Reference Number: UHB 541 **Version Number:** 1	**Date of Next Review:** *13/03/2028* **Previous Trust/LHB Reference Number:**

Adult CMHT DUTY Procedure

Introduction and Aim

Duty workers within the CMHT are available every day to manage and respond to the daily unscheduled requests of the CMHT.

One or more daily delegated clinical staff are rostered to be available to act as a dedicated means of contact for patients, referrers and general members of the public throughout the working day. The duty worker(s) will also be expected to undertake emergency and urgent assessments on their day of duty and answer queries of clinical concern. All tasks should be actioned on the day, only carrying tasks over by exception. The duty system is currently not resourced nor designed to be an emergency response service.

The CMHT Service Lead will have overall responsibility for ensuring that the CMHT operates a duty system within normal working hours.

Objectives

This procedure is designed to help describe the role and function of the duty system in CMHT's it will help standardise the expected work requirements undertaken by the daily allocated duty worker and duty lead. It is deliberately not intended to be specifically prescriptive but lays out the expected roles and responsibilities.
Not all clinical cases will align with the devised procedure. In instances where this is the case, clinical judgement and informed rationale will be required for actions taken in response to daily working tasks. Each time this is the case, safe care and individual need must be prioritised.

Scope

This procedure applies to all of our staff in CMHT's undertaking the duty role -whether duty worker, duty lead or duty team support, as directed by the CMHT service lead, including those with honorary contracts.
Throughout this document reference to "CMHT Service Lead" and "Integrated Manager" should be seen as the same role.

Equality and Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	Wales Mental Health Measure 2010 Parts 2 and 3 Code of Practice
Approved by	*Controlled Documents Oversight Group*

Accountable Executive or Clinical Board Director	*Daniel Crossland*
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Disclaimer **If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document autho or the Governance Directorate.**	

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	*13/03/2025*	*19/05/2025*	*Version 1*

1. **DUTY WORKER ROLE AND RESPONSIBILITIES:**

a) One or more qualified clinician(s) will be allocated as the duty worker every day. This could be an Occupational Therapist, Social Worker, Nurse or Psychologist. A **duty lead** clinician will also be identified for each day (see: **2. DUTY LEAD ROLE AND RESPONSIBILITIES**.)

b) The duty worker will respond to all duty related CMHT queries as soon as is practicable.

c) The duty worker will make themselves available to receive queries (either through telephone or face to face contact) that require a clinical response, in addition to any allocated staff, during the standard operational hours of the CMHT. **If the allocated clinician. i.e. Care Coordinator or Co-worker is available to respond, then they should do so in the first instance.** The duty worker, supported by the duty lead, will hold full autonomy and authority to mobilise resources as required throughout the shift, and this should be understood and respected by each member of the wider team.

d) Each CMHT service lead may implement and organise a “duty team”, this may include a “duty buddy” or “second duty”. Additionally, a “duty admin lead” and “duty medic lead” could be allocated. A duty lead will always need to be allocated. The Duty Lead will hold overarching senior responsibility for all duty activities that day and report to the Integrated CMHT manager.

e) The frequency of allocated days of duty work for each individual clinician will be negotiated and agreed between the CMHT service lead and the respective professional lead - on a pro rata basis, but also with a recognition towards other statutory and mandatory duties within everyone ‘s job role.

f) The duty worker may feel able to answer most duty queries through accessing a variety of resources including a review of the clinical records, utilising their own knowledge and experience, but also though liaising with the clinical and administrative team.

g) Duty work examples include:

- Passing a clinical query from a known patient on to a patient’s care coordinator, co-worker. If the query is a direct request to a consultant psychiatrist, the relevant medical secretary should be approached in the first instance.
- Liaising with the CMHT Service lead and / or duty lead to respond to clinical **concerns, clinical risks** or reports of poor experiences and concerns from those that use the CMHT.
- Working closely with the admin team throughout the day, for example, to ensure all referrals are accurately logged on the system, checking duty desk and clinic appointment schedules etc.
- In respect of untoward incidents, submitting DATIX incident reports for the attention of the CMHT Service Lead or relevant professional lead.

h) **Urgent and Emergency referral requests** will be received by telephone directly from referrers*. The "*Duty Worker Referral Form*" (appendix 1) should be used by the duty worker to determine relevant clinical indicators, risks, priority and actions in the event of the referred person not attending. This referral form is embedded within the referral module, within the patient's electronic records on PARIS.

   i. Following receipt of the referral and a mutually agreed appointment time (within referral response times) has been arranged with the referrer and service user, an assessment will be completed. The clinician will **focus on managing risk and safety planning.** The outcome of the assessment and agreed action plan will be clearly communicated to the referrer and the patient that day with this action clearly documented on the patient's PARIS record. Actions should be taken to ensure the plan is followed up (appointment, allocation, closure) and completing any onward referrals as indicated.
   ii. Relevant documentation, including a case note, WARRN, assessment form and consent to info share should all be completed on the patient's PARIS record.
   iii. When giving feedback to the patient following the assessment, the patient's level of understanding of the outcome should be checked and documented. In all cases, a formal assessment outcome letter in writing should be sent to both patient and referrer within 10 working days of the assessment.

*If referrals have been received by post or electronically via WAP or PARIS which are marked as urgent or emergency the following process should be followed (see referral SOP):

   i. The duty worker should attempt to contact the referrer to assess the level of urgency and advise them of the correct referral procedure.
   ii. If the referrer is not available to speak to, attempts should be made to discuss this with another member of the referring team.
   iii. If no one is available from the referring team to discuss the referral with then attempts to contact the service user should be made to gather further information and assess the level of urgency required.
   iv. A Datix incident form should be completed identifying the referrer and incorrect procedure (see referral SOP).
   v. DATIX incident reports should be directed to the relevant Quality and Safety manager or Senior nurse responsible the referring

agency. For PCIC, the current Q&S manager is Rachel.Armitage@wales.nhs.uk

i) Self-referrals

i. If a patient contacts the team wishing to self-refer this should be passed to the duty worker.
ii. Additional information will be gathered from the patient concerning regarding mental state and relapse indicators. If, following discussion it has been **mutually agreed** between duty worker and patient that a Part 3 self-referral and subsequent **full re-assessment is not required,** then relevant information and advice will be given to the patient. This discussion and information should then be fully and clearly captured in a PARIS case note, as the end of that intervention.
iii. If following this discussion, in addition to the advice and information, the patient is clearly requesting a Part 3 self-referral and re-assessment of need, the duty worker will begin the Part 3 self-referral process.

j) Part 3 self-referral process

i. Ascertain the level of urgency by completing the duty worker referral form with the patient (appendix 1) and agree the timeframe for the assessment with the patient.
ii. If, following the completion of the duty worker referral form, and the duty worker considers the patient's needs to require an emergency or urgent assessment, the duty worker will arrange for an assessment to take place either within 4hrs (if an emergency) or 48hrs. The priority must be **mutually agreed,** if there is disagreement, the higher priority should be followed. If considered a routine need, this will follow the CMHT usual process for managing self-referrals and the patient will need to be assessed within 28 working days (see referral SOP and Parts 2 and 3 MHM Code of Practice).
iii. The duty worker will also ensure the referral is recorded as a Part 3 self-referral on PARIS and complete a case note of the discussion and actions agreed.
iv. All people who self-refer under Part 3 of the MHM **must** receive their Part 3 referral outcome letter within 10 working days of their assessment. The performance indicator used to measure this, is date the letter is printed from PARIS.

k) Notification of Deaths

i. If the CMHT receives information that a patient may have died, the call should be passed to the duty worker or duty lead to take the information and complete the actions required (as per flowchart process – appendix 2)

l) Time management

The duty worker should not plan any scheduled work in for the day they are allocated the duty role.

m) The duty worker should evidence the day's activities by documenting each interaction and information received within the relevant patient's electronic record on PARIS. If there is not a PARIS record for the person and it is not indicated that a PARIS record is created, records should be kept within the duty diary.

n) End of day checks. This will need to be a lone working check to ensure all staff are safe at end of shift (see also C&V Lone worker policy and your local Lone worker process UHB Lone Worker Policy . Building checks specific to your building, e.g. checking windows are closed. The CMHT team manager will hold overall responsibility for this but would expect the duty worker to facilitate and provide the information.

2. DUTY LEAD ROLE AND RESPONSIBILITIES:

Daily you will be responsible for the operational management of an assembled duty team who will report to you as duty lead. The duty team will include a duty worker and may include second or third duty (known as duty buddy) and may include a duty admin lead for the day, along with a duty medic for the day.

a) You will be visible and available to your team throughout the working day. You will adopt a senior lead clinical role throughout the working day to support decision making and safe clinical pathway management

in relation to each referral and enquiry into the Community Mental Health Team.

b) You will be responsible for ensuring minimum staffing levels are maintained within the duty team. **You will be supported by the CMHT Service lead to have the autonomy, authority and expectation to utilize all required resources within the CMHT to maintain a safe and clinically effective duty team.**

c) Should demand exceed the assembled duty resource at any one time, the Duty Lead will liaise with the CMHT service lead to implement a request for assistance from neighbouring Locality CMHT's and / or the Crisis Resolution and Home Treatment Teams.

d) **You will meet with the duty workers throughout the day and at end of the day to consolidate the day's activities.**

e) You will ensure the duty team (could be delegated to the duty team members or singularly managed by duty lead) process all **routine** referrals that have been received throughout the day, in that they are reviewed, (i.e. read by a clinician, either duty lead or duty workers), actions documented and opened by a member of the admin team, to the CMHT **by the end of the working day**.

f) You will provide support and advice to the duty team in relation to all **urgent** and **emergency** referrals, inc. Part 3 MHM requests, to agree next steps, e.g. facilitating an assessment within agreed timeframes, seeking out medical support / advice if necessary and mobilizing resources.

g) You will ensure all **PPN's** that have been received on your allocated day are reviewed as per each Local Authority's guidance. Actions are documented in PARIS and a further action plan if applicable is followed up. (see agreed PPN processes for your Local Authority Locality area - appendix 3)

h) You will ensure wherever resources allow, all assessments, **3 day follow up requests** (for unallocated cases) or patients who need to be seen on the day as an urgent referral or emergency referral should be dealt with in their entirety on the day. Wherever possible, no assessments should be forwarded over to subsequent duty days.

i) Any assessments that must be carried over to the next working day should preferably be discussed with the next day's duty Lead. If a face-to-face discussion is not possible, written information should be relayed through the duty diary.

j) You will be expected to undertake mental health assessments alongside the duty team members or singularly, as indicated and when required.

k) You will be expected to help support the duty worker or take the lead with the coordination of services to help facilitate Mental Health Act assessments when indicated. Mostly this will consist of contacting the Duty AMHP manager who will make the arrangements, but you will be expected to assist where needed.

l) You will be expected to support the duty team where hospital admission may be indicated, e.g. liaising with crisis team leads in respect of any referrals that may require a level of arbitration or clinical support.

m) You will liaise closely with the CMHT Service Lead, keeping them updated and requesting additional resources where necessary, throughout the day.

3. DUTY GUIDANCE FOR ADMIN STAFF:

a) If the duty worker cannot take a call, it is first important to establish if it is appropriate to take a message or if an alternative clinician will need to take the call. The main reason for not taking a message would be; service user (or carer on behalf of) is calling and in heightened state of distress and/or voicing **immediate** risk of harm to self or others. If an alternative clinician is required, firstly, attempt to locate any duty staff (this could be duty buddy and / or duty lead) or allocated CMHT staff member. If none of the above are available, try any clinicians in the building and inform them that no other duty/allocated staff are available, and you have someone who is voicing an immediate risk, and you need a clinical member of staff to speak to them. Inform then that it is not appropriate to take a message. Document on PARIS the name of the clinical member of staff you passed the call to.

b) If it is appropriate to take a message please take as much detail as possible and email the following people (depending on your duty system); allocated staff, duty worker, buddy/2nd duty worker, duty lead, and duty medic. Please also put an entry onto PARIS that you have emailed the above people and a copy of message content.

c) Where the message refers to a duty referral or a service user calling who is potential risk of harm please flag the email as high importance. If you are aware that duty/buddy/lead will not be available for a protracted period of time, please make a note on email subject.

d) The onus for actioning these requests will then be with the Duty team though allocated staff should also do this if they have capacity to do so, communicating with the others that they have accepted responsibility.

e) **Administration staff are not expected to undertake any degree of clinical triage or prioritising, this is a clinical role and therefore is essential that admin staff are supported by the whole clinical team and by staff identified in Duty roles.**

Recommended email subject headings: *(notes in italic not to be included)*

DUTY Call- Service user call requires call back this morning/afternoon/today *(delete as appropriate)*

DUTY Call- Professional calling with query requires call back this morning/afternoon/today *(delete as appropriate)*

DUTY Call- Duty Self/GP referral, referrer felt this could wait … *(note time period agreed e.g.1hr if aware of current assessment)*

DUTY Call- Repeat call, awaiting call back can this be actioned ASAP can duty lead address this please

DUTY Call- requires action ASAP duty/buddy in assessment *(or other reason why busy)* can duty lead contact or delegate to team member please

Key information to capture in email:

Person calling-

Patient details including PARIS ID *(if not person calling)*-

Time of call-

Request for help details- *e.g. either referral information given or service user reason for calling*

Appendix 1

DUTY WORKER REFERRAL FORM

Emergency/Urgent /Self-Referral Information Collection.

(NB: EVEN IF SELF REFERRAL ASSESS FOR URGENCY)

Guidance for duty workers taking emergency/urgent /self-referral information

Patient Information Required	
Name:	

Date of Birth:	
Address:	
Telephone number(s): **MAKE SURE CURRENT NUMBERS**	
Clinical details:	
Previous Mental Health Contact:	

Physical Status:	
Available support:	
Carer Responsibility	

Indicators of Urgency: Risk

Information Required	
Stated intent to harm / kill self	
Stated intent to harm others	
CLEAR plan **CLEAR preparation**	

Recent attempt	
Previous attempts	
Triggers for these thoughts	
Family History	
Recent psychiatric hospital stays	
Current available support	
Evidence of self neglect	
Protective Factors	

Indicators of Best Place to see Client

Information Required	
Known forensic history:	
Any practice concerns re: aggression:	
Known drug / alcohol misuse:	
Is client currently under the influence?	

Practicalities

Is this an emergency or an urgent referral – this needs to be agreed with the referrer.

Is the patient willing to be seen

Where is patient now, who with, able to get to us if needed?

How will the appointment time be communicated to them?

Are they willing for relatives to be contacted, if so can the referrer provide names and telephone contact numbers?

Is the referrer willing to leave their direct contact number (personal / work mobile) to receive updates?

What action needs to be taken if the patient cannot be contacted, and we are unable to get back to the referrer the same day e.g. surgery closed; e.g. police welfare check?

Following any emergency or urgent assessment, outcome feedback from CMHT to referrer will be by telephone same day or next working day – and documented on PARIS case notes that this action has been completed. This is in addition to any faxes, emails or letters.

Referrer Contact Name:	**Telephone No:**
GP details if not known (and if referrer not GP)	

Time of referral

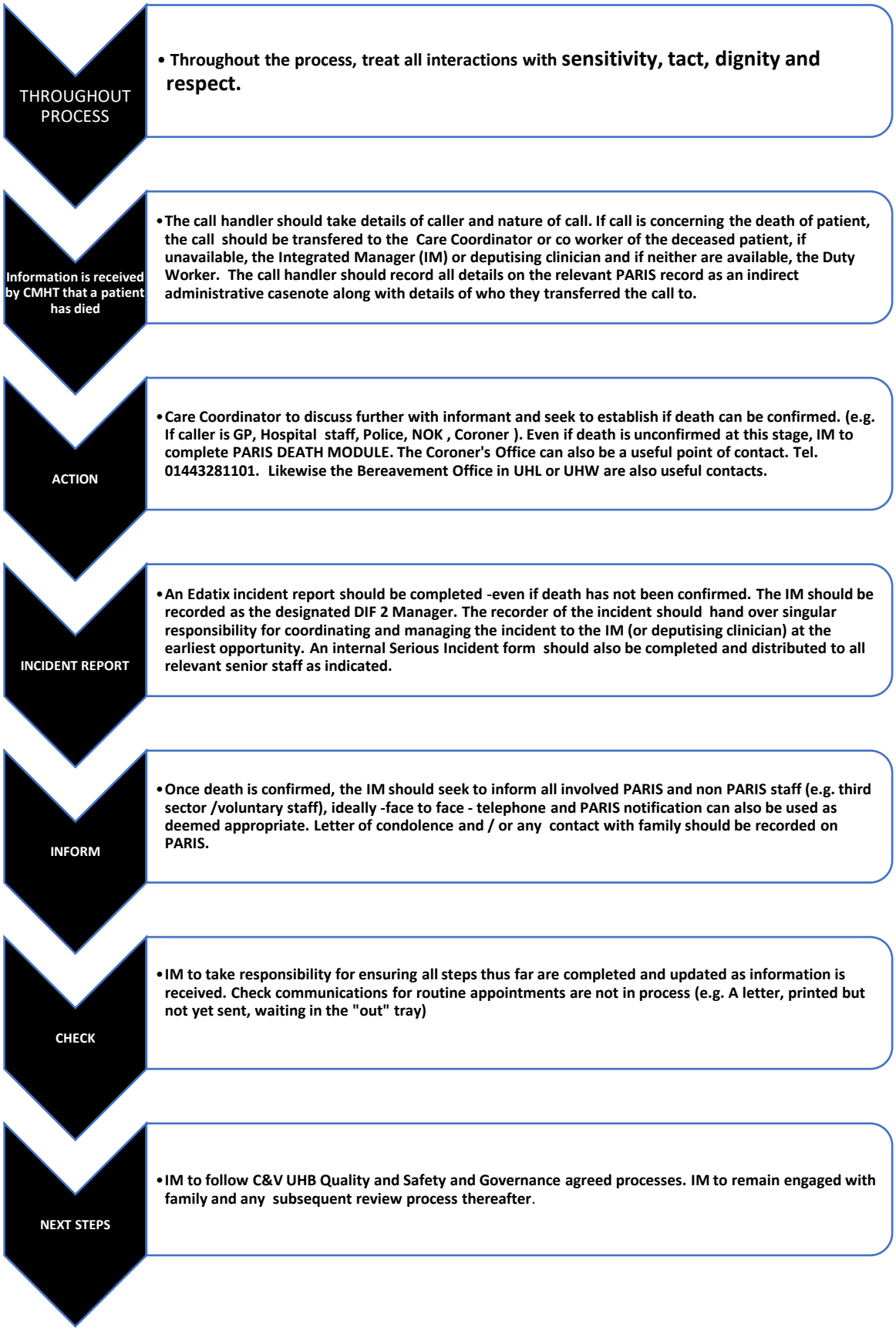
Outcome of referral

Signed: _____ Date: _____

Print: _____

Appendix 2

Process to be followed by CMHT staff in the event of receiving information relating to the death of patient.


THROUGHOUT PROCESS
• Throughout the process, treat all interactions with sensitivity, tact, dignity and respect.
Information is received by CMHT that a patient has died
•The call handler should take details of caller and nature of call. If call is concerning the death of patient, the call should be transfered to the Care Coordinator or co worker of the deceased patient, if unavailable, the Integrated Manager (IM) or deputising clinician and if neither are available, the Duty Worker. The call handler should record all details on the relevant PARIS record as an indirect administrative casenote along with details of who they transferred the call to.
ACTION
•Care Coordinator to discuss further with informant and seek to establish if death can be confirmed. (e.g. If caller is GP, Hospital staff, Police, NOK , Coroner). Even if death is unconfirmed at this stage, IM to complete PARIS DEATH MODULE. The Coroner's Office can also be a useful point of contact. Tel. 01443281101. Likewise the Bereavement Office in UHL or UHW are also useful contacts.
INCIDENT REPORT
•An Edatix incident report should be completed -even if death has not been confirmed. The IM should be recorded as the designated DIF 2 Manager. The recorder of the incident should hand over singular responsibility for coordinating and managing the incident to the IM (or deputising clinician) at the earliest opportunity. An internal Serious Incident form should also be completed and distributed to all relevant senior staff as indicated.
INFORM
•Once death is confirmed, the IM should seek to inform all involved PARIS and non PARIS staff (e.g. third sector /voluntary staff), ideally -face to face - telephone and PARIS notification can also be used as deemed appropriate. Letter of condolence and / or any contact with family should be recorded on PARIS.
CHECK
•IM to take responsibility for ensuring all steps thus far are completed and updated as information is received. Check communications for routine appointments are not in process (e.g. A letter, printed but not yet sent, waiting in the "out" tray)
NEXT STEPS
•IM to follow C&V UHB Quality and Safety and Governance agreed processes. IM to remain engaged with family and any subsequent review process thereafter.

Appendix 3

PPN Process for Cardiff Mental Health Services

The Social Services and Wellbeing Act (2014) has brought about several changes to adult safeguarding that we need to be aware of in adult mental health services.

Section 128 introduced a statutory duty on the police and other partners to inform the local authority in certain circumstances if they believe a person in their area is an `adult at risk'. This means that we must consider and act, if required, on all PPNs that we receive from the police.

When we are considering a PPN, we are not considering eligibility for secondary mental health services, we are considering what response, if any, is required and who is best placed to respond.

Section 126 defines an adult at risk as being an adult who:

a) is experiencing or is at risk of experiencing abuse or neglect AND

b) has needs for care and support AND

c) as a result of those needs is unable to protect him/herself against the abuse/neglect or the risk of it

N.B. PPN's for Cardiff citizens are submitted centrally to the Adult Safeguarding Team who screen the PPN and if appropriate send on to the appropriate team based on the information provided via email.

Any PPN received by the CMHT to be considered and documented using these 3 headings:

Screening: read the PPN, check for accuracy (it may have come to mental health erroneously, in which case re-route back to Adult Safeguarding) and note the date of receipt. Proceed with enquiries -

Initial Evaluation: this may involve collecting, reviewing and gathering information (for instance reading through existing case notes).

Determination: what is the outcome of the initial evaluation? What, if anything, should be done? Make a note of this and who will be responsible for making this happen.

1) PPN is received by the Local Authority CMHT administrator from Adult Safeguarding in a separate PPN mental health inbox to which all LA administrators and Social Work Team Managers have access to. The inbox is checked daily by team

administrators, and colour coded according to which CMHT is the most appropriate recipient. Team administrators retrieve their team's PPN and logs each individual PPN on a shared spreadsheet with any outcomes.

2) PPN is cut and pasted into a case note on PARIS by Local Authority administrator – date should be recorded as the date on which the incident occurred. This should be for all PPN's where they have a PARIS record. If they no PARIS record a decision needs to be made by the CMHT Integrated Manager whether a record is created and PPN recorded.

3) If not currently known or open to the team the Integrated Manager (or nominated Lead) screens PPN and makes initial decision (**'Screening'** and **'Initial Evaluation'** stages), which should be documented on Paris within **7 days of receipt** of PPN.

4) CMHT Integrated Manager (or nominated Lead) notes any safeguarding issues which may have to be addressed immediately.

5) If the person the PPN is referring to is allocated within the team, care co-ordinator (and others involved) notified by LA administrator on PARIS. The care co-ordinator will then be responsible for making enquires, following through any safeguarding actions, deciding on the outcome and documenting this on Paris (the **'Determination'** stage). Enquiries should be made and an outcome ('determination') decided and documented **within 7 days** of the PPN being received.

6) If the person has an open referral and is awaiting assessment (but not allocated within the team), the Integrated Manager (or nominated Lead) (**'Screening'** and **'Initial Evaluation'** stages) will then be responsible for any safeguarding decisions (**'Determination'** stage). In the same way as before, enquiries should be made and an outcome ('determination') decided and documented on PARIS within 7 days of the PPN being received.

7) If the person does not have an open referral and is not open to the team and there does not appear to be any indication of need for secondary mental health care LA admin will return this PPN to Adult Safeguarding. If the person has previously been open to the CMHT or there are clear, current significant mental health issues indicated, it is expected that the CMHT will support Adult Safeguarding in any enquiries that they might be making. In this circumstance Adult Safeguarding will document actions on Carefirst and the CMHT Integrated Manager (or nominated lead) will document on Paris any actions/decisions that the CMHT will take forward.

Example of PPN process documentation when person known to team:

Screening: PPN received today 30.5.2018, occurrence date of 24.5.2018.

Initial Evaluation: Case notes indicate that John has been seen by his care co-ordinator since this incident occurred and no longer feels suicidal.

Determination: care co-ordinator has been made aware of PPN. No further action.

Matthew Russell Operational Manager Mental Health Cardiff Council 08/09/2022