Northamptonshire Healthcare NHS
NHS Foundation Trust

Operational Policy
And
Clinical Services Standards

Early Intervention Psychosis Service

N-STEP
(NORTHAMPTONSHIRE SERVICE FOR THE TREATMENT OF EARLY PSYCHOSIS)

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Table of Contents

1. Document Control Summary

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If this policy requires Trust Board ratification please provide specific details of requirements	

2. Glossary of Abbreviations

AMHP	Approved Mental Health Professional
AWT	Access to Waiting Times Standards
BFT	Brief Family Therapy
BLIPS	Brief Limited Psychotic Symptoms
CAMHS	Child and Adult Mental Health Services
CBT	Cognitive Behaviour Therapist
CPA	Care Programme Approach
CPD	Continuing Professional Development
DH	Department of Health
DUP	Duration of Untreated Psychosis
DVLA	Driver and Vehicle Licensing Agency
EI	Early Intervention
EIS	Early Intervention Service
FERN	First Episode Research Network
GAP	Global Assessment of Functioning
GHQ	General Health Questionnaire
GPs	General Practitioners
MHA	Mental Health Act
NHS	National Health Service
NSF	National Service Framework
PANSS	Positive and Negative Symptoms Scale
RC	Responsible Medical Clinician
SCIPANSS	Structured Clinical Interview for the Positive and Negative Syndrome Scale
ST&R worker	Support Time and Recovery worker
UCAT	Urgent Care and Assessment Team

3. Introduction

Research has shown that the average delay between onset of psychotic symptoms and first treatment has been between one and two years (McGorry and Jackson, 1999). It is also apparent that the longer the individual and their family remain untreated or unsupported, the greater the opportunity for serious physical, psychological and social harm (Lincoln and McGorry, 1999).

There is further evidence to indicate that where problems develop, in either social or personal functioning, they usually do so in the first three years – 'the critical period' (Chatterjee and Liberman, 1999) and the problems that develop during this critical period; e.g. unemployment, impoverished social networks or loss of self-esteem; tend to be more aggressive and to have a disproportionately greater impact on later functioning (Birchwood et al, 1998).

Individuals experiencing first episode psychosis should have access to a range of evidence-based biological, psychological and social interventions as recommended by NICE guidance and the Access and Waiting Time Standards. The service promotes a sense of hope and optimism and a recovery based approach, streaming service users away from the chronically ill. Early Intervention in Psychosis is provided by a discrete, specialist service, which consists of a multi-disciplinary team. Its sole responsibility is the management of people in the early phase of psychotic illness, to whom it aims to offer vocational, cognitive, psychosocial and medical interventions.

Early Intervention means detection and treatment of psychosis during the critical early phase of illness. Delays cause unnecessary distress, increase the risk of relapse and are potentially harmful for the person, their family and friends. Early treatment has been shown to improve the long-term course of psychosis (Birchwood, 2002).

4. Eligibility Criteria - Who Is the Service For?

Age and Diagnosis Criteria

The N-Step is for patients within Northamptonshire who are;

1. Aged between 14 and 35 with a first presentation of psychotic symptoms.
2. Aged between 14 and 35 and in the first three years of psychotic illness. Including people with co-morbid substance misuse, personality disorder, and forensic needs.

In addition, N-Step is positioned to offer a service to a group of service users assessed as being at high risk of transition to psychosis (i.e. service user thought likely to be in the prodrome of a psychotic illness). In terms of its

operation, this part of the service is ready for implementation but not yet rolled out.

People who are already receiving care from mental health services are eligible, providing the above conditions are met.

N-Step is only able to accept service users who are aged fourteen to sixteen if there is an identified CAMHS Psychiatric Consultant in place.

5. What Is The Service Intended To Achieve?

The objectives of N-Step are to facilitate early identification and treatment of psychosis and therefore reduce the disruption to the young person's functioning and psychosocial development. Without early intervention, there is often an extended period of delay (2-3 years on average) when problems intensify (McGorry, 2001). The service aims to reduce this period of disruption.

5.1 Principles and Philosophy

Early Intervention Services should offer:

1. Culture, age & gender sensitivity.
2. Family orientation.
3. Meaningful and sustained engagement based on assertive outreach principles
4. Separate age appropriate facilities.
5. Emphasis on normal social roles and service users' development needs, particularly involvement in education and achieving employment.
6. Emphasis on managing symptoms rather than on the diagnosis.

N-Step includes the following additional principles:

1. A style of service based around recovery.

2. A service designed and delivered through effective partnerships and co-production.

6. Role and Function of N-Step

Key features of N-Step are:

1. Recovery orientation.
2. Promoting social inclusion and placing high value on social and peer group acceptance.

3. Age appropriateness.

4. Minimising stigma.
5. Emphasis on family interventions.
6. Assertive engagement.
7. Optimising outcomes.

Adhering to the above philosophy and principles should lead to N-Step being distinctive from traditional mental health services particularly in relation to recovery, emphasis on social inclusion, age-appropriateness and its approach to engaging service users and families.

Working with a recovery oriented philosophy means recognising a broad concept of recovery, including both objective components e.g. improvements in symptoms and social functioning and also subjective components e.g. achieving a life which is meaningful and satisfying to the individual service user. This subjective component will be different for each service user. It may not be achieved automatically when symptoms and social functioning recover. Or it may be achieved in spite of residual symptoms and disability.

Offering an age-appropriate service is important in achieving engagement and satisfaction with services, and avoiding additional stigma that may arise from services being inappropriate to age. It means responding to the variation in age-related needs that occur across the wide fourteen to thirty-five age range. There are particular psychological needs associated with younger service users. Younger service users may have different priorities e.g. placing a high value on social and peer group acceptance. They have particular needs from services e.g. for attention to confidentiality, agreement of arrangements for communication with families, more frequent need for family interventions. They may be deterred from using services through their being perceived as similar to school and other agencies with negative associations.

Successful engagement is important in optimising outcomes. Encouraging engagement will mean close attention to making services not just acceptable but also inviting, prioritising things that are important to service users, and fostering strong therapeutic relationships.

Assertive engagement means continuing to make the service available to service users who are not currently wanting to engage. However, engaging assertively may sometimes conflict with service users' rights to choose for themselves, excessive assertiveness may itself provoke disengagement, and sometimes service users may benefit from being allowed to take risks and make mistakes. Strategies to address these issues may include encouraging service users to tell us if they are finding contact with the service excessive, and considering different ways of encouraging service users who disengage to work with the service.

Overall, adhering to the principles of recovery, age-appropriateness, and assertive engagement will have several important implications for N-Step:

1. All working practices will reflect these aspirations e.g. groups, leaflets, DVDs, contact arrangements, assessment and case management processes, communication, and communication with families.

2. Recognition that service users will often have different perceptions and priorities from staff and N-Step as a whole.

3. Staff to prioritise seeking advice on the development of N-Step from service users and from other young people, and from their families.

6.1 Service Objectives:

1. Reduce the stigma associated with psychosis.

2. Improve professional and lay awareness of the symptoms of psychosis and the need for early assessment.

3. Reduce the length of time young people remain undiagnosed and untreated.

4. Develop meaningful engagement, provide evidence-based interventions and promote recovery during the early phase of illness.

5. Increase stability in the lives of service users, facilitate development and personal fulfilment.

6. Provide a user centred service i.e., a seamless service available for those from age fourteen to thirty-five years that effectively integrates child, adolescent and adult mental health services and works in partnership with primary care, education, social services, youth and other services.

7. At the end of the treatment period, ensure that the care is transferred thoughtfully and effectively.

6.2 Treatment Aims:

1. Explore the possible causes of psychotic symptoms and treat them.

2. Educate the person and their family about the illness.

3. Reduce disruption in a person's life caused by the illness.

4. Support the person through recovery.

5. Reduce the person's chances of having another psychotic experience in the future.

6.3 How Will This Be Measured?

This will be measured by Access to Waiting Times standard which currently stands at 2 weeks from the point of referral.

In addition, the service reviews the following areas:-

Reduction in the duration of untreated psychosis (DUP)

The duration of untreated psychosis is the time from emergence of the first persistent psychotic symptom to the receipt of effective antipsychotic medication. There is a strong association between DUP and prognosis. Therefore a key rationale for early intervention is to improve prognosis by reducing DUP.

Social inclusion and local indicators

Exclusion from the workforce is a key problem for people with major psychiatric illness. The service will aim to increase the number of patients in training or paid employment, including stable accommodation. In addition, risk assessments, ethnicity data, and waiting time targets will be monitored weekly.

7. Service Model

7.1 Overall service structure

The service is based countywide and is delivered by one countywide team. The population size of the county is approximately 733,000.

The borough of Northampton, including its surrounding towns and villages is served by N-Step team based at Campbell House in Northampton. The Kettering based N-Step office covers Wellingborough, Kettering, Corby and East Northamptonshire towns and villages.

7.2 N-Step Teams

The Team consists of a County Wide Operations Manager and a number of Care Coordinators (Occupational Therapists and Nurses), STR workers (Support, Time and Recovery workers), administrative staff, Psychiatrist, Psychologists, Peer Support Workers and an Employment Support Worker.

Each team provides a core strategy of care/interventions, including care-co-ordination, assessment, care planning, and relapse prevention and family work.

Additional interventions include group work, physical health checks, and access to psychological input.

The service works closely with the UCAT, CATSS and county council's emergency duty team for out of hour's operations, including CAMH's. The service utilises an acute pathway leading to in-patient hospital wards.

7.3 Working with CAMHS

The teams offer specialist Child Adolescent Mental Health (CAMHs) input and joint working with CAMHs psychiatrists. The psychiatrist will be a CAMHs practitioner, the rest of the MDT will be consisted of N-Step and CAMHs practitioners.

7.4 Cultural Competence

One of the principal objectives of N-Step is to improve the accessibility and cultural appropriateness of mental health services for the multi-cultural population of Northamptonshire.

Despite the policy of equal access to care, research has shown that access to mental health care varies by linguistic and cultural background. In a significant number of cases, language barriers and the cultural complexity of the cases has prevented adequate assessment in conventional mental health care settings.

In order to accurately diagnose and treat patients from diverse backgrounds it is essential for N-Step to consider the cultural meaning of different symptoms and the social context of distress.

This will start with a (cultural) formulation of a case but also requires development of assessment instruments, new strategies and techniques of intervention.

Cultural competence is a priority consideration for N-Step. Arrangements for addressing these issues operationally are being developed. These include working closely with representative community groups offering consultation on cultural issues.

However, the ethos of the service will be that cultural competence is paramount through all interventions provided by staff. Staff have access to relevant training, which addresses cultural aspects. Interpreting services will be used where appropriate. The service has recognised the importance of translation of its information, including leaflets into the most common minority languages. This is accessed on an individual case by case basis.

7.5 Strategies of care

All service users for whom the service is appropriate are offered a range of strategies of care, which are provided by the care co-ordinator and delivered through the care programme approach (CPA). Key aspects include:

1. Care coordination and risk management.
2. Engagement in a supportive therapeutic relationship.
3. Detailed assessments.
4. Attention to basic needs and social inclusion e.g. housing, education and work, income/finance, physical healthcare, practical support.
5. Basic psycho-social interventions.
6. Work with families including Family Behavioural Therapy.
7. Group work.
8. Psychological interventions.

Service users have access to a range of interventions in-keeping with AWT standards. These build upon and complement the interventions provided by the whole team, these include:

1. Medication management.
2. Cognitive Behavioural Therapy for service users with persistent psychotic symptoms.
3. Cognitive Behavioural Therapy for service users who are in N-Step service but who do not have persistent psychotic symptoms.
4. Individual family interventions.
5. Social inclusion and recovery.
6. Substance misuse.
7. Cultural consultation
8. Employment Support with Employment Support Specialist.

All N-Step staff have basic skills in psychosocial interventions. Some clinicians are more specialist in areas such as CBT-P and Behavioural Family Therapy.

8. Pathways In To N-Step

8.1 Referrers

Referrals come from the UCAT's via initial screening and assessment.

Referrals can be made direct from Primary care, but will be facilitated by the screening teams in the UCAT's in order to ensure single point of entry and to offer immediate signposting to other services if N-Step is not appropriate.

Referrals can also be accepted within existing NHFT mental health teams.

Threshold for referral

Potential referrers are encouraged to have a low threshold for referral, i.e., to refer on the basis of suspicion rather than certainty of psychosis.

Arrangements to assist referrers include:

1. Information to assist potential referrers e.g. symptoms of psychosis, screening tools, referral pathway.

2. Encouraging referrers to discuss potential referrals informally with an N-Step clinician.

3. Identifying 'link-workers' within teams likely to regularly refer to N-Step, e.g. wards and community mental health teams, and keeping in regular touch with these through regular e-mails or newsletters, or visits and presentations.

4. Contributing to training sessions e.g. induction for junior doctors, primary care educational programmes and secondary mental health service staff and countywide GP awareness sessions and school liaison.

5. Service user and carer information packs.

6. Referrals are accepted by telephone, in writing or through SystmOne.

N-Step will ensure that service users are identified as early as possible, e.g. regular contact with in-patient wards.

The teams are not able to take referrals on an urgent basis to provide a response to a crisis. Where there is a need for immediate response, the referrer will be advised to also refer the service user to the appropriate crisis / home treatment or out of hour's service. These systems are established locally.

Referral Criteria

- Aged 14-35 (under 16 year olds via CAMHS initially)

- Experiencing a first episode of psychosis (indicative of Mental Health Cluster 10) and treatment has not exceeded the previous 12 months

- The service does not exclude co-morbidity with substance misuse or personality problems or where there is a concurrent forensic or offending history

- Service users are not excluded where the diagnosis is Drug Induced Psychosis: however care must be taken to differentiate between a psychotic illness, precipitated by drug use, and drug intoxication

Exclusion criteria

- Psychosis through Organic Cause e.g. cerebral tumour.
- Aged under 14 years old and over 36.
- Primary diagnosis of Personality disorder.
- Previously diagnosed bi-polar affective disorder or bi-polar disorder without psychotic symptoms.

9. Response to Referrals

9.1 Initial Response

Referrals will be taken by an EIS administrator, or duty worker who will confirm that they are eligible for N-Step in terms of administrative criteria - age, GP, etc., using a screening pro-forma to record these details. Usually this screening will be completed in the initial telephone conversation with the referrer, and further information will be taken by a 'duty' worker.

N-Step worker will contact an appropriate practitioner if necessary, otherwise, they will aim to discuss the referral immediately with the referrer, using the standard pro-forma to record the referrer's concerns including, the level of urgency and suggested arrangements for contacting the service user. A duty system is in place to take all new referrals during team opening hours.

In cases where N-Step is not appropriate for administrative reasons (age, address or misunderstanding of the purpose of N-Step etc) the screening pro-forma will still be completed. A letter will be written to the referrer explaining why the service is not appropriate, and where relevant suggesting appropriate pathways to care.

9.2 Practical Arrangements For Determining if N-Step is the Appropriate Service (Suitability Assessment)

The practitioner receiving the referral is responsible for ensuring that arrangements are made for assessment to be started as early as possible by appropriate members of the team. These assessments will be allocated through a service assessment rota.

Assessments to determine suitability of N-Step for the service user will usually be carried out initially by care co-ordinators. Where there is uncertainty over a decision, N-Step assessor(s) will involve the team psychiatrist, psychologist and occupational therapist to help inform diagnostic criteria.

Suitability assessment will usually include discussion with the referrer.

In some cases talking to staff who know the service user and reading the case notes may lead to referrer and N-Step assessor agreeing that N-Step is not the appropriate service for the service user and in these cases suitability assessment may not include a face to face meeting with the service user.

Suitability assessments will be carried out as soon as possible, if necessary using an assertive approach. If the service user's needs require a response sooner than N-Step can provide, referrers will be advised to contact the appropriate crisis or other emergency service.

Where service users are referred from within mental health services, joint assessment with the referring service will be required as far as practicably possible.

Where possible, assessments will take place in a setting of the service user's choosing, with preference given to low stigma settings e.g. the service user's home and premises unconnected with mental health services. Assessors will follow the Trust's Lone Worker policy. In addition, the teams have their own tailored lone working policy relevant to separate ends of the county.

If suitability assessment is difficult because the service user does not want to be seen, then N-Step assessors will liase with other professionals involved, and where appropriate with the service user's family.

N-Step will continue to make efforts to arrange assessment until a decision has been taken that this is inappropriate - such a decision would only be taken following a multidisciplinary discussion within the team and discussion with the referrer. Responsibility for the service user will remain with the referrer until written acceptance is received.

9.3 The Role of the Assessor

CPA responsibility (if applicable) rests with the referrer until such time as the patient is accepted by N-Step. This decision will be multi-professional and agreed during MDT discussions.

The assessor will aim to ensure that the assessment is completed for each service user within 14 days:

1. N-Step screening proforma, including details of the service user's preferred arrangements for contact and correspondence, HoNOS and Mental Health Assessment Tool for N-Step on SystmOne.
2. Other screening instruments as required, such as: BPRS, QPR, CAARMS and PANSS.

9.4 Objectives of Suitability Assessment

The suitability assessment will determine whether the service user enters N-Step, and their immediate needs.

The suitability assessment will aim to clarify the referrer's concerns, the service user's concerns, the family's view, and any immediate risks.

For all service users, the assessor will consider whether the service user meets criteria for deciding that N-Step is the appropriate service or not, and will complete or update a CPA care plan and risk assessment profile by the end of the assessment period.

Referring agencies must complete relevant risk assessment paperwork and other relevant risk documentation prior to referral. If the agency is referring in from another agency, which does not subscribe to the NHFT documentation i.e., out of area transfers, then localised relevant risk assessments should be completed.

The assessor will consider the possibility of any apparent psychotic symptoms being due to acute intoxication, or to borderline or dissasociative pathology rather than psychosis.

There are two possible decisions about the role of N-Step:

1. Service User has psychosis and is offered care through N-Step.

2. N-Step is not appropriate for the service user, but remains under the care of the referrer or under the care of the GP. Additional recommendations may be made about pathways to appropriate care.

9.5 Substance Misuse

If it seems likely that the service user's symptoms occur only briefly in direct response to acute intoxication or withdrawal states, the service user may not be eligible for N-Step. If it seems likely that the service user's symptoms have persisted for several weeks in the absence of acute intoxication or withdrawal, then service user enters will be accepted for assessment. Decisions are often difficult and the aim will be to err on the side of over inclusiveness

For all service users, it will be important to clarify as far as possible the date when they last used each drug (even though sometimes this will turn out to be inaccurate). Urine tests will sometimes be helpful, bearing in mind that cannabis may continue to be detected for up to 4 weeks after last used. Consent will be sought by staff before tests are done.

The service will link to S2S to aim for a smooth transition between services and seek this specialist help where relevant. In addition, staff with drugs and alcohol expertise will be utilised within the service.

9.6 What Happens After The Decision About Suitability Is Made?

Service users where N-Step is appropriate

The assessor will agree immediate priorities with service user and family, agree a crisis plan with the service user and family, and contact the referrer in writing. They will also contact the service user's GP in writing and if possible by telephone.

Where relevant, the service user will be advised that they need to inform the DVLA and their insurers of their illness and cease driving until the DVLA have confirmed they are able to do so again.

Identification of care co-ordinator

An N-Step care co-ordinator will be identified as early as possible.

The service user will remain the responsibility of the referrer until they have been formally accepted by N-Step and transfer to an N-Step Care Co-ordinator has been agreed. In some cases where the service user is accepted by N-Step it will be appropriate for there to be a gradual transition to N-Step taking over care co-ordinator role.

In exceptional circumstances N-Step team and referrer may agree that it may be in the service user's interests for N-Step to provide input but for a care co-ordinator to be appointed from within another service, e.g. a Learning Disability service.

As soon as service users are offered a service by N-Step, the Care Co-ordinator will begin to implement core strategies and interventions and will arrange referral to additional staff i.e., psychology or additional mental health services according to the service user's needs i.e., supported accommodation. This includes consent form, My Story, HoNOS, Risk, QPR and 3 Changes Checklist.

9.7 Treatment and Interventions

All treatment and interventions should be in line with NICE guidance and the Access and Waiting Time Standards:

Medication

The principle underlying the use of neuroleptics medication in the early stages of psychosis is to ensure that the service user’s experience of medication use is as positive as possible (Bebbington 2000). The prescribing of medication should occur in the context of building a trusting relationship with the service

user and providing information about their illness appropriate to the needs and capacity of the individual. In addition, the care coordinator/lead professional and psychiatrist will regularly monitor the individual's concordance skills, and how these may be supported. Medication used will be the minimum necessary for effective treatment and it is anticipated that prescribing practice within the team will show a preference for low dose, anti-psychotics. Evidence suggests that there are particular risks to metabolic functioning associated with the use of atypical antipsychotic medication. NSTEP will aim to ensure that metabolic monitoring is undertaken, either from within the team or through liaison with primary care.

Psycho-Social

A range of psychosocial interventions will be used, as indicated by the assessment process and NICE guidance. Interventions that may be employed include:

- The identification of relapse and crisis signatures for the individual patient
- Cognitive Behavioural Therapy
- Education for patients and carers about severe mental illness
- Psycho-education about drug and alcohol use and mental health
- Psycho-education about prescribed medication and medication regimes
- Provision of anxiety management training
- Support in accessing vocational training, employment, education and leisure/social pursuits.
- Involvement of family / carers in care planning / CPA process / crisis planning with service user's consent.

Family Work

Family interventions are seen as a core component of the N-Step team. Where appropriate N-Step provides family therapy, more brief behavioural intervention (focussing on education, communication and problem-solving), as well as dedicated Early Psychosis Carer Education and Training Groups with sessions based around illness education, support and preserving carer's own health. Staff are all trained in Behavioural Family Therapy. There are also regular carer café's to allow carers a place to ask questions and receive support.

Group Activities

It is intended that service users will be supported to access mainstream facilities wherever possible. However, some service users may lack confidence in doing so, or may initially benefit from participating in activities alongside other service users for peer support. For this reason N-Step aims to facilitate a number of groups as a way of encouraging an increase in activity and socialisation. Regular reviews of the group programme ensure suitability of what is offered and identify any areas for the future development of this aspect of the service.

10. Integrated Mental Health System

Effective functioning of N-Step 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 the appropriate service providers meet identified needs of the service user and these reflect and endorse the fundamental principles of the CPA.

The information gathering process, the maintenance of good clinical records and good communication form the basis of risk management. Comprehensive information sharing at points of entry and exit from N-Step teams will aid continuity. Close working arrangements with the inpatient admission unit and UCAT are essential.

Working With Other Services

N-Step does not work in isolation of other community services. It will work closely with other teams as follows:

Children and Adolescent Mental Health Services (CAMHS)

N-Step will accept children from age 14 as set out in the Transitions Policy. RC responsibility will remain with the CAMHs RC.

Primary Care & Voluntary Sector/Community Resources

N-Step will work in close liaison with service users, GPs and Primary Care. Following assessment, N-Step will refer service users who do not require specialist Mental Health intervention back to the referrer, or back to their GP for follow-up care in the community.

Transfer Within NHFT Mental Health Services

N-Step will jointly plan the discharge, or transfer with the service user, family, and the receiving Care Coordinator. The named worker within N-Step is responsible for the care coordination and for ensuring there is a discharge plan in place, which refers to the previous three years of N-Step treatment. Crisis/Contingency plans and effective risk assessments will be devised.

11. Pathways Out of N-Step

Discharge before Three Years

Discharge before three years can occur when a service user moves out of the area, N-Step will continue to provide a service until the service user has engaged with services in the new area. The care co-ordinator will be responsible for ensuring that effective transfer of care takes place.

Service users who have capacity to take an informed decision not to continue to receive care will have the option of discharge back to the care of their GP, but will still retain the option of resuming contact with N-Step as long as they remain eligible.

Disengagement by the service user will not necessarily lead to termination of contact with families or other involved agencies.

Discharge at Three Years

From entry into N-Step service, service users will be made aware of the three year time-scale to their care plan. Planning for discharge will start well in advance of the expected date. Service users will be offered support in preparing for discharge. Service users leaving N-Step may move on to one of a range of options:-

1. Primary care.
2. Ongoing input from PCART or Community Forensic Service.

Staff likely to be involved in providing a service to the service user following discharge from N-Step will be invited to a CPA meeting three to six months before discharge from N-Step is envisaged.

At this CPA meeting a discharge plan will be agreed between the service user, their family, N-Step and any service providing ongoing input.

Where appropriate, family members will also be referred on to appropriate services when service users are handed over at the end of their time with the service. This referral will include a written summary of work that family

members have done and clear recommendations for future treatment. This document will be agreed with family members wherever possible.

Where appropriate, transfer to move-on services will be gradual, if necessary with N-Step and the new service providing some services in parallel for a transitional period. Where appropriate N-Step will offer flexibility over the timing of discharge.

11.1 Transfers from EIS to Primary Care

N-Step will liaise with Primary Care to plan the discharge from services and will ensure there is a crisis/contingency plan and updated risk assessment. Family contact will be central to this planning.

For a majority of Service Users reaching and maintaining recovery may mean no longer requiring ongoing contact with secondary services, and Primary Care Teams will meet their needs. Once it has been identified that the service user no longer requires support from Secondary Services through the CPA process, they can then be managed within Primary Care in relation to the stepped care model stages 1-3, following appropriate liaison.

The following is required prior to discharge;

- Liaison with the GP;
- A CPA review which includes everyone involved in the service user's care,
- At the review, a plan will be agreed which contains at a minimum:

    1. How the service user can access services if needed.
    2. Action needed by the GP (primary care practice).
    3. Service user's relapse signature.

- A written copy of the plan will be given to the service user and everyone involved in his or her care including the service user's GP. This will be recorded on the standard care plan letter.

11.2. Treatment of service users who move in and out of area

It is recognised that some service users may move in and out of area on a regular basis, in particular the transient student population who may live in one area during term time, and return to their home address during holidays. This could be for a number of days or a number of weeks. In such circumstances, it would not be appropriate or useful to discharge the patient from the team's caseload, if it is known that they will be returning in the foreseeable future. It is important that the service user continues to

receive services appropriate to their need wherever they are residing at any given time.

In these instances it should be ascertained which team will hold CPA (if applicable) and medical responsibility at any given time and this must be documented accordingly, and in particular where there are any shared arrangements in place. Where a service user treated by N-Step moves out of Northamptonshire, with the service user's consent, the N-Step team should make every effort to establish an appropriate service/team in the receiving area and make a referral to them as soon as possible. Once it has been established that the receiving team will take the service user on to their caseload, the N-Step team should share all relevant information regarding the service user, including any assessments or current care plans. Similarly, this should be requested of any services that refer in to the N-Step Team should service users move into NHFT's catchment area.

It should be established with the service user and all those involved in their care who will take responsibility for prescribing and what the arrangements are for any crises or unforeseen emergency. This should take into account service user's wishes as well as the practicality of any such arrangements. Care plans should reflect these arrangements and any changes amended as necessary.

Should there be any significant changes to the service user's health, treatment plan or anything else of note, this must be communicated between the relevant teams and documented. It is particularly important that, when the service user relocates from one area to the other, the most recent team involved provides a thorough update to the current team.

12. Management of Services

The Director of Mental Health has lead responsibility for the strategic development of the Countywide N-Step.

12.1 Team Meetings

N-Step North and South will have weekly multidisciplinary clinical meetings; assessment outcomes, items include review ongoing cases, management of significant risk issues and discharge planning including contingency plans. Covering their geographical area. Once Monthly the whole team will meet and discuss ongoing issues within the service.

N-Step staff will also participate in personal development, annual appraisals and service development meetings.

12.2 Service user and carer involvement

N-Step offers family education and it works with the patient advice and liaison service (PALS). All carers and families will be provided with a Carer's Pack, offered BFT if appropriate. The family will be asked to contribute to My Story and other Care Plans.

12.3 Clinical Supervision

All N-Step staff will have clinical supervision (2 per quarter) with a relevant professional with appropriate skills, and with opportunity of a range of different clinical supervision options. Within supervision, a contract may be agreed between supervisor and supervisee, depending on the nature of the supervision.

12.4 Managerial Supervision

All staff are expected to have managerial supervisons of 2 per quarter with their line manager. In the case of Care Coordinators this will be the Operational Manager.

12.5 Staff Support

Support is available to staff for de-brief and counselling, including routine peer support, Trust wellbeing services and protected team days.

12.6 Safety and Lone Working

The teams duty worker will coordinate local lone working protocol. The teams will adhere to Trust and employers' safety and lone working policies, and have developed local procedures for implementing these, including ensuring that:-

- Initial assessments conducted away from health or social services premises are carried out by two practitioners (one of whom may be from outside N-Step).

- Subsequent assessments where there are any safety concerns will be carried out jointly by two practitioners (one of whom may be from outside N-Step).

13. <u>Feedback from Service Users And Carers</u>

Service users and their carers who receive the service will be made aware of the Patient and Advisory Liaison Service (PALS), the Complaints Procedure, Advocacy Services and I Want Great Care.

14. Clinical Effectiveness

Quality of service delivery will be improved by ensuring that service users are actively involved in their care, that interventions are research and evidence-based and appropriate to the needs of the individual.

Clinical outcomes and local implementation will be measurable in line with National Service Frameworks and NICE guidelines.

15. Serious Incidents (SIs)

EIS will be subject to the Trust's reporting policies and will share learning from incidents.

16. Training and Continuing Professional Development

Multi-professional and multi-agency training will be developed and provided to improve collaborative work and to enable more effective service delivery to service users and carers.

Training and development will reflect the requirements of the Trust, N-Step and individual staff needs. Staff will receive an annual appraisal through the Trust appraisal process.

The Team will provide placements for students from various disciplines, which will comply with the professional requirements. Team members will be encouraged to undertake the role of placement supervisors with the appropriate level of training.

17. Health & Safety

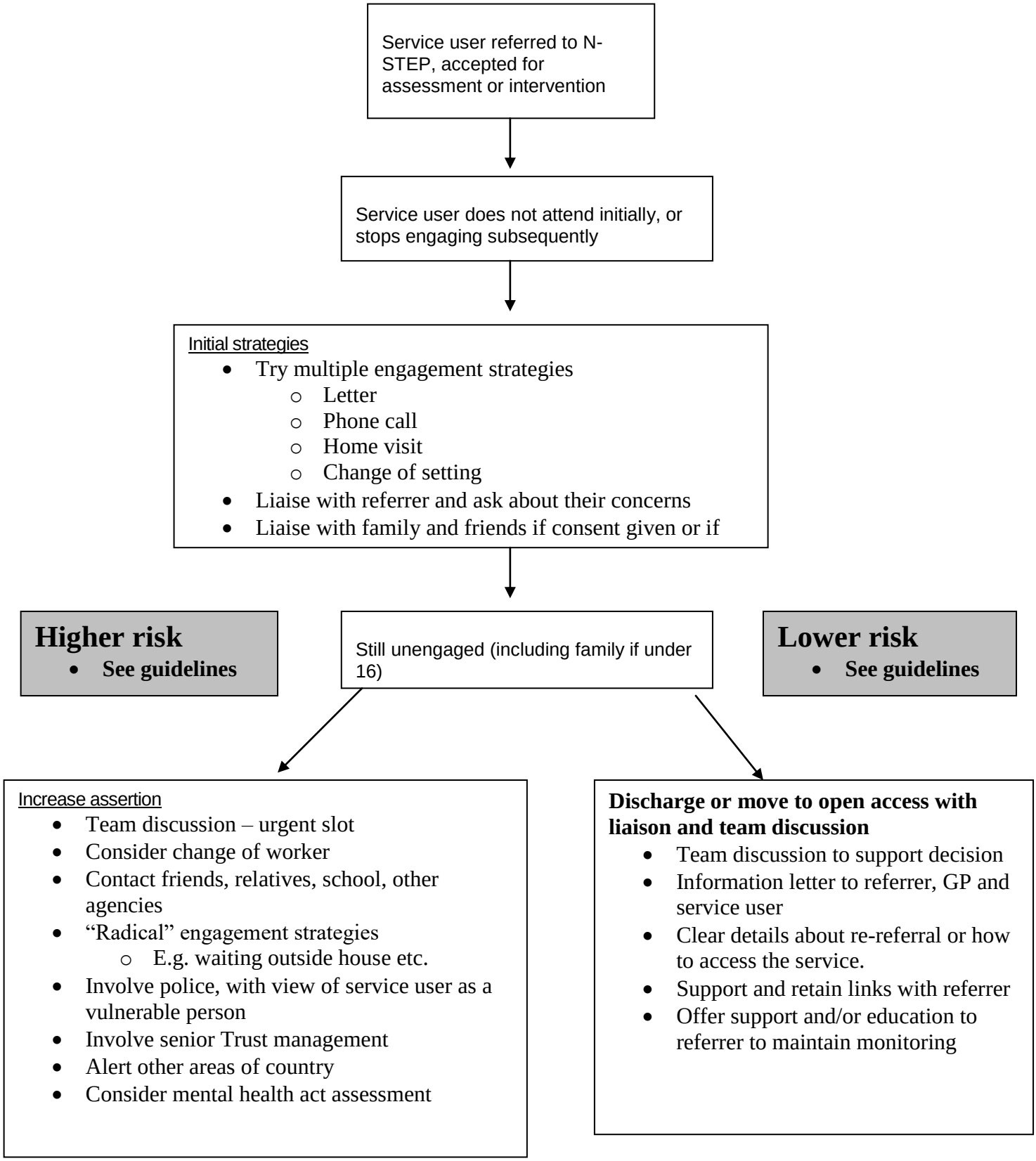
The Operations Manager will be responsible for maintaining the Risk Register and developing action plans for the identified risks in line with the Trust Policies. N-Step will comply with the Trust Policy on Lone Working and ensure that local procedures are in place to ensure safe working.

18. Monitoring & Review of Policy

This Operational Policy and Standards will be reviewed no less than every 2 years to reflect major changes in national policy and practice and feedback from local stakeholders and service user experience.

Appendix 1 - Disengagement /DNA Protocol

1) Service users who disengage or do not attend the assessment process



Guidelines for Determining Response to Disengagement

Evidence suggests prodromal signs or non-psychotic difficulties

- Capacity for consent and informed choice
- Involvement with other services
- Good social support and involved in a network
- Being monitored

Evidence of acute psychosis

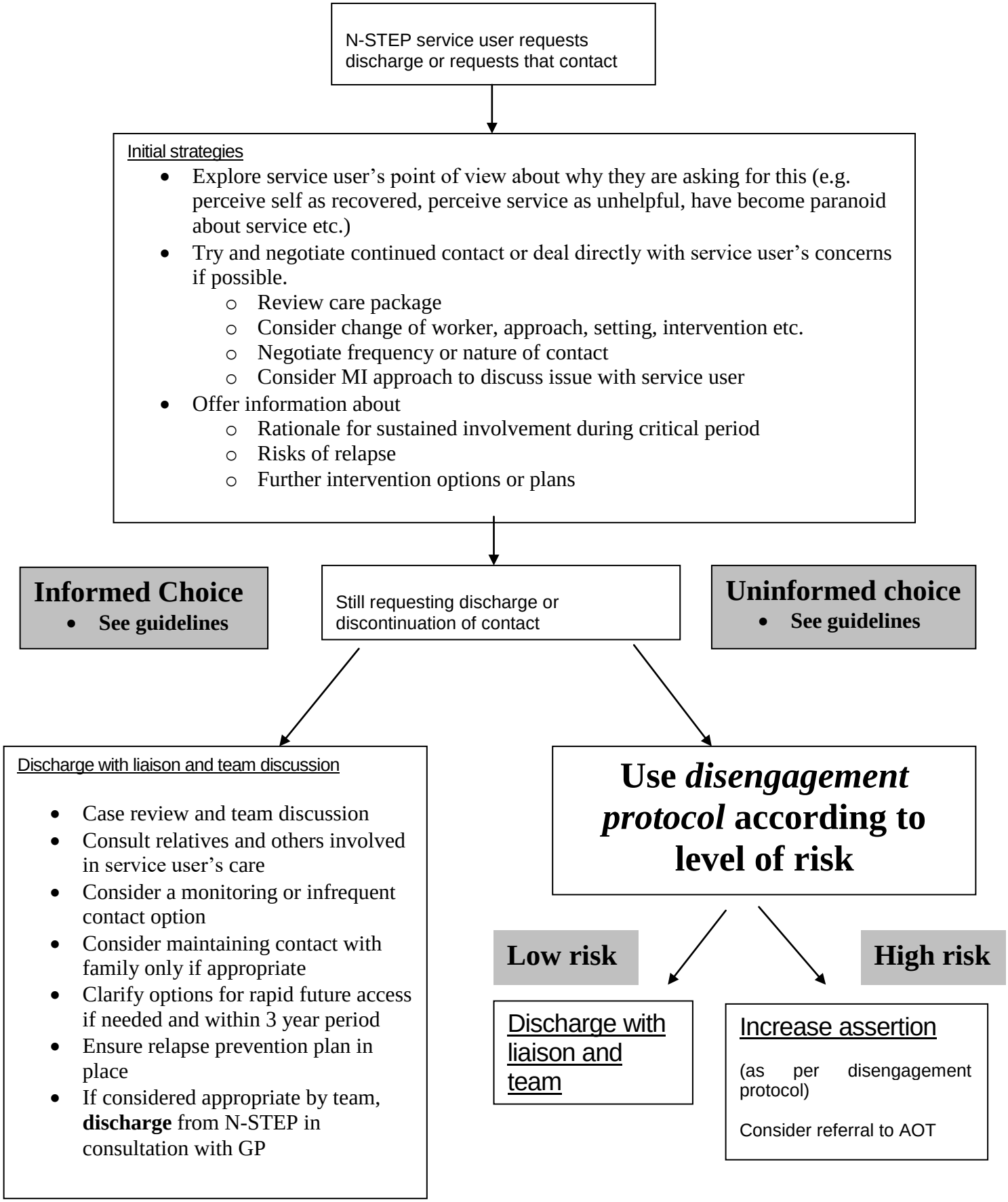
- High level of concern from others
- Evidence of risk of harm to self or others
- Evidence of risk of self-neglect
- No capacity for consent
- Child protection concerns

Lower risk
Discharge with team discussion

Higher risk
Increase assertion

All factors are assessed on **best available evidence** having liased with referrer and significant others as outlined in protocol

Service users who request discharge, or request that we discontinue contact



Guidelines for Considering Informed Choice

- Request is not the direct result of psychosis
- Service user has been well-engaged for a reasonable period of time
- Service user is aware of any further interventions that are on offer to them
- Service user understands possible risks of ceasing contact with service at this time

- Desire to disengage is direct result of psychotic experiences
- Service user has never been well-engaged with service and there has been little or no sustained intervention
- Wanting to disengage as soon as first episode resolves (i.e. as soon as symptoms subside)
- Client is unwilling to discuss or consider future risks, including risk of relapse

Informed choice  **Uninformed choice**

All factors are assessed on **best available evidence** having liased with referrer and significant others as outlined in protocol

Appendix II

EQUALITY ANALYSIS REPORT

Equality Analysis Report	
Name of function:	N-Step, Operational Policy
Date:	May 2018
Assessing officers:	Nick Warren

Description of policy including the aims and objectives of proposed: (service review/redesign, strategy, procedure, project, programme, budget, or work being undertaken):

- This document provides clear guidance for use by mental health staff working N-Step
- It will provide operational information about expectations for the pathway.

Evidence and Impact – provide details data community, service data, workforce information and data relating specific protected groups. Include details consultation and engagement with protected groups.

Evidence base:

- NHFT Equality Information Report August 2012
- Northampton County Council :Northamptonshire Results: 2011 Census Data Summary

	Corby	Daventry	East Northants	Kettering	Northampton	South Northants	Wellingborough	Northants	England
2001	**53,400**	**72,100**	**76,600**	**82,200**	**194,200**	**79,400**	**72,500**	**630,400**	**49,449,700**
2011	**61,100**	**77,700**	**86,800**	**93,500**	**212,100**	**85,200**	**75,400**	**691,900**	**53,012,500**
% rise	**14.4%**	**7.8%**	**13.3%**	**13.7%**	**9.2%**	**7.3%**	**4.0%**	**9.8%**	**7.2%**

- Ethnicity: 85.7% (White) and 14.3% (BME)- 1.75% (dual heritage); 4.01% (Asian); 2.5%(Black including British, African and Caribbean) ; 0.85 % (Chinese) ; 6.05 % (white other EEA, polish, Gypsy & Traveller)
- Gender: 49.6% males; 50.4% females (including 1% transgender)
- Disabled people: 19% (including 3.5 % < aged under 18)
- Faith communities: 71% Christian; 29% minority faith: (includes Hindu, Muslim, Sikh, atheists, non-belief)
- Sexual orientation (gay, lesbian or bisexual): 5 - 7% (Stonewall estimate)

Service Information: provide any relevant service data or information to inform the Equality Analysis including service user feedback, external consultation and engagements or research.

Equality Analysis Report	
Name of function:	N-Step, Operational Policy
Date:	May 2018
Protected Groups (Equality Act 2010)	**STAGE 3: Consider the effect of our actions on people in terms of their protected status?** The law requires us to take active steps to consider the need to: ▪ Eliminate unlawful discrimination, harassment and victimisation. ▪ Advance equality of opportunity ▪ Foster good relations with people with and with protected characteristic Identify the specific adverse impacts that may occur due to this policy, project or strategy on different groups of people. Provide an explanation for your given response.
Age	- This document does not cover • Children under the age of 14 • Adults over the age of 35 This decision has been made as under 14's and adults over the age of 35 are currently not within N-Step's remit.
Disability	All disabilities are covered
Gender (male, female and transsexual, inclu. Pregnancy and maternity)	Covered by Document
Gender reassignment	Covered by Document, individual needs assessed as required
Sexual Orientation (incl. Marriage & civil partnerships	Covered by Document
Race	Covered by Document
Religion or Belief (including non belief)	Covered by Document
Equality Analysis outcome: Having considered the potential or actual effect of your project, policy etc, what changes will take place?	
None	
Action Plan	

Equality Analysis Report			
Name of function:	N-Step, Operational Policy		
Date:	May 2018		
Issue to be addressed	**Action**	**Who**	**Date to be completed**
Ratification – a completed copy of the Equality Analysis form must be sent to Equality and Inclusion Officer to be approved.			
Approving Officers	**Nick Warren**		
Date of completion:	**May 2018**		