Key Lines of Inquiry

No	Question	GMMH response
1	Can further details be provided of when GP practices can contact the CMHT consultant for advice each week?	There is a dedicated weekly telephone resource via which a GP is able to speak with the relevant Psychiatrist Consultant – 'Call A Psychiatrist'. The Trust recognises that the times dedicated for the 'Call A Psychiatrist' may not always be convenient. In such cases a GP can now have direct access to the Duty Mental Health Practitioner in each of the CMHT offices, who have now been allocated with mobile phones. These mobile contacts are dedicated for use by GPs seeking advice, particularly for urgent queries and concerns. Also GPs can seek routine advice from the named linked worker aligned directly to the GP Practice, and with whom the GP may have already developed a good working relationship.
2	Can GPs email consultants with queries they have? If not an explanation as to why not would be useful	There is no dedicated email address for consultant queries. GPs can use the 'call the psychiatrist' service which operates a booking system. This is dedicated, uninterrupted time in the Consultant's week to spend with GP colleagues by telephone/skype. If there is a better model to the current system, the Trust is willing to consider these. GPs can also contact the link worker or use the new mobile phones allocated to the Duty Mental Health Practitioner if they have any urgent queries or concerns. The team can be rung anytime and the duty worker will log the query and agree a timescale for a response from the team manager and/or team consultant, if required. This is likely to be on a case by case basis so no fixed response time is offered as we would respond to that need and risk accordingly.
3	There are concerns that phone advice can't do a full psychiatric history and examination so if someone goes wrong who is to blame?	If the Consultants feel they could not give advice without seeing the patient they would advise referral for initial CMHT assessment and if required medical review as part of that if patient felt to be sufficiently unwell or complex after assessment by Mental Health practitioner or Non-medical prescriber.
4	Please can you provide a copy of the referral criteria for CMHTs?	The CMHT Standard Operating Procedure gives referral criteria as follows: The Community Mental Health Team (CMHTs) provides a service to adults under the national CPA framework and in accordance with the Care Act (2014). Eligibility for service provision will be determined by the process of initial health and social care assessment to identify individual need. **Inclusion** • Individuals requiring ongoing specialist care for severe mental health problems, which reach sufficient levels of disability, severity, risk defined by step care principles and NICE Guidelines. • Individuals with severe disorder of personality, often involving significant risk, where it can be established that there is likely to be a benefit from continued contact and support within the CPA framework. • Individuals who have been assessed as having needs which meet

		National Eligibility Criteria under the Care Act (2014) • Referrals from Child and Adolescent Mental Health Services (CAMHS) for individuals approaching the age of 18 years may be considered for a period of joint working prior to full transfer of care. Transitional protocols should be applied in such circumstances as described the Joint Protocol for the planned transition of young people from CAMHS and Children's Services to Adult CMHT people from CAMHS and Children's Services. • Individuals with mild learning disability associated with serious mental disorder. • The Care Act (2014) places a duty on the Local Authority, or the body charged with executing its functions in accord with S.75 Agreement and thereby the Trust, to carry out a needs assessment for all people who have mental health needs requiring care and support. A social care duty may arise when people are assessed in accordance with The Care Act (2014), even though no specialist mental health care provision may be required. • The Care Act (2014) places a responsibility on GMMH Manchester services to assess a Carer's needs for provision of services, where the Carer appears to have such needs. The CMHTs will assess the impact of caring on a carer. **Exclusion** • Mild to moderate mental health problems, unless their social care needs meet the National Eligibility Criteria. Such people will have their needs met in accordance with the stepped care model, as underpinned by NICE guidance. • Acquired brain injury unless this appears to have resulted in a mental disorder. • Primary drug or alcohol problem as this will be coordinated through Drug and Alcohol Services. The CMHTs will provide input (in conjunction with drug and alcohol services) for people with a dual diagnosis of severe mental illness and substance/alcohol misuse. • Primary diagnosis of dementia.
5	Can you confirm if any changes have been made to the referral criteria over the last 12 months, against what is detailed in the original service specification? If not, whether the criteria is being interpreted more strictly.	Changes have been made to how referrals are processed by teams: **Pre-Enhanced Community Model (ECM) Management of Referrals** All referrals were directed to the CMHT via the UCAT Team. The CMHT Operational Procedure allowed referrals to then be directed to a consultant's outpatient clinic without first being assessed by a member of the CMHT • The CMHT staff receive and review all referrals • Where the GP requests a consultant's opinion or medication advice, these are automatically directed to a consultant outpatient appointment without first being assessed by the CMHT. • When CMHT staff are uncertain about a referral they will direct to a consultant outpatient appointment.

		Concerns with management of referrals by the old process: That process for managing referrals caused a number of concerns: • High outpatient consultant caseloads, CMHTs redirect referrals to outpatient clinic and discharge service users to outpatient clinics creating bottle necks and long delays. • High waiting lists for consultant outpatient appointment with associated level of clinical risk • Service users waiting between 3 and 8 months for their first appointment • Limited ability for consultant to support the CMHT, due to providing outpatient clinics • The process for managing referrals is not in line with wider trust CMHTs and support to a wider system. **Summary of Key ECM Changes** A clinically-led focus group involving Lead Consultants and Heads of Operations met to discuss the concerns highlighted above and proposed a number of changes to be made to the CMHT Operational Procedure. Proposed changes: The revised practice is for the CMHT to triage **all** assessments and refer to the consultant as required. The option to refer for a consultant-only opinion will be removed but is still a referral option for the CMHT post-triage. The changes to the operational procedure are as follows: • New referrals will be processed via the CMHT duty system, this will involve: - CMHT practitioners undertaking preliminary screening/triage/assessment - Facilitating consultation with the Team Psychiatrist if clinically indicated - Referrals will no longer be assessed by the consultant in an Outpatient Clinic - this includes referrals for a Medication/Diagnostic review. • Discharge from the CMHT will take place at the same time as discharge from the Team Consultant. • Discharge from CMHT to outpatient clinic is stopped. • Reference to the Outpatient Only Clinic in the CMHT SOP is to be removed, and replaced with the term medical review to cover Consultant/medical review of service users under the team. These changes have previously been communicated to GPs. The dedicated page on the GMMH website is currently under development which will explain the changes mentioned above, contact details, referral criteria, crisis number, later life referral pathway etc.
6	When a referral is rejected, can the	This information should be included in the standard template letter sent to referring GPs after screening/triage/assessment. Internal auditing

	named clinician who made the decision, together with their contact details, reason for why the referrals was rejected and advice about GP management of patient be included in the letter?	has shown that implementation of this requirement has been inconsistent. Improving compliance and internal audit is being led via divisional Senior Leadership Teams.
7	Do GMMH advise the GP of a more appropriate service if referral is rejected? If a referral to a different team within GMMH is needed, is that referral sent by GMMH or rejected and sent back to the GP?	If a referral is not accepted and there is an available appropriate alternative, sign posting should be routinely included within letters, sometimes referrals are actually made by duty practitioners rather than just sign-posting for the referrer. Any onward internal referrals to services within the Trust are made from the receiving team, unless the referral pathway state this is not possible. The teams have been informed that they should action all onward referrals to IAPT and not be sent back to the GP to do this.
8	Who is medico legally responsible when rejections are made based on a letter, and the clinical effect it has on the patient.	They would be collective and shared responsibility on individual decision making of any referral and subsequent action as to whether to accept or reject the referral. GMMH would be accountable to this decision making.