

11.4. If a service user who has Ordinary Residence in Tower Hamlets has been placed in residential care outside of the borough, the care management responsibilities remain within the respective CMHT, even if their health care is transferred outside of the Trust.

11.5. If a service user is no longer assessed to be eligible for services from secondary mental health care, then they must be discharged from services ensuring that any further care is effectively transferred to the appropriate agencies. This will usually occur following a CPA review meeting, with information being disseminated to key people as necessary.

**Figure 6**

**Recording of Information:**

- The CPA Care Plan (CPA9) should reflect any key changes to a care plan where transfer is to occur. The original should be kept in the notes, with copies circulated to key people, including the GP, the user and, where appropriate, their carer(s). A Transfer of Care (CPA17) form should be completed and circulated when key changes occur outside of CPA Reviews, or when a service user is discharged from services.

- The relevant part of the RAP form should be completed and processed.

- Information should be entered as necessary on to MHC and SWIFT.

12. **Specialist Roles**

12.1. It is important to distinguish between the role of the care co-ordinator, which can be undertaken by all professionally qualified team members, and the role of team members when providing a specialist service for a user. Thus, a care co-ordinator may ask another team member with a particular skill (e.g. in cognitive behavioural therapy) to provide a specialist service to a user as part of that person’s care plan.
12.2. The CMHT will seek to offer a range of specialist services to support the work of care co-ordinators. Users will have access to specialist assessments and interventions from psychologists, psychiatrists, nurses, social workers and occupational therapists. Every practitioner offering a specialist service will be appropriately trained or undergoing recognised training with adequate supervision from a qualified practitioner.

12.3. Each worker asked to undertake a specialist intervention will be responsible for working with the user and care co-ordinator to identify clear goals for the piece of work, expected ways of achieving these goals and a likely time-frame. Professional responsibility for the content of the work rests with the specialist worker and his/her professional line manager or supervisor.

13. **Liaison with In-patient Services**

**Arranging admissions to hospital:**

13.1. CMHT staff need to discuss admission with the Consultant and a senior member of the ward team in order to arrange an admission direct to the ward (i.e. bypassing A & E). For further guidance, the admission policy should be referred to.

13.2. For ‘known’ users being assessed in A&E, The A&E Liaison staff should attempt to contact the relevant CMHT for an update on the user’s situation, and assess for alternatives to admission.

**Named Nurse and Care Co-ordinator Roles & Responsibilities:**

13.3. The principles of CPA (assessment, care plan, regular reviews, care co-ordinator) apply “regardless of setting”\(^{(15)}\), including those admitted to in-patient services. Therefore, the care co-ordinator remains responsible for the overseeing of the process during admission.

13.4. For service users known to the CMHT, the named nurse on the admission ward will have a responsibility to ensure the care co-ordinator is aware of the admission within one working day. The care co-ordinator must ensure that relevant information (i.e. CPA care plan; crisis & contingency plan; most recent assessment) is faxed or sent to the ward within 72 hours of admission.

13.5. For those known to services, it is important that the care co-ordinator liaises with the named nurse in convening a meeting to review the most recent CPA care plan as soon as possible following admission (i.e. do not wait until discharge).

13.6. For those new to the service, the named nurse takes on the role of care co-ordinator until another professional is identified at a CPA review meeting (which should happen as soon as possible following admission, and must happen before discharge). The respective CMHT should be made aware of all new admissions to the ward and, where appropriate, a member of the Access team should become involved in the assessment process at an early stage. This is in order to prevent situations where late referrals to the CMHT, or late allocation by the CMHT, could lead to a delay in discharge.
13.7. The following flow-chart indicates the key stages of the CPA process from admission to discharge from in-patient services, outlining the responsibilities of the care co-ordinator and the named nurse:

![Flow-chart](Image)

**CPA Care Plans on Discharge from Hospital:**

13.8. Evidence suggests that particular attention needs to be paid to arranging care for those discharged from hospital.\(^{(21,22)}\) Care plans for those under the enhanced level should include more intensive provisions for the first three months after discharge from in-patient care, and specific reference to the first post-discharge week. The implementation of the care plan should be assessed by the care co-ordinator within the first month of discharge.

13.9. All service users receiving follow-up from mental health services must have a named care co-ordinator upon discharge. In exceptional cases where this cannot be arranged (e.g. unplanned discharges) the ward manager must liaise with the consultant and relevant CMHT manager to ensure a care co-ordinator is identified.
14. **Links with Other Services**

14.1. The teams will each develop links with significant other local agencies working with users with mental health problems including:
- Links with designated GP practices (see 14.2)
- Other Social Service Teams (e.g. Children and Families)
- Substance Misuse Services
- Child & Adolescent Services (see 14.6)
- Psychological Therapies
- Services for Older People
- Services for People with Learning Disabilities
- Forensic Services
- Voluntary, independent and user groups
- Advocacy (see 14.8)
- Housing
- Probation
- Police
- Prisons *[^Appendix III for DoH guidance]*

**Primary Care and GP Liaison:**

14.2. A link-worker / liaison system to main practices in each patch will be developed:
- They will attend the Practice on a regular basis, which is negotiable between the worker and the Practice
- They will be an additional point of contact, *not an alternative* to direct contact with care co-ordinators and other members of the CMHT.
- They can offer advice on clinical issues and practical issues on how to access Trust and London Borough of Tower Hamlets services.
- They can offer advice and education to all Practice staff regarding mental health issues.
- They will have a general knowledge of the current Practice mental health caseload
- The role is not rigid and may be developed between the Practice and the CMHT

14.3. Each Practice will have direct access to any member of the CMHT, where available. The Practice may consult the team regarding the care of a specific service user, general clinical and mental health issues, or regarding other services available. The aim is to develop a Service Level Agreement (SLA) wherever a link worker is allocated to a practice.

14.4. Reference should be made to the *Standards of Communication between the Adult Mental Health Services and General Practitioners in Tower Hamlets* document, produced in March 1999, which contains standards with the intention of promoting better joint working.
14.5. The teams are also expected to provide a liaison service to local primary health care providers.

**Links with Child & Adolescent Services:**

14.6. The following clinics are points of contact for each respective CMHT. Reference should be made to the protocol developed between Children & Families Assessment Teams and CMHT’s.

**Joint Case Registers:**

14.7. With regards to development work via the Department of General Practice at Queen Mary & Westfield College, it is intended the CMHT’s will liaise with each GP practice to produce a case register, which will then be regularly updated jointly with the practice concerned. This register should include the name of the care co-ordinator, and consultant psychiatrist for the service user concerned.

**Access to Advocacy:**

14.8. People using or requesting a mental health service have a right to have access to an independent advocate. It is good practice to encourage service users to gain advice and support from an independent advocacy service when their needs are being assessed. Any CMHT member of staff can access the MIND in Tower Hamlets advocacy service (020 8983 4252). Teams will have informal links with the MIND in Tower Hamlets Advocacy Service at St. Clements (020 7377 7000 ext. 5065/5067).

**Access to Interpretors:**

14.9. All members of the team should be aware of how communication difficulties affect each service user and should ensure that everything possible is done to overcome all barriers to communication using patience and sensitivity. Family members, carers or friends should not be used as interpreters when assessing a user’s mental state or carrying out an assessment under the Mental Health Act (1983). When the need arises, the team should make every effort to identify interpreters who match the service user in gender, religion and dialect. Interpreting includes sign language.

14.10. Wherever available and appropriate the CMHT should draw on the cultural diversity and skill and knowledge base of its core staff team to act as interpreters. Interpreting services may also be purchased using Trust or Social Services procedures and resources.
**Access to Physical and Dental Care:**

14.11. Care Co-ordinators should, whenever possible, ensure that clients are registered with a GP and Dentist. It is a consistent research finding that people with long term mental health problems have poorer general physical health than the rest of the population. Care co-ordinators should ensure that the user’s physical health is monitored and that appropriate services are accessed (e.g. access GP services at least yearly).

15. **Record Keeping**

15.1. The Trust aims to have one up to date effective database system which will provide details of the current core dataset, care co-ordinator, level of CPA, date of next review, risk indicators, needs assessment and care plan. However, the current situation is that relevant information will be entered on to existing systems MHC and SWIFT. Access to the database should be available at A&E.

15.2. The Team will have one unified set of community notes for each client that will be kept at the team base.

**Documentation and Recording Team Activity:**

15.3. Standards for record keeping should be in accordance with guidelines produced by professional bodies and locally developed policies and procedures.

**The following standards should be adhered to:**

15.4. All written information should be legible and concise, typed where possible or written in black ink

- Information is best written down as soon as it has been received, or as near as possible to that time on the day it was received. All contacts should be recorded promptly.
- All entries should be signed and dated. Name and status should also be printed.
- Time of intervention should be recorded where necessary.
- Files should be kept in order, and material appropriately filed. All files should be in a central filing location.
- Notes should be kept in date order.
- Copies of Outpatient or GP letters, ASW reports and MHRT reports should also be sent to medical records for each user who has hospital medical notes in addition to their community file.
- The care co-ordinator should ensure that copies of CPA documentation are sent for filing in the medical file in line with CPA policy.
- Letters and other correspondence should be copied to others involved in the user’s care as appropriate (e.g. when there have been changes in a client’s presentation/needs).
- The care co-ordinator must ensure that the information held on the agreed information system is kept up-to-date.
16. **Administration**

16.1. Each CMHT will have two administrative staff, one from a social services background and one from a health background.

16.2. The health administrator will take a lead in providing the clerical and secretarial support to the team. The social services administrator will undertake the business and finance functions. There will, however, be a number of roles performed by both and they will on occasions provide cover for each other. Detailed procedures are currently in development, which shall be summarised within this operational policy once finalised.

16.3. The Team Manager will have line management responsibility for the two administrators, working closely with the Social Services Administration Team Manager.

17. **Training and Development**

17.1. The team includes Administrative, Community Mental Health Nurse, Social Work, Occupational Therapy, Psychology and Support staff. Staff will be expected to maintain their own up-to-date professional registration and eligibility to practice. The Team Manager will check this on an annual basis. Access to professional advice and support will always be facilitated.

17.2. All qualified team members will be expected to have or acquire the core skills required for professionals working with users experiencing severe mental illness (see Figure 9). In addition, both social work and health staff will be offered training opportunities, which would equip them to provide specialist interventions. Training needs of non-qualified staff will also be addressed. Some additional professional skills will remain within profession (e.g. the administration of depot medication, ASW assessments). The Senior Practitioners and Team Manager will regularly review the skill mix of the team.

17.3. Desirable additional team skills include:

- Group Working
- Family Working (e.g. Thorn / Systems Therapy / Milan etc.)
- Psychosocial Interventions (e.g. Solution-Focused Therapy)
- Creative Therapies
- Cognitive Behavioural Therapy (CBT)
- Inter-Personal Therapy (IPT)
Core Skills: Management and Administration

- Knowledge of current systems of care and the policy background (CPA; care management; functions and organisations of primary care).
- Understanding of mental health law and related legislation.
- Understanding of the roles of various disciplines and agencies involved in the provision of mental health care.
- Awareness of the role and contribution of non-specialist and support staff, and ability to supervise and provide support to those staff.

Core Skills: Assessment and care planning

- Skill in conducting a collaborative needs-based assessment, including risk [see 9. Assessment].
- Ability to develop a care plan based on a thorough and comprehensive assessment of the user, family and social system [see 10. Care Planning and Review].
- Ability to develop crisis and contingency plans.
- Knowledge and skill in effective inter-personal communication.
- Awareness of cultural and gender issues in mental illness and an awareness of the principles and practices of equal opportunities and anti-discriminatory practice.
- Knowledge and skill in creating therapeutic co-operation and in engaging with users and carers in a supportive manner.
- Awareness of user perspectives on the provision of treatment and continuing care
- Knowledge of care management principles.
- Ability to liaise effectively with a wide range of agencies providing services for users and carers.

Core Skills: Collaborative working

- Awareness of the need to work in partnership with carers and social networks.
- Ability to work effectively as a member of a multi-disciplinary mental health team through clarity about the role and purpose of the team and its individual members.
- Understanding of sources of conflict and development of basic teamwork skills including negotiation and conflict resolution.
- Comprehension of the need for and willingness to participate effectively in multi-disciplinary team supervision.

Based on Sainsbury Centre for Mental Health proposals.
17.4. National policy\(^{(15)}\) states that “both health and social care managers should ensure that the care co-ordinator can combine the roles of CPA care co-ordinator and care manager roles by having:

- competence in delivering mental health care (including an understanding of mental illness)
- knowledge of service user / family (including awareness of race, culture and gender issues)
- co-ordination skills
- access to resources”

**Supervision and Development:**

17.5. The Senior Practitioners and Team Manager will review and plan development needs across the team. Long-term training courses will be balanced with a variety of short courses and development opportunities and attempts will be made to ensure equity of access to these opportunities across the team, with regard to the needs of the service.

17.6. The Senior Practitioners and Team Manager will use supervision to establish a development ‘loop’ in which skill gaps will be identified, developments discussed to meet those skill gaps, strategies identified, opportunities to implement new skills afterwards provided, and a review of further development needs therefore to continue the loop.

17.7. The teams will provide opportunities, in conjunction with medical staff, for clinical case discussion.

**Lines of Supervision:**

17.8. Sector Managers will provide supervision for the Team Managers. The Team Managers will provide supervision for the Senior Practitioners. For all other team members, supervision will be provided by the Senior Practitioner, except where the Team Managers undertake to cover gaps in provision. Where the supervisor is from another profession and background, professional issues identified may be discussed with a professional lead/advisor from the relevant profession, in consultation with the line manager.

**Standards of Supervision:**

17.9. Reference should be made to a Joint Supervision Policy drafted in January 2000 (based upon the Tower Hamlets Social Services Supervision Guide) which outlines the purpose of, different types of, arrangements for, responsibilities within and processes of, supervision.

- Supervision will take place on a regular basis at least once per month. These sessions should take place in a quiet space and be given priority by both the supervisor and the supervisee.
• Supervisors must be aware of policies from the respective organisation, e.g. sickness and absence, leave, disciplinary, grievance and special leave.

• Supervision sessions will explore personal development issues and training issues. These will also be reviewed formally within the performance review systems in use in the respective organisations.

• Supervisors and supervisees should be mindful of confidentiality. Issues raised by a member of staff may be discussed by their manager within their own supervision structure.

• Notes of sessions will be recorded in an agreed format.

**Training, Development and Appraisal Schemes:**

17.10. Staff appraisal systems will remain within the employing agency but undertaken by the member of staff’s line manager/supervisor.

17.11. Team members will have access to in-house training provided from either agency. Access to external courses will depend on the appropriateness of the request and the available budget. A joint service induction and training will be provided for new staff.

17.12. Team Managers (and Senior Practitioners) will liaise with the Social Work Advisor, Sector Managers and respective Trust and Local Authority training and development departments with regards to identifying and meeting training needs of their team members.

**Team Meetings and Development:**

17.13. Each team will provide regular ongoing meetings, which will discuss allocation issues, general business and case review.

17.14. Teams will address their own needs for away days and development seminars. It is proposed that six development days will be set aside in the first year, focusing on team building issues, development of the service model and integrated team functioning.

**Workload Management:**

17.15. Each member of staff’s workload, including caseload size and complexity, will be monitored as part of supervision. Work will continue to look at the possibility of implementing an effective workload management tool. However, caseload size will still be dependent on staff resource availability.

17.16. The Senior Practitioners, along with the Team Manager, will have responsibility for monitoring caseloads across the team as part of the on-going management of the team.
18. **Safety in the Community**

18.1. We are committed to developing a culture at all levels in the organisation that is supportive of health and safety. We consider health and safety to be an integral part of effective management in both day-to-day service delivery as well as policy planning and development.

18.2. All staff members are responsible for familiarising themselves with all policies, procedures and guidelines within the Trust and Social Services which impact on safety, including:
- Policy and Guidelines for Local Lone Worker
- Prevention of Violence to Staff
- Social Services Directorate Health and Safety (Managers Pack)
- Health, Safety and Welfare at Work
- Management of Health and Safety at Work
- Clinical Risk Management Policy (part 1)
- Safety in the Community Guidelines

19. **Confidentiality and Sharing of Information**

*n.B. Reference should be made to the policy on Data Protection (currently being developed by the East London & The City Mental Health NHS Trust)*

19.1. All information held by the CMHT’s will be obtained and processed fairly in accordance with health service and local authority guidance and government legislation. The *Data Protection Act (1998)*\(^{(16)}\) came into force on 1\(^{st}\) March 2000 and provides safeguards for the processing of personal data. All staff dealing with personal information should be aware of the need for compliance to the Act and associated provisions, in particular those concerning the rights of service users in respect of access to and use of information in their care records (manual as well as computerised). Staff should also be aware of the requirements of the common law duty of confidence as set out in *The Protection and Use of Patient Information*.\(^{(24)}\)

19.2. The information held within the CMHT’s will be adequate, relevant to its stated needs and purposes and not excessive. It will not be held any longer than is necessary or required by law. The CMHT’s will make every reasonable effort to ensure that the information they hold is accurate and up-to-date, and will correct or erase any errors identified in the information they hold.

19.3. Individuals on whom information is held will be allowed access to such data in accordance with government legislation and professional judgement.

*Sharing Information: User Consent*
19.4. As outlined in the East London & The City CPA Policy, at an early stage during the assessment process, the assessor should discuss with the service user the issue of information sharing. They should seek to gain consent from the user to sharing information with other organisations in order to help with their care. The resulting consent, limited consent or withheld consent will be recorded in the case file **[Permission to Share Information (CPA4) form]**.

19.5. Where a user has refused consent, or has indicated certain restrictions which they wish to place on information sharing, this should be respected where possible.

19.6. However, withheld consent does not preclude information sharing in all circumstances. The Data Protection Act defines circumstances where sensitive information may be shared where consent has not been granted. Particularly relevant circumstances are outlined in figure 10 below.

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**Figure 10**

The processing is necessary:

(a) in order to protect the vital interests of the data subject or another person, in a case where:

(i) consent cannot be given by or on behalf of the data subject, or,

(ii) the data controller cannot reasonably be expected to obtain the consent of the data subject, or,

(b) in order to protect the vital interests of another person, in a case where consent by or on behalf of the data subject has been unreasonably withheld.

The processing is necessary:

(a) for the administration of justice.

The processing is necessary for medical purposes as is undertaken by:

(a) a health professional, or,

(b) a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

*taken from the Data Protection Act (1998)*

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**Sharing Information: Within CMHT**

19.7. The East London & The City Trust and Tower Hamlets Social Services operate in partnership to provide seamless care for mental health service users and their carers. Since the information is required by the CMHT to support the user’s care, withholding consent to sharing information within the team or between the four locality teams is not consistent with providing care. Shared access within the team is a prerequisite for providing care and is part of the user’s care package.
19.8. There should be complete and total access for all staff within the CMHT’s to all information relating to all users under their care. There should be no distinction in access between health and social services personnel. Administrative support personnel should also have complete access to all records, since they have some responsibilities to maintain the information.

**Sharing Information: With Other Service Providers and Organisations**

19.9. Information may be shared with other organisations involved in providing services to the service user in order to ensure that:

- the user has access to the services to which he or she is entitled
- the user receives good quality, integrated services
- other organisations are aware of the user’s needs and can provide responsive services
- other organisations or individuals are aware of potential problems when dealing with the user
- the safety of the user, other service providers, and the general public is maintained

19.10. Information will only be shared with the defined list of organisations as necessary unless further agreement is obtained from the user. Information will only be provided on a ‘need to know’ basis in terms of the level of detail supplied, and the organisations/individuals to which it is provided. The level of detail, and with whom information is to be shared, will be based on a professional decision.

**Sharing Information: Responsibilities**

19.11. Where consent for sharing information sharing has been given and the scope of the information falls within this protocol, then the appropriate level of information may be passed on by any member of the CMHT, including administrators.

19.12. Other situations would include where consent is withheld, the information requested or the requestor is outside the scope of the protocol, or where a high risk factor is identified. In such cases the decision on what information to share and with which organisations, must be taken by the care co-ordinator, in conjunction with the CMHT manager if necessary. The final responsibility for the decision lies with the CMHT manager. In these cases, a written record of reasons for disclosure of confidential information must be kept.

**Security Measures:**

19.13. Each CMHT will need to have appropriate security measures in place to guard against unauthorised access to information on computer and on paper, including the alteration, disclosure and destruction of data. Measures will also be in place to ensure against the accidental loss or destruction of information.
19.14. All files should be kept in the central locked filing system when not in use by staff. Files should not be taken home. When a staff member needs to transport files between buildings, this should be done in a sealed envelope addressed to themselves.

19.15. Where possible, information should not be given out over the telephone. Where this cannot be avoided, the identity of the caller should be confirmed, for example by checking the details of the requestor (e.g. GP practice) by telephoning them back.

19.16. Important confidential service user information should be saved to the file server to prevent access to this information in the event of a PC being stolen.

19.17. All fax machines used for sending or receiving personal or confidential data will be placed in a secure location, a ‘safe haven’, to prevent casual browsing by unauthorised personnel.

19.18. The copying, archiving or dumping of any electronic or paper-based information will be treated with the same level of security and access restrictions as applied to live data.

19.19. Access to files for users should be done via a written request and should be dealt with through the Trust and London Borough of Tower Hamlets policies by a senior member of the team and the consultant psychiatrist.

19.20. Relatives have no legal right of access to a user’s file. Such requests for information should be referred to the Sector Manager and consultant psychiatrist.

20. **Quality & Audit**

20.1. Each CMHT will comply with the relevant quality and audit requirements and clinical governance arrangements of both health and social services with regards to all aspects of care delivery.

20.2. The teams will aim to address quality standards within an agreed programme focussing on standards referred to throughout this operational policy:
- standards for communication in response to referrals
- file-keeping
- community care documentation
- team data-gathering
- student placements
- supervision

**Approved Social Worker (ASW) work:**

20.3. Quality Monitoring for ASW work will be undertaken by the Social Work Advisor, via the ASW reports. These will also be checked by the MHA Commissioners during visits when they examine file documentation. ASW work will also be audited via the re-warranting process when ASW portfolios are checked.
Management of Medication:

20.4. Documentation will be monitored by the Pharmacist on regular visits. The Pharmacist will also check on management of the clinic rooms to ensure procedures are followed.

Involvement of service users and carers:

20.5. Service users and carers will be provided with written information regarding the functions of the CMHT and related care processes, such as CPA, Community Care Needs Assessments, Advocacy Service, Complaints Procedures, Access to Information and with information relating to compulsory admissions under the Mental Health Act.

20.6. The Team Managers will both make themselves available on a regular basis to meet with users in the various user groups. Similar arrangements will be made to link with local carer groups.

20.7. The teams will seek to audit users’ and carers’ views of the service provided by means of locally developed links (e.g. issuing of questionnaires).

Communication Strategy:

20.8. A strategy will need to be taken at both the service and team level to ensure periodical updates of information are made available to those agencies which are regular referrers to the CMHT’s (e.g. Housing, Probation, GP practices and Voluntary Sector agencies).

20.9. A range of printed information will be made available to other agencies about the details and functions of the CMHT’s.

20.10. Among those services to be advertised will be the core functions of the team, for example:

- screening at point of entry
- full health and social care assessments (incorporating risk)
- advice, information, and brief interventions
- long-term support for service users with severe and enduring mental illness
- provision of some group activities
- other specialist services available

21. Complaints & Suggestions

21.1. Where a service user or carer has particular concerns about the service they are receiving, they should be encouraged in the first instance to discuss this with someone involved in their care.
21.2. All service users and carers will be given full information with regards to the respective NHS Trust and Social Services complaints procedures. The Team Manager will monitor all complaints initially.

21.3. Users and carers will be made aware of how to contact independent advocacy, through the local advocacy service, the local community health council, or patient advocacy and liaison services (PALS) as they develop.

21.4. The teams will fully comply with Serious or Potentially Serious Incident Policy, as recently implemented by the Trust.
22. References


8. The Health Act 1999 *Section 31 Partnership Arrangements*. (HMSO, London)


