Cheshire and Wirral Partnership
NHS Foundation Trust

**Document level:** TW
**Code:** AM2
**Issue number:** 3.01

# Procedure for 72 hour follow up visits following discharge from CCG commissioned adult mental health inpatient care

| | |
|---|---|
| Lead executive | Acute Care Director |
| Authors details | Clinical Director - Acute Care<br>01514827737 |

| | |
|---|---|
| Type of document | Standard Operating Procedure |
| Target audience | Adult and older peoples mental health staff |
| Document purpose | The aim of this procedure is to ensure clarity and consistency in the delivery of the 72 hour follow up after a person has been discharged from an adult ward. The document gives clear guidance on the eligibility, delivery and service responsibilities regarding 72 hour follow up contact. |

| | | |
|---|---|---|
| Approving meeting | Clinical standards and practice sub committee | Date 27-Aug-20 |
| Implementation date | 27-Aug-20 | |

| CWP documents to be read in conjunction with | |
|---|---|
| CP1<br>CP42<br>CP20 | Admission to and transfer/discharge from hospital policy<br>Care Programme Approach Policy<br>Operational policy for crisis resolution and home treatment teams within the adult and older peoples mental health division |

| **Document change history** | |
|---|---|
| What is different? | Updated post 2018 National confidential inquiry into suicide and safety in Mental Health and 2019/20 contractual requirements |
| Appendices / electronic forms | No changes |
| What is the impact of change? | Will this new document change the way we do things currently |

| | |
|---|---|
| Training requirements | No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP. |

| **Document consultation** | |
|---|---|
| Clinical Services | SMH Care Group |
| Corporate services | Safe Services, Effective Services |
| External agencies | |

| | |
|---|---|
| Financial resource implications | Yes- 2019/20 CQUIN |

| External references |
|---|
| 1. HQIP (2018) National confidential inquiry into suicide and safety in Mental Health |

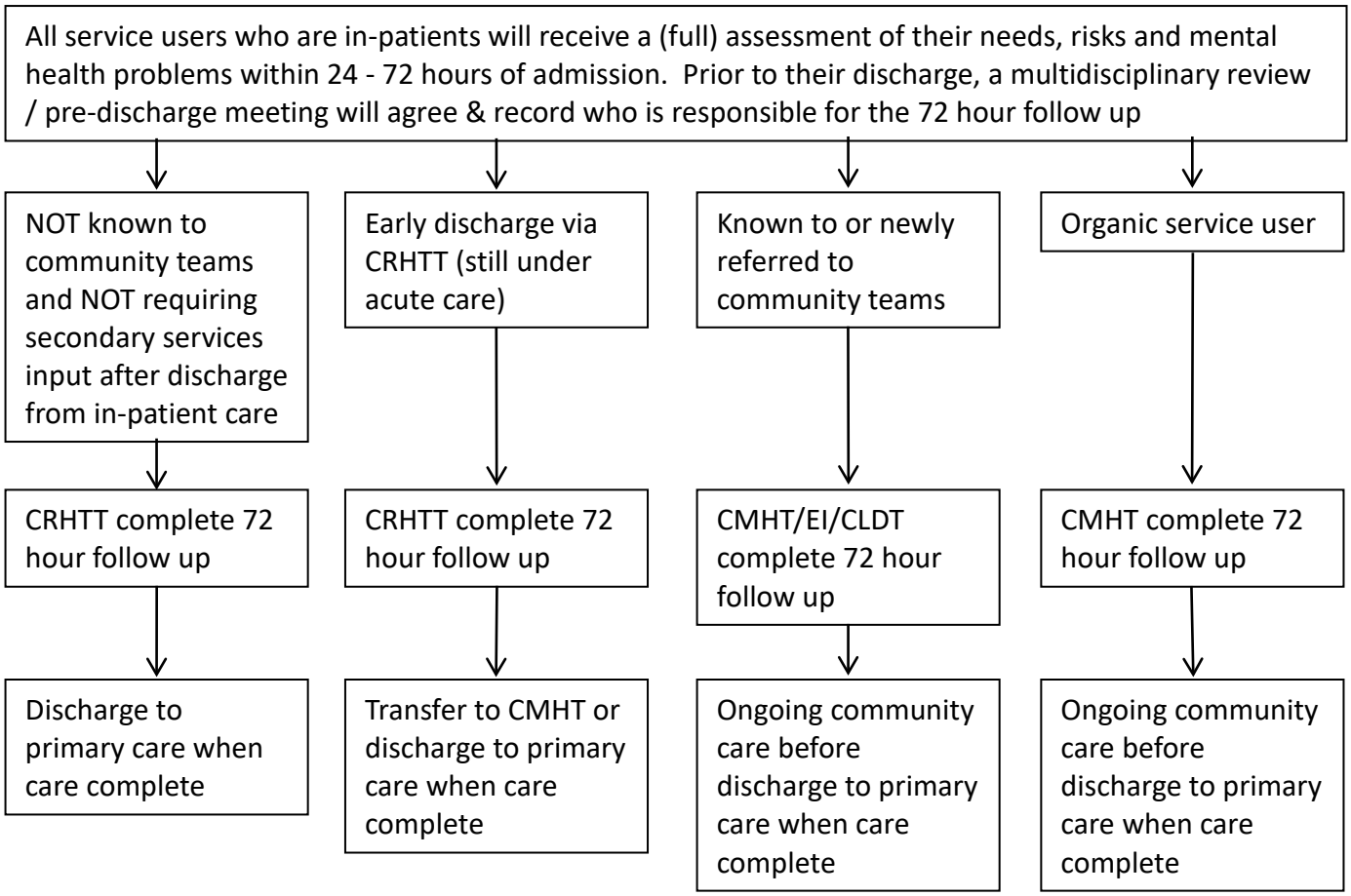
https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-69-Mental-Health-CORP-annual-report-v0.4.pdf

| Equality Impact Assessment (EIA) - Initial assessment | Yes/No | Comments |
|---|---|---|
| Does this document affect one group less or more favourably than another on the basis of: | | |
| - Race | No | |
| - Ethnic origins (including gypsies and travellers) | No | |
| - Nationality | No | |
| - Gender | No | |
| - Culture | No | |
| - Religion or belief | No | |
| - Sexual orientation including lesbian, gay and bisexual people | No | |
| - Age | No | |
| - Disability - learning disabilities, physical disability, sensory impairment and mental health problems | No | |
| Is there any evidence that some groups are affected differently? | No | |
| If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? N/A | | |
| Is the impact of the document likely to be negative?<br>- If so can the impact be avoided?<br>- What alternatives are there to achieving the document without the impact?<br>- Can we reduce the impact by taking different action? | No<br>N/A<br>N/A<br><br>N/A | |
| Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted.<br><br>If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department. | | |
| Was a full impact assessment required? | No | |
| What is the level of impact? | Low | |

**Contents**

**Quick reference flowchart**

For quick reference the guide below is a summary of actions required.



## 1. Introduction

The period following discharge from mental health inpatient units to community settings can come with increased risk of self-harm for people. Mental health services currently adhere to a standard of ensuring follow-up from inpatient care within seven days of hospital discharge for all people receiving support through the Care Programme Approach (CPA). However, recent findings from the 2018 National Confidential Inquiry into Suicide and Safety in Mental Health showed that most post-discharge deaths by suicide occurred in the first week after leaving inpatient care, with the highest frequency on the third day after discharge. Many of these people died by suicide before their first follow-up appointment. Based on this new evidence many services already aim to complete follow-up within 2-3 days post discharge for all people from inpatient care (not only those on CPA).

### 1.1 Aim

The aim of this procedure is to ensure clarity and consistency in 72 hour follow up contact. Clear guidance on the eligibility, delivery and service responsibilities regarding 72 hour follow up visits will greatly assist in-patient, crisis home treatment, and community staff to further develop joint working and ensure that the service user is at the centre of a seamless service, and receives support tailored to their needs and risks irrespective of their diagnosis.

## 2. Type of contact

Wherever possible a face-to-face follow up appointment should be completed.
However, where assessed (by the discharging multi-disciplinary team (MDT) or by the allocated follow up team) to be clinically appropriate, teams may contact the person by telephone, Skype, Facetime, or other suitable technology, as long as there is direct contact with the person.

## 3. Duties and responsibilities

### 3.1 Service user eligibility

Everyone discharged from a CCG-commissioned adult mental health inpatient bed (listed below) to their place of residence, care home, residential accommodation, or to non-psychiatric care requires a 72 hour follow up;

- Acute adult mental health care
- Acute older adult mental health care (organic and functional)
- Psychiatric Intensive Care Unit (acute mental health care)
- Locked rehabilitation
- High dependency rehabilitation
- Long term complex rehabilitation/ Continuing Care

### 3.2 Service users open to, or referred onto, the community teams

The majority of adult service users who are admitted to one of the adult mental health in-patient wards will already be known to and under the care of, or ‘open’ to, one of the Trust’s main mental health teams which support people in the community; Crisis Resolution Home Treatment Team (CRHTT), Community Mental Health Team (CMHT), Early Intervention in Psychosis Team (EI) or Community Learning Disability Team (CLDT). In addition to service users who are already known to these teams before their admission, some individuals who are admitted to one of the Trust’s in-patient wards for the

first time will subsequently be referred on to one of the community teams for future care and treatment.

The responsibility for carrying out the 72 hour follow up contact for all service users is set out in quick reference flow chart 1.

### 3.3 Service users not open to, nor referred on to, the community teams

A proportion of people who have an in-patient episode are assessed during admission as not requiring further input or treatment from any of the community teams once they leave hospital and will therefore be discharged back to primary care. In these cases, a one-off 72 hour follow up contact will be carried out by CRHTT after which the person will be discharged back to primary care.

## 4. Documenting multi-disciplinary teams decisions regarding the responsibility for 72 hour follow up contacts

Every service user admitted to an acute ward will have their needs, risks, future support and treatment requirements assessed. Prior to each person's discharge a MDT review / pre-discharge meeting will confirm who i.e. which team will be responsible for carrying out the 72 hour follow up contact. In circumstance where someone is discharged without an MDT, the person responsible for the discharge will confirm which team is responsible for carrying out the 72 hour follow up contact and liaise with the relevant team to inform them. This decision making process must be documented in every case, regardless of the outcome. For service users who are being discharged back to primary care, it is particularly important to record the decision making process and the risks which were considered.

For adult service users, on their discharge from the ward a Gatekeeping form will be completed by the CRHTT and the team responsible for the 72 hour follow up contact will be recorded in this electronic patient record document.

## 5. Documenting 72 hour follow up contacts

The team completing the 72 hour follow up should use the combined event note in the electronic patient record, which has an event option for a 72 hour follow up. The checklist in Appendix 1 should be used to provide a high quality 72 hour follow up.

## 6. Unsuccessful follow ups

If the team responsible for the follow up are unable to contact the service user or carer within the 72 hours and have genuine concerns about the service users safety they should inform the police/appropriate professional and request they do a welfare check. Services should work together to follow up a service user, community teams should consider requesting assistance from CRHTT outside of working hours.

## 7. Discharges out of area

Service users being discharged out of the trust will require a follow up from the relevant local NHS mental health provider. The Onward referral form in the electronic patient record should be utilised to record which NHS mental health provider is responsible for the follow up.

**Appendix 1 – 72 hour follow-up checklist**

| | |
|---|---|
| Date of follow up | |
| Conducted by | |
| Name of Patient | |
| DOB | |
| Address | |
| Tel No | |

| | |
|---|---|
| GP | |
| CPA Care | ☐ Yes<br>☐ No |
| Care Coordinator | |
| Consultant | |
| Team | |
| Date of admission | |
| Date of discharge | |
| Ward | |
| Hospital | |

| | | | | | |
|---|---|---|---|---|---|
| Admission | ☐ Informal<br>☐ Section 2<br>☐ Section 3<br>☐ Section 117<br>☐ Other | | | | |
| Discharged to | ☐ Own home<br>☐ Residential<br>☐ Supported Accommodation<br>☐ Other (specify) | | | | |
| Lives alone | ☐ Yes<br>☐ No | | | | |
| Lives with others (specify) | | | | | |
| Next OPA with | | When: | | Where: | |
| No follow up required | ☐ | | | | |
| Medication | | | | | |
| Clozapine | ☐ | Next blood test | | | |
| Lithium | ☐ | Next blood test | | | |
| Memory drugs | ☐ | | | | |
| Next GP appointment for medication | | | | | |
| Compliance | ☐ Good<br>☐ Variable<br>☐ Poor | | | | |
| Plan to ensure compliance | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| CRHTT involvement | ☐ | Frequency | | Duration | |
| Next joint review with Care Coordinator | | | | | |
| Carers views | | | | | |

**Mental state examination**

| | |
|---|---|
| Appearance and behaviour | |
| Speech | |
| Mood | |
| Thoughts | |
| Delusions | |
| Hallucinations | |
| Cognitive functions | |
| Insight | |

**Risk assessment**

| | |
|---|---|
| Suicide/self harm | |
| Violence/aggression | |
| Self neglect | |
| Risk to children | |

**Management plan to reduce risks**

| |
|---|
| |

**Support services**

- ☐ Advocacy services
- ☐ Recovery services
- ☐ Drugs services
- ☐ Alcohol services
- ☐ Talking changes / psychology
- ☐ OT

| | |
|---|---|
| Care package / home care | |

| | |
|---|---|
| Employment issues | |
| Accommodation issues | |
| Benefits / finances | |

**Comments**

| |
|---|
| |