Livewell Southwest

Assertive Outreach Service (AOS) Team Operational Policy

Version No 3

Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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Reader Information

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Associated documentation	**Related LSW Policies**: Assertive Outreach Medication Policy Lone Working Policy at Assertive Outreach Mobile Phone Policy for Assertive Outreach Care Programme Approach Policy and Standards

	Confidentiality Policy Infection prevention and Control Clinical Record and Note Keeping Policy and Health Record Audit Tool AOS Staff Induction Pack AOS Student Induction Pack Clinical Supervision Policy Information Sharing: Guidance for Practitioners and Managers Line Management policy Smoking - Zero Tolerance This list is not exhaustive; please see the Intranet for latest clinical policies and procedures.
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Document review history

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0.1	New document	July 2009		New document
1		September 2009		Approved at Policy Ratification Group.
1.1	Reviewed	Sept 2011	Author	Reviewed, no changes made.
1.2	Review	July 2011and Nov 2011	Assertive Outreach Team Manager	Reviewed to reflect team changes And recommendations from SUI's
1.3	Review	Dec 2012	Assertive Outreach Team Manager	Minor changes regarding the formats of meetings and an addition about information sharing following a recommendation from a SIRI.
1.4	Review	Oct 2013	Assertive Outreach Team Manager	Reviewed and amended to reflect locality community structure and care pathway.
2	Ratified	Nov 2013	Policy Ratification group	Ratified.
3	Reviewed	September 2015	AOS Manager	Minor amendments. Replace all references to e-pex with SystmOne, and changes in time for our team meetings. Plus adding an abbreviation RC (responsible clinician) in the abbreviation list)

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Assertive Outreach Service (AOS) Team Operational Policy.

1. Introduction

"To help the client live a stable life of decent quality, in an environment that facilitates personal growth and provides opportunities for personal fulfilment."

Professor L. Stein (1983)

1.1 Effective assertive outreach service delivery is ultimately about improving the service users quality of life, and experience of services. The service aims to:

- Proactively establish and maintain therapeutic alliances with individuals, whenever possible, with the view to identifying personal aspirations and working towards their expressed wishes.

- Provide an intensive and co-ordinated team approach, to the support of individuals and their carers, who experience severe and enduring mental health problems.

- Enabling people to live in their local community in ways that are acceptable to them, and responsive to their needs.

- To undertake effective care co-ordination utilizing the LSW Care Programme Approach (CPA) according to LSW policy.

- Offer care co-ordination, an identified care co-ordinator and a recovery based care package.

1.2 Objectives

- To develop proactive engagement skills to facilitate effective working relationships with service users reluctant to engage with traditional services.

- To work in an integrated manner with other locality based mental health services to ease access to the Assertive Outreach Team.

- To provide a service that recognises local demographic factors that affect service uptake and to target disadvantaged groups such as homeless people and black and ethnic minority backgrounds.

- Offering emotional and practical support in environments acceptable to clients within the community.

- Using interventions that build on the individual's strengths and encourage individual's ability to make choices about their life fostering movements towards independence and equality in the community.

- Enable individuals to define and make sense of their experiences, and facilitate progress towards resolution of personal dilemmas.

- Facilitating access to a full range of health services, for promoting physical and mental wellbeing.

- Providing a proactive, collaborative and educative approach to treatment and follow up with the ability to respond to changes in need.

- Being flexible in the intensity and timing of support offered.

- Supporting each individual to obtain or retain the most suitable accommodation.

- Supporting each individual to obtain and retain benefit entitlements.

- Helping individuals to maintain family and social relationships, and develop supportive social networks.

- Delivering treatment and support, which is sensitive to the religious and cultural beliefs, values and cultural practices of the service user.

- Encouraging individuals to develop awareness of anticipating risk, and responding in ways that maximize it; and encouraging positive risk taking.

- Working with people to identify and reduce the effects of substance misuse.

- To liaise closely with other specialist and general parts of the comprehensive health services.

- Proactive approach to treatment and follow up with the ability to respond rapidly to changes in need, recognizing increased associated risk factors.

- To reduce a person's likelihood of admission/re-admission to hospital.

- To offer individual a range of social inclusion activities, based on the needs expressed.

- Delivery and administration of medication and treatment to service users who require intensive monitoring and without such would be non-concordant leading to relapse. This would include providing education around their medication, to build a consensus with the individual on how medication can best aid in their recovery.

2. Purpose

2.1 The development of Assertive Outreach in the UK is a significant component of mental health service provision is largely due to the combination of major policy review and a focus on delivering evidence

based practice. The Sainsbury Centre 'Keys to Engagement' proposed *"There is a small but significant group of severely mentally ill people who have multiple long term needs and who cannot or do not want to engage with services, unless engagement is achieved and people in this group are provided with safe and effective service they will continue to face social exclusion"*

2.2 The purpose of this policy is to provide a unified operational policy for the Assertive Outreach Service, and outline how the core components of effective practice are to be delivered across a diverse geographical area. It is a working document that will be continually reviewed and updated in line with local need.

2.3 The Service has been developed to meet Government directives in the National Service framework for Mental Health (DoH 1999) and the NHS plan (DoH 2000). The model of care is well researched and originated from work by Professor L. Stein in America in the late 1970's. This policy will reflect how the service will maintain fidelity to the model of care whilst recognizing the specific needs of our locality.

2.4 It will provide an operational frame work within which team members operate and provide guidance for other teams on procedures for referral, assessment and discharge.

3. Abbreviations and brief explanation of terminology

Assertive Outreach Service – AOS

Responsible Clinician – RC

Support Worker – SW

Assistant Practitioner– AP

Department of Health – DH

National Service Frameworks – NSF

Policy Implementation Guidance – PIG

Service Users – A term used to describe members of the public who access mental health services. In this document in has been used interchangeably with "patients" and "clients".

General Practitioner – GP

Out of Hours – OOH

Home Treatment Team – HTT

Care Programme Approach – CPA

Approved Mental Health Practitioner – AMHP

HoNoS- Health of the Nation outcome Scores

RTT-- Referral to Treatment Time

SEMI - Serious and Enduring Mental illness

STR – Support Time Recovery Worker

WRAP – Wellness and Recovery Action Plan

Community Mental Health Team – CMHT

CPA Review – A 6 monthly review of the service user's care and treatment plan.

PBR - Payment by Results

National Institute of Clinical Excellence – NICE
Multidisciplinary Team – MDT

Care Co ordinator – A designated staff member who "co ordinates" the package of care a service users receives

Cognitive Behavioural Therapy – CBT

Personal Development Plan – PDP

Line Management Supervision – LMS

RC- Responsible Clinician

SystmOne - Electronic Patient Data recording (paperless service)

Insight – A team focused on working with young people based in Plymouth

Shekinah Mission – A charity working with the homeless in Plymouth

Serious Incident requiring investigation - SIRI

Glenbourne – Plymouth's Acute Inpatient Unit - GB

Mental Health Act – MHA

Mental Health Act Assessment – MHAA

Disclosure and Barring Service - DBS

Person Centred Plans – WRAP and the Recovery Star

Health of the Nation Outcome Scales - HoNos

4. Operational Criteria

- Manageable caseloads of no more than1:12, agreed individually with clinicians using the Line management process. Caseload numbers will be dependent on the individual service users needs taking into account complexities and risk.
- Offering a comprehensive range of interventions.
- A team approach.
- Working on the clients territory.
- Multi-disciplinary working.
- Service users will have a period of stability before moving to the CMHT or returning to Primary care and be able to be maintained on fortnightly contact. There are occasions when it may be appropriate in some cases that service users return directly back to the care of their GP with a comprehensive care plan and contingency / crisis plan in place.

4.1 Who we aim to engage

4.1.1 Assertive Outreach is a community based model of care that works with the small number of people in the population that suffer from a severe and debilitating mental illness.

4.1.2 Assessments of eligibility will be taken on an individual basis and the following list should help the prospective refers and the Assertive Outreach Team make these decisions.

4.1.3 Individuals who have severe and enduring mental health diagnosis and have difficulty maintain engagement with services can be referred to the Assertive Outreach team.

4.1.4 Team members will be happy to discuss cases and attend CPA Reviews or Risk Management Meetings before referrals are made to the team. Typically clients will be on the enhanced CPA and will be in HoNoS PBR Clusters 12, 13, 16, and 17.

4.2 Referral Criteria

4.2.1 Referral criteria have been developed based on the Department of Health's Mental Health Policy Implementation Guide 2002 (Assertive Outreach – Chapter 4) but at the same time being sensitive to the specific needs of the locality of Plymouth.

4.2.2 Service users must be suffering ongoing severe and enduring mental illness aged 18 or above on referral, most typically schizophrenia and or severe affective disorder. Clients must have a history of poor,

intermittent or chaotic engagement with services. Receiving services or in need of services equivalent to the enhanced level of the Care Programme Approach.

4.2.3 Service users will usually have had numerous admissions to hospital or a history of a transient lifestyle where admission has been avoided.

4.2.4 Evidence of difficulty in maintaining lasting and consenting contact with traditional statutory services and lack of meaningful engagement with services.

4.2.5 Individuals must be registered with a GP in the Plymouth area.

In addition service users will typically have a number of the following:

- History of violence or a persistent offending.
- Poor response to previous treatment.
- At risk of persistent self-harm, neglect and/or social exclusion / isolation, Vulnerable to abuse or exploitation by others.
- Homelessness or difficulty maintaining a tenancy.
- Where a service users support network becomes intolerable or unable to sustain the individual as a result of their severe and enduring mental illness.
- Combined substance misuse and SEMI (dual diagnosis).
- History of non-concordance with treatment/care plan **OR**
- Has received intensive treatment from mental health services for a period of more than 3 years.

4.3. Exclusion Criteria

4.3.1 The assertive outreach service recognises the importance of serving our defined service user group. To provide an effective service we have outlined inclusion criteria and on advice from the Sainsbury Centre for Mental Health have designed exclusion criteria to ensure fidelity to the model. This list is designed to give focus to the team during the screening process:

- Those who are currently well engaged with services but are difficult to manage.
- Substance misuse as a primary diagnosis.
- Personality disorder as a primary diagnosis.
- Organic condition.
- Moderate to severe Learning disability.
- Coping independently with existing levels of support.
- Living in high support residential or institutional settings, and are likely to stay there for the foreseeable future.
- Living outside the catchment area.
- Clients under the age of 18.

4.4. Referral Process

- Referrers are invited to ring and book to attend a team meeting to discuss a potential referral.
- To make a referral please complete the Livewell Southwest SystmOne CPA Referral form. Notification should be made to the Team leader for AOS by email that a referral has been placed on the system and the email should be copied to the AOS Office Manager.
- The Care Co-ordinator, Consultant, Service User and family (if appropriate) must be aware of the referral.
- The referral will be placed on the RTT waiting list and regularly checked by the Office Manager or AOS administrative staff.
- AOS will respond in writing within one week of the referral confirming it has been received. The date of the next MDT and when the referral will be discussed will be in this letter.
- The referral will be discussed in the Tuesday MDT. Referrals which have been received that week will be allocated at that meeting.
- Referrers are welcome to attend the Multi-disciplinary team meeting to discuss referrals made, this should be arranged with the Team Leader.
- It is anticipated that the initial screening assessment will take up to 8 weeks as the team start to engage with the service user. If a service user has a particularly complex case a decision may be made to have a longer period of assessment.

4.5. Assessment process

- All assessments will be completed by a Doctor and a qualified member of staff from AOS.
- A CPA assessment, Risk assessment and Baseline HoNoS (Health of the Nation Outcome Scales) will be completed at the time of assessment. Further assessments may be included if clinically indicated.
- The assessment will be on placed on SystmOne and a paper copy sent to Care Co coordinator, Referrer, GP and Service User if appropriate.
- Relatives and carers will be involved where appropriate.
- Joint assessments may be conducted with Social Services if there is an unmet social aspect to their care needs.
- During assessment further consideration will be given to individuals who may be at high risk of acquiring an infection due to lifestyle and this will monitored in line with the Infection prevention and control policy.
- The Outcome of the assessment will be fed back to the referrer, care co coordinator, GP and service user. The documentation on SystmOne will be completed in line with CPA policy.
- If the referral if not deemed appropriate for AOS, a full rationale for the decisions made and recommendations to the referrer will be made.
- Waiting list will be managed within the referral to treatment time criteria.

4.6 Responsibility of the Referrer

4.6.1 The referrer is responsible for completing all requested information for the process of referral (including last CPA Plan and risk assessment) and will continue to remain as CPA Care Co-ordinator until a CPA transfer has occurred as per LSW policy. During the assessment period the usual package of care should be delivered.

4.7 Transfer into AOS Service

4.7.1 Following referral, assessment period and Team acceptance of the client, it is expected that the current CPA Co-ordinator will arrange a CPA meeting to facilitate the transfer of the client and agree/arrange any necessary transitional joint working i.e. between CMHT and AOS in respect of on-going individual work/individual client needs, for a temporary period of time.

4.7.2 The current RC will write to the AOS RC informing them of their current management plan. Once successful transfer of care has been completed, CPA responsibility will be taken on by the Assertive Outreach Team. In line with effectively functioning 'team approach' with a nominated care co-ordinator ensuring that the necessary CPA responsibilities are carried out by the team.

4.8 AOS Operating hours

Daily – Monday to Friday 9am-8pm.

Saturdays: 9am -5pm and Bank Holidays 9am-5pm.

Outside of these hours service users are encouraged to use Mental Health Matters Service.

4.9 Team Structure

Team structure is developed in line with 'PIG' and consists of consultant psychiatrists, staff grade psychiatrist, manager, Team leaders, nurses, occupational therapist, social inclusion worker, Associate practitioners and STR workers.

4.10 In addition to this AOS can easily access

- Psychologists.
- Psychotherapists.
- Family Therapists.
- Pharmacists.
- Approved mental health practitioners/Social Workers.

4.11 Team Meetings

A minimum standard of daily handover and no less than weekly team clinical reviews are established. This is especially important on a

Monday as the AOS team will meet to feedback from work over the week end.

AOS is subdivided into two teams, both teams will then meet separately to discuss all cases, even if briefly, and plan and allocate any planned work for the week. We will discuss any out of hours (OOH) patient contact that arose over the week end and any potential work that may have generated.

4.12 Daily meetings

- The Team Leaders will organise and lead this meeting or in their absence another Band 6 member of AOS.

- There is an “Activity Sheet” which incorporates all essential visits, medication deliveries and depots which will be discussed on a Daily basis. It is the Team leaders’ responsibility that all essential contacts are allocated to appropriately skilled staff.

- The ethos will be to involve all team members in all cases although there will be an allocated care coordinator. No service user in AOS should be lone worked by a Care Coordinator unless it is indicated in their care plan.

- Each team is expected to follow up any outstanding work from the evening before, any immediate issues following on from Ward Round on Wednesday, ensure all work has been allocated for that day, all visits and crisis work has been covered etc.

- Discussions which occur on a Tuesday in MDT will be documented on SystmOne using the MDT sheets. They will be signed by the AOS Manager or Team Leader and filed on SystmOne within 3 days.

- Any risk issues discussed will be immediately documented in the service users risk assessment and changes to the care plan done in the treatment team meetings for whole team awareness.

4.13 Clinical supervision

- Two smaller Team meetings will be held on Tuesday between 09:30 and 11.00 to review their team caseload. The purpose is for each Care coordinator to discuss their caseload within their team, focusing on their current care plans and level of contact. These are designed to help the care-coordinator share practice and risk issues within the team and allow the MDT to offer their input and support with the caseload. This will be done on a rotational basis so every care-coordinator has the opportunity to discuss their caseload every 5 weeks.

- Discussions will be recorded as a professional only contact on SystmOne.
- The whole AOS team meets to discuss community clients in crisis between 11.00 and 12:30. Discussions which occur in both these forums will be recorded on SystmOne using CPA review form.
- A psychologist attends the Team meeting on a monthly basis to provide team supervision, referral feedback and learning opportunities.

These are mandatory, essential meetings which will be minuted and MDT sheets will be completed on SystmOne. Clinical work is not to be planned during these times. Participation, ideas and challenging each other's practice in a supportive way looking at different ways of working and problem solving, sharing risk and ideas is the goal of these meetings.

4.14 Range of interventions.

All team members will be involved in all service user related activities; whilst still recognizing individual personal and professional specialist skills, attempting to match these to specific needs. The following is not an exhaustive list, but covers the main expectations of team activities:

- Creative, meaningful engagement on the service users terms.
- Assessment (including mental state, risk, needs and strengths).
- Symptom Management.
- Psychosocial interventions.
- Care planning, implementation, evaluation, and review (to include relapse prevention, crisis resolution/contingency planning).
- Medication management (including education, promoting informed choice, assessment, monitoring side effects, collaborative review).
- Meeting and maintaining accommodation needs within local resources.
- Ensuring rightful entitlement to welfare benefits.
- Financial management.
- Practical assistance and supporting activities of daily living, with the aim of promoting a level of independence in: shopping, cooking, laundry, housekeeping, self-care).
- Accessing and supporting physical health through your GP.
- Promotion of meaningful daytime occupation (including social, leisure, education, employment, vocation).
- Consideration for cultural and spiritual well-being.
- Working with substance misuse.
- Working with the criminal justice system.
- Working towards social inclusion.
- Advocacy.
- Interagency and multidisciplinary liaison.
- Carer/family work.

- Working to reduce stigma and discriminatory practices towards persons with mental health problems.
- Work to avoid hospital admission wherever possible seeking alternatives where it is safe to do so and looking at all alternatives.
- In reach work when an admission to hospital is necessary.

4.15 Communication

- Effective functioning of an Assertive Outreach service largely depends on integration and good communication with other statutory and non-statutory mental health services. The aim is to promote continuity of care, and to ensure that identified needs of the service user are met by the appropriate service providers.

- Ideally, all communication with these providers will be discussed with the service user first. All communication to other providers will be in line with the Organisations Confidentiality policy and Information sharing protocols to ensure service users privacy at all times.

- The AOS team will deliver services, locality facing.

4.16 How users and carers will be involved in the service

4.16.1 Service users will have access to the appropriate interventions as identified with their care coordinator and Responsible Clinician through CPA Reviews. Where needs cannot be met within the team we will refer you to the relevant agency.

- All service users will have a copy of their own crisis plan and telephone numbers.
- All service users will be able to access an AOS mobile in times of crisis as discussed with their care coordinator and the Team Manager.
- All service users will have support from our STR workers and Community Support Workers to develop their own WRAP / Recovery plan.
- All service users will be supported to access social care assessments and we will work towards promoting direct payments to support them in achieving their goals and care plans.

4.17 Transfer (exit) out of AOS Service Gradual disengagement

4.17.1 The term ‘discharge’ often holds fears of losing a valued source of support. It is envisaged that the Assertive Outreach Service will always be working towards making itself redundant for the individual service user i.e. the type of service and level of intensity will no longer be appropriate. However it is also recognised that for most people this will

take many years, with sudden termination of LSW led contacts often resulting in unintentional relapses.

4.17.2 When the client and the team consider they are ready to be transferred to a mainstream service, i.e. set goals have been achieved, the CPA Co-ordinator will arrange a CPA meeting to discuss and co-ordinate this transfer. A period of up to six months (if appropriate), of joint working will be undertaken between the allocated agency and AOS's staff, to ensure a seamless smooth transition and continuity of the clients care.

4.18 Safety

4.18.1 The Assertive Outreach Service will conform to the existing and developing LSW policies governing the safe and effective practice of mental health services. Health and Safety legislation will be adhered to, and precautions necessary to ensure the welfare of staff and service users will be appropriately considered. In line with the organisations work place risk assessments all team members have use of a mobile phone and operate a lone working device for increased safety.

4.19 Client Records

4.19.1 The Assertive Outreach Team is committed to using single electronic clinical records. Service users' records will be kept in accordance with Livewell Southwest policies.

4.19.2 Service user contact details will also be inputted into the LSW data input system (SystmOne) and subject to data protection. All computers will have a password. It will be the practice of all staff to share as much information as possible with the service users. If a service user requests access to their notes, in accordance with Access to Health Records Act (1991/1992), they will be supported by their Care Co-ordinator to facilitate this process. Access to records will be in accordance with the relevant policies and procedures of the Organisation.

4.19.3 The Organisations system for collating statistics will be used to monitor contacts with service users, caseload size as well as other demographic risk and CPA information, to aid in the monitoring of the service.

4.20 Medical Input

4.21 All service users referred to the Assertive Outreach Team will be under the care of one of the Responsible Clinicians operating within the assertive outreach team. If a person is admitted to hospital, their care will move to the inpatient consultant for the duration of their admission. The Responsible clinicians are supported by a staff grade psychiatrist.

Medical cover is provided from Monday-Friday 9-5. On call arrangement outside of these hours which the AOS team can access.

5 Training and Staff Development

5.1 Alongside the mandatory training as per LSW policy, the training and development needs across the Service will be reviewed by the Team Leaders, through team discussion and individual supervision. This is to ensure the use of resources focuses on the needs for delivering an effective Assertive Outreach Service.

5.2 Team members will be given a formal induction programme when commencing with the team. The team will follow a course of continual evolution and review. Team development will be given priority and met by development training and supervision days. Individual team members will be encouraged to develop specialism, which will benefit the effectiveness of the team. Each staff member will partake in a system of appraisal. As part of this appraisal, training needs and personal development needs will be identified and negotiated.

5.3. Students.

AOS are keen to support student's placements from Nursing, medical and psychological backgrounds, we have a number of staff who are mentorship and sign off trained and look to provide a quality learning environment for up to a maximum of 2 students at any one time.

5.4 Line Management/Supervision

All Assertive Outreach Staff will receive regular supervision on an 8 weekly basis. Management supervision is performed via the line management structure, this gives the staff the ability to review caseloads, on-going performance and review the targets set out in their appraisal. As well as focussing on areas of good practice.

6. Monitoring Compliance and Effectiveness

6.1 The Assertive Outreach Service is striving to provide an evidence based quality service under the umbrella of clinical governance. The Service will undertake regular reviews and evaluate the effectiveness of services using a range of audit tools and guidelines to compliment these outcomes for the service to promote good practice and maintain fidelity to the model of care.

Audits include:-

- Hospital Bed days
- Length of stay in hospital
- Referrals into service

- Discharges out of AOS
- HoNoS PBR monitoring
- Social Care assessments
- CPA record keeping Audit
- Depot Audit.
- Meridian patient questionnaire/Feedback

6.2 We are undertaking separate service user satisfaction surveys at present; we promote and embrace service user feedback utilizing service user satisfaction tools and user services to enable us to gain feedback to develop the service in line with client needs and wants. These will conducted 6 monthly as part of the CPA review process.

6.3 To review and feedback the progress of the team, in terms of its governance and compliance.. An AOS Business meeting will be held on the First Tuesday of every month from 11:00-12:30. This will be chaired by the Team Manager and in their absence one of the team leaders.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 17th September 2015