Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

BNSSG ICB Board Meeting

Date: Thursday 16th January 2025

Time: 09:30-12:00

Location: Virtual, via MS Teams

Agenda Number:	6.3	
Title:	Intensive and Assertive Community Mental Health Services Review	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: To approve		
Key Points for Discussion:		

This paper is presented to update the Board on the outcome of the Bristol North Somerset South Gloucestershire (BNSSG) review into our Intensive and Assertive Community Mental Health services. The context, work undertaken to date, and planned next steps are shared for comment, feedback and support. The paper sets out our commitment to ensuring services meet the needs of our local population.

On 26th July 2024, NHS England (NHSE) instructed all ICBs to review their Intensive and Assertive Community Mental Health services. It was intended that the reviews provide an opportunity to reflect on the community provision in place for people with severe and relapsing mental illness, and for systems to identfy and enact specific actions to ensure people receive the care they require.

The outcomes of reviews are twofold. To provide assurance to ICBs that services are well placed to meet the needs of individuals with complex mental health needs. This will be addressed through local action plans that identify and drive forward service improvements

in the short and medium term using internal resources. Secondly, to develop resource requirements and workforce options to inform and support national policy priorities. BNSSG and Bath and North East Somerset, Swindon and Wiltshire (BSW) ICBs have worked with Avon and Wiltshire Partnership Trust (AWP) to undertake this review across our local populations and develop an action plan, with both local (BNSSG) and trust wide (BNSSG & BSW) actions applying across the AWP footprint. All ICBs have been asked to discuss the reviews and local progress at open ICB Board by the end of December 2024, and it can be noted that this item was originally scheduled for December prior to the Board meeting being rearranged. Within BNSSG, AWP and the ICB have worked together alongside people with lived experience, Voluntary Community and Social Enterprise (VCSE), GP and local authority partners in undertaking the review. The ICB Board is asked to approve the work undertaken to date, identify any gaps and support the progress of the work continuing as recommended below.	
Recommendations:	▪ BNSSG ICB, AWP and partners (including General Practice, VCSE, Local Authorities and Lived Experience) continue to work together and oversee progress made against areas identified for improvement through our local action plan. ▪ The action plan will be monitored through the BNSSG Community Mental Health Programme Board. The Mental Health Operational Delivery Group (MH ODG) will oversee this work with support provided through the Mental Health & Learning Disability and Autism Health and Care Improvement Group (MHLDA HCIG). ▪ Updates will continue to be shared with the AWP Enhanced Quality Contract Oversight Group for alignment. ▪ Continue to work in collaboration with BSW ICB and AWP on progress against trust wide improvements. ▪ The communications team is engaged and will support messaging.
Previously Considered By and feedback:	Previous versions of this paper and progress on the review have been received by: • BNSSG Community Mental Health Programme Board 12th September 2024 • BNSSG ICB Executive Team Meeting 23rd September 2024

	• AWP Enhanced Contractual Quality Oversight Group 25th September 2024 • Mental Health Operational Delivery Group 31st October 2024 • Mental Health, Learning Disabilities and Autism Health and Care Improvement Group 4th November 2024 • AWP Enhanced Contractual Quality Oversight Group 26th November 2024
Management of Declared Interest:	No conflicts have been identified
Risk and Assurance:	This review may present some reputational risk to AWP and the ICB as the transparent approach undertaken will identfy areas where improvement could be made.
Financial / Resource Implications:	Not applicable at this stage.
Legal, Policy and Regulatory Requirements:	This review is mandated by NHSE and is a 2024/25 priority within operational planning guidance.
How does this reduce Health Inequalities:	Devising and implementing improvements in these services will address inequalities in Mental Health services which are intrinsically linked to deprivation, especially regarding individuals in scope of this service review.
How does this impact on Equality & diversity	ICB System Intelligence (SI) analysis on this cohort has identified areas for further work to ensure equity of access, experience and outcomes which are part of the action plan.
Patient and Public Involvement:	Six Focus Groups were undertaken through the review process and included. ○ People with lived experience and carers, ○ Leads from general practice, ○ Local Authorities (social care), ○ Wider VCSE partners including: Nilaari, Second Step, One 25, St Mungo's, Independent Mental Health Network, Developing Health and Independence (DHI) and Bristol Drugs Project (BDP), Changing Futures.
Communications and Engagement:	NHSE has asked that we discuss our review and developing actions in public through ICB board. Our local system groups (MH ODG and MHLDA HCIG) will receive regular updates on progress and have system wide membership and attendance.

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Sponsoring Director / Clinical Lead / Lay Member:	Dave Jarrett, BNSSG ICB Chief Delivery Officer, & Senior Responsible Officer (SRO) for Mental Health

6.3 Intensive and Assertive Community Mental Health Services Review

1. Background

On 26th July 2024 NHS England issued ICB's the instruction to review Intensive and Assertive Community Mental Health services. The reviews were intended to provide an opportunity to reflect on the community provision in place for people with severe and relapsing mental illness, and identify specific actions needed to ensure people are receiving and engaging in the care they need.

Safety is a pivotal consideration. While it is more likely that someone with severe mental illness will harm themselves rather than other people, Serious Untoward Incidents (SUIs) such as the tragic events in Nottingham in 2023 highlight the need for services to engage and treat individuals that pose a risk of harm to others when unwell.

NHSE guidance to systems on the review process identified the priority group of individuals for whom intensive and assertive mental health services may not be meeting all needs. This group included individuals who:

- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms
- Are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely to present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

ICBs were requested to rapidly check existing service policies and practice, to ensure that Did not Attends (DNA's) are never used as a reason for discharge for this vulnerable group. It was established that in BNSSG, provider policies and procedures did not use DNA's as a reason for discharge and this was confirmed to NHSE on 31st July 2024.

Subsequently, through the detailed process of the full review it was identified that in practice, this can occur in both BNSSG and BSW as part of a reason for discharge. Addressing this is a key part of our local action plan as described below.

ICBs were required to complete a template and return to NHSE with the outcome of our review by 30th September 2024 and our submission can be seen in Appendix 3.

The guidance supporting the review (Appendix 2), highlights that reviews should seek a range of input from colleagues across services and other partners, as well as direct engagement with patients who have lived experience of using these services, carers and families. Locally we have endeavoured to do this with a detailed engagement process and series of focus groups to obtain information in practice, gaining views of staff, service users, and community partners. This has been invaluable in developing our shared understanding of our services.

ICBs were asked to produce local action plans focusing on practical steps to address any potential gaps in provision highlighted through the review. Action plans should include short-term and medium-term actions with minimal resource implications and ensure that DNA is never used as a reason to discharge in both practice and policy.

Within BNSSG, AWP and VCSE organisations St Mungo's and Second Step provide the Intensive and Assertive Community Mental Health services in scope of this review. The full review process and outcomes can be found in Appendix 1.

ICBs were also asked to consider potential longer-term actions, which may have resource implications identified in the review process. This information was returned to NHSE on the 8th November 2024 and BNSSG advised NHSE that due to the timeframes our costings were indicative only. We will continue to work with NHSE on more detailed information as it is requested, and this information is being considered by NHSE as part of their national planning process.

2. Review Findings

All ICBs were required to return to NHSE a summary of their review findings by 30th September 2024. In addition to our return (Appendix 3), BNSSG submitted additional detail describing the main findings of the report which will inform our action plan. The main findings are summarised below:

Area	Areas for Improvement
Policies & Practice	Ensure policies appropriately reflect the Mental Health Act, Mental Capacity Act, Human Rights Act and the Care Act. Processes for when an individual refuses consent and where there is non-concordance with medication. To undertake Equality Impact Assessment on policy review. Define roles and responsibilities for non-statutory partners (e.g. VCSE) and collaboration across Local Authority, emergency, housing providers and services for people with Learning Disabilities and or Autism.
Governance, partnership and monitoring	Policy leads feeding into system planning groups. System learning following serious incidents. Monitoring arrangements across partners for people who may require intensive and assertive community care.
DNA usage	Implement system to regularly review DNA and related discharge. Undertake Deep Dive of individuals who may have been discharged due to capacity.
Pathways	Develop a more coordinated and effective Assertive Outreach approach across BNSSG, aligning statutory and VCSE services.
Local data & population health management	Better use of data sets across providers and ICB to ensure equity of access, experience and outcome.
Medicine Management	Review non-concordance.
Risk Assessment Care planning and Safety	Improve joined up working across system partners and development of the Your Team, Your Conversation, Your Plan approach which is replacing the Care Programme Approach (CPA) framework.
Equality and Diversity	Develop stronger links with Learning Disability and Autism services. Implement the Patient and Carers Race Equity Framework (PCREF).

	Improve engagement with community providers and community partners, including religious and faith groups.
Discharge from services	Improve consistency, including in approach to non-attendance and discharge process.
Workforce	Address gaps in workforce understanding of effective approaches to engaging and supporting people with psychosis.
Local serious incidents, patient experience, complaints & compliments	Improve process for how recommendations from serious incident reviews inform both provider and system responses.

It can be noted that locally, there were areas of good practice highlighted by partners and these include:

- Early Intervention in Psychosis Services (AWP): Teams are resourced to ensure small caseloads and to offer an array of interventions to engage and support the needs of people with psychosis.
- ROSE Team (AWP): Examples shared of staff providing highly personalised support for people from our most marginalised communities who are poorly served by mainstream services.
- 'LINK Team' (AWP / Second Step): which supports people in Bristol who are street homeless or at imminent risk of homelessness, and who also experience severe emotional distress associated with a mental health problem. The team includes individuals from organisations across Bristol, including Second Step, St Mungo's, Bristol Drugs Project, AWP and Bristol City Council, who seek to bridge gaps in service provision by working together to support those who struggle to access services.
- 'My Team Around Me' (Changing Futures): which bring together multi-agency professionals and people experiencing multiple disadvantage to help them access the breadth of support they need.
- ACE service (St Mungo's): which works with people from different communities in Bristol, including the LGBTQI+ community, asylum seekers and refugees, rough sleepers, parents, and those with risky drug and alcohol use, to help them to engage in mental health and wider support services.

2.a Local Action Plan

NHSE has advised the review be ***'a thorough frank and honest appraisal of the as is situation with integrity maintained throughout'***. AWP and partners have conducted the review in this spirt. As such the areas above provides the framework for our local action plan. AWP will lead the response to this action plan, with both local (BNSSG) and Trust wide (BNSSG / BSW) actions focusing on short and medium-term improvements not requiring additional resource.

The improvement areas above address workforce and we will continue to work with AWP and wider providers, BSW ICB and NHSE on possible future workforce models. This will be in addition to the submission made on the 8th November 2024 with indicative financial requirements.

Our focus is on the short-term and medium-term changes required that can be made as a local system.

2.b Next Steps

The plan will be reviewed regularly at the Community Mental Health Programme Board, to oversee progress. The ICB will ensure that the action plan delivers against the priorities as identified through the review and described above. Wider governance and assurance will come from the MH ODG to ensure this work continues as planned with ultimate responsibility and support from the MHLDA HCIG. Through these system governance groups any risk to progress will be escalated accordingly.

3. Financial Resource Implications

Not applicable at this stage. There are no current requests for information from NHSE, and at this stage no immediate funding has been identified for systems. Current requirements will form part of our planning process as per our business as usual approach.

4. Legal Implications

This review is mandated by NHSE and relates to the 2024/25 priorities and operational planning guidance, which asked systems to:

'Review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge'

NHSE has shared guidance on how to complete the review which has been followed and we engage in regular NHSE regional touch points for guidance, to share feedback and learning as part of the overall assurance process.

5. Risk Implications

A review of this nature will carry some reputational risk to the ICB and AWP. This is a deep dive into services that have not been subject to recent review or investment. This risk will impact all ICBs / mental health providers and is not a local risk.

It is important to note the significant transformation that has occurred in BNSSG Mental Health services over the last ten years through both the NHS Five-Year Forward View and the Long-Term Plan, and that the community services in scope for this review have not been part of those transformations and investment, and that this is a timely opportunity for review.

6. How does this reduce health inequalities

An action plan is being developed that will support a range of improvements for our Intensive and Assertive Outreach Services. This includes working closely with community partners who support those who experience the greatest health inequalities, with robust monitoring to measure impact. Whilst Mental Health and deprivation are intrinsically linked this is more so the case for this population and as the actions are progressed, we expect to see reduced inequality.

7. How does this impact on Equality and Diversity?

As outlined in NHS England's Advancing Mental Health Equalities Strategy, different groups experience inequalities in access, experience and outcomes (e.g. Black men are under-represented in accessing preventative services and overrepresented in our acute pathway).

This review proactively sought the views of partners who serve communities receiving the poorest outcomes, e.g. Nilaari / St Mungo's. Through the action plan, a series of recommendations will outline the opportunities to create greater equity, including through the implementation of BNSSG's Patient and Carer Race Equality Framework. An Equality Impact Aassessment will be undertaken when sharing the final plan.

ICB SI analysis on this cohort has identified areas for further work to ensure equity of access, experience and outcomes.

8. Consultation and Communication including Public Involvement

Focus groups with people with lived experience of psychosis, and carers, were included within this review, and the approach taken has been overseen by BNSSG's Community Mental Health Programme Board which includes lived experience representation of people with severe mental illness.

NHSE has asked that we discuss our review and developing actions at a public ICB board by the end of December 2024.

'To support transparency of findings we are asking all reviews to be presented and discussed at your public ICB board meetings alongside an action plan for how you will implement the national guidance'

Frequent updates against the action plan will be shared at the MH ODG and less frequent more detailed updates at MHLDA HCIG.

Appendix 1 - Review process and outcomes

To conduct the review a range of activities were undertaken between July and September 2024.

a) Review of DNA policies

A rapid review of Did not Attends (DNAs) policies and procedures was undertaken with AWP and St Mungo's to ensure that DNAs are never used as a reason for discharge for this group of individuals. It was established that the policies and procedures did not use DNAs as a reason for discharge. This was confirmed with NHSE on 31st July 2024.

b) Review methodology

BNSSG in collaboration with Bath, North East Somerset, Swindon and Wiltshire ICB developed organisational and team Self-assessment Tools utilising the NHS Midlands Maturity Tool (attached) and NHSE guidance for Intensive and Assertive services. The template was shared for completion by key services within AWP, St Mungo's and Second Step, as the commissioned providers of Assertive Outreach services.

The internal teams identified in AWP were:

Bristol
Bristol Mental Health Assessment & Recovery Team - Central & East
Bristol Mental Health Assessment & Recovery Team - North
Bristol Mental Health Assessment & Recovery Team - South
Bristol Mental Health Complex Psychological Interventions
Bristol Mental Health Early Intervention
Bristol ROSE (Recovery Outreach Service & Engagement Team)
North Somerset
North Somerset Early Intervention
North Somerset NMP Recovery Caseload
North Somerset Psychological Therapies Service
North Somerset Recovery Team
North Somerset ROSE (Recovery Outreach Service & Engagement Team)
South Gloucestershire
South Gloucestershire Early Intervention

South Gloucestershire Early Intervention 117 Review
South Gloucestershire Early Intervention ARMS
South Gloucestershire Psychological Therapies
South Gloucestershire Recovery North Team
South Gloucestershire Recovery South Team
South Gloucestershire ROSE (Recovery Outreach Service & Engagement Team)

The following services commissioned by BNSSG ICB to VCSE partners, completed team level self-assessments:

- Second Step: Bristol Mental Health Community Rehab Service (including sub-contract to AWP) and LINK service (sub-contracted by AWP)
- St Mungo's: Assertive Contact and Engagement service (ACE).

In addition, six focus groups / interviews have been undertaken with:

- People with Lived Experience (including carers)
- GPs
- VCSE partners
- Social Care

A review of service specifications for relevant services was also undertaken, alongside 2 Domestic Homicide reviews and 2 Safeguarding Adult Reviews.

c) Review Completion

From the information gathered from the self-assessment tools, focus groups and specifications a thematic review was undertaken to establish:

- Assurance that the services in area can identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up.
- Any gaps in services ability to meet the needs of this group.
- Any barriers / challenges to the provision of intensive and assertive community mental health care as described in the national guidance (e.g. workforce, financial, competencies to deliver NICE recommended interventions)
- Specific provision in place relating to:
  - Do you have key workers and/or care coordinators in place who can provide continuity of care during periods of service user disengagement?
  - Do services involve families and carers?
  - Is there a process for long term planning of care?
  - Is there clear information sharing protocols in place?
  - Are Did Not Attends ever used for this patient group?
  - Are discharges overseen by a multi-disciplinary team?

d) Review Outcome

NHSE has advised the review be 'a thorough frank and honest appraisal of the as is situation with integrity maintained throughout'. AWP and partners have conducted the review in this spirt. A wealth of information has been returned and consolidated into

Appendix 3 – our review response to NHSE. Which has been developed from reviewing the detailed teams and provider level response to the assessment tool in Appendix 4.

Our response is in line with BSW ICB, as part of the AWP footprint. Indications from the NHSE region are that other ICBs are in a similar position with their review outcomes.

Appendix 2 – ICB Guidance on intensive and assertive community mental health care

Attached

Appendix 3 – ICB Response to NHSE 30th September 2024

Attached

Appendix 4 – ICB Self-assessment tool

Attached

Classification: Official

NHS England

Guidance to ICBs on intensive and assertive community mental health care

Publication reference: PRN01456_ii

Contents

1. Introduction

Many people who experience psychosis are able to receive evidence-based care and treatment which enables them to recover from their psychotic episode and/or be supported to live a life that is meaningful to them alongside the management of ongoing symptoms. Some people who experience psychosis, particularly where paranoia is present, struggle to access evidenced-based care and treatment. This can be due to core services not being able to meet people's needs, the impact of symptoms such as paranoia or a lack of understanding from the individual that they are unwell. . For this group of people, it is critical that mental health services are able to meet the person's needs by adapting the approach to engagement, providing continuity of care, and offering a range of treatment options for people experiencing a varying intensity of symptoms. .

People with these needs can be very vulnerable to harm from themselves and from others; for a very small number of people relapse can also bring a risk of harm to others. ICBs have a duty to provide care and treatment in a way that meets the needs of this group. Improving the care and treatment of individuals who require an intensive and assertive approach from health services is a priority for the NHS.

As a first step in improving care, NHS England included a requirement in the 2024/25 NHS Priorities and Operational Planning Guidance that all Integrated Care Boards (ICBs):

> "Review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge."

This document provides guidance to support ICBs to undertake these reviews. It has been developed with the support of an Expert Advisory Group which included representatives of the Royal College of Psychiatrists and the Department of Health and Social care. A full list of Expert Advisory Group members is available at Annex A. The guidance provides information on:

- The characteristics and presentations of individuals in scope
- Themes and lessons for services from previous severe untoward incidents
- The features of intensive and assertive community care
- How ICBs should undertake local reviews

As part of these reviews, ICBs are asked to report any gaps and barriers to delivering good care that they have identified (e.g. resourcing and workforce implications of delivering this care) to regional NHS England teams. Chapter 5 provides more information on how ICBs

should undertake local reviews and a reporting template is available with this guidance to further support ICBs.

Intensive community care and wider community mental health provision

While this guidance and the local reviews being conducted by ICBs necessarily have a specific focus on intensive and assertive community treatment, this is intrinsically linked to the need for high quality and safe care across community mental health services. ICBs will need to take a whole population view to determine how to meet the needs of the small group of individuals who require intensive and assertive community care described in this guidance, while also ensuring that they can provide the best possible care to all people with severe mental illness (SMI), stepping up and down intensity in response to people's fluctuating needs.

Recognising the importance of improving the quality and safety of care across all community mental health services, NHS England will continue to work with the Expert Advisory Group to develop further guidance for ICBs that is broader in scope. Phase 2 of this work will provide guidance across a range of issues relating to the provision of high quality and safe care in community mental health services. This will include specific focus on care coordination and the role of key workers, personalised care and support planning, access to NICE recommended treatments and other interventions, and the management of interfaces with other mental health services. This work will begin in Q3 2024/25 with a focus on care coordination.

Human Rights considerations

Assertive outreach teams are often tasked with minimising potential harms including harms to the individual, their friends and families and to others in the community. Clinical decision making requires balancing each of these to find an optimal solution. Knowledge of the Human Rights Act and its application can support this, ensuring that decisions go beyond merely considering a person's absolute right to life to a balanced approach considering their right to be free from inhuman or degrading treatment.

Decisions should also consider the full range of non-absolute rights including the person's right to liberty as well as the right to a private and family life. A good understanding of Human Rights should support decision making to ensure the rights of all concerned are considered. It should also ensure any potential restrictions that are made to non-absolute rights are applied in a lawful, legitimate and proportionate manner. Knowledge and understanding of the Mental Health Act and how it aligns to the Human Rights Act is also vital as well as proposed reforms which are aimed at facilitating a patient-centred therapeutic approach.

Key messages

Services have a duty to engage with people with SMI and their families/carers

Lack of engagement may be a result of the service offer not being what they want or need; reflective of previous poor treatment; a lack of cultural relevance/understanding; the individual not recognising that they are unwell and need treatment.

Intensive and assertive community care requires dedicated staff

Systems have a responsibility to ensure they commission the right mix of services to support the needs of their local populations. This includes a dedicated resource to provide intensive and assertive care for those individuals wo need it.

‘No wrong door’ approach

Community mental health services should be operating a ‘no wrong door’ approach and be well joined up with other statutory services and Voluntary Community Social Enterprise (VCSE) partners to identify people who might require intensive and assertive care and who are less likely to present via standard routes

Continuity of care is vital

An appropriately experienced and competent key worker needs to be in place for individuals; someone who knows the person well and their history to avoid missed red flags and to respond to signs of relapse.

Holistic and engaging care

Services should provide care that is holistic, engaging and trauma informed – helping people with the things that matter to them and using biopsychosocial formulation-based approaches to meet those needs and promote personal recovery (including substance use, finances, housing, etc.)

2. Scope of local reviews

The aim of local reviews (see chapter 5 for more detail on how ICBs should undertake reviews) is to ensure appropriate intensive and assertive mental health care and treatment is available to meet the needs and to support the wellbeing of a particular group of people with severe mental health illness.

The group under consideration includes individuals who:

- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms
- Are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

This list is not exhaustive and it is to be expected that many of the individuals described above will not be in contact with services currently or will be on the caseload of a service that cannot adequately meet their needs. This group of people are often marginalised, very vulnerable, at high risk of accommodation instability or homelessness, and not accessing services for multiple reasons. They are at risk of suicide and physical ill health. These are individuals who have serious mental illness and are often experiencing command hallucinations telling them to harm others which they feel unable to ignore, or experiencing high levels of threat due to paranoid beliefs. Not only are they feeling unsafe, but those around them including staff members often report feeling worried or scared about their actions. When they are not receiving appropriate services this may be because they are in the wrong service, or because the service is struggling to engage with them, or they are unknown to the system.

According to the National Confidential Inquiry into Suicide and Safety in Mental Health in 2018:

- 11% of people convicted of homicide were mental health patients
- 6% had a delusional mental illness such as schizophrenia or psychosis
- 4% had an alcohol dependence
- 3% had a drug dependence

ICB and provider boards will need to ensure that they have appropriate governance, partnership working arrangements and monitoring systems in place to identify individuals in their communities that require intensive and assertive community care to meet their needs and to keep them and others safe. Identifying individuals who require intensive and assertive community care requires proactive identification across all services, recognising that people with the needs described above may be on caseloads of services that cannot adequately meet their needs.

3. Key themes and lessons from Serious Untoward Incidents (SUIs)

While it is more likely that someone with severe mental illness will harm themselves rather than other people, Serious Untoward Incidents (SUIs) such as the tragic events in Nottingham in 2023 serve to highlight the need for services to seek to engage and treat individuals that pose a risk of harm to others when unwell.

Previous SUIs contain a number of themes that demonstrate the importance of high quality and safe care within ‘core’ community mental health services. ICBs should consider the ability of core community mental health services to provide care against these themes as described below, alongside the need for a specific service offer for the individuals in scope..

Service failure identified	Why is this important	What should happen
Lack of continuity of care and failure to join-up presentation history. **Missed 'red flags' of earlier minor offending / not reflected in risk assessments**	Knowledge of an individual's care history is vital to ensure services understand that person's needs and how to meet them.	Effective care coordination is essential to the provision of high quality and safe care for all people with severe mental illness; it allows for a longitudinal view of an individual's care history, as well as providing a point of contact at the point of relapse, when a stepping up of care is required. A key aim of the Community Mental Health Framework is to maximise continuity of care and ensure no 'cliff-edge' of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, we should move towards a flexible system that proactively responds to ongoing care needs. As the Framework states, all service users should have a suitably experienced and competent named key worker as part of a multi-disciplinary team (MDT) approach to meeting their needs, alongside high quality and dynamic co-produced personalised care plans. Access to the most important information is vital, particularly given the likely staff changes within services over the longer term. Information gathering and collection should be multi agency and not just health focused. Electronic Patient Records (EPRs) should ensure the most important information is easily accessible and immediately obvious to clinicians/key workers. For all people with severe mental illness, it is important that staff are able to quickly identify a person's individual signs of relapse and can support a rapid 'stepping up' of care. • Decisions to discharge people who have been discharged from community mental health services should be documented, noting any personal relapse indicators and known harms/risks if these are not responded to promptly. • Routes back into community mental health services should be clearly identified and communicated at discharge and there should be a low threshold for readmittance.

		For people identified in chapter 2, important information may include risk and offending history alongside access to past psychiatric history. A good risk assessment is not predictive but seeks to understand the types of situations where an individual may have presented as high risk – for example, in response to environmental factors like access to drugs, and what support should be put in place to minimise the risk of harm for the individual to themselves or to others. In line with NICE guidance, services should avoid using risk assessment tools as a predictor of future risk[1]. Instead, assessments should 'focus on the person's needs and how to support their immediate and long-term psychological and physical safety. Mental health professionals should undertake a risk formulation as part of every psychosocial assessment.'[2] NHS England recognises there is more to do to support services in establishing robust approaches to care coordination and information sharing and will prioritise this in the development of further guidance for ICBs on high quality and safe care in community mental health services.
Lack of, or poor involvement of carers or family members	Carers and/or family members can provide vital context and information on an individual's wellbeing, adherence to treatment, etc. that may not be forthcoming from someone not engaged in a standard service offer	For all people with severe mental illness in need of care within community mental health services, engagement with families, carers and close friends who are involved should be seen as standard practice, not limited to times of relapse. If families are asking for help, this should be viewed as a potential red flag - services must listen and get involved. A lack of understanding about the limits of confidentiality is often a barrier to listening to the views of families and carers. Although it is important to respect an individual's wishes about sharing information with family and friends, this should not preclude services from gathering information and listening to their concerns. Clinicians and services need to be clear about the limits of confidentiality and what this means in practice when talking to and listening to relatives, friends and carers.[3]

[1] https://www.nice.org.uk/guidance/ng225/chapter/rationale-and-impact#risk-assessment-tools-and-scales-2
[2] https://www.nice.org.uk/guidance/ng225/chapter/Recommendations#risk-assessment-tools-and-scales
[3] https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2017-college-reports/good-psychiatric-practice-confidentiality-and-information-sharing-2nd-edition-cr209-nov-2017

		Local confidentiality guidance should be available to support staff to engage appropriately with family members, friends and carers. Organisational charters and frameworks for involvement of families and carers are helpful, as are the use of outcome measures completed by families and carers. Accessibility considerations should also be accommodated, for example for the provision of interpreters, sign language, etc. for both service users, families and carers.
No long-term planning of care	Some people experience long-term severe mental illness with periods of relapse and remission. A long-term view of an individual's care is therefore vital	Coproduced personalised care and support plans should be needs focused and take a long-term view of an individual's care. Decisions to discharge people from core community mental health services should be taken with a personalised understanding of the long-term nature of a person's presenting problems. This should consider both the positive, protective factors that support someone's improved mental health, as well as potential triggers/causes of relapse in future. For all people with severe mental illness, it is important that staff can quickly identify their individual signs of relapse and can support a rapid 'stepping up' of care. • Decisions to discharge people from core community mental health services should be documented noting any relapse indicators and known harms/risks if relapse is not responded to promptly. • Routes back into core community mental health services should be identified and communicated to all relevant parties at discharge and there should be a low threshold for readmittance. Failure to engage with services should not be a reason for discharge in those with known severe and enduring relapsing remitting mental illness.
Poorly planned, precipitous discharges from hospital	A significant change in circumstances is related to an enhanced risk of harm. This is especially true of discharge from hospital, as patients may be going	Detailed guidance on proactively planned and effective discharge from acute inpatient mental health services for adults and older adults is available here: https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#effective-care-across-the-inpatient-pathway

	back to less than ideal community circumstances – e.g. ready access to recreational drugs, lack of structured support or activity, etc and unstable accommodation with a risk of homelessness	A person's accommodation stability and potential risk of homelessness should be assessed and addressed as part of discharge planning, with social care staff involved as part of a multi-disciplinary care package when necessary.
Failure to review treatment / medication	People with severe mental illness should have access to a full range of evidence-based treatments, including medication and psychological therapies	Individuals should have access to staff with appropriate experience and competence within Community Mental Health settings to support assessment, monitoring and delivery of treatment, monitoring and review of medication. Clinicians need access to clinical supervision and should have an understanding of how to make judgments on the use of oral medication vs depot medication in community settings (see below). Continuity of care (see above) is important in identifying any signs of deterioration that might prompt a medication review. Engagement with family, carers and close friends who are involved can support identification of early warning signs of deterioration or relapse that might prompt a medication review. Access to NICE recommended psychological therapies for severe mental health problems should be provided, as should access to include social and occupational interventions.

The use of Community Treatment Orders and Depot medication

In cases where there is a history of poor engagement, consideration should be given to the use of supervised treatment within the framework of a Community Treatment Order for eligible individuals (usually those subject to Section 3).

A decision to use a Community Treatment Order should be based on individual circumstances, however there may be shared factors which may be of relevance to this decision, including:

- the presence of severe mental illness including psychotic presentations, in which an individual shows a poor awareness of their illness (including the need for treatment and their risks associated with relapse)

- evidence of previous positive response to treatment
- previous poor compliance with the treatment plan (including discontinuation of medication)
- previous hospital detentions due to the risks they pose during relapse to their own health and safety and to others
- disorganised behaviour/avoidance of contact resulting in being lost to follow up
- unsuccessful prior attempts to engage the individual with a less restrictive approach

The authority to recall the individual to hospital in the event of failure to adhere to the treatment plan or in the event of deterioration must be necessary rather than simply desirable. The purpose of any conditions stipulated in the Community Treatment Order should be to ensure psychiatric treatment (including monitoring of the individual's mental health) and to mitigate against the identified risks associated with relapse. As outlined in the Mental Health Act Code of Practice[4], the least restrictive and maximising independence principles should be considered and, wherever possible, there should be consultation with family and carers. The longer-term intention should be to facilitate engagement and the formation of a therapeutic alliance and to aid holistic support and continuing recovery.

A related issue is the consideration of depot antipsychotic medication for those with psychotic illnesses, with or without the use of a Community Treatment Order. For individuals with a pattern of poor engagement as described above, there may be a history of inconsistent treatment due to disorganisation and/or a refusal of treatment. While this subject has proved challenging to study, a large real-world observational study concluded that depot antipsychotic injections were substantially more effective than oral antipsychotics (excluding Clozapine) in reducing the risk of rehospitalisation or any treatment failure (defined as discontinuation or switch of antipsychotic medication). Therefore, in this specific patient cohort, the administration of a regular depot injection may be the only way to ensure individuals are getting the medication they need, it also provides more frequent opportunities for clinical monitoring.

[4] Tiihonen J et al. (2017) Real-World Effectiveness of Antipsychotic Treatments in a Nationwide Cohort of 29 823 Patients With Schizophrenia. JAMA Psychiatry. 2017;74(7):686-693

4. Features of intensive and assertive community care

This guidance uses the term ‘intensive and assertive community care’ to describe service provision that is designed to meet the needs of the group of people described in chapter 2. This care involves high frequencies of contact with individuals (intensive) alongside an assertiveness of approach to ensuring people get the right treatment and care.

This includes ‘Assertive Outreach’ which is a distinct, evidence-based service model for people with psychosis who for various reasons are not engaged with secondary psychiatric services. The features of this service described in the table below, closely follows the Dartmouth Assertive Community Treatment Scale (DACTS). Annex B has more information on this model.

Over the past three years, ICBs have been implementing new models of care, as set out in the Community Mental Health Framework, based upon the needs of their local populations and maximising their community assets. People with complex needs such as those described in chapter 2 are in scope for transformed community mental health services, with the Framework committing that ‘people with the highest levels of need and complexity will have a coordinated and assertive community response.’[5]

While some ICBs may already commission ‘Assertive Outreach’ teams or similar, others may not currently commission a specific team or service that is focused on intensive and assertive approaches. A key message of this guidance is that while ICBs are not required to commission Assertive Outreach teams, meeting the needs of individuals described in chapter 2 requires dedicated resource. Outlined below are the features of a ‘dedicated function within community mental health services’ this describes the core elements of intensive and assertive community care that need to be in place to meet the needs of these individuals. This has been developed based on the advice of the Expert Advisory Group supporting NHS England with the development of this guidance (see Annex A). Both approaches should be well integrated with wider Community Mental Health services to ensure that individuals can step up or step down care as appropriate to their needs.

In undertaking local reviews, ICBs should consider the needs of their local populations and geography. This should include reviewing local data on who is currently accessing services and identifying population groups who are not. To support this, ICBs should also consult with people with lived experience who have used their local services. ICBs should also consider their existing model of integrated primary and community mental health services and use the table below to identify whether they are commissioning services that have the right mix of

[5] p11, Community Mental Health Framework, NHS England (2019)

staff with dedicated time, competences and experience to meet the needs of these individuals. In particular, people from racialised and ethnic minority backgrounds experience systemic barriers to accessing care and receiving the support that meets their needs. ICBs should continue to embed the changes outlined in the Patient and Carer Race Equality Framework (PCREF)[6] across all aspects of policy, procedure and practice.

[6] https://www.england.nhs.uk/long-read/patient-and-carer-race-equality-framework/

Service feature	Dedicated function within CMH services	Full Assertive Outreach model

Access to dedicated and qualified staff	• Staff have dedicated and protected time to respond immediately when required, including:
	  ○ Dedicated psychiatrist time
	  ○ Dedicated registered mental health nursing staff
	• Access to CMH MDT expertise including occupational therapy, psychology, social work, housing, and substance use specialists.
	• Staff working with this group of individuals have a high-level of skill in engagement and relationship building
	• Staff working with this group of individuals practice assertive engagement
	• All staff have an extensive understanding of psychosis and how it can present, the treatment options (including full range of evidence-based treatments that might be beneficial), harm minimisation and risk management and the use of statutory frameworks, as well as an understanding of an assertive rehabilitation approach
	• Staff have sufficient time in job plans to meet the needs of the people in scope
	• Staff have access to interpreters and know how/when to use them
		• Team approach. Entire MDT team has a live knowledge of the patient including their treatment, care plan, progress and risks
		• Dedicated psychiatrist time
		• Dedicated registered mental health nursing staff time
		• Team structure facilitates at least daily handovers and at least weekly MDT reviews
		• Discrete team of at least 10 staff, not “integrated” into other teams
		• Assertive engagement practised
		• Principle of not ‘brokering out’ – in house psychology, occupational therapy, social work, substance use worker, housing support
		• All staff have an extensive understanding of psychosis and how it can present, the treatment options (including full range of evidence-based treatments that might be beneficial), harm minimisation and risk management and the use of statutory frameworks, as well as an understanding of an assertive rehabilitation approach
		• Staff have sufficient time in job plans to meet the needs of the people in scope
		• Staff have access to interpreters and know how/when to use them

Extended hours operation	• 24/7 crisis line is aware of individuals on CMH caseload requiring intensive and assertive community support • Staff are available by telephone to support a crisis response out of hours	• Service operates extended hours, including weekends
Time unlimited	• **For this group of people DNA (did not attend) should never be used as a reason for discharge** • Staff continue to proactively engage with individuals during periods where engagement is challenging • If/when discharge from a core mental health service is decided to be appropriate, then a clear record of the decision making process needs to be included on the patients record	• Patients are actively monitored and appropriate support and treatment provided to meet their changing needs • Care is time-unlimited and the team operates a “no drop out” policy • A discharge plan in in place, with clear arrangements for the individual to re-enter the service if appropriate • Discharge plan is developed and shared with other agencies
Small caseload	• Small caseloads with dedicated staff should allow for sufficient level of intensive and assertive care	• Small caseloads (see DACT fidelity scale for information on caseload sizes).[7]
Manages stepping up and down of care	• Focus on harm minimisation/risk management, including: continuity of care, comprehensive history, individual formulations, and family engagement • Ability to step up care to access appropriate services including crisis, acute, forensic and rehabilitation services when appropriate	• Takes responsibility to manage crisis presentations, inpatient admissions, in-reach, and discharges from hospital • Manages step down to core community mental health services in partnership with CMH MDT

[7] https://case.edu/socialwork/centerforebp/resources/dartmouth-assertive-community-treatment-scale-dacts-protocol

	• Engagement with the individual's friends and family takes place to determine whether care needs stepping up or down	
Identification of individuals in need of intensive community treatment	• Clear pathway exists within integrated CMH services offer to identify individuals in need of intensive and assertive community care • An integrated community mental health rehabilitation pathway is present, and can provide advice and consultation where and identified rehabilitation need is identified. • Engagement with the individual's friends and family takes place where possible, to determine the right care pathway for the individual	• Dedicated team with explicit inclusion criteria for treating people presenting with psychosis with high risk of deterioration and relapse who are not engaged with other services • Alternative pathways and services exist, including mental health rehabilitation when the specific intervention is identified as beneficial for the individual
Assertive engagement of individuals	• Combination of core healthcare setting-based work and community outreach • Appointment reminders are in place, using different engagement techniques to match the person's needs i.e. not limited to written or text reminders • Engagement with the individual's friends and family where possible, and their views taken into account • Peer support workers support engagement with individuals	• Predominantly community-based outreach to individuals • Appointments can take place out of traditional settings, i.e. within a public space, or the individuals home • Engagement with the individual's friends and family where possible, and their views taken into account • Peer support workers support engagement with individuals
Collating and sharing information	• Assessments (including risk assessments) and care plans (including safety plans) must be co-produced whenever possible and carefully documented and accessible to the individual, their families and friends (where appropriate), and others providing care. They should be shared with receiving professionals upon transfers of care (both between	• Assessments (including risk assessments) and care plans (including safety plans, advance choice documents) must be co-produced whenever possible and carefully documented and accessible to the individual, their families and friends (where appropriate), and others those providing care. They should be shared with receiving professionals upon

	services within a Trust) and when a patient moves between areas, as well as other agencies as appropriate and in line with Caldicott Principles[8] • Risk of homelessness and unstable accommodation is a known concern for this group of people and should be routinely assessed and addressed when care is transferred	transfers of care (both between services within a Trust) and when a patient moves between areas, as well as other agencies as appropriate and in line with Caldicott Principles • Risk of homelessness and unstable accommodation is a known concern for this group of people and should be routinely assessed and addressed when care is transferred
Care and safety planning	• Formulation approach based upon understanding of an individual's history • Use of legal frameworks as appropriate to individual need (e.g. Section 117, CTOs), including to deliver medication for those patients with serious mental illness that are known to be non-compliant with medication • Engagement with the individual's friends and family where possible • Individuals should have access to the full range of evidence-based interventions (such as psychological therapies) that may address their needs (including physical health needs) not medication alone	• Daily planning meetings and weekly MDT reviews • Use of legal frameworks as appropriate to individual need (e.g. Section 117, CTOs) including to deliver medication for those patients with serious mental illness that are known to be non-compliant with medication • Assessments need to be completed by an appropriately trained and highly skilled professional • Individuals should have access to the full range of evidence-based interventions (such as psychological therapies) that may address their needs (including physical health needs) not medication alone
Safety / harm management	• Assessments include the use of legislative frameworks such as the use of S117 or community treatment orders • Assessments and interventions must be completed by a trained and highly skilled professional	• Assessments include the use of legislative frameworks such as the use of S117 or community treatment orders

[8] https://www.gov.uk/government/publications/the-caldicott-principles

	• Activities of daily life assessments are conducted on a regular basis, and when appropriate, there is an ability to step up care to access appropriate services including crisis, acute, forensic and rehabilitation services • Engagement with the individual's friends and family where possible • Key workers should be familiar with early warning signs of relapse and appropriate interventions as per the care plan • Discontinuation of medication against advice and disengagement should be specifically monitored • Multiagency frameworks (*Multi Agency Risk Assessment Conference* (MARAC)[9], Multi-agency public protection arrangements (MAPPA)[10] to be deployed as appropriate	• The team should be familiar with early warning signs of relapse and appropriate interventions as per the care plan • Discontinuation of medication against advice and disengagement should be specifically monitored • Multiagency frameworks (MARAC, MAPPA) to be employed as appropriate
Coordination of care	• An appropriately experienced and competent key worker is in place • Meaningful interventions and co-produced care plans are in place • There is continuity of care, with the key worker supporting step ups and downs of care to ensure they meet the individual's needs • Cover for staff members with care co-ordination role responsibilities is seamless when such staff are on leave, sick or move on from the team	• An appropriately experienced and competent key worker regularly engage with the individual and their family and friends as appropriate • There is active input in place from other agencies, including; social care, housing, public health, criminal justice system, and the VCSE sector • Meaningful interventions and co-produced care plans are in place

[9] https://safelives.org.uk/about-domestic-abuse/domestic-abuse-response-in-the-uk/what-is-a-marac/
[10] https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

		• Cover for staff members with care co-ordination role responsibilities is seamless when such staff are on leave, sick or move on from the team

5. How should ICBs undertake reviews of policies and practice?

All ICBs have been asked to review their local policies and practices in relation to providing intensive and assertive community care. The following provides guidance on how those reviews should be undertaken.

What are ICBs being asked to review?	Using the information detailed in this guidance, particularly chapter 4, ICBs are asked to review the policies and practices they have in place to identify and provide appropriate care to people with severe mental illness who might need intensive and assertive community care, as defined in section 2. ICBs should use this process to identify gaps and barriers to providing good care as set out in this guidance (e.g. resourcing and workforce challenges) and report these back to NHS England.
Who should be involved in reviews?	Reviews should seek to involve all relevant partners, including: • Commissioners of community mental health services • Providers of NHS community mental health services • People with lived experience of complex psychosis • Families / carers of people with lived experience of complex psychosis • Commissioners of inpatient mental health services and community crisis services • Services managers/clinical leads from community mental health services • Adult Secure Provider collaboratives/adults secure pathways • Relevant local partners (e.g. local authorities, local safeguarding boards, VCSE partners) • ICB policy and governance leads • ICB quality and safety leads • Data and business intelligence analysts
What policies and practices are in scope for reviews?	Reviews should consider all relevant policies and practices that involve delivery of care to individuals in scope (see chapter 2). This includes reviewing policies for teams delivering dedicated intensive and assertive community care as well as core community mental health services. ICBs should also review governance, partnership and monitoring arrangements that support the identification of individuals who might need intensive and assertive community care, as well as the capacity of local services to provide appropriate levels of care. Consider reviewing local data and intelligence on populations currently accessing services, as well as those who aren't. Local reports on serious incidents, patient experience (good and poor), and patient complaints should also be reviewed.

When do reviews have to be completed?	Reviews should be completed by 30 September 2024, with the outcome of the review communicated to your Regional NHS England team. We recognise that this is just the first step, with continued work required to improve the depth of the reviews and develop longer-term action plans to address identified gaps in provision. It is vital that DNAs (Did Not Attends) are never used as a reason for discharge from care for this vulnerable patient group. All ICB systems are asked to rapidly check that existing service policies and practice are clear on this issue and confirm this to the NHSE Regional Mental Health Team.
How should outcomes of reviews be communicated to NHS England?	A template for reporting the outcome of reviews has been shared alongside this guidance. Templates should be returned to your Regional team by 30 September.
What happens once reviews have been completed?	Regional NHS England teams will lead the review of the returns and continue to work with ICBs where gaps in provision have been identified to ensure alignment with national guidance. The National NHS England team will collate national trends from the reviews, and use it to inform future policy, as well as communicate the outcomes to the CQC and Department of Health and Social Care.

Annex A: National Expert Advisory Group

Alison Brabban	Clinical Advisor to Adult Mental Health Team, NHS England
Mayura Deshpande	Consultant in forensic psychiatry and National Specialty Advisor in secure care to NHS England
Nuwan Dissanayake	Consultant Psychiatrist Assertive Outreach Service, Leeds and York Partnership Trust
Clair Hayden	Clinical Director for Mental Health Complex Care for North West England, NHS England
Rebecca Daddow	Head of Adult Secure Mental Health, NHS England
Jon Kennedy	Consultant Psychiatrist Assertive Outreach, Birmingham and Solihull Mental Health Trust
Lade Smith	President, Royal College of Psychiatrists
Liz Durrant	Deputy Director of Mental Health, Learning Disability and Autism Quality, NHS England
Andy Bell	Chief Executive, Centre for Mental Health
Esther Horner	Head of Severe Mental Illness and Offender Health, Department of Health & Social Care
Carolyn Houghton	Associate Director, Rethink Mental Illness
Geoff Heyes	Senior Programme Manager, NHS England
Emily Amess	Project Manager, NHS England
Ursula James	Associate Director of Mental Health, NHS England South East Region
Jo Kirk	Assistant Director Mental Health, NHS England Midlands Region
Chris Lynch	Expert Advisor, NHS England
Debra Moore	Deputy Head of Quality Transformation, NHS England
Emma Wadey	Deputy Director Mental Health Nursing, NHS England

Ben Walford	Expert Advisor, NHS England
Tonita Whittier	Senior Programme Manager, NHS England

Annex B: Assertive outreach teams

Assertive outreach is a clearly defined model for delivering community mental health care provided within a multidisciplinary team (MDT) approach, where all staff are involved in a person's care package.

The objectives of this model of care are to:

- seek out people and work with them in locations where they feel comfortable, rather than requiring them to attend clinics;
- maintain people within the community wherever possible and to avoid unnecessary hospital admissions; and
- to provide an assertive, holistic and rehabilitative approach to care with a greater intensity of input than a standard team.

The assertive outreach model, has a strong evidence base and a fidelity scale, the Dartmouth Assertive Community Treatment Scale. The evidence suggests that the model should only be used for people with psychosis who find it difficult to engage with treatment and traditional mental health services, and may have a history of repeated relapses and admission to hospital, often under detention. Patients often have cooccurring needs, which could include homelessness, substance use, and a history of violence or other offending behaviour. Therefore, the whole assertive outreach team are involved in an individual's care with live knowledge of the person including their treatment, care plan, progress and risks with a team structure which facilitates daily handovers and regular MDT reviews.

The team has dedicated staffing with consultant psychiatrist input to support with prescribing, formulation, physical health, legal issues and risk management. Key workers have small caseloads which allows for a minimum of one or two contacts per person per week and the teams work extended hours and weekends to ensure they can provide support when individuals need it. The service is time-unlimited and support for the individual should continue indefinitely. Continuity of care during poor engagement or inpatient admissions is vital.

Evidence

Research evidence and outcome data suggests that the assertive outreach model reduces admissions and promotes effective engagement with individuals who are the most unwell. You can find more information here:

- Assertive Outreach in Mental Health: A manual for practitioners | Oxford Academic (oup.com)
- Assertive community treatment in UK practice | Advances in Psychiatric Treatment | Cambridge Core
- act-dacts-protocol.pdf (case.edu)

Annex C: Service user experiences

In undertaking the development of this guidance we have benefitted from a huge range of expertise, including the advice of members of the NHS England Adult Mental Health Lived Experience Advisory Network. The members contributing to this work have lived experience of community mental health services. However we have not been able to talk directly with people with lived experience of intensive and assertive community care (or assertive outreach). We have however sought to make use of existing research where possible to support the development of this guidance.

Research that includes the direct experience of service users is limited however there are a small number of studies into staff and user engagement in assertive outreach services. More research is required that has an explicit focus on understanding the experiences of individuals from minoritised ethnic groups and NHS England would welcome further research in this area.[11]

To support the development of this guidance, members of the NHS England Adult Mental Health Lived Experience Advisory Network undertook a 'snapshot' review of research literature on engagement within Assertive Outreach teams. The purpose of this review was to identify practices that the research identified as promoting positive engagement with service users, as well as those that were less engaging. The summary below summarises the key findings from this snapshot review.

Associated with more engaging assertive approaches:

- Staff understanding, empathy and respect
- Collaborative, trusting relationships with patients
- Maintaining non-coercive contact with patients
- Practitioners who listen, are caring and committed; validating patients' thoughts and feelings
- Consistent relationships with individual practitioners over time
- A focus on social support that addresses social isolation
- Support to participate in activities away from home
- Cultural awareness and sensitivity with effective interpreter support
- Patient choice and control over medication
- Acknowledging patients' mental health journeys
- Being offered alternatives to face to face meetings and a range of means of contact
- Awareness of the impact of mental health stigma, from society and sometimes services, on a patient's life
- Awareness of how stigma intersects with race in the lives of patients
- A focus on psychotic symptoms/experiences rather than difficult emotions

[11] See: https://raceequalityfoundation.org.uk/health-and-care/mental-health-and-racial-disparities-report/

Associated with less engaging assertive approaches:

- Support that fails to address stigma and its intersection with racism, unemployment, the impact of family breakdown
- Not feeling listened to or involved in care decisions
- A lack of attention to patients' life experiences of racism, discrimination, and marginalisation
- A lack of recognition and understanding of the role of past negative experiences of MH services on patients' current 'engagement'
- Intrusive and controlling practices
- Frequent changes to the care team or support offered
- A preoccupation with risk
- A focus on psychotic symptoms/experiences
- A lack of human connection and empathy
- Inflexible and rigid approaches to care
- Too medication focused
- Stigmatising attitudes from MH services
- A lack of cultural sensitivity
- A lack of support with the specific impact of medication on areas of everyday life. This includes goals around work and education and the impact of medication on sex and intimacy

Intensive and assertive Community Mental Health treatment: ICB review outcome template

Review details - to be completed	
ICB Name	
Region	
Please list the providers in your area, which the review covers	
Has system completed a review of its policies and practices in line with national guidance?	
Name of SRO overseeing review	
Operational lead responsible for completing review	
Please provide the email address for the operational lead responsible for completing the review	

About this template

NHS Priorities and Operational Planning Guidance 2024/25 required all ICBs to review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge. This template is to be completed by ICBs to provide feedback to NHS England on the outcome of their local reviews.

This template accompanies national guidance to ICBs on Intensive and Assertive Community Mental Health care. The national guidance sets out in detail:
- The characteristics and presentations of individuals in scope
- Themes and lessons for services from previous severe untoward incidents
- The features of intensive and assertive community care
- How ICBs should undertake local reviews
- How ICBs should undertake local reviews

NHS England Regional teams will lead the review of the returns and continue to work with ICBs where gaps in provision have been identified to ensure alignment with national guidance. The National NHS England team will collate national trends from the reviews, use it to inform future policy, as well as communicate the outcomes to the CQC and Department of Health and Social Care.

Reviews should be completed by 30 September 2024, with the outcome of the review communicated to your regional NHS England team. We recognise that this is just the first step, with continued work required to improve the depth of the reviews and develop longer-term action plans to address any gaps in provision.

Intensive and assertive Community Mental Health treatment: ICB review outcome template

Purpose of local reviews

The purpose of local reviews is to to ensure appropriate intensive and assertive mental health care and treatment is available to meet the needs and to support the wellbeing of a particular group of people with severe mental health illness. The group under consideration includes individuals who:

- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms
- Are vulnerable to relapse and/or deterioration with serious related harms associated (esp. but not limited to violence & aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

Please refer to chapter 2 of the national guidance for a full description of the individuals in scope of this review.

Involvement of all relevant services and stakeholders - to be completed

ICBs should involved all relevant partners in local reviews. Please refer to chapter 5 of the national guidance for a list of services and stakeholders that should be involved in the review.

Which provider organisations were reviewed?	The following services completed self-assessment template (the template complied using the NHSE Midlands Maturity Matrix & NHSE national guidance on assertive and intensive mental health) AWP: Recovery Teams, EiP, ROSE (Recovery Outreach Service & Engagement) Team VCSE: o St Mungo's - ACE service o Second Step- Link Service and Community Rehabilitation Service Six Focus Groups were undertaken which included; people with lived experience and carers, General Practice leads, social care, LA's and wider VCSE partners including: Nilaari, Second Step, One 25, St Mungo's, Independent Mental Health Network (IMHN), Developing Health and Independence (DHI) and Bristol Drugs Project (BDP) and Changing Futures.

Policies and practices reviewed - to be completed

Reviews should consider all relevant policies and practices that involve delivery of care to individuals in scope (see above). This includes reviewing policies for teams delivering dedicated intensive and assertive community care as well as core community mental health services. ICBs should also review governance, partnership and monitoring arrangements that support the identification of individuals who might need intensive and assertive community care, as well as the capacity of local services to provide appropriate levels of care. This review should clarify that DNAs are never used to discharge this patient group. Consider reviewing local data and intelligence on populations currently accessing services, as well as those who aren't. Local reports on serious incidents, patient experience, and patient complaints and compliments should also be reviewed.

Which of their policies and practices were reviewed?	For both AWP and St Mungo's the following policies were reviewed: o Care planning - Your Team your conversation , your plan o Did not attend (DNA) o Trust Supervision and debrief o Safeguarding o Medication Management o Information sharing protocol The service specifications for St Mungo's & AWP Rose Team were reveiwed as specifically commissioned by the ICB to provide intensive and assertive outreach.

Outcome of review - to be completed

Using the information detailed in the national guidance, ICBs are asked to review the policies and practices they have in place to identify and provide appropriate care to people with severe mental illness who might need intensive and assertive community care (as defined in chapter 2). ICBs should use this process to identify gaps and barriers to providing good care as set out in this guidance (e.g. resourcing and workforce challenges) and report these back to NHS England.

Following your review are you assured that the services in your area are able to identify, maintain contact, and meet the needs of people who may require intensive and assertive community care and follow-up?	No
In no, what are gaps in their ability to meet the needs of this group were identified?	Please see enclosed Table
If no, what are the barriers / challenges that were identified to the provision of intensive and assertive community mental health care as described in the national guidance? (e.g. workforce, financial, etc.)	Key Gaps: o Staff capacity across teams (large caseloads) o Staff capability (e.g. training for staff to understand psychosis and treatment options) o Access to psychologically based interventions - skill mix / competency / capacity o Dedicated access to psychiatry in ROSE team and ACE team o Continuity of care challenged by staff resource and capacity o System digital solution to support information sharing o Integration of care between providers (e.g. AWP / VCSE / GPs) o Ensuring learning from reviews, such as DHRs, are implemented across system partners.

It would be good to understand some of the secific provision in place:	*Do you have key workers and/or care coordinators in place who can provide continuity of care during periods of service user disengagement?*	*Yes*
	Do services involve families and carers?	*Yes*
	Is there a process for long term planning of care?	*Yes*
	Are there clear information sharing protocols in place?	*Yes*
	Are DNAs ever used as a reason for discharge for this patient group?	*Yes*
	Are discharges overseen by an multi-disciplinary team?	*Yes*

What next steps have been identifed to improve care for individuals in scope of the reivew following the completion of your review?	Action Plan in development

Closing questions

Thank you for taking the time to support this review. Please return the completed template to your regional NHSE team.

Following the review were areas of good practice identified that you would like to share, including any innovative approaches or use of digital tools? If yes, please provide details	o Early Intervention in Psychosis Services (AWP): Teams are resourced to ensure small caseloads and array of interventions to engage and support the needs of people with psychosis. o ROSE Team (AWP): Examples shared of staff providing highly personalised support for people from our most marginalised communities who are poorly served by mainstream services. o 'LINK Team' (AWP / Second Step): which supports people in Bristol who are street homeless or at imminent risk of homelessness, and who also experience severe emotional distress associated with a mental health problem. The team includes individuals from organisations across Bristol, including Second Step, St Mungo's, Bristol Drugs Project, AWP and Bristol City Council, who seek to bridge gaps in service provision by working together to support those who struggle to access services. o 'My Team Around Me' (Changing Futures): which bring together multi-agency professionals and people experiencing multiple disadvantage to help them access the breadth of support the need. o ACE service (St Mungo's): which works with people from different communities in Bristol, including the LGBTQI+ community, asylum seekers and refugees, rough sleepers, parents, and those with risky drug and alcohol use, to help them to engage in mental health and wider support services.

What additional support is required from NHSE to meet the needs of the individuals in scope?	To be outlined in the Action Plan that is in development. A strengthened national focus and investment to support the needs of people with psychosis would be welcomed.

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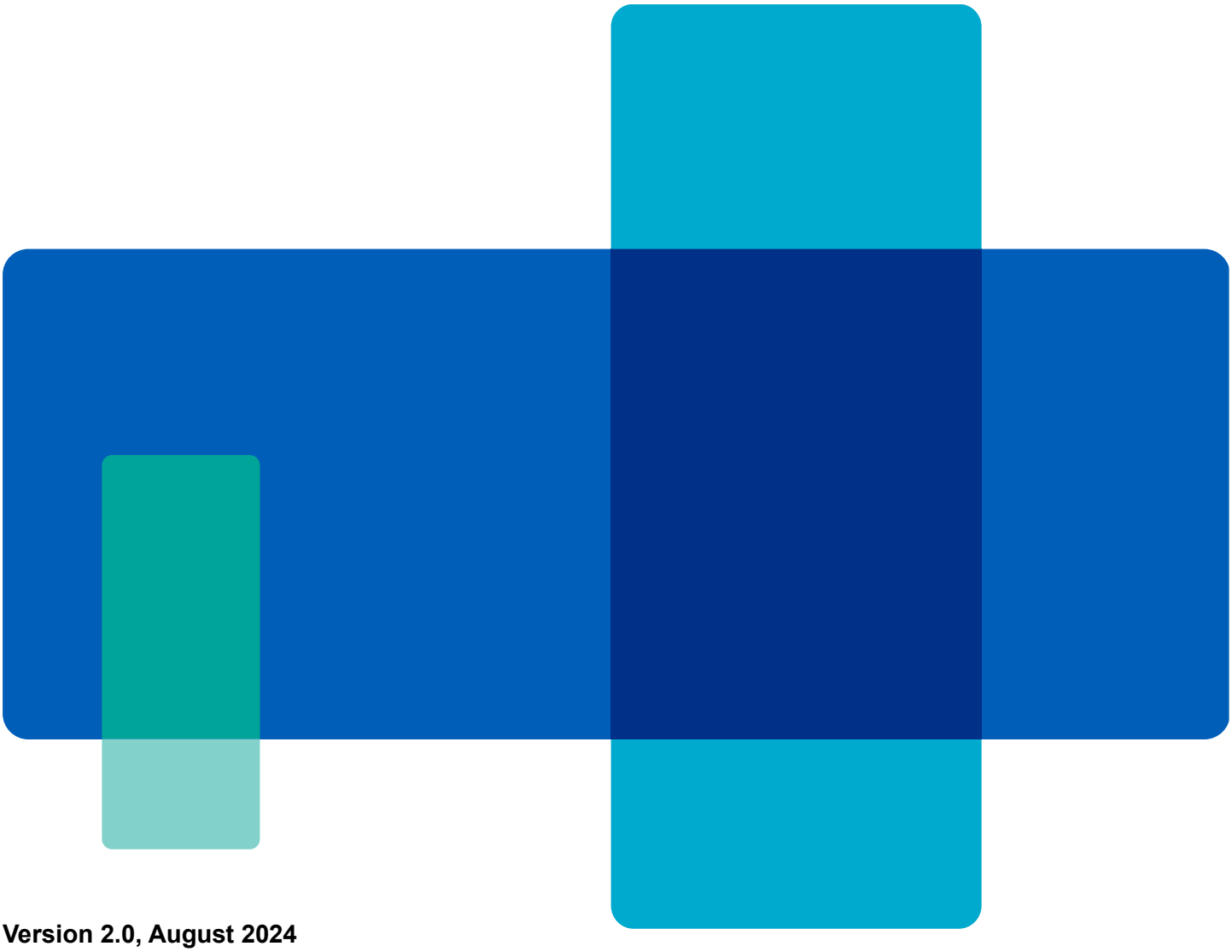
NHS England Midlands

Community Mental Health Service Review

ICB Maturity Index Self-Assessment Tool



Version 2.0, August 2024

Contents

Introduction & Purpose

The purpose of this tool is to support ICBs in their own self-assessment of their current level of service provision and capacity in relation to adequately and safely providing the function of assertive and intensive community support for people with serious mental illness, where engagement is a challenge.

It serves as an enabler for ICBs in bringing together views, perspectives and understanding across different service sectors and pathways to address the 2024/25 operational planning guidance ask as below:

- 'Review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge' (p24). 2024/25 priorities and operational planning guidance (england.nhs.uk).

The tool consists of 14 domains containing a series of exploratory questions and prompts; these are drawn from an initial review of the NHS England Midlands Region submission of Community Mental Health Services operational policies, standard operational procedures, information related to assertive outreach and intensive support, guidance about dual diagnosis and substance misuse, risk assessment process, and DNA/Cancellation/Missed Contacts procedures. The tool also draws upon information from NHS England's Adult Mental Health Team, in their presentation at the first Midland Community Services Review Task and Finish Group (June 2024).

Assertive outreach and intensive case management related information is drawn from the Dartmouth Assertive Community Treatment Scale (DACTS) (Teague et al 1995), the Dartmouth UIK (DUK), and the Assertive Outreach Handbook (Rob Macpherson and Nathan Gregory). This is to support ICBs in assessing whether they have in place the elements of policy and service provision to support these people's needs.

Completion of the tool will support ICBs in responding to the questions included in the 14 domains that will be issued with national policy guidance and which ICBs are requested to return to NHS England to confirm policies and practice has been reviewed.

Definition of cohort:

People presenting with psychotic symptoms (irrespective of diagnosis) who are known to mental health services presenting with repeated mental health inpatient admissions. There is involvement with multiple partner agencies/services and the person has multiple social needs (housing, finance, self-neglect, isolation). The person often presents with co-occurring drug and alcohol problems, and may not respond to, want to, or may struggle to access and use 'routine' monitoring, support and treatment that would minimise harms. The person is vulnerable to relapse and/or deterioration with serious related harms associated not limited to violence and aggression. The person requires responsive and intensive pro-active support. Concerns may have been raised by family/carers.

Completing the document:

To gain all the perspectives it is best to complete this tool as part of a shared group discussion. Some questions are asking for detail at an operational level about what and how things happen. It is suggested to involve a range of clinicians, providing services across the whole of the pathway, and including operational managers, policy leads responsible for policy development and governance, quality and safety leads, and experts by experience. It would also be worth considering involvement from data analysts and pharmacists.

The questions and prompts have been colour coded against the following three categories:

	These questions form the essential components to be considered and built into the core function of your community mental health services pathway.
	These areas consist of key components which would enhance and grow your service offer to people using your community mental health services.
	These desirable components further broaden the opportunities for improving your community mental health service offer.

What this tool will do?

- It will enable and facilitate a structured and focussed conversation across provider and professional services.
- It will provide structure and shape to those elements of community mental health services that should be in place to provide appropriate assertive outreach and intensive support for people with serious mental illness, and to minimise any risks that may arise.
- Give a rounded picture of where your community mental health service policies and practice are currently against good practice.
- Give an indication of the elements of service that you all feel are working well and those that require more development.

Findings and Actions Table:

This is available at the end of the tool to assist with developing action plans.

Leadership and Governance

As a part of this review process systems were invited to identify an SRO for this workstream.

We recommend that utilisation of this document is overseen by those colleagues and signed off through appropriate senior leadership governance channels. For example: ICB SRO, Chair of Mental Health Partnership Board, Trust Medical Director, Trust Director of Nursing, ICB Chief Medical Officer and ICB Chief Nursing Officer.

1. Function of assertive outreach / intensive case management

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do we know who the population of people with serious mental illness where engagement is a challenge are.	☐	☐	☐	☐		
Guidance suggests there should be criteria in policy and pathways for the assertive outreach / intensive case management function in community service provision. For example, this includes:						
A severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability.	☐	☐	☐	☐		
A history of high use of inpatient or intensive home-based care (e.g. more than two admissions or more than 6 months inpatient care in the past two years).	☐	☐	☐	☐		
Difficulty in maintaining lasting and consenting contact with services.	☐	☐	☐	☐		
History of violence or persistent offending.	☐	☐	☐	☐		
Significant risk of persistent self-harm or neglect.	☐	☐	☐	☐		
Poor response to previous treatment.	☐	☐	☐	☐		
Dual diagnosis of substance misuse and serious mental illness that increases risk of negative outcome including contact with forensic services.	☐	☐	☐	☐		
Detained under Mental Health Act (1983, amended 2007) on at least one occasion in the past 2 years.	☐	☐	☐	☐		
Unstable accommodation or homelessness.	☐	☐	☐	☐		
Vulnerable to presenting to crisis or duty services with relapse or deterioration of mental state where serious harm to self/others is identified if intervention/treatment is not provided.	☐	☐	☐	☐		
High level of contact or involvement with emergency services when mental state deteriorates.	☐	☐	☐	☐		
How do we know if the function of assertive outreach/intensive case management is provided in our community mental health services.	☐	☐	☐	☐		

1. Function of assertive outreach / intensive case management (Continued)

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Guidance suggests that the assertive outreach / intensive case management function should have a strong multidisciplinary approach. For example, this includes access to:						
Team leader.	☐	☐	☐	☐		
Clinical psychologists.	☐	☐	☐	☐		
Mental health nurses.	☐	☐	☐	☐		
Occupational therapists.	☐	☐	☐	☐		
Vocational specialists.	☐	☐	☐	☐		
Consultant psychiatrists.	☐	☐	☐	☐		
Psychological therapists.	☐	☐	☐	☐		
Substance use specialists.	☐	☐	☐	☐		
Social workers (who can operate the Care Act principles collaboratively).	☐	☐	☐	☐		
Peer support workers.	☐	☐	☐	☐		
Pharmacists.	☐	☐	☐	☐		
Housing support.	☐	☐	☐	☐		
Guidance suggests services providing the function of assertive outreach / intensive case management should have:						
Smaller caseloads. (10-12 cases per staff member).	☐	☐	☐	☐		
Have a high frequency of face-to-face contact from multiple members of the team.	☐	☐	☐	☐		
Work predominantly in the community (as opposed to office based).	☐	☐	☐	☐		
Take responsibility for crisis services, operate out of hours, take responsibility for hospital discharge.	☐	☐	☐	☐		
Offer time-unlimited support and have a no drop out policy.	☐	☐	☐	☐		
Provide assertive engagement mechanisms such as street outreach or use of the Mental Health Act.	☐	☐	☐	☐		
Use engagement and persistence as a constructive rather than a restrictive approach to keeping track of people (E.G through recreational, educational, or social activities).	☐	☐	☐	☐		
Use methods such as outcome measure to establish how well service users are engaged with services.	☐	☐	☐	☐		

2. Clinical Pathways

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do our policies describe the pathways for:						
CRHT.	☐	☐	☐	☐		
Inpatient admission and discharge.						
• How do we know if our staff follow our inpatient admission and discharge process.	☐	☐	☐	☐		
• Community staff contact during inpatient admission.	☐	☐	☐	☐		
• How do we know if our community staff provide inpatient contact during hospital admission.	☐	☐	☐	☐		
Out of area admissions.						
• How do we know if our staff follow the process for out of area admissions.	☐	☐	☐	☐		
Psychological interventions.						
• We have sufficient numbers of staff to support access to NICE recommended psychological therapies for severe mental health problems.	☐	☐	☐	☐		
• Do our psychological interventions address antisocial behaviour and potential underlying mental illness.	☐	☐	☐	☐		
Transformed CMH services.						
Assertive or intensive community support.	☐	☐	☐	☐		
Homelessness.						
• For homeless people do our pathways detail approaches to engagement and information sharing.	☐	☐	☐	☐		
People who use substances.						
• Does our pathway for people who use substances describe interventions for drug induced psychosis.	☐	☐	☐	☐		
People with co-morbidities with a particular focus on people with Learning Difficulties and Autism.	☐	☐	☐	☐		
Rehabilitation services.	☐	☐	☐	☐		
Supported living.	☐	☐	☐	☐		
Forensic services.	☐	☐	☐	☐		
Vocational services.	☐	☐	☐	☐		

2. Clinical Pathways (Continued)

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Physical health interventions and how assertive engagement can prevent deterioration.	☐	☐	☐	☐		
Older Adults.	☐	☐	☐	☐		
Children and Young people.	☐	☐	☐	☐		
How a person steps up and down dependent on need.	☐	☐	☐	☐		
How a person moves between different mental health services.	☐	☐	☐	☐		
Pathway escalation/disputes.	☐	☐	☐	☐		
We have some good examples that demonstrate to us that providers outside core services or from other pathways (e.g.) UEC, can and do bring to attention people with SMI they have some concerns about.	☐	☐	☐	☐		
How do we know if our CMH services operate a 'no wrong door' approach and if they are joined up with other statutory services and Voluntary Community Social Enterprise (VCSE) partners.	☐	☐	☐	☐		
We have a process for testing that our cross-services communication channels work to trigger an effective response from our MH services.	☐	☐	☐	☐		
We have mechanisms in place that reduces the impact of people accessing different services across different pathways (EG Crisis – CMH – Primary Care).	☐	☐	☐	☐		
Process/Pathway Review						
Have our staff had an opportunity to review or shape how the pathways work.	☐	☐	☐	☐		
Do we review our pathways and have we mapped the process.	☐	☐	☐	☐		
Do we have a forum where clinicians can discuss complex cases within the ICB/provider trust.	☐	☐	☐	☐		
Do we have a forum where clinicians and managers can discuss complex cases across organisational boundaries (i.e. Police, housing support, homeless services, ambulance service, substance use services).	☐	☐	☐	☐		

3. Workforce

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
How do we know if our staff have read our policies for example during staff induction.	☐	☐	☐	☐		
Have we detailed staff support and wellbeing. For example: How do we provide debriefs and support for staff if things go unexpectedly or staff experience harm.	☐	☐	☐	☐		
Have we defined the staff sickness management process and process for reallocation of cases, so people are not lost to follow up.	☐	☐	☐	☐		
How do we know if our staff receive supervision and reflective practice to discuss cases.	☐	☐	☐	☐		
How do we know if staff are trained in the requirements for delivering the service they work in.	☐	☐	☐	☐		
How do we know if staff follow the process for lone working and is this described in our policies.	☐	☐	☐	☐		
How do we know if staff have caseload management including trigger mechanisms regarding early warning signs and escalating levels of risk.	☐	☐	☐	☐		
Are the roles for staff including lead professional/key worker defined.	☐	☐	☐	☐		
Staff along our pathways (inclusive of our assertive outreach function) are sufficiently skilled to support people who may have multiple morbidities (including learning difficulties or autism).	☐	☐	☐	☐		
How do we know if staff have the competencies for the lead professional/key worker roles that we have defined.	☐	☐	☐	☐		
As part of the move away from CPA our service users have access to a suitably experienced and competent named key worker as part of an MDT approach to meet their needs. This is supported by a high quality and dynamic co-produced personalised care plan.	☐	☐	☐	☐		
We are clear that our staff providing support as part of our assertive outreach/intensive case management function have an extensive understanding of psychosis and how it can present, the treatment options (including full range of evidence-based treatments that might be beneficial), harm minimisation and risk management and the use of statutory frameworks.	☐	☐	☐	☐		

4. Risk assessment and safety planning

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
In line with NICE guidance, do our services avoid using risk assessment tools as a predictor of future risk.	☐	☐	☐	☐		
We have sufficient checks in place that inform us that:						
Staff are following risk assessment procedures.	☐	☐	☐	☐		
Staff are following Safeguarding procedures.	☐	☐	☐	☐		
Staff are trained in risk assessment and safety planning.	☐	☐	☐	☐		
Staff are trained in our Safeguarding procedures.	☐	☐	☐	☐		
Staff have followed procedures for 72-hour follow up post hospital discharge.	☐	☐	☐	☐		
Staff act upon triggers such as early warning signs to prevent and manage risk.	☐	☐	☐	☐		
Our risk assessment process captures red flags and minor early offending (i.e. low-level assaults).	☐	☐	☐	☐		
Our risk assessment process captures early signs of support seeking (IE: ED presentations) with early poor engagement.	☐	☐	☐	☐		
Our risk assessments focus on the person's needs and how to support their immediate and long-term psychological and physical safety.	☐	☐	☐	☐		
Our mental health professionals undertake a risk formulation as part of every psychosocial assessment.	☐	☐	☐	☐		
Our risk assessment recognises that if families are asking for help, this should be viewed as a potential red flag and services must listen and get involved.	☐	☐	☐	☐		
Do we have local confidentiality guidance to support staff to engage appropriately with family members, friends, and carers.	☐	☐	☐	☐		
Do we know if our clinicians and services are clear about the limits of confidentiality and what this means in practice when talking to and listening to relatives, friends, and carers.	☐	☐	☐	☐		
Our risk assessment recognises the importance in respecting an individual's wishes about sharing information with family and friends, that this should not preclude services from gathering information and listening to their concerns.	☐	☐	☐	☐		
Does our risk assessment process describe risks associated with the persons illness continuing its progression with the likelihood of a short / shorter than expected time period before the next acute presentation?	☐	☐	☐	☐		
Does our risk assessment process recognise importance of joining up presentation history/episodic care and long-term planning of care.	☐	☐	☐	☐		
Does our risk assessment refer to Multiagency frameworks (Multi Agency Risk Assessment Conference (MARAC), Multi-agency public protection arrangements (MAPPA).	☐	☐	☐	☐		

5. Legislation

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do our policies refer to:						
The Mental Health Act and Mental Capacity Act.	☐	☐	☐	☐		
Community Treatment Orders.	☐	☐	☐	☐		
Processes where a patient is refusing consent.	☐	☐	☐	☐		
The Human Rights Act and its application.	☐	☐	☐	☐		
The Care Act.	☐	☐	☐	☐		
Our S117 Policy.	☐	☐	☐	☐		
Are our staff able to access information and support related to legislation.	☐	☐	☐	☐		
How do we know if our staff are trained in our policies related to legislation.	☐	☐	☐	☐		

6. Interface with other services

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do our policies define the role and responsibility of the VCSE.	☐	☐	☐	☐		
We actively collaborate with LD&A services to ensure our service offer is inclusive.	☐	☐	☐	☐		
Do our policies describe links with the Local Authority.	☐	☐	☐	☐		
Do our policies describe links with emergency services such as the Police and Mental Health Response Vehicles.	☐	☐	☐	☐		
Do our policies describe links with housing providers.	☐	☐	☐	☐		

7. Recovery and personalisation

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
How do we evidence that our assessments are personalised, and recognise the individuality, strengths and abilities of people to shape their own lives and secure their own safety.	☐	☐	☐	☐		
Do our policies define outcome measures such as Engagement Measures, DIALOG+, ReQOL.	☐	☐	☐	☐		
Do our policies detail involvement of family and friends.	☐	☐	☐	☐		

8. Meeting the needs of diverse populations

	No, action needed	No, action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Our policies, procedures and practice reflect the changes outlined in the Patient and Carer Race Equality Framework (PCREF).	☐	☐	☐	☐		
Does our workforce reflect the diverse communities in our locality.	☐	☐	☐	☐		
Have we embedded equalities thinking in planning, and reducing inequalities related to support, treatment and for people requiring assertive and intensive engagement?	☐	☐	☐	☐		
We make use of our data/information about our diverse communities to understand the potential barriers to accessing treatment and care for people.	☐	☐	☐	☐		
We have a good understanding of the rates of referral and rate of detentions under the MHA for mental health services from all our diverse communities.	☐	☐	☐	☐		
Have we adopted new ways of working to prevent people revolving through the criminal justice system, CMHT, inpatients under a section of the MHA.	☐	☐	☐	☐		
We have trained our staff in equality, diversity and inclusion including anti-racist and anti-oppressive practice and is this embedded in our mental health teams.	☐	☐	☐	☐		
We have developed strong networks with LD&A services, religious and community leaders to facilitate engagement in the planning and development of services to ensure care and treatment is appropriate and responsive.	☐	☐	☐	☐		
How do we know if our staff have accommodated accessibility considerations and know how and when to use them EG the provision of interpreters and sign language for both service users, families and carers.	☐	☐	☐	☐		

9. Medication management

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
How do know if our staff are following our medicines policy.	☐	☐	☐	☐		
How do we know if our staff are following our process for people who are non-concordant with medication.	☐	☐	☐	☐		
How do we know if staff are specifically monitoring people who are discontinuing medication against advice and disengaging from services	☐	☐	☐	☐		
How do we know if our staff are following our process for addressing side effects of treatment and reviewing treatment.	☐	☐	☐	☐		

10. Experts by Experience

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Are experts by experience involved in our policy development.	☐	☐	☐	☐		
Are Experts by Experience embedded in our service development work for community mental health services.	☐	☐	☐	☐		
We have involved people delivering and receiving services in having focused conversations about how we best raise our own awareness/stay connected to any potential concerns that may not be directly known to our core services.	☐	☐	☐	☐		
We have included people from our diverse communities to inform our policy and practice delivery (inclusive of people with learning difficulties and autism).	☐	☐	☐	☐		

11. Discharge from services

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
For people who are not attending or cancelling appointments / dropping out of services:						
In Section 5 of the CMH guidance it is made clear that DNAs should never be used as a reason for discharge. Do we have a clear policy in place to state this for people with severe and relapsing mental illness?	☐	☐	☐	☐		
How do we know if staff across our services are adhering to this process for this cohort of people.	☐	☐	☐	☐		
How do we know if our staff are involving family and friends.	☐	☐	☐	☐		

11. Discharge from services (Continued)

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
How do we know if our staff are involving GPs.	☐	☐	☐	☐		
How do we know if our staff consider other services that exist and have capacity that might better meet the wishes of the person.	☐	☐	☐	☐		
How do we know if our staff agree this route with the person and pass all necessary information to that service.	☐	☐	☐	☐		
How do we know if our staff where alternatives do not exist, consider assertive approaches or use of the Mental Health Act.	☐	☐	☐	☐		
How do we know if our staff use the MDT to make decisions to discharge people and record the reasons for discharge.	☐	☐	☐	☐		
How do we know the number of non-agreed discharges to ensure trends can be identified and addressed.	☐	☐	☐	☐		
How do we know if our community mental health services have a low threshold for readmittance.	☐	☐	☐	☐		
How do we know if staff identify any relapse indicators and known harms/risks of relapse if not responded to promptly.	☐	☐	☐	☐		
How do we know if staff identify routes back into community mental health services at the point of discharge.	☐	☐	☐	☐		

12. Data

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Have we undertaken a local mental health needs assessment to help us to understand the population of people with serious mental illness where engagement is a challenge to guide the development of a whole system pathway.	☐	☐	☐	☐		
Do we have a local community mental health data dashboard that displays and organises our own service data to help staff: - Look at someone's history of using mental health services. - Looks at changes in a range of factors to indicate potential /additional support needs. - Drive decision-making on individuals potentially in need of intensive support.	☐	☐	☐	☐		

12. Data (Continued)

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
We routinely review data across our MH pathway where we can identify, respond to and monitor emerging themes and trends (e.g.) Local reports on serious incidents, patient experience, and patient complaints and compliments.	☐	☐	☐	☐		
Our Teams/services review clinical outcome data in a routine manner to make improvements to the service.	☐	☐	☐	☐		
We consider local data and intelligence on populations currently accessing services, as well as those who aren't.	☐	☐	☐	☐		
Have we routinely measured and monitored service user experience/ satisfaction as part of the development work for community mental health services.	☐	☐	☐	☐		
Is the referral to treatment process reported so that waiting times can be monitored.	☐	☐	☐	☐		

13. Policy variation control

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do our policies follow the required conventions for policy management for example:						
Have a version control number.	☐	☐	☐	☐		
List the names and title of the authors.	☐	☐	☐	☐		
List the name and title of the responsible director/SRO.	☐	☐	☐	☐		
Have a review date and are up to date.	☐	☐	☐	☐		
State the frequency of the policy review.	☐	☐	☐	☐		
State the date of approval, and - the name and details of the person who has approved the policy.	☐	☐	☐	☐		
Have an Equality Impact Assessment (EIA).	☐	☐	☐	☐		
Detail the frequency of the Equality Impact Assessment (EIA) and when is it due for review.	☐	☐	☐	☐		

14. Governance

	No, action is needed	No, but action in hand	Yes, but needs improvement	Yes, working well	Comments	Category
Do we have a lead person(s) responsible for policies.	☐	☐	☐	☐		
Do our lead person(s) feed into a community mental health planning groups and/or project boards.	☐	☐	☐	☐		
Do our community mental health planning group and/or project board have representation from key clinicians.	☐	☐	☐	☐		
Do our community mental health planning groups and/or project boards have representation from Trust Executives/Senior Managers.	☐	☐	☐	☐		
Do our community mental health planning groups and/or project boards meet monthly.	☐	☐	☐	☐		
Do we have a governance structure for policy review, oversight and sign off that includes: - Chief Medical Officer, Chief Nursing Officer, system operational governance, quality governance and mental health provider collaborative.	☐	☐	☐	☐		
Have we got a mechanism for learning across the system following serious incidents where we get things right and where we don't.	☐	☐	☐	☐		
Do we have a culture that takes out blame and where people feel safe to raise concerns.	☐	☐	☐	☐		
We have considered the governance, partnership and monitoring arrangements that support the identification of people who might need intensive and assertive community care, as well as the capacity of local services to provide appropriate levels of care.	☐	☐	☐	☐		

Development and contribution to the Maturity Index

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Helen	Perfect	Head Community, Older Adult MH Services	Leicester, Leicestershire & Rutland ICB
Kelly	Plant	Mental Health Community Transformation Operational Delivery Manager	Black Country Healthcare NHS Trust
Claire	Potts	General Manager Community	C&W Partnership Trust
Jodie	Shepherd	Head of Services (CMH Coventry)	C&W Partnership Trust
Sarah	Taylor	Service Manager	Nottinghamshire Healthcare NHS Trust

References

- National Confidential Inquiry into Suicide and Safety in Mental Health.
- Assertive Outreach Handbook. Editors: Rob Macpherson and Nathan Gregory (Dartmouth Assertive. Community Treatment Scale (DACTS) (Teague et al 1995) and Dartmouth UIK (DUK).
- Research evidence and outcome data suggests that the assertive outreach model reduces admissions and promotes effective engagement with the most unwell patients. You can find more information here:
  - Assertive Outreach in Mental Health: A manual for practitioners | Oxford Academic (oup.com)
  - Assertive community treatment in UK practice | Advances in Psychiatric Treatment | Cambridge Core
  - act-dacts-protocol.pdf (case.edu)

Resources

Detailed guidance on proactively planned and effective discharge from acute inpatient mental health services for adults and older adults is available here: https://www.england.nhs.uk/long-read/acute-inpatient-mental-health-care-for-adults-and-older-adults/#effective-care-across-the-inpatient-pathway
Dartmouth Assertive Community Treatment Scale (DACTS).

Guidance to integrated care boards on intensive and assertive community mental health care
Guidance to integrated care boards on intensive and assertive community mental health care | NHS England | Published 26th July 2024.

ICB:	

Findings and Actions Tables

Domain	Essential	Priority Areas	Enhancers	Priority Areas	Desirable	Priority Areas
1. Function of assertive outreach / intensive case management						
2. Clinical Pathways						
3. Workforce						
4. Risk assessment and safety planning						
5. Legislation						
6. Interface with other services						
7. Recovery and personalisation						
8. Meeting the needs of diverse populations						
9. Medication management						
10. Experts by Experience						
11. Discharge from services						
12. Data						
13. Policy variation control						
14. Governance						

Date Completed:		Review Date:	

ICB:	

Findings and Actions Table

Domain	What was the finding	What is the action	Who will be responsible for the action	When will the action be completed	Has the action been completed	Comments
1. Function of assertive outreach / intensive case management						
2. Clinical Pathways						
3. Workforce						
4. Risk assessment and safety planning						
5. Legislation						
6. Interface with other services						
7. Recovery and personalisation						
8. Meeting the needs of diverse populations						
9. Medication management						
10. Experts by Experience						
11. Discharge from services						
12. Data						
13. Policy variation control						
14. Governance						

Date Completed:		Review Date:	

ICB:	

Completion and Sign-Off

Maturity Index completed by (Governance Committee Membership)

Name	Designation

ICB SRO Signature:				Date	
Trust Medical Director Signature:		Organisation:		Date:	
Trust Director of Nursing signature:		Organisation:		Date:	
ICB Chief Medical Officer Signature:		Organisation:		Date:	
ICB Chief Nursing Officer Signature:		Organisation:		Date:	