Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Access to Mental Health Care Assessment and Treatment - General

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P114	Chief Operating Officer	Quality and Safety Committee	3 years

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Contents

1. Introduction

This AWP document sets out service standards for service users referred into the Trust, ensuring reasonableness and fair management for all.

This general access policy is supported by more detailed Standard Operating Procedures (SOPs) for each component of our services which provide an access point to secondary care. These bring together and align with CPA policy, service specification and were developed in consultation with service users, carers and PCT/GP commissioners.

2. Policy statement and service standards

The AWP Policy Statement is that we will provide a range of services that are delivered in the right place, at the right time, are personalised to the needs of the individual and promote the greatest possible ease of access – for first time service users and those who are re-referred.

The Trust is committed to ensuring equality of access to our services and will endeavour to ensure that arrangements are made to support those individuals who have a communication or support need for example for those who communicate through British Sign Language or for where English is not their first language. We recognise that we may need to make reasonable adjustments for those who have a disability in order that they are able to access the services we provide.

In pursuit of this, AWP has agreed with the Commissioners of its services a series of access standards. In most cases, the standards are applicable across all six Commissioning areas within the Trust, where this is not the case, local variation is referenced below.

- Referral to assessment (RTA);
  - Emergency assessments to commence within 4 hours (delivered by Intensive teams, via 24/7 services)
  - Urgent / routine assessments by Primary Care Liaison teams to be prioritised using clinical triage, with a maximum wait between referral and assessment of 28 days (i.e. 4 weeks). Variation in Swindon locality, where the Primary Care Liaison Service offer assessment within 24 hours (for those service users that wish to be seen that quickly)
  - Urgent / routine assessments by Memory teams to be prioritised using clinical triage, with a maximum wait between referral and assessment of 28 days (i.e. 4 weeks).
- Referral to treatment (RTT);
  - IAPT services:
    - National target to achieve 75% of treatment starts within 6 weeks
    - National target to achieve 95% of treatment starts within 18 weeks
  - Early Intervention for people with suspected first episode psychosis:
    - National target to achieve 50% of treatment starts within 2 weeks, where treatment is defined as a NICE compliant intervention
  - Secondary Mental Health services:
    - Local target to achieve 95% of treatment starts within 18 weeks of referral

3. Service processes: unpacking the standards

3.1 Referrals

Receipt of any valid referrals (from any care professional or service permitted by an English NHS Commissioner (e.g. CCG, GP, Local Authority, other Healthcare provider, or assigned third

or private sector agent) and any self-referral where there is a local agreement for such arrangements is the point at which the waiting time starts.

All referrals will be logged onto appropriate electronic record system (e.g. RiO, IAPTUS) on the day of receipt.

If a referral is not accepted as legitimate the considered view of the team and the reasons for it should be notified to the referrer during the telephone screening, and should be followed up with confirmation in writing within 48 hours (by email or letter as per agreed operational practice with GPs).

3.2 Booking appointments

It is good practice that appointments should, wherever possible, be arranged in person with individuals. In addition, a minimum offer of 2 appointments on different days, with at least 3 weeks' notice, should be provided. However, clinical needs may dictate that such a notice period may not be appropriate even for routine referrals, with assessments commenced within days of referral, not weeks.

The 'three week rule' and 'offer of appointment choices' are tests of reasonableness to avoid situations where individuals feel they have been offered an appointment that is too soon, or difficult to attend due to existing commitments. While these specific tests may not always be achievable, it is for all staff and managers to ensure that this spirit of fairness is observed in how appointments are offered and booked.

4. Non-attendance outcomes

If an individual does not attend (DNA) an agreed assessment or subsequent appointment, all efforts should be made to find suitable alternatives using the principles in 3.2. If there is further non-attendance, efforts should be made to book a new and attended appointment. As a minimum this will be one attempt for routine/low risk referrals, but more for higher risk groups such as those referred to Crisis Services. It is expected that in all but very exceptional circumstances any person accepted for a crisis or urgent assessment will be seen before closing the referral. Individual SOPs set out requirements for different services.

Did not attend (DNA), is defined as where a client fails to attend an appointment and provides no notice that they will not be able to attend. (ref 1)

Where an individual DNAs 2 successive appointments and where there has been no contact between the events (from the time of the first DNA, to the end of the 48 our window after the second DNA) a letter must be sent to the GP notifying them of the DNAs within 48 hours of the second DNA. This letter should be imported onto RIO within 48 hours of the second DNA.

The definition of a contact in these circumstances is where there has been contact with the service user of significant value as per RiO clinical manual guidance for recording contacts and telephone calls. Telephone contacts for the purpose of arranging appointments do not count as a contact in these circumstances.

It is a **clinical decision**, based on a clinical risk assessment using all available information, to close a referral. However, if there is still failure to attend fairly scheduled and appropriately communicated appointments the referral should be closed, and the referrer and individual informed, unless there are compelling clinical or access to service reasons for further attempts to engage. In all cases, the principle should also be to discuss with the referrer, prior to the decision, where this is possible. A letter closing the referral should be sent in all cases, to the individual and referrer, setting out the process undertaken to date to secure an appointment, any relevant clinical/assessment information gathered, alternative sources of support, process for re-referral and setting out the reasons for the discharge. This letter should be imported onto RiO within 48 hours of the decision to discharge and before the referral is closed.

Where an individual cancels and re-schedules appointments the principles above do not apply.

Where the Trust cancels appointments, due to unforeseen circumstances, the principles in ref 1 must be applied.

5. Assessment

Mental Health Liaison Services (based in Primary Care, Acute Trusts, Emergency Departments and Care Homes) will commence initial face to face assessment. This will establish whether the individual will be accepted for short-term interventions by the liaison teams or whether a more specialist assessment is required for secondary, longer-term treatment. This latter stage of assessment will be in the secondary team and to develop an appropriate individual care plan from a range of evidence-based interventions. Practitioners at both the initial and subsequent care planning assessments will broker all elements of assessment and care packages, as part of a single integrated assessment process. This includes working across strategic business units (e.g. where the individual presents with co-morbidities).

Where, following initial assessment, an individual is not indicated for services (either Liaison or Secondary Care) the case must be closed within 2 weeks of assessment. No CPA status or care cluster should be applied. The referral should either be transferred to a more appropriate service or returned to the referrer. A letter closing the referral and summarising the outcome of the assessment, together with any formulation, advice and signposting should be sent to the GP and service user. It is best practice that this be written to the individual and copied to the GP. A short summary of this needs to be sent within 48 hours of the discharge date with any fuller clinical reports sent no later than 2 weeks. This referral should then be closed on RiO.

6. Internal Service Transfer

Periodically, service users move between geographic areas or between service specialties (e.g. where the balance of care indicates care coordination would be more effectively managed by an alternative service).

Once indicated for transfer, this will take place within 2 weeks unless agreed otherwise for specific clinical or service user considerations.

Where this is the case, transfer will be planned and managed in a sensitive way taking in to account individual service user needs. The existing service care coordinator will be responsible for management of the transfer and ensuring all communication is clear to the user, referrer and receiving service.

As per CPA policy, care will remain with the originating team, until it has been officially transferred through a CPA review or a comprehensive handover meeting.

7. Planned Treatment End/Onward Referral

All open cases should be reviewed systematically and regularly in line with the Trust's CPA and Risk Policies, according to need and as part of the team's case management processes.

Where treatment is considered to have been completed and a discharge is planned, this should be done in partnership with the service user (carer, where appropriate) and referrer.

A full discharge plan will be negotiated with the service user in advance, and the planned discharge date will give adequate time to prepare the service user, carer and any receiving service (where appropriate) for this transition. A full discharge letter will be issued to the referrer and service user within 48 hours of the actual discharge date and imported to RiO.

8. Implementation: Roles and Responsibilities

Within the parameters defined in this Policy, SBUs have developed Standard Operating Procedures that set out how the General Policy for Access will be adhered to. They contextualise it to the specific service type including any service-specific service standards (e.g.

for specialty teams under the NSF), any exclusions or deviations, within the clinical or operational rationale.

An audit programme, arranged by the Director of Nursing Compliance and Quality sponsored by the Deputy Director of Operations, will give assurance that the principals and spirit of this Policy are being implemented across all teams.

The Deputy Director of Operations will ensure that performance data is available at team, SBU, area and PCT level to support teams to monitor their delivery of the range of indicators contained in this Policy. This will be in the form of ReportZone Performance Reports (to all teams and DUs), monthly balanced scorecards and quarterly activity reports, available through Ourspace.

The Board and its Executive Management Team has a duty to satisfy itself that this Policy is being implemented in full. Scorecard and dashboard indicators directly relate to these, which forms a systematic and on-going surveillance approach. They may also require bespoke reports from the Director of Operations and independent assurance reports from the Director of Nursing and Quality and the Deputy Director of Operations.

The Director of Operations is accountable for ensuring that all Delivery Unit staff (from Director to frontline worker) are aware of this policy, key targets and have robust plans in place that ensure delivery. Critically, this policy must be understood and operationalised; and evidenced in the audit programme as well as in delivery of key indicators of service quality.

9. Monitoring

The Trust has in place monitoring reports that allow managers to view in real time their compliance with the various standards outlined in section 2 above. This information is reported monthly to both the AWP Trust Board and Commissioners.

10. References and Related Policies

NICE Clinical Guideline 178, (2014). Psychosis and schizophrenia in adults: prevention and management: https://www.nice.org.uk/guidance/cg178/chapter/1-recommendations

Care Programme Approach and Risk Policy:
http://ourspace/Trust/Policies/Documents/P032.doc

Trust Servies Standard Operating Procedures for Access:
http://ourspace/Trust/Operations/Pages/SOP_AccessToServices.aspx

Version History

Version	Date	Revision description	Editor	Status
1.0	04 May 2010	Final approved version after discussion at Quality Health Governance Committee	ART	Approved
1.1	12 Oct 2011	Approved by Quality and Effectiveness Management Group for minor amendments and inclusion of standards for serial DNA GP letters. RTT guidance also updated.	ATw	Approved.
1.2	01 Nov 2011	Revisions following discussion and agreement at the Performance Solutions Group Policy Review Sub-Group, 25.10.11	GM	Approved.
1.3	01 Feb 2012	Final revisions following discussion and agreement at the Performance Solutions Group Policy Review Sub-Group, 20.01.12	GM	Approved.
1.4	02 May 2012	Including amendments as approved by Quality & Effectiveness Management Group 12.04.12	Atw	Approved.
2.0	12 July 2012	Final approved version including agreed amendments as approved at Quality and Healthcare Governance Committee 10.05.12		Approved
3.0	20 May 2016	Approved Quality and Standards Committee	Acting Director of Operations	Approved
3.1	11 November 2019	Extended until end November	COO	Approved