Humber Teaching
NHS Foundation Trust

# MULTI-DISCIPLINARY TEAM (MDT) CARE PLANNING GUIDELINES

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**VALIDITY – Guidelines should be accessed via the Trust intranet to ensure the current version is used.**

**CHANGE RECORD**

| Version | Date | Change details |
|---|---|---|
| *1.0* | *3 Aug 2022* | *New Guideline Document. Approved at MH Division Practice Network (03.08.2022).* |
| *1.1* | *5 April 2023* | *Minor amendment. Addition of Appendix E - MDT Discussion prompt sheet. Approved at MH Division Practice Network (5 April 2023).* |
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## 1. Introduction

This document presents guidelines for clinicians working in the Mental Health Division of Humber Teaching NHS Foundation Trust (The Trust) for how and when to involve others in care planning and review for people they are supporting. The guidelines are applicable to those under planned care in primary or secondary mental health services, and also for those who may be accessing unplanned care, e.g. crisis and inpatient mental health services.

Consistent with the current CMHT Framework Guidance (2019), the extent to which others are involved in care planning and review, and who those others are, is dependent on the specific circumstances of each individual case. The relationship between the different options presented in this document is not hierarchical; none of the options are inherently 'better' than any other, instead the key principle is that of ensuring that the involvement of others in care planning and review is suitable for the specific tasks and issues that are being considered. Consequently, the type of care planning and review used in a particular case, and the extent of involvement by others, is expected to change over time, dependent upon the changing issues and challenges presented (e.g. an individual's care planning may initially involve a range of clinicians and services at one point, but be reduced to only those with direct involvement with the individual when risks and issues in care lessen).

When involving others in care planning and review, the extent of the care plan that they are involved in planning and reviewing should be based on what is appropriate and relevant in each given situation. For example, a GP may be particularly involved in elements related to physical health and medication, whilst not being involved in planning the way mental health crisis services support an individual. In other cases, it may be appropriate and relevant for another clinician or service to be involved in planning and reviewing the entire care plan. The appropriate level should be agreed between the lead professional, the individual, and the relevant others involved.

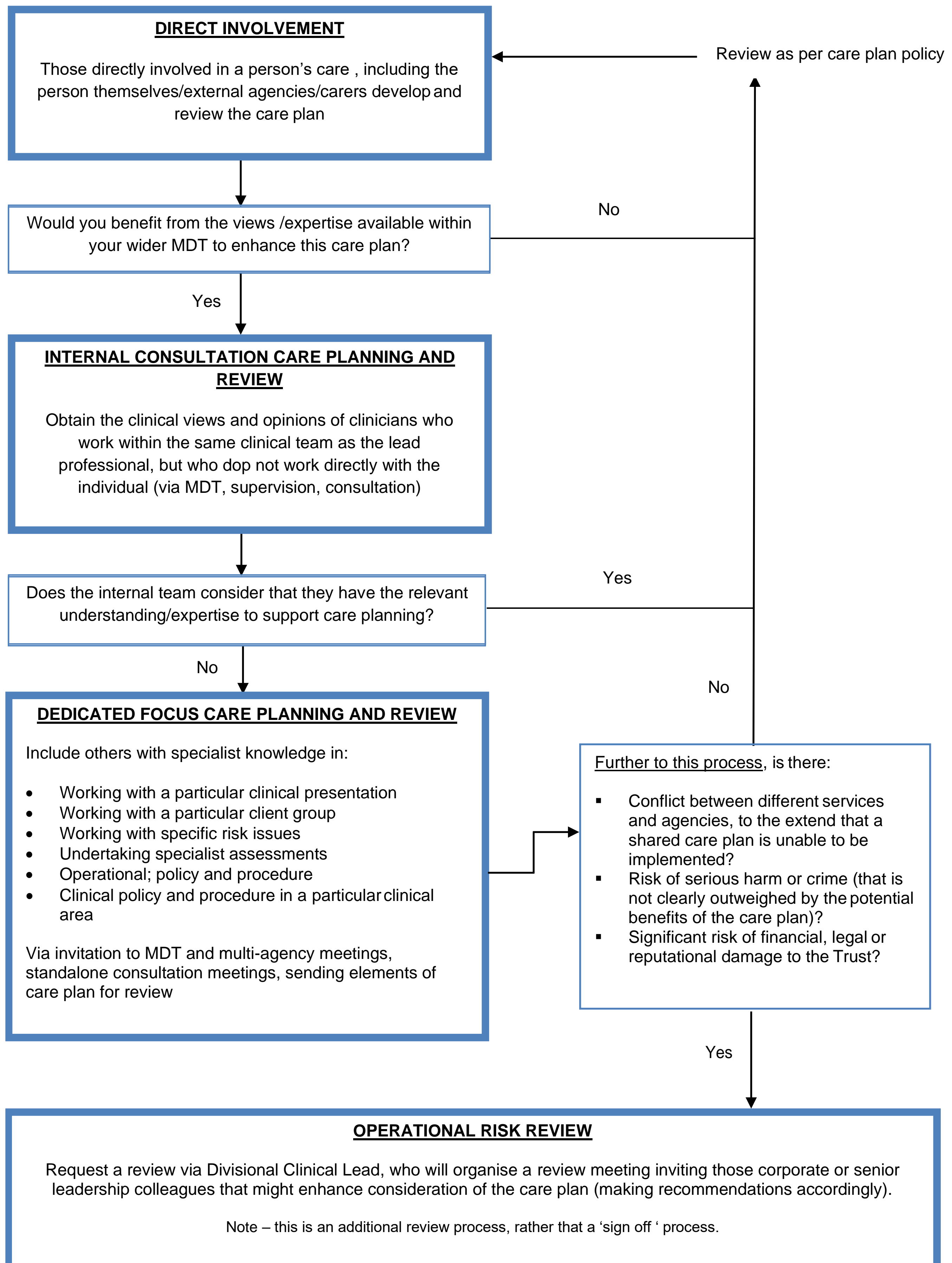
A common concern for clinicians is that of obtaining 'organisational approval' for the care they are providing, particularly when working with a particular individual entails high or unpredictable levels of risk. The guidelines outlined in this document are approved and supported by the MH Division Practice Network and ODG and therefore, provided clinicians follow these guidelines, by appropriately involving others in care planning and review where necessary, the care being provided by clinicians can be considered to be supported by The Trust. The Department of Health's (DoH) 'Best Practice in Managing Risk' guidance outlines that avoiding *all* risk is counterproductive, and that "as long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time" (p.9, 2009); the remainder of this document outlines how clinical and operational support can be utilised to meet these guiding principles.

For all individuals being supported in the Mental Health Division, a lead professional should be identified who takes responsibility for co-ordinating and organising the care of that individual from a professional perspective. This may change depending on the context, for example an inpatient care plan may be professionally led by an individual's named nurse, whilst their community or broader care plan is professionally led by their care co-ordinator.

The principles in this document apply to both broad care planning and review, and more specific care areas, for example planning and reviewing plans for managing risk.

## 2. Guide to the Document: Use this to navigate to the most useful section for you

### Care Planning and review with Other Process



## 3. Direct Involvement Care Planning and Review

**(use Care and Intervention Plan form on Care Planning tab in Lorenzo to record plan)**

In many cases, effective and appropriate care planning and review is possible by including only those who have direct involvement with the individual. In such cases, the lead clinician should take responsibility for ensuring an appropriate framework is provided for those directly involved to contribute to the planning and review of care. This may include extending invites to joint appointments or meetings, or circulating documentation for review by others, for example.

Direct Involvement care planning and review should, where possible, include the individual themselves. With the individual's consent, family, friends, carers or advocates that have a regular supportive role for the individual would also be appropriate to include.

This type of care planning and review may involve clinicians and professionals from multiple services and agencies, and/or other clinicians from the lead professional's service; inclusion is defined not by the organisation that the professional works for, but by the degree of direct involvement the professional has with the individual whose care is being planned or reviewed. It should be borne in mind that the individual may have substantial direct involvement with a particular clinician or professional from another service or agency, but that that involvement is not relevant to the care being planned and reviewed with mental health services. As such, there is no prescriptive list of who should or should not be included in care planning and review; instead the lead professional and individual whose care is being planned or reviewed should work together to identify the appropriate people to include. In some cases, for example teams with a range of staff members who may have contact with an individual (e.g. Mental Health Response Service), it may be considered more appropriate to invite a senior member of staff, or it may be appropriate to invite a specific other member of staff who works particularly closely with the individual.

Regarding care planning related to risk, the DoH (2009) outline that whilst there are times when, due to loss or lack of capacity, decisions must be made to prioritise safety and make decisions independently of the individual, where possible individuals and those close to them should be given opportunities to collaboratively plan for positive risk taking. Positive risk management is described as follows:

Positive risk management includes:

- working with the service user to identify what is likely to work – and what is not;
- paying attention to the views of carers and others around the service user when finally deciding a plan of action;
- weighing up the potential costs and benefits of choosing one action over another;
- being willing to take a decision that involves an element of risk because the potential positive benefits outweigh the risk;
- developing plans and actions that support the positive potentials and priorities stated by the service user, and minimising the risks to the service user or others;
- being clear to all involved about the potential benefits and the potential risks; and
- ensuring that the service user, carer and others who might be affected are fully informed of the decision, the reasons for it and the associated plans.

Department of Health, 2009

The Sainsbury Centre position paper for implementing recovery in organisations (2009) promotes care planning which prioritises self management , joint planning for crisis management, and a greater level of choice over treatment options. The same paper suggests that all risk management plans should be subject to the following considerations (Boardman & Shepard, 2009):

- Did this risk procedure increase or decrease the person's sense of control?
- Did it increase or decrease their access to opportunities outside mental health services?
- Did it increase or decrease their hope for the future?

## 4. Internal Consultation Care Planning and Review

**(use MDT form in Care Planning tab in Lorenzo to record the meeting)**

This type of care planning and review broadens the range of clinicians and professionals involved in the process. In addition to those included through Direct Involvement, Internal Consultation Care Planning and Review incorporates the clinical views and opinions of clinicians who work within the same clinical team as the lead professional, but who do not work directly with the individual.

This type of care planning may be achieved in a variety of ways, for example:

- By discussing care in a Multi-Disciplinary Team (MDT) meeting
- By discussing care in a consultation with another/other member(s) of the MDT
- By discussing care in supervision (Note: this includes regular supervision that is provided by clinicians outside of the clinical team to the lead professional)

Such consultation may involve the care plan in its entirety being considered, or may provide specific guidance or suggestions for particular elements of care in line with the professional knowledge of those from whom consultation has been sought (e.g. how risk behaviours will be responded to; how physical health will be monitored).

Consultation may also lead to changes in care plans that reflect the entry of a new professional, service or agency to work directly with the individual, for example being referred to a specific clinician within the team, or being referred to another service or agency (e.g. Positive Assets, a therapy service, Local Authority safeguarding services).

Addition of others to care planning and review in this way may occur because:

- Risk has increased but remains at a level that can be effectively managed by the wider team
- The case poses dilemmas for the clinicians involved that would benefit from a broader perspective
- The care plan may entail responses from other clinicians (e.g. via a duty system) that requires team awareness and involvement
- There appears to be a need for intervention or support that falls clearly within the professional skills of another member of the MDT

It is well accepted that multidisciplinary team discussion improves quality of care planning (e.g. DoH, 2007, RCP, 2009). The DoH (2009) advise that the most effective care planning, particularly in relation to risk, is a collaboration between the service user, their carer (where applicable), and the wider multidisciplinary team. It is suggested that the inclusion of senior colleagues can also be beneficial in care planning pertaining to risk.

The lead professional is responsible for ensuring that clinical discussions are documented on Lorenzo.

*Social Care Packages Funded by Local Authorities*

Social care packages funded by local authorities are an example of when an individual is referred for a specialist assessment. There would be no expectation that dedicated focus services (as described below) had been involved unless otherwise requested or required.

## 5. Dedicated Focus Care Planning and Review

**(use Dedicated Focus Care Planning Meeting form – appendix A and in Care Planning tab in Lorenzo to record meeting)**

The community mental health framework (NHSE, 2019) is clear that services should be structured so that dedicated knowledge and expertise is accessible across mental health services, to minimise transitions in care (i.e. transitioning an individual from a generic team to a team with a dedicated focus). The following outlines how dedicated knowledge might be sought to enhance care within existing provision. The DoH (2009) recommends consultation with clinicians, services or agencies with a dedicated focus in assessing and managing risk.

Relevant others in this type of care planning may be considered to possess additional knowledge and skills in:

- Working with a particular clinical presentation
- Working with a particular client group
- Working with specific risk issues
- Undertaking specialist assessments
- Operational policy and procedure
- Clinical policy and procedure in a particular clinical area

This type of care planning can be achieved in a variety of ways, for example:

- Invitation to MDT and multi-agency meetings
- Standalone consultation meeting
- Sending elements of care plan to others to be reviewed

As with Internal Consultation Care Planning and Review, this type of care planning and review may entail others being involved in the entirety of care planning and review, or may involve the provision of specific guidance or suggestions for particular elements of a care plan in line with the professional knowledge of those whose input has been sought.

Inclusion of dedicated focus services and agencies may also lead to changes in care plans that reflect the entry of a new professional, service or agency to work directly with the individual, for example being referred to another service or agency for a specialist assessment or intervention.

A list of roles, services and agencies that may be considered for inclusion in care planning and review to provide a dedicated focus, SEE APPENDIX C: Dedicated Focus List

This is updated every six months.

Inclusion of additional others with a dedicated focus is likely to follow an MDT or between-service agreement that care planning and review without the inclusion of those with a dedicated focus has not been effective. This may include:

- Risk remaining unchanged or increasing following previous changes to the care plan at the Internal Consultation level
- Other lack of clinical progress with a specific client group or presentation for which a dedicated focus service exists locally
- Disagreement within or between teams or clinicians involved in the individual's care
- Requirement or request for specific information for which a dedicated focus service exists (e.g. about the Mental Health Act; about a specific therapeutic approach)

It is not uncommon for individuals supported by the Mental Health Division to present with difficulties that may overlap with other divisions/dedicated focus areas of the organisation, despite the individual's primary needs being met by the Mental Health Division. It is recognised that no service area can have a detailed knowledge of all possible issues that an individual may require support with, and therefore in such cases, consideration should always be given to consultation (including where an individual has declined a referral to a particular service for direct treatment) with appropriate and available dedicated focus services as a matter of course.

The lead professional is responsible for ensuring that clinical discussions are documented on Lorenzo.

*Services Requiring External Health Funding*

The needs of some individuals exceed the support available from locally commissioned services. In such cases, funding must be sought from the relevant clinical commissioning body (Humber and North Yorkshire Integrated Health Board (ICB)). Requests for funding (including for community packages of care) should not be made without first having included all those with a relevant dedicated focus in the care planning and review for the individual. This will ensure that all potential local options have been considered.

Where it is considered that a request for funding is appropriate, the case manager from the relevant ICB should be contacted and invited to discuss the care of the individual and what is being requested. It is common for this to include a meeting with the ICB case manager, attended by the most relevant dedicated focus clinicians or services, however this may also be achieved by provision of reports and correspondence from dedicated focus clinicians or services to the ICB case manager by the lead professional. The level of direct liaison with clinicians and services beyond the lead professional required at this point will be dependent on the specifics of the case and determined by the ICB case manager.

*Vulnerable Adult Risk Management (VARM) Process Hull and East Riding*

The VARM process should be considered in the following circumstances:

- Where the person is perceived to have the capacity to make the decision(s) that is /are creating significant concern about their safety (risk of significant harm).
- Where there is no alleged perpetrator and the risk arises from the capacitated individual's refusal to engage with services and/or self-neglect in one or more areas of their life
- Where there is an alleged perpetrator and the capacitated person refuses to engage or accept associated and identified risks, and the person is at serious risk of harm or death
- Where there is a public safety risk or possible criminal activity that would endanger others (please note: any criminal activity should be reported to the Police)
- Where existing support has been offered and the person has not accepted support from health and social care to resolve the issues/risks identified.

VARM information is found on the link below:

Safeguarding Adult Concerns (humber.nhs.uk)

## 6. Operational Risk Review

In a small number of cases, the approaches to care planning and review outlined above may not have been considered sufficient to:

- Resolve conflict between different services and agencies, to the extent that a shared care plan is unable to be implemented
- Reduce the risk of serious harm or crime to a level that can accepted as a risk that is outweighed by the potential benefits of the care plan
- Reduce a significant risk of financial, legal or reputational damage to the Trust

In such cases, care can be reviewed from an organisational viewpoint. A request for this level of care review should only be made when all clinical options have been exhausted to negate the above issues.

Requests for an operational risk review should be made via the Clinical Lead for the Mental Health Division (referral form – appendix B). For community cases the following clinicians should be in agreement with this request:

- The lead professional (ordinarily the care co-ordinator or case manager)
- The team clinical lead

For inpatient cases the following clinicians should be in agreement with this request:

- If receiving a community mental health service, the lead community clinician (ordinarily the care co-ordinator or case manager)
- The modern matron
- The inpatient Responsible Clinician

The service manager (of community and/or inpatient, as appropriate) should be informed of the referral.

It is not a function of operational risk review to resolve commissioning issues for perceived gaps in services, nor to resolve clinical disagreements without clear efforts to already do so via the inclusion of all relevant dedicated focus services.

Operational risk reviews will incorporate senior members of the organisation from all potential areas of the Trust; those involved with be determined by the specific issues for review.

The link below outlines the process of requesting and being involved in an operational risk review.

The lead professional is responsible for ensuring that clinical discussions are documented on Lorenzo.

See APPENDIX D: Requesting an Operational Risk Review Meeting

## 7. References:

Boardman, J., & Shepherd, G. (2009). Implementing recovery: a new framework for organisational change. *London: Sainsbury Centre for Mental Health*.

Department of Health (2009) Guide to Best Practice in Supported Decision Making. London: Department of Health.

Department of Health (2007), “Creating capable teams approach (CCTA): best practice guidance to support the implementation of new ways of working (NWW) and new roles”, London.

RCP (2009), Good Medical Practice, 3rd ed., Royal College of Psychiatrists, London.
REFERENCE COMMUNITY MH FRAMEWORK

## Appendix A: Dedicated Focus Consultation Record Form

<table>
<tr><td colspan="4"><u>Dedicated Focus Care Planning and Review</u></td></tr>
<tr><td>Name:</td><td></td><td>NHS no.:</td><td></td></tr>
<tr><td>Date:</td><td colspan="3"></td></tr>
<tr><td>Attendees:</td><td colspan="3"></td></tr>
<tr><td colspan="4">Record of discussion:<br>Include information discussed, options considered and rationale for each</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">Plan:<br>State timescales and responsible persons where appropriate</td></tr>
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## Appendix B: Operational Risk Review Referral Form

Adult and Older Peoples Mental Health Division

**Please note:** Before completing the electronic referral form evidence should be provided that the stepped approach to seeking support, advice and guidance has been followed. Without evidence of the process being followed this referral will **not** be considered by the panel.

**Name of referrer:** ……………………………………………………………………………

**Job Title: ………………………………………………………..……………………………**

**Agreed by your team Clinical Lead? : Yes No**

**Team Name and Locations: ……………………………………………………………..**

**Contact Details:** Telephone Number:**……………………………………………..……**

Email address**: ……………………………………………..……..**

**Reason for referral/nature of problem:**

*(Outline main issues that you are expecting advice, guidance or reassurance on from the panel. For inpatient cases please include what has been tried already and reason for it being unsuccessful)*

**IMPORTANT: before returning the completed referral form, have you:**

- **Held a CPA or strategy meeting within the last 2 weeks? YES □ NO □**
- **Have you followed all the clinical processes outlined in this guidance including the dedicated focus care planning and review? YES □ NO □**

**Please tell us what other agencies/services have been involved:**

**Have you attached comprehensive assessment? YES □ NO □**
**Have you attached current risk assessment? YES □ NO □ Have you attached current care plans? YES □ NO □**
**Have you attached the minutes of the dedicated focus care planning and review meeting? YES □ NO □**

**Please send completed form to Paula Stabler: paula.stabler@nhs.net**

## Appendix C: Dedicated Focus List

| | Relevant Issues | Contact Details |
|---|---|---|
| Chronic Fatigue Service | Chronic Fatigue Syndrome | 01482 738060 |
| Community Forensic Service | Offending behaviour and risk to others | 01482 692183, hnf-tr.rmhfc@nhs.net |
| Community Mental Health Teams (Adult) | General mental health for working age adults | Beverley<br>Bridlington<br>Driffield<br>Goole<br>Haltemprice<br>Holderness<br>Hull West<br>Hull East |
| Emotional Wellbeing Service - ER | Offers a number of different therapies to help support you with emotional wellbeing. | 01482 335451 |
| Complex Emotional Needs Service (CENS) | Personality Disorder and complex emotional needs | Dr Samantha McKenzie – Clinical Psychologist, Clinical Lead<br>01482 689156, hnf-tr.CENS@nhs.net |
| Division/Trust Clinical Leads | Senior clinical leadership | Paul Johnson – Mental Health Division Clinical Lead<br>Dr Kwame Fofie – Humber Teaching NHS Foundation Trust Clinical Lead |
| East Riding Partnership | Drug and alcohol service in East Riding | Hull - 01482 336675 / hnf-tr.erphull@nhs.net<br>Goole - 01405 608210 / hnf-tr.erpgoole@nhs.net<br>Bridlington - 01262 458200 / hnf-tr.erpbridlington@nhs.net |
| East Riding of Yorkshire Council Safeguarding | Local Authority safeguarding of children and young people in East Riding | 01482 396940 / safeguardingadultsteam@eastriding.gov.uk |
| Evolve | Eating Disorder service for ages 18+ with a Hull GP | Kim Flockton, Clinical Lead<br>01482 344083 |
| Family Therapy and Family Interventions | Therapy and interventions for families affected by mental health problems in Hull and the East Riding. | Gail Bradbury (gailbradbury@nhs.net), Family Therapy Lead |
| Forensic Outreach and | Offending behaviour and risk to others in | 01482 336740 |

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| Liaison Service (FOLS) | individuals with a learning disability and/or autism spectrum conditions | |
| Health Trainers | Offers a variety of services across Yorkshire and Humber and provide knowledge and opportunity for people to make and sustain positive lifestyle changes. | 01405 766861, HNF-TR.healthtrainers@nhs.net |
| Hull City Council Safeguarding | Local Authority safeguarding of children and young people in Hull | 01482 616092, adultsafeguarding@hullcc.gov.uk |
| Humber Adult Autism Diagnosis Service (HAADS) | Autism spectrum conditions and other neurodevelopmental conditions | 01482 336740, hnf-tr.haads@nhs.net<br>Dr Sushie Dobbinson, Clinical Lead |
| Humber Dialectical Behaviour Therapy (DBT) | DBT and working with individuals with a 'personality disorder' presentation and/or deliberate self-harm | Dr Nathan Badger, Team Lead, 01482 689156, hnf-tr.humberdbt@nhs.net |
| Humber Family Connections | Group-based course focusing on education, skills training and support for people who are supporting a person with difficulties associated with emotion dysregulation | 01482 689156, hnf-tr.humberfamilyconnections@nhs.net |
| Humber Safeguarding | Internal Trust advice and guidance for safeguarding children and vulnerable adults across the organisation | HNF-TR.SafeguardingHumber@nhs.net<br>Rosie O'Connell, Safeguarding Lead |
| Humber Traumatic Stress Service (HTSS) | Trauma, post-traumatic stress disorder, trauma-informed care | 01482 689158<br>Dr Lynsey Holmes/Dr Anne Parry, Clinical Leads |
| Humberside Fire and Rescue | Advice on fire safety and adaptations | 01482 565333 (general enquiries) |
| Huntington's Disease Service | Huntington's Disease | 01482 738060 |

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| Infection Prevention and Control | Internal Trust advice on managing infection risks | HNF-TR.HumberNHSFTinfectioncontrol@nhs.net |
| Information Governance | Internal Trust advice on information security, information retention, information sharing. | 01482 477854, hnf-tr.igteam@nhs.net |
| Inpatient Modern Matron | Senior clinical leadership relating to inpatient care | Jessica Slingsby<br>Nigel Hewitson |
| Inpatient Service Manager | Senior operational leadership relating to inpatient care | Jenni Jordan |
| Lead Social Worker | Advice about issues relevant to social work and social care | Fran Ashton (lead), Paul Sullivan and Vicky Tasker (Principal Social Worker) |
| Community Learning Disability Service | Learning disability (e.g. considering assessment, adaptations to treatment) | Hull - 01482 336740<br>East Riding - 01377 208800 |
| Legal Services | Internal Trust legal advice | Lisa Davies, 01482 477840 |
| Legislation | Internal Trust advice including application of mental health act and mental capacity act | her-tr.mentalhealthlegislation@nhs.net |
| Let's Talk | For those in the Hull area who are looking for support with anxiety and depression disorders. | 01482 247111 |
| Matthew's Hub | Support service for autistic people without a learning disability aged 13 or over, living in Hull or East Riding who have, or are waiting for a diagnostic assessment. | 01482 221028, hello@matthewshub.org |
| Medical Director | Senior medical leadership | Dr John Byrne |
| Memory Clinical and Dementia Services | For people of all ages with a memory problem. | 01482 336617 |
| Mental Health Crisis Intervention Team | Urgent care service for people living in Hull and the East Riding of Yorkshire, ages 18-64, who are | 0800 138 0990 |

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| | experiencing an acute mental health crisis. | |
| Mental Health Liaison Service (MHLS) | Mental health assessment and presentations at acute hospital | 01482 226226 |
| Mental Health Physiotherapy (ER) | | |
| Mental Health Physiotherapy (Hull) | | |
| Mental Health Triage and Assessment Team | Provide routine mental health triage and assessment to people ages 18-64 who are living in Hull and East Riding of Yorkshire. | 01482 216624, hnf-tr.mhtat@nhs.net |
| Mentalization-Based Treatment (MBT) team | MBT to individuals in Hull and the East Riding. | hnf-tr.mbtservice@nhs.net |
| Multi-Agency Public Protection Arrangements (MAPPA) | Multi-agency forum for management of risk of offending | Kate Yorke, Kate.yorke@nhs.net / Jeanette Jones-Bragg, jjones-bragg@nhs.net |
| Older Adult Community Teams | General mental health for older adults aged 65+, experiencing mental health problems. | Holderness - 01482 344400<br>Beverley and Haltemprice - 01482 344222<br>Bridlington and Driffield - 01262 458220<br>Goole – 01405 608288<br>Hull and Bransholme (HICTOP) – 01482 335795 |
| Older Adult Psychology | General mental health for adults 65+, difficulties associated with ageing, cognitive decline and dementia | Dr Clare Hilton |
| Patient Safety Team | Help with CQC and compliance, blue light alters/practice notes, SI's and SEA's, Clinical Audit, NICE guidance and Quality Standards compliance, Peer Review, Patient Safety Alerts, Zero Events monitoring | 01482 301725, HNF-TR.GovernanceAndPatientSafety@nhs.net |

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| Perinatal Service | Mental health issues related to pregnancy and birth, for people in Hull, ER, North and North-East Lincolnshire | 01482 336837, hnf-tr.perinatalmentalhealthteam@nhs.net |
| Police Mental Health Liaison | Advice about managing risk of offending, actions to take, and police responses to patients | John Thirkettle, john.thirkettle@humberside.pnn.police.uk |
| Positive Assets | Help people with mental health difficulties to gain paid suitable and meaningful employment | hnf-tr.PositiveAssets@nhs.net |
| Primary Care Mental Health Networks | | Beverley – Paula Wright<br>Yorkshire Coast & Wolds – Natalie Birdsall-Charnock<br>Bridlington – Michael Gill<br>River & Wolds – Ian Collins<br>Harthill – Alex Ellis<br>Cygnet – Jackie Vagg<br>Medicas – Karoline Kur<br>Nexus – Angela Broadley<br>Modality – Emma Dowson |
| Professional Lead for Psychology | | Dawn Peters |
| Psychological Medicine | Impact of physical health on mental health, interaction of physical and mental health, medically unexplained symptoms | Marie Acton, 01482 738060 |
| Psypher | For people aged between 14 and 65, who are experiencing their first episode of psychosis or might be at risk of developing psychosis. | 01482 336786 |
| Renew | Drug and alcohol service in Hull | 01482 620013 |
| Recovery College | Free, co-produced educational platform which focuses on recovery and wellbeing | 0800 9177752, hnf-tr.recoverycollege@nhs.net |
| Specialist Psychotherapy Service (SPS) | Psychoanalytic psychotherapy perspective on | 01482 689156 |

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| | complex presentations. | |
| STaRS | Maximising people's recovery from mental health, aiming to support and restore people to their optimal physical, cognitive, psychological and social functioning. | 01482 336830 |
| Trust Pharmacy | Medication | 01482 389113, HNF-TR.MedicinesInformation@nhs.net |
| Yorkshire Ambulance Service Frequent Callers and Complex Cases | Liaison for ambulance responses, ambulance system warning flags (e.g. risk) | Ian Cook, ian.cook3@nhs.net |

## Appendix D: Requesting an Operational Risk Review Meeting

Any team within adult mental health can request an operational risk review, provided the guidelines outlined in the main document have been followed.

A referral form is available on Lorenzo as a CDC form, accessible in the adult mental health clinical chart under the [WHICH TAB]. The referral form should be completed on Lorenzo and then printed to pdf from Lorenzo using the print functionality or printed and scanned. The resulting pdf file should then be sent to Paula Stabler (paula.stabler@nhs.net). If required information on the referral form is not provided, this will be requested, and an operational risk review meeting will not be undertaken until that information is provided.

The decision to hold a panel or not will be taken by the Clinical Lead for the Mental Health Division, or in their absence, a nominated alternative. The meeting and invitees will then be co-ordinated by an administrative representative of the Clinical Lead. Clinicians requesting an Operational Risk Review meeting may be asked for clinicians that they think should be included in the meeting from their service areas.

If a request for an operational risk review is declined the clinical teams involved must continue to work within Trust policy and procedures at all times with the previously referred case. Any declined request will be accompanied by rationale for declining and suggestions of which policies and procedures can be followed if they have not already been. If there is a change in circumstances in future, another request for an operational risk review can be made.

### Frequency of Operational Risk Review Meetings

Meetings will be arranged following acceptance of a request and should take place within twenty working days of that date, however this is subject to member's availability and it may not always be possible to convene a meeting within the twenty day period.

Operational Risk Reviews cannot be arranged with urgency. It is expected that clinicians and teams ensure interim decisions around the risks posed have been made whilst waiting for the review meeting.

### Agenda and Supporting Papers

The request should include copies of a comprehensive assessment and formulation, most recent care plan review, risk assessment and current care and treatment plans. These supporting papers will be collated by the meeting co-ordinator and circulated at the meeting. There will be a standard reporting system for decisions and actions which will be circulated to meeting members within three working days.

### Minutes

Minutes of the meeting shall be taken and kept in a V drive folder held by division admin during this process, and should be uploaded to the appropriate electronic record system(s) by the lead professional following completion.

### Outcome of Operational Risk Review

It is envisaged that in most cases verbal feedback on the case will be given at the meeting and subsequently communicated in writing by the meeting chair or nominated person.

Ordinarily such a review will be a single meeting; at all times the clinical team retain clinical and managerial responsibility for the case being discussed.

Action plans from the meeting are for the clinical team to use and it is the responsibility of the clinical team to monitor progress within the normal care processes; plans are not the responsibility of any member of the Operational Risk Review meeting unless expressly allocated as such during the meeting.

**Review and Evaluation**

Outcomes of operational risk reviews will be shared by a representative of the meeting with the Clinical Risk Management Group (CRMG), who in turn will notify Organisational Development Group (ODG).

## Appendix E: MDT Discussion Prompt Sheet

MDT discussion prompt sheet (to be adapted for individual services areas, according to need – whilst areas may choose to add additional discussion points, it is recommended that all areas outlined here are regularly considered within an MDT forum):

- Attendance – ensure representation from multiple professional disciplines – always record who attended, as well as invites with apologies.
  **Consider** – does your immediate team have the appropriate skills and knowledge for care planning and review, or would it be useful to invite, or elicit feedback from, a professional from a different clinical area (e.g. safeguarding, learning disability services, the Complex Emotional Needs Service) – see the 'dedicated focus' section of 'MDT Care Planning; Good Practice Guidelines' for further guidance
- Service user and carer feedback – what are the concerns, wishes, and goals of the service user and their primary support network?
- Formulation and diagnosis – the primary focus (as per 'Trauma Informed Care') should be on 'what has this person experienced, and what does that mean for what they experience now?', rather than 'what is wrong with them?'. It is essential that the individual circumstances are understood, and care is tailored accordingly. Equally, there is a role for diagnosing within our systems, to guide prescribing, and the implementation of evidence based practice – consideration should be made within the MDT of NICE guidelines, the evidence base, the inclusion of others with additional knowledge in that clinical area. *The role of the MDT is to work together to find a balance between utilising guidance and evidence, with individualised, person centred care – this will often involve clinical debate, the role of the chair is to facilitate discussion and support the team in reaching a synthesis in views.*
- Safety – is the service user safe, both in our care and in their home context (e.g. suicide, self neglect, domestic violence, risk of falls)? Are those around the service user safe (e.g. domestic violence, aggression)? Are there practical steps that we can take to improve safety, and are any safety or safeguarding concerns fully documented?
- Addictions and physical health – have physical health needs and addiction been considered? Do we need to seek additional support/advice?
- 'Engagement' and medication compliance – if any issues related to medication compliance or engagement with any areas of service are noted, consider this in the context of what is known/the formulation – what can we do to support access to intervention?
- Carers – ensure carer views are represented within the MDT, and consider needs of carers, both paid and unpaid. Consider any needs of the service user as a carer for others.
- Actions and feedback – have actions from previous MDTs been reviewed? Have current actions being clearly defined, with an allocated person responsible and clear timescales? Who will feedback to the service user, and where appropriate, their carer/supporters?
- Documentation – ensure a person has been allocated to document the MDT discussion; *it is essential to document **how** decision/plans/actions were reached, including the alternatives considered.*