Adult Mental Health Community Services Operational Policy

This Operational Policy refers to the Support and Treatment Teams (STT) and the Targeted Treatment Team (TTT).

Version: 2.1
Executive Lead: Chief Operating Officer
Lead Author: Service Line Leader, Community Transformation
Approved Date: 21st April 2015
Approved By: SBU East & North Quality and Risk Committee
Ratified Date: 9th June 2015
Ratified By: Policy Panel
Issue Date: 27th July 2015
Review Date: 27th July 2018

Target Audience:
This Policy must be understood by:
- Community Mental Health Teams
- Any related service which may make referrals to the Team
- All staff dealing with this Care Group
P1 - Version Control History:
Below notes the current and previous Version details- full history is in Part 3

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<td>27th July 2015</td>
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P2 - Relevant Standards:

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

P3 - The 2012 Policy Management System and the Policy Format:
The PMS requires all Policy documents to follow the relevant Template

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

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

- **Guidance Template** is a sub-section of the Policy to guide Staff and provide specific details of a particular area. An over-arching Policy can contain several Guidance’s which will need to go back to the Approval Group annually.

- **Recovery Care Pathways (RCP)** are documents that describe a clear route from assessment, through intervention to recovery.

Symbols used in Policies:

- **RULE** = internally agreed, that this is a rule & must be done the way described.
- **STANDARD** = a national standard which we must comply with, so must be followed.

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

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

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

All current Policies can be found on the Trust Policy Website via the Green Button or http://trustspace/InformationCentre/TrustPolicies/default.aspx
## Preface

Preface concerning the Trust Policy Management System:

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1. **Service User Referral Flow Chart**

**N.B.** Staff from the Support and Treatment Team and the Targeted Treatment Team are allocated to undertake initial assessments within the Initial Assessment Clinics.

The Wellbeing Team will refer people with more complex disorders to the Support and Treatment Team for a full assessment and the Support and Treatment Team then make a referral along the care pathway to the relevant specialist team i.e. Eating Disorders, OCD, Forensic Services.
2. Summary

This document outlines the operational procedures for Hertfordshire Partnership University NHS Foundation Trust (HPFT or the Trust) Adult Mental Health Community Services. The Adult Mental Health Community Services offer a multi-disciplinary pro-active and comprehensive service to people suffering from severe and enduring mental illness who have complex needs and will require interventions along a treatment care pathway.

This group – the people eligible for services – are defined as those who are assessed as falling within Payment by Results clusters 5 to 17 (See appendix 6).

Following significant service transformation, these services are now delivered through three teams in each quadrant of Hertfordshire.

These are:

- The Wellbeing team.
- The Support and Treatment Team.
- The Targeted Treatment Team.

There is a separate Operational Policy for the Wellbeing Team.

This Operational Policy refers to the Support and Treatment Teams (STT) and the Targeted Treatment Team (TTT).

3. Purpose

The purpose of Adult Mental Health Community Services is to work with service users within a model of care that aids recovery and enables them to return to their full potential in day to day life.

The principles under which it operates are that it delivers consistent, transparent services which are accountable, easy to navigate and promote autonomy and recovery.

These Community Services will be delivered within each quadrant of the county, and will aim to:

- Increase stability and quality in the lives of service users and their carers/families through provision of timely and clinically effective health and social care interventions that meet the needs of the individuals referred.
- Manage the risks presented by service users – to themselves and others – so that they stay safe.
- Improve service users’ social functioning and social inclusion.
- Promote service users’ participation in their own recovery and through educational support enable them to develop coping strategies and mastery over symptoms of mental illness through Care Pathways.
- Improve where necessary the service user’s engagement with services.
- Work in partnership with carers so that carers are supported in their role and the service users benefit.
- Demonstrate mental health services that are community-oriented – keeping hospital admissions and lengths of inpatient stay to the minimum that is clinically required.
- Demonstrate adherence to the Trust values of being Welcoming, Kind, Positive, Respectful and Professional.
4. Definitions

FACT - Flexible Assertive Community Treatment
STT - Support and Treatment Team
TTT - Targeted Treatment Team
SPA - Single Point of Access
CPA - Care Programme Approach
PBs – Personal Budgets
RCP - Recovery Care Pathways
FEP - First Episode in Psychosis
CAMHS - Community Adolescent Mental Health Service
MHSOP - Mental Health Services for Older People
ADTU - Acute Day Treatment Unit
A&E - Accident & Emergency
RAID - Rapid Assessment, Intervention and Discharge
AMHP – Approved Mental Health Professional
PBR – Payment by Results
AMH – Adult Mental Health
Passed on - Description of process used in PARIS where no activity or allocation has taken place and it preserves the ability to allocate within the correct team or service
Referred on - Description of process used in PARIS where an activity or allocation has taken place and the referral needs to be moved to another team or service
MARAC - Multi-Agency Risk Assessment Conference
MAPPA - Multi-Agency Public Protection Arrangements
HONOS - Health of the Nation Outcome Score
PANSS - the Positive and Negative Symptom Scale
ADOS - Autism Diagnostic Observation Scale
ADHD - Attention Deficit Hyperactivity Disorder
ADD - Attention Deficit Disorder
DNA - Did not Attend
OCD - Obsessive Compulsive Disorder
CEDS - Community Eating Disorder Service

5. Duties and Responsibilities

The Chief Operating Officer is ultimately responsible for ensuring that services are provided in compliance with this operational policy.

The relevant Service Line Leads are responsible for ensuring that the policy is implemented fully and consistently across their quadrants, reporting to the Managing Director.

RULE Team managers and team leaders are responsible for ensuring that the staff who report to them are familiar with the policy and that their practice reflects it.

RULE Professional leads including medical leads should support their operational manager colleagues in ensuring compliance with this policy through supervision and other means.

RULE All staff in these services should take responsibility for familiarising themselves with the policy.
6. Adult Mental Health Community Services Teams

The STT and TTT will have Team Leaders and a Quadrant Manager (referred throughout as the team manager) who will work across both teams, this policy refers only to STTs and TTTs. Each quadrant also has a Wellbeing team with a dedicated manager.

The AMH Community Services Teams unite specialist medical, nursing, occupational therapy, social work, psychological therapies, arts therapies, accommodation workers, STaR workers, vocational advisors, and administrative staff within one service.

Each AMH Community Services Team has a Manager who is responsible for the day to day management of the team, the quality of the service provided and the recording of accurate and complete data. The manager will also be overseeing clinical work.

Consultant psychiatrists provide medical leadership, and they and the specialty doctors carry out medical assessments, diagnosis and medical treatments within the teams. Physical care of community based service users remains the primary responsibility of the GP (who should inform the AMH Community Services of any relevant changes in the service user’s treatment), with consultants acting in an advisory capacity and providing specialist treatment. Psychiatrists and nurses will be responsible for mental health treatment related health care checks. Further guidance on Trust responsibilities with regard to the physical health of service users can be found in the Physical Healthcare Policy (May 2013). Consultants have an important role in providing consultation and advice to AMH Community Services colleagues. Team leaders in each quadrant report to their AMH Community Services manager who is line managed by the Service Line Leader (Community Services) for the relevant geographical patch.
Each team has one or more named Consultants who between them provide a standard number of sessions within that team. For each team within each quadrant, there will be at least one Principal Consultant, who will work closely with the team leader and quadrant manager on issues related to clinical governance and decision making at multi-disciplinary meetings.

**RULE** Caseload numbers are defined by the caseload weighting tool and will be in the region of 25-35 per whole time equivalent care coordinator. Within this caseload staff are expected to take on other duties such as Approved Mental Health Professional (AMHP) assessments and responding to complex safeguarding and other issues (Appendix 5) Arts Therapists and those who work with groups will have caseloads built on a pro rata basis.

The caseload weighting tool will be implemented through supervision where caseloads should be reviewed regularly.

7. **Team Locations and Opening Hours**

The teams will operate out of Hubs and Spokes in each Quadrant across Hertfordshire.

The core operating hours are from 09:00- 17:15, Monday- Thursday and 09:00-16:30 on Fridays. Evening and weekend working will be operated in response to the needs of individual service users and will be especially important with regard to those managed under FACT. Local arrangements will be in place to ensure that staff have access to Trust or other premises as necessary.

8. **Service User Profile and Eligibility for Service**

STTs and TTTs serve those in Payment by Results clusters 5-17 and 0.

**RULE** The STT will treat service users in the cluster range 5-8 with conditions associated with serious non- psychotic disorders including Personality Disorder and Neuro-Developmental disorders who are cluster 0.

**RULE** The TTT will treat service users in the cluster range 10-17 with conditions associated with Psychosis.

See appendix 6 for more details.

Service users in clusters 1-4 will be treated by the Wellbeing Teams.

Service users with organic conditions associated with ageing will be treated by a specialist in their condition. I.e. Dementia specialist services.

Those who have drug and/or alcohol issues as well as mental health issues are eligible for a service when they fall within the relevant clusters. Services for them are likely to be provided in partnership with the voluntary sector, and, principally Spectrum.

Each of the S&TT and TTT will offer services to those from 18 years of age. However, clients on the CAMHS FEP pathway above the age of 16 may be also offered services from these teams (principally the TTT) such as therapeutic interventions. Where this occurs, prescribing and medical responsibility will remain with the CAMHS FEP Consultant Psychiatrist, and also Care Co-ordination per se, with the CAMHS team.
8.1 Specific Exclusion Criteria - all Teams

People who present with significant risk to self or others are not appropriate for the Wellbeing Service (IAPT) teams and should be referred to secondary care services. The relevant GP must be informed.

Individuals identified as experiencing severe anger management problems with no mental health problem.

People with a current primary diagnosis of substance or alcohol misuse should be referred to relevant drug and alcohol services (Spectrum).

Individuals with a current diagnosis, or provisional diagnosis, of severe levels of mental ill health should be referred to secondary care services (Steps 4 and 5).

Individuals open to on-going care from secondary care mental health services should not also be seen by Wellbeing Service (IAPT) services.

Individuals with a current primary diagnosis of personality disorder.

Individuals whose primary diagnosis would place them outside of Clusters 1-4.

Individuals with a moderate to severe learning disability whose clinical needs can best be met within specialist learning disability services.

Individuals who are under the age of 16.

Individuals aged 16 and 17 who have a history of self-harming and impulsive overdosing.

Individuals not registered with a Hertfordshire GP

9. Access to healthcare for people with a Learning Disability

RULE HPFT have a responsibility to ensure that all people with a Learning Disability access appropriate services and that they receive the best treatment available in line with good practice and legal frameworks. This means that those with learning disabilities and mental health issues should not be excluded from adult mental health community services simply on the grounds that they have a learning disability. Therefore all services will:

- Make reasonable adjustments so that each person has the same opportunity for health, whether they have a learning disability or not. (Equality Act 2010).
- Assume that each person presented to the service has capacity. If assessment shows they do not, a decision must be made in their best interest. (Mental Capacity Act 2005).

Staffs are expected to:

- spend time with the individual to gain an understanding of their preferences for treatment.
- ask them where they would prefer to be treated.
• Provide additional support to assist with communication, this support will be available via easy read material and/or audio equipment. Templates for appointment letters and easy read information leaflets are available via the Performance page on the intranet.
• Use the buddy system where support is available from the local specialist Learning Disability Buddy staff member.
• If an individual continues to have difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support.
• All people with a learning disability may have a Health Action Plan or Purple Folder and all Adult Community Service staff will ask for permission to see these and contribute to the plan when appropriate.
• Value and welcome the contribution of the relatives/carers/advocate.

10. Referral Process

All new referrals will be received via the Single Point of Access who will have triaged them for suitability if they believe they meet the criteria for secondary mental health services and will book them in to a face to face assessment within the initial assessment clinic. Telephone contact within the referral process will only be acceptable in order to facilitate a face to face contact or to clarify information which will be germane to making a full assessment.

SPA will triage all referrals and allocate for a face to face assessment between The Wellbeing Team (those cases which indicate they would be in Clusters 1 to 4), CATT (acute crisis situations), and an integrated generic assessment process for STT and TTT (those cases which indicate they would be in clusters 5-17&0). Referrals for first episode psychosis will be fast tracked and seen within 14 days by staff in TTT. These referrals will be identified by the completion of the First Episode in Psychosis (FEP) pathway form on the PARIS system by staff from the TTT.

Internal referrals will be ‘passed on’. These will normally come from Acute Mental Health Pathways and will be appear in each team’s duty desk on PARIS. Clients referred from Acute Pathways will be furnished with emergency follow-up contact numbers by the Acute staff member making the referral. Referrals originating from these pathways will require follow-up and a thorough risk assessment – best practice guidelines are that these should occur within 7 days. Referrals from the 48hr assessment beds require a community assessment within 7 days. Where there has been a period of treatment within the acute pathway there will be a handover with a CPA transfer to a named care coordinator with an up to date needs assessment and discharge summary provided by the Acute Service.

Referrals from the Wellbeing Team will be internal referrals and will be treated as new referrals and will be booked in to the initial assessment clinic in order that their data is entered on the PARIS system, this process is known as a ‘step up’.

When SPA have booked in a face to face assessment for STT & TTT assessors to undertake a full assessment, the outcome of which, is that the service user does not require secondary mental health intervention, but requires primary care intervention they will refer to the Wellbeing Team and this process will also be known as a ‘Step Down’.

When interventions in secondary care are complete but the service user still requires some Psychological intervention which is available in the Wellbeing Team they may be referred to them and will be discharged from secondary care and discharged from the PARIS system. This process is known as a ‘Step Down’.

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A flowchart which describes the processes around Step-ups and Step-downs between S&TT / TTT and the Wellbeing Team is available in Appendix 17. It is of particular note that the Single Trusted Assessment principle shall apply as far as it is possible in all stepped up and down cases in order to limit unnecessary re-assessments. Stepped-up referrals will require an S&TT / TTT risk assessment and a social care assessment as per usual practice.

**RULE** The worker is expected to correspond in writing within 5 working days to both the GP and the service User informing them of their referral being made from secondary care to the Wellbeing Team, and vice versa, from Secondary Care to the Wellbeing Team.

Referrals from the Child and Adolescent Mental Health Service (CAMHS) will be treated as an internal referral so will be “passed on via Paris”. The expectation is that this will occur via Consultant to Consultant letter, in line with best practice around transition planning and with respect to the Care Act.

All transfers between STT and TTT will be treated as internal transfers which will follow the care co-ordination transfer process.

Referrals being made for Dialectical Behavioural Therapy (DBT) are expected to be for those service users with a complex personality disorder and so will normally be within the STT. Requests for DBT from outside the STT will be considered as internal transfers of care and will require a full Personality Disorder Assessment prior to acceptance.

Referrals identified post initial assessment as requiring Specialist Psychological intervention will be managed according to the Psychological Therapy Management Process (see **Appendix 13**, all Psychological Work takes place within the teams

Requests for accommodation or employment support will be considered as internal transfers for both STT and TTT.

Requests for arts therapies from TTT will be considered internal referrals and the care will remain under the TTT.

External referrals from other Mental Health Providers outside of Hertfordshire will only be accepted following an appropriately rigorous CPA Transfer process. (Appendix 2, Services for Personality Disorder; Appendix 3, Referral Process and Appendix 9, Initial Assessment Process).

### 11. Assessment Procedures

**STANDARD** Assessments for routine community mental health services will be completed within 28 days.

**STANDARD** Assessments for FEP Pathway will be undertaken within 14 days using approved range of assessment criteria.

**STANDARD** Urgent assessments will be completed within 24 hours.

**STANDARD** Urgent social care assessments will be completed within 72 hours.
A single joint electronic clinic diary across STT and TTT will be maintained and made available for SPA to book initial assessment appointments.

STT and TTT will provide generic assessment clinics. Allocation to appointment slots will be made on the basis of geography (postcode of service user) rather than GP registration. SPA will be provided with guidance on the most appropriate initial assessment slots to use in each situation. These initial assessments will be comprehensive and will form the basis of the service user’s future care with HPFT being known as the “Single Trusted Assessment”.

The team administrator and/or receptionist will ensure that the assessment clinic diaries are maintained showing available clinic appointment slots on each day. SPA will identify the next available initial assessment slot.

All referrals will be logged on a SPA tracker and will be tracked through their initial assessment and onto commencement of treatment, discharge or being passed on to another team.

SPA will contact each AMH Community Services Team if they are unable to book a referral into a slot within the 28 days. It is the team’s responsibility to create capacity to prevent 28 day breaches.

**Urgent referrals**

SPA will liaise with the Team Manager if an urgent appointment is required and there are no routine assessment slots available within the required timeframe. Urgent appointment slots will be allocated by the local team managers and SPA will be informed of the appointment times. Each team will protect urgent initial assessment slots that will be utilised for urgent referrals should there be insufficient capacity within the number of protected slots, SPA will contact the duty manager, who will allocate a worker to undertake the emergency initial assessment.

A duty service will operate from 0900 to 1715 Monday to Thursday (0900 to 1630 Friday) to manage physical “drop in” presentation at hubs and to respond to queries and issues raised by stakeholders including GPs, commissioners, service users and carers. Outside of these hours the responsibility for Mental Health Act assessments falls to the Safeguarding out of Hours Service, with additional support for crises from the Mental Health Helpline and CATT.

The person identified as the Duty Manager / Senior will be responsible for ensuring best practice around urgent referrals, and management support will be available to the Manager / Senior via the CMHS Manager.

**Referral Tracking – from SPA to Single Trusted Assessment**

The remit of this task is to track all referrals to the STT and TTT. New referrals are received from SPA and Internal Transfers.

The Team Leader or allocated duty desk support (allocated by Team Leader) for the day will in the morning and during the day check the Duty Desk on PARIS for any referrals that have come into the Team. The SPA diary and any SPA Trackers received should also be reviewed to ascertain if appointments have been attended.

Daily tracking of referrals on the Tracker is then carried out by checking on PARIS to see if the service user attended their Initial Face to Face Appointment. Both Attendance and Did
Not Attend (DNA) should be recorded on the Tracker. If a service user DNA’s, checks should be made to ensure whether the clinician has offered another appointment or discharged. If offered another appointment, the new appointment date should be added to the Tracker.

If the service user is discharged following DNA, this should be marked on the Tracker with “Discharged due to DNA.” If the service user attends, this should be tracked via PARIS to ascertain the outcome of the Assessment and which Care Pathway the service user has been placed on. This information should be added to the Tracker and the date of Start of Treatment also added, (Please see DNA Policy April 2014).

Once a service user is seen for Initial Assessment, the Clinician should add the Assessment Outcome to PARIS and complete the appropriate Care Pathway on the Referral document on PARIS. It is the responsibility of the member of staff performing the referral tracking function to chase this up if this is not done, usually via email to the Clinician. If, despite repeated requests this is not done, this should be highlighted to the Team Manager.

Any likely breach of the 28 day rule (or 24 hrs in the case of Urgent Referrals / 14 days for FEP) should immediately be highlighted to Team Manager.

A number of inventories are to be used to ensure oversight of referral tracking; these are listed in Appendix 18.

Single Trusted Assessment Process

It is very important under this new model for Adult Community Mental Health Services that service users and carers do not have to undergo repeated assessments of their needs in order to receive a service. Thus one assessment only should be enough to decide whether a service user requires the Wellbeing service, the STT or the TTT. Furthermore, the Single Trusted Assessment should commence at all points of entry into the service, for example where clients’ first point of contact is with RAID or CATT.

There will always be a small number of cases where further information or extra specialist advice is needed before suitability for a particular service can be confirmed, but these should be kept to a minimum. One such example of this will be in referring to CATT where further, cumulative assessment may often be necessary to determine if the clinical scenario is appropriate for their services.

The single trusted assessment will be carried out by all qualified professionals i.e. Psychiatrist, OT, Psychological Therapists, Nurses, Social Workers,

Joint assessments involving a psychiatrist and one other qualified professional in the team may be required in cases that are highly complex or present high levels of risk.

RULE Assessments will be cumulative if necessary.

The assessment will first determine whether the person needs to have on-going treatment in secondary care, and is eligible for social care under the national eligibility criteria. Note that the Local authority (in the form of HPFT) MUST undertake an assessment for any adult who appears to have any level of needs for care and support regardless of whether or not the local authority (HPFT) thinks the individual has eligible needs (Care Act, 2014). Note that a Single Trusted Assessment which commences in RAID will not cover this aspect of the assessment, which for RAID clients would only occur thereafter if the client is referred to a S&TT or TTT. Social
care assessment training will be available for all staff who are conducting social care assessments.

Once this has been established, if ongoing secondary care is needed, the assessment will be completed by confirming:

- which recovery care pathway is most appropriate to meet the needs of the service user.
- the Payment by Results (PbR) cluster number.

**RULE** The Cluster number should be recorded on the PARIS system by no later than the 2nd face to face appointment

- whether care should be provided by STT or TTT.
- what level of care co-ordination (CPA or standard care) is required.
- who will be the care co-ordinator.
- A HoNOS score.
- A diagnosis with an ICD10 coding.

Where assessments have been carried out by staff who are not medical doctors, diagnoses must be discussed with psychiatrists in the team before being recorded on Paris.

Once assessed and deemed eligible for service, the assessor should complete all initial assessment and care planning documentation as outlined in the Care Co-ordination Policy and Recovery Care Pathway documents. Appendix 16 details the record keeping requirements related to assessment.

Once assessed, at times when service demand outstrips capacity, temporarily waiting lists will be developed and overseen by the Quadrant Management Team and Service Line Lead escalating to the Managing Director where indicated.

Once placed on a pathway, the next appointment / pathway interventions should be made in the appropriate geographical hub or based on service user’s choice so that the pathway interventions can begin to be delivered.

Bookings can only be made by administrative staff in each hub within the electronic diary system on Paris. (Psychiatrists must allocate at least one urgent slot per day to cover emergencies). Provision for urgent initial assessments must be provided in a flexible manner to meet demand in each locality.

Assessors may bring a case to the next STT or TTT meeting when other forms of treatment outside the remit of these teams is required or if there are difficulties in allocating a care co-ordinator.

Team managers are responsible for allocation of work to team members aided by the caseload management tool. This will be by a system of direct allocation of cases to individual clinicians based on complexity and capacity. (Appendix 5 Caseload Weighting Tool)

This includes prompt allocation of a care co-ordinator in each case. If delays are occurring even when the system is working efficiently team managers should escalate the issue to their Service Line Lead.
Team managers and senior clinicians will be available on a rota basis to assessors from Initial Assessment Clinics to discuss outcome of assessments or issues that have arisen during the clinics.

Support out of hours is available through the manager on call system accessible via Oak & Beech wards.

12. Care Coordination

**STANDARD** The care coordination process will be followed in all cases where service users meet the threshold for management under the Care Coordination Policy (January 2014) that incorporates the Care Programme Approach (CPA).

Care Coordination will be monitored through case management and supervision to ensure equitable distribution of cases to the most appropriate professional to organise the interventions at each point on the appropriate care pathway.

Transfer of care coordination will not be considered complete until the receiving care coordinator confirms in writing that they have accepted responsibility for the service user’s care.

Care Coordinators will be responsible for ensuring that the service user receives all appropriate interventions within the identified care pathway. They will be responsible for ensuring there is a current risk assessment and care plan for all service users under their care.

Other points to note about care plans:

- They should reflect the needs and risks previously addressed and show how they will be addressed.
- They should focus on the recovery goals of the service user and be co-produced.
- They should include non-Trust services that are required and be tailored to meet the needs of each individual service user.
- **RULE** They should be reviewed at least annually, but even for those on CPA such a review does not require all relevant parties to be brought together for a meeting. If it is practical and convenient to gather views without relying on one meeting the policy allows the care co-ordinator to do this.

STTs and TTTs will work with service users under both CPA and Standard care. If the criteria derived from the Department of Health guidance (2008) are consistently applied, the proportion of service users in both teams on CPA should not exceed 33%.

When a service user is stepped up to FACT, it must be confirmed that they are on CPA. In effect, they will then join a small group which at any one time are a high priority subset of those on CPA because of the severity of their mental health problems, their vulnerability, and the difficulties of engaging effectively with them.

Service users with identified employment needs will be discussed with Employment and Vocational Advisors who will meet with the service users and discuss their needs more fully and take appropriate action (please see [appendix 10](#)). It is to be noted that vocational support can also be found in the Third Sector and in Employment Centres.
Service Users with accommodation needs will be discussed with Senior Social Workers and allocated to Accommodation Advisors as appropriate.

13. Discharge and Transfer

Whilst recovery is always the goal, some service users, because of the nature and complexity of their mental illness, may require on-going treatment and support for several years and long term assistance will be offered when this is the case although this may be organised through other providers.

When a service user moves to another area in the Trust or outside of the Trust, Adult Community Services will arrange transfer to the relevant local team. See HPFT Transfer and Discharge Policy (March 2014). The care co-ordinator is responsible for ensuring the transfer takes place smoothly and at no time is the service user left without appropriate support and medical treatment.

In a small number of cases it may be necessary to transfer care within a quadrant’s Adult Community Mental Health services.

When this arises, transfer should be arranged as described in the Transfer and Discharge and Care Co-ordination Policies – with essential elements being a review meeting for those on CPA, and agreement of the new care co-ordinator before the previous care co-ordinator relinquishes the role. All social care needs identified in the care plan must be completed and personal budgets ceased at the time of discharge.

Within each Quadrant’s Adult Community Mental Health Services it may also be necessary to step up the level of care for a service user from TTT (or less commonly STT) so that they can receive Flexible Assertive Community Treatment. This process is described in section 15.4.3.below.

When a service user is discharged from the Trust, the final Care Plan received by both GP and service user, will include a contingency plan identifying risk factors, warning signs and actions to be taken in the event of any difficulty occurring after discharge to the GP takes place. As with other GP letters copied as care plans to the service user, these will be sent within 5 working days.

RULE GP letters will be sent within 5 working days.

Should a service user refuse to engage with the AMH Community Service (including FACT), or refuse to continue to accept services the situation will be discussed within the weekly team review meeting. Risks to self and others will be assessed and a care plan, dependent on risks and need, agreed. The GP will be informed and a review meeting will be convened to plan how any further service could be delivered. This plan may include transfer or discharge. Exceptionally transfer from the AMH Community Service (via the Review Meeting) may be where the service user is being care coordinated by the Eating Disorder Service (CEDS) or the Forensic Service where these services are accepting Care Coordination responsibility. CEDS accepts referrals from SPA or other HPFT Adult services to its central base in Rosanne House where an Eating Disorder is the central problem. In other clinical scenarios where it is not the central problem they will work in consultation with other services.

All discharges/transfers will be undertaken by CPA procedures to include the following:

- The reason for discharge/transfer.
- The service user’s status and condition at discharge/transfer.
• A written final evaluation summary of the service user's progress towards identified treatment/care goals as appropriate.

• A detailed statement/care plan as appropriate for action after discharge/follow-up.

Service users in residential or supported living settings will always require care coordination with at least annual review to ensure they are in the right level of care in the least restricted environment in order to meet their assessed needs.

In some circumstances service users will be stepped down to Enhanced Primary Care Services within the Wellbeing Team, this will be considered an internal referral.

Service users who are being discharged following a protracted period of treatment and who may relapse within a short period of time will be fast-tracked through SPA back into the team and pathway from which they were discharged.

Service users who are re-referred after a period of longer than one month will not be fast tracked and will need to follow standard referral processes as their needs may have significantly changed.

14. Staffing

The teams will be staffed by a range of mental health professionals, trained and equipped to deliver the interventions required along the Recovery Care Pathways to meet service user’s needs. This will include Psychiatrists, Nurses, Social Workers, Psychological Therapists, Occupational Therapists, Accommodation STaR Workers, STaR workers, Employment and Vocational Advisors, Art Psychotherapists and Dramatherapists, Community Pharmacist and Peer Support Workers and they will receive clinical and professional supervision in line with the managerial and supervisory structures (see appendix 11 Supervision Structure).

Medical Cover will be provided by the team consultant, each Quadrant will have a Principal Consultant per team who will act as a representative of the psychiatrists, on matters relating to clinical governance. The Principal Psychiatrist will not be expected to become involved in individual clinical matters which will still be the responsibility of the treating psychiatrist in conjunction with other members of the multidisciplinary team.

Medical Staff will undertake assessments including physical monitoring, in keeping with the Shared Care Guidelines, with the specific agreement defining roles and responsibilities being clearly documented in the clients’ notes. The Physical Health Care Policy (May 2013) defines physical monitoring responsibilities - for example checking lithium levels, ordering blood tests, taking blood pressure, weighing patients, prescribing medication including explaining its efficacy and potential side effects to service users. They will undertake diagnosis and provide service users and carers with information regarding symptoms and treatment options and relapse prevention strategies. Annual physical health checks will be organised for clients at whatever point in the service they are when their health check becomes due.

The role of the psychiatrist is to provide comprehensive assessments; including where appropriate, Mental Health Act assessments, formulate bio-psycho-social care plans, and offer evidence based treatment and advice. Consultant Medical Psychotherapists play an important role in S&TT, including referrals management for psychological therapy, therapeutic assessments and treatment of complex cases, and supervision.

Medical staff will act as Community Responsible Medical Officers for service users on community treatment orders under the Mental Health Act. Consultant Psychiatrists will be available for consultation to all other members of the clinical team.
The teams will be led by a Quadrant Team Manager with Team Leader for the STT and TTT in each quadrant area. Additional clinical leadership will be provided by each team’s Principal Consultant Psychiatrist. The senior Social Worker, Clinical Nurse Specialist, Advanced Occupational Therapist, Psychological Therapist Lead, Art Psychotherapy Lead and Dramatherapy Lead, will also ensure professional standards are met through clinical supervision and caseload management. The Quadrant leadership team will receive support from HR finance and other corporate services as required.

Reception staff are line managed by the Site Services Manager and all administrative staff including medical secretaries are line managed by the Team Leader.

15. Working Procedures

This section outlines the working procedures for the various functions now contained within STTs and TTTs. Extra detail is provided around the Flexible Assertive Community Treatment element which is new and very important because of the high risk service users it can be expected to take on and manage effectively.

(See Appendix 9 Quadrant Multi-Disciplinary Team Meeting Process).

15.1 General Points

Community AMH Services are committed to a recovery model that builds on the personal strengths and resilience of the service user. Encouraging hope and respecting diversity, the service user, their family and support networks are central to the process of the clinical work undertaken by Community AMH Services staff.

Assessments, whenever possible, will include the views of family and friends and they will be offered support and information about the illness and the care process as per the Carers’ Support Model (appendix 7).

All assessed service users will be put on to a care pathway and allocated a Payment by Results cluster number. The care pathways (see appendix 4) identify the range of treatment interventions recommended by NICE guidelines and the likely duration of treatment from the Trust.

All staff will deliver a range of interventions to assist the service user recover from ill-health and maintain stability. The interventions include:

- Appropriate risk management and care planning within the Recovery Model.
- Intensive FACT model.
- Appropriate medical treatment and medication management.
- Psychological Therapies.
- Ensuring physical health needs are addressed.
- Basic skills of daily living.
- Setting up social care packages through Direct Payments - A social outcome assessment must be completed to identify the unmet social care needs, which could include a personal budget and the use of a direct payment. (see personalisation policy Feb 2013).
- Assistance in accessing welfare benefits and suitable accommodation.
- Help in accessing local opportunities for work and education.
- Early signs and symptoms recognition & management of symptoms.
- Support for carers (Appendix 7).
• Information regarding Advocacy Services.
• Advice and access to treatment for substance misuse.
• Ensuring that service users make and keep important appointments and that service users leave their out-patient appointments in possession of their next appointment (where one has been agreed).
• Safeguarding of Vulnerable Adults and Children.
• Participation in MARAC and MAPPA.
• Administration of Appointeeship when necessary.

If a person receiving a service from Adult Community Services requires assessment under the Mental Health Act, the Approved Mental Health Professional (AMHP) is likely to be identified via the AMHP rota held by the local team. Planned Mental Health Assessments will, if possible, and dependent upon staffing levels be undertaken by an AMHP from within the AMH Community Services.

If a service user’s mental health is deteriorating and in-patient admission needs to be considered AMH Community Services step-up to FACT should also be considered. The Crisis, Assessment and Treatment Team (CATT) will be consulted before any final decision on admission is taken.

CATT will also ensure that using a Host Family option will always be considered as will admission to the Acute Day Treatment Unit (ADTU).

Ordering Storage Carriage and Administration of Drugs will be undertaken in line with the Control and Storage of Drugs Act (1974) and the HPFT Drugs Administration Policy. Depot Medication and Denzapine will normally be managed within Depot Clinics which will be run under Standard Operating Instructions.

Finally, there are a number of key components relating to work within Community AMH Services they include:

• Intensive case management will occur for those on CPA.
• Close Liaison and working with the Primary Care Team and local teams.
• Regular review, at no more than annual intervals, of the Care Plan within the PbR. cluster review periods (Mental Health Payment by Results Guidance for 2013-14 DOH).
• Ensuring all service users have a copy of their Care plan which they are signed up to or documented evidence when the care plan is in place in their ‘Best Interests’.
• Record keeping on PARIS.
• Weekly Multi-Disciplinary team meetings to offer an opportunity to consider and discuss clinical issues such as treatment outcomes, practice issues and new developments, please see Appendix 8, Local Team meetings Practice Governance Agenda header template.
• Information from Board, Executive and Senior Management cascaded to all levels of staff as outlined in the Communications Strategy.
• Inter-agency working to maximise recovery opportunities for service users.
• Participating in Audit and Practice Improvement Initiatives.
15.2. Managing Risk

RULE All service users will be expected to have a risk assessment when first taken on by Trust services and at least annually thereafter.

An up to date risk assessment should be completed at each PbR cluster review and this will be recorded along with a care plan to mitigate those risks as well as a contingency plan to manage crisis situations. Where possible CPA, HONOS and Cluster Reviews should be aligned to enable improved casework management.

All Carers will be considered pivotal in providing information and participating in the development of care and contingency plans (due regard being taken to overcome confidentiality issues with service users).

In line with the Risk Management Policy and Procedure (August 2013) all risk assessments will need to be completed and on PARIS within the agreed Trust timescales of a maximum of five working days.

The needs of any children in the family must be considered. Children’s welfare and safety is paramount and it is the responsibility of all staff to ensure they identify and respond to concerns. Where concerns have been identified a written referral to Children, Schools and Families must be made, in accordance with the Safeguarding Children Policy (February 2014). Staff should seek to discuss concerns about child welfare and safety with the service user and relevant family members, unless to do so would place the child at increased risk of harm. Disclosure of relevant information for the purposes of referral may need to take place against the wishes of the service user if the child is considered to be at risk of harm. Where safeguarding procedures are necessary the Consultant Psychiatrist must be made fully aware of all aspects of the case.

Where adult abuse is occurring or believed to be occurring then staff must pass their concerns on to a responsible manager. The Safeguarding Adults from Abuse procedures must be followed where there is concern that abuse of a vulnerable adult may have occurred. In all cases where there is actual or risk of potential abuse or exploitation, staff should consult the Trust Safeguarding Adults from Abuse policy in conjunction with the Safeguarding Adults Interagency Procedures. Further guidance and contact details can be obtained from the Trust Safeguarding Adults from Abuse Policy (April 2014) and the Trust’s Safeguarding Team. The timescale for making a decision to hold a Safeguarding meeting must be taken within a 24 hour period on receiving the referral, and recorded on PARIS.

15.3. Services for Carers

Services to carers will be delivered within the Carer Support Model and the Carers Recognition Act 2012 (Appendix 7).

STANDARD Carers have a statutory right to support Where an individual provides or intends to provide care for another adult the LA (HPFT) MUST consider whether to carry out a carer’s assessment if it appears that the carer may have any level of needs for support. Carers are entitled to help in their own right as carers so that they can carry on in that role.

They are also often invaluable allies for Trust staff – in understanding risk factors, in monitoring the mental state of the service user, and in promoting compliance with treatments.
The Trust is committed to implementing the Triangle of Care which restates best practice with regard to working with carers.

Where Carers own needs become the focus of Trust services these will be managed within their own dedicated referral pathway, and be instigated by an independent referral through SPA.

See also Carers’ Assessment Practice Guidance (September 2010).

15.4. Specific Services

1. Support and Treatment Team.

The STT staffing will comprise of Nurses, Social Workers, Psychiatrists, Psychology, Dramatherapist, Occupational Therapists, Art Psychotherapist, STaR workers, Specialist Personality Disorder Workers, Peer Support workers, for both service users and carers, Employment Advisors, Accommodation and Pharmacist.

The team provides integrated health and social care interventions for people whose needs are best met by Recovery Care Pathway B and those on Cluster 0 who will receive a Care Bundle described further below. This will include individuals with non-psychotic disorder (very severe and/or difficult to treat: non psychotic over-valued ideas and / or high disability and /or chaotic and challenging lifestyles.) This group includes those who are severely depressed and/or anxious. This group will not present with distressing hallucinations or delusions. They may often be at high risk of suicide and may present with safeguarding issues. This group could include treatment resistant eating disorder, OCD, personality disorders and enduring depression.

Individuals with a diagnosis of Bipolar Disorder will not be excluded from this pathway if this pathway meets their needs better than Pathways C, D and E AND they meet one or other of the inclusion criteria. However, where the presentation is centrally related to the bi-polar disorder their needs will be best served within the Targeted Treatment Team.

The Recovery care Pathways detail the service interventions that are most appropriate for groups of people with similar presenting needs. For example the pathways provide information on NICE guidance for effective treatments that should be considered and cover indicated treatments across the professional disciplines. They also include recommended number of sessions.

The guidance on the pathways does not replace individual clinical or professional judgement, but rather provides a benchmark against which clinical and professional treatment decisions can be compared. They also provide a vehicle to provide equity of provision by introducing standard treatments that are known to be effective in the treatment of certain conditions, whilst eliminating those that provide little or no proven treatment value.

The team offers extended use of Dialectical Behaviour Therapy treatment methods and milieu as a group therapy programme, supported by specially trained Personality Disorder therapists.

Referrals for the assessment and treatment of adults of working age with Aspergers Spectrum Disorders (ASD) should come to the Support and Treatment Team (STT), except where there is an obvious co-morbid and active psychosis (in which case the Targeted
Treatment Team will provide the service) Assessment protocols of ASD in adults are implemented by specifically trained staff (usually Clinical and Counselling Psychologists) in each of the quadrant teams. These protocols involve the use of nationally recognised structured and semi-structured interviews with the individual, and sometimes a parent and or other family member where this is necessary and possible.

These formal assessments complement the clinical assessment work carried out by other staff, notably Psychiatrists. Assessments are stratified in such a way as to optimise the relationship between the quality of the diagnostic opinion reached and the intensiveness of the process. Thus, clinical observation and the administration of screening tools form the least intensive level of assessment; whilst the application of the Autism Diagnostic Observation Schedule (ADOS) forms the most intensive assessment, with other, less demanding semi-structured interview tools being available between these. It is to be noted however that it is not always possible to reach a definitive diagnosis of ASD.

Assessments of ASD are available to those individuals who are referred with a significant indication that a diagnostic assessment is indicated. There is a specified time allocation for this assessment work in each quadrant which is currently set at 2 full working days per month (or one half day per week).

Treatment of ASD itself, and of mental health problems diagnosed alongside ASD is managed in a manner entirely commensurate with all other problems seen within the STT, i.e. the usual referral criteria for the STT apply. At the time of writing the evidence base for the efficacy of psychological treatments of ASD is still in development – this is likely to be the case for some time to come. Given this, clinical judgements about prognosis with treatment, should rightly be applied as in all clinical scenarios. Reasonable adjustments in approach, whether adopting a CBT or any other evidence-based modality, should be made in order to optimise the individuals’ ability to make use of the treatment offered. They will receive interventions via a Cluster 0 Care Bundle.

The standard recovery care pathways provide a three tier range of psychological interventions in the STT of up to 12, 20 and 40 sessions, if it is felt that these are also reasonably sufficient for psychological interventions with this client group.(see Appendix 13 Psychological Therapy Referral Management Process) The expected minimum number of sessions expected to be delivered by Psychological Therapists and Arts Therapists is 15-20 contacts per weeks equating to 15-20 hours face to face clinical contact, weighted for those with managerial or leadership roles.

Alongside the psychological treatment offered to this client group within HPFT there is also social care provision from Hertfordshire Community Services provided by the Aspergers Team. Again, the usual criteria apply for this service, i.e. the national eligibility criteria for social care (please see the referral form for this service in Appendix 15).

Referrals for service users Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD) will also receive interventions determined by the Cluster 0 Care Bundle. Prescribing for this service user group will be undertaken under the auspices of the Primary Care Shared Care Protocol, in which individual arrangements should be negotiated with clients’ GPs according to clinical need, and clinical practice. This shared care protocol shall be recorded in the clients’ notes defining agreed roles and responsibilities.

A weekly clinical meeting for all staff is held to address all issues relating to clinical matters, safeguarding, child protection and referrals and allocation of service users and carers.

A monthly business and practice governance meeting for all staff is held.
2. **Targeted Treatment Team.**

The TTT staffing will comprise of Nurses, Social Workers, Psychiatrists, Psychological Therapists, Dramatherapist, Occupational Therapists, Art Psychotherapist, STaR workers, Peer Support workers, for both service users and carers.

The team provides integrated health and social care interventions for people whose needs are best met by Recovery Care Pathways D, E and FEP (First Episode Psychosis). This means that the team will have expertise in the management of individuals with psychosis – ranging from those who are acutely unwell to those who are disabled by the mental illness who may require longer term treatment and support to recover and find the quality of life to which they aspire.

A weekly clinical meeting for all staff is held to address all issues relating to clinical matters, safeguarding, child protection and referrals and allocation of service users and carers.

A monthly business and practice governance meeting for all staff is held. Local Practice Governance agenda and process, please see Appendix 8.

**N.B. Employment Advisors and Accommodation Workers will be available to both the STT and TTT.**

3. **Flexible Assertive Community Treatment.**

The FACT staffing will comprise of Nurses, Social Workers, Psychiatrists, Psychological Therapists, STaR workers, Peer Support workers, for both service users and carers and will be a subset of the TTT. Input from the Community Pharmacist will be especially relevant as medication review will be critical to re-stabilisation.

All those under the care of FACT will be managed under the CPA.

Although FACT can be provided to some service users under the care of STT, the majority of those who require flexible assertive community treatment will be people with psychosis under TTT.

The Flexible Assertive Community Treatment (FACT) model of service will provide enhanced input to service users who are becoming increasingly vulnerable because of their complex needs and disengagement from services. It will be more intensive and proactive than the services previously provided.

At the point where it is considered the service user has recovered to a degree they no longer require the FACT model; they should be stepped down to care from STT or TTT. Their care co-ordination type should be reviewed at this point. If clinically appropriate, it is possible that they could be discharged from the Trust to the care of their GP.

The care coordinator will not change when an individual is stepped up or stepped down from FACT.

**RULE** Referrals to FACT for weekend interventions will be planned in advance so as to allow for planning and provision of care well before the weekend begins.

More detail is provided in Appendix 1.
4. Psychological Services

Psychological Services are fully embedded within the S&TTs and TTTs and delivered according to the Pathway documentation (see Appendix 4). Assessment and treatment packages are delivered according to the same KPIs as those in the teams (where Psychological Services are the sole service being offered). Once assessed, and where clients are offered treatment packages solely within Psychological Services, active waiting-time management strategies will be deployed to support clients whilst they wait, and to manage risk. These strategies will include the offer of a ready place in a post-assessment group (where appropriate), and the need-centred arrangement of regular contact from the service and signposting to other agencies whilst waiting, and where appropriate.

The provision of Psychological Services in the teams is characterised by the privileging of evidence-based therapies, the routine use of outcome measures (notably CORE, but also additional others tailored to presentation where necessary), the complementary use of Goal-Based Outcome Scores (GBOS), and the routine use of a Service-User experience measure.

Psychological Services will often be delivered in group based formats but offered according to the clients’ ability to make use of this mode of treatment.

16. Induction, Staff Support, Supervision, Appraisal and Training in the use of this Policy

<table>
<thead>
<tr>
<th></th>
<th>Permanent Staff</th>
<th>Temporary Staff</th>
<th>Student/ Learners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Induction to Service</strong></td>
<td>Local Induction on 1&lt;sup&gt;st&lt;/sup&gt; day and attendance at Trust Induction. Team Leader will ensure registration with PARIS (provision of secure login)</td>
<td>Local Induction on 1&lt;sup&gt;st&lt;/sup&gt; day</td>
<td>Local Induction on 1&lt;sup&gt;st&lt;/sup&gt; day</td>
</tr>
<tr>
<td><strong>Supervision Arrangements</strong></td>
<td>Monthly</td>
<td>Monthly</td>
<td>As required by training placement</td>
</tr>
<tr>
<td><strong>Appraisal</strong></td>
<td>Annual</td>
<td>Annual</td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>Mandatory training and any other training identified to support job role, professional development and delivery of interventions along the Care Pathways For taught courses, contact the Learning &amp; Development Team: <a href="mailto:Learning@hpft.nhs.uk">Learning@hpft.nhs.uk</a></td>
<td>Mandatory training</td>
<td>Any training to support student in job role</td>
</tr>
</tbody>
</table>
17. **Comments, Complaints and Compliments**

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

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

18. **Communications**

The treatment and information service users are given should meet the individual’s communication needs especially where there are specific language and sensory communication requirements. The HPFT guidance on Communicating with Service Users from Diverse Communities (July 2013) provides further information and the procedure for the interpreting service.

Where there are specific cultural/religious practices which affect compliance with treatment the service users should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead. Service users should always be directed to sources of information regarding their condition and treatment including information on medications offered.

19. **Records Management, Confidentiality and Access to Records**

When taken on for care, service users should be given written information about their rights with regard to clinical information held by the Trust about them.

PARIS is the electronic patient record used by HPFT. Staff are required to record all contacts with the service user on PARIS. If difficulty arises, such as the system is unavailable, a written note can be made in the paper light record which should be transferred to the PARIS record at the earliest opportunity.

A 'Paper-Light' record (known as the Contingency Paper Record) should be kept for all clients which includes documentation in line with the Care Records Management policy and the Clinical Information Filing policy.

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

Requests for Access to Records, {whether by the service user or a third party,} including where legal access is requested, should be referred to the Quadrant Leadership Team Manager/Team Leader or centrally via the Information Governance Team.

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

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

20. **Health and Safety**

Every employee and those persons working on behalf of the Trust have a duty to take reasonable care for the health and safety of themselves and other persons who may be affected by any acts or omissions by themselves.

Staff should cooperate with the organisation so far as it is necessary to enable management to carry out its legal duties relating to health and safety matters i.e. follow instructions and training, use equipment provided for their protection, report defects/damage/ health and safety concerns.

Staff have a duty to remedy and or report any hazards or unsafe working practices in the immediate working area to the appropriate manager or supervisor.

Staff have a duty to disclose any potential conflict of interest which may compromise the treatment of service users or the reputation of the Trust.

21. **Practice Governance**

The Quality and Risk Management Committee for SBU East and North (which provides adult mental health community services), will agenda any items relating to Adult Community Service practice governance issues.

It will be responsible for monitoring the quality of these services and will escalate up to the Integrated Governance structure (via the Trust wide Quality and Risk Management Committee) any quality issues which it considers it cannot manage. Local Risk Registers will be maintained at Team and Quadrant level. Where necessary risks will be escalated to the Strategic Business Unit Risk Register (see Appendix 8).

The local Quadrant Practice Governance meetings will report to the SBU Quality and Risk management committee.

The SBU practice governance lead will maintain and support this framework for quality monitoring and improvement, working closely with Service Line Leads.

The SLLs in turn will expect their team managers to communicate relevant learning to their staff – with regard above all to safety, clinical effectiveness, the service user and carer experience and staffing.

22. **Embedding a culture of Equality & RESPECT**

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Service user, carer and/or staff access needs (including disability)</th>
<th>Providing services that are accessible to all sections of the local population including black and minority ethnic groups; people with disabilities; people of both genders regardless of their sexuality, and those in process of gender reassignment; and older people.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement</td>
<td>Adult Community Services will actively involve service users and carers in planning and delivering recovery-focused mental health services</td>
</tr>
<tr>
<td>Relationships &amp; Sexual Orientation</td>
<td>The Adult Community Services care coordination process from receipt of referral through to the on-going care planning takes account of the needs of people in different relationships as well as those in none. This includes consideration of issues around sexual orientation (and any barriers for people around their orientation). Adult Community Services will ensure the assessment of the needs of carers and other family members to ensure appropriate support is given within available resources. The Child Needs Assessment will be completed at the Initial assessment stage and kept under review as the needs of any service user or the children change. The needs of any Adult Community Services service user who is pregnant will be taken into account and reflected in the care planning process.</td>
</tr>
<tr>
<td>Culture &amp; Ethnicity</td>
<td>It is recognised that some minority groups are over-represented in statutory mental health services while others may face discrimination in accessing preventative, therapeutic or mainstream support services. Overcoming such disadvantage and discrimination by appropriate engagement, advocacy and a person-centred flexible approach are key components of the Flexible Assertive Outreach model, as is delivery of a service that ensures the culture and ethnicity of service users is reflected in the planning of their care.</td>
</tr>
</tbody>
</table>
The treatment and information service users are given will meet the individual’s communication needs especially where there are specific language and sensory communication requirements.

**Spirituality**
The spirituality of service users will be reflected in the planning and delivery of their care. This should focus around the HOPE model for:

- **H** – Sources of Hope
- **O** – Needs re: organised religion
- **P** – Personal belief structure (including non-faith)
- **E** – Effects on care of practicing spiritual beliefs. (positive and negative)

**Age**
Adult Community Services will be provided on the basis of their ability to meet the needs of individual service users, rather than criteria such as age. Therefore, whilst older people with mental health problems may have other sources of intensive support at home, they are not excluded from provision of services simply on the basis of age. If an older person is receiving a service from Adult Community Teams, joint working with Older Peoples Services may be appropriate. If the Older Person has not engaged and there is significant improvement to them the older person needs to be referred back to Older Peoples Services. Younger persons under the age of 18 will have their needs met by the Community Adolescent Mental Health Service (CAMHS) Outreach Team.

**Gender & Gender Reassignment**
The particular needs of ‘protected groups’ are upheld at all times by Adult Community Services, individually assessed on entry to the service, and reflected in the care planning process. This includes the needs of people based on their gender and gender reassignment status.

**Advancing equality of opportunity**
The Adult Community Services will continue to gather service user and carer feedback that will be regularly reflected on within the Practice Governance section of team meetings, to inform the continuing improvement of delivery of services. Adult Community Services will work with all sectors of the community to ensure the building of social capital and a culture of inclusiveness.

---

23. **Process for monitoring compliance with this document**
### Action: Audit to monitor compliance with this document

<table>
<thead>
<tr>
<th>Lead</th>
<th>Method</th>
<th>Frequency</th>
<th>Report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Governance Lead</td>
<td>Audit aspects of the policy against documented practice</td>
<td>At least one complete audit cycle within the review period of the policy</td>
<td>PAIG /SBU Quality and Risk Meeting</td>
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</tbody>
</table>

### Action: One to one supervision

<table>
<thead>
<tr>
<th>Lead</th>
<th>Method</th>
<th>Frequency</th>
<th>Report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>SLLs</td>
<td>SLLs will ensure that their team managers and clinical leads provide supervision in accordance with the Supervision policy which includes monitoring of policy compliance</td>
<td>As stated in Supervision policy</td>
<td>MD</td>
</tr>
</tbody>
</table>
PART 3 – Associated Issues

24. Version Control

**STANDARD**

<table>
<thead>
<tr>
<th>Version</th>
<th>Date of Issue</th>
<th>Author</th>
<th>Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1</td>
<td>1st July 2014</td>
<td>Service Line Leader, Community Transformation</td>
<td>Superseded</td>
<td>This policy will replace the existing Community Mental Health Policy, Community Personality Disorder, Assertive Outreach Operational Policy and Early Intervention in Psychosis Policy.</td>
</tr>
<tr>
<td>V1.1</td>
<td>September 2014</td>
<td>Service Line Leader, Community Transformation</td>
<td>Superseded</td>
<td>Updated by Deputy Service Line Lead EPMHS Herts to include 8.1</td>
</tr>
<tr>
<td>V1.2</td>
<td>1st May 2015</td>
<td>Service Line Leader, Community Transformation</td>
<td>Superseded</td>
<td>Updated in various ways to reflect current practice, in conjunction with MD and SLLs and Care Act 2014</td>
</tr>
<tr>
<td>V2</td>
<td>27th July 2015</td>
<td>Service Line Leader, Community Transformation</td>
<td>Superseded</td>
<td>Full review</td>
</tr>
<tr>
<td>V2.1</td>
<td>4th July 2016</td>
<td>Compliance and Risk Manager</td>
<td>Current</td>
<td>Included OT in teams listed</td>
</tr>
</tbody>
</table>

25. Archiving Arrangements

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

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

26. Associated Documents

**STANDARD**

The following are the main Trust policies which inform this document:

- Care Co-ordination Policy.
- Carers’ Assessment Practice Guidance.
- Safeguarding Children Policy.
- Safeguarding Adults from Abuse Policy.
- Transfer and Discharge Policy.
- Did Not Attend (DNA) Policy.

27. Supporting References

**STANDARD**
Comments and Feedback – List people/ groups involved in developing the Policy.

<table>
<thead>
<tr>
<th>Associate Medical Director</th>
<th>Head of Operational HR</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSR Project Lead</td>
<td>Head of Operational HR</td>
</tr>
<tr>
<td>Managing Director SBU East and North</td>
<td>Practice Governance Lead SBU East and North</td>
</tr>
<tr>
<td>Clinical Director SBU East and North</td>
<td>Clinical Director CSR</td>
</tr>
<tr>
<td>Service Line Leads – Community Services</td>
<td>Head of Psychological Therapies and Recovery</td>
</tr>
<tr>
<td>Quality &amp; Standards Facilitator</td>
<td>Head of Social Work and Safeguarding</td>
</tr>
<tr>
<td>PACE Manager</td>
<td>Head of Allied Health Professionals</td>
</tr>
<tr>
<td>Equalities Manager</td>
<td>All members of CSR Implementation/Steering Group</td>
</tr>
<tr>
<td>Deputy Service Line Leads</td>
<td>Executive Director for Quality and Safety</td>
</tr>
<tr>
<td>Heads of Professions</td>
<td>Chief Operating Officer</td>
</tr>
<tr>
<td></td>
<td>Medical Director</td>
</tr>
</tbody>
</table>
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Flexible Assertive Community Treatment

1. Statement of intent

This clinical model will describe the way the Targeted Treatment Team will provide team-based, intensive, and community treatment to patients with a severe mental illness. The approach focuses on providing intensive care and treatment for the most severely ill group of individuals with mental illness in the community, in particular, hard to engage patients at risk of hospitalisation, and those who have demonstrated that they are unable or unwilling to engage with services. FACT aims to ensure continuity of care, to prevent admissions, and to stimulate inclusion, so that clients can participate in society. Some service users on the FEP pathway may require FACT intervention. The development of FACT services within Community Teams does not affect, alter or in any other way change, the clinical role, or operational policy of the CATT team.

2. Definitions

TTT - Targeted Treatment Team.
FACT - Flexible Assertive Community Treatment.
CPA - Care Programme Approach.

This document sets out:

- A description of the patient profile.
- A set of outcomes against which patient care, and operational practices can be measured (HONOS/ PANSS - for FEP).
- The patient pathway.
- The description of how the clinical model will operate.

3. Vision for the new clinical service

The service will provide care for individuals requiring intensive, team based, and community treatment. All interventions will be based on the best evidence and practice in the field of mental health, consistent with the relevant recovery care pathway.

The new clinical service will provide a significant opportunity to improve care and the outcomes of the work that is done. In order to achieve this we will:

- Provide intensive community treatment when required.
- Everyone referred for FACT should be on a CPA.
- Step down service user's level of care co-ordination as soon as their needs change.
- Eradicate the disjointed demarcation of services, allowing for continuity of care coordination.
- FACT care plan developed with MDT input in conjunction with service users and carers.
- Frequently review the needs and management plans of all service users receiving higher levels of care (FACT).
- Employ a multidisciplinary team to provide evidence based interventions.
- Utilise un-qualified staff when required, allowing qualified staff to optimise their time and input.
- Ensure that robust management processes are in place.
4. **Framework of principles**

Integration: clinical care which includes medical, psychological, social care, occupational, education and life skills development are all essential and must be coordinated.

Recovery care pathways: each patient will have individualised care that reflects the requirements of the pathway. All FACT referrals following acceptance will be placed on pathway E except those requiring early intervention which will be on the FEP pathway.

Supporting staff: it is recognised that working with this patient group will at times be demanding and difficult. Staff will be supported and developed to enable them to tackle these challenges and the culture of learning and reflection will be recognised and embraced by clinical leaders and managers linked to the Trust’s systems.

Recovery Model: the clinical model endorses the recovery principles of hope, a belief in recovery, promoting patient strengths, developing the case for service users to increase their role in their own needs and risk management, social inclusion and promotion of peer support worker roles.

5. **Organisation of services**

Each Quadrant has a number of bases with representatives from the Targeted Treatment Team providing clinical care in these localities.

**Clinical care pathway:**

Referrals to the flexible assertive community treatment (including those from the Support and Treatment Team) will be made directly to the team leader of the Targeted Treatment Team and can be presented at the daily meeting. Their care needs will be discussed and incorporated into an individualised care plan. This will be shared with the service user and carer who will be pivotal to its development.

Typical care plans will include; increased frequency of contact to ensure compliance with medication, flexible contacts (in line with client need as far as this is possible), increased indirect partnership working with carers and other agencies, a focus on addressing: basic social needs, establishment of strong therapeutic relationships, urgent social crisis, managing current risks and complexity of need and reduction of harmful behaviour.

**Duties and responsibilities:**

A subgroup of staff from the Targeted Treatment Team will be identified to deliver FACT interventions.

This subgroup of individuals will operate a unified team approach providing extra support and treatment required for individuals receiving FACT.

The care coordinator will not change when an individual is stepped up or stepped down from FACT. During the service user’s time with FACT, their usual care coordinator will work closely with the FACT subgroup of staff to provide integrated care and will lead on developing the care plan and risk management with the service user and carer.

**Internal processes**
A weekly clinical review meeting will be held for all members of the Targeted Treatment Team to discuss cases, including FACT cases.

There will be a smaller briefer, daily meeting attended only by the FACT subgroup of staff. This meeting will update staff on the previous day’s contacts, provide a systematic assessment of the day-to-day progress and status of all service users on FACT, and enable the team manager to assign and supervise staff and adjust the treatment and service activities allotted for the day as necessary.

The FACT workers will maintain a written daily log as well as a daily team assignment schedule which is drawn from individual service users' weekly contact schedule.

Medical interventions and responsibility will be maintained by the usual psychiatrist when a service user is stepped up to FACT. If required, additional expertise may be sought from the medical colleagues with an expertise in TTT advice and consultation. The principle Psychiatrist for the TTT will fulfil this role.

The provision of medication to FACT clients often necessarily involves a degree of support from staff. This can be a vital part of service delivery but needs to be thoughtfully considered in order to avoid the pitfalls of potential secondary dispensing of medication. It is permissible to deliver medication to clients in whatever form it was dispensed by the pharmacy, and to assist clients in taking their own medication. However, it is not permissible to dispense the medication from the container supplied by the pharmacy, into any other container. HPFT Pharmacists can provide support to FACT staff in considering the processes and issues around this practice.

Each Targeted Treatment Team will have a team leader who is responsible for the day-to-day management of the FACT subgroup; this function will be delegated by the team manager.

Each FACT subgroup will have the capacity and organisational ability to provide sufficient qualified and unregistered staff to service users to deliver the interventions as set out in their risk management plans.

FACT involvement will vary depending on service user need as agreed in the daily MDT FACT briefings.

**The service user profile**

The target group are:

- Those service users who suffer from severe and enduring mental illness who have complex needs and have demonstrated that they are not currently able and willing to engage with other community mental health services.
- Those service users who have experienced frequent relapses or repeated use of inpatient services, and require additional input to advert crisis.
- Service users who are vulnerable and at risk due to the nature of their mental illness and difficulties in engaging with other community mental health services.
- Service users with a First Episode in Psychosis who have not yet engaged.
- Service users that require at least thrice weekly contact.
- Service users that present a significant risk of self-harm or harm to others or severe self-neglect.
• Service Users who have a dual diagnosis which impacts on their ability to meet their mental health needs.
• Service users who are relapsing and who have benefited from FACT intervention in the past.

The service user profile is also likely to have many of the following characteristics:

• Severe and persistent mental disorder such as schizophrenia, schizoaffective disorder, bipolar affective disorder, recurrent severe depression with high level of disability.
• Multiple complex needs including a number of the following: 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, detained under the mental health act on at least one occasion in the past 2 years, unstable accommodation or homelessness, severe inability to establish or maintain a personal social support system.
• History of poor, intermittent or chaotic engagement with services, including difficulty in engaging in treatment or poor compliance with treatment and follow-up.

People with personality disorder who have a diagnosis of coexisting severe mental illness are also eligible for FACT. Care will be taken not to exclude people with complex needs from FACT on the basis of their coexistent personality disorder diagnosis.

Similarly, people with a learning disability and also mental health problems where the mental health needs are best met by mental health services should not be excluded from FACT.

Referrers will need to be very clear about why service users will benefit from FACT intervention and what they have already tried to mitigate the risks presented.

**Step up or step down**

Step up occurs when coordinated, more intensive care provided by a network of health care professionals in FACT is required to implement the treatment plan.

Some service users, because of the nature and complexity of a mental illness, may require ongoing intensive treatment and support on a long-term basis. In these cases, whilst FACT may be involved for a short period, other support options such as residential rehabilitation either from the Trust or via a funded placement may have to be explored.

Relevant issues for consideration prior to Step-up to FACT are described in the figure below:

---

**When to Step-up to FACT**
*(Flexible Assertive Community Team)*
Does the Service User require treatment that would prevent admission to an inpatients unit?

YES

NO

Refer to CATT OR Host Family OR ADTU

Think FACT under following criteria:

Does service user needs:

a) Intensive support as per care plan, for example, do they require 3+ face-to-face contacts a week? (This does not include group work)

b) Significant deterioration in a Service Users' mental health

c) Supervision of medication for more than 3 days a week

d) No alcohol or illicit drug dependence as a primary diagnosis

If service user does not meet outline criteria then they will not be eligible for FACT

Refer to Care Co-ordinator OR Mental health Team

FACT will accept referrals for service ONLY up to the point of the Friday morning FACT meeting

Step-down from FACT
(Flexible Assertive Community Team)
If improvement

Symptoms getting worse/
More severe/acute
FACT support not enough

Discharge back to Care Co-ordinator
OR
Adult Community Mental health

Joint assessment with CATT
And
Refer to previous FLOW CHART

Step down to STT or TTT will occur when the service user’s needs can be managed on an individual case load basis. Service users can be stepped back up again at a later time if necessary. This process is described in the figure below:

- A critical feature of the FACT service delivery is that of a “team approach”.

- **RULE:** All FACT staff will know and work with all FACT service users. Continuity of care will be provided by the FACT service as a whole with care being coordinated by the referring care coordinator. Thus all team members are involved in the day-to-day proactive approach to service user support which augments their usual care team during the duration of the crisis.

- The team approach commences from the referral for FACT intervention moving on to the engagement process, adding to a comprehensive assessment of needs and strengths and leads to the planning, implementation and evaluation of care.

- **RULE:** In line with the Care programme Approach the staff member allocated as Care Co-ordinator for a given service user will remain centrally involved during the step up to
FACT intervention. This person will specifically hold the lead role for ensuring the agreed programme of care is delivered by the team and is in line with the Sainsbury Centre guidelines on a “Team Approach with Care Co-ordination”

- All team members will be actively involved in sharing the responsibility for providing planned interventions and support. Some tasks may be carried out by staff members with a particular speciality.
- A weekly clinical review meeting is held attended by all the team together with representatives from other agencies involved in the support of service users.

**RULE:** Each active service user on Adult Community caseloads are discussed regularly, and at least once monthly, at the weekly review meeting together with any service user currently under assessment and any new referrals to the FACT model.

- At the weekly review meeting initial plans are agreed by the FACT regarding their work/contacts with service users for the week.
- Feedback on the previous week’s plans/interventions is given and any relevant information or concerns recorded.
- The weekly clinical review meeting allows time to comprehensively review, reflect and plan for each individual service user through multidisciplinary discussion.
- A brief daily planning meeting is usually held every morning or late afternoon to: update staff on previous day’s contacts to provide a systematic assessment of the day to day progress and status of all service users.
- To enable the Team Leader to assign and supervise staff and adjust the treatment and service activities allotted for that day as necessary.
- The FACT model requires the maintenance of a written “daily log” (or equivalent) as well as a daily “team assignment schedule” (or equivalent) which is drawn up from the individual service user’s “weekly contact schedule” (or equivalent).
- Any routine services which are usually provided by the Targeted Treatment Team, or the Support and Treatment Team, will continue to be delivered within FACT.

**Engaging with the Service User and Carer**

**RULE:** A minimum level of contact for individuals receiving fact level of care will be:

- In line with the individual Service User’s agreed Care Plan, which will always document the frequency of contact.
- A regular daily review using the FACT model approach.
- Proportionately greater in its scope and intensity at all stages of service than could be provided by the Support and Treatment or Targeted Treatment Teams.
- Each Care Co-ordinator will hold a keyworker session with each service user at least once a month and this will be documented in the PARIS system.
- The care plan for the service user will be reviewed at least every six months, and the reviewed document will be uploaded to PARIS at this time.

**Services for People with Personality Disorder**
Community Personality Disorder Services will be provided as part of STTs.

1. **Assessments**

Personality Disorder Assessments will consist of:

- Use of psychometric measures.
- Interviews with service user, relevant family/ friends and staff involved with the service user’s care.
- Risk assessment.
- Development of a collaborative psychological formulation.
- Confirmation of diagnosis, full explanation and psycho-education about the diagnosis.
- Development of a collaborative care-plan, containing short-term and long-term goals.
- Development of collaborative risk management plan, using a positive risk strategy where appropriate.
- Message of therapeutic optimism.
- Allocation of permanent member of staff with experience and expertise in working with personality disorder.
- Carer’s assessment offered to relevant family members.
- Assign clear roles and responsibilities to all staff working with the service user and their family.

2. **Support and Treatment Options for Personality Disorder**

The Support and Treatment Teams follow NICE guidelines for medical and psychological support.

The range of generalist interventions specifically focussed on personality disorder includes:

- Care coordinators adopting Structured Clinical Management Approach (Bateman 2013), with support, advice and supervision from specialist personality disorder therapists.
- Crisis planning, using a positive risk strategy where appropriate.
- Psycho-education on personality disorder for Service Users and Carers.
- Assertive engagement.
- Focus on building a strong therapeutic relationship.
- Consistency: Regular sessions with a permanent worker, not just in times of crisis.
- Addressing substance use issues.
- Addressing other impulsive maladaptive behaviours e.g. binge eating, gambling, impulsive spending etc.
- Problem solving around chaotic lifestyle e.g. assistance in accessing suitable accommodation.
- Regular review using structured and semi-structured rating scales and assessment tools.
- Support for up to three years +, focussed on the recovery model. Aimed at identifying short term and long term recovery goals and empowering the service user in working towards these goals.
- Managing change and transitions. Service users with personality disorder often lead chaotic lives with frequent crises. Times of significant change, including transitions across services, are known times of increased risk. Reviews of care should be carried out at these times and extra support may be necessary.
• Careful, gradual transition out of mental health services, including consideration of avenues for on-going support from outside the trust, including friends and family, non-statutory organisations such as Mind, use of personal budgets for this purpose e.g. Turning Point.

**Delivering Psychological Therapies to service users with personality disorder in Support and Treatment Teams.**

Part of the benefit which severely personality disordered individuals derive from their treatment comes through their experience of being involved in a well-constructed, well-structured and coherent interpersonal endeavour.

The psychological treatments shown to be effective with personality disorder have certain common features, they tend to:

- Be well structured.
- Devote considerable effort to the enhancing of compliance.
- Have a clear focus whether that focus is a problem behaviour such as self-harm or an aspect of interpersonal relationship patterns.
- Be theoretically highly coherent to both therapist and client.
- Be relatively long term.
- Encourage a powerful attachment relationship between therapist and patient, enabling the therapist to adopt a relatively active rather than a passive stance.
- Be well integrated with other services available to the patient.

**Personality Disorder and Risk.**

Managing risk for service users with significant Personality Disorders requiring specialist intervention will be allocated a specialist Personality Disorder worker who will:

- Work with the individual to enable positive risk taking, ensure urgent matters of risk and crisis are discussed at the weekly quadrant DBT consultation meeting.
- Specialist personality disorder therapists can provide consultation with respect to unplanned crisis admissions of service users with personality disorder, consulting with the ward to review the admission, and plans for discharge, in consultation with the acute nursing staff, the consultant psychiatrist, and CATT, using principles of positive risk and contingency management strategies.
- A specialist personality disorder therapist will attend professionals meetings with RAID staff for frequent attenders of A and E who have a diagnosis or likely diagnosis of personality disorder.
- A specialist personality disorder therapist will attend professionals meetings convened for service users with personality disorder, where there may be on-going unmanaged high risk or safeguarding issues.
- All service users with personality disorder will have an up to date risk assessment and collaborative risk management plan, using a positive risk strategy. The plan will be shared with the whole team who are working with the service user, including carers (when appropriate) and GP.
N.B – Team names within the tracking flow chart/ tracking files are defined internally as team 1, team 2 and team 3

- All pathway coordinators must complete all fields before marking as tracked and moving to tracked files
- If not allocated to wellbeing team, support & treatment or the targeted team, please double check with managers before placing in tracked file to ensure referral is completely tracked
- All drop downs should be sufficient to record all referral outcomes – in the event the drop down does not specifically state preferred outcomes please indicate in the comment box.
# Pathway Reference Sheet

**Adult A: Non-psychotic disorders – mild/moderate/severe**

## Pathway A

Pathway A is for service users with needs relating to common Mental Health Problems (low severity, low severity with greater need, Non Psychotic-Moderate Severity, Non-Psychotic Severe)

This group includes those with:
- definite but minor problems of depressed mood, anxiety or other disorder
- moderate and more severe depression and/or anxiety and/or other increasing complexity of needs, but who do not present with any psychotic symptoms.

This group of individuals may experience disruption to function in everyday life and there is an increasing likelihood of significant risks. Needs would, for the most part be met through primary care settings.

Care for service users on Pathway A will be mostly provided by Team 1, although access to services within Teams 2 and 3 is available where appropriate.

## Included

People experiencing mild to severe levels of: Depression, GAD, Panic Disorder, OCD, Phobias including social anxiety disorder, PTSD, Anger, Eating problems and mild to moderate eating disorders, Adjustment difficulties.

In some individuals these may present in the context of: Asperger’s, high functioning autism, ADHD, Mild to moderate learning disability, Mild self-harm, Mild to moderate drug and alcohol problems. Clients should be willing to engage in interventions.

## Excluded

Very poor functioning in more than one domain of life, Significant identified risk to self or others, Significant severity or complexity, Current or recent (6m) psychotic symptoms, Current or recent (6m) episode of mania, Drug or alcohol issues as a severe primary problem interfering with engagement.

## OUTCOMES

- Recovery goal as identified in the care plan
- FACS needs assessment
- Honos IAPT Minimum data set
- Disorder specific measures: (OCI, SPIN, shAI, MI, IES-R)

## Service

- IAPT KPIs
- All IAPT PBR domains
- Having your say forms
- Complaints and Compliments
- Serious Incidents (SI) and patient safety incidents monitoring

## Service user
Pathway Reference Sheet: Adult B
Needs related to non-psychotic disorders that are very severe & complex
Expected time on pathway: 6 months - 3 years*

Pathway B is for service users with needs relating to non-psychotic disorders whose needs are very severe and/or difficult to treat and/or who have chaotic and challenging lifestyles. Care for service users on this pathway will be mostly provided by The Support and Treatment Team, although access to services within the other teams can be drawn down if necessary to meet their needs. Pathway can be allocated following face to face assessment when the criteria are met.

! Ensure you are familiar with complete pathway document before using this sheet. If in doubt re-check.

* Longer duration applies mainly to those with needs clustered 7 or 8

**Included**

Individuals where inclusion criteria are not met
- Individuals where the needs are better met by another pathway
- Drug and alcohol misuse without psychiatric co-morbidity
- Individuals with neuro-development disorders without additional needs
- Bipolar disorder will not be excluded if this pathway meets needs better than psychotic pathways and one or more of the inclusion criteria are met

**Excluded**

Individuals with non-psychotic disorders (very severe and/or difficult to treat) and includes those who:
- Are severely depressed and/or anxious.
- Although not having distressing hallucinations or delusions, may have some unreasonable beliefs, although these may occur in the context of a personality disorder.
- Are difficult to treat, including treatment resistant eating disorder, OCD.
- Have moderate to severe disorders that are very disabling, and have received treatment for a number of years with considerable disability remaining likely to affect role functioning.
- May be at high risk for suicide and may present safeguarding issues and have disruption to everyday living.
- Have a range of symptoms and chaotic and challenging lifestyles, who are characterised by moderate to very severe deliberate self-engagement and who can be hostile with services engagement.

**Outcomes Measures**
- Wellness and Recovery goals as identified in the care plan & Health and Wellbeing Plan
- Having your Say
- Honos

**Likely Primary Diagnosis**
- F32 Depressive Episode (non-psychotic), F33 Recurrent Depressive Episode (non-psychotic), F40 Phobic Anxiety Disorders, F41 Other Anxiety Disorders, F42 Obsessive-Compulsive Disorder, F43 Stress Reaction /Adjustment Disorder, F44 Dissociative Disorder, F45 Somatoform Disorder, F48 Other Neurotic Disorders, F60 Personality disorder.
What needs to be done
- Case Notes & activity recording after all contacts/actions
- Offer copies of all reports/letters to the individual & also send to their GP

With all who are being assessed...
- Give information about service & info sharing.
- Complete all appropriate sections of Needs Agreement & Risk Assessment & Record first assessment activity.

When appropriate also...
- Allocate Care Coordinator.
- Score HONOS & Allocated Pathway & Care Cluster.
- Give information about diagnosis & treatment choices.
- Identify family/carers & offer carers handbook & assessment.

With all who are being offered care...
- Discuss and give Health & Wellbeing plans & Deliver care & record treatment start event.

With all who are being reviewed...
- Review Needs, Risk, Care Plan, Clustering & Pathway.
- Identify any new family/carers & offer (reoffer) carers assessment.
- Construct New Care Plan including expected review and completion dates & offering information about anything new.

With all who are being discharged:
- Complete Health & Wellbeing Plans.
- Honos & Give Having Your Say form

The Pathway

New Referral (Via SPA) Assessment booked.

Transfer Handover booked.

Outcome based Assessment (Review for known individuals) (Complete within 28 days) Assess Health & Social Care Needs Plan care to meet identified needs with service user using intervention list

Implementing & Coordinating Care Plan with the Individual as they direct their recovery Start within 18 weeks

Review First review by 6 months or sooner if significant changes occur, then every 12 months

Discharge Start to prepare 3 months prior

Transfer To Bundle/Service/pathway

Actual choice should be based on Goals and Needs agreement, informed by NICE, clinical judgement, individuals’ choice & circumstance, & provided within agreed limits. Reasons for non-NICE choices to be evidenced.
- Access to Accommodation & Benefits Advice
- Art Psychotherapy
- Biological Interventions (e.g. ECT)
- Cognitive Assessment (Psychology & Psychiatry)
- Community Care coordination & support
- Dramatherapy
- FACT Intervention
- Occupational Therapy
- Peer Support
- Personalised social care planning (inc Personnel Budget)
- Pharmacotherapy (Self managed)
- Pharmacotherapy (Supported)
- Psychiatry Review & Intervention
- Psychological Intervention (Individual or Group or Family or Consultation)
- Intensive Psychological Interventions for Borderline PD – DBT)
- Recovery Group (OT)
- Residential Rehabilitation
- Social care interventions
- Specialist assessments (e.g. ADHD, ASD)
- Supported living placements
- Signposting
- Support for families and carers (including carers support and/or contingency planning)
- Supported living placements
- Vocational & Employment Advisors

Draw down from other pathways or acute/crisis bundles as needed, including safeguarding.
(NB: in alphabetic not choice order)
Pathway Reference Sheet: Adult D
On-going Recurrent Psychosis
Expected time on pathway: 1 - 3 years

The D pathway is for individuals with needs related to ongoing or recurrent symptoms related to a psychosis. Care for service users on this pathway will be mostly provided by The Targeted Treatment Team, although access to services within the other teams can be drawn down if necessary to meet their needs. Pathway can be allocated following face to face assessment when the criteria are met.

Ensure you are familiar with complete pathway document before using this sheet. If in doubt re-check.

<table>
<thead>
<tr>
<th>Likely Primary Diagnosis</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>F20-F29 Schizophrenia, schizotypal and delusional disorders, F1x.5 Psychotic disorder (but not where the psychotic symptoms are an expected reaction to hallucinogens or during acute cannabis intoxication), F1x.7 - Residual disorders and late-onset psychotic disorder, F30 - Manic episode, F31 - Bipolar affective disorder, F32.3 and F33.3 (depression only when severe with psychotic symptoms)</td>
<td>Wellness and Recovery goals as identified in the care plan &amp; Health and Wellbeing Plan Honos</td>
</tr>
</tbody>
</table>

Individuals with needs related to ongoing or recurrent symptoms related to a psychosis
It includes individuals experiencing a range of difficulties, including:
- those with low symptoms with no impairment.
  - those with high symptoms and disability (where symptoms are not week controlled)
  - those with severe psychotic symptoms
They may also
- have impairment in self-esteem and efficacy and vulnerability to life stressors
- have some anxiety or depression, where there is significant disability and a major impact on role functioning.
- be vulnerable to abuse or exploitation.

Individuals where inclusion criteria are not met
- Individuals where the needs are better met by another pathway
- Drug and alcohol misuse without psychiatric co-morbidity
- Individuals where these symptoms are occurring for the first time.
- The needs of people with primary diagnosis of F00-03 dementias.
What needs to be done
• Case Notes & activity recording after all contacts/actions
• Offer copies of all reports/letters to the individual & also send to their GP

With all who are being assessed...
• Give information about service & info sharing.
• Complete all appropriate sections of Needs Agreement & Risk Assessment & Record first assessment activity.
when appropriate also...
• Allocate Care Coordinator.
• Score HONOS & Allocated Pathway & Care Cluster.
• Give information about diagnosis & treatment choices.
• Identify family/carers & offer carers handbook & assessment.
• Construct Care Plan from identified needs (inc expected review and completion dates).

With all who are being offered care...
• Discus and give Health &Wellbeing plans
• Deliver care & record treatment start event.

With all who are being reviewed...
• Review Needs, Risk, Care Plan, Clustering & Pathway.
• Identify any new family/carers & offer (reoffer) carers assessment.
  • Construct New Care Plan including expected review and completion dates & offering information about anything new.
• Give Having Your Say form.

With all who are being discharged:
• Complete Health & Wellbeing Plans.
• Honos & Give Having Your Say form
• Agree Transition Supports
• Close notes.

The Pathway

New to HPFT (via SPA) Assessment booked.
Transfer/New Handover booked
Outcome based Assessment (Review for known individuals)
(Complete within 14 days, 2 days for urgent)
Assess Health & Social Care Needs
Plan care to meet identified needs with service user using intervention list

Implementing & Coordinating Care Plan with the Individual as they direct their recovery
Start within 18 weeks for new. Minimum 1 contact per month unless discharge predicted within 12 months

Review
First review by 6 months or sooner if significant changes occur, then every 12 months

Discharge
Start to prepare 3 months prior
Transfer To Bundle/Service/pathway

Actual choice should be based on Goals and Needs agreement, informed by NICE, clinical judgement, individuals’ choice & circumstance, & provided within agreed limits. Reasons for non-NICE choices to be evidenced.
• Access to accommodation & Benefits Advisors
• Art Psychotherapy
• Biological Interventions (e.g. ECT)
• Cognitive Assessment (Psychology & Psychiatry)
• Community Care coordination & support, inc health promotion
• Dramatherapy
• FACT Intervention
• Occupational Therapy
• Peer Support
• Personalised social care planning (inc Personnel Budget)
• Pharmacotherapy (Self managed)
• Pharmacotherapy (Supported)
• Psychiatry Review & Intervention
• Psychological Therapy- Intermediate (PIP workers)
• Psychological - Specialist, Formulation led) Therapy
• Recovery Group (OT led)
• Residential Rehabilitation
• Signposting
• Social care interventions
• Specialist assessments (e.g. ADHD, ASD)
• Support around substance misuse
• Support for families and carers (including carers support and/or contingency planning)
• Supported living placements
• Vocational & Employment Advisors

Draw down from other pathways or acute/crisis bundles as needed, including safeguarding. (NB: in alphabetic not choice order)
Pathway Reference Sheet: Adult E
Psychosis & Affective Disorder
Expected time on pathway: 3 years +

Pathway E is for service users with needs relating to Psychosis and Affective disorders who are difficult to engage. This group has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. This group has a history of non-concordance. It is anticipated that due to the including criteria being difficult to engage, allocation to this pathway will occur as part of a review where it has been agreed that usual routes of intervention have been tried and exhausted. Care for service users on this pathway will be mostly provided by The Targeted Treatment Team, although access to services within the other teams can be drawn down if necessary to meet their needs.

Ensure you are familiar with complete pathway document before using this sheet. If in doubt re-check.

### Likely Primary Diagnosis
- F20-29 Schizophrenia, F Delusional disorders Bipolar affective disorder. This may include first episode psychosis where engagement is an issue.

### Outcome Measures
- Wellness and Recovery goals as identified in the care plan & Health and Wellbeing Plan
- Having your Say Honos

### Included
- Individuals experiencing moderate to severe psychotic disorders with a history of non-concordance and engaging poorly with services, and are therefore needing more assertive engagement. They will therefore generally be transferring pathway, unless coming from another service.
  - They may have enduring symptoms with unstable or chaotic lifestyles
  - Be vulnerable, and engage poorly with services.
  - Often have co-existing substance misuse
  - Be vulnerable and present a risk to self and others.
  - Be severely depressed and/or anxious. They may present a risk to self and others. Role functioning is often globally impaired.

### Excluded
- Individuals where inclusion criteria are not met
  - Where another pathway better meets their needs/is more appropriate.
  - Individuals with drug and or alcohol problems who have no co-existing mental health difficulties.
  - Who do not have significant issues of engagement.
The Pathway

With all who are being assessed...
- Give information about service & info sharing.
- Complete all appropriate sections of Needs Agreement & Risk Assessment & Record first assessment activity.

When appropriate also...
- Allocate Care Coordinator.
- Score HONOS & Allocated Pathway & Care Cluster.
- Give information about diagnosis & treatment choices.
- Identify family/carers & offer carers handbook & assessment.
  - Construct Care Plan from identified needs (inc expected review and completion dates).

With all who are being offered care...
- Discuss and give Health & Wellbeing plans
- Deliver care & record treatment start event.

With all who are being reviewed...
- Review Needs, Risk, Care Plan, Clustering & Pathway.
- Identify any new family/carers & offer (reoffer) carers assessment.
  - Construct New Care Plan including expected review and completion dates & offering information about anything new.

With all who are being discharged:
- Complete Health & Wellbeing Plans.
- Honos & Give Having Your Say form.

Outcome based Assessment
(Complete within 28 days)
Assess Health & Social Care Needs
Plan care to meet identified needs with service user using intervention list

Implementing & Coordinating Care Plan with the Individual as they direct their recovery
Start within 4 weeks
Min 2 weekly contacts

Review
First review by 6 months or sooner if significant changes occur, then every 12 months

Discharge
Start to prepare 3 months prior

Transfer
To Bundle/Service/pathway

Actual choice should be based on Goals and Needs agreement, informed by NICE, clinical judgement, individuals choice & circumstance, & provided within agreed limits. Reasons for non-NICE choices to be evidenced:
- Access to accommodation & benefits advice
- Art Psychotherapy
- Biological Interventions (e.g. ECT)
- Cognitive Assessment (Psychology & Psychiatry)
- Enhanced Community Care coordination & support
- Dramatherapy
- FACT Intervention
- Occupational Therapy
- Peer Support
- Personalised social care planning (inc Personnel Budget)
- Pharmacotherapy (Self managed)
- Pharmacotherapy (Supported)
- Psychiatry Review & Intervention
- Psychological Therapy- Intermediate (PIP workers)
- Psychological - Specialist, Formulation led) Therapy
- Recovery Group (OT led)
- Residential Rehabilitation
- Signposting
- Social care interventions
- Specialist assessments (e.g ADHD, ASD)
- Support for families and carers (including carers support and/or contingency planning)
- Supported living placements
- Vocational / Educational Advisor

Draw down from other pathways or acute/crisis bundles as needed, including safeguarding. (NB: in alphabetic not choice order)
Pathway Reference Sheet: Adult FEP
First Episode Psychosis
Expected time on pathway: 6 months - 3 years

The FEP pathway includes those presenting to the service for the first time with mild to severe psychotic phenomena or are identified as ARMS. Care for service users on this pathway will be mostly provided by The Targeted Treatment Team, although access to services within the other teams can be drawn down if necessary to meet their needs. Pathway can be allocated following face to face assessment when the criteria are met. Ensure you are familiar with complete pathway document before using this sheet. If in doubt re-check.

### Likely Primary Diagnosis

- F20-F29 Schizophrenia, schizotypal and delusional disorders
- F1x.5 Psychotic disorder (but not where the psychotic symptoms are an expected reaction to hallucinogens or during acute cannabis intoxication)
- F1x.7 - Residual disorders and late-onset psychotic disorder
- F30 - Manic episode
- F31 - Bipolar affective disorder
- F32.3 and F33.3 (depression only when severe with psychotic symptoms)
- At Risk Mental State, or Ultra High Risk

### Outcome Measures

- Wellness and Recovery goals as identified in the care plan & Health and Wellbeing Plan
- Honos
- Duration Untreated Psychosis (DUP1), (DUP 2), DUI for FEP

### Included

- Individuals with psychotic disorders within the first three years of their first psychotic symptom unless not previously treated for psychosis or with At Risk Mental State or Ultra High Risk - These are presentations where a risk of developing psychosis is suspected due to brief, limited psychosis that has previously self remitted, BLIPS.
  - They may also have emotional dysfunction or co-morbid depressed mood and/or anxiety/traumatic experiences and/or other behaviours.
  - Drinking or drug taking may be present but will not be the only problem.
  - There will be mild to moderate impairment / problems with activities of daily living. Poor role functioning with mild to moderate problems with relationships. They will be vulnerable to harm from self and others. Some may be at risk of non-accidental self-injury or a threat to others.

### Excluded

- Individuals where inclusion criteria are not met
  - Individuals where the needs are better met by another pathway
  - Drug and alcohol misuse without psychiatric co-morbidity
  - F06.0 – F06.3 (Psychosis caused by clearly identified underlying medical condition/physical disease/organic brain disorder.
  - Been receiving services in relation to psychosis for more than 3 years.
With all who are being assessed...
- Give information about service & info sharing.
- Complete all appropriate sections of Needs Agreement & Risk Assessment & Record first assessment activity.
  when appropriate also...
  - Allocate Care Coordinator.
  - Score HONOS & Allocated Pathway & Care Cluster, Record DUP
- Give information about diagnosis & treatment choices.
  - Identify family/carers & offer carers handbook & assessment.
  - Construct Care Plan from identified needs (inc expected review and completion dates).

With all who are being offered care...
- Discus and give Health & Wellbeing plans
- Deliver care & record treatment start event.

With all who are being reviewed...
- Review Needs, Risk, Care Plan, Clustering & Pathway.
- Identify any new family/carers & offer (reoffer) carers assessment.
  - Construct New Care Plan including expected review and completion dates & offering information about anything new.
  - Give Having Your Say form.

With all who are being discharged:
- Complete Health & Wellbeing Plans
- Honos & Give Having Your Say form
- Agree Transition Supports
- Close notes.

The Pathway

With all who are being assessed...
- New Referral (Via SPA) Assessment booked.
- Transfer Handover booked.

Outcome Based Assessment (Review for known individuals)
- Complete within 14 days, 2 days for urgent
- Assess Health & Social Care Needs Plan care to meet identified needs with service user using intervention list

Implementing & Coordinating Care Plan with the Individual as they direct their recovery
- Start within 4 weeks

Review
- First review by 8 weeks or sooner if significant changes occur, then every 6 months

Discharge
- Start to prepare 3 months prior

Transfer
- To Bundle/Service/pathway

Actual choice should be based on Goals and Needs agreement, informed by NICE, clinical judgement, individuals’ choice & circumstance, provided within agreed limits. Reasons for non-NICE choices to be evidenced.
- Access to Accommodation & Benefits Advice
- Art Psychotherapy
- Assertive engagement
- Biological Interventions (e.g. ECT)
- Cognitive Assessment (Psychology & Psychiatry)
- Community Care coordination & support, inc health promotion
- Dramatherapy
- FACT Intervention
- Health promotion (care coordinator)
- Occupational Therapy
- Peer Support
- Personalised social care planning (inc Personnel Budget)
- Pharmacotherapy (Self managed)
- Pharmacotherapy (Supported)
- Psychiatry Review & Intervention
- Psychological Therapy - Intermediate (PIP workers)
- Psychological - Specialist, Formulation led Therapy
- Recovery Group (OT led)
- Residential Rehabilitation
- Signposting
- Social care interventions
- Specialist assessments (e.g ADHD, ASD)
- Support around substance misuse
- Support for families and carers (including carers support and/or contingency planning)
- Supported living placements
- Vocational & Employment Advisors

Draw down from other pathways or acute/crisis bundles as needed, including safeguarding.
(NB: in alphabetic not choice order)
Adult Community Mental Health Caseload Weighting Tool

Introduction

The Department of Health Policy implementation guide for Community Mental Health (CMHT PIG) prescribes a caseload of around 35 cases per full time member of a Community Mental Health Team (CMHT) this does not take into account the other time burdens on workers in the CMHT’s, e.g. Assessment Clinic, Duty Response or AMHP work.

Within HPFT the agreement is that a caseload for a fulltime clinician in Adult Community Mental Health Services will be between 25-35 cases depending on complexity of need or additional duties.

The system of allocation of cases to case workers is therefore based on a capacity system where the Team Manager or Team Leader is aware of the work load of each of the workers in the team and allocates to a level of around 35 cases per person. This does not take into account the complexities or levels of input that the service users’ needs to promote their recovery and ultimately consider discharge from caseload. This too, in turn, means that some workers have a higher degree of in-depth high need cases and another may have a caseload of stable service users who are in the process of discharge form service and as such have a lower need for input. Yet the worker has still got a full caseload and is therefore not viewed as able to take on new referrals.

A more equitable system, therefore, needs to be employed in the allocation of cases to Adult Community Mental Health Service workers. One such system is to use a caseload weighting, here each case is evaluated and given a score commensurate with the level of care needed to maintain the service user safely. This weight is then totalled to give an up to date list of the cases that an individual is supporting.

Many of these weighting tools are, however, time consuming and complex to complete and thus considered to have little use, save for the objectivity they provide in caseload management. The attached tools was created with this in mind and is designed to be a limited time burden to the worker whilst giving an objective measure of the work load within the Adult Community Mental Health Service.

Further the tool has been designed to allow for discussion in management supervision and thus allow for the constructive negotiation of movement within the stepped care model, the promotion of recovery and independence for each individual service user that the Adult Community Mental Health Service supports.
The Caseload weighting tool
User Guide

The tool consist of a grading profile, a scoring sheet and a summery sheet to record the total scores for each service user or carer you are supporting. The tool is designed to be of minimal time burden in its completion and once familiar should take limited time to review the scores from the previous evaluation in readiness for the next supervision. The tool has been designed so that Team Leaders and Managers can agree a total weighting for their area taking in to account the other demands on the team members. i.e. meetings, assessment, clinics, duty the number of days worked and training in progress.

The grading profile grid below sets out 12 criteria against which the care coordinator should grade the service user they are seeing. The grid takes into account time and risk management elements of the input needed to safely maintain the service user. The overall scores should then be discussed in supervision to assist you and you supervisor in determining the management of your caseload. Cases that consistently score low can then be reviewed for discharge and similarly cases that consistently score high should have their treatment and care plan reviewed. To score a service user or carer you are giving support to simply move along the grid to the statement that best suits where the person is at (1 -3) put this on the score sheet and total at the end (this will be between 12 and 36).

Caseload weighting score sheet below is used by the care coordinator to record the individual scores per person taken from the Grid. Use more than one sheet if more cases listed than one sheet.

Supervision record sheet. Once the score sheet is completed transfer the final scores with the persons first name and initial on to the supervision record sheet, this should then be discussed with your management supervisor. Use more than one sheet if more cases listed than one sheet.

The last page of the tool gives a calculation to assist you in determining the average weight of a case on your case load.

For further clarity see the examples on page 57.
Grading profile Grid

For each service user consider the position on the grid below

<table>
<thead>
<tr>
<th>Service User</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>visited</td>
<td>Weekly</td>
<td>Every 2 weeks</td>
<td>Less than 2 weekly</td>
</tr>
<tr>
<td>Care level</td>
<td>CPA</td>
<td>Std Care</td>
<td>Exempt / Models of care</td>
</tr>
<tr>
<td>DSH behaviour</td>
<td>Is self-harming</td>
<td>Has DSH thoughts not acted on</td>
<td>No thoughts self-harm</td>
</tr>
<tr>
<td>With CATT</td>
<td>Ready for Discharge to STT &amp; TTT</td>
<td>With CATT</td>
<td>Not with CATT</td>
</tr>
<tr>
<td>On In Patient unit</td>
<td>Ready for discharge</td>
<td>IP</td>
<td>Not applicable</td>
</tr>
<tr>
<td>In Patient on section</td>
<td>Has Tribunal / managers hearing</td>
<td>Detained</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Admitted to hospital / CATT in last 12 months</td>
<td>More than twice</td>
<td>Once</td>
<td>Not at all</td>
</tr>
<tr>
<td>Seen at</td>
<td>Out of area</td>
<td>Home</td>
<td>Office</td>
</tr>
<tr>
<td>Travel time to see SU</td>
<td>More than an hour travel each way</td>
<td>More than 30 less than 60 minutes</td>
<td>Less than 30 minutes (include office)</td>
</tr>
<tr>
<td>Having medication changed</td>
<td>Changes currently been made</td>
<td>Changes made more than 3 weeks ago</td>
<td>Medication remains unchanged</td>
</tr>
<tr>
<td>Social networks support of family and friends Housing needs</td>
<td>Poor social network and little or no contact with family Is homeless or about to become homeless</td>
<td>Few friends and has contact with family. Has adequate social network In temporary housing</td>
<td>Fully self supported and has many friends and family contact is maintained Settled permanent accommodation</td>
</tr>
<tr>
<td>Personal Budget in</td>
<td>Application for PB is in progress</td>
<td>PB review is progressing</td>
<td>Does not need PB</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>S/User initial</th>
<th>score</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Once you have completed the scoring per case calculate the weighting for the case load

Total all the scores together this gives the grand total

<table>
<thead>
<tr>
<th>Service users first name and last initial</th>
<th>Score</th>
</tr>
</thead>
<tbody>
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Grand Total equals = (A)

Number of Service users counted = (B)

Divide A / B = C

C is the average weight of the case load ..........................
This should be discussed in supervision to determine your work load capacity

Example

Case load weighting score sheet

<table>
<thead>
<tr>
<th>S/User initial</th>
<th>score</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>JM</td>
<td>3 3 2 1 1 1 2 2 1 2 3 3</td>
<td>24</td>
</tr>
<tr>
<td>TB</td>
<td>1 2 1 1 1 1 3 3 1 3 1 1</td>
<td>19</td>
</tr>
<tr>
<td>DLaR</td>
<td>1 1 1 1 1 1 2 1 1 1 1 1</td>
<td>13</td>
</tr>
<tr>
<td>DM</td>
<td>2 3 2 1 1 1 2 1 1 2 1 2</td>
<td>19</td>
</tr>
<tr>
<td>AA</td>
<td>3 2 3 1 1 1 3 2 2 3 3 3</td>
<td>27</td>
</tr>
</tbody>
</table>

Supervision record sheet

<table>
<thead>
<tr>
<th>Service users first name and last initial</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jim M</td>
<td>24</td>
</tr>
<tr>
<td>Tony B</td>
<td>19</td>
</tr>
<tr>
<td>David L</td>
<td>13</td>
</tr>
<tr>
<td>Denny M</td>
<td>19</td>
</tr>
<tr>
<td>Alexis A</td>
<td>27</td>
</tr>
<tr>
<td>Grand Total</td>
<td>102</td>
</tr>
</tbody>
</table>

Grand Total equals $= 102$ (A)

Number of Service users counted $= 5$ (B)

Divide A / B = C

C is the average weight of the case load … 20.4 …..

Case load weighting equals (A)………102 …
Payment by Results Clusters  
(DoH Mental Health Clustering Booklet 2012/2013 v.3.)

0 – Variance  
Despite careful consideration of all the other clusters, this group of service users are not adequately described by any of their descriptions. They do however require mental health care and will be offered a service.

1 – Common Mental Health Problems (Low Severity)  
This group has definite but minor problems of depressed mood, anxiety or other disorder but they do not present with any distressing psychotic symptoms.

2 – Common Mental Health Problems (Low Severity with Greater Need)  
This group has definite but minor problems of depressed mood, anxiety or other disorder but not with any distressing psychotic symptoms. They may have already received care associated with cluster 1 and require more specific intervention or previously been successfully treated at a higher level but are re-presenting with low level symptoms.

3 – Non-Psychotic (Moderate Severity)  
Moderate problems involving depressed mood, anxiety or other disorder (not including psychosis).

4 – Non-Psychotic (Severe)  
This group is characterised by severe depression and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

5 – Non-Psychotic Disorders (Very Severe)  
This group will be severely depressed and/or anxious and/or other symptoms. They will not present with distressing hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.

6 – Non-Psychotic Disorder of Over-valued Ideas  
Moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc, where extreme beliefs are strongly held, some personality disorders and enduring depression.

7 – Enduring Non-Psychotic Disorders (High Disability)  
This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have improvement in positive symptoms, considerable disability remains that is likely to affect role functioning in many ways.

8 – Non-Psychotic Chaotic and Challenging Disorders  
This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.
9 – Cluster - Blank cluster
Under review by Department of Health.

10 – First Episode Psychosis
This group will be presenting to the service for the first time with mild to severe psychotic phenomena. They may also have depressed mood and/or anxiety or other behaviours. Drinking or drug-taking may be present but will not be the only problem.

11 – Ongoing Recurrent Psychosis (Low Symptoms)
This group has a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are currently experiencing a period of recovery where they are capable of full or near functioning. However, there may be impairment in self-esteem and efficacy and vulnerability to life.

12 – Ongoing or Recurrent Psychosis (High Disability)
This group have a history of psychotic symptoms with a significant disability with major impact on role functioning. They are likely to be vulnerable to abuse or exploitation.

13 – Ongoing or Recurrent Psychosis (High Symptoms and Disability)
This group will have a history of psychotic symptoms which are not controlled. They will present with severe to very severe psychotic symptoms and some anxiety or depression. They have a significant disability with major impact on role functioning.

14 – Psychotic Crisis
They will be experiencing an acute psychotic episode with severe symptoms that cause severe disruption to role functioning. They may present as vulnerable and a risk to others or themselves.

15 – Severe Psychotic Depression
This group will be suffering from an acute episode of moderate to severe depressive symptoms. Hallucinations and delusions will be present. It is likely that this group will present a risk of suicide and have disruption in many areas of their lives.

16 – Dual Diagnosis
This group has enduring, moderate to severe psychotic or affective symptoms with unstable, chaotic lifestyles and co-existing substance misuse. They may present a risk to self and others and engage poorly with services. Role functioning is often globally impaired.

17 – Psychosis and Affective Disorder – Difficult to Engage
This group has moderate to severe psychotic symptoms with unstable, chaotic lifestyles. There may be some problems with drugs or alcohol not severe enough to warrant care associated with cluster 16. This group have a history of non-concordance, are vulnerable and engage poorly with services.

18 – Cognitive Impairment (Low Need)
People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.
19 – Cognitive Impairment or Dementia Complicated (Moderate Need)
People who have problems with their memory, and or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.

20 – Cognitive Impairment or Dementia Complicated (High Need)
People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.

21 – Cognitive Impairment or Dementia (High Physical or Engagement Needs)
People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.
Carer Support

Carer identified by either: service user, care coordinator, self-referral to SPA

Care coordinator allocates to STaR Worker for team 2 or 3 for carer support.

**Maximum of 5 sessions available with support worker on practical issues or provide emotional support. Can include:**

- Carer assessment offered and completed.
- Discussion to clarify issues of confidentiality and/or consent
- Discussion re: carers own health (if not covered by carer assessment)
- Application for carers grant/short breaks (only where carer assessment completed)
- Carer contingency plan
- Discussion re: carer understanding of diagnosis (where this information is already known to the carer)
- Signposting to other organisations or HPFT team for ongoing support/ group support

**Maximum of 5 sessions available with support worker on practical issues or provide emotional support. Can include:**

- Three way meeting with support worker, carer and cared for person.
- Carer assessment offered and completed.
- Discussion re: carers own health (if not covered by carer assessment)
- Discussion re: carer understanding of diagnosis from relevant team.
- Application for carers grant/short breaks (only where carer assessment completed)
- Carer contingency plan
- Signposting to other organisations or HPFT team for ongoing support/
- Referral for family therapy (if required)

Consent from SU

No consent from SU
Urgent Carers referral – work flow

Urgent referral for Carer support

Instant allocation within 24 hours to a qualified, to action details of support as per the contingency plan/carers wishes.

Allocation to a STaR /Peer worker for follow up, once details of contingency plan or Carers wishes have been identified.

Continue supporting carer as set out in contingency and carers care plan if they have one.

Support to discontinue/revert back to original once immediate emergency is over.

Continue with support through the routine referral work flow.
Self-referral to SPA – Triage/Conversation & Information letter.

Support identified

SU assessment

Referral made for carers support to CC / SSW to appropriate Duty desk.

Allocated to STaR & Peer Worker for follow up & to remain primary worker throughout. CC/SSW to remain Co Worker.

Carer assessment
Max of 5 sessions with STaR & Peer Worker.
3 way meetings with SU if consent given.

First contact by telephone within 14 days of allocation / letter offering first appointment if not contactable.

Offer of carer assessment during first appointment within 14 days of first contact

Consider options for future intervention

Carer assessment declined
Carer to make contact with STaR / Peer Worker if there is any change
Worker to remain the Primary contact throughout.
Sign post for longer term support. Carers groups & Carers in Herts.
Local Team meetings Practice Governance Agenda header template

Practice Governance Agenda Headers for Local Team Meetings - (Please note: Notes to be taken not minutes)

**Quality and Risk Management** - Examples for this header include:
- Sharing good practice within the Trust
- Clinical audit reports, including monitoring and progression of relevant audit action plans
- Clinical outcomes (e.g. HoNOS)
- NICE technology appraisals clinical guidelines and quality standards
- CQC concordance
- Quality Account and CQUIN measures of quality
- Policy and practice issues
- Feedback from and to the service line lead patient safety group and SBU Quality and Risk Meeting

**Service User and Carer Experience** - Examples for this header include:
- Complaints, compliments and PALS information including review of most recent weekly complaints report to provide monitoring and progression of complaints management process
- National Service User surveys
- Having Your Say reports
- Patient Experience Trackers Reports
- Other sources of feedback

**Workforce and Organisational Development** - Examples for this header include:
- Key aspects of workforce data such as sickness rates, turnover rates, PDP rates, and mandatory training
- Staff Survey results and action plans
- Supervision
- The respective Codes of Conduct and professional practice guidance.
- Training needs, skill mix, capacity issues
- Leadership and management training
- Internal communication and organisational culture
- Feedback from direct service staff on, for example, workload and staff morale

**Sharing Good Practice**
Providing an opportunity for staff in a service area to reflect on examples of good practice, awards, and compliments
Local Team Meetings Proposed Agenda format that includes Practice Governance and Patient Safety - Not exhaustive!

AGENDA

<table>
<thead>
<tr>
<th></th>
<th>Apologies</th>
<th>ACTION</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Matters Arising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Agenda</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Notes of last meeting and matters arising &amp; Introduction to meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service User and Carer Experience</td>
<td></td>
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<td></td>
<td>o Having your say report</td>
<td></td>
<td></td>
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<td></td>
<td>o Service User &amp; Carer Engagement report</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Complaints</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>o Incidents</td>
<td></td>
<td></td>
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<td></td>
<td>Risk Management and Patient Safety</td>
<td></td>
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<td></td>
<td>o Patient Safety Feedback</td>
<td></td>
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<tr>
<td></td>
<td>Quality and Best Value</td>
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<tr>
<td></td>
<td>o Announced and unannounced visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workforce and Organisational Development</td>
<td></td>
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<tr>
<td></td>
<td>o Sickness</td>
<td></td>
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<td></td>
<td>o Training</td>
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<tr>
<td></td>
<td>Sharing good practice</td>
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<td></td>
<td>• Good practice</td>
<td></td>
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<tr>
<td></td>
<td>• Awards</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Compliments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Any Other Business</td>
<td>Reviews</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Date of Next Meeting:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Quadrant Multi-Disciplinary Team Meeting Process

Weekly team meetings attended by all members of the multi-disciplinary team. These are to be organised to suit the team structure as it is arranged in each quadrant. The agenda of these meetings will include the following standing items:

1. Review of last week’s notes
2. New feedback on cases of concern currently open to the TTT/STT
3. CATT Feedback of any TTT/STT cases on CATT caseload
4. Ward Feedback of any TTT/STT cases in any ward in the Trust, including follow up of required action regarding delayed transfers of care (DTCs)
5. ADTU Feedback of any TTT/STT cases under ADTU
6. Safeguarding Adults Cases
7. Safeguarding Children – Subject to Child Protection
8. Cases waiting for Allocation
9. Key communication updates
10. Practice issues which require specific approaches to be adopted.
11. Intake Feedback
12. Referrals outside of SPA

The TTT/STT Manager is responsible for ensuring systems are in place to share notes of the team meeting with all members of the MDT and check all members of the MDT have read and understood the notes.

Monthly Business and Governance meetings must be attended by all members of the multi-disciplinary team that will include update on Trust wide Practice Governance issues and discussion of local practice governance issues, consideration of performance data, updates on new policies and practice initiatives that may include visiting speakers, information from Executive and Senior Management to be cascaded to all levels of staff and any other matters of business as required.

The agenda of the meeting will include the following standing items:

1. TTT/STT Business including performance against key performance indicators and communication updates
2. Quality and Risk
3. Service User and Carer Experience
4. Workforce and Organisational Development
5. SUIs, Complaints and Compliments, Performance Indicators

The CMHS Manager is responsible for ensuring systems are in place to share notes of the team meeting with all members of the MDT and check all members of the MDT have read and understood the notes. Please see separate guidance on Practice Governance Meetings.
Quadrant Leadership Team Meetings

TTT/STT Senior Management meetings – the TTT/STT Manager, Team Leader/s, Consultant Psychiatrist and any other relevant professional leads should meet on a regular basis, at least bi-monthly, to review the performance and quality of the service provided in their CMHS, discuss complaints, incident and safeguarding utilising available data and evidence, and working together to address any barriers to provision of a service of consistent high quality.

Any team training needs should also be identified and flagged to the Learning and Development Department so that these can be met.
Vocational Services Referral Criteria, pathway guidelines and Operational Procedures

Service Overview

The role of the Vocational Service is to offer Service Users advice, support and signposting in order to gain employment, find a course of study or a voluntary placement. The Vocational Service may also work with Service Users who are currently employed or at college/university and who are struggling to attend work/college due to their mental health condition.

For Service Users (SU) who know what vocational goals they wish to pursue and do not need any or need minimal support, the Vocational Advisor (VA) to offer advice, resources and signposting to the referring staff member to assist the SU to achieve their vocational goal/s.

Referrer/Care Co-ordinator.

For SU’s who are unsure of their vocational goal/s, the VA to offer a short-term intervention to assist the SU to devise a Vocational Action Plan (VAP) and to offer signposting.

1 – 3 x 60 minute sessions.

If the SU requires support to achieve their VAP, the VA will offer an intervention to the SU, e.g. job seeking advice, how to write a CV, advice on completing job application forms, sourcing work placements, study or volunteering, advice on disclosing their disability to an employer, advising on reasonable adjustments, etc.

If the SU does not need any or needs minimal support, the VA to offer advice, resources and signposting to the referring staff member to assist the SU to achieve their vocational goal/s.

Supported Employment/Education – If the SU is signed off sick from work/education, or they are finding it difficult to attend work/education as a result of the mental health condition, the VA can offer advice on reasonable adjustments, signposting to legal advice (if necessary) and support to return to work/education.

24 x 60 minute sessions for maximum of 1 year (TBA in clinical supervision).

Referral Criteria

That the Service User:-

- Is receiving support from STT or TTT (For Team 1 SU’s, Vocational Advice may be accessed via Herts Mind Network and Work Solutions)
- Is not receiving vocational support from another provider, e.g. Herts Mind Network, Work Solutions, JC+ Work Programme or Work Choice, etc.
- Is willing to engage with the VA to receive guidance and support relating to matters of work, training, education and/or volunteering
- Needs support to set vocational goals and/or to achieve their vocational goals
- Is signed off sick from work/education, or they are finding it difficult to attend work/education as a result of the mental health condition
If the SU needs minimal or no support, the Vocational Advisor will offer advice, resources and signposting to the referring staff member so they can assist the SU to achieve their vocational goal/s.

**Accessing Vocational Service**

Worker to discuss in person or via email with VA why their input is needed.

Worker completes the **Vocational Needs Screening Tool** with the Service User and passes to Senior Vocational Advisor in their Quadrant.

**Vocational Advisor – Summary of Role**

- Reviewing vocational referrals
- Vocational profiling and assessments
- Workplace assessments and Job Analysis
- Career advice & guidance
- Job seeking advice
- Assisting with writing CV’s and advising on job application forms
- Networking with Employers, education and voluntary providers
- Sourcing work placements
- Keeping up-to-date with employment law, HR Policy & Practice and National supported employment initiatives
- Job retention, Supported Volunteering and Supported Education
- Advising and signposting CareCo’s on vocational matters
- Liaising with CareCo’s and key workers
- Liaising with Jobcentre +
- Making referrals to Access to Work
- Assisting SU’s to access legal advice on employment-related matters (CAB, ACAS)
- Employment-related Benefits advice
- Visiting SU’s at their place of work/volunteering/study and holding review meetings with their Manager/HR
- Support in disciplinary/performance/redundancy processes
- Advising SU’s and their CareCo, the employer/college, HR/OccHealth on reasonable adjustments
- Job searching
- Type of support = 1-1’s, email, telephone, text, attending meetings with their employer/HR/OccH/CAB
- Attending CPA’s
- Interview advice and 1-1 mock interviews
- Writing clinical notes on Paris.
- Maintaining Employment Related Databases
- Meeting Employment Related Key Performance Indicators
Vocational Needs Screening Tool

The following screening questions will help to identify those Service Users who are most likely to actively engage in and benefit from vocational needs assessment and advice.

This form is to be completed with the Service User, and signed by them. Please ask them to consider each of the factors listed and agree how to rate their current situation.

Please read the questions and the guidelines for each rating, then circle the score for the description that best fits the current situation. For a score of 5-10 consider need for Occupational Therapy. For a score 11-20 consider need for Vocational Advisor.

Name: ……………………………….. D.O.B.: ………………. NHS No: …………………………

Referring Staff Member: ……………………… Date of Screening: …………………..

<table>
<thead>
<tr>
<th></th>
<th>4 Very</th>
<th>3 Moderately</th>
<th>2 Somewhat</th>
<th>1 Not At All</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How interested are you in finding work / pursuing vocational goals?</td>
<td>Definite interest in finding work/pursuing vocational goals</td>
<td>Some interest, with reservations</td>
<td>Some interest with encouragement, with many reservations/ anxieties</td>
<td>No interest at all, may be actively opposed</td>
</tr>
<tr>
<td>2. How much do you engage in structured activity at the moment?</td>
<td>Actively involved in structured activity several days per week. Needs no encouragement</td>
<td>Involved in structured activity at least one day per week. May need some support or encouragement</td>
<td>May take part in structured activities with lots of encouragement and support. Not reliable or regular in attendance</td>
<td>Not currently active in any structured activity</td>
</tr>
<tr>
<td>3. How willing are you to participate in an assessment of your vocational needs?</td>
<td>Very keen and interested in getting help with finding work</td>
<td>Willing to participate with reservations</td>
<td>Willing, but unenthusiastic. Doubts need for any help</td>
<td>Not willing. Doesn’t want help, or believe it is needed</td>
</tr>
</tbody>
</table>

Adapted from Vocational Needs Screening Tool, Central & North West London NHS Foundation Trust.
### 4. How stable is your present accommodation?

<table>
<thead>
<tr>
<th><strong>Very</strong></th>
<th><strong>Moderately</strong></th>
<th><strong>Somewhat</strong></th>
<th><strong>Not At All</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Living in present accommodation for at least 6 months, rented or owner occupied. No plans to move in the next year</td>
<td>Recently moved into own flat, or living in supported accommodation for at least 6 months. Unlikely to move in the next 6 months</td>
<td>In temporary accommodation, but expecting to move into permanent accommodation soon</td>
<td>Homeless, or living in hospital, or about to move</td>
</tr>
</tbody>
</table>

### 5. How stable is your mental health at the moment?

<table>
<thead>
<tr>
<th><strong>Very</strong></th>
<th><strong>Moderately</strong></th>
<th><strong>Somewhat</strong></th>
<th><strong>Not At All</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No significant problems in the last 6 months, no changes to treatment; any symptoms experienced are not affecting day to day functioning</td>
<td>Minor problems recently, e.g. change in medication, some problems with symptoms which may affect daily functioning</td>
<td>Active symptoms, significantly affecting daily functioning, may be in hospital, recently discharged or currently having medication changed</td>
<td>Currently in hospital, having treatment for active symptoms of mental health problems</td>
</tr>
</tbody>
</table>

### 6. Do you require any training, education or assistance with communication?

Do you need help with speaking and understanding English, reading, writing or arithmetic? If English is not your first language, do you need help with any aspect of learning English? Do you need an Interpreter?

### 7. Are you receiving vocational support from another Organisation such as Work Solutions, Mind or Work Programme/Work Choice? (please circle)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

### 8. Are you currently employed or in education? (please circle)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

### 8a. If YES, are you finding it difficult to attend work or your course due to your mental health condition? (please circle)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>
Appendix 12

Initial Assessment Process

1. GP referral → SPA Triage
2. Medical apt? (not CCHT) → Yes → Attend
   No → Pass to CCHT
3. Attend → Yes → Book medical appointment
   No → Declined process
4. Pass to CCHT → Yes → Book medical appointment
   No → No or Correct referral?
5. Initial Assessment
   - Daily check of Team Duty Inbox
     - Yes → Conduct initial assessment
     - No → No or Correct referral?
   - New referrals
     - Yes → Take on discharge
     - No → No or Correct referral?
6. Update PARIS with outcome
7. Decision ratification
8. Update PARIS as attended
9. Discharge process

SPA Triage

- Medical apt? (not CCHT)
- Attend
- Pass to CCHT
- Declined process
- Signposting process
- Did Not Attend process
- Book medical appointment
- Book (non-standard) appointment
- Inform SPA of non-standard appointment date & time
- Re-direct in PARIS
- Update PARIS as CDRK
- Did Not Attend process
- Conduct follow-up appointment
- Treat and discharge?
- Update PARIS with outcome
- Allocate care coordinator
- No (initial appointment non-medical)
- Medical input required?
- Make follow-up appointment
- Conduct follow-up appointment
- Update PARIS with outcome
- Allocate care coordinator
- End
Psychological Therapy Referral Management Process

Appendix 13

GP, Self-Referral, Friends, Family, Carer

Single Point of Access Triage (max 28 day wait)

Initial Assessment Clinic

Identify Specialist Psychological Input intervention needed on Care Pathway

If YES

- OPT in letter for Specialist Psychology intervention sent to Service User
- Pre-treatment Inventories sent to Service User
- Allocate temporary care coordinator
- Care Coordinator to identify Wait time till face to face appointment with Specialist Psychological Team

Allocate to a waiting list (Maximum 18 week wait)

In depth Specialist Psychological Summative assessment

Establish Therapy goals

Allocate to treatment package from appropriate Recovery Care Pathway

Offer Post Assessment Group

Complete identified Psychological sessions

Evaluate Sessions against treatment outcome/goals

Identify if further number of sessions needed

If YES

Commence further Specialist Psychological Sessions in line with pathway and NICE guidance (once sessions complete re-evaluate and discharge)

If No

Discharge from Specialist Psychology Therapy (complete necessary PARIS documents)

Discharge completely from PARIS if Psychology is the only remaining open service

Care Coordinator

- Identify needs
- Develop care plan with the service user
- Update Risk Assessment
- Commence other intervention outlined at assessment
CEDS Referral Pathway

Referral (Direct/SPA/Other MH or Wellbeing teams)

- Triage

Suitable

- Routine assessment offered within 28 days
- Urgent assessment offered within 4 working days

Unsuitable

Back to GP / referrer and/or signpost to another service

Suitable for CEDS

Service User full agreement

Service user ambivalent to change – high risk, GP unwilling to hold alone

Service User ambivalent to change – low risk

Routine: Placed on waiting list for therapy / other interventions (< 18 weeks)
Psycho-education provided. Interim appointment offered every 4-6 weeks or more frequent if indicated
High risk/low weight: offered support/therapy, Intensive Community Management or referral to inpatient unit

- Psychiatric Input / Medication
- Medical monitoring
- Specialist nursing
- Dietetic support
- Support working
- Tertiary (e.g. in-patient) and Secondary Care (e.g. STT, TTT, CDAT, CATT) referrals made as and when appropriate.

Psychoterapy e.g.
- Guided self-help (6 contacts over 3 months)
- CBT (20/40 sessions +1/2 follow up)
- IPT (16/40 sessions +1/2 follow ups)
- CAT (16/40 sessions +1/2 follow ups),
- Family Therapy (16 sessions +1 follow up)
- Group Therapy (12 sessions +1 follow up)

Complete symptom remission

Partial symptom remission

No or very little symptom relief

Review leading to:
- More therapy sessions
- Different kind of therapy
- Parallel family work
- Break in therapy
- Medical monitoring
- Other interventions

Discharge back to GP / referrer
REFERRAL FORM ASPERGER SOCIAL CARE TEAM

Please return this to:-
Hertfordshire Community Asperger Team
AP2106, Apsley 1
Brindley Way
Hemel Hempstead
HP39BF

Or email to: asperger.team@hertfordshire.gov.uk
If you have any queries please call the team on 01442 453535

<table>
<thead>
<tr>
<th>INFORMATION ABOUT THE PERSON WHOM THIS REFERRAL IS BEING MADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME:</td>
</tr>
<tr>
<td>ETHNICITY:</td>
</tr>
<tr>
<td>DATE FORM COMPLETED:</td>
</tr>
<tr>
<td>GENDER:- MALE/FEMALE</td>
</tr>
</tbody>
</table>

ADDRESS & TELEPHONE NUMBERS/EMAIL ADDRESS

<table>
<thead>
<tr>
<th>INFORMATION ABOUT THE REFERRER - IF BEING MADE BY SOMEONE ELSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you discussed this referral with the person? YES/NO (Please circle)</td>
</tr>
<tr>
<td>NAME OF REFERRER:</td>
</tr>
<tr>
<td>ADDRESS &amp; TELEPHONE NUMBERS/ EMAIL ADDRESS OF REFERRER:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship with the person being referred:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis: Do you have a diagnosis of Aspergers Syndrome/High Functioning Autism?</td>
</tr>
<tr>
<td>Do you have any other conditions such as ADHD, Tourettes Syndrome, Anxiety, OCD, Depression etc</td>
</tr>
</tbody>
</table>
Please state clearly the purpose of this referral to the Asperger Social Care Team:

<table>
<thead>
<tr>
<th>PRACTICAL ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing: Please give a brief description of your living arrangements and any support you currently receive.</td>
</tr>
<tr>
<td>Day/Leisure Activities: Please give a brief description of your day to day activities (e.g. school, college, work, groups etc)</td>
</tr>
<tr>
<td>Physical Health: Do you have any physical health needs? e.g. epilepsy, diabetes, asthma, allergies etc</td>
</tr>
<tr>
<td>Mental Health: Do you have any current mental health needs? If so please give details. Do you take any medication for these?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASD SPECIFIC ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication: Please tell us about anything we should know about your communication needs</td>
</tr>
<tr>
<td>Special Interests or skills: Do you have any special interests or skills? If so, please give brief details</td>
</tr>
<tr>
<td>Particular dislikes or fears: Do you have any strong dislikes or fears? If so, please give brief details and whether these cause you problems in your day to day life.</td>
</tr>
<tr>
<td>Please list any people that you would like us to contact to be involved with your assessment ie parents, siblings, friend etc</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Any additional information you would like us to know that has not been included on this form:</td>
</tr>
</tbody>
</table>
IA checklist

This appendix is to be read in conjunction with the Trust’s DNA Policy.

On PARIS –

1. Casenotes
   - Record whether patient attended / DNA (see step 8) and outcome

2. Record activity
   - Under activity type – select 1st face to face assessment or DNA by Client
   - Under activity 1. Select assessment

3. Complete Needs Assessment
   - incl social care needs in line with national eligibility criteria (Care Act, 2014)
   - save and sign off completing your own name as completed by & authorised by

4. Complete Risk assessment

5. Complete HoNOS & save (do not complete clustering at this point)

6. Complete & attach IA summary letter to Referrer
   - Use IA summary template letter, copy to service user – on shared drive

7. Procedure to follow when Service User does not attend Routine Initial Assessment appointment
   1. Assessment Worker to contact the service user by phone.
   2. If the service user answers the phone inquire if another appointment is required.
   3. If yes, book another appointment through IA administrator. IA administrator to confirm appointment in writing.
   4. If no, discuss with Duty Manager who will review the risk assessment and record decision in casenotes. Inform Service User re outcome.
   5. If service user doesn’t answer the phone inform the duty manager. IA administrator will write to the service user asking them to make contact within in 7 days if an appointment is required.
   6. No contact within 7 days. Duty manager to review and if there is no further information to review discharge will follow. IA administrator to inform G.P and service user in writing of the discharge explaining clearly what has been offered prior to this discharge.

Please ensure that all contacts with a service user and decisions made are recorded accurately in casenotes.

The above applies to referrals that have been triaged as low/no risk routine assessments. Do not apply the above to the urgent/priority referrals seen on the duty system.

8. Procedure to follow when Service User does not attend Urgent / Duty Initial Assessment appointment
   Following a DNA of an urgent / duty appointment always discuss with the Duty Manager before agreeing the next step. Following DNA of an appointment an attempt to contact the service user by telephone should always be made.

   Duty Manager to review the risk assessment for the service user and record decision in casenotes

9. Present case at Post Assessment meeting or discuss with Duty Manager / Senior
   - Agree Care Co-ordinator if appropriate
- Book follow up OPA with OPA administrator after agreement with Consultant Psychiatrist.
- Agree pathway allocation – see 10.
- Inform Service User of outcome of discussions

10. Outcome – options
Pathway allocations (PASS ON)
   a) – for TTT – allocate to pathway D or E or FEP
   b) - for STT - allocate to pathway B.
   c) - for WBT - allocate to pathway A - discharge from PARIS – referral letter to wellbeing team / referrer / service user (IA template)
   d) Not suitable for secondary services – discharge - letter to Referrer / GP & Service User

11. Complete Clustering

12. Duty Manager to inform IA Administrator of agreed outcomes so that the referrals can be progressed / rebooked and detailed recorded onto PARIS .

13. 1\textsuperscript{st} appointment following IA (OPA, Therapy, care coordination) tick Treatment Start box
Referral pathway / process for step up from Well-Being Team

1. All paperwork/ referral from Well Being to be send by email following telephone discussion with duty senior / duty worker.
2. Step up from Wellbeing to be discussed with duty Senior/Duty worker before sending paperwork/ referral via email.
3. Step down to Well Being to be discussed with local Wellbeing team mgmt / senior clinician before sending paperwork/ referral via email.

---

Appendix 17

Client known to Well Being Team

- Client may need Step up to secondary services
  - Well-Being to discuss with Duty Senior/ duty worker
  - Accepted for Initial Assessment
  - Not Accepted

Client Requires Medical input re diagnosis, medical review, medication management, outpatient appointment, Anxiety, etc.

- Well-being to Discuss with consultant providing medical input for Well-being; Either by Email or Phone
  - OPA / Assessment
  - Appropriate for Secondary service STT/ TTT
    - No
    - Yes
      - Intervention i.e. Psychology/ psychotherapy /Care Coordinator/ OPA follow up
        - Discharge
        - Step down

Appendix 18
Inventory of Trackers

28 Day Wait for Assessment

Provided on a Monday from the performance team. This lists service users new to the teams who have not yet received an assessment during this current episode of care by any team.

Please note this list will not include service users who have had a previous assessment by another team before being passed/referred to your team.

No CC List

Provided by performance on a Monday.

This needs to be checked clinically by the team to ensure all allocations to a CC are made on Paris. If no CC identified need to ensure there is a plan in place for all service users and team management know the position for each service user that is unallocated.

Paris Duty Desk

All new referrals from any source will initially go into the Paris duty desk and will leave when either discharged or allocated to a worker.

When a CC leaves and their name is removed from Paris the service user will re-enter the duty desk.

The desk needs to be checked at least twice daily for any new work to ensure all service users have a plan of intervention.

Duty manager for each team is responsible from a clinical perspective.

All new referrals identified in the duty desk must be transferred to the team tracker to ensure service users progress through assessment and into treatment if required.

SPA IA Diary

All new referrals requiring IA will be in this diary. Service users who have cancelled/DNAs will need follow up booked in this diary.

Regular review of this is needed to ensure we are offering enough future appointment to ensure we can meet our 28 day wait time targets for initial assessment.

SPA Tracker

This report is delivered each day by email from OMNI to admin trackers and team leaders.

This required daily review by the admin trackers and the duty manager. This report shows all new referrals from SPA into the teams for initial assessment. It will show any appointments that are booked to breach that will need bringing forward. It also highlights service users who don’t have an appointment booked and will require one organising.

Please note due to problems with the OMNI report admin trackers are required to run the COGNOS version on a daily basis.

Request for Allocation List
This list contains request for a CPN/SW/OT following an initial assessment/request by psychiatrist/psychologist/previous CC has left the team/CPA transfer/request from other teams, CATT,Ward,,ADTU.

Each service user should have an interim plan until allocation is completed.

All service users on the list should be allocated based on urgency and risk.

**Team Tracker**

Every new referral into the team, from any source needs to be placed on the team tracker.

The team admin trackers need to be informed of any new referrals so they can place the service user on the tracker.

Service users are then tracked to ensure IA is completed and safe transfer into treatment with a named CC or discharged back to referrer.

It is the responsibility of the team manager and leader to ensure this is kept up to date and no service users are lost to follow up.

**Psychology Waiting List**

This list contains all service users who have been referred for psychology assessment/treatment.

This can be following an initial assessment or during a period of current treatment.

Psychological Services staff need to review weekly with the team admin trackers so they are aware of all referrals to psychology following IAs.

**Awaiting Psychology/Psychiatry**

In development.
We say you need a continued Social Care Outcomes Assessment if-

In order to meet the eligibility criteria for care and support services, you need to be unable to achieve or have difficulty achieving at least two outcomes.

We may “pause” the assessment whilst we try and support you through preventative services and other appropriate resources in order to meet your social care needs.

<table>
<thead>
<tr>
<th>First name (s)</th>
<th>Surname</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARIS ID</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Social Care Outcomes**

<table>
<thead>
<tr>
<th>Significant impact in Area of need</th>
<th>Tick box if Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td></td>
</tr>
<tr>
<td>Homeless or unstable housing</td>
<td></td>
</tr>
<tr>
<td>Developing or maintaining relationships</td>
<td></td>
</tr>
<tr>
<td>Accessing and engaging in employment, training or occupation</td>
<td></td>
</tr>
<tr>
<td>Ability to look after children for which they have responsibility</td>
<td></td>
</tr>
<tr>
<td>Ability to use community facilities (eg. public transport)</td>
<td></td>
</tr>
<tr>
<td>Managing and maintaining Nutrition</td>
<td></td>
</tr>
<tr>
<td>Maintaining Personal hygiene</td>
<td></td>
</tr>
<tr>
<td>Managing Toileting needs</td>
<td></td>
</tr>
<tr>
<td>Ability to dress appropriately</td>
<td></td>
</tr>
<tr>
<td>Ability to move safely round the house</td>
<td></td>
</tr>
<tr>
<td>Ability to maintain the home environment</td>
<td></td>
</tr>
</tbody>
</table>
6. SOCIAL CARE OUTCOME ASSESSMENT FORM

SOCIAL CARE OUTCOMES ASSESSMENT

<table>
<thead>
<tr>
<th>Are you able to manage the following outcomes (consider the significance test below)</th>
<th>Yes/No, Or not relevant to desired outcome</th>
<th>Why we said this (description of the need):</th>
<th>If it has been identified that you cannot achieve this outcome, describe how this impacts upon your wellbeing (refer to guidance)</th>
<th>This is how you would like things to be different in order to improve your wellbeing in the areas identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to manage and maintain your nutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to maintain your personal hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to manage your toilet needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to dress appropriately</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to make use of your home safely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to maintain a habitable home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to develop and maintain family or other personal relationships</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to access and engage in work, training, education or volunteering</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to make use of necessary facilities or services in the local community including public transport, and recreational facilities or services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to carry out any caring responsibilities you have for a child.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The How it affects you / Significance Test
We say you need support if:

You are unable to achieve an outcome without assistance.

And/or, if achieving the outcome:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Please Tick if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Causes you significant pain, distress or anxiety</td>
<td>☐</td>
</tr>
<tr>
<td>Endangers or is likely to endanger your health or safety, or that of others</td>
<td>☐</td>
</tr>
<tr>
<td>Takes significantly longer than would normally be expected</td>
<td>☐</td>
</tr>
</tbody>
</table>

In order to meet the eligibility criteria for care and support services, you need to be unable to achieve at least two of the outcomes in the table above.

Is there a Carer?

Yes/No

If Yes Name

Relationship

Carer’s assessment Offered?

Outcome of Social Care assessment

☐ We have identified that you do not have a physical or mental impairment or illness and are not eligible for care and support services. We have given you information and advice which may be helpful to you.

☐ In order to meet the eligibility criteria for care and support services, you need to be unable to achieve at least two outcomes. The information you have given indicates you are not eligible at this time. We have given you information and advice which may be helpful to you.

☐ We have identified that you are unable to achieve two or more outcomes but these have not had a significant impact on your wellbeing and are not eligible for care and support services. We have given you information and advice which may be helpful to you.

☐ We have identified that you are unable to achieve two or more outcomes and these have a significant impact on your wellbeing and are met by preventative or community resources.

☐ We have identified that you are unable to achieve two or more outcomes and these have a significant impact on your wellbeing and you are eligible for care and support services.
Information has been given to the service user and or their representative that the services they receive may be subject to a financial assessment and possible charge.

☐

The information you provided during this assessment will be used to assess your need for care and support. Your information will be held securely and confidentially in accordance with the Data Protection Act 1998. This information may be shared with other professionals/agencies in order to provide the support you need and if required for the investigation of or prevention of a crime

Consent to sharing given by service user:

Client Signature and Date:

Inform Client with whom will this be shared: Service User, Carer, GP, Other agencies (please specify)

Emergency contacts: Information card given or add:

During working hours (0900am – 1715pm) please contact
SPA 0300 7770707

Out of hours you can reach our Helpline by calling 01438 843322.

If you develop a physical illness please arrange to see your GP
<table>
<thead>
<tr>
<th>Authorisation:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>Role</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
### Personal details of the carer

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details and/or what we discussed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surname</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NI Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postcode:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred contact No.</td>
<td>Mobile or Home</td>
<td></td>
</tr>
<tr>
<td>Email address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Details of the cared for person

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details and/or what we discussed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your Carers Assessment was completed on: By:

HPFT contact number:

### Before your assessment

Information gathered from your original contact with us:

This is what you, or someone else acting on your behalf, told us:

Welcome to your assessment:

All of the information below should be completed prior to the carer assessment taking place:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details and/or what we discussed</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information that we gave you and any actions taken before your assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explanation of</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Supporting carers factsheet and items discussed

<table>
<thead>
<tr>
<th>Preparing for your assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions you should/could take before your assessment</td>
</tr>
<tr>
<td>Support that you are already receiving</td>
</tr>
</tbody>
</table>

### At your assessment this is what you told us:

**About you and what is important to you:**

**About your situation, the person (or people) you care for and the care you give them:**

**About how your caring role impacts on your life:**

**About what you do and what you would like to be doing, outside your caring role:**

**How would you like things to be different in the future:**

(This may include changes to the amount or type of care you provide)

**About other services that you are currently receiving that you would like us to know about?**
To help you and the person you care for, we gave you this information about your rights and the things available in your local community:

Do you have needs of your own because you provide care to an adult who needs care and support? (This is someone who’s needs arise from a physical or mental impairment or illness)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Is your physical or mental health affected by your role as a carer or is it likely to be?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

Is a Carer’s Contingency Plan required?
An additional Carers Contingency Plan will be completed with you and you will be provided with a copy.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**The following table identifies what we have agreed your needs are based on what you are/aren’t doing or what you can/can’t do.**

**Table 1: Areas of need**

<table>
<thead>
<tr>
<th>You are:</th>
<th>Yes/ No</th>
<th>Why we said this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to carry out caring responsibilities for a child (if caring for a child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to provide care to another adult (if caring for an adult)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to maintain a habitable home Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to manage and maintain nutrition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to develop and maintain family and other personal relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to engage in work, training, education or volunteering</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Able to make use of necessary facilities or services in the community including recreational facilities or services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Able to engage in recreational activities.</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 2: Impact on wellbeing and desired outcomes

<table>
<thead>
<tr>
<th>Maintain your personal dignity (including making sure you are treated with respect)</th>
<th>If the answer to any of the questions in Table 1 is “no” this is how it affects you</th>
<th>This is how you would like things to be different in order that you can improve your wellbeing in the areas identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintain your physical and mental health and emotional wellbeing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stay safe and be protected from abuse and neglect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise control over day-to-day life (including over your care and support)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participate in work, education, training or recreation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieve social and economic wellbeing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain your domestic, family and personal relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access suitable living</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Eligibility Statement

We are committed to supporting everyone who is a carer. We offer information and advice to all carers and can help you find support in your community, which for many will meet their needs.

Some carers need additional support to balance their caring role with their own wellbeing. These carers may be eligible for ongoing or further support from HPFT.

Following your assessment we confirm you meet the criteria for carers support and you are eligible for assistance through an ongoing carer’s personal budget or one off payment. A personal Budget is Money that is allocated to you to pay for support to meet your assessed needs.

Or

Following your carer’s assessment we can offer you information and advice and support you to find help in your local community.

Why we said this:

Consent

The information you provided during this assessment will be used to assess your need for care and support services. Your information will be held securely and confidentially on a computer and on file in accordance with the principles of the Data Protection Act 1998. This information may be shared with other professionals in order to provide the support you need.

I confirm the information that is recorded in this assessment is correct □

I am happy to be contacted in future to feedback on my experience of having this carer assessment □

I would like a copy of my carer assessment to be sent to my GP so that they are aware of my needs and can register me as a carer: □

GP Address:
<table>
<thead>
<tr>
<th>Carers Signature</th>
<th>Date:</th>
<th>Advocate Signature (if applicable)</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Worker Signature</td>
<td>Date:</td>
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</tr>
</tbody>
</table>

**we are...**

- **Welcoming**: Valued as an individual
- **Kind**: Cared for
- **Positive**: Supported and included
- **Respectful**: Listened to and heard
- **Professional**: Safe and confident