Crisis Assessment and Treatment Teams
Operational Policy

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Executive Lead: Interim Director for Service Delivery
Lead Author: CATT Service Manager
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Target Audience:
This Policy must be understood by:
❖ All staff working in Crisis Assessment and Treatment Teams (CATTs)
❖ Any related service which may make referrals to CATTs
Preface - concerning the Trust Policy Management System (PMS)

P1 - Version Control History:
Below notes the current and previous Version details- full history is in Part 3

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P2 - Relevant Standards:

a) Equality and RESPECT: The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

b) NICE Quality Standard – for service user experience in mental health

c) NICE CG133 – Self Harm: Longer term management

P3 - The 2012 Policy Management System and the Policy Format:

- Policy Template is the essential format for most Policies. It contains all that staff need to know to carry out their duties in the area covered by the Policy.

- Operational Policies Template provides the format to describe our services, how they work and who can access them

- Care Pathways Template is at the moment in draft and only for the use of the Pathways Team as they are adapting the design on a working basis.

Symbols used in Full Policies:

RULE =internally agreed, that this is a rule & must be done the way described

STANDARD = a national standard which we must comply with, so must be followed

Managers must bring all relevant policies to the attention of their staff, where possible, viewing and discussing the contents so that the team is aware of what they need to do.

Individual staff/students/learners are responsible for implementing the requirements appropriate to their role, through reading the Policy and demonstrating to their manager that they understand the key points.

All Trust Policies will change to these formats as Policies are reviewed every 3 years, or when national Policy or legislation or other change prompts a review. All expired & superseded documents are retained & archived and are accessible through the Compliance and Risk Facilitator Policies@hertspartsft.nhs.uk

All current Policies can be found on the Trust Policy Website via the Green Button or http://trustspace/InformationCentre/TrustPolicies/default.aspx
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PART 1 – Preliminary Issues:

1. **Summary**

   This policy explains the responsibilities and service provision of the Crisis Assessment and Treatment Teams (CATT) in the Trust. The CATTs are integrated multi-disciplinary teams offering a crisis assessment service, followed, when appropriate, by an intensive, short-term additional Home Treatment Service. The service is available 24 hours, 7 days a week. The service is part of the Acute Care Pathway within Hertfordshire Partnership NHS University Foundation Trust (HPFT) services.

2. **Purpose**

   CATTs were developed to meet Government directives through the National Service Framework for Mental Health (1999), the NHS Plan (2000) and the National Service Implementation Guide (2001). The model of care that CATTs are based on indicates that a service which provides a 24-hour, 7 days a week multi-disciplinary assessment, treatment and support service to people in crisis as a result of severe mental health difficulties is as good as or better than outcomes achieved by traditional hospital treatment. Service users and carers generally prefer community-based support and treatment, promptly delivered and available over a 24-hour period, as an alternative to hospital admission.

3. **Aims of the Service**

   3.1 To act as the gatekeeper to in-patient services and be routinely involved and consulted during the assessment period when in-patient admission is being considered.

   3.2 To rapidly assess and identify whether home treatment or any alternative method of managing the crisis would be appropriate in order that in-patient admission could be avoided.

   3.3 To offer well co-ordinated intensive interventions and support to service users and carers in the early stages of a crisis, this will include the identification of carers needs

   3.4 To ensure interventions building on the strengths of the service user and assist the service user and any involved carers, to understand and manage the crisis whenever possible at home.

   3.5 To work in partnership with people using mental health services and their families or carers, offering help, treatment and care in an atmosphere of hope and optimism, taking time to build trusting, supportive, empathic and non-judgemental relationships as an essential part of care.

   3.6 Where appropriate to assist in managing the admission to hospital when no alternative community based treatment is feasible.

   3.7 If in-patient care is necessary, to be actively involved in inpatient care and discharge planning and, when appropriate, provide short term intensive care at home to enable early discharge.
3.8 To offer a 24 hour, 7 days a week service.

3.9 To assist the service user and relevant carers to learn from the crisis and endeavour to reduce the service user’s vulnerability to crisis and maximise their resilience and recovery.

3.10 To offer advice to referrers in the management of a crisis when hospital admission is not being considered.

4. Definitions

CATT – Crisis Assessment and Treatment Team
CMHS – Community Mental Health Service
FACT – Flexible Assertive Community Treatment
CAMHS – Child and Adolescent Mental Health Service
SMHTOP – Specialist Mental Health Team Older Persons
EPR – Electronic Patient Record
PDD – Predicted date of discharge
PG – Practice Governance

5. Key Principles

RULE

5.1 Short-term treatment at home is offered, as an alternative to hospital admission, whenever this is appropriate. From time to time admission for in-patient care will be necessary and, when appropriate, CATTs will also offer intensive support at home leading up to and following discharge in order to achieve the earliest possible discharge date.

5.2 For effective CATT functioning within the entirety of the HPFT system the following principles are essential:

CATTs must be-

- actively involved in all requests for admission, and in the associated assessments
- actively involved in all MHA assessments
- central to the decision making process for admission, in alliance with other involved teams
- central to and active within the early discharge process
6. Team Locations and Opening Hours

6.1 Full contact details of the Hertfordshire CATTs are to be found in Appendix A.

6.2 CATTs are based at the locations in Appendix A from 8:30am – 9.30pm 7 days a week including bank holidays. From 9.30pm – 8.30am, each team is present at either the local A&E department or the Mental Health Unit carrying out urgent assessments there and in other locations as required.

6.3 Medical cover during the working week is provided from 9am – 5pm Monday to Friday by the CATTs Consultant Psychiatrist with his/ her supporting medical staff.

6.4 Medical cover out of hours during the week and at weekends will be provided by the resident junior trainee doctor on-call with access to the on-call registrar (SpR) at all times. The On-Call Consultant has overall medical responsibility during out of hours and can be contacted by either the Junior Trainee or the SpR.

7. Service User Profile and Eligibility for Service

7.1 The CATTs will provide assessment, followed by home treatment where appropriate, for adults aged 18 years and over with mental health problems who are in crisis, and where the crisis episode is of such severity that admission to hospital is being considered.

7.2 CAMHS provide all services for service users in crisis who are aged under 18. If a child/adolescent (under 18 years old) with mental health problems presents in crisis at A&E out of hours, CATT will support duty doctors in their assessment. If a 16 – 18 year old requires out of hours crisis support awaiting follow up from the Adolescent Outreach team during usual working hours, CATT will provide that support.

7.3 People taken on for home treatment will typically be:

- Those with an acute episode of functional mental illness (e.g. acute psychotic episode, schizophrenia, manic depression, moderate to severe depressive disorder) who would otherwise require admission
- Those who present with acute stress reactions with secondary suicidal ideation/ intent who would otherwise require admission but who often respond well to brief input from home treatment.
- Previously unknown people who are acutely unwell who require assessment over a 1 – 2 week period to determine the diagnosis and who otherwise would require admission.
- Those with severe functional mental illness who require in-patient care and will benefit from intensive home treatment in the period following discharge from hospital.
- Specific short treatments, such as the introduction of Clozapine and other atypical psychotropic medication, which may normally require admission to hospital.
- Individuals with dual diagnosis (being a diagnosis of serious mental illness and substance misuse) who become acutely mentally unwell. Refer to the Trust Dual Diagnosis Procedure.
- People with a co-morbid personality disorder.
- People with one of the above who also have a co-morbid alcohol related issues and/or who are homeless.
- People who are clinically appropriate for early discharge from psychiatric in-patient care. This includes in-patients at home on Section 17 leave and service users on Community Treatment Orders.

7.4 Service users will normally, but not exclusively, be permanent residents of the catchment area. The team will be expected to assess those from outside the catchment who present in crisis to determine the most appropriate way of dealing with the crisis. Temporary residents (e.g. in bed and breakfast) will not be discriminated against: the prime consideration should be need. If people are temporary residents without a local GP, again need is the key. CATTs will encourage local registration, even if for a temporary residence.

7.5 Wellbeing Team Service Users can be referred direct to CATT if they are in crisis of such severity that admission to a psychiatric inpatient unit is indicated. The referral will be made by the Wellbeing Team leader. This responsibility may be delegated to avoid unnecessary delay.

7.6 Adults with a primary diagnosis of Dementia will not be eligible for CATT. People with a primary organic problem such as dementia may be suitable for Intensive Outreach Team support through the SMHTOP team.

7.7 Adults with co-occurring mental illness and substance misuse are eligible for home treatment when clinically appropriate. If the referred person is intoxicated at the time of referral, and the referrer feels the person is at serious risk of harm, the referrer should lead on arrangements to ensure the safety of the person until they can be fully assessed. CATT will contribute to the assessment of risk, and support the referrer in developing an interim plan of care until the person is medically fit for mental health assessment. CATT does not provide home treatment for substance misuse detoxification. Refer to the Trust-Spectrum Procedure for the Care and Treatment of service users with co-occurring mental illness and substance misuse for further information.

7.8 CATT will accept referrals of adults who have taken an overdose. Advice will be given to the referrer to arrange treatment for the overdose as a priority, by transfer to A&E for physical health checks, before the CATT assessment proceeds.

The normal procedure for any person presenting in A & E is that they are initially seen by A & E staff who will assess their immediate medical needs. Following attention to immediate medical needs a referral to the CAT Team can take place.

Advice, support and an initial plan will be offered until necessary medical attention has been given. Once pronounced medically fit by ED staff a full assessment can then be carried out by the CAT Team with appropriate intervention and follow-up where necessary. When the physical condition does not preclude psychiatric assessment CATT will carry out a parallel assessment whilst the medical condition is being treated.
7.9 For referrals from Bedfordshire and bordering counties in regards to the contracts/agreements HPFT has with these organisations, please refer to District of Residence Section in Community Mental Health Services Operational Policy.

8. Access to healthcare for people with communication, involvement and capacity needs.

**STANDARD** HPFT have a responsibility to ensure that all people access appropriate services, have their views represented throughout the assessment and care planning process, and that they receive the best treatment available in line with good practice and legal frameworks.

**RULE** HPFT have a responsibility to ensure that all people with a learning disability access appropriate services and that they receive the best treatment available in line with good practice and legal frameworks. Therefore all services will ensure that:

- Reasonable adjustments are made to ensure that each person has the same opportunity for health. (Equality Act 2010)(Care Act 2014)
- Assume that each person presented to the service has capacity. If assessment shows they don’t, a decision must be made in their best interest. (Mental Capacity Act 2005)
- Everyone has a right to expect and receive appropriate healthcare. (Human Rights Act 1998)
- If an individual has substantial difficulty in communicating or being involved in the assessment and care planning processes, then appropriate actions are taken to ensure that the individual is enabled or represented during the process (eg reasonable adjustments or advocacy). (Care Act, 2014)

Adjustments will include:

- spending time with the individual to gain an understanding of their preferences for treatment
- To ask them where they would prefer to be treated,
- To provide additional support to assist with communication, this support will be available via easy read material/and/or audio equipment. Templates for appointment letters and easy read information leaflets are available on the Performance page on the intranet.
- If an individual continues to have difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support
- All people with a learning disability may have a Health Action Plan or Purple Folder and all HPFT staff will ask for permission to see these and contribute to the plan when appropriate
- To value and welcome the contribution of the relative/carer/advocate

9. Referral Procedure

**RULE** CATTs must be consulted 24 hours, 7 days a week, whenever admission to a psychiatric hospital is being considered (with the exception of 7.6 above).
9.1 All service users referred to CATT services will have an assessment prior to admission to the CATT service. Admission will not take place without this assessment.

9.2 When a service user currently open to services is in crisis and in-patient admission is being considered, the Care Co-ordinator (or their delegated representative) will generate a referral to CATT. The referral will be made following a recent assessment (in the previous 3 working days) of the service user and rapid consultation with the responsible consultant and other members of the multi-disciplinary team. A current risk assessment, up to date assessment, current medication prescribed and relevant past history should be made available to CATTs.

9.3 If a hospital admission is indicated by known information about the service user, every effort should be made for a single joint assessment involving the referring team and CATT, to reduce the number of assessments service users have to participate in.

9.4 Referrals are usually made by telephone to CATT and should meet the eligibility criteria outlined in Section 7 above.

9.5 If an emergency admission is being planned, CATTs should be notified immediately by the Trust staff involved in planning an emergency admission, so that early CATT assessment occurs.

9.6 All new referrals to Trust services are made through the Trust Single Point of Access service. If a Service User not known to services is in crisis and the referral indicates a crisis of such severity that in-patient admission is being considered, SPA will screen the referral. All possible information, including any accessible records should be scrutinised. The level of urgency should be determined. Following screening immediate contact with CATTs should be made if in-patient admission may be necessary and relevant EPR documentation completed by SPA before transfer to CATT for assessment.

9.7 Out of hours referrals will be accepted direct to CATT for assessment from local GPs, GP On call Service, the HCC Out of Hours Safeguarding Team, NHS Direct, On-Call Consultants, Community Support Teams, HPFT Mental Health helpline, Mental Health Liaison and the Police Surgeon. Details of the service user’s situation will be required and it is anticipated, a short screening assessment and information regarding any previous contact with mental health services will have been gathered prior to any contact with CATTs.

9.8 CATTs may agree self-referral as part of an agreed care plan with service users who have experience of using CATT services. Any self-referral will be notified to the Care Co-ordinator of the service user within 4 hours of receipt by the CATT team.

9.9 Referrals should be made direct to the local team until 9.00pm each evening, 7 days a week including bank holidays. After 9.00pm and before 9.00am referrals should be made to the quadrant CATT professional on night duty. (See appendix “A “for contact details)

9.10 RAID, ADTU and Princess Alexandra Hospital crisis team may carry out a ‘Trusted assessment’ for inpatient admission. Ideally they would discuss this referral with CATT however, if they are unable to do so they may proceed with the admission. A Trusted assessment is where a full initial assessment is carried out by the RAID or ADTU workers and discussed with their medical colleagues (on call or own team
doctor). The patient’s needs must meet the eligibility criteria for admission and not be suitable for any other alternative to admission. This would also be considered as part of the trusted assessment.

### RULE

When the CATT professional on night duty, or any On Call Doctor or Out of Hours Approved Mental Health Professional offers a CATT daytime assessment and/or home treatment, this information should be faxed to the local service (for attention of Care Co-ordinator) and the receipt of the fax should be acknowledged with CATT making a follow up telephone call the next working day. These actions should be documented on the EPR for the service user. The results of the out of hour’s assessment will be respected and the local service will ensure the service user is contacted during the first shift of the day. The service user’s needs for home treatment may be re-assessed by the day time team. If the outcome is recommendation for transfer to a different Trust team, or discharge from Trust Services, the service user will be kept fully informed about the decision making process for this. Expectations of automatic home treatment should not be unduly raised by Out of Hours staff.

### 10 CATT Assessment Procedures

#### RULE

Within one hour of receipt of a referral, CATT will contact the referrer to agree the level of urgency and a time for the assessment to occur. The planned assessment will usually occur in the referred service user’s home (if this is feasible and clinically appropriate taking into due account any safety issues). The assessment may take place at other Trust sites such as a Mental Health Unit or the local A&E Department. Whenever possible, the referrer or Care Co-ordinator should be present during the CATT assessment. The Care Co-ordinator should always be informed of a referral or contact with a known service user. In their absence the CMHS manager should be informed.

#### RULE

It is expected that all assessments will take place within 4 hours of referral, unless specific circumstances dictate otherwise (e.g. awaiting a MHA assessment).

10.1 At assessment, CATT staff will provide a clear explanation of the purpose of the assessment, and the possible outcomes of the assessment, including the information that a CATT episode of care, if offered, is for a maximum of six weeks. A comprehensive mental health and social care assessment will be undertaken. CATT will be mindful that previous assessments may have taken place and relevant information may already be available. The team will bear in mind that it is important service users are not subjected to having the same information requested time and time again. Nevertheless there will be a need to explore the current mental state, current risks, reasons underlying the crisis and potential for working with CATT (including the service user’s attitude towards proposed CATT involvement, objectively and subjectively). Physical health needs will also be actively considered (see 13, below). CATT team members will take extra care to understand and emotionally support the service user in crisis, considering their level of distress and associated fear, especially if they have never been in contact with services before, or if their prior experience of services has been difficult and/or they have had compulsory treatment under the Mental Health Act (1983; amended 1995 and 2007).
The CATT worker attending the assessment will be responsible for completing or updating the relevant assessment to record the information collected in the CATT (Initial) assessment and the Risk Assessment to record the risks, and risk management plan. If the service user is new to Trust Mental Health services CATT will be responsible for completing a new Initial Assessment. If the service user is already open to Trust Mental Health services, the most recent initial assessment will be re-assessed by CATT.

10.2 Out of Hours, CATT staff working in A&E should follow 9.3 above if they are undertaking CATT assessments, and follow the RAID Operational Policy if they are undertaking an A&E assessment. If an A&E assessment results in CATT taking the service user on, 10.4 above will be followed for the documentation of the assessment.

10.3 It is expected that CATT assessments at night will be carried out by one qualified member of staff. There will be occasions (following an assessment of risk covering e.g. client history and presentation), where two assessors are deemed necessary in the interests of safety, timely intervention etc. Staff will be able to request support from other CAT team members, bleep holders, the clinical lead or Duty doctor. During the day time, CATT will usually undertake joint assessment with two CATT assessors. If the referring team is present at the assessment, it is appropriate to utilise a single CATT assessor for the assessment.

10.4 Medical staff may be present at an assessment, but this is not a requirement. The assessment will be carried out by a suitably experienced assessor from the team. Medical review will be arranged as appropriate if the client is taken on, or if admission is necessary. Assessments should not be delayed due to non-availability of medical staff unless a pressing need for medical assessment has been identified. At all times, if the CATT assessor feels a medical opinion is necessary or the Service User presents as requiring admission, the CATT Doctor/ Consultant (during working hours) or the Senior Trainee Psychiatrist (On Call Specialist Trainee) (outside working hours) will be consulted. From 9am – 5pm, the CATT Consultant and CATT Junior Medical staff are available for advice, support and a joint assessment if necessary. Outside of working hours the 2nd On Call Doctor can be called to go out on CATT community assessments, and the On Call Consultant can be consulted if there are any disputes. Appendix C provides more information on the Joint Medical/CATT Protocol when Acute Admission is required.

10.5 Leading and recording the Assessment - CATT will normally lead and record assessment in which they are involved with the exception of a Mental Health Act assessment. The CATT doctor is responsible for documenting their own history taking, examination findings, formulation and management plan. The responsibility for leading and recording a Mental Health Act Assessment lies with Approved Mental Health Professional.

10.4 If the Care Co-ordinator of the person being assessed is present agreement will be reached, prior to the assessment, on who should lead and staff will take into account any known preferences of the service user

10.5 When Mental Health Act assessments, including Section 136 assessments, are requested, the AMHP will inform CATT and whenever possible will involve and consult them in the assessment. The final decision regarding the application to hospital under the Mental Health Act lies with the AMHP.

10.6 If the mental health of a service user receiving a period of home treatment deteriorates, a Mental Health Act assessment may need to be arranged. If this occurs,
CATT will ensure that they involve the duty AMHP immediately, and whenever possible, within normal working hours.

10.7 Out of hours requests for a Mental Health Act assessment by the Safeguarding Out of Hours Service (SOOS) will only be made in emergencies and following discussion with the CATT Consultant or on-call Duty Consultant. See Appendix C, Protocol for CATT/SOOS Working.

10.8 If CATT have requested a Mental Health Act assessment, a team member will be present at the assessment unless this is not advised or possible.

10.9 If an advanced directive or advanced statement is in place, the HPFT policy on the use of Advance Decisions and Advance Statements will be adhered to. CATT will ensure the contents of Advance Decision and Advance Statement is noted as part of the assessment.

11. Outcome of the Assessment

11.1 If the assessment determines that neither home treatment nor admission to hospital is required, and the service user is already open to an existing Trust service, that service will be responsible for agreeing and arranging on-going services. The Service User will be referred back to the referring service/ source with clear documentation of the clinical reason for doing so. If there is any dispute in relation to this decision, CATT will work jointly with the existing service to ensure there is an interim plan of care for the service user until the dispute is resolved.

11.2 In the case of a previously unknown person assessed as requiring no secondary mental health service, CATTs will refer the person back to their GP, with clear documentation of the clinical reason for doing so.

**RULE**

In the case of a previously unknown person assessed that neither home treatment nor admission to hospital is required but that they do require on-going secondary care, referral will be made to the appropriate team. CATT will maintain the care coordination role in relation to such service users until transfer to the secondary care team has been completed – being the team has accepted the referral, documenting an interim care plan in a CATT care plan document outlining the actions to support the service user until transfer has taken place.

**RULE**

In all cases of CATT decision that home treatment and admission are not required, CATT will ensure a risk assessment is documented, and that contingency plans are considered and agreed with the service user and relevant carers. CATTs will then arrange and agree alternative arrangements for the service users care, as outlined above. Whilst any alternative plan for care is being arranged, CATT will hold responsibility for monitoring the mental health of the service user and provide sources of information and advice for support, self help resources or services that may be available in the community.

11.3 To avoid admission, CATT will aim to:

- explore with the service user what support systems they have, including family, carers and friends
- support a service user in crisis in their home environment
• make early plans to help the service user maintain their day-to-day activities, including work, education, voluntary work, and other occupations such as caring for dependants and leisure activities, wherever possible.
• consider offering a crisis package to support social care activity to prevent admission
• where carer appears to be providing support, offer a carer’s assessment

At the end of a crisis assessment, CATT will ensure that the decision to start home treatment depends not on the diagnosis, but on:

• the level of distress
• the severity of the problems
• the vulnerability of the service user and any issues of safety and support at home
• the person’s cooperation with treatment.

RULE
When the outcome of the assessment is that an episode of CATT home treatment is appropriate, the care plan to meet the needs and risk assessment of the service user will be documented in an initial CATT care plan, outlining the nature of CATT involvement over the next few days and copy provided to the service user, and their carer (if agreed with service user). See also Section 12.3 below.

11.4 When the outcome of the assessment is that an episode of inpatient admission is appropriate see section 14 below. The CATT assessment will be documented on the relevant assessment.

12. Managing Risk

RULE
CATT will ensure that a comprehensive risk assessment is undertaken as part of all CATT assessments, in line with the Trust Policy for Clinical Risk Assessment and Management of Individual Service Users. If the CATT assessment results in an episode of home treatment, the risk assessment will inform the CATT care plan – with direct link in the care plan between actions and assessed risk (see 12.3 below). An integral part of the CATT treatment episode will be for the service user to have responsibility for their own actions and associated risks supported by the Care Plan and the team’s interventions. Capacity assessments will be undertaken if there is any indication the service user may not have capacity to take responsibility for their own actions, and the outcome of the capacity assessment will be utilised to inform the care plan for the service user. See also Section 8

12.1 CATT will ensure that NICE CG133 is followed when assessing the risk of repetition of self-harm or risk of suicide.

• identify and agree with the person who self-harms the specific risks for them, taking into account:
• methods and frequency of current and past self-harm
• current and past suicidal intent
• depressive symptoms and their relationship to self-harm
• any psychiatric illness and its relationship to self-harm
• the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
• specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
• coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
• significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
• immediate and longer-term risks.

NICE clinical guidance states that risk assessment tools and scales should not be used to predict future suicide or repetition of self-harm. Tools may be used to contribute to the gathering of information as part of the risk assessment process.

12.3 Care and Risk management plans for Home Treatment

**RULE**

A CATT care plan will:

• Identify service user strengths and existing resources in order to facilitate their recovery.
• Identify the actions, with a recovery focus, to address the specific factors (psychological, pharmacological, social and relational) identified in the assessment – see also 17.3.
• Confirm the frequency of visits (usually daily) and actions that will be taken if contact is not made i.e. requesting a welfare check if next of kin cannot be contacted and or cannot confirm reasons for SU not being able to meet CATT. Any change to frequency of visits should always link to an updated risk assessment confirming the evidence of change in risk that underpins change in frequency (see 20.3 below)
• Include the risk management plan.

A CATT risk management plan will be a *clearly identifiable part of the CATT plan and stated as part of the decision for Home treatment* and should:

• address each of the long-term and more immediate risks identified in the risk assessment
• address the specific factors (psychological, pharmacological, social and relational) identified in the assessment as associated with increased risk, with the agreed aim of reducing the risk of repetition of self-harm and/or the risk of suicide.

This will be documented in an Enhanced Risk Assessment document and

• include a *contingency plan* outlining self-management strategies and how to access services during a crisis when self-management strategies fail
• Ensure that the risk management plan is consistent with the long-term treatment strategy.

A copy of the risk management plan and contingency plan will be included in the CATT care plan that is provided to the CATT service user, and their carer, if the CATT service user agrees information can be shared in this way.

While risk assessments are regularly reviewed all service users transferred from another team to CATT service will have a timed review of their risk assessment two weeks from the date of admission to the service and this will include a review of the risks associated with the transfer.
CATT will inform service users of the limits of confidentiality and that information in the plan may be shared with other professionals.

**RULE**

12.4 All CATT contacts with CATT service users will review dynamic risk factors. This review will be documented in the EPR. Any change to the CATT care plan, such as change in frequency or type of contact, will only be made following multi-disciplinary team review of the risk assessment. Such review will be documented in an updated Risk Assessment on the EPR providing evidence to underpin any change in frequency or type of contact and will be followed with amendment to the CATT care plan, with updated copy provided to the CATT service user and their carer, if the CATT service user agrees information can be shared in this way.

13. Resolution of Disputes Following Assessment (see 10.7 for out of hours)

13.1. In certain circumstances disputes over a clinical decision to offer home treatment can arise. For example:

- A duty doctor who is not a member of the CATT\'s service offers home treatment but CATT\'s has not been involved in the assessment or agreed to offer the service

Or

- There is a difference of opinion between individual CATT staff and/ or medical staff and/ or Approved Mental Health Professional over whether home treatment or in-patient admission or discharge back to the GP is the appropriate way forward

13.2. When disputes arise it is essential that they do not lead to the needs of the service user being overlooked, leading to the likelihood of increased risks.

13.3. All CATT services ensure the service user\'s needs are central to the decision making process. Decisions must be clearly recorded and agreed with the CATT Team Manager/ Leader (or delegated representative).

13.4. When there is a difference of view over clinical presentation or management of the Service User, the matter will be escalated to the next level. The CATT Manager or Team Leader or 1st On Call Manager will be involved. The final decision will be made by the CATT Consultant or the On Call Consultant.

13.5 Service user, their carers’ and or representatives should be provided with information on the complaints procedure.

14. Admission for In-patient Care

14.1. If the decision of the CATT assessment is that voluntary in-patient admission is necessary the decision must then be taken on how the admission is managed. When inpatient admission is deemed necessary, after CATT assessment, it is the
responsible of CATT to arrange admission [except for MHA Assessments – see 14.3]. Bed finding will be carried out in line with the Trust Bed Management Policy.

14.2 At times, a bed in the local Mental Health Unit will not available and the service user must be transported to another unit where a bed is available.

14.3 In the case of a Mental Health Act assessment, it is the AMHP’s responsibility to arrange transport and hand-over the care of the service user, together with the appropriate Mental Health Act documentation, to the admitting nurse. If resources and time permit, CATT staff should assist the AMHP.

14.4. If the service user is being admitted as a voluntary patient, CATT will arrange a hand-over of care to the admitting nurse. The service user and carers should be involved in any discussion regarding the admission including if a local admission cannot be arranged. Information about whether the service user has children and who they remain in the care of must also be handed over to the admitting nurse. When a service user has a child under the age of 5 years and, in consultation with the service user, CATT should consider informing the health visitor of the admission. The referring team should assist CATT where possible in effecting admission.

14.5 At times, a service user being offered voluntary admission may choose to await a bed becoming available in a local Mental Health Unit. If this is the case, CATT will involve the service user and relevant carers in a discussion regarding the risks that may occur as a result of the delay. A contingency plan will be agreed and the GP/referrer/Care Co-ordinator will be informed.

14.6 If a same day admission cannot be arranged, CATT will make a plan for contact that is informed by risk assessment, and documented in the EPR. Face to face follow-up will be made the next day and appropriate actions will be taken to ensure the admission occurs.

14.7 Service users awaiting admission, and their carers’, should not, on any account, be left unsupported by CATT, unless some other appropriate means of support has been arranged by CATT.

15. Actions Following CATT Assessment

RULE

15.1 Following a CATT assessment, information on the outcome will, whenever feasible, be communicated by telephone on the same day to all referrers.

15.2 A copy of the assessment, a risk assessment and the CATT care plan documented on the EPR, will be completed as soon as possible, and within 48 hours of assessment. These will be made available to:

- The Care Co-ordinator (known service users)
- The CMHT Manager (Users previously not known or currently closed to the service)
- Copy of care plan to the GP, the service user, and their carer with service user permission

For those services that do not have access to the EPR, a copy will be sent within 2 working days.
15.3. Physical Examination
When a service user has been accepted for a period of home treatment, the patients physical health needs to be evaluated which includes taking a comprehensive history, a mental state examination, and a choice about which physical investigations need to be done. If a physical examination of the service user is warranted, this will only be undertaken with the consent of the service user. All physical health assessment and actions will be recorded in the EPR.

15.4 All CATT written communication with other health/social care professionals will be copied to the service user, unless the service user declines this. If the CATT MDT agrees a particular communication would be of harm to share with the service user, the reason for this decision should be documented in the EPR.

16 Length of Involvement

16.1. When the CATT assessment identifies the need for intensive involvement at home, a clear remit for their involvement will be agreed with the service user and the local community services. Plans will be made in order to ensure discharge from the crisis service occurs within specified time limits.

16.2 The CATT would expect to remain involved with the service user during the period of crisis and whilst home treatment is required. This service however must be time limited and it is anticipated the maximum length of treatment will be no greater than 6 weeks.

16.3 When the primary diagnosis of the service user is personality disorder, a short period of home treatment, up to 7 days, may be offered, although in exceptional circumstances this may be longer. There will be a clear plan identifying the roles and contact agreement for each worker involved.

17 Care Coordination

**RULE**
The Care Programme Approach (CPA) is the framework for care co-ordination and resource allocation within mental health services. All service users of CATT will be cared for under the care level of CPA.

17.2 When a service user is accepted for treatment by CATT, they, and any involved carers, will be involved in discussion and formulation of a CATT Care Plan. It is the responsibility of the CATT key worker to ensure the care plan is documented in the EPR care plan document with the title of CATT care plan. It is the responsibility of the CATT key worker to ensure the service user, and carer, with service user permission, are provided with a copy of the care plan and have on-going opportunities to be involved in the review of the care plan.

17.3 The CATT Care plan will include
- Details of the Risk Management and Contingency Plan identifying risk factors, warning signs and agreed actions to be taken when concerns arise at home or work.
- Consideration of all health and social care needs, and goals to meet identified needs
- details of the frequency and type of contact (see Section 20.3)
• information regarding CATT withdrawal at the end of the crisis period.
• evidence that the Trust Recovery Principles (Appendix D) inform care planning
• service users strengths and consideration of existing resources

17.4 The CATT keyworker will ensure the CATT care plan is kept under regular review and that any changes to the care plan are updated on the EPR care plan document.

17.5 The CATT keyworker will also ensure the HoNOS/Clustering tool is completed when CATT episode commences, and is repeated at transfer from CATT service.

17.6 Each CATT will undertake a weekly check that all people taken on by CATT in the preceding 7 days have had their needs assessment, risk assessment and care plan completed.

17.7 CATT will consider the service users social needs and address these by way of:
• Advice, information and signposting
• Social Care crisis package
• Social Outcomes Assessment (to determine eligibility for a personal budget)
If it is not appropriate for CATT to undertake this assessment then CATT will make appropriate arrangements and referrals to Community Services.

17.8 CATTs will follow all procedures outlined in the Trust Delivery of Care Policy and the Trust Policy on the Discharge and Transfer of Service Users in the Care Planning Process.

18 Role of Care Co-ordinator for existing service users

18.1 When an existing service user of Trust services is offered a brief period of care from the CATT, this is an additional and intensive home treatment service that is not expected to replace the services already received. The existing designated Trust Care Co-ordinator will actively work with the CATT and the service user in order to offer the most comprehensive service possible during the period of crisis. Joint visits and separate, but co-ordinated, visits should be routinely and regularly arranged during this period.

18.2 Case management responsibility will remain with the designated Care Co-ordinator. CATT will identify a keyworker, who will be a qualified professional. The CATT keyworker will have overall responsibility for the co-ordination of CATT care during the episode of CATT treatment, and will be responsible for communicating with the Care Co-ordinator, GP and any other involved professionals during the CATT episode.

18.3 The Care Co-ordinator will remain responsible for undertaking Social Outcomes Assessments, commissioning and reviewing personalised packages of care and support.

19 Care Co-ordination for New Service Users

19.1 The CATT assessor is responsible for completing CPA information when the service user is not a current user of services. For these individuals, a member of the CATT will be nominated Care Co-ordinator during the CATT episode of treatment. When the period of treatment nears completion, the care co-ordination role will be transferred
appropriately to a member of the CMHT through the CPA process. Simultaneously the medical responsibility will be transferred to a local community consultant.

19.2 CATT will notify the Manager of the appropriate Trust team for the on-going care of the new service user and indicate, as soon as possible, whether on-going involvement by the CMHS will be required when CATT withdraws.

19.3 When on-going help is identified, the Manager of the team for on-going care of the new service user will ensure allocation of a Care Co-ordinator as a matter of priority. If it has been identified prior to or at discharge that Service User requires a Social Outcomes Assessment, then this must be highlighted to the Manager of the receiving team as part of the transfer plan. Allocation and introduction of the new Care Co-ordinator should occur prior to CATT withdrawing.

20. Working Procedures

20.1 **Treatments/ Interventions Offered**

20.1.1 CATTs are committed to a recovery model of work which builds on the personal strengths and resilience of the service user.

**RULE**

All CATT interventions will encourage hope and respect diversity.

CATT staff aim to develop trusting, supportive and engaging relationships with service users and their families, that fully involve them in decision making and foster peoples autonomy and independence when possible. The service user, their family and support networks are central to the process of any work undertaken by CATTs.

20.1.2 CATT will offer intensive, focussed, short term treatment based upon the recovery model. The following are examples of the type of intervention provided by the team as part of the management plan to service users eligible for CATTs services:

- Co-ordination of CATT care
- Ensuring robust home treatment
- Intensive support through frequent home visits
- On-going needs and risk assessment
- Provision and close supervision of prescribed medicines, including concordance
- Ensuring that comprehensive written information about the nature of, and treatments and services for, their mental health problems is available in an appropriate language or format
- Active involvement with service user and carers re: decision-making
- Practical help with basics of daily living
- Advice and information and signposting to resources in the community
- Self help information and resources
- To inform and empower service users, carers/ families in all aspects of care
- Support for family/ carers, including carers’ assessment
- Solution focused/ Problem solving interventions
- Cognitive therapy based interventions
- Stress management
- Brief supportive counselling
- Improving social networks
- Relapse prevention through identifying warning signs
- Developing a relapse prevention plan
- Consultation, assessment and input as appropriate from the Psychology Service
- Accessing day care facilities
- Providing swift access to inpatient facilities where required
- Access to crisis accommodation where available/appropriate
- Access to Host Families
- Access to social care crisis package

The associated Care Bundle (Appendix G) will be used by staff as a framework for service delivery, outlining what is done, when it is done, and why it is done. It will be of use in Induction and Audit processes locally, and may be used to support service information packs available to Service Users and Carers.

20.1.3 If the primary diagnosis is personality disorder the structured programme of intervention should, whenever possible, be agreed in a Professionals Meeting and all roles, responsibilities and contact agreed.

RULE
CATT will seek the views of service users and carers by making available the Trust Having Your Say forms, and ensuring a Having Your Say form is sent to all service users on transfer from CATT after completion of an episode of treatment. The Having Your Say information will be used to inform continuous improvement to CATT services.

20.2 Working with families/carers

20.2.1 The family members of CATT service users play a valuable and important role in partnership working to support the care and treatment of the service user. CATT staff will ensure they involve families/carers/significant others in discussions about the care and treatment of the service user. At initial assessment the service user's permission will be confirmed to allow full communication with families/carers/significant others, taking into account the capacity of the service user to give permission. If permission is not given, good practice in communicating with families/carers/significant others when upholding service user wishes for confidentiality will be followed. (More information is available from Carers and Confidentiality in Mental Health – Partners in Care, 2004).

20.2.2 CATT will ensure families, carers or significant others

- are involved in supporting a person under the care of CATT by offering offer written and verbal information on the CATT service, treatment interventions, and mental health issues such as self-harm, including how families, carers and significant others can support the person
- offered contact numbers and information about what to do and whom to contact in a crisis
- offered information, including contact details, about family and carer support groups and voluntary organisations, and help families, carers or significant others to access these
- informed of their right to a formal carer's assessment of their own physical and mental health needs, and how to access this (see 20.2.4)
- Identification of young carers and referral on for appropriate support, including carers assessment if appropriate

20.2.3.
The needs of any children in the family must be considered. Children’s welfare and safety is paramount and it is the responsibility of all staff to ensure they identify and respond to concerns. The Child Need Screening form should be updated, and any identified needs included in care planning. Where concerns have been identified a written referral to Children’s Services must be made, in accordance with the Hertfordshire Area Child Protection Procedures. Staff should seek to discuss concerns about child welfare and safety with the service user and relevant family members, unless to do so would place the child at increased risk of harm. Disclosure of relevant information for the purposes of referral may need to take place against the wishes of the service user if the child is considered to be at risk of harm. (See Safeguarding and Child in Need flowchart)

20.2.4
Any person who identifies themselves or is identified as a carer will be offered a carers assessment under the care act 2015.
A carer’s assessment will be only undertaken by the CATT for carers of service users new to mental health services. The Care Co-ordinator of existing service users is responsible for organising carer’s assessments.

20.3 Contacts

RULE
The CATT care plan for each service user should detail the frequency and type of contact – including which CATT professional is making that contact - that it is agreed CATT will provide. This will usually be daily in recognition of the crisis presentation. The frequency and type of contact will be informed by the risk assessment, and the thinking behind decisions on frequency and type of contact will be clearly documented in the EPR.

RULE
CATT will usually provide contact face to face on a home visit. There will be times when it is appropriate to combine this with telephone contact. A risk assessment will be updated to include risk assessment of telephone contact before telephone contact is included as part of the CATT care plan. Telephone contact will only be included in the care plan following MDT discussion and agreement. The maximum number of days of telephone contact only by CATT will be three days, before face to face contact is undertaken.

20.3.1 If the service user declines the recommended type and/or frequency of contact, the capacity of the service user to make this decision should be considered with a capacity assessment which is documented in the EPR. The capacity assessment should be used to contribute to a risk assessment and care plan to respond to the service user declining contact.

RULE Any “did not attend” or cancellation of contact (whether by the service user or CATT) will be risk assessed the same day by the CATT multi-disciplinary team. Such risk assessment will include consideration of welfare check being undertaken – and will document the thinking that underpins decisions for next contact and/or date to undertake welfare check if no contact. Decisions on the response to no contact will be approved by the CATT Team Leader or their delegated representative the same day. The Trust Did Not Attend Policy should also be followed, in considering options to respond to identified risks for non-contact.

20.4 Meetings
CATT meet daily with a handover meeting held each day. Any actions agreed in handover will be documented in the EPR of the relevant service user. Each CATT will have dedicated whiteboard for collating and allocating handover tasks.

CATT meet at least weekly for a Multi-disciplinary Clinical team meeting chaired by the Consultant Psychiatrist (or delegated representative). Any actions agreed in the MDT will be documented in the EPR of the relevant service user. The format for documentation from the MDT is attached at Appendix E.

Each CATT holds a monthly team meeting chaired by the team leader/s. Each CATT is part of a Senior Management Meeting chaired by the CATT Team Lead. The CATT Team Lead joint chairs an Acute Care Pathway Governance Forum, and attends the Acute and Rehab Business, Governance and Patient Safety meetings. All of these meetings will include the standard practice governance agenda headers as standing agenda items:

- Quality & Risk Management
- Service user and carer experience
- Workforce and organisational development.

Each CATT ensures arrangements are in place to meet on a regular basis with Community Services for Adults of Working Age and for Older Persons.

21. Deteriorating Mental Health during a Period of Home Treatment

21.1 During any period of home treatment further deterioration in mental health could occur and consideration may then need to be given to a period of in-patient care. If this should happen, the CATT doctor or the On-Call Core/GP Trainee and On Call Specialist Trainee must be involved in the assessment of the situation and an up-to-date risk assessment completed.

21.2 If there is any dispute between professionals over whether or not a service user should be admitted, the matter will be referred to a Manager and referred to the CATT Consultant or On Call Consultant for a final decision.

21.3 Should admission for in-patient treatment be required, the Community Consultant will be advised by a member of the CATT and medical responsibility will be transferred to the Inpatient Consultant where applicable.

21.4 In-patient admission should be arranged according to Section 10 above.

21.5 In some situations, a Mental Health Act assessment may be necessary. This will be assessed whenever possible before 4pm and the CATT assessor, On Call Consultant and Duty AMHP notified accordingly. SOOS will only be involved after hours for Mental Health Act assessments when an emergency occurs. See Appendix .

21.6 CATT will inform SOOS of possible emergency situations on the relevant SOOS “alert” form.

22. Early Discharge from In-patient Care
CATT will visit the Inpatient Ward daily and attend each ward weekly bed meeting to be actively involved in:

- identification of people who would benefit from early discharge/home treatment,
- the agreement of the predicted date of discharge
- support of any anticipated early discharge.

A member of the CATT will be present at a ward meeting, ward rounds and reviews to discuss whether early discharge of any service user could be facilitated with a short period of intensive home treatment. CATT will undertake assessments of out of area patients on their wards, on behalf of that patient’s local CATT team to ensure patients are not disadvantaged by being placed out of their locality.

22.2. The CATT service is additional to any other community service needed and CATT would work together with the Care Co-ordinator to ensure the intensity of the service meets the service user’s need.

22.3 All discharges from inpatient care to CATT care will not take place without confirmation of the team that is providing the 7 day follow up documented in a transfer care plan. If CATT are involved this will usually be CATT.

22.3. Service users detained under the Mental Health Act where Section 17 leave has been agreed will be accepted by CATT for home treatment whilst the leave period occurs as appropriate.

22.4 If a service user is admitted out of County due to a lack of HPFT beds, the CATT lead and Bed Manager are responsible with the relevant Modern Matron for ensuring a rapid return to a local bed. Where possible, the relevant CATT will facilitate and support this process through CPA attendance, needs assessment, liaison and home treatment as appropriate.

22.5 All transfers of care will be in accordance with the Trust Discharge-Transfer of Care Policy.

22.6 When CATT are involved in transfer from in-patient services, CATT will provide 7 day follow up documenting this on the EPR in appropriate event.

23. Transfer/Discharge from CATT services
The transfer from any care can be a vulnerable time for service users. A transfer from the intensive service of CATT to a less intensive service requires considered planning.

RULE
CATTs will follow all procedures outlined in the Trust Delivery of Care Policy and the Trust Policy on the Discharge and Transfer of Service Users in the Care Planning Process. Transfer from CATT to on-going Trust services will be made following a transfer CPA at which the Care Plan and risk assessment for the service user will be updated.

RULE
All service users transferred to Trust services from CATT on CPA will be subject to 7 day follow up by the on-going service. The arrangements for this follow up should be documented in the transfer CPA documentation.
• CATT will agree and document discharge plans with the service user, and their on-going Care Co-ordinator and include contingency plans in the event of problems arising after discharge. This may include the grounds for self-referral back to CATT, including relapse signature indicators. The discharge plan will ensure clear information about access to services 24-hours day (including details of the out of hour’s helpline) is available to service users so that they can discuss any problems arising after discharge.
• The service users care plan and risk assessment will be updated by CATT when transfer back to referring/to receiving team is arranged.
• Before discharge or transfer of care from CATT, CATT will discuss arrangements with any involved family or carers.
• Service users will be given clear information about all possible support options available to them after discharge or transfer of care.

24. Staffing

The CATTs unit specialist medical, nursing, social work, occupational therapists, support workers and administrative staff within the team base, and share knowledge and expertise without recourse to professional boundaries to promote a collaborative and comprehensive team approach and shared values:

• All staff, including managers will uphold their codes of conduct, maintaining their knowledge base and expertise
• All staff will maintain concordance with the CATT competency framework – Appendix E.
• Staff will show respect for service users, carers and colleagues
• Staff will ensure service users are at the centre of all they do
• Teams will be proactive in offering health promotion and stigma reduction

25. Liaison and Working Relationships with Other Mental Health Services

Close working relationships between other mental health services in the Acute Care Pathway, Community services and Older Person Services is essential. This will be achieved through joint working, attendance at ward rounds, local team meetings, the development of specific interface meetings (e.g. with SPA and with Older Persons services) and through CPA reviews.

CATTs will provide, each week, a list of names of their service users to the relevant team 2/ team 3 for each service user to ensure care coordinator remains aware of the service users engagement with CATT

26. Medical Cover and Medication

Medical Responsibility

**RULE**

When a period of home treatment is agreed, the Consultant Psychiatrist attached to the CATT will be the Responsible Consultant and hold medical responsibility. This includes service users already open to services unless there are good reasons for the transfer of medical responsibility not taking place. It also includes those Service Users on wards, who are discharged to CATT. When CATT is involved with a service user who is also using an Acute Day Treatment Unit, medical responsibility will be provided by the Acute Day Treatment Unit.
26.2. When CATT involvement terminates and further treatment and support is required by mental health services, this responsibility will usually be transferred within a Care Programme Approach review, to the relevant Consultant Psychiatrist within the (e.g.) CMHS or Assertive Outreach services. The Care Plan and relevant Contingency Plans will be part of the agreed hand-over of care.

26.3. In the case of existing service users, the transfer of medical responsibility may be part of an existing care plan and a transfer CPA review may then not be required. This will be a matter for assessment by CATT and take into account delays that may occur if an early CPA review date cannot be arranged.

26.4 Should no secondary mental health service be required, the service user will be discharged through the CPA system to the care of the GP with relevant Care Plan and Contingency Plans, including risk factors and early warning signs of any possible relapse.

26.5. Service users requiring in-patient admission remain the responsibility of the community consultant until such responsibility is transferred to the In-Patient Consultant.

26.6 CATT will follow the HPFT medication policies at all times and comply with the medication policy in relation to CATT.

27. **Induction, Staff Support, Supervision, Appraisal and Training in the use of this Policy/Service**

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<td><strong>Induction to Service</strong></td>
<td>Induction on 1&lt;sup&gt;st&lt;/sup&gt; day</td>
<td>Induction on 1&lt;sup&gt;st&lt;/sup&gt; day</td>
<td>Induction on 1&lt;sup&gt;st&lt;/sup&gt; day</td>
</tr>
<tr>
<td><strong>Supervision Arrangements</strong></td>
<td>Monthly</td>
<td>Monthly</td>
<td>Monthly</td>
</tr>
<tr>
<td><strong>Appraisal</strong></td>
<td>Annually</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>All Mandatory Training and any other training identified as part of personal development plans. All CATT staff directly working with service users are required to achieve basic competencies in working with families, CBT techniques, and welfare rights.</td>
<td>To provide evidence of attendance of mandatory training</td>
<td>Any training necessary to support placement</td>
</tr>
</tbody>
</table>

28 Comments, Complaints and Compliments
28.1 All comments, compliments and complaints should be dealt with in accordance with the Trust Compliments Concerns and Complaints Policy and Procedure (see Policy document).

28.2 The policy requires all verbal or written complaints to be acknowledged within two working days with copies forwarded to the appropriate line manager and the Complaints Manager at Trust Head Office, Waverley Road, St. Albans. Comments and Compliments, once responded to, should be sent for information to the Complaints Team at Trust Head Office. Leaflets outlining the procedure are available [in or on location].

29 Communications

The treatment and information service users are given should meet the individual’s communication needs especially where there are specific language and sensory communication requirements. The HPFT guidance on Communicating with Service Users from Diverse Communities provides further information and the procedure for the interpreting service.

Where there are specific cultural/religious practices which affect compliance with treatment the service user’s should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead.

30. Records Management, Confidentiality and Access to Records

PARIS is the electronic patient record used by HPFT. Staff are required to record all contacts with the service user on PARIS. If difficulty arises, such as there is no access to a computer, a written note can be made in the paper light record.

All matters relating to service users’ health and personal affairs and matters of commercial interest to the Trust are strictly confidential and such information must not be divulged to any unauthorised person

Requests for access to records whether by the service user or a third party including where legal access is requested should be referred to the Ward Manager/Team Leader or centrally.

In order to provide evidence that the best possible care and treatment is give to the service users, staff must follow the record management and confidentiality polices listed below.

- Care Records Management Policy
- Clinical Information Filing Policy
- Protection & Use of Service User Information Policy
- Formal Access to Service User Records Policy
- Freedom of Information Act Policy
- Written & Electronic Communications Policy
- Corporate Records Management Policy

31. Health and Safety

Every employee and those persons working on behalf of the Trust have a duty to take reasonable care for the health and safety of themselves and other persons who may be affected by any acts or omissions by themselves. To cooperate with the organisation so far as it is necessary to enable management to carry out its legal duties relating to health and safety matters i.e. follow instructions and training, use equipment provided for their protection, report defects/damage/ health and safety concerns.
HPFT have a duty to remedy and or report any hazards or unsafe working practices in the immediate working area to the appropriate manager or supervisor.

32. Practice Governance

Practice Governance is a standing agenda item on CATT team meeting agendas, with the headings of Quality and Risk Management, Service User and Carer Experience and Workforce and Organisational Development. CATTs link to Acute Care Pathway Practice Governance Forums, to the Acute and Rehab Business and Governance meeting, and Acute and Rehab Patient Safety meeting by the CATT Lead attendance at these meetings.

33. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of ‘protected groups’ are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

**RULE**

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

The following table reflects – specifically for this policy – how the design of the service and processes involved has given consideration to all protected groups so ensuring equality and dignity for everyone.

**NB** this information reflects how staff will act in accordance with the Equality Act 2010 in meeting the needs of all protected groups.

<table>
<thead>
<tr>
<th>Service user, carer and/or staff access needs (including disability)</th>
<th>CATT is a home treatment service that usually delivers services in the homes of service users. CATT offers services to adults aged over of 18 years. Those under the age of 18 have dedicated services provided by CAMHS. CATT will offer support to the CAMHS service as defined in this policy. CATT staff will take into account the needs of people with disabilities, considering communication needs and any other access needs during the assessment process, and any episode of CATT care. The treatment and information given will meet the individual’s communication needs including where there are specific language and</th>
</tr>
</thead>
</table>

sensory communication requirements. CATTs arrange and utilise interpreters as required by the service user.

CATTs will support service users and carers to understand any printed information that they are provided with, and will facilitate the provision of printed information such as medication information in appropriate formats such as easy-read, if required.

CATT does not work with people with a diagnosis of dementia as people with a diagnosis of dementia have access to the specialist dementia services of the Intensive Outreach Team.

All people using the service are:

- Are treated in a way that is considerate and respectful to the person
- Have their privacy, dignity and independence respected and maintained.
- Are supported to express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.

The families of people using the service are:

- Supported to express their views and involved in consultation about the care, treatment and support of the service user
- This will be facilitated in line with the wishes of the service user, and in line with good practice practice guidelines for working with families when the service user declines to consent to share information

<table>
<thead>
<tr>
<th>Involvement</th>
<th>CATTs actively involve service users in planning service development, and in providing feedback about their experiences of the service to inform continuous improvement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships &amp; Sexual Orientation</td>
<td>The CATT care pathway from receipt of referral through to the ongoing care planning takes account of the needs of people in different relationships as well as those in none. This includes consideration of issues around sexual orientation (and any barriers for people around their orientation). CATTs will identify any needs for carer assessment to ensure appropriate support is given within available resources. The Child Need Screen will be completed at CATT assessment and kept under review as the needs of any children change. The needs of any CATT service user who is pregnant will be taken into account and reflected in the CATT risk assessment and care planning process.</td>
</tr>
<tr>
<td>Culture &amp; Ethnicity</td>
<td>CATTs provide a service that ensures the culture and ethnicity of service users is reflected in the planning of their care. CATT staff understand how to ask questions in needs assessments about culture and ethnicity, and that any related identified needs are documented and catered for in the agreed care plan for the CATT episode of care.</td>
</tr>
<tr>
<td>Spirituality</td>
<td>The assessment of needs that is undertaken when a CATT episode commences will include consideration of spirituality and take account of the HOPE model:</td>
</tr>
</tbody>
</table>

H – Sources of Hope
<table>
<thead>
<tr>
<th><strong>O</strong> – Needs re: organised religion</th>
<th><strong>P</strong> – Personal belief structure (including non faith)</th>
<th><strong>E</strong> – Effects on care of practicing spiritual beliefs. (positive and negative).</th>
</tr>
</thead>
</table>

### Age
CATT services are provided to people aged 18+. Service users aged 17 and under have specialist support from CAMHS but CATT will provide support to young persons under the age of 18 as defined by this policy.

### Gender & Gender Reassignment
CATT services will recognise any particular needs due to gender and gender reassignment, as part of the assessment process and in planning care with the service user.

### Advancing equality of opportunity
The CATTs will continue to gather service user and carer feedback that will be regularly reflected on within the Practice Governance section of team meetings, to inform the continuing improvement of delivery of CATT services.

### Promoting and considering individual wellbeing
Under the Care Act 2014, Section 1, the Trust has a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing is a broad concept and is described as relating to the following areas in particular:
- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life including over the care and support provided and the way in which it is provided;
- Participation in work, training, education, or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation;
- The individual’s contribution to society.

There is no hierarchy and all should be considered of equal importance when considering an individual’s wellbeing. How an individual’s wellbeing is considered will depend on their individual circumstances including their needs, goals, wishes and personal choices and how these impact on their wellbeing.

In addition to the general principle of promoting wellbeing there are a number of other key principles and standards which the Trust must have regard to when carrying out activities or functions:
- The importance of beginning with the assumption that the individual is best placed to judge their wellbeing;
- The individual’s views, wishes, feelings and beliefs;
- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
- The need to ensure that decisions are made having regard to all the individual’s circumstances;
- The importance of the individual participating as fully as possible;
- The importance of achieving a balance between the individuals wellbeing and that of any carers or relatives who are involved with the individual;
- The need to protect people from abuse or neglect;
- The need to ensure that any restriction on the individuals rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.

35. Process for monitoring compliance with this document

**STANDARD**

<table>
<thead>
<tr>
<th>Action:</th>
<th>Lead</th>
<th>Method</th>
<th>Frequency</th>
<th>Report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Audits to monitor the provision and quality of care plans and risk assessments</td>
<td>CATT Team Leaders</td>
<td>Audit a random sample of care plan and risk assessments ensuring practice of all CATT staff is subject to audit</td>
<td>Weekly</td>
<td>CATT Senior Management Meeting</td>
</tr>
<tr>
<td>Local Audits to monitor compliance with aspects of this document</td>
<td>CATT Leads</td>
<td>Audit CATT practice against particular requirements of policy</td>
<td>One complete audit cycle within the review period of the policy</td>
<td>SBU Quality and Risk Meeting</td>
</tr>
<tr>
<td>CATT audit as part of Practice Audit and Clinical Effectiveness Team Annual Plan to monitor compliance with this document</td>
<td>PG Lead</td>
<td>Audit CATT practice against requirements of policy</td>
<td>One complete audit cycle within the review period of the policy</td>
<td>Practice Audit Implementation Group SBU Quality and Risk Meeting</td>
</tr>
</tbody>
</table>
PART 3 – Associated Issues

36. Version Control

**STANDARD**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date of Issue</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1</td>
<td>Archived</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V2</td>
<td>Archived</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V3</td>
<td>26.9.11</td>
<td>Service Manager</td>
<td>Superseded</td>
<td>Archived</td>
</tr>
<tr>
<td>V4</td>
<td>7/5/2013</td>
<td>Practice Governance Lead, West Herts SBU</td>
<td>Superseded</td>
<td>Policy in new format, in line with PMS</td>
</tr>
<tr>
<td>V4.1</td>
<td>19.9.13</td>
<td>Practice Governance Lead, West Herts SBU</td>
<td>Superseded</td>
<td>Care Bundle added</td>
</tr>
<tr>
<td>V4.2</td>
<td>24th November 2014</td>
<td>Practice Governance Lead, West Herts SBU</td>
<td>Superseded</td>
<td></td>
</tr>
<tr>
<td>V4.3</td>
<td>1st May 2015</td>
<td>Practice Governance Lead, West Herts SBU</td>
<td>Superseded</td>
<td>Updated to include Care Act 2014 Addendum</td>
</tr>
<tr>
<td>V5</td>
<td>17th November 2015</td>
<td>CATT Service Manager (South West)</td>
<td>Superseded</td>
<td>Care Act updated and other updates</td>
</tr>
<tr>
<td>V5.1</td>
<td>19th January 2016</td>
<td>CATT Manager</td>
<td>Superseded</td>
<td>Addition to 7.8</td>
</tr>
<tr>
<td>V5.2</td>
<td>11th July 2016</td>
<td>CATT Manager</td>
<td>Current</td>
<td></td>
</tr>
</tbody>
</table>

37. Archiving Arrangements

**STANDARD**

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet.

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

38. Associated Documents

**STANDARD**

This Operational Policy takes into account relevant legislation and existing HPFT Policies and Guidance including:

- Clinical Risk Assessment and Management for Individual Service Users
- Fair Access to Care Services in Hertfordshire
- Health and Safety Policies (HPFT and ACS)
- Hertfordshire Inter-agency Response to Allegation of Abuse of Vulnerable Adults
- Care Coordination Policy
- Lone Worker and Essential Travellers Policy
- Policy on Prevention and Management of Violence
- Policy, Procedure and Guidance on the Management of Care Records
- Post Incident Support to Staff
- Learning from Incident
- Guidelines for the Management of Personality Disorders
- HPFT Policy on the Use of Advance Decisions and Advance Statements

39. Supporting References

STANDARD

- Department of Health Mental Health Policy Implementation Guide (2001)
- The NHS Plan (2000)
- Carers and Confidentiality in Mental Health – Partners in Care, 2004
- NICE Quality Standard – for service user experience in mental health
- NICE CG133 – Self Harm: Longer term management

40. Comments and Feedback

List of people/groups involved in the consultation.

<table>
<thead>
<tr>
<th>CAT Teams</th>
<th>Acute Medical Leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>CATT Team Leads</td>
<td></td>
</tr>
<tr>
<td>Acute Service Line Lead and Deputy Service Line Lead</td>
<td>SLLs for Community, Older Persons, CAMHS, EPMHS, SPA</td>
</tr>
<tr>
<td>AMHP Development Manager</td>
<td>Team Leader – SOOS, HCC</td>
</tr>
<tr>
<td>Nice Guidance Coordinator</td>
<td>CMHS Managers and Team Leaders</td>
</tr>
<tr>
<td>PG Lead – E&amp;N SBU</td>
<td>West Herts SBU Managing Director and Clinical Director</td>
</tr>
<tr>
<td>FACT Team Leaders</td>
<td>Acute Bed Manager</td>
</tr>
<tr>
<td>E&amp;N Herts SBU – Clinical Director</td>
<td>Head of Nursing and Patient Safety</td>
</tr>
<tr>
<td>Executive Director for Quality &amp; Safety</td>
<td>Acute and Rehab Modern Matrons</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>TITLE</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Appendix A</td>
<td>CATT Location and Contact Details – For Internal Use Only</td>
</tr>
<tr>
<td>Appendix B</td>
<td>CATT/SOOS working</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Joint Medical/CATT Protocol</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Recovery Principles</td>
</tr>
<tr>
<td>Appendix E</td>
<td>Format for the documentation of CATT Multi-Disciplinary Team meeting</td>
</tr>
<tr>
<td>Appendix F</td>
<td>Using a Competency Framework for staff working in Crisis Assessment Treatment Teams (CATT)</td>
</tr>
<tr>
<td>Appendix G</td>
<td>Assessment Checklist</td>
</tr>
</tbody>
</table>
For Internal Use Only

Hertfordshire Crisis, Assessment and Treatment Teams Location and Contact Details

Please note CATT telephone numbers should not be given to members of the general public

North West CATT (St. Albans and Dacorum)

Team Base:
The Orchards
Ashley Close
Off Bennetts End Close
Hemel Hempstead HP3 8EH

Telephone: 01442 275 430/ 248 602
Fax: 01442 275 494/ 275 495
Email: Sarah.Biggs@hertspartsft.nhs.uk
Team Email: northwest.catt@nhs.net

North CATT (Stevenage, Hitchin, Letchworth)

Team Base:
North CATT
Mental Health Unit
Lister Hospital
Coreys Mill Lane
Stevenage SG1 4AB

Telephone: 01438 784765
Fax: 01438 784766
Email: Team Email: north.catt@nhs.net

South East Herts CATT (Ware, Bishops Stortford, Cheshunt and Waltham Cross)

Team Base:
Teal Place
27a High Street
Ware SG12 9BA

Telephone: 01920 860200
Fax: 01920 860220
Email: Team Email: southeast.catt@nhs.net
South West Herts CATT (Watford and surrounding district)

Team Base:
Colne House
21 Upton Road
Watford
Herts WD18 0JP

Telephone: 01923 837 145
Fax: 01923 229 132
Email: helen.dudeney@hpft.nhs.uk
Team Email: southwest.catt@nhs.net

South Herts CATT (Welwyn, Hatfield, Hertford and surrounding villages)

Team Base:
Alban House
Brownfields
Welwyn Garden City AL7 1AY

Telephone: 01707 363 440
Fax: 01707 363 450
Email:
Team Email: east.catt@nhs.net
HERTFORDSHIRE PARTNERSHIP TRUST and ADULT CARE SERVICES of HERTFORDSHIRE COUNTY COUNCIL

Protocol for CATT/ SOOS working

The aim of this protocol is to promote closer working and understanding between the HCC Safeguarding Out of Hours Service and the Trust CATTs.

The main issue is a process for referring those who may require a formal Mental Health Act assessment outside of the normal ASW rota hours operated in each Locality.

1. Whenever possible the duty CATT workers should be made aware by the out of hours HCC worker of a request for a formal MHA assessment if they have not already been notified of this by the referrer.

2. If CATT are actively involved (i.e. have accepted the referral), they should be present at the MHA assessment or be contactable by telephone to at least discuss what assistance might be available if admission can be avoided.

3. Any referral for a MHA assessment to HCC out of hour’s team from CATT staff needs to be discussed with the on call Consultant first and then a referral made to HCC. This requires medical cover to be in place and an on call management rota.

4. If the need for a MHA assessment can wait until the next CMHT working day – it should.

5. The HCC Out of Hours opening hours are as agreed in the Service Level Agreement with HPFT. These are Monday to Thursday 17.15 hours to 09.00, weekends start at 16.30 on Fridays to 09.00 Mondays. The team operates twenty four hours Saturdays, Sundays and Bank Holidays.

6. Agreement needs to be reached with the referring CMHS that if a matter is referred to CATT earlier in the day and subsequently turns out to require a formal MHA assessment who will do it from within the daytime ASW rota. CATT may require a decision cut off time for such referrals i.e. 16.00 hours before which CATT must have completed their initial assessment. For new referrals coming to CMHS after this but before the end of the working day responsibility for progressing assessment remains with the duty ASW and CATTs. It will not be accepted by the HCC Out of Hours duty worker.

7. CMHS need to develop protocols around gate-keeping, progressing referrals and AMHPs requests and assessment outcomes.

8. All CATTs must have access to HCC Alert forms so that HCC can be forewarned if a user may become in need of their attention.

9. Other issues such as child protection, elder abuse etc. should be referred straight to HCC.
JOINT MEDICAL/ CATT PROTOCOL
(To be followed when Acute Admission is required)

Summary
The purpose of this protocol is to ensure that all times, decisions regarding admission are based upon the principles of team work, joint expert knowledge and the ability to collectively decide the best outcome for the service user.

Endorsement
This protocol has been endorsed by the Acute Consultant lead and the senior management team within Acute Mental Health Services.

Pre-Admission Process – during Working Hours
The CATT assessor will ensure the CATT Consultant or Junior Doctor is consulted about the presenting patient, when admission is being considered.

The CATT assessor at this stage will begin to identify a vacant NHS bed as defined by the Acute Bed Flowchart through the bed manager/ modern matron.

If there is a conflict between any of the clinicians involved regarding clinical presentation/management plan, further advice can be sought from:

- CATT Team Leader/ Manager
- CATT Consultant/ Lead Consultant.

Pre-Admission Process – Out of Hours
The CATT assessor will ensure the junior Core/GP trainee on call and the On Call Specialist trainee are consulted about the presenting patient, when admission is being considered.

The CATT assessor at this stage will begin to identify a vacant NHS bed as defined by the Acute Bed Flowchart through the bed manager/ MHU Bleepholder.

If there is a conflict between any of the clinicians involved regarding clinical presentation/management plan, further advice can be sought from:

- 1st on call Manager
- Consultant on call

It is the responsibility of the Inpatient Consultants to ensure that all newly admitted patients are reviewed by themselves or their Specialist Trainee the following morning. This is not optional.
Recovery Principles

Principles of Recovery Oriented Practice, which underpin all our services, are:

1. Individual uniqueness and user centrality to service provision: *in practice:*
   - recognises that recovery is a personal journey and unique for each individual.
   - understands that Recovery is not necessarily about cure. Recovery outcomes are personal and unique for each person and go beyond an exclusive health focus to include an additional emphasis on social outcomes and quality of life.
   - places individuals at the centre of the care they receive. Through a person centred and needs led approach, individual recovery outcomes are achieved.

2. Real Choices: *in practice:*
   - supports people to make their own choices about how they want to lead their lives and acknowledges choices need to be meaningful and creatively explored.
   - supports people to build on their strengths and to take as much responsibility for their lives as they can at any given time.
   - is proactive in supporting people to take positive risks and to make the most of new opportunities whilst balancing responsibilities for duty of care.

3. Attitudes and Rights: *in practice:*
   - involves listening to, learning from and acting upon the communications from individual service users, their relatives and others about what is important to each person.
   - promotes and protects people’s legal and citizenship rights
   - supports people to maintain and develop meaningful social, community, recreational, occupational and vocational activities.

4. Dignity and Respect: *in practice:*
   - consists of being courteous, respectful and honest in our interactions.
   - involves sensitivity and respect for each individual’s values and culture.
   - challenges discrimination and stigma wherever it exists both within our own services and the broader community.

5. Respectful Partnerships: *in practice:*
   - acknowledges each person is an expert on their own life and that recovery involves working in respectful partnership with individuals, their relatives and carers to provide support in a way that makes sense to them.
   - acknowledges the importance of the sharing appropriate information and the need to communicate clearly and to enable effective engagement with services.
   - involves working in hopeful, positive and optimistic ways with people who use our services, their families and carers, and the communities within which they live, to support them to realise their own hopes, goals and aspirations.
TITLE: CATT Multi-Disciplinary Clinical Team Meeting chaired by Dr X

Date:

Name-

DOB (NHS Number)
Address

HoNos-cluster x and date.
Physical Examination: date of completion
Physical health screen: date of completion
Blood test - date of completion
Care Co-ordinator-
ICD 10 and diagnosis-

Date taken on -
Referred by -
Medication:

Mental state:

Last medical review: Date

Contacts:

Recovery Goals:

Provisional Discharge Date:

Discharge Destination:

Plan:
Using a Competency Framework for staff working in Crisis Assessment Treatment Teams (CATT)

1. **Introduction:**

The role of staff working within CAT teams demands the highest levels and application of clinical skill especially with regard to the assessment of service users, their treatment and the communication of detailed information to others.

The role of the CATT assessor is broadly compatible with that of the Approved Mental Health Professional (AMHP) in that both groups of staff make assessment decisions which may be 'life critical' to the service user or others.

However AMHP’s work within a legislative framework and have a clear schedule of expected competencies which reflect the depth and complexity of the skills and knowledge required. There is also a requirement to be able to demonstrate the relevant clinical skills on a regular basis.

There is not at the moment a comparable system within CATT services and this framework seeks to redress this.

It is to be expected that within such teams (CATT) a variance in capability exists. In order to address this issue there must be a system of working practice, education and supervision in place that takes such variance into account.

Without such a system less experienced staff may be exposed to a level of responsibility and expected performance that they cannot reliably maintain. Expert levels of performance should not be expected from ‘novice’ members of staff without a concurrent expectancy of errors in judgement.

Clinical education must begin with a clear understanding of the difference between competence and expertise and of how appropriate competencies might be judged. Once such an understanding has been identified and agreed then a method of assurance must be applied in order to ensure a consistently high standard of practice.

Complex clinical skills and knowledge of their appropriate application are developed via practice over what may be a long period of time. An induction or occasional training is insufficient to develop such complex skills and do not provide assurance of competence.

This document seeks to identify both the relevant skill sets required and a reliable framework for the assurance of competency within HPFT CATT’S.

**Present Situation**

Within the current teams which constitute the HPFT CATT service there is some excellent practice with managers providing good levels of support and advice. Skill sets within teams reportedly vary from relative novice to expert, and specialist risk assessment training has been provided for assessors as this has been recognised as a key training need.

Induction training has taken place and team managers have recognised the need for additional support for new members of staff. In some teams this has taken the form of supervised practiced and enhanced levels of supervision. Teams work closely with medical colleagues and steps have been taken to harmonise training and education for all team members. There is a need to develop a system of consistent education and assurance across all teams and the proposed framework should be seen as an enhancement of the work which has already taken place.

2. **A Schedule of Key Competencies**

The following 5 key areas of competence are adapted from those contained within regulation 3(2) of the Mental Health (Approved Mental Health Professionals) (Approval) (England)
Regulations 2008. These most closely mirror the skill sets required of CATT assessors and provide legitimacy in the absence of other definitive guidance.

An achievement of such competencies should not be assumed to provide evidence of ‘expert’ status but should be seen as defining the core skills required of all assessors.

**Key Competence Area 1: Application of Values to the CATT Assessor Role.** The Assessor should have, and be able to demonstrate in practice

- the ability to identify, challenge and, where possible, redress discrimination and inequality in all its forms in relation to CATT practice
- an understanding of and respect for individuals’ qualities, abilities and diverse backgrounds, and is able to identify and counter any decision which may be based on unlawful discrimination
- the ability to promote the rights, dignity and self-determination of patients consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty
- a sensitivity to individuals’ needs for personal respect, confidentiality, choice, dignity and privacy while exercising the CATT role

**Key Competence Area 2: Application of Knowledge: The Legal and Policy Framework.** Whether the assessor has, appropriate knowledge of and ability to apply in practice

- mental health legislation, related codes of practice and national and local policy guidance
- relevant parts of other legislation, codes of practice, national and local policy guidance, in particular the Children Act 1989(1), the Children Act 2004(2), the Human Rights Act 1998(3) and the Mental Capacity Act 2005(4);
- a knowledge and understanding of the particular needs of children and young people and their families, and an ability to apply CATT practice in the context of those particular needs
- an understanding of, and sensitivity to, race and culture in the application of knowledge of mental health care and treatment
- an explicit awareness of the accountability of CATT assessors in relation to their employing organisation (HPFT)

**And the ability to**

- evaluate critically local and national policy to inform CATT practice
- base CATT practice on a critical evaluation of a range of research relevant to evidence-based practice, including that on the impact on persons who experience discrimination because of mental health
Key Competence Area 3: Application of Knowledge: Mental Disorder, whether the assessor has a critical understanding of, and is able to apply in practice

- a range of models of mental disorder, including the contribution of social, physical and development factors
- the social perspective on mental disorder and mental health needs, in working with patients, their relatives, carers and other professionals
- the implications of mental disorder for patients, their relatives and carers
- the implications of a range of treatments and interventions for patients, their relatives and carers

Key Competence Area 4: Application of Skills: Working in Partnership - whether the assessor has the ability to

- articulate, and demonstrate in practice, the social perspective on mental disorder and mental health needs
- communicate appropriately with and establish effective relationships with patients, relatives, and carers in undertaking the CATT role
- articulate the role of the CATT in the course of contributing to effective inter-agency and inter-professional working
- use networks and community groups to influence collaborative working with a range of individuals, agencies and advocates
- consider the feasibility of and contribute effectively to planning and implementing options for care such as alternatives to compulsory admission, discharge and aftercare
- recognise, assess and manage risk effectively in the context of the CATT role
- effectively manage difficult situations of anxiety, risk and conflict, and an understanding of how this affects the assessor and other people concerned with the patient’s care
- discharge the CATT role in such a way as to empower the patient as much as practicable
- negotiate and assist in the management of compulsory admission to hospital or arrangements for supervised community treatment
- balance and manage the competing requirements of confidentiality and effective information sharing to the benefit of the patient and other persons concerned with the patient’s care

Key Competence Area 5: Application of Skills - Making and Communicating Informed Decisions

Whether the assessor has the ability to-

- assert a social perspective and to make properly informed independent decisions
• obtain, analyse and share appropriate information having due regard to confidentiality in order to manage the decision-making process including decisions about supervised community treatment
• provide reasoned and clear verbal and written reports to promote effective, accountable and independent CATT decision making
• exercise the appropriate use of independence, authority and autonomy and use it to inform their future practice as a CATT assessor, together with consultation and supervision
• evaluate the outcomes of interventions with patients, carers and others, including the identification of where a need has not been met
• make and communicate decisions that are sensitive to the needs of the individual patient
• keep appropriate records with an awareness of legal requirements with respect to record keeping and the use and transfer of information

3. **Providing Assurance and Identifying Need**

Professionals working in clinical practice gain experience and knowledge in a number of ways. One of the most effective of these is via ‘apprenticeship’ wherein learner staff observe practice taking place, practice themselves under assessed supervision and when judged competent may practice unobserved.

There should also be a requirement for the yearly skills appraisal of all staff undertaking crisis assessment so that education and support needs are subject to a continuing cycle of review and adaptation. Such an appraisal would be easily facilitated if completed within a framework of continuing education and review such as that suggested below.

In order to build upon the present system of observed practice the following may be considered for adoption:

• All team members would have and maintain a practice logbook which would contain the 5 areas of competence
• Each area of competence would be broken down into its individual elements
• New team members would be required to demonstrate competence in all 5 areas over a period of 6 to 12 months dependent upon prior experience
• Competence in each area would be assessed through set periods of observed practice facilitated by an ‘expert’ team member (this need not necessarily be the team manager)
• Each area of competency would have a minimum measure applied—for example 10 observed assessments before new staff allowed to practice unobserved
• Each competency would be accredited by the accountable manager once the appropriate measure had been successfully achieved
• Existent team members would undertake training needs assessment in order to identify their individual level of experience and to organise an appropriate level of support and supervision if so required. Their practice logbook would be completed by agreement with the accountable manager
• Each measure of competency would be specific to the previous experience of the staff member concerned

As well as a process of observed practice assurance would be sought by a process of regular case note monitoring and the assessor would, during supervision, be expected to provide and discuss examples of work relevant to specific areas of competence. Such a process would provide further evidence for the completion of their practice logbook.
4. **Training and Education**

Specialist training and education should be provided and embedded within the culture of teams undertaking highly skilled high risk clinical work as without it staff learn by trial and error rather than by design. Assessors need highly specialised training in order to develop the knowledge sets and cognitive resonance necessary for the undertaking of complex assessments. Such training and education might contain the following elements designed to develop peripheral and contingent thinking with regard to complex sets of information.

- Regular discussion of case studies and SUI’s with an expert professional
- Human factors awareness - essential in all high risk clinical activity
- Error management - failure modes effects analysis - self assessment
- Research and treatment developments in relation to acute mental illness

The use and effectiveness of case studies as a learning tool is to be recommended as staff are better able to contextualise information that is directly related to their own practice and experience. As a proposed measure all staff members should be required to present at least one case study per year to their peers. Such reviews can take place within the same team or can be inter team.

Human factors awareness, error management and failure modes effects analysis are all tools recognised and recommended within high risk industries and by the NPSA (National Patient Safety Association) such training should be undertaken as a priority for all team leaders.

These tools are designed to promote safe thinking and increase reliability within complex processes. Such skills and knowledge should be viewed as essential requirements for staff undertaking assessment work.

5. **Implementation and Facilitation**

The implementation of the proposed framework need not be complicated or cumbersome. There exists a wealth of skill and experience within the current service and this should be utilised in order to ensure that the framework is relevant and achievable.

The setting of measures for each area of competence is not a science but a judgement made by experience. A planning meeting can be held and initial measures set for all new members of staff. Such a meeting must involve senior clinicians and managers as well as nursing leads and relevant governance staff as they will be expected to provide on-going support to the project especially with regard to decisions concerning levels of competency amongst existing staff members.

6. **Conclusion**

Working as an assessor in a CAT team should be viewed as an aspiration for nursing staff and the enhanced clinical and professional skills required need to be recognised, desired and responded to by the organisation. A basic framework for assessing the competency of staff is essential to the quality of the service especially in relation to patient safety and the achievement of positive treatment outcomes.
## Application of Values to the CATT Assessor Role. The Assessor should have, and be able to demonstrate in practice

1. ✓ the ability to identify, challenge and, where possible, redress discrimination and inequality in all its forms in relation to CATT practice
   ✓ an understanding of and respect for individuals’ qualities, abilities and diverse backgrounds, and is able to identify and counter any decision which may be based on unlawful discrimination
   ✓ the ability to promote the rights, dignity and self-determination of patients consistent with their own needs and wishes, to enable them to contribute to the decisions made affecting their quality of life and liberty
   ✓ a sensitivity to individuals’ needs for personal respect, confidentiality, choice, dignity and privacy while exercising the CATT role

## Application of Knowledge: The Legal and Policy Framework. Whether the assessor has, appropriate knowledge of and ability to apply in practice

2. ✓ mental health legislation, related codes of practice and national and local policy guidance
   ✓ relevant parts of other legislation, codes of practice, national and local policy guidance, in particular the Children Act 1989(1), the Children Act 2004(2), the Human Rights Act 1998(3) and the Mental Capacity Act 2005(4);
   ✓ a knowledge and understanding of the particular needs of children and young people and their families, and an ability to apply CATT practice in the context of those particular needs
   ✓ an understanding of, and sensitivity to, race and culture in the application of knowledge of mental health care and treatment
   ✓ an explicit awareness of the accountability of CATT assessors in relation to their employing organisation (HPFT)

**And the ability to:**

 ✓ evaluate critically local and national policy to inform CATT practice
 ✓ base CATT practice on a critical evaluation of a range of research relevant to evidence-based practice, including that on the impact on persons who experience discrimination because of mental health

## Application of Knowledge: Mental Disorder - Whether the assessor has a critical understanding of, and is able to apply in practice

3. ✓ a range of models of mental disorder, including the contribution of social, physical and development factors
the social perspective on mental disorder and mental health needs, in working with patients, their relatives, carers and other professionals

the implications of mental disorder for patients, their relatives and carers

the implications of a range of treatments and interventions for patients, their relatives and carers

**Application of Skills: Working in Partnership - Whether the assessor has the ability to**

4. articulate, and demonstrate in practice, the social perspective on mental disorder and mental health needs

communicate appropriately with and establish effective relationships with patients, relatives, and carers in undertaking the CATT role

articulate the role of the CATT in the course of contributing to effective inter-agency and inter-professional working

use networks and community groups to influence collaborative working with a range of individuals, agencies and advocates

consider the feasibility of and contribute effectively to planning and implementing options for care such as alternatives to compulsory admission, discharge and aftercare

recognise, assess and manage risk effectively in the context of the CATT role

effectively manage difficult situations of anxiety, risk and conflict, and an understanding of how this affects the assessor and other people concerned with the patient’s care

discharge the CATT role in such a way as to empower the patient as much as practicable

negotiate and assist in the management of compulsory admission to hospital or arrangements for supervised community treatment

balance and manage the competing requirements of confidentiality and effective information sharing to the benefit of the patient and other persons concerned with the patient’s care

**Application of Skills: Making and Communicating Informed Decisions - Whether the assessor has the ability to**

5. assert a social perspective and to make properly informed independent decisions

obtain, analyse and share appropriate information having due regard to confidentiality in order to manage the decision-making process including decisions about supervised community treatment

provide reasoned and clear verbal and written reports to promote effective, accountable and independent CATT decision making

exercise the appropriate use of independence, authority and autonomy and use it to inform their future practice as a CATT assessor, together with consultation and supervision
| ✓ evaluate the outcomes of interventions with patients, carers and others, including the identification of where a need has not been met |
| ✓ make and communicate decisions that are sensitive to the needs of the individual patient |
| ✓ keep appropriate records with an awareness of legal requirements with respect to record keeping and the use and transfer of information |

Author of Original document – Ian Martin, 24.10.10
## Assessment Checklist

**Service Users Initials:**
**Service Users DOB:**
**NHS Number:**

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>1</td>
<td>Complete assessment form (yellow form)</td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>Open CATT episode</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Care note entry of assessment</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>Child needs form</td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>Health of the Nation Outcome Scale (HONOS) – clustering</td>
<td></td>
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</tr>
<tr>
<td>6</td>
<td>Enhanced risk assessment</td>
<td></td>
<td></td>
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<tr>
<td>7</td>
<td>CC2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Care plan – if taken on</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>Medication form (pink and white)</td>
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<td></td>
</tr>
<tr>
<td>10</td>
<td>GP letter</td>
<td></td>
<td></td>
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<tr>
<td>11</td>
<td>Put service user on board – if taken on</td>
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<td></td>
</tr>
<tr>
<td>12</td>
<td>Print off front sheet, care plan and risk assessment – if taken on</td>
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<tr>
<td>13</td>
<td>Put service user on night report – if taken on</td>
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<tr>
<td>14</td>
<td>Ensure all documents have been confirmed</td>
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<tr>
<td>15</td>
<td>Ensure that all general information is on the EPR / NHS no. etc</td>
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<tr>
<td>16</td>
<td>Ensure Service User is booked in to see the CATT doctor the next working day.</td>
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<tr>
<td>17</td>
<td>Close CATT episode – if not taken on</td>
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<tr>
<td>18</td>
<td>Ensure verbal handover to ward if SU is for admission</td>
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<tr>
<td>19</td>
<td>Becks Hopelessness Scale when appropriate</td>
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<tr>
<td>20</td>
<td>CATT leaflet / mental health helpline card / access to records</td>
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<tr>
<td>21</td>
<td>CP1 / CP2 if new service user</td>
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<tr>
<td>22</td>
<td>Date of last admission (is this referral and possible admission within 28 days)</td>
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<tr>
<td>23</td>
<td>Carers pack offered and carer/involved family members aware of right to carer’s assessment</td>
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<td></td>
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</tbody>
</table>

**Member of staff:**
**Date:**

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Appendix G
<table>
<thead>
<tr>
<th>Our Values</th>
<th>we are...</th>
<th>you feel...</th>
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<tbody>
<tr>
<td>Welcoming</td>
<td>✓ Valued as an individual</td>
<td></td>
</tr>
<tr>
<td>Kind</td>
<td>✓ Cared for</td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>✓ Supported and included</td>
<td></td>
</tr>
<tr>
<td>Respectful</td>
<td>✓ Listened to and heard</td>
<td></td>
</tr>
<tr>
<td>Professional</td>
<td>✓ Safe and confident</td>
<td></td>
</tr>
</tbody>
</table>