# Enter & View Visit to
# South West London and St George's
# Mental Health NHS Trust
# East Wandsworth
# Community Mental Health Team

# 2 and 18 July 2019

**Acknowledgement**

**The Healthwatch Wandsworth Enter & View Team would like to thank the management, staff, patients and relatives who made us welcome and assisted us in carrying out our visits and in preparing this report.**

**The Project Team**

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# Enter & View Visit to South West London and St George's Mental Health NHS Trust East Wandsworth Community Mental Health Team 2 and 18 July 2019

## Executive Summary

### Section 1. Introduction

Healthwatch Wandsworth (HWW) is the patient and public champion for the community in the areas of health and social care. Mental health is regularly identified by our members as a major priority. We were aware that the emphasis of mental health policy, nationally and locally, has been on minimising the need for hospital admissions by relying increasingly on community services.

The role of Community Mental Health Teams (CMHTs) is to provide treatment and support in the community at secondary level – that is, to people with serious mental illness who cannot be adequately treated or supported by primary care services but who do not need to be in hospital. We knew that South West London & St George's Mental Health NHS Trust (SWLStG) had undertaken a recent transformation and improvement scheme in an effort to improve the quality of the performance of its CMHTs. We decided that it would be timely to carry out our first Enter & View visit to a CMHT, and elected to visit the East Wandsworth CMHT, one of three such teams in the Borough. We aimed to use observation and interviews with service users and their carers to report:

1. How the service operates.

2. How far the service is meeting the needs of users and carers.

3. The impact of recent changes in service structure or operation.

4. How well the service works with other teams within and outside the Trust including on physical health and social care.

### Section 2. Preparing for the E&V visit: background information

In order to gain comprehensive information about the East Wandsworth CMHT before the formal E&V visits, team members had a preliminary meeting with senior managers. This was followed by a visit to reconnoitre the team's base at Harewood House. Additionally, we requested written information about the team, its policies and its working. The background information we received about role and operation of the Wandsworth CMHTs, and the East Wandsworth team in particular, is set out in some detail in Section 2.2 of the full report and in Appendices A to C.

### Section 3. The Enter & View Visits

We designed a schedule of questions for our semi-structured interviews that we hoped would cover key aspects of a patient's experience. They aimed to explore:

- The quality of the information about treatment and involvement in and choice about treatment (including Care Planning)
- The quality of a patient's relationship with the team.
- Continuity of care.
- Convenience and quality of treatment location.
- Experience of crisis planning and management.
- Physical health services.
- Social care.
- How well the team works with carers.
- Any experience of being discharged from the CMHT and links between teams including discharge from inpatient care.

Over two days, we conducted interviews with eleven patients; we received additional information from an informal carer, and a written response from one other patient. The report gives demographic details of the patients we spoke to, and the length of time they had been under the care of East Wandsworth CMHT.

## Section 4. Findings from interviews with patients

Section 4 contains details of the information we obtained from patients about their experiences in the different areas covered by our schedule of questions. The views we collected were mixed, as might be anticipated due to the varied and complex experiences of people with a mental illness. The feedback from patients was generally positive – sometimes very positive but most identified some concerns of varying severity. Some individuals singled out their recovery support workers for special praise; it was clear that care-co-ordinators and other team members were offering patients practical help with difficult matters over finance and housing, as well as providing emotional support.

We heard a variety of comments on the subject of choice: some people were happy with their level of involvement, while others were less satisfied. Poor continuity of care in relation to the care co-ordinator had been a problem for some, with negative effects on their feelings of stability. We considered that there was some lack of clarity over arrangements for crisis management. The carer we spoke to reported a number of specific concerns, namely over the continuity of care, being listened to by staff, and the discharge process. One of the patients who was most critical of the service had a long history of psychotic illness and we found it difficult to decide how much their views were attributable to the complexity involved.

## Section 5. Our Conclusions and Recommendations

Given the often disheartening impact of severe mental illness on individual patients and their families, the generally positive, and sometimes very positive, tone of the feedback we received from most of the patients of the East Wandsworth Community Mental Health Team to whom we spoke suggests that the concerted efforts to improve the performance of the team over the last year or so have had a considerable impact. Credit is due to the management and the hard-pressed clinical staff for this.

At the same time most patients identified some concerns, in many instances quite minor but for others more significant. These related to aspects of information, involvement and choice; respect for individuals; continuity of care (while some of the examples here can be considered "historic", there was a more recent one which suggests that despite efforts to improve recruitment and retention the problem has not gone away); crisis management; working with carers and discharge.

In addition we were concerned that several of the patients we saw said that they were not aware of care plans, the next steps in their treatment or crisis plans.

Some of these issues appear to fall within existing norms and procedures and we would recommend team management to consider what more might be done to ensure that these are fully adhered to. This includes:

1. Respect for individuals: ensure that patients are not only respected but feel respected.

2. Choice: ensure that patients are given and understand as wide as possible a range of choices regarding their treatment, including a change of care coordinator if wanted.

3. Continuity of care: seek to minimise unwanted changes of care coordinator and of consultant psychiatrist and preparing patients for change, particularly of care coordinator, so far as possible.

4. Working with carers: ensure that carers feel that their voice is heard.

5. Discharge: ensure that all patients (including those not on CPA) and their carers are properly prepared for discharge and that following discharge a letter is sent to the GP within 7 days.

In addition to meet some of the expressed concerns we have some ideas for improvement that may involve changes in existing procedures. We would like to recommend:

6. The Trust should develop a welcome pack and/or welcome email for patients referred to a CMHT. This should cover what patients and carers should expect from the team and who to contact both during and outside working hours. There might need to be different version for CPA and non-CPA patients;

7. More should be done to provide a reliably and directly accessible, as well as clinically qualified, out of hours (including weekends) source of advice and support for CMHT patients experiencing difficulty, with access to the Crisis and Home Treatment Team as necessary.

8. The team need to ensure that patients are involved in the co-creation of their care plans (or the next steps in their treatment if they are not on CPA) and their crisis

plans and that they understand them and have a copy. In order to be able to document and monitor this requirement routinely the Trust should consider the need to amend its existing electronic records system.

Finally, while acknowledging the recent improvements under the current management team and not wishing to cause disruption by further organisational changes, we wonder whether in the longer term patients and their families might not be better served if the sheer size of the East Wandsworth CMHT could be reduced by increasing the number of teams in Wandsworth or rebalancing them in some other way. We accordingly recommend:

**9.** The Trust should consider with the responsible commissioners the case for devoting additional resources to reducing the overall size and caseload of the East Wandsworth team in the longer term while minimising disruption.

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## The Full Report

## 1.0 Introduction

### 1.1 About Healthwatch Wandsworth

Healthwatch Wandsworth (HWW) is the patient and public champion in the areas of health and social care services. At the national level, we send our reports to Healthwatch England. HWW is funded by the Department of Health through the local authority, Wandsworth Borough Council. Our staff and volunteers are managed by an independent local voluntary organisation, Wandsworth Care Alliance (WCA). HWW is governed by an Executive Committee consisting of four Trustees of WCA and four members directly elected by the community. Our activities are developed in consultation with the public at our Assembly meetings and as we collect feedback from people about their experiences of health and social care in Wandsworth. To decide on where to focus our work we look at what people have told us when taking part in our surveys or sharing experiences with us, we speak to local health and care decision makers to hear about their plans to develop services and we use information on local health data to set our priorities.

### 1.2 Enter & View

Healthwatch Wandsworth has the statutory authority to visit health or social care services provided in the borough, or which cater for the local population but are located outside the borough. We can observe how services are delivered. Our main aim is to talk to patients or clients, their close relatives or carers, and senior staff responsible for managing the services. Our main focus is on the service user's experience of care.

Our E&V volunteers receive full training and are DBS (Disclosure & Barring Service) checked before they can become authorised visitors. After each visit, the team produces a report containing its findings and recommendations. The reports are then sent to the service provider for comment, and to relevant bodies such as Healthwatch England, the Care Quality Commission (CQC), and those responsible for commissioning and providing the service we have visited. Finally, our report and any response from the service provider to our recommendations are posted on the Healthwatch Wandsworth website.

### 1.3 Purpose of Visit

We plan our programme of Enter and View visits to cover a wide range of services in the light of the information available to us and the priorities identified through consultation with the Healthwatch Wandsworth membership. Mental health is regularly identified by the membership as a major priority - as indeed it has recently become for the NHS as a whole. We have already carried out visits to a number of inpatient wards provided by the South West London and St George's Mental Health NHS Trust for working age adults (Ward 2 at Springfield Hospital, Tooting, in December 2016 and January 2017; and Laurel Ward at Queen Mary's Hospital, Roehampton, in February 2017) and for older adults (Crocus Ward at Springfield Hospital in October 2016). We are aware that the emphasis of mental health policy, nationally and locally, has for some time been on minimising the need for hospital

admission by relying increasingly on community services, and that the Mental Health Trust has been devoting considerable attention to modernising and transforming its community services. From our contacts in recent years, unsystematic though they have been, with the services' users and their carers we have been aware that performance by the Community Mental Health Teams (CMHTs) has been variable and that there has been room for improvement in care standards. We have however noted the encouraging decision by the Care Quality Commission (CQC) following its visit to the Trust in February 2018 to uprate SWLStG's community services from "Requires Improvement" to "Good".

We accordingly decided to carry out a Enter and View visit to one of the Trust's Wandsworth Community Mental Health Teams (covering East Wandsworth, Central Wandsworth and West Battersea, and Putney and Roehampton respectively) with a view to exploring to the extent possible through observation and interviews with service users and their carers:

1. how the service operates;

2. how far the service is meeting the needs of users and carers;

3. the impact of recent changes in service structure or operation;

4. how well the service works with other teams within and outside the Trust including on physical health and on social care.

## 2.0 Preparing For Our Visit

### 2.1 Meeting with Service Managers

On 10 May 2019 three members of the Enter and View team met Michael Hever, Head of Nursing and Quality for the Community Service Line, Rick Dalton, Clinical Manager, Wandsworth Community Services, James Black, Interim Manager of East Wandsworth Community Mental Health Team, and Pelegia Mapfumo, Co-manager of the Wandsworth Single Point of Access. We discussed possible arrangements for an Enter and View visit and the service managers kindly provided a great deal of background information in answer to our questions. In the light of discussion, we agreed to suggest dates for a visit or visits to the East Wandsworth CMHT in June or July and to supply written information to alert service users and carers to our visit.

On 19 June two team members visited Harewood House at Springfield Hospital, where the East Wandsworth CMHT is based, to reconnoitre the layout and to discuss detailed arrangements for our Enter and View visits with Rick Dalton. We also met James Black and some members of his team.

## 2.2 What we learned about the Service before our Enter and View visits

### 2.2.1 Role

We were told that the role of CMHTs is to provide treatment and support in the community at the secondary level i.e. to people with serious mental illness who cannot be adequately treated or supported in primary care by their GP or primary care psychological therapy services (such as Talk Wandsworth) but who do not need to be in hospital.

There are currently three CMHTs for adults between the ages of 18 and 75 in Wandsworth, each covering a defined area of the borough, provided by the Trust (which also serves the boroughs of Merton, Sutton, Kingston and Richmond). Most people over the age of 75 are seen by the Older People's CMHT which also sees some people aged less than 75 years who are physically frail or have cognitive problems. This report concerns our visit to the East Wandsworth team which covers an area in the East of the borough. The team base is in Harewood House at Springfield Hospital.

The Wandsworth CMHTs are now what are often described as Recovery and Support Teams (RST), as the function of making initial assessments following referral from GPs is carried out by a separate team, the Single Point of Access (SPA) also based at Harewood House. Referrals are also received directly from a number of other Trust teams, including the Liaison Psychiatry team at St George's Hospital, the Crisis and Home Treatment team and inpatient wards. Patients discharged from the CMHTs to their GP can if necessary be referred back directly to the CMHT within three months after discharge. In all cases the CMHT is responsible for deciding whether a person qualifies for the Care Programme Approach (CPA - see below) and if so for drawing up a care plan.

The role of the CMHTs is distinct from a number of other teams also working in the Wandsworth community, in particular the Crisis and Home Treatment Team which is responsible for supporting people in a mental health crisis and if necessary arranging their admission to hospital, the Early Intervention in Psychosis Team which is responsible for the care of adults who have experienced a first episode of psychosis, the Complex Needs Team which is responsible for the assessment and treatment of people with a personality disorder, the Traumatic Stress Service and Talk Wandsworth which provides psychoeducation and psychological therapy for people with mild and moderate mental health problems[1]. The CMHTs no longer have prime responsibility for social care as in November 2015 the social workers previously embedded in the CMHTs were taken back under direct management by Wandsworth Borough Council.

Wandsworth residents in acute mental health crisis and at risk of harm to themselves or others can be referred to one of the Trust's inpatient wards. The Trust also provides a number of highly specialist units (some on a national basis) including Deaf services and

[1] Talk Wandsworth is separately commissioned by Wandsworth CCG. Although South West London and St George's currently provides the service, it is managed separately and service users should not be under the care of both Talk Wandsworth and a CMHT or other Trust service apart from the Recovery College.

services for people with Eating Disorder, Obsessive Compulsive Disorder and Body Dysmorphic Disorder.

### 2.2.2 Care Programme Approach

About half the people being treated by the Wandsworth CMHTs are on the Care Programme Approach (CPA). This is a statutory framework of care involving a care plan (required to be reviewed at least annually) and a Care Co-ordinator. Inclusion of individual service users on CPA is a clinical decision for the CMHT in accordance with criteria and procedures set out in the Trust's CPA Policy - a copy of the section on When Support of CPA is Needed is at Appendix A. Care Co-ordinators are responsible for working with CPA patients (and where appropriate their carers, family or friends) and initially drawing up a care plan in conformity with the Trust's care planning standards (see below). Thereafter patients have regular 1:1 sessions with their Care Co-ordinator, which may - at their choice - be at the team base at Harewood House or at home. The majority of such contacts are home visits but the teams apparently encourage people to come to Harewood House on the grounds that it can be good for them to get out and about more. Subject to the fundamental standards (see below), the frequency of face-to-face sessions and their possible replacement by telephone contacts is governed by the Care Co-ordinator's clinical judgement of the service user's support needs backed up by supervision with the team manager and team discussion at weekly "zoning" meetings (see below).

Most non-CPA patients are initially allocated to a consultant psychiatrist whom they see periodically on an outpatient basis and may also receive psychological therapy or support from a Recovery Support Worker or an employment specialist. They do not have a Care Co-ordinator but there is always a named professional responsible for their care, if only the psychiatrist. In the case of both East and Central Wandsworth CMHTs, non-CPA patients normally attend at the Outpatient Clinic at Harewood House and the outcome letter following each appointment serves the function of a care plan.

### 2.2.3 Recent Modernisation and Transformation initiatives

Along with the Trust's other CMHTs, the East Wandsworth CMHT has been subject to a co-ordinated process of modernisation and transformation since 2015. This has included the following changes not already mentioned, some of which have featured in the Trust's Quality Account in recent years:

- trust-wide move from borough-based organisation to Service Line Management: the CMHTs are now part of the Community Service Line which serves adults (generally aged between 18 and 75);

- consolidation by amalgamation from 4 to 3 Wandsworth CMHTs;

- introduction of minimum quality standards (now renamed fundamental standards) covering various aspects of access procedures and timescales, treatment, discharge planning etc. A copy of these standards is at Appendix B;

- improved care planning standards: in 2017 following work with service user and carer representatives the Trust adopted a comprehensive set of 10 Care Planning Standards expressed in the form of first person statements on behalf of the service user (such as "I co-produced my care plan with my named nurse/care co-ordinator and where appropriate my family, friends or carers"). Every care plan should include at least two of the person's own Recovery Goals;

- a system of risk assessment by zoning red, amber, green: see Appendix C;

- the development of a caseload weighting tool which scores individual patients in terms of complexity and support needs to derive an overall measure of a care co-ordinator's caseload as well as to provide a basis for discussion in supervision with the team manager;

- an audit has been carried out of cases where there has been a high frequency of transfers of care co-ordination: this has led to improved procedures for ensuring a properly documented handover and advance notification of this either by face-to-face or in a telephone conversation;

- all Trust teams have carried out a self-assessment in consultation with carers' representatives under the Triangle of Care, an independent standards and accreditation scheme on working with carers and families;

- the East Wandsworth CMHT has been the subject of a specific Recovery Action Plan since February 2018 which has now been completed under the leadership of the present Interim Team Manager, James Black. This was due to earlier concerns regarding the quality of care provided by this team. It was recognised that systems in the team needed to be more robust. The Plan covered timely allocation and intervention, risk management, care planning, staff supervision, compliance with performance indicators and safe medication management.

### 2.2.4 Current functioning of the Team

We asked about information available to service users and carers about referral to CMHTs and what to expect from this. We were told that there is only a generic leaflet available, entitled "What You Can Expect from Our Services" which deals with hospital admission as well as referral to a CMHT. It states that the emphasis of Trust services is on recovery, which means helping people to get on with their lives and to focus on the things that are important to them. Every person using Trust services receives an assessment, a care plan and a named professional. A care plan is defined as a written plan describing the care and support a person will receive from the Trust together with steps the person can take to keep mentally well, any support from Social Services, issues relating to health, medication, housing, income and employment as well as about support from carers, family or friends. People should receive a copy of their care plan to keep. The leaflet cross-refers to a more detailed patient information leaflet on Care Planning.

There are, we were told, three main pathways into which most service users fall, associated with the most frequent diagnoses for people on CPA: Psychosis, Personality Disorder and Mood Disorder. Use is made of the Health of the Nation Outcomes Scale (HoNOS) developed during the early 1990s by the Royal College of Psychiatrists as a

measure of the health and social functioning of people with severe mental illness. Model packages of care appropriate for the different HoNOS "clusters" are available as templates on the electronic patient information system (RIO) which is used for care planning and other patient-related functions. However, Care Co-ordinators are expected to tailor each individual's care plan in discussion with the service user and where appropriate their carers, family or friends.

The Psychosis Pathway typically consists of antipsychotic medication (which in some cases, eg. where there is a risk of non-compliance, can be administered by a CMHT member in the form of a regular "depot" injection) and psychosocial and motivational interventions in sessions with the Care Co-ordinator designed to help overcome the "negative" symptoms of psychotic illness which can be as damaging to the quality of people's lives as the more obvious "positive symptoms" (such as hallucinations or delusional thinking). Psychological therapy may also be offered in some cases.

The Personality Disorder pathway focuses less on medication and more on learning skills to regulate emotional instability and impulsive behaviour. There is a separate Wandsworth Complex Needs Team to which people can be referred if they are able to engage in their treatment programmes which can be demanding and extended in time. The role of the CMHT is thus sometimes to help people achieve the basic level of stability needed to be referred to Complex Needs. The approach mainly used for personality disorders within the Wandsworth CMHTs is described as mentalisation-based therapy (MBT) which aims to improve people's capacity to understand the mental state, of oneself or others, that underlies overt behaviour. The team's psychologists provide a group training programme called STEPPS (Systems Training for Emotional Predictability and Problem Solving). If referred to the Complex Needs Team, after an initial assessment phase, patients are discharged from the CMHT but may need to return to its caseload after treatment.

The Mood Disorder pathway is meant for people suffering from severe depression or from bipolar disorder. Treatment typically combines antidepressant and/or mood stabilising medication with psychosocial and motivational interventions in sessions with the Care Co-ordinator or more formal psychological therapy with a Clinical Psychologist.

The majority of people suffering from anxiety disorders are referred to Talk Wandsworth for psychological therapy rather than to a CMHT. Some people with very severe problems are referred to one of the Trust's specialist services, such as those for OCD or Eating Disorders.

Twice-weekly "zoning" meetings are held at which Care Co-ordinators and other team members discuss with the team the risk levels of patients on their caseload on the basis of the latest information and decide upon any adjustment needed in the frequency or nature of contact. We were told that about 25 to 30 (4 to 5 percent) of the caseload are zoned red or amber at any one time. While the fundamental standards require every patient on CPA to be seen at least every 4 weeks, we were told that service users zoned as Red (the highest risk level) should be contacted at least once a week, preferably face-to-face but if necessary by telephone. Where patients are seen to be moving into a crisis the team

considers how their support needs can best be met and may in appropriate circumstances refer individuals to the Crisis and Home Treatment Team (who are also located in Harewood House (although formally part of the Trust's Acute Care Service Line).

According to the Trust's Care Planning leaflet for patients every care plan should include a crisis plan to help identify the early warning signs of a crisis, explore the use of coping strategies and support to reduce the crisis and prevent hospitalisation. We were told that currently 98% of service users on CPA have a collaborative crisis plan (i.e. a plan developed collaboratively with the service user and whoever else they want to be involved). It was however suggested that in practice these crisis plans may not be of much direct use to the CMHT who rely more on their knowledge of the service user, their professional skills and a broad "hierarchy of needs" approach in helping service users and carers manage a crisis but they can be of particular use to the out of hours Support Line which service users and carers can ring if they need urgent help. Crisis plans are of course also intended to be of use to service users and their carers.

The Trust's whole approach to assessment and care planning is holistic. This means that patients' physical as well as mental health needs should be identified and monitored. The CMHT has specific responsibility for monitoring the side-effects of psychiatric medication and this is why they arrange blood tests for patients prescribed clozapine (carried out by a separate Clozapine Service) and a number of other medications and carry out cardio-metabolic assessments (CMA) of all patients on anti-psychotic medication. The Trust has a target to perform CMAs for at least 75% of such patients in the community services each year. The East Wandsworth team's current performance is at 98.3%. Most of these tests are done at Harewood House but some are carried out in other suitable community venues eg. GP surgeries. The results of this testing is shared with patients' GPs. Apart from testing for side-effects of psychiatric medication, the CMHT does not carry out physical health tests or treatment but should identify any unmet physical health needs and ensure that these are notified to the responsible GP.

Since 2015 the Trust is no longer responsible for carrying out social care functions in Wandsworth which are the responsibility of the Borough Council's Social Services Department. The identification of social care needs is however part of the holistic assessment process and should normally be considered by the Single Point of Access team or inpatient ward when the client is first referred. If the SPA or ward identify a social care need, they would initiate contact with the Council's mental health social work team. If and when the client is transferred to a CMHT it is the latter's responsibility to track the social work team's response. If social care needs not identified at the time of the original assessment emerge subsequently, it is for the CMHT to ensure referral to the social work team. We were told that liaison with the social work team has improved. Care coordinators can make direct contact with a client’s allocated social worker if they have one. Otherwise they have to go through the Council's Access Team but this arrangement is, we were told, proving efficient and responsive.

The recent Independent Review of the Mental Health Act[2] has expressed some concern about the national use of compulsory Community Treatment Orders (CTOs) which it considers have been significantly overused. We were however told that CTOs were uncommon in the Trust and that only 5 patients of the East Wandsworth CMHT were currently subject to CTOs.

The length of time people stay under the care of the CMHTs can vary widely between a few months or even weeks and a period of years (see below). Discharge standards are incorporated within the CPA policy and summarised in the fundamental care standards at Appendix B. Staff should work towards discharge from the outset of treatment. Patients and their carers should be duly informed and involved in a discharge review and a discharge letter sent to the GP within 7 days.

It can often help clarify the role and functioning of a service to ask "what does success look like?". Given the complexity of the service and the variety of the conditions and situations dealt with, however, measuring the success of CMHTs is clearly problematic. The Trust has in place, sometimes in response to national requirements, a series of Key Performance Indicators (KPIs) against which limited aspects of individual CMHTs' performance are measured. These include such issues as access and treatment waiting times, follow-up after hospital discharge, care plan and risk assessment reviews, completion of cardio-metabolic assessments and a variety of workforce measures. But none of these give an overall picture or even a partial picture of the impact on patients. The Trust has for some time had a system for Real Time Feedback from service users and carers but we were told that this had had problems, particularly for CMHTs. The Trust has spent some time working with service user and care representatives to review and update the feedback system and have now launched a new system for online feedback named Feedback Live. We were also told that work is in hand to develop a Patient-Reported Outcome Measure (PROM) for the Trust's community services, using a recently developed system called Dialog. It is to be hoped that these developments will in due course lead to improvements in the responsiveness and effectiveness of the Trust's community services.

### 2.2.5 Staffing

As at the time of our visits the staffing of the team (whole time equivalent) was:

| | |
|---|---|
| Manager | 1 |
| Community Psychiatric Nurses | 10.8 |
| Occupational Therapists | 2 |
| Psychiatrists | 2.8 |
| Clinical Psychologists | 1.8 |
| Recovery Support Workers | 2 |
| Employment Specialists | 2 |
| TOTAL | 22.4 |

[2] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

In addition the team benefits from two junior medical posts (speciality registrars):these are fluid posts, changing every 6 months. Although the team was fully staffed, the manager, two of the nurses, and one each of the OT and medical staff were employed on a temporary locum basis (on contracts normally for three months). Care coordination is carried out by nursing and OT staff: we were told that there were 12 care coordinators at the time of our visits.

### 2.2.6 Caseload and Referrals

| The caseload of East Wandsworth CMHT as at May 2019 was: | |
|---|---|
| CPA held by non-Trust service | 7 |
| Not on CPA | 238 |
| On CPA | 333 |
| Total | 578 |

We were told that the team have worked to reduce care co-ordinator caseload sizes and at present no care co-ordinator has a caseload over 27 service users. The objective, according to the Interim Manager, is to bring this to 25 which would allow for any period of increased demand. The overall caseload of the team is, we understand, significantly larger than that of other CMHTs within the Trust.

We asked about the source of referrals and were given a breakdown of the 611 referrals received in 2018/9 but it emerged that these figures were inflated and skewed by the inclusion of a large number of service users transferred from the Trust's community rehabilitation service when this was wound up. In any case the largest source of referrals is from GPs (302 referrals in 2018/9) which outweighs referrals from inpatient wards (39) and from IAPT (psychological therapy) services, presumably mainly Talk Wandsworth IAPT (30 referrals). A number of other smaller referral sources are recorded, including A&E, recovery cafés, Social Services and other mental health teams.

### 2.2.7 Team Base

East Wandsworth CMHT is currently located at Harewood House, Springfield Hospital (Building 1, entrance 2). Access to the building is currently made more complicated by temporary barriers put up in connection with the site redevelopment. Door 2 opens onto a reception and waiting area serving the range of teams operating in the building. Apart from the second floor which is given over to an inpatient eating disorders ward (Avalon), the teams all form part of Wandsworth Community Services, including the Single Point of Access (Assessment team), the East Wandsworth and the Central Wandsworth and West Battersea CMHTs, Crisis and Home Treatment and Complex Needs teams. The Wandsworth Early Intervention Service, located elsewhere on the Springfield site, also uses the outpatient area at Harewood House. The teams which have been co-located at Harewood House since 2012 are likely to remain there for a couple more years until the hospital rebuilding programme has been completed.

The reception staff and a security officer sit behind a screen. The security officer has access to the system of fixed and personal alarms used in the building. There are a few chairs for people to wait in the reception area but to the left of the entrance (coming in) there are two more waiting rooms, the further of which is normally used by patients waiting for the clozapine clinic when this is operating.

Three corridors radiate from the reception area. One of these is devoted to the Complex Needs team. The other two contain a number of consulting or treatment rooms. All these rooms are available on a booking system to the various teams, including the East Wandsworth CMHT. This is accordingly where patients may come for outpatient appointments with their psychiatrist, meetings including CPA reviews with their care coordinator, group or one-to-one appointments with psychologists, OTs, Recovery Workers, depot injections and physical health appointments such as cardio-metabolic assessment or medication-related blood testing. One of these corridors has noticeboards giving information for patients on a variety of topics and racks containing Trust information leaflets.

Stairs from one of the corridors lead up to the first floor where, among other teams, the East Wandsworth CMHT have their team base consisting of the manager's office, the psychologists' office and two team rooms. Patients and carers do not normally visit this floor.

### 2.2.8 Other Information

Following a comprehensive inspection of SWLStG in February 2018 during which they visited 14 out of the Trust's 33 community teams the CQC revised their rating of the Trust's community services for adults of working age to "Good" in each of the 5 domains (Safe, Effective, Caring, Responsive, Well-led). The CQC's inspection report published in June 2018 devotes pages 34-39 to community services for adults of working age and is accompanied by an Evidence Appendix of which pages 90-155 are devoted to these services. In summary, the inspectors found that the services had addressed the issues that caused them to be rated as "Requires Improvement" following the previous inspection in March 2016. The main areas of improvement recorded were in the areas of safety and staff supervision but the inspection report also noted clear care pathways, excellent working relationships with teams internal and external to the Trust, staff working with patients to develop holistic, person-centred and recovery-focussed care plans and to improve physical health. On the other hand, staff did not always fully review and update risk assessments after a transfer from another team or after an incident.

At the time of completing this report in September 2019 the CQC are conducting a further inspection of the Trust, the report of which will be published in due course.

The CQC also carry out an annual community mental health service user satisfaction survey. The 2018 survey was published in November 2018 and included responses from 202 users of the SWLStG community services across the 5 boroughs. Scores on the 28 questions asked ranged from 3.8 to 9.5 out of 10. Most of the scores were considered by the CQC as "about the same" as those for other Trusts. The lowest scores mainly concerned help

finding support for wellbeing, the highest mainly concerned the organisation of care. Overall experience of mental health services was scored at 7.1 out of 10, the highest score for any London Trust, although this reflects a fall in other London Trusts' scores rather than an increase in SWLStG's.

We notified Wandsworth Carers Centre, the local organisation representing carers, of our plans to visit East Wandsworth CMHT and invited them to let us have any feedback or identify any carers with recent experience of the team who might be willing to give us feedback. One carer was identified in this way and interviewed on 26 July - their input is incorporated in the Findings below.

### 2.3 Final Preparations

In the light of our objectives and the information obtained we drew up a list of questions on which to base our interviews with patients and a parallel form on which to record our interview notes. We agreed with the managers dates for two visits on 2 and 18 July, sent them a poster alerting people to our visit (which we subsequently saw displayed by the reception desk at the team base). We also supplied a letter which the CMHT used as a basis for discussion with individual patients to identify those willing to speak to us.

## 3.0 Our Enter and View Visits

On 2 July two members of the Enter and View team visited the East Wandsworth CMHT team base from 9.30 am. They were welcomed by Abu Sankoh, Deputy Team Manager, Rick Dalton and James Black and given a schedule of six patients who had agreed to attend and be interviewed and a room to use for this purpose. Abu was on hand during the day. In the event two of the patients did not come and accordingly only four interviews could be conducted. The team members left at 4.30 pm after a brief feedback meeting with James Black, the Interim Team Manager.

On 18 July by arrangement two rooms were made available. Three members of the Enter and View team arrived at 9.30 am and shortly after were joined by a Healthwatch Wandsworth Outreach Volunteer acting in a supportive capacity. Again they were welcomed by Abu Sankoh and given a schedule of eight patients who had agreed to attend and be interviewed. In addition, a further patient had been identified by Healthwatch Wandsworth as interested in giving feedback and an appointment had been made for them. In the event four of those identified did not come but Abu was able to find two other patients attending the team base on that day and who were willing to be interviewed. Accordingly seven interviews were conducted. One member of the team and the Outreach Volunteer left at about 2 pm and the other two at around 5 pm after a brief feedback meeting with James Black.

After our visits Healthwatch Wandsworth passed to the team a survey response completed on 8 July by or on behalf of a patient giving some relatively brief feedback on the East Wandsworth CMHT. This feedback is incorporated into the Findings below.

Thus we have obtained feedback from a total of 12 users of the service and one carer.

Of the 12 patients seven were being treated under the Care Programme Approach (as described at 2.2.2 above) and five were non-CPA patients. Of the 11 we interviewed seven were male and four female; three were aged under 30, one between 30 and 40, three between 40 and 50, and four over 50; five were White British, four Black African, Caribbean or Black British, one of Middle Eastern and one of Asian origin. So far as we could make out, at least five had been under the care of the East Wandsworth team (or its predecessors) for more than five years (sometimes with breaks or periods of hospitalisation), three for between two and 5 years, and another three for periods of less than two years. We saw patients who were being seen or who had seen psychiatrists, CPNs, OTs, support workers, psychologists and employment specialists, people who had been inpatients and people who attended the Recovery College and the Crisis Café as well as Talk Wandsworth, giving a wide range of services utilised either concurrently or in the past. So while our methodology does not allow us to claim to have interviewed a representative or indeed a random sample of the team's caseload (as most of the service users were approached by team members and invited to come for interview) we feel we have encountered a reasonable spread of experience.

## 4.0 Our Findings

People's experience of mental ill-health can be very varied and complex. We received conflicting evidence from those we spoke to and it is hard to draw a balance.

On the one hand ten out of the twelve very differently situated patients who gave us feedback about the East Wandsworth CMHT, were generally positive, sometimes very positive, about the care they were currently receiving from the team, although some had specific issues or had bad experiences along the way.

On the other hand two patients and a carer, despite some positive comments, gave predominantly negative feedback. One CPA patient with a long history of psychotic illness had a variety of dissatisfactions, some of which could perhaps be ascribed to the effects of their illness and to the impact both the illness and the medication they need to take have had on their life. Another patient, only recently referred to the team and not needing to be on CPA, felt inadequately supported and informed in their current situation. The carer we spoke to had a number of specific concerns (about continuity of care, being listened to and about discharge). More will be said about all these issues below.

### 4.1 Accessing the team

We asked people about their experience of being referred to the CMHT. There was a variety of access routes and a variety of experience. A few had been with the team so long that they had no clear recollection of the referral process. Of the more recent referrals, three CPA patients had had a smooth transition from an inpatient ward to the care of the CMHT in 2015, 2017 and 2019, thanks to having been allocated a care coordinator from the team while (or before) they were on the ward. One of these was particularly grateful for what the care coordinator had done for them at that stage in relation to housing and other issues.

A patient originally on CPA but now discharged from it described accessing the team in 2016 as "a terrible experience": they were discharged to the team from an inpatient ward and received a copy of the discharge letter but heard nothing from the team; a month and a half later their GP chased up and the Home Treatment Team were brought in to support the patient; but apparently another two months passed before they were assigned a care coordinator. The patient recalls that their "progress was stalled " and "the first six months didn't exist". This patient suggested it would make for smoother access to the team if everyone referred to the team was given a welcome pack or email about the team and what to expect, including contact details for use if in difficulty. *(We pick this suggestion up in our recommendations at 5.0 below.)*

A further CPA patient had an uncomfortable experience of hospital discharge in 2018, with an immediate post-discharge crisis and significant difficulty accessing help at a weekend. This patient felt that the Trust should do more to help people deal with problems immediately following discharge from hospital. *(We pick this suggestion up in our recommendations at 5.0 below.)*

The two more recently referred non-CPA patients also had varying experience. One was apparently referred from the Home Treatment Team who prepared the way by drawing up with the patient a basic plan of action to help them cope. They were then seen within a reasonable time frame by a psychiatrist, prescribed medication and referred for specific psychological therapy: there was a wait of three months for therapy but this has been successful and the patient has accepted the wait as reasonable in the light of their own experience of working in an allied field.

By contrast another patient was referred from Talk Wandsworth, the primary care psychological therapy service, as a deterioration in mood had caused concern; they received a triage assessment by the Single Point of Access and referral to the East Wandsworth team. They were then seen three times at monthly intervals by a psychiatrist for what was viewed as a further assessment; the patient had difficulty trying to rearrange the fourth appointment and at the time of our interview was waiting for a new appointment and unclear about the options for further treatment which had only been the subject of preliminary discussion. Having lost the support of the ongoing therapy they had previously been receiving at Talk Wandsworth, the patient felt inadequately supported and informed. *(With the patient's agreement we fed this back to the Interim Team manager who undertook to arrange for the date of the next appointment to be sorted out with the patient.)*

### 4.2 Information, involvement and choice (including care planning)

We asked a number of questions about Care Plans and whether people felt sufficiently informed, involved and had enough choice with their treatment.

The production and regular review of a care plan is a key feature of the statutory Care Programme Approach and the Trust has devoted considerable effort to developing, implementing and auditing standards for care planning which fully involve the patient. It is therefore noteworthy that, while three of the six CPA patients we interviewed were aware

of having a care plan and some mentioned use made of it, another three told us that so far as they are aware they do not have a care plan. Two of these were however happy with their treatment and felt sufficiently informed. (*With the patients' consent we put this situation to the Interim Team Manager who was able to verify from the team's records that up to date care plans existed for these patients. But he told us that the structure of the Trust's electronic records system, although it included a section marked "client views", did not provide clearly for recording that the care plan has been co-written, understood by the client and that a copy has been supplied. He intends to make alternative arrangements to capture this information in future. He has also plans to discuss the issue on the agenda for a team meeting. We return to this matter in our recommendations at 5.0 below.)*

Non-CPA patients should receive an outcome letter after each psychiatric review appointment: we were shown one such letter by a patient and it contained sections marked Care Plan and Crisis Plan. Those working with a psychologist should be given a clear statement of the therapy goals and the approach being taken. We heard no concerns about information or involvement from three of the five the non-CPA patients we interviewed. One however thought they had stopped receiving copies of the outcome letter following psychiatric reviews. *(With the patient's consent we reported this to the Interim Team Manager who said he would arrange for a fresh copy of the last such letter to be sent to the patient.)*

On the question of choice we heard a variety of comments. On medication, a few patients felt they had no choice but to take the medication prescribed (although they were under no legal obligation to do so to receive treatment, in the absence of a Community Treatment Order) but one patient said that the medication affected their sexual performance and hence relationship with their partner. Another, who was hoping for psychological therapy, said that they were told that unless they took a higher dose of medication “we are unable to help you” and also felt ill-informed about potential options for “psychotherapy” one of which was a private “pay what you can” option as other options could involve a significant waiting time. More generally, at least three patients said there was enough choice, although some had not taken up options offered. One other CPA patient felt there was no choice but they "didn't mind". Among the various forms of treatment and support mentioned to us were psychotherapy, art and music therapy, courses at the Recovery College, employment support, referral to a gym and practical support from a Recovery Support Worker. One patient suggested that the team should offer or signpost complementary therapies such as massage. *(We cover the issue of choice in our recommendations at 5.0 below.)*

### 4.3 Relationship with team

The professionalism and clinical expertise of the CMHT's medical and other professional staff is clearly crucial to the team's success in assisting people's recovery. We, like the majority of patients and carers, are not in a position to form any judgement on this. But also of major importance in the recovery process is the relationship that patients are able to form with the staff who are helping them. In practice, patients' knowledge of CMHT

members is limited to those with whom they have regular contact: their psychiatrist, their care coordinator (if on CPA) or their therapist or support worker (if not). Of the 11 patients we interviewed, a total of nine had positive (in some cases very positive) things to say about their current care coordinator (we counted at least four different CPNs and an OT) or their psychologist, employment adviser or recovery support worker. One patient also made specific reference to their psychiatrist who was able to speak their language of origin and thus establish a very positive relationship.

In one instance (already mentioned at 4.0 above) a patient, when interviewed, had critical things to say about their care coordinator (although we understand that the patient is also currently very dependent on the care coordinator and makes frequent telephone contact). These included not being listened to, not being taken seriously in terms of their values and aspirations and even being laughed at. Without being in a position to endorse the validity of these comments, we would suggest that it is important not just that patients should be respected in their individuality, but that they should feel respected. (*We cover this point in our recommendations at 5.0 below).*

One other finding seems relevant here. As mentioned above, a recently referred non-CPA patient, who had not yet been assigned a team member other than the psychiatrist, clearly felt adrift and unsupported. *(We attempt to cover this in our recommendations at 5.0 below.)*

### 4.4 Continuity of care

The Care Programme Approach relies heavily on the role of the care coordinator to monitor, facilitate and trouble-shoot people's recovery from severe mental illness. Patients typically invest a lot of themselves in this relationship and changes of care coordinator can cause difficulty, particularly if unexpected and unprepared. We asked the seven patients who had been on CPA with the team about their experience. Two had only been with the team for a relatively short period and had not had a change of care coordinator. Nor had another patient who had been with the team for two and a half years. Another had had one change in two to three years and had had the present care coordinator for a year. Another patient had had 10 care coordinators in 10 years (which seems quite a lot) but has had the present one for a year already. Another after waiting "ages" to be assigned a care coordinator in 2017 had two changes in relatively short succession and then "gave up" and switched to non-CPA care. The carer said that their relative had two or three changes of care coordinator in what was probably less than a year in 2017 and 2018 before obtaining some stability. Another patient has had two changes in the last year which they felt "a little shocking". Two patients mentioned that they had seen several psychiatrists and were not happy about this. *(We mention the issue of continuity in our recommendations at 5.0 below.)*

### 4.5 Location

The majority of the patients we interviewed were used to coming to Harewood House for their psychiatric reviews and meetings with care coordinators or psychological therapists. Only two seemed to be receiving home visits, one of these being from a recovery support

worker providing largely practical help as well as emotional support. Several of those we interviewed lived nearby and found it a convenient venue. Only one would have preferred more home visits. There was no criticism of the space and facilities apart from one patient who described the waiting area as "not friendly or comfortable". We are conscious that the team conducts many home visits and that our sample is likely to have been skewed in this respect.

### 4.6 Crisis planning and management

We asked patients about their experience of crisis planning and management and received a variety of responses. Those patients who were unaware of a care plan were similarly unsighted on crisis planning. A few patients spoke coherently about this issue. One long term patient no longer on CPA was apparently able to contact the Crisis and Home Treatment Team (CHTT) when needed although they did not have such a close relationship with them as with their recovery and Support Worker. Another patient spoke of a recent crisis which was quickly resolved: the CHTT had been involved but they were experienced as "bad" while the East Wandsworth team were "good". A third patient referred through the CHTT had developed a preliminary crisis plan with them, but then went into the issue in greater depth once assigned a psychologist at East Wandsworth. As mentioned above, the example which we saw of an outcome letter following a psychiatric review contained a section marked Crisis Plan. Several patients mentioned having the number for a "Crisis Line" - we understand this to be the Trust's out of hours Support Line which is able to signpost people to help in a crisis. Several patients had used the "Crisis Café" operated by Hestia with the support of the CHTT. But the experience reported under 4.1 above of a patient discharged from hospital and unable to get help they needed at a weekend suggests there is some way to go before the accessible 24/7 crisis care envisaged in the NHS Long Term Plan is fully realised. (*We return to this and the recording of patients' involvement in crisis plans in our recommendations at 5.0 below.)*

### 4.7 Physical Health

In policy statements on mental health there is increasing emphasis on the lower life expectancy of people with mental health conditions and the need to "close the gap". While most patients we spoke to recognised that primary responsibility for their physical health lay with their GP, several patients mentioned blood tests (for effects of medication) and cardio-metabolic checks carried out by the East Wadsworth team. Two patients mentioned being referred to a gym or offered use of the gym at Springfield Hospital (but neither had yet taken this up). One patient, despite an apparently healthy lifestyle, was suffering kidney damage, possibly as a side-effect of long term antipsychotic medication. Another patient who suffered from auto-immune conditions which interacted with their mental health felt that health services tended to be too narrowly focussed and not to recognise the connections.

### 4.8 Social Care

The majority of the patients we interviewed received support from the benefits system, social services or the voluntary sector. Four patients mentioned assistance in dealing with these issues from the team and/or the Trust's Welfare Benefits Team (which offers welfare benefits advice, consultancy and representation for patients). Another recently referred non-CPA patient's current struggle with the benefits system was adversely affecting their mood but they did not appear to have had any offer of help from the team.

### 4.9 Working with Carers

Over half of those we interviewed had supportive parents, other family members or friends who they were happy to involve to a greater or lesser extent in their care. They found the team helpful and open to involving their supporters. One patient had been offered family therapy but their parent had not wanted to join in, so the offer was not taken up. A few of the longer-term male patients seemed rather isolated, living alone and having no family and few, if any, friends.

The carer we spoke to said that they had been accepted as their relative's carer and generally consulted. They had attended major meetings when the patient was unwell and unable to speak up for themselves. They had a number of issues to pursue in view of changes in the patient's symptoms but felt they were not being heard until they brought along a representative from the Carers Centre to act as an additional advocate. *(We cover working with carers in our recommendations at 5.0 below.)*

### 4.10 Discharge

The carer we spoke to had a very unsatisfactory experience to report in relation to their relative's discharge from the East Wandsworth team's care earlier this year. The patient was called in for what they apparently believed to be a regular appointment and was told that they were being discharged. The patient apparently accepted this but told no-one and the carer was unaware of it. Sometime later, as a result of the patient becoming unwell, it emerged that they had been discharged from the CMHT. Apparently the GP surgery and the Primary Care Plus worker (whose role includes supporting patients newly discharged from secondary care) there had received no notification either. *(Lack of preparation, failure to involve the patient's relative and failure to notify the GP all appear to be at odds with the provisions on discharge in the Trust's CPA policy. We cover this in our recommendations at 5.0 below.)*

Most of the patients we interviewed were not expecting to be discharged from care soon. One patient expressed a wish to be discharged but this did not seem a realistic prospect in the near future. A couple of patients mentioned good experience of being discharged back to their GPs on past occasions. One CPA patient would welcome a reduced level of support, including coming off the CPA list, but thought that they would need continued monitoring for the effects of clozapine. Two non-CPA patients had come or were coming to the end of their successful work with psychologists but were left feeling unclear about their status with the team as a whole and felt that their discharge should be marked in

some appropriate way *(We fed this situation back to the Interim Team Manager and he undertook to reflect on it. We attempt to cover the issue in our recommendations at 5.0 below.)*

## 5.0 Our Conclusions and Recommendations

Given the often disheartening impact of severe mental illness on individual patients and their families, the generally positive, and sometimes very positive, tone of the feedback we received from most of the patients of the East Wandsworth Community Mental Health Team to whom we spoke suggests that the concerted efforts to improve the performance of the team over the last year or so have had a considerable impact. Credit is due to the management and the hard-pressed clinical staff for this.

At the same time most patients identified some concerns, in many instances quite minor but for others more significant. These related to aspects of information, involvement and choice; respect for individuals; continuity of care (while some of the examples here can be considered "historic", there was a more recent one which suggests that despite efforts to improve recruitment and retention the problem has not gone away); crisis management; working with carers and discharge.

In addition we were concerned that several of the patients we saw said that they were not aware of care plans, the next steps in their treatment or crisis plans.

Some of these issues appear to fall within existing norms and procedures and we would recommend team management to consider what more might be done to ensure that these are fully adhered to. This includes:

1. Respect for individuals: ensure that patients are not only respected but feel respected.

2. Choice: ensure that patients are given and understand as wide as possible a range of choices regarding their treatment, including a change of care coordinator if wanted.

3. Continuity of care: seek to minimise unwanted changes of care coordinator and of consultant psychiatrist and preparing patients for change, particularly of care coordinator, so far as possible.

4. Working with carers: ensure that carers feel that their voice is heard.

5. Discharge: ensure that all patients (including those not on CPA) and their carers are properly prepared for discharge and that following discharge a letter is sent to the GP within 7 days.

In addition to meet some of the expressed concerns we have some ideas for improvement that may involve changes in existing procedures. We would like to recommend:

6. The Trust should develop a welcome pack and/or welcome email for patients referred to a CMHT. This should cover what patients and carers should expect from the team and who to contact both during and outside working hours. There might need to be different version for CPA and non-CPA patients;

7. More should be done to provide a reliably and directly accessible, as well as clinically qualified, out of hours (including weekends) source of advice and support for CMHT patients experiencing difficulty, with access to the Crisis and Home Treatment Team as necessary.

8. The team need to ensure that patients are involved in the co-creation of their care plans (or the next steps in their treatment if they are not on CPA) and their crisis plans and that they understand them and have a copy. In order to be able to document and monitor this requirement routinely the Trust should consider the need to amend its existing electronic records system.

Finally, while acknowledging the recent improvements under the current management team and not wishing to cause disruption by further organisational changes, we wonder whether in the longer term patients and their families might not be better served if the sheer size of the East Wandsworth CMHT could be reduced by increasing the number of teams in Wandsworth or rebalancing them in some other way. We accordingly recommend:

**9.** The Trust should consider with the responsible commissioners the case for devoting additional resources to reducing the overall size and caseload of the East Wandsworth team in the longer term while minimising disruption.

**Revised 18 September 2019**

**Disclaimer:**

**Please note that our findings in this report relate to observations and interviews on particular days. It should not be taken as a representative portrayal of the experiences of all service users, carers and staff associated with the East Wandsworth Community Mental Health Team over time.**

## Appendix A: When is Support of CPA Needed? (Extract from CPA Policy)

**Characteristics to consider when deciding if support of CPA is needed**

**Complex needs:**

Key groups of patients requiring CPA are those who have the following:

- Multiple diagnoses e.g. organic + functional mental disorder, or complex interaction between physical health disorder and mental state
- Complex mental health needs & difficult to engage or frequent relapse
- A recent history of violence or suicide attempt
- Self neglect to a degree that it endangers physical health
- Red zone for extended period
- Parental responsibility

**Higher Risk & Multi-Agency input:**

1. Severe mental disorder (including personality disorder) with high degree of clinical complexity
2. Current or potential risk(s), including:
    - Suicide, self harm, harm to others (including history of offending)
    - Relapse history requiring urgent response
    - Self neglect to a significant extent
    - Non concordance with treatment plan
    - Vulnerable adult: adult/child protection
    - Exploitation e.g. financial/physical/emotional/sexual
    - Behavioural or psychological symptoms
    - Adult Safeguarding or Child protection issues
3. Current or significant history of severe distress/instability or disengagement.
4. Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability
5. Multiple service provision from different agencies, including housing, physical care, employment, criminal justice, voluntary agencies
6. Currently/recently detained under the Mental Health Act or referred to crisis/home treatment team
7. Significant reliance on carer(s) with associate high level of carer stress or has own significant caring responsibilities
8. Experiencing disadvantage or difficulty as a result of:
    - Parenting responsibility
    - Physical health problems/disability
    - Unsettled accommodation/housing issues
    - Employment issues when mentally ill
    - Significant impairment of function due to mental illness
    - Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues

## Appendix B: Care Planning and Care Programme Approach (CPA)

**(Community Quality Standards)**

### Transfers/Referral to RST

- Inpatient wards: Care Coordinator allocated within 72hrs
- Tertiary Services: Care Coordinator allocated within 28 days
- HTT Teams: Care Coordinator allocated within 5 working days
- SPA Transfer: Care Coordinator allocated within 5 working days

### Initial Care Plan/CPA Reviews

- Initial Care plan provided within 14 days & reviewed in CPA within 3 mts.
- Service User, Carers/Relatives, GP, other care providers will be invited.
- Minutes of CPA to be sent to all to the above within 10 working days.
- Care Plan to stipulate frequency of contact with Care Coordinator (1-4 weeks)
- Work towards discharge from the outset of treatment

### On-going CPA Reviews

- Annually or crisis/changes in care or circumstances
- Issues Addressed: Recovery goals, Risk, Finance issues, Accommodation, physical health, mental health, friends and family.
- Service User, Carers/Relatives, GP, other care providers must be invited.
- Care Plans must identify service users recovery capital/resilience and also incorporate carer/relative support and input.

### Discharge to GP or Transfer to other service

- Discharge CPA involving Service User, Carers/Relatives, GP, other care providers
- Discharge/transfer to other Mental Health provider
- Discharge to GP/Primary care – rapid access within 6mts of discharge
- Transfer to Primary Care Plus

## Appendix C: Zoning: Extracts from Trust's CPA Policy

Zoning involves categorising service users into Red, Amber and Green. Zoning takes place at the regular team meeting and is recorded on the team board. The system targets resources and links, interventions and care plans to each zone for each patient.

- **Red** zone represents patients who are considered to be currently at risk or in crisis and whose care requires intensive contact and review.
- **Amber** zone represents patients who are unwell; require frequent contact but who do not present major risks.
- **Green** zone contains patients who are stable and proactively engaging with their care plan.

Care plans and interventions should be adjusted to correlate with the relevant zone e.g. a client on Red zone must have a care plan that demonstrated an increase in the support offered by the team to address the increased level in need/risk. Zoning can also represent the client's pathway through the team as the client will initially commence their journey with the team on Red zone and over time will progress through Amber and on to Green. Most service users will experience difficulties or crisis and will need to be rezoned to reflect this increase in need or risk. Zoning can also be used to guide the clinical team plan for service users e.g. if a client in the Green zone for a period of time this might indicate that they are ready to be discharged.