HPFT

Adult Community Mental Health Services Operational Policy

This Operational Policy refers to Adult Community Mental Health Services

HPFT Policy

Version	3.1
Executive Lead	Executive Director for Service Delivery & Customer Experience
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Document on a Page

Title of document	Adult Community Mental Health Services Operational Policy		
Document Type	Policy		
Ratifying Committee	West SBU Quality and Risk Committee		
Version	**Issue Date**	**Review Date**	**Lead Author**
3.1	29/03/2019	27/02/2022	Practice Governance Lead
Staff need to know about this policy because (complete in 50 words)	Staff need to read this Policy to be informed about the ACMH Service and understand the processes from referral to treatment, to review and to discharge.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	Movement away from TTT and STT to Quadrant Adult Community Mental Health Services The Adult Community Mental Health 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. Specific pathways are currently in development. ACMHS form part of a planned and integrated whole system approach to care that is delivered in conjunction with Enhanced Primary Mental Health Care (Wellbeing) Team, crisis, inpatient, rehabilitation and specialist services.		
Summary of significant changes from previous version are:	Movement away from TTT and STT to Quadrant Adult Community Mental Health Services		

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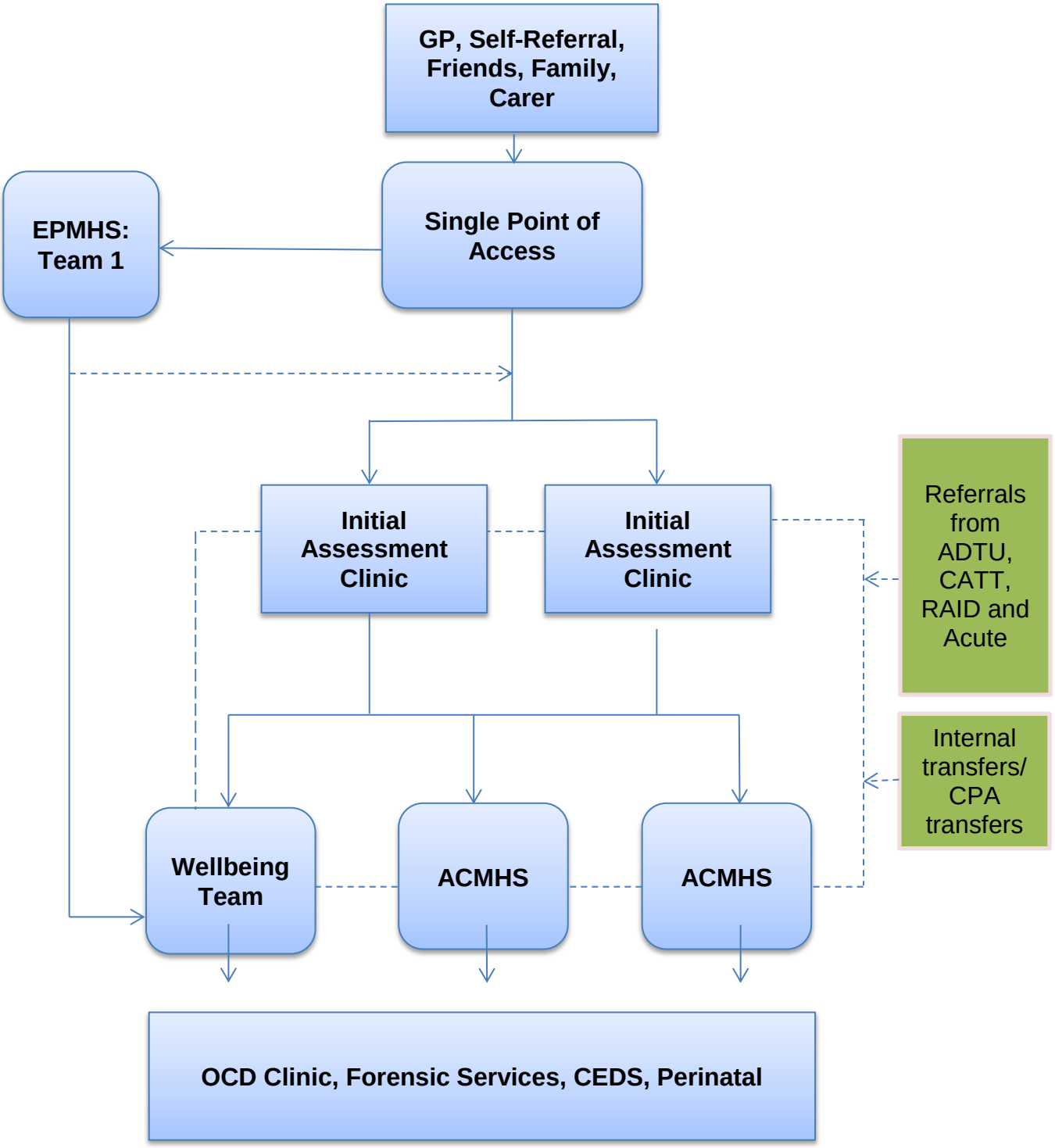
1. Service User Referral Flow Chart not sure this is useful. All referrals do not go through SPA.



N.B. Staff from the Adult Community Mental Health Service Team is allocated to undertake initial assessments within the Initial Assessment Clinics.

The Wellbeing Team will refer people with more complex disorders to the ACMHS for a full assessment and the ACMHS 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 Community Mental Health Services (ACMHS).

ACMHS form part of a planned and integrated whole system approach to care that is delivered in conjunction with Enhanced Primary Mental Health Care (Wellbeing) Team, crisis, inpatient, rehabilitation and specialist services.

ACMHS deliver recovery orientated services in line with the principles of recovery.

The Adult Community Mental Health 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. Specific pathways are currently in development.

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). The service also works with service users who are clustered at 0 – who will have ADHD or ASD diagnosis.

ACMHS are commissioned to provide diagnostic assessment for people with ADHD, ADD and ASD.

ACMHS additionally work within the NHS principles and values outlined in the NHS constitution which applies to all who work for the NHS and everyone who receives a service from the NHS.

These include

- The right to access services within maximum waiting times
- A commitment to smooth transition between services
- The right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly registered organisation that meets required standards of safety and quality
- The right to be treated with dignity and respect
- The commitment to share information including copies of letters
- The responsibility of patients to treat NHS staff with respect
- The responsibility of patients to keep appointments or cancel within a reasonable time

3. Purpose

The purpose of Adult Community Mental Health 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 Adult Community Mental Health 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 user's 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

ACMHS	Adult Community Mental Health Services
CATT	-Crisis Assessment Treatment Team
FACT	- Flexible Assertive Community Treatment
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, Interface and Discharge
AMHP	– Approved Mental Health Professional
PBR	– Payment by Results
AMH	– Adult Mental Health
SMHTOP	-Specialist Mental Health Team for Older People
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
PATH	**-** Psychosis, Prevention, Assessment and Treatment in Hertfordshire Team
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 Executive Director of Service Delivery and Customer Experience 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 their Managing Director.

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.

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

All staff in these services should take responsibility for familiarising themselves with the policy.

Link to the Care Act 2014 for primary legislation:

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

PART 2 What needs to be done and who by

6. Adult Community Mental Health Services (ACMHS) Teams

ACMHS Staff

The ACMHS core team unites specialist medical, nursing, social work, occupational therapy, psychological therapy, are psychotherapy, drama therapy, psychology, support workers and administrative staff within the service reporting to a single management structure.

Each ACMHS has a team leader who reports to a Community Mental Health Service Manager who is responsible for the quality of the service provided. The Team Leader is responsible for the oversight of day to day delivery of services by the ACMHS team. Each quadrant has Clinical Nurse Specialist and Senior Social Worker roles that are responsible for the line management and professional leadership of nursing and social work staff.

Each ACMHS Quadrant has at least one identified Lead Consultant Psychiatrist known as the medical lead.

Consultant psychiatrists provide medical leadership within the ACMHS, and they and their junior doctors carry out medical assessments, diagnosis and medical treatments within the teams. The skills, knowledge and experience of Consultant Psychiatrists will be used to best effect by concentrating on service users with the most complex needs, acting as a consultant to multi-disciplinary teams and promoting distributed responsibility.

The ACMHS Manager is line managed by Community Service Line Leads who report into Strategic Business Unit Management groups.

ACMHS also have other specialist staff such as psychologists, psychological therapists, Arts therapists and vocational support.

7. Team Locations and Opening Hours

The core operating hours are from 09:00- 17:15, Monday- Thursday and 09:00-16:30 on Fridays.

8. Service User Profile

The service is provided to adults aged 18+.

The ACMHS provides services to those in Payment by Results clusters 5-17 and 0.

Service users will be 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.

Service users will be in the cluster range 10-17 with conditions associated with Psychosis.

https://improvement.nhs.uk/documents/599/Annex_C_-_Mental_Health_Clustering_bookletl.pdf

Service users in clusters 1-4 will be treated by the Wellbeing Teams or within Primary Care

Eligibility for Service

Service users with organic conditions associated with ageing are not eligible for this service. They should be referred to Specialist Mental Health Team for Older People (SMHTOP) service.

Service users with an acquired brain injury or memory difficulties associated with substance misuse are not eligible for this service. Referral should be made to the Adult Disability Service in Hertfordshire County Council (HCC).

Those who have drug and/or alcohol issues as well as serious mental health issues are eligible for a service when they fall within the relevant clusters. Services will be provided in conjunction with Specialist Drug and Alcohol Services – click here for the policy

Service users experiencing a first episode of psychosis will be referred direct to the PATH service.

Individuals identified as experiencing severe anger management problems with no mental health problem are not eligible for this service.

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

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

District of Residence

The District of Residence of any person is sometimes difficult to determine. The guidelines below seek to address the issue and clarify lead responsibility for ensuring any dispute is resolved. The term 'district' refers to the Local Authority District Councils of Hertfordshire.

During any period of time whilst a dispute is being resolved the ACMHS that has received the referral must ensure the service user is offered an appropriate service and care is taken that the issue of the District of Residence does not delay any required treatment.

If a person is a resident of Hertfordshire, with home address in Hertfordshire, the District of Residence is normally determined by the GP practice where the person is registered. This rule however does not always apply. Many people, particularly on the boundaries of Hertfordshire, are living in a post code address which is in a different ACMHS area to the GP practice where they are registered. When this is the case the service user post code will usually determine the appropriate ACMHS to offer a service. This will be the ACMHS local to the area in which the service user is living.

HPFT will provide mental health treatment for all persons registered with a Hertfordshire GP (regardless of address) except in areas where there is an explicit agreement for such services to be commissioned by another provider.

Social care services will be provided to all residents of Hertfordshire regardless of the GP surgery with which they are registered. When a person is residing in a neighbouring County, social care services will be provided by the County in which they reside.

People of no fixed abode who are not registered with any GP practice become the responsibility of the ACMHS in the local area providing the initial emergency care. It follows therefore that if the person assessed has to be transferred to an out of area contracted secure bed that person remains the responsibility of the Hertfordshire ACMHS where the most recent mental health assessment took place.

When a service user who is open to a ACMHS in one district moves house to a new district, transfer of care should happen within the Trust Transfer Policy expectations. Service users will be encouraged to register with a GP local to their new address but this should not be a barrier to using their local ACMHS services.

If a patient is being placed/discharged into HPFT catchment area but the patient was detained under Section 3 of the Mental Health Act after April 2016 then the admission responsibility remains with the NHS Trust who has S117 responsibility.

If a service is not immediately available in the service users district of residence then they can be offered the service in another e.g. psychological or art therapy groups

9. Access to healthcare for people with a Learning Disability

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 Community Mental Health 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

External referrals:

All external referrals from GPs, including via the primary care resource, will be sent to the Single Point of Access (SPA). SPA will additionally accept self-referrals providing the service user meets the required suitability for accessing HPFT services.

SPA will triage referrals for suitability. ACMHS will make available initial assessment slots according to the capacity of the ACMHS team to provide this service. If a referral is triaged for a full secondary mental health assessment, SPA will book the referral in to a face to face assessment within the initial assessment clinic.

If there are a greater number of referrals than Initial Assessment (IA) slots, SPA will email the Duty Email of the ACMHS to highlight the referral and that there are no available appointments within the routine waiting time of 28 days.

The ACMHS will review resources and take responsibility for the onward appointment booking. This may involve further triage of the referred case to determine next steps. SPA will not book referrals into breach appointments.

An assessment booked into a slot over 28 days from the date of referral is a ‘breach’ of the requirement to offer initial assessment within 28 days.

Internal referrals that require an initial assessment:

Internal referrals that may require a full initial assessment by ACMHS are those referrals that have not been taken on by another Trust team. This would include RAID, Street Triage, and Wellbeing. These referrals will be ‘passed on’ with full completion of the referral page on

PARIS, email to the Team Duty email, and discussion with team duty manager on the closest team working day to referral. The ACMHS will take responsibility to book an initial assessment within routine waiting time. Social care outcomes screening must take place at the initial assessment.

There is separate guidance for the transition of CAMHS service users to ACMHS.

Referrals from the Wellbeing Team will be internal referrals that may require an initial assessment 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'.

It is agreed that the common principles for managing step ups should be via the duty inbox and Wellbeing will keep the person open until the step up has been confirmed. It is also agreed that where and when possible a telephone call between the ACMHS team and Wellbeing to discuss the step up should take place.

Examples are; some teams confirm that the step up has been accepted and some don't and some teams ask for step ups via the duty inbox and others prefer it to go to team leaders for decision making.

Internal referrals can be taken based on trusted assessment:

Internal referrals that do not always required a fresh initial assessment can be made by any Trust team who has already been working with the referred service user and has identified the needs of the service user can be more appropriately met by the ACMHS. These referrals will be passed on with full referral page completion. The ACMHS will triage the referral information within two weeks of receipt and provide feedback to the referrer. The referring team will retain responsibility during this period. The ACMHS will confirm the case has been taken on to the referrer. A further initial assessment may be deemed necessary by the ACMHS to confirm treatment needs. This will be completed within the routine 28 day waiting time from date of internal referral if required.

Where there has been a period of treatment within the acute pathway there will be a handover with a CPA transfer to the ACMHS with an up to date needs assessment and discharge summary provided by the Acute Service.

Where there has been a period of treatment within the Wellbeing Service, refer to the Wellbeing Service Operational Policy for step up/step down process.

Referrals from the Child and Adolescent Mental Health Service (CAMHS) will be managed within the CAMHS Transition Protocol - Click Here

External referrals from other Mental Health Providers outside of Hertfordshire will only be accepted following CPA Transfer process.

11. Assessment Procedures

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

Urgent assessments will be completed within 24 hours.

Three month re-referral

If SPA receive a referral that has been discharged within the previous three months, this will be passed on to the team with full completion of the referral document to the treatment team, and email to the team duty email to notify the team of the re-referral. The team will triage the referral to determine if the re-referral is appropriate for the team to take on. If so, the team will confirm access to services without requirement of an initial assessment. If the referral is not appropriate for the team, the referral will be discharged, with signposting identified, with a letter to the service user and GP.

Urgent referrals

SPA will contact the duty manager, who will allocate a worker to undertake the emergency initial assessment.

Outcome of assessment

Refer to the Initial Assessment Did Not Attend Standard Operating Procedure (click here)

Each ACMHS will provide a post assessment review within the multidisciplinary team to provide oversight to the outcome decision of initial assessment.

Duty Service

A duty service will operate from 0900 to 1715 Monday to Thursday (0900 to 1630 Friday) to manage physical "drop in" presentation at hubs, support to service users and carers when named contacts are not available, 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 crisis from the Mental Health Helpline and CATT.

The ACMHS will have an identified Duty Manager / Senior Duty Worker each day who will be responsible for ensuring management support to the duty service of the team.

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 to determine eligible social care needs (Care Act, 2014).

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

- the initial care plan
- the indicated immediate risks
- Care Level
- HONoS including PbR Cluster

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

- 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 Delivery of Care Policy and Recovery Care Pathway documents. Confirmation of the service users address and preferred method of contact should be ascertained at this time.

Once assessed, when service demand outstrips capacity, allocation categories will be used and overseen by the Quadrant Management Team and Service Line Lead to identify care coordination needs. If it is not possible to allocate to Acute Pathway referrals this will be escalated to the Service Line Lead, for review with the Managing Director.

12. Treatment Pathways

The post assessment meeting will confirm the initial care plan for a service user.

If the service user has not been assessed with needs that will be met by the ACMHS, they will be discharged with signposting to the appropriate service. Discharge correspondence to the service user and their GP will be completed.

If the service user is assessed with needs that will be met by the ACMHS, this will be within one or more of the following options in line with their Cluster group

- Outpatient review
- Psychological therapy referral
- Arts Therapies referral
- Occupational Therapy
- Social Care Outcomes Assessment
- Allocation of a social worker, CPN, or Occupational Therapist for those with the most complex needs. This worker will be the named care coordinator for these cases, and will take the priority cases for the team.
- Support Worker intervention
- Placement provision
- Some teams are offering a mini team low intensity treatment service via nurse-led clinics.

Specific pathways are currently being developed. All service users will be provided with information about how they contact the service if their needs change and they require a change to their care plan.

Care Co-ordination for CPA

Care Co-ordination for CPA will be provided in line with the Trust Delivery of Care Policy. Where alternatives to a named care co-ordinator provide appropriate support, such as a funded placement, a named care co-ordinator will not always be allocated. ACMHS Managers will maintain oversight of the allocation categories and staff caseloads to ensure the most complex cases are prioritised for allocation. If a priority case cannot be allocated due to capacity this will be escalated to the service line lead.

ACMHS will work with service users under both CPA and Standard care.

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 Mental Health Services will arrange transfer to the relevant local team. See HPFT Transfer and Discharge Policy (July 2015). 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 Delivery of Care 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 to Flexible Assertive Community Treatment. This process is described in section 15.4.3.below.

When a service user is discharged from the Trust, a discharge letter will be sent to the GP and service user, which 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.

Should a service user refuse to engage with the Adult Community Mental Health 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.

All discharges/transfers will include the following:

- The reason for discharge and/or transfer.
- The service user's status and condition at discharge and/or transfer.
- A written final evaluation summary of the service user's progress towards identified treatment/care goals as appropriate.
- A detailed statement and care plan as appropriate for action after discharge/follow-up.

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

14. Team Meetings

- Weekly Multi-Disciplinary team meetings to offer an opportunity to consider and discuss clinical issues such as treatment outcomes, practice issues and new developments
- Monthly Business and Governance
- Community Governance and Patient Safety – to be attended by ACMHS Manager to feed into the team Business and Governance Agendas

15.1 General Points

The service will deliver a range of interventions to assist the service user to recover from ill-health and maintain stability.
Mental Health Act: Refer to relevant policy

15.2 Medicines Management

Each ACMHS has a named pharmacist from the HPFT Community Pharmacy team who visits the unit monthly. The visit may include:

- Carrying out Safe and Secure Handling of Medicines (SSHM) Audits
- Clinical screening of Depot/LAI Charts and Clozapine Charts (if available)
- Supporting staff and training

Your pharmacist will act as a point of call for Medicines Information queries and advice

Pharmacy Information Folders within each Adult Community Mental Health Service base should be available within Clinic rooms and should be regularly updated when advised by Pharmacy.

These contain:

- Key pharmacy service information
- Key medicines related policies
- How to access the HPFT Pharmacy webpage
- Fridge and room temperature monitoring sheets
- Useful online resources with regards to medicines and treatments in mental health
- Polarspeed SOP
- Depot SOP
- FP10 SOP
- Expiry date checking SOP
- Pharmaceutical waste disposal SOP
- Quarterly medication incident report
- Annual safe & secure handling of medicines audit

The majority of medicines within the Community Teams will be manged within the Depot and Clozapine Clinics; local SOPs should be used where available. The FACT and PATH teams may also be involved in prescribing, administering and handling medication. All adult CMHTs should have a Local SOP for medicines following the guidance from within the Trusts' Medicines Policy.

For additional information please refer to trust Policies listed below:

- Medicines Policy
- The Role of Unregistered Members of Staff in the Administration of Medicines Policy
- Clozapine Policy
- Long Acting Injection Nurse Led Clinic SOP CD policy
- Monitoring and Recording of Clinic Rooms and Refrigerator Temperatures Policy
- Expiry date checking

15.3 Care Plans

Service users with the most complex needs will be cared for under the Care Programme Approach (CPA) and will work in partnership to develop their care plan as a Wellbeing Plan.

The Wellbeing Plan will be personalised to focus on the person's own goals and what specific care, support, and treatment they will need to help them achieve them. It will encourage participation by keeping planning stages accessible and getting rid of barriers to involvement. The personalised approach to managing risk and crisis will focus on self-management and independence.

Service users with less complex needs will be cared for on a standard care level and will usually receive their standard care careplan within a letter such as an outpatient letter.

15.4 Managing Risk

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 CPA Review as a minimum, and always when risk information changes. For those service users on Standard care the risk assessment should be reviewed as and when risk information changes or as a minimum annually.

This will be recorded along with an up to date care plan to mitigate those risks as well as a contingency plan to manage crisis situations. Service users who present frequently in crisis across the health and social care system will be encouraged to complete an additional 'my emergency plan'. Click here.

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).

The needs of any children in the family must be considered. Children's welfare and safety is paramount and it is the responsibility of all staff to ensure they identify and respond to concerns. The child need screening tool should be completed in the risk assessment when service users are in contact with children. Where concerns have been identified a written referral to Children, Schools and Families must be made, in accordance with the Safeguarding Children Policy & Procedures (May 2018). 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.

ACMHS are Safeguarding Adults Investigating Teams. Where adult abuse is occurring or believed to be occurring then staff must pass their concerns on to an investigating manager within the team. 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 (August 2018) 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. Pages - Safeguarding

HPFT have statutory duties to support Carers, and to discuss with them their aspirations around education, leisure and work, as well as helping them to see a life beyond caring should they so desire. This is further reinforced through the Triangle of Care – and approved model for working with carers within mental health settings through the following six standards:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2. Staff are 'carer aware' and trained in carer engagement strategies.
3. Policy and practice protocols re: confidentiality and sharing information are in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff is available, with a relevant range of information across them care pathway.
6. A range of carer support services is available.

It is important to identify as soon as possible anyone who has an input to caring (standard 1 of triangle of care). This should be free of judgement about the level or amount of carer input they are providing. Our duty of care as an NHS organisation requires us to be responsive and supportive of the needs of carers and anyone supporting (however little) someone using HPFT services should be assumed to have a caring role (standards 2 & 5 of triangle of care). click here

Carers have a statutory right to support where an individual provides or intends to provide care for another adult. Under the Care Act 2014, the Local Authority (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. In addition, under the Act, Carers are eligible for Safeguarding in their own right when they are at risk of abuse from the person they care for. Refer to the HPFT Safeguarding Adults from Abuse Policy.

Carers are entitled to help in their own right as carers so that they can carry on in that role. 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.

15.5 Autistic Spectrum Disorder

The ACMHS provides a diagnostic service for the assessment of adults of working age with suspected Autism Spectrum Disorders (ASD).

Assessments of ASD are available to those individuals who are referred with a significant indication that a diagnostic assessment is indicated
ACMHS are commissioned to provide a treatment service for ASD, if they have a mental health problem that requires the input of the ACMHS and of any mental health problems diagnosed alongside ASD. 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. Evidence base is not the only criteria for psychological treatment as a full assessment and discussion will take place the service user and will include service user choice where possible.

The ACMHS will complete the initial social care outcomes assessment. If the service user with ASD is eligible, the ACMHS will put in place an initial package of care, which will then be passed to the Adult Disability Service in HCC for onward provision.

15.6 Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD)

Referrals for service users Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD) will also receive assessment and treatment where required. Prescribing for this service user group will be undertaken by the ACMHS. ACMHS will work in line with agreed Shared Care Guidelines (click here)

If a service user with ADHD or ADD has co-morbid mental health issues these will be assessed in line with service eligibility across Wellbeing and AMHS services.

16. Flexible Assertive Community Treatment.

The ACMHS in each quadrant provides enhanced input to service users who are becoming increasingly vulnerable because of their complex needs and are disengaging from services, despite continued symptoms of serious mental illness. Each ACMHS will contribute staffing resource to the provision of this service. This will provide more intensive contact over a 7 day period which can include daily visits.

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 general care in the ACMHS.

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.

17. Psychological Services

Psychological Services are fully embedded within the ACMHS and delivered according to the Care Pathways. 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. Awaiting for Psychology category will be applied on the EPR.

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.

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

	Permanent Staff	Temporary Staff	Student/ Learners
Induction to Service	Local Induction on 1st day and attendance at Trust Induction. Team Leader will ensure registration with PARIS (provision of secure login)	Local Induction on 1st day	Local Induction on 1st day
Supervision Arrangements	Monthly	Monthly	As required by training placement
Appraisal	Annual	Annual	Annual
Training	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 & Development Team: Learning@hpft.nhs.uk	Mandatory training	Any training to support student in job role

19. 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 (click here for policy).

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, The Colonnades, Beaconsfield Road, Hatfield, AL10 8YE. 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].

20. 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 Accessible Information Policy provides further information and the procedure for the interpreting service (click here for policy).

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.

21. 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.

22. Practice Governance

The Quality and Risk Management Committee for each Strategic Business Unit which provides Adult Community Mental Health 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 and following discussion and agreement, ACMHS may escalate risks to the Strategic Business Unit Risk Register.

The local Quadrant Practice Governance meetings will report to the Countywide Adult Community Practice Governance and Patient Safety meeting which in turn will report into the SBU Quality and Risk Management Committee.

The SBU Practice Governance Team will maintain and support this framework for quality monitoring and improvement, working closely with Service Line Leads.

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

23. 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.

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.

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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.

Service user, carer and/or staff access needs (including disability)	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.
Involvement	Adult Community Services will actively involve service users and carers in planning and delivering recovery-focused mental health services
Relationships & Sexual Orientation	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.
Culture & Ethnicity	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. 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.

24. Process for monitoring compliance with this document

Action:	Lead	Method	Frequency	Report to:
Audit to monitor compliance with this document	Practice Governance Lead	Audit aspects of the policy against documented practice	At least one complete audit cycle within the review period of the policy	PAIG /SBU Quality and Risk Meeting
One to one supervision	SLLs	SLLs will ensure that their team managers and clinical leads provide	As stated in Supervision policy	MD

		supervision in accordance with the Supervision policy which includes monitoring of policy compliance		

PART 3 – Associated Issues

25. Version Control

Version	Date of Issue	Author	Status	Comment
V1	1st July 2014	Service Line Leader, Community Transformation	Superseded	This policy will replace the existing Community Mental Health Policy, Community Personality Disorder, Assertive Outreach Operational Policy and Early Intervention in Psychosis Policy.
V1.1	September 2014	Service Line Leader, Community Transformation	Superseded	Updated by Deputy Service Line Lead EPMHS Herts to include 8.1
V1.2	1st May 2015	Service Line Leader, Community Transformation	Superseded	Updated in various ways to reflect current practice, in conjunction with MD and SLLs and Care Act 2014
V2	27th July 2015	Service Line Leader, Community Transformation	Superseded	Full review
V2.1	4th July 2016	Compliance and Risk Manager	Superseded	Included OT in teams listed
V2.2	September 2016	Compliance and Risk Manager	Superseded	Addition of an Initial Assessment DNA process following learning from incident W57230
V3	27th February 2019	Practice Governance Lead	Current	Full review & movement away from TTT and STT to Quadrant Adult Community Mental Health Services
V3.1	29TH March 2019	Practice Governance Lead	Current	Amendments to appendicies

26. Archiving Arrangements

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.

27. Associated Documents

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

- Delivery of Care Policy
- Carers' Assessment Practice Guidance.
- Clinical Risk Assessment and Management: Policy and Procedures Physical Healthcare policy.
- Safeguarding Children Policy.
- Safeguarding Adults from Abuse Policy.
- Transfer and Discharge Policy.
- Did Not Attend (DNA) Policy.
- Standard Operating Procedure for DNA Initial Assessment Adult Mental Health Services

28. Supporting References

Department of Health, (March 2008) Refocusing the Care Programme Approach
www.dh.gov.uk/publications
The CPA and Care Standards Handbook, The Care Programme Approach Association, 2008.

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

Managing Director SBU East and North & West	Head of Operational HR
Clinical Director SBU East and North & West	Head of Nursing and Patient Safety
Service Line Leads – Community Services	Practice Governance Lead SBU East and North
Quality & Standards Facilitator	Clinical Director CSR
PACE Manager	Head of Psychological Therapies and Recovery
Equalities Manager	Head of Social Work and Safeguarding
Deputy Service Line Leads	Head of Allied Health Professionals
Heads of Professions	Executive Director for Quality and Safety Chief Operating Officer Medical Director

APPENDICES

Appendices	Page
Appendix 1 - Flexible Assertive Community Treatment **Appendix 2** - Pathways **Appendix 3** - Payment By Results Cluster **Appendix 4** - Protocol for Allocation - Initial Assessment Process **Appendix 5** - Community Eating Disorder Pathway	

Flexible Assertive Community Treatment

1. Statement of intent

This clinical model will describe the way the Adult Community Mental Health Service 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

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 -The patient pathway.

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 ACMHS Team providing clinical care in these localities.

Clinical care pathway:

Referrals to the flexible assertive community treatment will be made directly to the team leader of the ACMHS 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 ACMHS 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 Adult Community Mental Health Service 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. The principle Psychiatrist for the ACMHS 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 ACMHS 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

Refer to CATT
OR
Host Family
OR
ADTU

NO

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

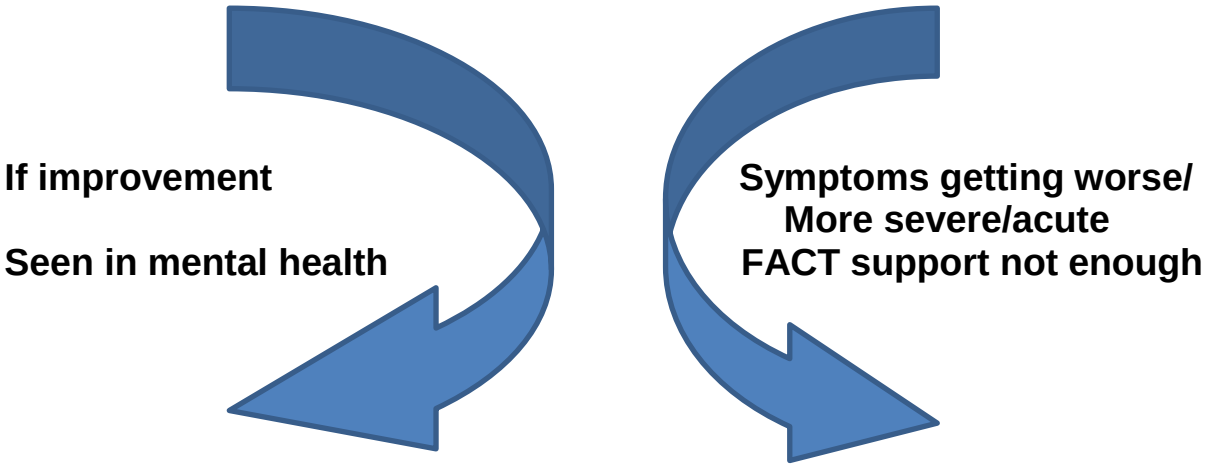
If service user does not meet outline criteria then they will not be eligible for FACT

Not eligible

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)



Discharge back to Care Co-ordinator

OR

Adult Community Mental Health

Joint assessment with CATT

And

Refer to previous FLOW CHART

Step down to ACMHS 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.

Pathway Reference Sheet

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

Introduction to the Pathway

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

OUTCOMES

Service user

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

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

Pathway Reference Sheet: Adult B

Needs related to non-psychotic disorders that are very severe & complex

Expected time on pathway: 6 months - 3years* Care Cluster 7and 8

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

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. PARIS

when appropriate also…

- Allocate Care Coordinator. PARIS
- Score HONOS & Allocated Pathway & Care Cluster. PARIS

• Give information about diagnosis & treatment choices.
• Identify family/carers & offer carers handbook & assessment. PARIS

With all who are being offered care…

- Discus and give Health &Wellbeing plans
- Deliver care & record treatment start event. PARIS

With all who are being reviewed…

•Review Needs, Risk, Care Plan, Clustering & Pathway. PARIS
•Identify any new family/carers & offer (reoffer) carers assessment.

- Construct New Care Plan including expected review and completion dates & offering information about anything new. PARIS

With all who are being discharged:

- Complete Discharge letter PARIS
- Honos & Give Having Your Say form PARIS

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

Re formulate care plan

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 - 3years Care Cluster 11,12,13 & 15

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.

Outcome Measures	Wellness and Recovery goals as identified in the care plan & Health and Wellbeing Plan Honos
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)

Included	**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.
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 • Individuals where these symptoms are occurring for the first time. • The needs of people with primary diagnosis of F00-03 dementias.

The Pathway

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. PARIS

when appropriate also…
- Allocate Care Coordinator. PARIS
- Score HONOS & Allocated Pathway & Care Cluster. PARIS

• Give information about diagnosis & treatment choices.
• Identify family/carers & offer carers handbook & assessment. PARIS
- Construct Care Plan from identified needs (inc expected review and completion dates). PARIS

With all who are being offered care…
- Discus and give Careplans
- Deliver care & record treatment start event. PARIS

With all who are being reviewed…
•Review Needs, Risk, Care Plan, Clustering & Pathway. PARIS

•Identify any new family/carers & offer (reoffer) carers assessment.
- Construct New Care Plan including expected review and completion dates & offering information about anything new. PARIS PARIS
- Give Having Your Say form.

With all who are being discharged:
Complete Discharge letter. PARIS
- Honos & Give Having Your Say form PARIS
- Agree Transition Supports
- Close notes. PARIS

Re formulate care plan

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: 3years + Care Cluster 16 & 17

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.

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.
In addition they may

- have enduring symptoms with unstable or chaotic lifestyles

have significant forensic needs

- 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.
- Psychosis and effective disorder/difficult to engage

Outcome Measures

n Goals as identified in the care plan
Having your Say
Honos

Likely Primary Diagnosis

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

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. PARIS

when appropriate also…

- Allocate Care Coordinator. PARIS
- Score HONOS & Allocated Pathway & Care Cluster. PARIS

• Give information about diagnosis & treatment choices.
• Identify family/carers & offer carers handbook & assessment. PARIS

- Construct Care Plan from identified needs (inc expected review and completion dates). PARIS

With all who are being offered care…

- Discus and give Care plans
- Deliver care & record treatment start event. PARIS

With all who are being reviewed…

•Review Needs, Risk, Care Plan, Clustering & Pathway. PARIS
•Identify any new family/carers & offer (reoffer) carers assessment.

- Construct New Care Plan including expected review and completion dates & offering information about anything new. PARIS

With all who are being discharged:

- Complete Discharge letter. PARIS
- Honos & Give Having Your Say form PARIS
- Agree Transition Supports

Re formulate care plan

Transition from other pathway

Transfer from other service
Handover booked

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)

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.

Appendix 4

Protocol for Adult Mental Health Service Allocation Categories

The Trust Delivery of Care Policy describes the framework of care delivery in the Trust to deliver safe and effective care in partnership with those who use Trust Services.

The Trust has two levels of care for Adult Mental Health Service Users. These are CPA and Standard Care. Trust Policy states Service Users on CPA will have a named care coordinator and Service Users on Standard Care will have a named practitioner.

Adult Mental Health Services aim to prioritise the allocation of named care coordinators and named practitioners to those service users who most need the involvement of active qualified professionals offering regular visits in the community.

Allocation of a named care coordinator or allocation category will take place within 10 working days of initial assessment and/or transfer screening.

Adult Mental Health Services have introduced named categories for service users who are not prioritised immediately for allocation of an individual named staff member.

This protocol describes the management of care for the named categories to support safe and effective care.

The team leader is responsible for checking the Allocation Category report on the Trust Performance system (SPIKE) on a weekly basis to provide assurance that the management of care for each category is maintained. Medical and Psychology clinicians should be involved in this weekly review when available.

If a support worker is providing interim contact for a CPA level case, the support worker should be provided with supervision every two weeks.

Team Allocation Categories:

Category	Category Definition	Management of care for this category
Allocation – Request Care Coordinator, Acute Pathway	This category is used for all requests for allocation from Adult Acute Inpatient Services, ADTU and CATT.	Referrals for allocation from Acute Services have priority for allocation. If a team is not able to allocate to this priority, this must be escalated to the Service Line Lead for review. A team member will attend a discharge planning CPA with the Acute Pathway team to gather more information to inform allocation and anticipated care and

		support needs in the community. A casenote is entered to confirm how contact with the service user is maintained. If there is no other worker involved with the service user, a duty worker or support worker in the team makes telephone contact with the service user in line with the agreed frequency set at the discharge planning CPA meeting. A casenote is entered following each contact, and any concerns are escalated to the Team Duty manager for review.
Allocation – Request Care Coordinator, Staff member has left Allocation – Request CC, Other	This category is used when a staff member is leaving, or the allocation of the case has changed for another reason (Other), and a replacement staff member is not yet available. The staff member who is leaving should provide a detailed case handover for each case to inform priority for allocation. All cases that require continued care and support in Adult Mental Health Services will be allocated to this category.	At case handover to this allocation category the frequency of current contact is confirmed. A casenote is entered to confirm how contact with the service user is maintained. If there is no other worker involved with the service user, a duty worker or support worker in the team makes telephone contact with the service user in line with the agreed frequency set at the case handover. A casenote is entered following each contact, and any concerns are escalated to the Team Duty manager for review.
Allocation – Request Care Coordinator, Following IA	This category is used for new referrals to AMHS who have been assessed as requiring an	The Post Assessment Meeting will confirm the care level, and care and support needs.

	allocated care coordinator under CPA or named practitioner.	A casenote is entered to confirm how contact with the service user is maintained. If there is no other worker involved with the service user, a duty worker or support worker in the team makes telephone contact with the service user in line with the agreed frequency set at the post assessment meeting. A casenote is entered following each contact, and any concerns are escalated to the Team Duty manager for review.
Allocation - In Placement	This category is used for service users who are in placement and do not require an allocated named care coordinator or named practitioner, as the placement is meeting the care and support needs of the service user.	The service user, their family and the placement will be advised of the team duty system details to contact if they have questions or concerns about care and support. Regular reviews will be undertaken with the placement. As a minimum these will occur annually. Some placements with multiple Trust Service users will have a placement link worker allocated to the placement, who will also provide additional contact.
Allocation - Stable on depot/clozapine	This category will be used for service users who are on standard care only and who are on Cluster 11. Cluster 11: This group has a history of psychotic symptoms that	The service user and their family will be advised of the team duty system details to contact if they have questions or concerns about care and support. A casenote will be

	are currently controlled and causing minor problems if any at all. They are currently experiencing a sustained 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.	entered to explain why the service user care cannot be handed over to primary care. Contact will be maintained in depot/clozapine clinic. The clinic practitioner will enter a casenote following contact, and escalate any concerns to the Team Duty manager.
Allocation – Group Intervention	This category will be used for service users who have been assessed as requiring a group work intervention and are allocated to a group which is running.	The service user and their family will be advised of the team duty system details to contact if they have questions or concerns about care and support. Contact will be maintained in the group intervention. The group practitioner will enter a casenote following contact, and escalate any concerns to the Team Duty manager.
Allocation – Low intensity treatment team (LITT)	This category will be used by teams piloting a LITT which is allocation to a team. This category will be used for service users who are are on Cluster 11 or Cluster 12.	The service user and their family will be advised of the LITT details to contact if they have questions or concerns about care and support. Contact will be maintained in the LITT. The LITT practitioner will enter a casenote following contact, and escalate any concerns to the Team Duty manager.
Allocation - Support Worker Intervention	This category will be used when a support worker is involved with a service user and this provides the care and support for the service	The service user and their family will be advised of the team duty system details to contact if they have questions or concerns about care and

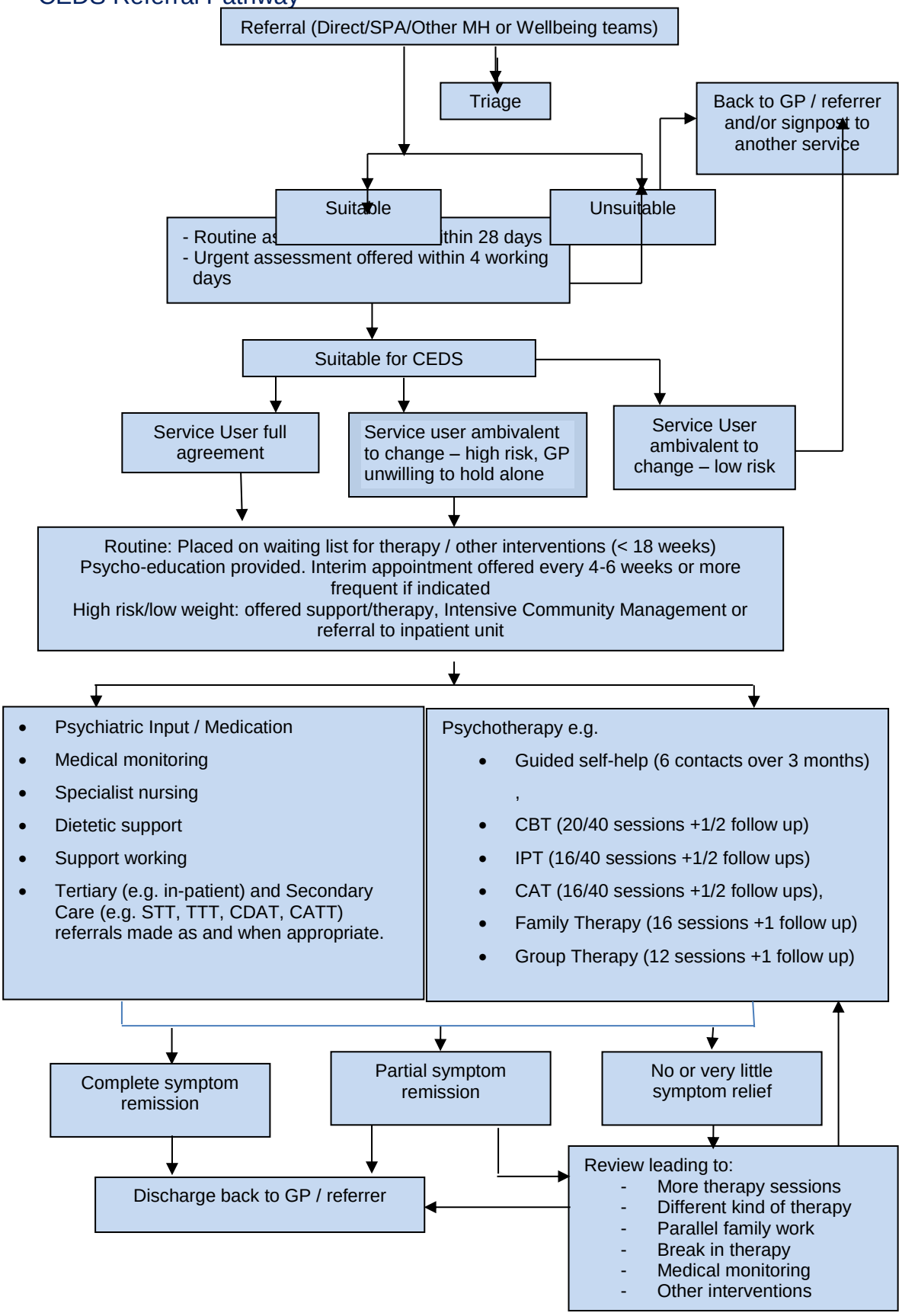
	user.	support. If a CPA service user is found to be appropriately supported with support worker intervention only for three months or more, consideration of a change of care level should be provided. A qualified worker will update a wellbeing plan (CPA) or care plan letter (standard care) for the service user as a minimum annually. This will include update of risk assessment, cluster review and consideration of carer support. The support worker will support these processes.
Allocation - Safeguarding	This category will be used when the team has investigating responsibility for a safeguarding referral and there is no other mental health care and support need.	The safeguarding process will be followed for the case with the investigating manager ensuring this is completed.
Allocation – External Transfer Request	This category will be used when the team has accepted a handover of care from another Trust or care provider.	At case handover to this allocation category the frequency of current contact is confirmed. A casenote is entered to confirm how contact with the service user is maintained. If there is no other worker involved with the service user, a duty worker or support worker in the team makes telephone contact with the service user in line with the frequency agreed at case handover A casenote is entered

		following each contact, and any concerns are escalated to the Team Duty manager for review.
Awaiting Allocation – For SOA	This category will be used when the team has identified at initial assessment that a full social care outcomes assessment is required and there is no other mental health care and support need.	The service user and their family will be advised of the team duty system details to contact if they have questions or concerns about care and support. The team leader will allocate a member of staff to complete the SOA within 18 weeks of referral.
Awaiting Allocation - Personal Budget only	This category will be used when the team has identified in a social care outcomes assessment that a continued personal budget is required, and there is no other mental health care and support needs that require the team intervention.	The service user and their family will be advised of the team duty system details to contact if they have questions or concerns about care and support. The team leader will allocate a member of staff to complete an annual review of SOA and Personal Budget.
Psychiatrist awaiting	This category will be used when the care and support needs of the service user will be met with follow up with a psychiatrist, and the service user is waiting for their first appointment.	A casenote is entered to confirm how contact with the service user is maintained. This will include a risk assessment of any need for contact within the waiting time until first appointment. If interim contact is required, a duty worker or support worker in the team makes telephone contact with the service user in line with the agreed frequency. A casenote is entered following each contact, and any concerns are

		escalated to the Team Duty manager for review.
Psychologist awaiting	This category will be used when the care and support needs of the service user will be met with follow up with a psychologist, psychological therapist, or psychological therapy group, and the service user is deciding if they want to opt-in, or waiting for their psychology assessment/service.	A casenote is entered to confirm how contact with the service user is maintained. This will include a risk assessment of any need for contact within the waiting time during the psychology opt-in period. If interim contact is required, a duty worker or support worker in the team makes telephone contact with the service user in line with the agreed frequency. A casenote is entered following each contact, and any concerns are escalated to the Team Duty manager for review.
No Care Coordinator	This category is automatically applied when no allocation category has been entered.	The team leader will review the allocation report each week, and ensure allocation categories are entered to clarify the follow up for each service user.

Appendix 5

CEDS Referral Pathway



Our Values

we are...	you feel...
Welcoming	Valued as an individual
Kind	Cared for
Positive	Supported and included
Respectful	Listened to and heard
Professional	Safe and confident

Our Values

Welcoming Kind Positive Respectful Professional