Discussion on a new Acute Care Pathway
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This discussion document sets out proposals to implement a new acute care pathway in the Adult Mental Health Division of Leicestershire Partnership NHS Trust (LPT) and make improvements to the way our Crisis Resolution and Home Treatment team, our community mental health teams and outpatient services operate. We want to provide productive services which are high quality, which achieve good service user satisfaction, experience and outcomes and which are also cost effective.

We want to improve our services because our aspiration is to make our services the very best. We recognise that our current adult mental health services do not always compare well with other providers and we know from our service user survey results, we need to do better.

The care pathway in the following pages is derived from draft national guidance and we think it provides a good starting point for our discussions. We want to use the expertise of our staff and tap into the enormous talent and experience we have in our Trust and embrace the views of our service users, the GPs who purchase our services, and other stakeholders to help get our care pathway right.

We do not underestimate the challenge of improving the productivity of our services. Doing so will need the support and commitment of many people. It will also require strong leadership and determination.

We now want to receive your comments and views.
The proposed underpinning values and principles for adult mental health services in Leicester, Leicestershire and Rutland, set out below, are drawn from those developed with service users and carers for the Trust as a whole. Our re-designed adult mental health service must reflect these values and principles. Adults with mental health problems in Leicester, Leicestershire and Rutland can expect that services will:

• Involve service users and their carers in the planning and delivery of care.
• Deliver high quality care and treatment which is known to be effective and acceptable.
• Be well suited to those who use them taking into account the diversity of our population.
• Be accessible so that help can be obtained when and where it is needed both in urban and rural areas.
• Promote service user safety and that of their carers, staff and the wider public.
• Offer choices and care which promote independence. In particular helping service users to reach their full potential.
• Be well co-ordinated between all staff and agencies.
• Deliver continuity of care with appropriate safe and supportive exit strategies and follow up.
• Empower and support our staff to be caring at all times.
• Promote the health and well-being of staff through good management support and clinical supervision.
• Develop and train staff to do a good job.
• Be properly accountable to the public, services users and carers through good quality information and an open, transparent accountability structure.
• Promote good mental health, encourage early identification and ill health prevention strategies.
The Adult Mental Health Division of the Leicestershire Partnership NHS Trust is introducing a new acute care pathway as part of its contract with the local Primary Care Trusts. This is part of a programme of service improvements we want to make over the next 12 to 18 months to make sure we provide quality services which have good service user experience/satisfaction/outcomes and are cost-effective.

The new acute care pathway is at the heart of those improvements and through this engagement document we are seeking the views of service users, carers, GPs, partner organisations such as the local authorities, the voluntary sector, PCTs and our own staff. It is important we understand what other people think of our plans before going ahead.

Throughout the document are a series of suggested questions which you may wish to answer if you respond to this engagement. Please answer as many of them as you wish together with other comments you wish to make. In the middle of this document is a pull-out list of those questions and sufficient space for you to add your own comments and you can use this sheet to respond to the engagement. You will also find details of how to respond.

We would be happy to meet and discuss this directly with organisations and groups. To arrange this, please contact our communications office on 0116 295 8997.
Single point of access

The diagram below is a very simple representation of a possible overall model showing service users, carers, GPs and other referrers accessing services via a single point of access for adult mental health services, and depending upon assessed need, moving through health and social care services. It is envisaged that service users and carers, including those who have been previously discharged from adult mental health services, will be able to contact a single telephone number 24/7 to receive advice and care.

The single point of access (SPA) will provide advice for adults with mental health problems and GPs and other health and social care professionals who may refer to our services. The SPA will operate as part of our Crisis Resolution and Home Treatment team, which will look after the first stage of our proposed new acute care pathway.

This diagram is a simplified illustration of a possible overall model
Acute mental health services serve those people experiencing, at risk of, or recovering from, a mental health crisis and comprise a number of key component service elements. An integrated pathway refers to the interlinked services and agencies working together to support service user and carer needs and achieve the desired outcomes.

The recovery approach is an important aspect of the acute care pathway and implementing this approach is part of the Trust’s work programme for 2011/12. At the heart of recovery “is a set of values about a person’s right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of ‘hope’ in sustaining motivation and supporting expectations of an individually fulfilled life”.

The beginning of an acute care integrated pathway is widely agreed to be when an individual is first referred to a Crisis Resolution and Home Treatment service. The end of the pathway is widely understood to be when they are handed on to another team or discharged from services post-acute phase or episode. There are 10 distinctive stages along the possible acute care pathway for the Trust’s adult mental health services as shown in the overall pathway diagram on page 9.

Each of the 10 stages is described in detail in the next few pages. The diagrams are complicated but show many of the important details of providing the best possible service and care.

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Inpatient services provide individualised whole person care that promotes recovery and inclusion.

Overall pathway

1. Pre-admission
   - Crisis Resolution and Home Treatment
   - Assessment
   - Gate keeping

2. Pre-admission
   - Preparation for admission

3. On admission
   - Initial care plan/risk management

4. Admission (within first 24 hours)
   - Orientation/information giving

5. Assessments (within first 72 hours)
   - Priority needs and intervention

6. Assessments (within first week)
   - Comprehensive assessment

7. Treatment (weekly cycle)
   - To promote recovery

8. Treatment (review stages)
   - Effective integrated pathway to managed care

9. Discharge (planning and discharge)
   - Appropriately timed according to need

10. A smooth transition out of hospital following recovery of mental health problems requiring inpatient care with appropriate follow-up on discharge

Question 4
What are your views about any or all of the stages of the care pathway?
Person comes to the attention of acute care pathway - defined as possibly requiring admission into an acute admission ward in near future - In Crisis

Telephone call - referral - initial response and collection of data - telephone crib sheet

Not known to services

Known to services

- Reasons for referral
- Up to date risk assessment
- Background information
- Cultural, religious and language information from:
  - GP
  - Carer
  - Referral agent
  - Others

Fax GP obtain up to date medication history

Initial assessment

- Clarify mental state
- Clarify capacity for decision

Complete benefit realisation analysis

Accept for Home Treatment

Identify CPA Co-ordinator

Identify named CRHT worker and team members primarily delivering care plan

Develop partnerships with other agencies/services Crisis Houses etc.

Go to Stage 10 Follow up/aftercare

Informal admission

Signpost to other service

Satisfaction survey

Close

Contain until handing over to another community team

Formal admission

Go to Stage 2 Pre-admission
Discussion to admit made by Crisis Resolution and Home Treatment Team

- Formal admission under the Mental Health Act
  - Contact bed manager. Identify bed, ward, hospital
  - Identify care co-ordinator and CRHT liaison staff
  - Inform carers of admission
    - Information about hospital
    - Telephone contacts
    - Visiting information
  - Information to users/patients
    - Transport links
    - Hospital facilities
    - Hospital/ward rules
      - no smoking
      - activity programmes
    - Facilities
    - Rights and responsibilities
  - Arrange transport to hospital/ambulance
  - Secure accommodation
  - Collect benefits book
  - Collect medications
  - Assist packing of bag
  - Advise policy for mobile phones, musical instruments, communication systems
  - Inform those that need to know
  - Collect information on records, care plans, risk assessment, reasons for admission

Escort to ward

Go to Stage 3 Admission

Key objectives
Patients should be treated in the least restricted environment which is consistent with their clinical needs.

Inpatient admissions and pressure on beds should be reduced.

Equity of access to an alternative to admission for patients and families must be ensured.
Stage 3 Admission
Initial care plan and risk management

Arrival

Patient accepted for admission
- Take appropriate steps to ensure safety as a priority of known risks with appropriate observation and interventions from arrival
- The patient and accompanying person are met on arrival, shown to an appropriate area and offered refreshments
- The patient is introduced to a member of staff who will be their point of contact for the first few hours

Is the patient detained under the MHA?
- Y
  - Complete Form 14 and obtain copy of SW report
  - Identify any communication issues such as preferred language/need for an interpreter/visual or hearing impairment
- N

All community assessment paperwork is available to the admitting team when the patient arrives on the ward, including mental health and current risk assessment
- Ascertain from the referring agency information as to the security of the patients home, whereabouts of children or pets
- Clarify who has medical responsibility and expectations if shared care
- Complete core admin documentation/data collection (on checklist)
- Patient receives a basic medical assessment and physical examination
- Assessment of capacity to consent
- Risk Assessment Tool - agree level of observation/plan
- HoNOS +, nutritional screening, smoke free exemption, level of escort

Substance Misuse Protocol
Every patient to be given an information leaflet re substances on wards.
- If patient scores one or more on HoNOS fill in SuMMBAT.
- Obtain a urine sample.
- Obtain patients permission for full drug screen within 48 hours.

Has the patient got any significant children?
- Y
  - Make patient/relatives aware of child visiting arrangements and make a case note entry for MDT review to assess risks/safeguarding the child. (Inform the Health Visitor of any child under the age of 5 years old.)
- N

Initial Care Plan developed with the patient to cover the first 72 hours including a risk management care plan.
- Next go to Stage 4 - Orientation
Orientation/information giving

- Show the patient around the ward, explaining the fire drill, any significant issues of safety and an explanation of the need for a locked door or any other hindrances to comings and goings.
- Check the patient property to ensure no risk / banned items, recording any property retained by staff on relevant form.
- Reinforce the hope and optimistic approach to recovery. Clarify expectations staff have of the patient in terms of the patient’s structured day, respect of property, personal dignity to others, need for observation and regulations concerning smoking, alcohol and drugs.
- Patient is given the units information booklet with information on advocacy explaining any necessary points to promote understanding.
- Patient rights as an informal or detailed patient have been given in a leaflet, read and level of understanding documented.
- Establish who are the relatives and carers and if the patient consents to them being giving information or being involved in current care - record in notes (give appropriate information if consent given).
- Inform CPA co-ordinator or any other care workers currently involved with service user, requesting any appropriate information/advance directives.
- Inform the patient who will be their primary nurse and that the primary nurse will be introduced to them when they are next on duty.
- Issue the patient a sick note.
- Identify if patient meets the criteria for 7 day follow up, making appropriate referrals.
- Complete admission checklist.
- Staff to record in the notes any information that will require repeating.

The ward is a safe environment for service users, staff and visitors, that promotes a therapeutic and safe experience.

Service users and carers are provided with information about the ward, their care and treatment and are actively involved in planning individual care.
Within 48 hours

From arrival

Assessment takes place at a time and in an environment that is acceptable to all parties

Nursing assessment begins on arrival for admission

If assessments indicate any of the following risks, develop care plan

The ward team agrees a team management plan for risk/violent/abusive behaviour that the primary nurse or delegated deputy negotiates with the patient, putting issues and appropriate interventions

Where the patient is found to have a physical condition which may increase risk of them of collapse or injury during restraint this is:
- clearly documented in their records
- regularly reviewed
- communicated to all MDT members
- evaluated with the patient and where appropriate, a carer

For disturbed/violent behaviour the patient is given the opportunity to discuss their preferences/advance directives regarding prevention techniques (de-escalation and observation) and if required, interventions for continued management (rapid tranquillisation, seclusion, physical intervention)

If a patient is identified as presenting with a risk of absconding, then a crisis plan is completed, which includes instructions for alerting carers and any other persons who may be at risk

The choice of medication is made jointly by the patient and the responsible clinician based on an informed discussion of
- relative benefits of medication
- side effects
- alternatives
- involving the patients advocate or carer where appropriate

Obtain the most recent community care plan signed by the service user for the case notes if the patient is already on CPA

MDT (including Crisis Resolution and Home Treatment Team) meeting (at least medical and nursing) to review any immediate identified priority issues such as:
- significant safety issues/management plan/personal safety plan/observation levels/escorted leave
- any child protection/visiting issues/restrictions
- any physical/self care/social needs

Findings from risk assessments are communicated across relevant agencies and care settings in accordance with the laws relating to patient confidentiality.

Go to Stage 6
Within 1 week

The patients involvement is sought in all decisions about their care and treatment

Within 72 hours

The patient and primary nurse meet to complete the initial ward assessment and negotiate their C/P within the first 72 hours of admission. All assessments are signed and dated

The patient is able to involve the people they rely on for support (carers/relatives/neighbours/friends) in their assessments

The primary nurse to contact any co-ordinator involved and/or CRHT team. Identify requirements for early discharge package

The principle carer is offered an interview within 3 working days of admission with a named professional during which
- the carer is given an explanation and an information sheet about ward procedures
- the carer is offered information on carer advocacy, welfare rights and mental health services
- the carer is offered an assessment of their own needs (refer via Social Care Direct/CMHT)

A comprehensive holistic assessment of strengths, areas of concern and needs is completed including the following:
- assessment of risk
- vulnerability
- child protection/childcare
- mental health state
  - behaviour
  - hallucinations/delusions
  - patterns of substance misuse including alcohol
- engagement
- physical wellbeing including:
  - diet/healthy eating
  - relationships
  - social contacts
  - educational needs (literacy and numeracy)
  - accommodation
  - employment
  - smoking cessation
  - language/cultural issues
  - spiritual needs

Assessments to be presented within the first week at the full MDT care review meeting to discuss the service users care, with input from the community care co-ordinator.

Go to Stage 7
Twice daily

To promote recovery from mental health problems requiring inpatient care

Stage 7
Weekly cycle - recovery

Daily

Each handover contains a discussion of risk factors and patient needs resulting in an MDT action plan for the shift, with individual and group responsibilities

Twice daily

Weekly

The patients involvement is sought in all decisions about their care and treatment

Daily

The patient has a structured day and the opportunity to have supportive one-to-one sessions with staff every day

Weekly cycle - recovery

Weekly cycle

There is a daily handover between the nursing staff, doctors and other relevant members of the MDT

There is a nursing handover at each shift

Patients have a minimum twice-weekly documented session with their primary/allocated nurse to review their progress

Before the weekly review, the primary nurse should complete a nursing review at the same time. It is also good practice for the primary nurse and CPA co-ordinator to liaise weekly to discuss progress

A full multi-disciplinary review at least weekly with the patient and carer allowing them to air their views in relation to the care package and ongoing management of risk (first review - primary/allocated nurse to be present with introduction of all MDT members)

Review outcome - to record the following (if applicable):
- brief summary including consent, MHA issues/status, change in health and functioning and risk issues
- if to repeat any assessments/risk profiles
- identify unmet needs and who will make any necessary referrals specifying a time period for the referral and recording when sent
- identified needs/agreed interventions (including any changes)
- estimated discharge/transfer date
- predicted follow up (7 day/s117/CPA/s25/guardianship)
- date of next formal review

Service user to be involved in developing their care plan
- views recorded in the notes
- deciding what is in the care plan, when/where/with whom to share information
- copy to be given to the patient and carer if patient agrees

Is the patient suitable for discharge/Home Treatment?

Y

Go to Stage 9 - discharge

N

Complete the process weekly unless at a CPA meeting or 3 monthly stage (see Stage 8 which shows the differences)

Treatment aims - clinical decision support tool
- significant reduction of symptoms
- prevention of relapse
- prevention of worsening of condition
- better adjustment to situation
- management of crisis
- reduce risk of harm to self
- reduce risk to others
- maintain appropriate contact
- maximise social role function
- maintain current role functioning
- return to best social role functioning
- significant improvement in quality of life

Nursing Review to include:
- progress since admission/reassessment/response to treatment
- legal status/observation levels/access
- communication
- mood
- sleep
- appetite
- thought
- perception
- interaction
- motivation
- insight
- drugs and alcohol
- comments of carer/family
- physical health
- risk review
- HoNOS+ (every 2 weeks)
- identified nursing needs
- other identified needs including care responsibilities, social, cultural and spiritual needs

Service user to be involved in developing their care plan
- views recorded in the notes
- deciding what is in the care plan, when/where/with whom to share information
- copy to be given to the patient and carer if patient agrees

Is the patient suitable for discharge/Home Treatment?

Y

Go to Stage 9 - discharge

N

Complete the process weekly unless at a CPA meeting or 3 monthly stage (see Stage 8 which shows the differences)
To promote an effective integrated care pathway to manage care whilst in hospital and ensure a smooth transition out of hospital.

Stage 8 Treatment and review

Full CPA review meeting (at least every 4 weeks)

The patient should have an appropriate timely and purposeful admission

As per weekly review but to include the following

If appropriate repeat any rating scales not included in the weekly review

Guidance note

Care planning arrangements in too many inpatient units are confined to admission and discharge arrangements. They are not sufficiently clear on the process of assessing, planning and delivering inpatient care itself or the expectations of the service user while an inpatient. Inpatient care planning should include continuity with CPA care coordinators, with existing care plans available to inpatient staff.

CPA co-ordinator and any other relevant professionals to attend a full CPA meeting providing the meeting with an update on progress to facilitate a review of:
- the current treatment package
- current risks
- agreed outcomes
- discharge arrangements

CPA outcome - to record the following (if applicable):
- brief summary including consent MHA issues/status, change in health and functioning and risk issues
- if to repeat any assessments/risk profiles
- identified unmet needs and who will make any necessary referrals specifying a time period for the referral and recording when sent
- identified needs/agreed interventions (including any changes)
- estimated discharge/transfer date
- predicted follow-up (7 day/s117/CPA/s25/guardianship)
- date of next formal review

Service user to be involved in developing their care plan
- views recorded in the notes
- deciding what is in the care plan, when/where/with whom to share information
- copy to be given to the patient and carer if patient agrees

Is the patient suitable for discharge/Home Treatment? (see weekly stage 7 - weekly flow chart pathway)

As per monthly review but include the following:

Discuss with MDT and patient advantages of referring to the dual diagnosis team.

If indicated, provide and explain the overdose warning card.

Full nursing and medical re-assessment if required including a physical examination and review of consent to treatment

As the full CPA review re-clarify the safety/social/mental health/physical health and self care needs

Return to Stage 7 (weekly cycle) or Stage 9 (discharge)
A proposed discharge plan is initiated and documented at the time of admission.

The patient is actively involved in developing their discharge plan and involving their carer(s) if requested.

Is the patient subject to Section 117 MHA 1983 (statutory aftercare)?

Arrange 117 meeting and consider if the service user should be subject to Section 25 MHA 1983 (follow full CPA review meeting stage on previous page).

It is the responsibility of the consultant to ensure that:
- in consultation with other professionals concerned, a comprehensive assessment is made of risks to the service user or other people, and communicated to the Care Programme Approach Co-ordinator
- the service user’s needs for health and social care are fully assessed and a care plan is developed to meet the service users’ continuing needs.

The patient is given timely notification of transfer or discharge and this is documented in the notes.

The patient is given a copy of a written aftercare plan, agreed on discharge.

Prior to discharge, the date of the next CPA review or other review dates is recorded in the notes and communicated to the patient and members of the MDT.

On the day of discharge:

Complete discharge checklist.

Repeat HoNOS+ and send onto the next service if applicable.

Review the risk profile and communicate any risks/management plan with the co-ordinator/significant others.

If the discharge is against medical advice inform relevant people/review risks and care plan/organise next review date.

Discharge from acute admission ward.
Stage 10 Aftercare

- basic needs checked and met
- named CPA keyworker
- care plan agreed
- carer involved
- agencies informed
- reasons for admission met
- socially inclusive recovery plan developed
- WRAP plan devised
- crisis plan developed
- emergency contact details
- 24 hour and 7 day follow up

From Stage 1 Home care

- All information and details forwarded to the agency/team responsible for aftercare and follow up

From Stage 7 Treatment early discharge

- Team responsible for aftercare provides 24 hour follow-up

From Stage 9 Discharge against medical advice

- Socially inclusive recovery plan

From Stage 9 Planned discharge

- Ensure housing is functional and secure, community is inclusive and reasons for admission remain controlled

- Implement Home Treatment discharge plan

- User/carer satisfaction survey -

- User focused monitoring focus groups/survey

- Revise - WRAP/recovery plans
  - relaps signatures
  - coping mechanisms
  - medication plans
  - community activity and prescription programmes
  - contact and advice numbers
  - contingency plans
  - carer support packages
  - support groups

- 7 day follow-up - provide Home Treatment until

- basic needs checked and met
- named CPA keyworker
- care plan agreed
- carer involved
- agencies informed
- reasons for admission met
- socially inclusive recovery plan developed
- WRAP plan devised
- crisis plan developed
- emergency contact details
- 24 hour and 7 day follow up

Discharge to primary care services

Discharge to non-acute community teams
Our Board is aware that some service users are unhappy with the locality ward model we use. They (and their carers) do not appreciate being admitted onto a locality ward where they may meet neighbours or local people they know who are either in-patients themselves or visitors.

The importance of confidentiality and privacy for many service users when admitted to hospital is well known. On the other hand, many health care professionals firmly believe the locality model ensures the best continuity of care for service users and allows for good working between the ward and local community mental health services after discharge from hospital.

One alternative is to have assessment wards and wards for people with particular diagnoses. Another is to organise wards covering localities on a larger scale but it is impossible to organise the wards to guarantee service users do not meet people from their own locality. We also have to take into account service user choice such as a preference for a single sex ward or mixed ward. No one single arrangement will meet everyone’s needs or preferences.

When we implement our new acute care pathway we have the opportunity to change how our wards work so we would like to hear your views.
Hospital admission is a last resort and alternatives to hospital admission are vital to make sure people are only admitted to hospital when that is the only place their health care needs can be met. As part of implementing the acute care pathway we plan to strengthen our Crisis Resolution and Home Treatment team and review the way our community mental health teams operate.

We are interested in hearing from service users, carers, GPs, our own staff and partner organisations about what other alternatives we should consider. We are particularly interested in how we could work with other organisations both statutory and voluntary so a range of community-based alternatives to hospital admission are available to the people of Leicester, Leicestershire and Rutland.

**Question 6**

What alternatives to hospital admission do you think could or should be provided by LPT or the Trust working in partnership with other organisations?
The cornerstone of our community-based services are our community mental health teams, all of which are co-located with local authority social care services. As part of introducing a new acute care pathway we will be reviewing their operation and how they are organised into localities across Leicester, Leicestershire and Rutland.

We have a number of specialist services such as assertive outreach, early intervention in psychosis and Crisis Resolution all of which have a specific function and target group of patients to serve. Some trusts in the country have amalgamated the specialist teams into larger CMHTs while preserving the specialist skills.

We believe our community mental health teams need renewed clarity about their role and in particular their contribution to avoiding unnecessary admissions, helping people to recover after a stay in hospital and progressing their continued recovery and independence.

We would like to hear your views about the role and function of CMHTs.

We also need to review how they work with general practice to help people with time-limited and common mental health problems. Therefore we are particularly keen to hear from GPs about how community mental health teams could work in the future.
We provide psychiatric outpatient clinics at 15 locations and there are 4400 people who only receive this service from us. Approximately half of those patients were referred to us in the previous 12 months with the remainder having been in contact with our outpatient service for up to three or four years or perhaps longer. It may be that in the future many of these service users could be supported through primary care services on the basis that expert advice is always available at times of greater need via our single point of access.

We want to review our provision of outpatient clinics, which are staffed by doctors who are our most expert and highly trained staff. We need to understand the specific role and function of outpatients clinics and their fit to our overall portfolio of services to ensure we use our most expert staff to help those most in need of their expertise.

The 15 locations we use to provide outpatients clinics include our current in-patient sites and various other NHS premises across the area. We are interested to know whether service users prefer not to attend outpatients appointments at inpatient sites and whether we should look to providing more appointments in GP practices and local health centres.

Question 9
What should be the specific focus of our outpatient clinics and should this service be primarily for time-limited interventions of no more than 12 months?

Question 10
At what locations are our outpatient clinics best provided?
Final comments

Thank you very much for taking the time and trouble to read this discussion document. We value your feedback and hope that you will take the time to complete the questionnaire.

Send or e-mail your response by 20th January 2012 to:

Nicky Mawer
Communications Department
FREEPOST RRKS-JGGE-EUTH
Leicestershire Partnership NHS Trust
George Hine House
Gipsy Lane
Leicester LE5 0TD

- You can complete the on-line questions on our website at www.leicspt.nhs.uk
- You can email yours views at feedback@leicspart.nhs.uk
- Views can be submitted by telephone or fax to the Communications Department. The service can be contacted by telephone: 0116 295 8997 or by fax: 0116 225 6679

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