Kent and Medway
NHS and Social Care Partnership Trust

Community Mental Health Services for Older People (CMHSOP) Operational Policy

Document Reference No.	KMPT.CliG.144.05
Replacing document	KMPT.CliG.144.04
Target audience	All KMPT services and external partners
Author	CMHSOP Senior Management Team
Group responsible for developing document	Older Adult Senior Management Team
Status	Authorised
Authorised/Ratified By	Clinical Effectiveness and Outcomes Group (CEOG)
Authorised/Ratified On	March 2022
Date of Implementation	April 2022
Review Date	November 2022
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	May 2022
Number of Pages	26
Contact Point for Queries	kmpt.policies@nhs.net
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DOCUMENT TRACKING SHEET

Community Mental Health Services for Older People (CMHSOP) Operational Policy

Version	Status	Date	Issued to/Approved by	Comments
0.1	Approved	01//4/15	Jon Parsons	Previously approved version
0.2	Draft	28/10/16	Older Adult Task and Finish Group	
1.0	Approved	20/12/16	Older Adult Service Line quality meeting	Ratified
1.1	Draft	11/05/18	Older Adult Task and Finish Group	Shared existing for comment
1.2	Draft	09/07/18	First draft out for consultation	
1.3	Draft	18/09/18	Quality DTM	No further comment.
2.0	Final	January 2020	Clinical Effectiveness and Outcomes Group (CEOG)	Approved
2.0	Final	July 2020	Medical Director	Ratified for publication after issue regarding uploading MAS Documentation onto RiO was resolved.
2.1	DRAFT	January 2021	CEOG	Updated SOP to reflect practice in the pandemic, and clear RiO reporting requirements
3.0	Final	January 2021	CEOG	Ratified
3.1	DRAFT	Sept 2021	CEOG	Full policy review based on experience of using this in practice for the last 6 months and taking into a count a wealth of ongoing clinical feedback during this period. Key changes: Referral screening form to be completed in all cases 72 LPS follow ups face to face Diagnosis entered on ICD10 and SNOMED codes on RiO Young onset dementia patients to be considered for CPA
4.0	FINAL	28/09/21	CEOG	Ratified
4.1	DRAFT	02/02/22	Sending updated draft out for consultation across the care group	Updated as per 6 monthly review agreement. Taking on board feedback and learning from the past 6 months.

				In particular: Process for caseload management in staff absence Updated triage guidance Clarity on entering diagnosis on RiO for MAS and functional patients
5.0	FINAL`	22/03/22	CEOG	Ratified

REFERENCES

Mental Health Act (1983).
Mental Capacity Act (2007)
National Service Framework (Mental Health and Older People)
Dementia Strategy (2009)
High Quality care For all (2008)
New Ways Of Working (2007)
New Horizons (2009)
Nothing Ventured, Nothing Gained (2010)
Carers Act (2015)
MH 5 year forward view NHSE 2016,
Dementia Care 5 Year Vision 2015,
Challenge on Dementia 2020: Implementation Plan 2016
National Covid guidelines 2020

RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

KMPT Supervision Policy	KMPT.CliG.045
KMPT Lone Working Policy	KMPT.CorG.024
KMPT Care Programme Approach Policy and Procedures	KMPT.CliG.001
Risk Management Policy	KMPT.CorG.112.03
Risk Management Strategy	KMPT.CorG.012.07
KMPT Training Policy	KMPT.HR.003
KMPT HoNOS Policy	KMPT.CliG.056
KMPT Single Point of Access Operational Policy	KMPT.CliG.170
KMPT & KCC Safe Guarding Vulnerable Adults Multiagency Policy	KMPT.CliG.006
KMPT Advanced Care Planning Guidelines	KMPT.CliG.133
Safeguarding Adults Policy	KMPT.CliG.006.0
Safeguarding Children and Young People	KMPT.CliG.030.05
KMPT Covid Operational Policy	COVID-19 Standard Operating Procedures (kmpt.nhs.uk)
Clinical Risk Assessment and Management of Service Users Policy	KMPT.CliG.009.07.
KMPT Did Not Attend (DNA) Policy	KMPT.CliG.014.05

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
January 2021	CMHSOP SMT		Full review of policy and additional sections and appendices included, as well as RiO reporting guidelines
Sept 2021	CMHSOP SMT		Full review of policy and additional sections and appendices included, as well as further updates to RiO reporting guidelines
Feb 2022	CMHSOP SMT		Process for caseload management in staff absence Updated triage guidance Clarity on entering diagnosis on RiO for MAS and functional patients Reference to the new Hybrid working SOP

CONTENTS

1 INTRODUCTION

1.1 Kent and Medway NHS and Social Care Partnership Trust (KMPT) provide core services to meet the specialist secondary care level mental health needs of older people with acute, serious and enduring mental health problems including people with or suspected as having dementia.

1.2 This policy relates to Older Adult Care Group (OACG) which provides specialist secondary care mental health services to older people in Kent & Medway.

1.3 This is an interim Standard Operating Policy (SOP) as we are in unprecedented times due to Covid 19 and this will reflect how the OACG will work during this time. This had been subject to review in September 2021, March 2022 and will have a further review in November 2022.

1.4 This operational policy includes RiO reporting requirements.

1.5 All contacts with patients are offered either video, telephone or face to face depending on clinical judgement, and taking into account identified risks. See Appendix N for guidance for patient contact type.

2 VALUES AND PRINCIPLES

Guiding Principles

2.1 The KMPT OACG CMHSOPs will work according to recovery oriented and personalisation values, to enable people who are experiencing mental health problems to stabilise and live independently in the community, and to optimise their physical and mental health and wellbeing.

2.2 CMHSOPs provide age appropriate services on a needs led basis. Needs led means that access to services should not be based solely on age, but on assessed needs, leading to an individual accessing the KMPT service that can best meet those needs. The expertise of older people's mental health services lies in the care and treatment of people with complex presentations of psychological, cognitive, functional, behavioural, physical and social problems, usually related to ageing.

2.3 Due to the complexity of the needs of many older people, services will be expected to work collaboratively with other agencies and stakeholders, providing integrated services where possible. These services will meet both physical and mental health care needs, promoting faster recovery from illness, preventing unnecessary hospital admissions, supporting timely discharge and maximising independent living.

2.4 The CMHSOPs offer community-based provision to adults with secondary mental health problems of sufficient severity or complexity to require specialist Older Adult intervention.

2.5 During the Covid 19 pandemic, CMHSOPs have prioritised remote contacts by video and phone. Face to face appointments have been offered based on clinical need and according to Trust guidance. As we recover from the pandemic, staff should now follow the Hybrid working SOP, which includes a minimum of 3 monthly face to face contact for all patients on the caseload, except routine MAS. All patients, including MAS patients should be consulted about the best form of contact. Sensory impairments that will affect video or telephone assessment should result in a face to face assessment for all patients, irrespective of their pathway.

2.6 Provision follows a multi-disciplinary approach that is flexible and prompt in response to individuals, and includes comprehensive assessment of mental health needs, and provision of effective, evidence-based interventions in line with our clinical care pathways. The services are accessible, non-discriminatory; respect cultural values and aim to be user friendly for Service Users, carers and their families. Our services also aim to reduce the stigma attached to mental health and dementia, and ensure that treatment and care is delivered in the least restrictive manner possible.

2.7 All Service Users have a right to confidentiality that must be maintained at all times. However, there is an assumption of disclosure on a 'need to know' basis, for example, when Serious Incidents or issues of Child Protection are under investigation or when information sharing is critical to the wellbeing or safety of an individual. It is an absolute must that agencies share information in these situations regardless of consent in line with the Data Protection Act 2018, the Caldicott Principles and as set out in DH: Information: to share or not to share.

2.8 All KMPT services use the RiO clinical recording system. All patient records are held within the system and staff are required to record all patient activity and contact in line with policy. All clinical staff should be able to access KMPT's previous electronic patient record, Epex.

3 RECOVERY AND SOCIAL INCLUSION

3.1 The principles of recovery underpin the care and interventions provided throughout the CMHSOPs. KMPT is signed up to the following principles of recovery which are consistent with the national programme and have strong service user involvement.

3.2 The broad vision of recovery involves:

- A process of changing one's orientation and behaviour from a negative focus on a troubling event, condition or circumstance to the positive restoration, rebuilding, reclaiming or taking control of one's life' (NIMHE (2004) Guiding Statement of Recovery)

3.3 Principles of recovery include:

- The primary aim in Recovery is for an individual to take control, make choices, and develop a sense of self-worth and hope.
- Recovery is a unique process because every individual is unique – it is a personal journey.
- Recovery involves a person accepting responsibility for their own wellness.
- Recovery is about engagement and inclusion, participating in one's community, engaging in employment, vocational, educational, leisure interests and enjoying life.
- Recovery requires a holistic approach that addresses an individual's psychological, social, environmental, spiritual and physical needs.

3.4 Where a person's presentation is complicated by other difficulties such as Learning Disability, sensory impairment, dual diagnosis, family, socio-environmental or cultural factors then additional support or advice may be requested and a partnership approach to care is used.

4 SERVICE DESCRIPTION

4.1 This description provides a general outline of CMHSOP services.

4.1.1 As per the contracted KMPT activity, intended users of secondary mental health services will have multiple, complex needs including a clinically diagnosable mental health problem, including dementia or suspected dementia.

4.1.2 The service provides mental health services on the basis of functional clusters 4 – 17 and organic clusters 18 – 21.

4.1.3 Within the CMHSOPs, the Memory Assessment Service provides diagnosis and/or sub-typing of dementia, and subsequent initial treatment/interventions, including post diagnostic support for people diagnosed with dementia, of any age. This does not include causes of cognitive impairment where the clinical picture is inconsistent with a query of dementia. E.g. traumatic brain injury, stroke. Whilst the service will offer an assessment for a patient that has cognitive impairment, if the assessment deems this as secondary to the brain injury or stroke, they will not be offered intervention and will be signposted to other specialist services to meet their needs.

4.1.4 CMHSOPs also provide a service to people with dementia of all ages where there is emotional disturbance (i.e. dementia and moderate to severe depression/anxiety/psychosis), severe and complex behavioural and psychological symptoms in dementia (BPSD e.g. aggression, marked agitation, marked disinhibition), or where there is significant risk to self or others.

4.1.5 The CMHSOP also provides a service to people with complex mental health needs with either physical illness or frailty which contributes to, or complicates the management of their mental health needs (exceptionally this may include people under 65), or with significant psychological or social difficulties related to the ageing process or end of life issues. This would normally include people over the age of 65.

4.1.6 People known to other KMPT services (either currently or within the last 12 months) who reach 65 years of age should not automatically be referred to the OACG on the basis of age alone. This is to ensure the person accesses the service best suited to their current needs. Transfer of care should follow the transition protocol (Appendix I).

4.2 The CMHSOP has a staff group with a comprehensive skill mix. This unites specialist Medical, Nursing, Psychology, Occupational Therapy and Administration skills within each team. The teams employ a multi-disciplinary team approach, valuing professional expertise and opinion, and working together with the service user and their carers**/**family/friends at the centre of everything we do.

4.3 Each CMHSOP has a Leadership team that usually consists of**;** Locality Manager, Consultant Psychiatrist, Psychologist, Team Leaders and Admin Co-ordinators.

4.4 CMHSOP services will usually be delivered during core hours of operation between 09:00 and 17:00, Monday to Friday with some element of service available on some of the Bank Holidays. Any deviation to usual opening hours will be in line with Business Continuity Plans.

4.5 Older people likely to meet clustering criteria can be referred to the service from any source (including direct self-referral or referral from a loved one, or third sector) and should be registered with a Kent or Medway GP. Referral reasons may include concerns regarding deterioration in the person's mental health or impairment/difficulties linked to dementia or suspected dementia.

4.6 Referrals that do not meet secondary mental health criteria will be passed back to primary care and within the communication to the referrer, alternative interventions should be identified (biological, psychological or social). This should include signposting to social services or opportunities through third sector support.

4.7 All clinical correspondence should be addressed and sent to the patient and copied to the GP.

5 SERVICE AIMS

5.1 The service aims to provide comprehensive, integrated and expert assessment of mental health functioning and dementia. This leads to individualised, person centred, effective, evidence based therapeutic interventions to reduce and shorten distress and optimise functioning. Depending on need, services provide care co-ordination as required within the framework of the Care Programme Approach (CPA). Where appropriate, services will refer on to tertiary and specialist services and work in partnership with other providers.

5.2 To provide specialist interventions and care for:

5.2.1 .Ongoing assessment, interventions and monitoring of people with severe and persistent mental health difficulties, including dementia associated with significant complexity, or characterised by poor intervention adherence requiring proactive follow-up.

5.2.2 People with a mental health difficulty with eligible needs, where there is a significant risk of self-harm or harm to others (e.g. acute depression or severe Personality Disorder).

5.2.3 Memory Assessment and Dementia Diagnosis and initial post-diagnostic support.

5.2.4 People with disorders requiring skilled or intensive interventions.

5.2.5 People requiring time limited interventions.

5.2.6 People requiring interventions under the Mental Health Act and Mental Capacity Act.

5.3 Duty

5.3.1 Duty is a system and process within the team that enables the service to respond to unexpected health needs, in a timely and knowledgeable manner and to provide an appropriate, responsive and safe outcome. Duty is available 0900 –1700hrs Mon – Fri.

5.3.2 This may include supporting the family and carers, providing advice and specialist interventions, and signposting to other services where clinically indicated.

5.3.3 Individuals who contact duty and are already open will be re-directed to their Care Co-ordinator or lead Health Care Professional (HCP) . If the Care Co-ordinator or HCP is temporarily unavailable and the call is urgent, the duty officer will respond on the Care Co-ordinator/HCP behalf and communicate this to the care co-ordinator/HCP asap.

5.3.4 For emergency new (4 hour) referrals being managed, as well as the Single Point of Access urgent (72 hour) referrals, the Duty worker will assess new patients.

5.4 The duty service does not hold a caseload or care co-ordinate.

5.5 The following actions are not duty functions;

- Duty does not hold screened cases awaiting assessment

- Duty does not hold cases when staff are on long term absence
- These cases will be re-allocated by the team leader
- Duty does not hold cases awaiting internal re-allocation
- Duty does not hold cases waiting to be allocated to a professional
- Duty does not hold cases awaiting psychology/psychotherapy

Rio Requirements:

Person open to service- as a minimum the progress note should be completed with appropriate information for the context. There may be occasions where further RiO fields are required to be completed depending on the nature of the call. For example, an updated risk assessment may be required. Outcome clinical contact in RIO diary

Person not open to service- If the query does not require a clinical response (example being a patient who's query requires signposting) there may not be a need to open a referral. A referral should be opened if there is clinical information that needs to be reflected in a progress note. If there is a clinical need for a referral it should be opened and discussed in multi-disciplinary triage. Outcome any clinical contact in the RIO diary.

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6 REFERRALS, TRANSFERS & TRIAGING IN COMMUNITY MENTAL HEALTH TEAMS FOR OLDER PEOPLE

6.1 Referrals

6.1.1 Referrals can be received in writing, electronically or verbally. However, referrers should be asked to provide an outline of concerns and sufficient information to identify individuals and other agencies involved. Self-referrals will be considered.

6.1.2 Self- referrals will be considered by the duty worker and may be signposted to a multi-disciplinary triage discussion for a decision on the correct pathway.

6.1.3 If the person is eligible for Section 117 aftercare, please follow the S117 policy guidance in CPA policy.

6.1.4 Referrals from other KMPT services requesting a clinic option are to be manage as such and a consultant psychiatrist will take a lead on this assessment, formulation and recommendation made. This might include forensic services or rehab for example.

6.1.5 Referrals should contain information on the following and be triaged on this basis;

- Mental health symptoms that the person has and for how long
- What interventions (biological, psychological and social) they have had and response to them
- What risks the person presents with (to self, to health and to others)
- Physical health history, including exclusion of exacerbating causes.
- Social situation, circumstances and any safeguarding concerns
- Current medication

- Whether the patient is aware of referral and their expectations from it
- Any other information that the referrer feels important, including blood tests and physical health tests if appropriate. We may approach the GP and/or the referrer for additional information that may be relevant to appropriately respond to the referral.

RIO Requirements:
On immediate receipt of referral, admin to upload and open to RIO

6.2 Transfers

6.2.1 On occasions, patients are transferred from SPoA, CRHT and Liaison Psychiatry. In all of these situations, we see all functional or complex dementia patients face to face within 72 hours irrespective of where they have been transferred to. This includes when a patient has been transferred to a community hospital bed or care home for example. In the case of a patient being referred from Liaison Psychiatry purely for a routine memory assessment, these referrals will enter the routine memory pathway and subject to the usual process of that pathway.

6.2.2 If a patient is transferred from another community mental health team or CMHSOP, they would be seen face to face with a time frame agreed by both the receiving and original service Care Co-ordinator or HCP. This may include a CPA if the patient is subject to the Care Programme Approach.

6.2.3 When patients are transferring from another KMPT service and for those whereby the OACG has been requested to input for a clinical opinion, as a minimum standard, the following information will be required:

- RiO assessment
- Presenting situation
- Mental state examination
- Risk assessment
- Formulation (understanding assessment information and developing an appropriate plan)
- A working diagnosis (shared with the person)
- Cluster (note cluster 3 and below does not meet the criteria for secondary mental health services)

RIO Requirements:
The patient is to be opened by the receiving team on the same day as the transferring team closes the referral. The referral screening form is then to be completed, with the correct pathway identified related to the reason for the referral. This should only be one of the following two options:

- Routine Memory Assessment
- Functional/Complex Organic

The Care Co-ordinator/HCP details are to be updated, with the previous clinician's details being closed before the new clinician's details updated afterwards. An appointment should be booked on RiO within 5 working days of receiving the referral and sent to the patient in the form of a booking letter (Appendix M).

6.3 Triage

Referrals received by the team should be triaged each working day by the MDT (Appendix A). As a minimum this should consist of a Team Leader and Consultant Psychiatrist so to ensure that the patient is placed on to the correct pathway, and ideally includes all other professional groups where relevant. In the absence of this being possible, if expertise from a different professional discipline is required, this should be sought as soon as possible. The patient archive system (PAS) should be utilised to support a robust triage, to ascertain if an individual has been previously known and should include a review of the risk history.

6.3.1 In the unexpected absence of the Team Leader or Consultant, the remaining multi-disciplinary colleagues should ensure an alternative appropriate clinician is identified to support MDT Triage.

6.3.2 Within RiO the referral screening document is to be used and fully completed.

6.3.3 Emergency referrals will be seen or referred to appropriate out of hours services within 4 hours. Urgent referrals will be seen within 72 hours and Routine referrals will be seen within 4 weeks.

6.4 For patients that are assessed as having a dementia younger in life (less than 65), these patients should be triaged as subject to a complex dementia pathway assessment and therefore considered for CPA given the additional risk factors that can include impact on children, employment, finances and longer- term burden on families. A routine memory assessment is therefore not appropriate for this group of patients.

6.5 Following the triage meeting, within 5 working days an appointment booking letter will be sent to the patient and copied to the GP. This letter should include a crisis plan with emergency contact details (Appendix M).

RIO Requirements:
A member of the triage team to take responsibility for recording each clinical case in progress note in RIO agreed at the beginning of the meeting.

The referral screening form is then to be completed, with the correct pathway identified related to the reason for the referral.
All screening boxes should be completed that are clinically relevant and reasons why it is possible to populate a box is noted.

- Routine Memory Assessment
- Functional/Complex Organic
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A brief progress note added to RIO that referral was discussed in MDT meeting following the clinical decision making in triage.

Referral reason in initial referral form to be updated with one of the options listed.

7 CLINICAL PATHWAYS & TREATMENT INTERVENTIONS

7.1 The OACG have clinical care pathways, some of which are new and under development:

- Routine Memory Assessment Service (MAS) Clinical Pathway – subject to standard care
- Complex Dementia Clinical Pathway – subject to standard care or CPA pathway
- Complex Emotional Difficulties Clinical Pathway – subject to standard care or CPA pathway
- Mood Disorders and Psychosis Clinical Pathway - subject to standard care or CPA pathway

Please refer to CPA policy to guide clinical decision making.

7.2 Initial Assessment and care planning for MAS Clinical Pathway:

7.2.1 Administration colleagues will contact patients and carers to plan and prepare patients for remote/virtual assessments using the guidance 'making a telephone or VC appointment' (Appendix E).

7.2.2 The initial assessment should make use of the Memory Assessment template (Appendix C). In addition, clinical outcome measures will be completed as part of the assessment process, as will the completion of the consent to share information form, including the option of being involved in research. Initiated in the COVID 19 pandemic, TICSm will be used for non-face to face assessments and ACE 111 face to face.

7.2.3 The care plan, risk assessment and crisis contingency plan will be agreed with the patient following their assessment and then feature in the form of template letter (Appendix C) sent to the patient. This is considered as the initial care plan and risk assessment.

7.3 Initial assessment for Complex Dementia, Complex Emotional Difficulties, and Mood disorders and Psychosis clinical pathways:

7.3.1 A full RiO core, care plan and risk assessment will be completed for patients on this pathway. Complete consent to share information including option of being involved in research.

7.3.2 Administration colleagues will contact patients and carers to plan and prepare patients for remote/virtual assessments using the guidance 'making a telephone or VC appointment' (Appendix E).

7.3.3 The assessing clinician will complete a HoNoS and assign a cluster. Any patients that meet the clustering criteria 1- 3 will not meet the threshold for secondary care treatment and will be discharged along with advice on where the person's needs are best met. This may include signposting to social services, community support and opportunities through third sector support.

7.3.4 If it is agreed that the person's needs meet the threshold for specialist secondary care mental health services, interventions on the clinical care pathway will be identified to form a treatment plan.

7.3.5 All clinical correspondence will be sent to the patient and copied to GP.

7.4 Administrators should check GP details and update the spine accordingly.

RIO Requirements:

- MAS template to be uploaded to clinical documents on RIO on completion of the assessment.
- TICS-m or ACE III to be completed and upload to clinical documents on RIO.
- Progress note to be completed in line with the Minimum Content Standards for clinical progress notes (see appendix B).
- Outcome diary appointment.
- Cluster and allocate a HCP/care coordinator.
- Depending on patient need place patient on the relevant intervention tab. For routine MAS patients, a MAS PSP letter should be generated. This letter will act as the risk assessment, care and crisis plan for documentational purposes on RiO.
- For patients Care plan, Risk Assessment and crisis contingency plan open RIO care plan and administrator to add 'please see uploaded MAS template or clinical letter dated' and sign and distribute care plan, risk assessment and crisis contingency.
- Patient related outcome measures (QoL-AD is the PROM for the MAS and complex dementia pathway, ReQoL is the Patient Reported Outcome Measure within the functional clinical pathways and CORE 10 and 34 can be used as an additional PROM for psychological therapy.
- Complete consent to share information including option of being involved in research.

8 DIAGNOSTIC APPOINTMENT:

8.1 All patients will be offered a diagnostic appointment with a diagnostic clinician within 18 weeks of referral. The appointment will be available via video, telephone or face to face depending on clinical need and the letter for the diagnostic appointment will either be included with their initial assessment outcome letter and PSP, or sent immediately after the assessment has taken place.

8.2 Admin colleagues will telephone patients four weeks before their appointment to confirm their attendance at their appointment. If the patient needs to have their appointment moved, this will give opportunity to use this slot for another patient, with notice.

8.3 If the prescription of medication is required, an assessment of capacity and best interest needs to be considered and completed.

8.4 The diagnosing clinician will make a diagnosis and record the ICD 10 and SNOMED code.

RIO Requirements:

- The diagnosing clinician records the ICD 10 and SNOMED on RiO
- Outcome appointment
- Completion of care plan letter using Big Hand template (appendix L)
- Diagnosis to be recorded on letter
- Admin to indicate evidence of completion of the care plan and risk assessment via the letter in the care plan and risk assessment sections of RIO by stating 'see letter dated…'
- If a prescription of medication is required an assessment of capacity needs to be completed in the progress notes if deemed to have capacity and if deemed not to have capacity in the capacity section on RIO

9 FUNCTIONAL TREATMENT INTERVENTIONS:

9.1 Following triage and completion of an initial assessment the following interventions are available where deemed a clinically appropriate care plan, with or without a diagnosis.

9.2 The groups are held per super locality and are available remotely via lifesize.

9.3 Patients can access the interventions on either of the pathways. In those localities that offer initial interventions, please see Appendix O for guidance on Patients Currently Awaiting Psychology Appointments.

Complex Emotional Difficulties Pathway Interventions	**Mood/ Psychosis Pathway Interventions**
Transitions Group (virtual) Skills and Support Group (virtual) Individual Psychology Occupational Therapy Individual Nursing Group STEPPS (via Community Recovery Care Group) Psychiatric Review	Initial Interventions Health and Wellbeing Group (virtual) Occupational Therapy Individual Nursing Psychiatric Review Individual Psychology

RIO Requirements:
Choose only the relevant intervention from the intervention drop down box.
Facilitators to complete the appropriate clinical outcome measures for the interventions they are delivering.

10 MEMORY ASSESSMENT POST DIAGNOSTIC OFFER AND MEDICATION

10.1 Review Clinics

The post-diagnostic pathway (Appendix F (1) & (2)) was revised during the Covid pandemic and will be offered in the sequence and timescales shown. The pathway includes all elements of the post-diagnostic offer, including medication reviews. The majority of patients will be discharged back to primary care on completion. Routine memory patients with continued clinical need for secondary mental health services beyond this post diagnostic offer are likely to need transferring onto the complex dementia pathway and be re-clustered to reflect the increased clinical complexity. This is likely to include being formally transferred onto the CPA Pathway.

RIO Requirements:
Progress note and outcome diary contact
If re clustering, consider CPA eligibility, update risk assessment and complete RIO care plan

10.2 Standard care and CPA Pathways:

10.2.1 People with complex needs who need support from more than one clinician or service are subject to the CPA Pathway and will be allocated a Care Co-ordinator. In the CMHSOP, in most cases this should include most of the non Cluster 18 patients. CPA patients are to have a minimum of a 4 weekly contact for intervention. For patients on standard care, the contact intervention should be a minimum of 8 weekly. Any deviation to this must be carefully recorded on the patients care plan.

10.2.2 Indicators suggesting people are likely to need CPA are:

- Severe mental health problems (including Personality Disorder) with a high degree of clinical complexity.
- Current or potential risk(s), could include;

- Suicide, self-harm (especially in later life), harm to others (including history of offending).
- Relapse history requiring urgent response.
- Self-neglect/non-concordance with treatment plan.
- Vulnerable adult: adult/child protection, Physical/emotional abuse, financial/sexual exploitation.
- Cognitive impairment.
- Experiencing significant or multiple losses.

- Current or significant history of serve distress / instability / disengagement or socialisation.
- Presence of non-physical co-mobility e.g. substance / alcohol / prescription drugs misuse / learning disability.
- Multiple service provisions from different agencies, including; housing; physical care; employment; criminal justice; voluntary agencies.
- Currently / recently detained under Mental Health Act, on CTO or referred to Crisis / Home Treatment team for intensive support.
- Significant reliance on carer(s) or has own significant caring responsibilities.
- Significant impairment of function due to mental illness.
- Social Factors including lack of meaningful daily activities and occupation, unsettle accommodation / housing issues.
- Physical Health concerns

10.3 The list is not exhaustive and there are not a minimum or critical number of items on the list that should indicate the need for CPA. Clinical and professional experience, training and judgement should be used in using this list to evaluate which service users will need the support of CPA.

10.4 Routine memory patients will receive care through the Standard Care pathway and their referral will be allocated to the initial assessor's case load with medical colleagues being allocated as the lead HCP once the patient is allocated the Cluster 18 pathway. All other

patients will be allocated across the remaining MDT. All clinical documentation should be completed in line with the 10 Golden Rules of Record Keeping (Appendix G).

10.5 In the event of the requirement of a change in Care Co-ordinator, there will be a discussion with the patient and their carers about the reason for the required change and an agreement as to where and when this will formally take place. This could take place in a CPA review meeting or in a joint appointment with the patient (whichever can be arranged sooner).

10.6 In the event of allocated workers/care co-ordinators being absent from work, please refer to the Sickness protocol for guidance (See Appendix P).

Rio Requirements:
Allocate to the correct pathway (standard care or CPA) and review 6-12 monthly
Clinician to allocate themselves as care coordinator/Lead HCP
For CPA patients, book the CPA appointment on RIO; ensuring it is planned and prepared in advance
All CPA reviews to be documented as a CPA review on RIO
In the case that a CPA patient is transferred to a different clinician, this must be formally re-allocated on RiO

11 RISK ASSESSMENT

11.1 All people referred to the service receive a risk assessment in line with Trust policy on clinical risk assessment and management. Section 10 gives clear guidance on when to assess and review risk. When assessing risk over the telephone or when using lifesize, the Practice Guidance on risk assessing using video or telephone facilities should be used alongside the Clinical Risk Assessment Policy (Appendix N)

11.2 For non-complex MAS assessments only, where there are no significant risks identified at Multi-disciplinary triage, risk assessments should be completed in line with the memory assessment template (Appendix C). For many people attending the MAS, risks will be minimal and the risk assessment within the template is sufficient. However, where this initial dementia focussed risk assessment identifies more significant risks, a full RiO risk assessment and Core assessment must be undertaken and the person moved onto the Complex Dementia Pathway. It is the responsibility of the initial assessor to decide whether a more general Rio risk assessment is required due to higher levels of risk and the patient is moved onto the correct pathway. Clinicians should seek advice and guidance at the soonest possible point for any patients they are unsure about. Similarly, in subsequent appointments with people who do not have a Rio risk assessment (MAS non-complex pathway), where new and significant risks emerge, and the person should be moved onto the complex dementia pathway and a full Rio risk assessment undertaken.

11.3 All patients should receive a crisis contingency plan in case their presentation and needs change.

11.4 All identified risks should be triangulated with the patient's care plan and a risk management plan put in place initially.

Important Note: ***For routine MAS patients that have been assessed as routine and low risk then the presentation and risk changes consider allocation of a care coordinator and CPA pathway.***

RIO Requirement:
Completion of RIO risk assessment
Re-cluster and review CPA pathway

12 CLUSTERING AND CLINICAL OUTCOME MEASURES

12.1 Clustering should be completed as per the HONOS policy, and at these key points:

- At Initial assessment
- When the cluster review period is due – this varies by cluster.
- At transition points or reviews
- On admission to hospital – within a week of admission, at 4 weekly intervals and at discharge
- At discharge from CMHSOP
- At transfer of care
- If there is a significant change in circumstances

:

Please review cluster depending on the guidance below

Cluster	Time Scale	Cluster	Time Scale	Cluster	Time Scale	Cluster	Time Scale	Cluster	Time Scale
		P05	6 Months	P05	6 Months	P10	12 Months	P15	4 Weeks
		P06	6 Months	P06	6 Months	P11	12 Months	P16	6 Months
		P07	12 Months	P07	12 Months	P12	12 Months	P17	6 Months
		P08	12 Months	P08	12 Months	P13	12 Months	P18	12 Months
P04	6 Months	P08b	12 Months	P08b	12 Months	P14	4 Weeks	P19	6 Months
								P20	6 Months
								P21	6 Months

12.2 Clinical Outcome measures include a CROM and PROM at initial assessment and discharge and 6 monthly review as a minimum. Appendix H, (1)

12.3 The Health of the Nation Outcome Scales (HoNOS) is the agreed clinician rated outcome measure (CROM) for application across the Trust.

12.4 ReQoL is the Patient Reported Outcome Measure within the functional clinical pathways. Appendix H, (2)

12.5 QoL-AD is the PROM for the MAS and complex dementia pathway work (and can be completed by carers/family/friends too).

12.6 MOHOST can be used as an additional CROM by OTs.

12.7 CORE 10 and 34 can be used as an additional PROM for psychological therapy.

Rio requirements:

- HoNOS should be completed following assessment, as well as when there is a significant clinical change and on discharge. This is for all patients and is the responsibility of all clinical disciplines.
- ReQoL should be completed with the patient following assessment, when there is a significant clinical change and on discharge. This is for functional patients only.
- QoL-AD should be completed with the patient, family or carer following assessment, when there is a significant clinical change and on discharge. This is for patients with dementia only.

13 DISCHARGE FROM INPATIENT SERVICES

13.1 Evidence suggests that people with mental health problems, especially those with severe and enduring mental illness are at particular risk of suicide and that the period immediately following discharge from inpatient care, is recognised as a time of increased vulnerability and risk.

13.2 Further to this, it is indicated that people who access follow-up care within 72hrs of discharge from psychiatric hospitalisation may be less likely to require readmission, are more engaged with community follow up care, and will have post-hospitalisation medication problems detected early.

13.3 All people receiving follow up from secondary care mental health services will be offered a 72hr follow up face to face appointment on discharge from an older adult inpatient ward as part of the discharge planning meeting. This will be completed by the Ward O.T primarily or by CMHSOP if no O.T is available. See 'Discharge Transition Pathway Flow Chart' (Appendix I)

13.4 For those patients that are discharged outside of Kent as part of discharge planning an MDT discussion needs to take place to decide whether a face to face 72 hour follow up or a video conferencing follow up is clinically indicated.

RIO Requirements:
Update care plan and risk assessment and complete progress note
Review the cluster and outcome diary contact

14 MULTIDISCIPLINARY APPROACH TO RISK MANAGEMENT - THE RED RISK BOARD MEETING (RISK EVALUATION AND DECISION, AN MDT APPROACH TO MANAGING RISK IN COMMINUTE MENTAL HEALTH SERVICES-DRAFT)

14.1 Each CMHSOP will hold a 'Red Risk Board Meeting' daily, , to focus on complex and high risk patients who need a more intensive approach to risk management but do not require acute care. Appendix J (1) Patient status board.

14.2 Progress note template. Appendix J (2) for red risk board must include:

- Presenting situation
- Risks identified for being on the red risk board
- Patient to go onto the board/stay on the board depending on risk
- Plan of care to reduce risk
- CPA pathway, Care Coordination, consider mental health support worker

14.3 Patient should not come off the Red Risk Board until the risk has reduced, follow up is arranged and the risk assessment and care plan has been updated by the MDT.

RIO Requirements:
All clinical discussions should be recorded in the patient's progress notes including any actions agreed. A progress note should identify when the patient is ready to be taken off the red board. Risk assessments, crisis plans and care plans should be updated at the time of discussion keeping the clinical recording live.

15 DISCHARGE FROM CMHSOPS TO PRIMARY CARE

15.1 Appropriate discharge for service users to primary care is a positive outcome and often forms part of the recovery process. Discharge from the service should be sensitive to the needs of individual and their carers, and include information (written and verbal to patient and written to GP) about how services can be accessed in case of future relapse or crisis. Discharge of service users allows capacity for new patients.

15.2 There are 2 levels for discharge depending on clinical pathway. For Non-Complex MAS Pathway a minimum of a band 6 registered clinician can discharge a patient when clinically indicated. For Complex Dementia, Complex Emotional Difficulties, and Mood disorders and Psychosis clinical pathways the decision to discharge should be made by MDT as best practice however with a minimum of a consultant and Care Co-Ordinator making this decision jointly (Appendix K)

15.3 Example indicators for discharge:

- Agreed intervention plan has been met and no further interventions are indicated by any members of the CMHSOP.

- The person's care can be managed within primary care. This may indicate referral to IAPT if the person has improved since referral but still requires interventions for mental health difficulties consistent with IAPT criteria.
- The person is believed to be compliant with medication and able to manage this safely.
- Any risk factors are satisfactorily managed (noting that risk in itself does not indicate a need to remain in specialist mental health service).
- Discharge has been agreed upon as part of the CPA process.
- Discharge due to non-engagement with services as per Policy.

15.4 Discharge Procedure

15.4.1 Clinicians within the Teams should discuss discharge plans with the Team Leader and/or Consultant Psychiatrist to ensure safe but efficient discharge processes. This should be part of, but not limited to, the regular caseload review process.

15.4.2 A written discharge summary will be produced in RiO and provided to both the person and their GP and will include:

- The diagnosis on acceptance to services and the diagnosis and progress on discharge.
- A summary of interventions provided and the effectiveness of those interventions.
- Details of any continuing needs and how they are to be met with recommendations for the on-going or future treatment (including medication).
- Signposting and third sector support options.
- Identified triggers and/or indication of the early warning signs of future deterioration of the individual's mental health
- Details of any entitlement to care under section 117 (if relevant).
- Arrangements of how to refer back to CMHSOP if required.

15.4.3 On the rare occasion, if a service user has been previously treated in a secure unit or has been under a Forensic legal framework then discharge from Secondary to Primary Care should not happen without first consulting the Kent Forensic Psychiatry Service.

RIO Requirements:
Review and close care plan
Update the risk assessment
Update the crisis plan.
Complete clinical outcome measure HoNOS/ReQOL/QoL-AD
Close current cluster

16 COMMUNICATION WITH GPS

16.1 Timely and quality communication with GPs supports recovery, wellbeing and safety. CMHSOPS will communicate with GPs at key points in the delivery of care.

16.2 All GP's have contact details of consultant psychiatrists in their areas

16.3 All clinicians should communicate any impact that physical health may be having on mental health risks, to the G.Ps and other specialists involved in the patient's care.

16.4 All Teams have a central email address that is monitored daily.

RIO Requirements
Any clinical conversations with GP to be reflected in the progress note

17 GOVERNANCE PROCESSES

17.1 All KMPT services are provided in line with Trust polices. The Trust Wide Care Group Meeting oversees operational services.

17.2 Within OACG CMHSOPS governance is provided through structured meetings.

Daily	Weekly	Monthly	4- 6 weeks
Red Board Meeting	Clinical Team Meeting	Reflective Practice	Management Supervision
Triage Meeting	CLIQ check escalation meetings (red CLIQ check)	Local Governance Meeting	Caseload Reviews
		Super Locality Meeting	Clinical Supervision
			Local Leadership Meetings

17.3 Within OACG Senior Management structured Meetings include the following. Information flows through the care group in the form of a 'meeting on a page' and invitation of feedback to the SMT via the local governance meeting agendas:

Covid Bronze Meeting – 1-5 times each week depending on Covid status Week1: Quality, Performance & Finance / Patient Experience and Clinical Effectiveness Week 2: Patient Safety and Risk Week 3: Incidents and Learning

18 SERVICE USERS AT THE CENTRE OF THEIR CARE

18.1 The promotion of service user involvement is fundamental to the delivery of services. The emphasis of care delivery will be on recognition and maximising the Service User's strengths, abilities and interests and building on these to encourage growth, development and social inclusion. Involvement in crisis planning and recognition of relapse indicators, advance decision and advanced statements are key, alongside the Personalisation process.

18.2 CMHSOPs will support individual Service Users to maintain and increase their independence and to manage their own care as far as possible. To reach this aim Service Users will participate in effective collaborative person centred care planning with goals agreed to work towards.

19 SERVICE USER & CARERS INVOLVEMENT IN CARE PLANNING

19.1 Carers are members of the patient's social network who help them with activities of daily living. Carers are identified and fully involved, wherever possible. Carers' views are important because of their knowledge of the client and their history and make a valuable contribution to assessments and care plans.

19.2 The obligation to maintain confidentiality does not prevent staff asking carers for information and concerns, or carers imparting information or voicing their opinions or concerns. There will be times when staff will disclose information in the public interest, for example, relevant personal information regarding risk.

19.3 CMHSOP staff are proactive in:

19.3.1 Identifying carers by asking the Service User whether someone provides them with support

19.3.2 Seeking carers' views and concerns, so that they can be taken into account when undertaking assessments and drawing up care plans.

19.3.3 Obtaining consent to share information relating to the Service User's care and treatment, explaining why it is helpful to involve carers and clarifying any information that the client does not want to disclose.

19.3.4 Clarify whether the Service User wants the carer involved in discussions about their care.

19.3.5 Ensuring appointment times suit both carer and Service User.

19.3.6 Encouraging the use of Advance Decision and Statements, particularly when it impacts on carer involvement.

19.3.7 Agreeing when carers should take on specific responsibilities as part of the care plan e.g. ensuring attendance at appointments or taking medication.

19.3.8 Copying correspondence and care plans to carers as part of the agreed care plan and in agreement with the Service User.

19.4 Triangle of Care.

19.4.1 OACG has adopted the Triangle of Care approach which is aimed at encouraging partnership working with carers at all levels of care from the individual to overall service planning.

19.4.2 the-triangle-of-care-carers-included-second-edition.pdf

20 SUPPORT FOR CARERS

20.1 Caring can be demanding and should be acknowledged by professionals and assumptions about the carer's ability and willingness to continue caring never just assumed. Carers have the right to a statutory assessment of their needs, regardless of the care pathway the patient is on. Each CMHSOP has a carer's champion who works within the team and coordinates and assists in the signposting service. They support providers to ensure all identified carers who would like to take up the offer receive a carer's assessment and interventions in line with the Care Act.

20.2 Carer communications and interventions are recorded on RIO in line with Trust policy.

20.3 Guiding principles

- The Care Act 2014 provides that: Carers' assessments must seek to establish not only the carer's needs for support, but also the sustainability of the caring role itself, which includes both the practical and emotional support the carer provides to the adult. Carers should not be expected to provide care where they do not have the access to information that they need to do so safely and appropriately.
- An Admiral Nurse is based within some CMHSOPs across Kent and Medway. This role specifically focuses on the provision of support to carers of individuals diagnosed with a dementia.
- Carers must always be advised of whom to contact in an emergency.
- Carers should be provided with information to help them deliver care.
- Consideration is given to carers own support plan when care planning.
- Family work and family therapy should be considered where appropriate in line with NICE guidance.
- Carers should be referred to the Voluntary Organisations who are commissioned to provide Carers Assessment.
- Young carers will receive support to minimise any effects of their caring responsibilities, consideration of referral to Children and Families Services and provided age appropriate information.

21 TRANSFER OF CARE

21.1 If a service users care is transferred from one area to another the responsibility for arranging the transfer of care lies with the existing hcp or care co-ordinator. The worker must notify the new team manager as early as possible and provide up to date assessments and care plans to the new team and advise the person in writing of their new arrangements.

21.2 CPA procedures apply across Kent and Medway, therefore the transfer of care between different localities should be straightforward. The lead worker will establish that the new team has accepted responsibility for the person's care before closing or discharging the individual. Transfer should not be unreasonably delayed due to disputes by the receiving team. Disputes in transfer should be brought to the attention of the Service Manager. Dates for transfer should be agreed and take place within 4 weeks.

21.3 Wherever possible, the receiving team must ensure there is joint working during the transition period of handover to enable continuity of care.

21.4 It is good practice to hold a transfer CPA review, particularly in cases where there are complexities or high risk, however, the transfer should not be unreasonably delayed as a result. The transfer review should include consideration of the risks associated with the move and the extent of further involvement by the Care Co-ordinator.

22 INTERFACE AGREEMENTS WITH OTHER KMPT SERVICES

22.1 CMHSOPS works alongside other KMPT services. The aim is to provide a seamless patient/carer experience with the patient and carer at the centre of every clinical decision we make. We offer a one door approach and internal referrals should be made between KMPT services. GP's should not be asked to make an internal referral.

22.2 Liaison Psychiatry. Patients must be reviewed face to face within 72 hours following discharge from acute hospitals following referral from Liaison Psychiatry unless being referred for a routine memory assessment. These will be referrals whereby the patient has presented to A&E in a crisis and a 72hr review is clinically indicated. Other referrals will be managed via the daily MDT Triage Meeting.

22.3 All people referred from CRHT to the CMHSOP should be placed on the red board and followed up by the CMHSOP within 72 hrs by a face to face visit or as clinically indicated at discharge planning meeting with CRHT.

22.4 Single Point of Access. CMHSOPS offer a daily urgent assessment slot. This is a bookable slot that is available to SPoA to use. Direct telephone contact between services is recommended in the event of any interface issues occurring.
http://i-connect.kmpt.nhs.uk/document-library/single-point-of-access-standard-operating-procedure/1509

22.5 Community Mental Health Services (Transitional Arrangements between Younger and Older Adults Community Care Groups).
http://i-connect.kmpt.nhs.uk/document-library/transition-pathway-protocol-between-chyps-ypws-and-amhs/346

RIO Requirements:
Transfer meeting to be reflected in the progress notes
Risk Assessment, care and crisis plan to be updated before transfer
Complete cluster review and other relevant clinical outcome measure prior to transfer
Close care spell and referral
Discharge letter to patient copied to GP

23 PATIENTS WHO DO NOT ATTEND (DNA) AND/OR ARE UNABLE TO BE CONTACTED

23.1 While DNAs are sometimes unavoidable, the missed appointments are not available for us to provide services to other patients.

23.2 The KMPT DNA Policy sets out how we will manage DNAs in order to maximise resources without compromising patient safety and access to services and care.

23.3 Actions will be determined by known level of risk and symptomatology and should always be discussed with a senior member of the team and documented within Rio progress notes.

Please refer to the Policy and Procedure for managing patients who Do Not Attend and/or are unable to be contacted for full details or we fail to contact.
http://i-connect.kmpt.nhs.uk/document-library/did-not-attend-dna-policy/281

RIO Requirements:
Appointment to be outcome appropriately
Progress note to indicate actions taken

24 STAFF OR FAMILY OF STAFF WHO BECOME SERVICE USERS

24.1 In order to maintain service user's confidentiality and dignity, staff or close family of staff members, who become service users of KMPT, will have services provided for them by a CMHSOP other than that which they are a staff member of, or have family as a staff member.

24.2 Each individual will be offered a service from the next nearest CMHSOP, and venues for contact should be considered to allow for maximum convenience for the person receiving services, maintaining their confidentiality. Arrangement of services is made in full consultation with the service user.

25 SAFEGUARDING

25.1 A 'vulnerable adult' is defined as 'a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation' (Law Commission 1995). The lead agency for Adult Protection across Kent and Medway is the Local Authority. Where an Adult Protection concern is considered serious, a formal safeguarding alert, (KASAFs in Kent and SAFs in Medway), under the Multi Agency Safeguarding Adults Adult Protection Policy for Kent and Medway, will be made to the local authority duty system.

25.2 The Multi Agency Safeguarding Vulnerable Adults Adult Protection Policy for Kent and Medway protocol, policy and guidance should be read in conjunction with the CPA Care Pathways Policy, KMPTs Safeguarding policy, and Serious Incident Reporting Procedures.

25.3 Should staff have a concern of a safeguarding nature they can discuss with line managers safeguarding team or local authority safeguarding to see if it reaches the criteria for raising as adult protection alert.
http://i-connect.kmpt.nhs.uk/document-library/multi-agency-public-protection-arrangements-mappa-policy/313

25.4 All Staff should read this internal policy in conjunction with the multiagency Policy on safeguarding adults.
http://i-connect.kmpt.nhs.uk/document-library/safeguarding-adults-policy/333

RIO Requirements:
Risk assessment, care and crisis plan to be updated to reflect the safeguarding alert
Update the safeguarding section on RIO
Outcome any clinical contacts in RIO diary

26 MENTAL HEALTH ACT

26.1 Mental health act assessments are carried out under the 1983 mental health act (as amended 2007) by an approved mental health professional (AMHP).

26.2 Currently people requiring mental health act assessments who live under KCC will receive a service from the dedicated county wide AMHP service. Medway assessments taking place out of hours are also carried out and co- ordinated by the KCC dedicated AMHP service. Medway AMHP complete and co-ordinate 'in-hours' mental health act assessments for Medway residents.

26.3 Effective hospital discharge planning including section 117 aftercare arrangements where a person has been detained in hospital under section 3 of the mental health act.

27 MENTAL CAPACITY ACT

27.1 The care group has a legal obligation to adhere to the Mental Capacity Act and all practitioners should adhere to the KMPT Mental Capacity Act policy.

RIO Requirements:
All MCA and Best Interest assessments to be documented in the MCA section in RIO.
Patients lacking capacity should have the MCA section completed in RIO

28 RESEARCH

28.1 The Trust is committed to enabling individuals to participate in research opportunities. The opportunity to be contacted about relevant research is included in the initial assessment, and documented on. In line with NHS England's expectations, all staff are expected to participate in audit/ service evaluation/ research/QI Projects as appropriate to their role, as part of the ongoing commitment to improving services. Any individuals wishing to participate will be supported to complete their registration where appropriate.

29 STAFF WORKING PRACTICES

29.1 Remote working

29.1.1 Due to the current Covid pandemic, current working practices are reflected in the current Covid SOP's.

http://i-connect.kmpt.nhs.uk/document-library/covid-19-standard-operating-procedures/5354

29.1.2 Service users are offered the most appropriate means of contact based on clinical need and discretion. This will always prioritise virtual appointments, unless face to face appointments are required in which to meet specific clinical needs.

29.2 Lone working

29.2.1 The trust recognises that staff may have to work alone in the delivery of clinical and non-clinical services. As with any potential risk to health & safety and welfare of staff, the risks associated with lone working need to be identified, assessed and managed

29.2.2 Local protocols must be in place and form part of all local induction for all new staff.

29.2.3 Staff working on the premises of another employee should liaise with the person in charge and incorporate any lone working arrangements for the premises into their own protocol.

29.2.4 Any lone working should be undertaken in accordance with the recent Covid SOP's.

http://i-connect.kmpt.nhs.uk/document-library/lone-working-policy/224

29.3 Staff supervision

29.3.1 Supervision is an important part of managing, motivating, supporting and training staff. Supervision will be carried out in line with KMPT supervision policy.

29.3.2 All staff should expect to receive managerial and clinical supervision in line with trust policy.

29.3.3 Clinical supervision may be a separate process which should supplement managerial supervision.

29.3.4 In addition, specialised supervision should be provided for staff that use specific psycho-social interventions to ensure services are developing and maintaining these skills appropriately.

29.3.5 Psychological practitioners will support the whole team in delivering appropriate psychological interventions through supervision, consultation and joint work.

http://i-connect.kmpt.nhs.uk/document-library/supervision-policy/344

29.4 Training and development

29.4.1 Training and development will reflect the needs of the trust and of the individual, as described in their personal development plan. Continuing professional development is a key element of ensuring the delivery of the highest possible quality of service.

29.4.2 All staff will be appraised annually during the appraisal window through their professional aligned processes with a six-month review. All new staff will attend the trust induction programme as well as receive a local induction to include reference to appropriate policies and procedures.

29.4.3 The staff priority for training will be attendance on statutory/mandatory training courses that are appropriate to their individual professional status. Once completed, other training opportunities will be identified and agreed within individual appraisal that supports the delivery of the service.

29.4.4 Students and trainees from various disciplines will be attached to the CMHSOP as part of their training. All such students will be advised of the operational policy and will have clearly understood supervision and mentor arrangements within the team. It is the duty of all disciplines to provide practice supervision to students. Service users have a right to choose whether a student is present during their appointment.

http://i-connect.kmpt.nhs.uk/document-library/training-policy/423

29.5 Health and safety

29.5.1 Health and safety risk is inherent in the delivery of health and social care. The trust is committed to the identification, assessment and reduction of all risk to service users, staff and the organisation through a process of risk assessment.

29.5.2 Health and safety risk assessment is a management responsibility; however, all employees must take reasonable care for their own health and safety at work. They must also take care of the health and safety of other persons. Employees must also

co-operate with their employer in meeting statutory requirements. Health and safety at work act 1974

29.5.3 Staff should always refer to the trust health and safety policy.

29.5.4 The policy will be implemented via each team through their local team governance meetings and the meetings minuted for evidence of awareness.

30 EQUALITY IMPACT ASSESSMENT SUMMARY

30.1 The equality act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of equality impact assessment will be pursued in order to provide assurance that the trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

31 HUMAN RIGHTS

31.1 The human rights act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

32 MONITORING AND COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	How will it be monitored	Who will monitor	Frequency	Evidence to demonstrate monitoring
The standards as defined in this policy	QUEST CLIQ Incidents Compliments Complaints Performance reports	OACG SMT via Patient Safety and Quality Team and SMT meetings	Monthly	Learning actions Discussions in team meetings Training and development Learning bulletins 6 monthly SOP review

APPENDICES

APPENDIX A	Triage Principles Flow Chart.docx	Triage flow chart
APPENDIX B	Progress Notes standar - word doc (draft Progress note template for psycho	(1) Progress note standard (community) (2) Example OP Psychology Progress note template
APPENDIX C	MAS Template.docx	Memory assessment template
APPENDIX D	Emergency Business Continuity Planning C	Emergency business continuity planning Covid 19
APPENDIX E	Face to face and remote consultation Guidance for making a VC or telephone ap	(1) Guidance for patent contact type (2) Guidance for virtual appointment
APPENDIX F	Post-diagnostic support pathway revi Routine MAS medication review flo	(1) Post-diagnostic pathway (2) Medication review clinic
APPENDIX G	10 golden rules of record keeping V2.0.p	10 Golden rules of record keeping
APPENDIX H	HoNOS Guidance.pdf ReQoL-10 How to Guide.docx	(1) HoNOS & Clustering Guidance (2) ReQol How to Guide
APPENDIX I	discharge transition pathway flowchart 72	Discharge transition pathway flowchart

APPENDIX J	 Template for RED Flag Board Progress M  Red Board Template.docx	(1) Red board progress note template (2) Red board patient status template
APPENDIX K	 Discharge Flow Chart.docx	Discharge flowchart
APPENDIX L	 Big hand template AA.docx	Big hand template
APPENDIX M	 OA Letter example for SOP.docx	Booking template letter
APPENDIX N	 VideoConfCTConsu ltationKMPT - Apper	Practice guidance: risk assessing using video or telephone facilities
APPENDIX O	 Guidance re II and psychological therap	Patients currently awaiting psychology appointments
APPENDIX P	 SICKNESS PROTOCOL.docx	Guidance for sickness reporting and safe caseload management
APPENDIX Q	 Guidance for improving Quality of	Triage guidance