**Summary:**
This Standard Operating Procedure describes the roles and functions of The Acute Mental Health Teams which form part of the Acute Care Pathway.

**Keywords:**
Adult Mental Health, AMHT, Acute, Acute Care Pathway

**Target Audience:**
Adult Mental Health Staff

**Next Review Date:**
June 2018

**Approved & Ratified by:**
AMH SMT

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Mental Health Division

This document should be read in conjunction with Acute Care Pathway Standard Operating Procedure

Acute Mental Health Team
STANDARD OPERATING PROCEDURE (SOP)
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1. Introduction

This Standard Operating Procedure describes the roles and functions of The Acute Mental Health Teams which form part of the Acute Care Pathway. The standards outlined in the Acute Care Pathway Standard Operating Procedure also apply to the Acute Mental Health Teams.

Southern Health NHS Foundation Trust (SHFT) Adult Mental Health Division in partnership with Local Authorities have developed an integrated way of working within the Acute Mental Health Teams which form part of the Acute Care Pathway.

This operating procedure needs to be read in conjunction with the overarching acute care pathway operating procedure.

2. Description of Service

The Acute Mental Health Teams for Southern Health Foundation Trust Adult Mental Health Division are based at

Elmleigh Inpatient Unit 61a New Lane Havant PO9 2JJ 02392 344562

Antelope House - Southampton: Royal South Hants Hospital, Brintons Terrace, Southampton, SO14 0YG, 023 8083 5500

Kingsley Unit - West Hampshire: Melbury Lodge, Royal Hampshire County Hospital, Romsey Road, Winchester, SO22 5DG, 01962 825560

Parklands Hospital - North Hampshire: Aldermaston Road, Basingstoke, RG24 9RH, 01256 817718

The Acute Mental Health Teams are a multi-disciplinary community based mental health service, providing rapid and responsive assessment and treatment 24 hours a day, 365 days a year to those people who meet the criteria for acute care.

3. The Aim of the Service

To work in a recovery focussed way to promote and improve health & wellbeing.

To work alongside Service Users in a focussed pathway of intensive support that is flexible and tailored to individual needs.

To support Service Users to move through the pathway following a crisis in mental health, to the next appropriate service.

To provide a responsive and effective gateway to the acute in-patient beds.

To proactively work with clients to prevent the need for people to come into hospital wherever possible, supporting the least restrictive option

To manage and gatekeep the acute inpatient beds and liaise with the Acute Support Team about demand and patient needs
provide accurate contemporaneous information about all admissions in area within other areas of SHFT and those admitted outside of SHFT in other NHS facilities and the private sector.

To support discharge from inpatient units.

4. **Referrals**

Referrals to the Acute Mental Health Team come from GP’s, other statutory agencies the Community Mental Health Team, Psychiatric Liaison Team, the Approved Mental Health Professional (AMHP) Service, as well in-patient teams (to facilitate supported discharge).

5. **Service Functions**

- Provision of high intensity support in the person’s home provided by a multidisciplinary team. The Acute Mental Health Team aim to work with these Service Users who are experiencing a mental health crisis that are currently involved with the CMHT and have reached the threshold of requiring more robust risk management and needing more than 2-3 visits per week due to evident deterioration in mental state.

- Referrals may also come via an emergency or urgent assessment or Psychiatric Liaison Team, the AMHT may work with people who are experiencing a crisis in mental health who are currently only being seen in primary care such as GP and/or Improving Access to Psychological Therapies (IAPT). Where this has been identified as a short term piece of work they may act as care coordinator / lead professional with the view of referring back to primary care.

- The AMHT is the gate keeping service for the acute care pathway in each area. All requests for admission to the pathway must be assessed / discussed with the Acute Mental Health Team. This is 24 hours per day, 365 days a year. This needs to be demonstrated through robust clinical documentation (on RiO).

- To assertively in reach to the Acute Care wards to identify those Service Users suitable for early facilitated discharge.

- To provide 7 day follow up in conjunction with CMHT's to Service Users discharged from wards.

- To provide recovery orientated services that focus on the strengths of the individual and encourage them to maintain independence, choice and control. We recognise that Service Users are ‘experts by experience’ and will make sure that these values are embedded in our service and apparent in everything that we do.

- To support people in their own homes as an alternative to hospital admission (including Clozapine initiation) in conjunction with the Community Mental Health Team (CMHT).

- Effective partnership working with carers and families. We recognise the crucial role of carers and families, and acknowledge they are members of the extended care team, and need appropriate information and support in their own right. When appropriate, they should be involved in the assessment, treatment and recovery process.
6. Screening / Triaging of Referrals

- At the point of referral to Acute Mental Health Team, it is essential that a clear explanation is given to the Service User, and their identified support network, if appropriate. Referral does not always necessitate admission to hospital. It is essential that the Service User is aware that the Acute Mental Health Team offers a range of services and they will provide the service most appropriate to an individual’s need.

- For referrals from the Community Treatment Team the Acute Mental Health Team can reasonably expect the Service User to have been reviewed by the care coordinator (or associated practitioner) within 24 hours prior to referral being made.

- The practitioner in charge of the shift is responsible for operating a dynamic and flexible response to referrals as they come in. If multi-disciplinary discussion is required in order to progress a referral at triage stage, this will not wait for a routine meeting - referrals should be dealt with as they come in.

- The process of screening requires the information received by the referrer to be checked to ascertain whether or not the individual being referred meets the eligibility criteria to receive services from the Intensive Support Team. All referrals to the Acute Mental Health Team are taken by telephone and need to be discussed with a Senior Practitioner (Band 6 or above, Team Leader in Southampton)

- Where a referral does not meet the eligibility criteria for services, this information will be supportively communicated to the referrer; signposting to more appropriate interventions may be necessary. These tasks will be carried out by senior staff in the team, where practicable.

- The Acute Care Transfer Facilitator in the team will take direct referrals from the in-patient multi-disciplinary ward reviews for facilitated discharge. Alternatively, the in-patient wards can directly refer to the Acute Mental Health Team.

- Carers are entitled to an assessment of their needs in their own right the team will facilitate the referral for this via a referral to ‘Carers in Southampton’. The Acute Mental Health Team will also work hard to foster sound working relationships with families and carers, particularly with regard to management of risk.

7. Assessment and Care Planning

All assessment & care planning is undertaken as described in The Care Planning and Care Programme Approach - Standard Operating Procedures for the Mental Health Division (SH CP 172, Appendix 1).

Once accepted on to the Acute Mental Health Team caseload, each Service User has an Initial Care Plan formulated from the Initial Assessment process. This will be in a letter initially, and a copy of the Initial Assessment will be written to the Service Users and copied to the GP with the plan included. For those Service Users who have Care Coordinators from the Community Mental Health Team, the Care Coordinator will remain involved and have minimum of once weekly contact with Service User & Acute Mental Health Team. All service users of the Acute Mental Health Team will have a Care Coordinator.
Following the Initial Assessment Process, a Service User focussed Care Plan will be drafted in collaboration with the Service User which they will sign a copy of, and retain, for their own use. This Care Plan will be located in the Care Planning Module on RiO.

All Service Users will also be asked to sign a ‘consent to share’ information document, itemising those people the individual allows us to communicate with.

Standards for care planning for AMHT:

- The Initial Care Plan will be completed on transfer to Acute Mental Health Team within 24 hours.
- The Care Plan will be based on the most up to date assessment and risk assessment and will relate to the reason Acute Mental Health Team care is required.
- The Care Plan will have the problem/needs described, which should also be from Service User’s perspective.
- The Care Plan will detail goals and interventions required and include the Service User’s strengths e.g. coping strategies.
- In addition Crisis Management Plans will document who staff can contact if unable to make contact with Service User at an agreed time.
- Risks identified must be clearly recorded in the Care Plan / Crisis Plan as to how these risks can be managed. This should be agreed with the Service User.
- The use of AMHT should form a learning experience for the service user and their care team to identify which solutions help them towards recovery when they are in crisis. This should result in an updated crisis plan.

Formal Care Plan reviews will take place a minimum of once a week within the multidisciplinary team. This formal review will be recorded in the Service User’s RiO record. It involves the views of the Service User wherever possible. The CPA process will be the foundation for care planning and should use Recovery based approaches, making use of Service User’s strengths and resources, as well as the problems or difficulties they are encountering.

On discharge from the Acute Mental Health Team, a Discharge Summary will be written to the Service User and also be copied to the GP. Any third party information will be excluded from this process in accordance with the Trust Policy.

The Acute Mental Health Team is also required to link with other professional groups, such as Psychological Therapy Services as required to form an effective recovery pathway.

8. **Service User Risk Management Plans**

Risk assessment should be a core component of any mental health or learning disability assessment, in any setting. The Department of Health Guidance, Best Practice in Managing Risk (DOH 2007) provides a framework based on the principle that modern risk assessment should be structured, evidence-based and as consistent as possible across settings and across service providers. The assessment of Clinical Risk and subsequent management of the identified risk is integral to Care Planning and in particular, the management of Service User safety in Southern Health NHS Foundation Trust.

The guidance notes, *Managing Clinical Risk Practice Guidelines (SH CP 28, Appendix 2)*, are intended to help staff from Southern Health NHS Foundation Trust implement the policy *Risk Management Strategy and Policy (SH NCP 25, Appendix 3)*; they should be read in conjunction with that policy.
All Service Users will have an up to date Risk Assessment and it is the expectation of practitioners visiting Service User’s homes that this is read prior to any visit. For CMHTs referring Service Users to the Acute Mental Health Team, there is an expectation that the risk assessment is updated, given that significant change has occurred to warrant increased input.

The individual risk assessment for each patient will be recorded in the Consultant letter or the risk assessment section of RIO

9. Safeguarding

- Safeguarding Service Users from harm and/or abuse is a key function of the Acute Mental Health Team.
- The Acute Mental Health Team will practice in line with the
  - Safeguarding Adults Policy (SH CP 15.12, Appendix 4)
  - Safeguarding Children Policy (SH CP 56, Appendix 5)
- The team will have a clearly defined Safeguarding Lead who will lead on the Safeguarding Investigation Process where the Acute Mental Health Team acts as the Lead Professional.
- The Acute Mental Health Team will adhere to the following process when safeguarding concerns are raised:

  Identify Safeguarding Concern
  ↓
  Preserve immediate safety (in conjunction with other agencies if appropriate)
  ↓
  Raise Safeguarding Alert through Ulysses
  ↓
  Discuss within multi-disciplinary team / Safeguarding Lead / Team Manager
  ↓
  Internal Lead Professional (if not the Acute Mental Health Team)
  ↓
  Seek advice from the Local Authority Safeguarding Adults team if required
  ↓
  Safeguarding Lead to lead on the investigation process if required

10. Interventions

Dependent upon the outcomes of the individual’s needs assessment, the multi-disciplinary nature of the Acute Mental Health Team means that a Service User will have access to a variety of services and interventions to meet their assessed short term needs where the individual meets the criteria for acute care:

- Evidence-based interventions such as the Intensive Support Programme (Appendix 6).
- Provision of a range of education sessions/workshops and group work e.g. Emotional Coping Skills, Anxiety Management
- Specialist psychiatric treatment of severe mental health disorders
- Specialist psychological therapies
• Medication Review
• Medication management (neuroleptics, clozapine, monitoring and medication reviews)
• Relapse prevention, development of crisis and contingency plans to prevent relapse in collaboration with their families and social networks
• Identification of safeguarding procedures for vulnerable adults and children (BIA, MLA, DOLS) and appropriate referrals.
• Physical health monitoring in liaison with primary care
• Acute Mental Health Team, in collaboration with CMHT, will also support Clozapine initiation in the community
• 7 Day follow-up from in-patient care
• To refer carers for assessment of their needs

10.1 Medicines Management in Acute Mental Health Team

To be read in conjunction with the Trust Medicines Control, Administration and Prescribing Policy (MCAPP), (SH CP 1, Appendix 7). The AMHT team will support Service Users to adhere to medication prescribed, ensure good communication regarding information about medication and monitoring for side effects or any physical health conditions.

The Acute Mental Health Team will have an identified senior nurse in the team who takes a lead on medicines issues, quality and medicine safety. The team will be supported by the Medicines Management Team.

Prescribing
A record should be made of all changes on to the Service User’s RIO record in a progress note and marked as a significant event. When medication is amended the General Practitioner (GP) must be informed of these changes.

Review of medication and associated physical health monitoring must be considered at each CPA review.

Medicines Reconciliation on Transfer into Acute Mental Health Team
Medicines reconciliation is the process of obtaining an up-to-date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes, deletions and additions resulting in a complete list accurately communicated. Sources of information include Service Users, carers, families, Service User’s own medication, GP fax of current medication, out-patient letters.

When a Service User is taken on by Acute Mental Health Team, a faxed request for current psychiatric and physical health medication and allergy/sensitivity information must be made by the team by fax as soon as possible. If a reply is not received within 24 hours, excluding weekends, then a follow up telephone call must be made to the GP’s surgery. The information received should be reviewed by a doctor and/or pharmacist and/or trained nurse/MHP as soon as possible and then filed in the secondary notes, section 7. The purpose of this review is to compare the information from the GP with the information documented on RIO to ensure that the latter is accurate. Documentation that the process has been completed should be made in a RiO progress note.
At the point of discharge from the Acute Mental Health Team a full list (discharge summary part A) of any changes made and additional medicines prescribed must be sent to the GP within 24 hours.

**Acquisition**

For all medicines stored at team bases, a named practitioner will be responsible for the ordering, stock control, rotation, expiry date checking and reconciliation of any discrepancies.

When a prescriber considers that a medication is needed by a Service User then this may be obtained by:

1) FP10 HNC prescription form.

2) From stock - either by administration by a trained nurse from stock boxes or dispensing by doctors into a new box/bottle and labelled as per MCAPP using pre-printed labels. This must be double checked by a trained nurse or MHP.

3) Dispensed as an individually labelled medication direct from the local hospital pharmacy (provided this service is covered by the service level agreement).

**Stock Medication**

Stock lists must be agreed with the Area Lead Pharmacist and reviewed regularly to ensure appropriate medication is available and to minimise waste. A record must be kept of all stock medication issued either by administration or dispensing. This should be in a bound record book. With a separate page for each medicine and should include the details:

**On receipt**
- Date received
- Name, form and strength of medication
- Quantity received
- Total quantity of drug held
- Signature of nurse receiving medication into stock
- Date

**On supply**
- Date of supply
- Service User’s name
- Quantity supplied
- Signature of issuing nurse/MHP/prescriber

**Administration**

All administration of medicines must be recorded on a Trust prescription chart. Only nursing staff and MHPs are authorised to administer medication.

**Removal of Service User’s Own Medication**

Occasionally it may be necessary, with the Service User’s permission, to remove medication from them for their own safety. This medication should be stored in a designated area of the team’s medicine cupboard and segregated from stock medication. This must only be used for this Service User and no-one else. All Service Users’ own medicines must be checked for suitability for use.

### 11. Key Roles within the Multi-Disciplinary Team

Acute Mental Health Teams are multi-disciplinary and share a common orientation promoting the principles of recovery. Each Service User will be given a named worker who will take the lead responsibility for their care, however given the intensive nature of
the team’s work; a collaborative whole team approach is required with clinical responsibility shared across the team. The skill mix encourages the use of a diverse range of approaches, interventions and treatments. All team members will approach their work flexibly.

The Multi-Disciplinary Team consists of:

- Team Manager / Senior Mental Health Practitioner / Team Leader
- Consultant Psychiatrists and other medical staff
- Mental Health Social Workers in some cases
- Nurses
- Non-medical prescriber
- Occupational Therapists
- Health Care Support Workers
- Psychological Therapists
- Admin Support Staff
- Acute Care Transfer Facilitator (shared resource across the Acute Care Pathway)

All practitioners will receive specific training in the Intensive Support programme.

12. **Transfer & Discharge**

In order to ensure the team can focus on skilled assessment and brief crisis intervention in keeping with its purpose and philosophy, the workload of the team will need to be focussed. The team workload must be managed effectively to best meet the serious demands on the team.

The team will practice in line with the Trust Admission, Discharge and Transfer Policy (SH CP 49, Appendix 8).

**Transfer**

There are arrangements for transfers between the Acute Mental Health Team and other Southern Health services. Transfers will be facilitated by liaison between the services or teams and RIO transfer mechanisms. CPA will be followed.

**Discharges**

Recovery is the focus of all mental health interventions and discharge from services is planned in partnership with the individual at their Initial Assessment and reviewed regularly. Discharge is based on the individual reaching their recovery goals, or no longer benefitting or accepting of support. Carers will always be involved in the discharge process in collaboration with the Service User. All imminent discharges should be discussed at case management or weekly MDT and clustering should reflect recovery.

Prior to discharge, it is essential that the Section 117 Mental Health Act 1983 status of the Service User is reviewed and Local Authority guidance followed to discharge this section.

A written discharge summary will be provided to both the individual and their GP within 10 days of discharge and much sooner in most cases. Also in cases where the individual has disengaged with services and policy guidance has been followed (Clinical Disengagement & DNA Policy – SH CP 97, Appendix 9) all reasonable efforts must be made to inform the individual verbally of discharge and this recorded on RIO.

The discharge summary will include:

- A summary of interventions provided
- The effectiveness of those interventions
13. Bed Management

Finding a Bed
Initially, the Acute Mental Health Team would check with their area acute wards to determine bed availability. Where possible, the Service User should be admitted to their locality hospital. Where this is not possible, either because there are no beds, or the person is deemed to require a hospital bed somewhere else in the division, the Acute Mental Health Team practitioner will use the global bed facility on RIO and will contact the senior nurse at the unit closest to the Service User’s home to secure a bed. (Procedure for Sourcing an In-patient Bed In and Out of Hours, Appendix 10).

14. High Users

AMHT staff will engage in the High User groups in their local areas to support consistent crisis and care plans for people who are high users of care services.

Anyone who attends A&E more than 3 times in a four week period will be flagged with AMHT and discussed in MDT to review safety, risk and need and agree whether any change to the current care plan is required.

15. Supervision

The Acute Mental Health Team Manager is responsible for ensuring that each team member receives management, clinical and professional supervision according to individual need and experience. Where this involves someone other than the line manager, this will be ratified by that manager.

The supervision process will inform the annual appraisal process, to ensure that staff professional training and development needs are addressed. This will include opportunities to access professional group supervision.

16. Health & Safety

Incidents of violence and aggression are a recognised risk when working in a healthcare environment; however, such incidents are unacceptable whatever form they take and whatever reasons are given for the persons actions.

The Trust accepts that the prevention of violence and aggression towards staff requires a high level of management commitment, professional competence and adequate resources. Furthermore, it recognises that actual or threatened violence and aggression towards staff can be very frightening and / or traumatic. The Trust recognises that the nature of being a Mental Health, Learning Disabilities and Social Care Trust, will mean caring for Service Users who at times exhibit challenging behaviours and/or display behaviours which can be aggressive and/or violent. As such, The Trust will provide
appropriate training to meet the diverse needs of our workforce in line with all national guidelines.

16.1 Risk Management

Restrictive Interventions Policy (SH NCP 23, Appendix 11).

Staff and Service Users of the Trust live and work in environments, and circumstances, which are often high risk and where many decisions have to be taken which are by nature risk management decisions, or a weighing up of relative risk options.

Risk Management is a process with four elemental stages;
- Identification of hazard or risk.
- Analysis and prioritising of risk.
- Management of risk by; elimination, substitution, reduction or transfer.
- Audit and review of chosen risk management action.

16.2 Lone Working Policy

This policy (Lone Working Procedure, SH NCP 24, Appendix 12) is designed to reflect good practice in relation to the protection of lone workers. The term ‘Lone Worker’ is used in the policy to describe a wide variety of staff who work, either regularly or occasionally, on their own, without access to immediate support from work colleagues, managers or others. This could be inside a hospital or similar environment, or in a community setting; there is no single definition that encompasses those who may face lone working situations and, therefore, increased risks to their security and safety.

17. Multi-Disciplinary Meetings

The Acute Mental Health Team will hold multi-disciplinary team meetings at least weekly for each area. These meetings will focus on the needs of Service Users in both the assessment and brief interventions element of the service and will also establish if a Service User needs to remain in the Acute Mental Health Team. Team members will be able to present information related to the Service Users they are working with, including immediate and short term goals, information about changing to other teams, and other factors which need to be shared.

The purpose of the Multi-Disciplinary Meeting is:
- To review Service Users on the caseload
- To RAG rate the risk level of all Service Users and review safeguarding needs
- To discuss discharges
- To discuss the need for Psychological Therapy and appropriate interventions or referral onto the Intensive Support Programme
- To provide a forum for guidance and management of cases
- To provide opportunity for team clinical supervision as an adjunct to weekly team clinical supervision
- To provide an opportunity to identify Service Users for Early Intervention Psychosis
- To identify potential delays in discharge planning and develop discharge plan

All multidisciplinary team discussions are to be recorded on Service User’s RIO record. The expectation is that all clinical team members prioritise attendance.

All MDT discussions/Huddle discussions will include a review of people who have DNA’d or are disengaging from the service.
18. **Leadership Meeting**

To ensure key operational issues which affect the Acute Mental Health Team performance and operational working are addressed there will be a bi-monthly meeting attended by senior team members including the Team Manager, Team Leader, Consultant Psychiatrist, Senior Psychologist and the lead administrator.

19. **Business Meeting**

To ensure good communication among all team members, regular business / team meetings will be held fortnightly to discuss the following:

- Team brief
- CQC issues
- Key performance issues
- Local issues to include LA updates
- Health and safety
- Learning from incidents / complaints / audit etc.
- What's going well? / What can we do differently?
- Patient feedback
- AOB

This meeting will need to maintain robust records, these will provide evidence of the work the teams are doing to ensure that the core business is appropriately monitored, reviewed and developed.

20. **Handover Arrangements**

The Shift Leader will take responsibility for ensuring that handovers are completed at every shift or team change.

21. **Interface with In-patient Service / Community Treatment Team / Mental Health Liaison Team / Police**

**Interface with Acute Care Teams:** Acute Mental Health Team staff will liaise directly with Acute Care Team in order to access services for Users.

**Interface with CMHT:** Acute Mental Health Team will refer Service Users, who require more than crisis work to the Community Mental Health Team where appropriate and with discussion with the CMHT.

Acute Mental Health Team will work alongside CMHT staff at times of crisis on a shared care basis.

The Acute Mental Health team will offer advice and support to colleagues within Primary Care Services.

Acute Mental Health Teams will work collaboratively with Community Mental Health teams to ensure good relations with GPs are maintained.

Medical advice and information to GPs and Primary Care staff is made readily available and all enquiries will be responded to within 4 hours in core hours.
When Service Users are assessed as having a co-morbid condition (predominantly mental illness combined with a learning disability, physical disability, misuse of substances, eating disorder etc.) the Acute Mental Health Team will work in partnership with other teams as necessary.

Acute Mental Health Team will work in conjunction with other professionals and agencies to provide education and guidance about mental health issues.

22. **Acute Care Forum**

Divisional Acute Care forum is attended by the Acute Care Pathway Manager and the Lead Nurse from the Acute In-patient Unit.

This informs the local Area Acute Care Forum which focuses on local acute care issues and this is jointly chaired by the Lead Nurse and the Acute Care Pathway Manager.

23. **Outcome Measures**

Throughout the care pathway we use a number of outcome measures in line with PROM/PREM and Clustering procedures. Service User satisfaction questionnaires are used with all Service Users. Other appropriate psychometric measures should also be used as required, as should goal focused measures.
24. **Appendices**

All trust policies need to be accessed via the Southern Health intranet site to ensure that the most up to date documents are referenced.

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<td>2</td>
<td>Managing Clinical Risk Practice Guidelines (SH CP 28)</td>
<td>See the Intranet, search using the policy number</td>
</tr>
<tr>
<td>3</td>
<td>Risk Management Strategy &amp; Policy (SH NCP 25)</td>
<td>See the Intranet, search using the policy number</td>
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<td>4</td>
<td>Safeguarding Adults Policy (SH CP 15.12)</td>
<td>See the Intranet, search using the policy number</td>
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<td>5</td>
<td>Safeguarding Children Policy (SH CP 56)</td>
<td>See the Intranet, search using the policy number</td>
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<td>6</td>
<td>Intensive Support Programme</td>
<td>Intensive Support Programme.docx</td>
</tr>
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<td>7</td>
<td>Medicines Control, Administration and Prescribing Policy (MCAPP) (SH CP 1)</td>
<td>See the Intranet, search using the policy number</td>
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<td>8</td>
<td>Admission, Discharge and Transfer Policy (SH CP 49)</td>
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<td>9</td>
<td>Clinical Disengagement &amp; DNA Policy (SH CP 97)</td>
<td>See the Intranet, search using the policy number</td>
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<tr>
<td>10</td>
<td>Procedure for Sourcing an In-patient Bed In and Out of Hours</td>
<td>Procedure for Sourcing an In-patient Bed In and Out of Hours.docx</td>
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<td>11</td>
<td>Restrictive Interventions Policy (SH NCP 23)</td>
<td>See the Intranet, search using the policy number</td>
</tr>
<tr>
<td>12</td>
<td>Lone Working Procedure (SH NCP 24)</td>
<td>See the Intranet, search using the policy number</td>
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This operating procedure needs to be read in conjunction with the overarching acute care pathway operating procedure.