OPERATIONAL POLICY

Psychological Therapies Service [PTS] Newham

Interim-COVID-Version (1) 2020

SECONDARY CARE PSYCHOLOGICAL SERVICES

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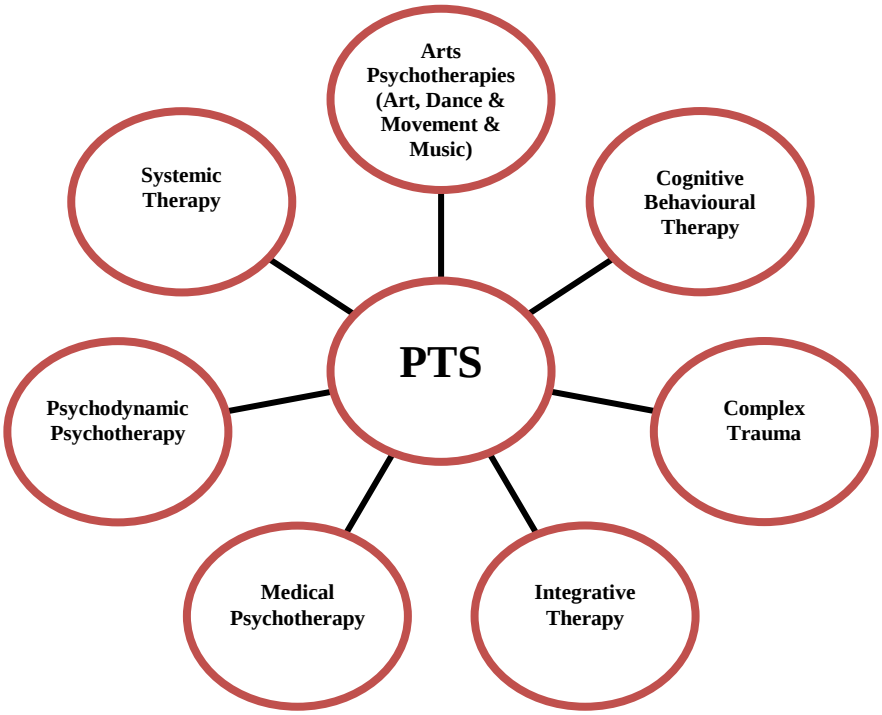

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1. PTS CORE PHILOSOPHY & PURPOSE

1.1 Mission Statement

"The understanding and treatment of all health problems, including mental health problems requires the professional, thoughtful and compassionate application of knowledge and skills derived from psychological, biological and social sciences. The service will be committed to approaches to mental health, which consider the social, economic and political context of mental health difficulties. The service will attempt to address the impact of socio-economic deprivation, political contexts, difference, discrimination and racism on mental health with a view to promote and enable the independence of people with mental health support needs, their integration into their local community and improvement in quality of life. We will work in partnership with those who consent to use our services, their families, their carers and other organisations to combat psychological distress".

1.2 General Introduction

Psychological Therapies Service (PTS) is part of Newham Secondary Care Psychological Services and aims to provide high quality, well-coordinated, needs led psychological care to Service users, their families and carers with severe, complex and chronic mental health difficulties, which cause impairment in multiple domains of functioning, distress and risk. Its remit is to support development of effective psychological therapies, to support workforce development as well as in creating a psychologically literate workforce across services and to bring a psychological perspective to the work of individuals, teams and systems in the London Borough of Newham. It focuses both on evidence-based clinical excellence and developing practice-based evidence relevant to meeting the needs of a very diverse population.

1.3 Core Principles & Values

a) Respect for human dignity and diversity across culture; ethnicity; race; sex; sexual orientation; gender reassignment; marriage and civil partnership; pregnancy and maternity; religion and belief; disability; age for both staff and the service users.
b) Psychological problems considered within their social, familial, economic and political context.
c) Recognition of the multi-cultural locality that the service serves in order to promote culturally appropriate therapeutic services.
d) Helping service users to make sense of their experiences and find novel solutions to complex problems.
e) Empowering service users to recognise and mobilise strengths and sources of support.
f) The prevention and alleviation of suffering.
g) Promoting the independence and/or healthy development of the individual, couple, family, group or system
h) Confidentiality, informed consent, choice, collaboration and partnership.
i) Developing best professional practice and bringing a psychological perspective to the work of individuals, teams and services by investing in workforce development.
j) Equity and fairness aimed to promote and develop choices.
k) Human compassion and tolerance coupled with professional knowledge and professional practice.
l) Awareness of accountability to clients/patients, management, the NHS and the wider public.
m) The service is committed to the principle of equal opportunities.

1.4 Aims of the Service

1) Provide high quality, well-coordinated, needs led psychological care to Service users, their families and carers with severe, complex and chronic mental health difficulties, which cause impairment in multiple domains of functioning, distress and risk, such as:

    - ***Personality Disorders***: Enduring and pervasive behaviour, causing considerable distress with intense and fluctuating affect leading to significant problems in interpersonal, social and occupational functioning.

    - ***Complex Psychosis:*** Delusions and hallucinations that are attenuated or relatively stable but where there remains considerable on-going emotional distress and loss of functioning, often again with precipitating or complicating adverse social circumstances, where addressing one group of symptoms alone will be insufficient to achieve meaningful change. This includes users who have been given diagnoses of Schizophrenia and Bipolar Affective Disorder.

    - ***Co-Morbid Mental Health Difficulties:*** More than one group of distinct symptoms, often one arising secondary to the other, often with precipitating or complicating adverse social circumstances, where addressing one group of symptoms alone will be insufficient to achieve meaningful change. Examples include; (a) chronic PTSD complicated by severe depression, dissociation, misuse of alcohol, physical pain and loss of employment (b) Co-morbid mental health difficulties coexisting with mild to moderate learning disabilities.

2) Offer centralised specialist psychological services, which are accessible to all users with severe, complex and chronic mental health difficulties. The service supports the developing psychological services located in the Primary Care Networks (PCNs), Crises Services, MDTs, and Inpatient Services.

3) Support other service providers for these Service users group by offering consultation, supervision and training to enhance quality and patient centred care and user's engagement.

4) Undertake joint working with other users, community organisations and other professionals to deliver user focused recovery based projects.

5) Contribute towards the Trust's Quality Improvement initiatives with research skills and methodologies and enhancing governance through reflective practice, audit, evaluation & research.

6) Enhance and contribute to diversity of culturally sensitive services to individuals, their families and carers with severe, complex and enduring mental health difficulties.

1.5 Objectives of the Service

1) Provide a range of accessible and joined up formulation centred effective psychological interventions based on stepped care and focused on positive outcomes for the service user, carers and families.

2) Offer needs led packages of culturally sensitive, responsive, high quality integrated psychological care based on assessment and formulation. This comprises of investigation of symptoms, problems, history and support structures including involvement of other services such as PCNs/MDT, community organizations as and when relevant.

3) Ensure that communication links are established between all of the agencies offering services to Service users and their carers by working proactively and sharing the responsibilities of care, as appropriate.

4) Reduce health inequalities, stigma, discrimination and reliance on prolonged hospital admissions. Reduce frequency of presentations at A&E and crises services. Reduce psychiatric morbidity, particularly:
   - depressive and anxiety symptoms
   - self-harming and suicidal behaviour
   - emotional and interpersonal distress.

5) Improve inclusion and employment status, including:
   - Maintaining service users' involvement in activities of daily living and work
   - Supporting service users in returning to activities of daily living and work.

6) Improve service user and carer experience and satisfaction with health services.

7) Support other services in management of Service users, through consultation, liaison and training to the health service (secondary and primary care levels), and non-statutory organisations.

8) Improve interface and care pathways and work closely with Primary Care Talking Therapies and therapy provision in PCNs and MDTs.

9) Develop and foster collaborative working relations with individual GPs and practices, Newham Primary Care Talking Therapies, PCNs, MDTs, Crises Services, Inpatient Services and voluntary or independent organisations to ensure communication links and enhanced quality of joined up care provision to Service users and carers.

10) Ensure appropriate training and education to support on-going service development and quality improvement, recognising the role that Service users and carers have to play in the education and training of professional staff.

11) Lead workforce development and provide support, training and consultation to the teams, staff and community organisations.

12) Support training and honorary placements across the service teams to support workforce development and enhance the service capacity. To work closely with community organisations and Spiritual and Cultural Services to ensure delivery of culturally appropriate services to diverse communities.

1.6 Scope of this Document

1) This current Interim-COVID-Version (1) of the PTS Operational Policy is an attempt to quantify the complex changes that have occurred as a result of the Pandemic and as such will be subject to further changes as the challenges evolve. The specific care pathway from referral to screening to assessment and intervention is based on an adaptation of the service to increased remote working, group interventions and limited face-to-face individual contacts.

2) As an Operational Policy, this document sets out to define and outline the Secondary Care pathways of new referred Service users into the Psychological Therapies Services and for existing Services Users referred within secondary care services into Psychological Therapies Services. This pathway will include screening, assessment and decision for treatment or referral on by clinicians. Fundamentally the processes aim to promote ease of access for psychological therapies**.**

3) The referral pathways of Service users from the Single Point of Entry to allocation of psychological therapy entail four main stages, namely:

    a. Referral
    b. Screening and Consultation
    c. Assessment
    d. Therapy Allocation

4) These four pathway stages will be focused on in turn within this Operational Policy regarding the specific processes and procedures within each. At each stage, both Administration teams at 409 High Street and the clinicians have specific tasks to ensure the smooth running of the referral care pathway.

5) This document aims to adhere to Trust standards pertaining to Information Governance and Clinical Governance. It serves to illustrate the agreed care pathway processes, procedures and documents needed within the Newham Adult Directorate and specifically psychological Services so that they are consistently adhered to and can be monitored and evaluated.

1.7 Wider Models of Care

Recovery Models

1) The recovery model aims to help people with mental health problems to look beyond mere survival and existence. It encourages them to move forward, set new goals and do things and develop relationships that give their lives meaning. Recovery emphasises that, while people may not have full control over their symptoms, they can have full control over their lives. Recovery is not about 'getting rid' of problems. It is about seeing beyond a person's mental health problems, recognising and fostering their abilities, interests and dreams. Mental illness and social attitudes to mental illness often impose limits on people experiencing ill health. Health professionals, friends and families can be overly protective or pessimistic about what someone with a mental health problem will be able to achieve. Recovery is therefore about looking beyond those limits to help people achieve their own goals and aspirations.

2) Recovery can be a voyage of self-discovery and personal growth. Experiences of mental illness can provide opportunities for change, reflection and discovery of new values, skills and interests. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. Recovery is the ability to live a fulfilling and productive life within and beyond the limits of the mental health problems. Guiding Secondary Care Psychological Services, the 'Recovery Process':

    a. Provides a holistic view of mental illness focusing on the person, not just their symptoms
    b. Believes recovery from severe mental illness is possible
    c. Is a journey rather than a destination

d. Does not necessarily mean getting back to where you were before
e. Happens in 'fits and starts' and, like life, has many ups and downs
f. Calls for optimism and commitment from all concerned
g. Is profoundly influenced by people's expectations and attitudes
h. Requires a well organised system of support from family, friends or professionals
i. Requires services to embrace new and innovative ways of working.

Co-Production Models

1) The National Development Team for Inclusion (2016) note that if co-production in mental health is to lead to meaningful and sustainable change, it has to be embedded within and across systems and reflected in how professionals and Service users, their Carers and groups come together, as equals valuing each other's skills, strengths and expertise. Central to Psychological Services will be the People Participation Service which facilitates Co-Production on multiple levels.

2) Co-Production refers to the contribution of service users to the provision of services. MIND (2013) define Co-Production as: A relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities. We already utilise Service users on multiple levels in the model and plan to develop our coproduction of particular groups.

MIND (2013). Co-Production in Mental Health: A Literature Review. New Economics Foundation. Mind: UK.
National Development Team for Inclusion (2016). Embedding Co-Production in Mental Health: A Framework for Strategic Leads, Commissioners and Managers.UK

Trauma-Informed Care Models

1) The common thread in mental health conditions is frequently a history of trauma or abuse. Trauma Informed Services provide a compassionate response based on this premise. They acknowledge the possibility of psycho-social factors to the development of conditions, and also understand that some of the presenting behaviour or symptoms are likely to be survival mechanisms related to their traumatic history.

2) Drawing on the 'Power, Threat Meaning Framework' (Johnstone et al., 2018) there is a key role for psychological services in meaningfully shaping this vision. Many people, especially those in less powerful positions, may be deprived of sound, evidence-based, alternative frameworks in order to make sense of their own and others' distressing or unusual experiences. This is a form of 'Epistemic Injustice' which is experienced by groups who lack shared resources to make sense of their experiences, due to unequal power relations (Fricker, 2007). Drawing on psychologically informed approaches within Population Health interventions will more explicitly address the complexities of people in diverse communities.

3) Linking Trauma-Informed care to Epistemic Injustice, the role of psychological services in understanding Population Health needs should be central to the delivery of all health care.

Fricker, M. (2007). Epistemic Injustice: Power and the Ethics of Knowing. Oxford Scholarship Online.

Johnstone, L. & Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society.

2. REFERRALS, SCREENING, ASSESSMENTS & THERAPIES

3.1 Access to Borough-wide Specialist Psychotherapies

Access to Borough-wide Specialist Psychotherapies is based on a 'Coordinated Access & Referral Processing Model'. The model entails the following steps:

1) Secondary Care Psychological Therapies will be accessed via HUB for new cases that are not already in secondary care services. Referrals from Newham MDTs can be sent directly.
2) All referrals for Psychological Therapies will be signposted to 409 for logging and a centralised screening meeting.
3) The meeting is to be chaired by the Lead Referrals & Assessment Coordinator. Membership of the meeting will comprise of the Lead Referrals & Assessment Coordinator and Psychological therapies staff to ensure representation across the team to inform decisions.
4) The Lead Referrals & Assessment Coordinator is to be responsible to oversee access, assessment and pathway to psychotherapeutic modalities.
5) Leads for the Psychological Therapies modalities additionally provide performance & governance oversight to this system.
6) The role of the Referral, Screening and Assessment Co-ordinator Lead entails a variety of strategic tasks which help with the referral practices across the borough, including:

    a) Facilitation of the interface between Primary and Secondary Care Services and referrals and care pathways.
    b) Chairing the Weekly Borough Referrals Meeting.
    c) Development and maintenance of standardised referral systems and procedures across the borough.
    d) Audit and evaluation of referral trends and screening trends across the borough.
    e) Strategic intervention within the system where referral problems occur such as between Primary Care Psychological Services and Secondary Care Psychological Services.

3.2 Referral Inclusion & Exclusion Criteria

The service will be provided to service users who are either registered with a Newham GP or a Newham resident (this includes people who temporarily resident within the Borough, e.g. refugees, asylum seekers, or homeless people). The Service supports Service users who:

- Are aged 18 years old upwards
- Are registered with a Newham GP or lives in Newham
- Are willing to attend therapy sessions in Newham
- Have severe, complex and chronic mental health difficulties, which cause impairment in multiple domains of functioning, distress and risk; impact significantly on their own lives or those around them; and who have been assessed as suitable for the treatment modalities offered.

Inclusion Criteria

1) Psychological Therapies Service (PTS) are a secondary care psychological service providing psychological therapies to Service users with complex, severe and enduring mental health problems.
2) Psychological Therapies Service (PTS) are commissioned to provide therapy for the residents of Newham. Service users who live out of the borough would be advised to seek therapy in their local areas. In exceptional circumstances we can see service users from out of the borough if permission is granted by Newham Medical Director.
3) The service is able to see people who need interpreters in Systemic and individual therapies. Currently we are not able to accept service users who need interpreters for group therapy.
4) The service is committed to see service users with mild to moderate Learning Difficulties and will offer reasonable adjustments to our pathway to help them engage.

Exclusion Criteria

1) Those under 18 and those between 18 and 19 who are in full time education.
2) People whose primary problem is misuse of drugs and alcohol and those who use substances in such a way as to prevent effective use of psychological interventions.
3) People requiring specialist forensic services.
4) People who require a care package indicating hospital admission or input by the acute day hospital.
5) Service users primarily suffering from a mental illness requiring treatment and stabilisation within an MDT setting due to risk and engagement issues prior to engaging with Psychotherapy Services.
6) Service users whose levels of risk to others and/or offending behaviour warrant treatment in forensic services.
7) Older adults whose physical health needs, frailty or cognitive impairments make it more appropriate for them to be managed by the Mental Health Care for older People's (MHCOP) Service.
8) Psychological Therapies Service (PTS) are not able to accept service users who are in crisis and in need of help of crisis support. Our target for first clinical contact is 11 weeks and we therefore only accept service users whose mental health is stable enough to be seen within that time frame (acute psychosis and severe suicidal crisis form part of our exclusion criteria).
9) The service is mindful that to be able to use therapy effectively, service users' basic needs have to be met. People who are experiencing social crises such as homelessness/lack of funds need help relating to these difficulties before being referred for psychological therapy.
10) Service users who are addicted to, or heavily rely, on substances needs to be committed and actively engaged in their recovery before we can accept referral to our service.
11) The service is not commissioned to see service users with eating disorder.
12) The service does not provide support to service users presenting with a primary diagnosis of autism but reasonable adjustments are advocated for service users presenting with mental health difficulties and autism.
13) The service is not set up to see service users with severe antisocial PD and sexual perversions.
14) **Due to Covid-19 pandemic we had to adapt our work to delivering remote therapy and we are currently not able to accept new Service users for face to face therapy.**

3.3 Screening

Pre-Screening

1. Referrals will be entered into the referral data base by the Assistant Psychologist/Administration
2. Pre-screening to identify referrals with insufficient information will be completed by the Assistant Psychologist
3. Referrals with sufficient information will be pre-screened by the Referrals & Assessment (R/A) Lead / other members of the screening team, to identify the most complex referrals to discuss in the meeting
4. Agenda for the screening meeting: Assistant Psychologist will prepare the agenda including referrals with insufficient information and referrals to be discussed.
5. Referrals are uploaded on RIO in the Screening Meeting.

Screening Meeting

1. Our screening process will ensure that we are able to safely meet our service users' needs. We are having a weekly screening meeting. Time: every Tuesday 12:00 to 2:00 pm
2. Participants: Leads, Administration, Assistant Psychologist, band 8a and 7 therapists will be invited to help with the screening
3. Agenda:
    - To share referrals with insufficient information
    - To discuss pending referrals from last week
    - To discuss the most complex referrals
    - All the appropriate referrals need to be screened by at least R&A Lead and another team member
4. Tasks in the meeting:
    - To decide if a referral can be accepted- All clinicians
    - Screening team members will be allocated specific tasks: presenting the referral, checking additional information on RIO and IAPTUS, completing outcomes on the data base, completing RIO notes (administration team)
    - If the referral is rejected, the team will compose the response to the referrer explaining the decision.
    - Administration team will document screening decision on RiO.

Post-Screening Meeting

1. Accepted referrals
    - Administration will open on RIO and Corenet within a week from the screening decision
    - Amin to send an Opt-in letter within a week from the screening decision
    - Administration will update the referral and assessment data base
2. Pending referrals
    - An allocated team member will contact a referrer to request missing information
    - The referral may be declined if the referrer does not respond with providing additional missing information.

3. Declined referrals
    - A comprehensive message to be sent to the referrer either during the screening meeting or afterwards by an allocated team member
    - Administration to open and close on RIO

3.4 Opt-In Process

1. Service user will be sent an Opt-In Letter by e-mail and post.
2. They will be requested to call us to book an assessment within two weeks.
3. Administration team to check referral & assessment data base which will automatically generate Opt-In time frame.
4. If the service user opts in within two weeks, they will be offered a telephone / video assessment within 11 weeks from the time of acceptance.
5. If the service user does not opt in within two weeks, they will be discharged on RIO, a RIO progress note made / standard letter to be sent acknowledging this.
6. Service users with Learning Disabilities will be called if they fail to respond to the opt-in letter.

3.5 Assessments & Therapy Allocation

Aims of Assessment

1. Initial assessments following acceptance of a referral will be aimed at collecting information to assess the service user's suitability for online specialist psychological therapies, to facilitate the process of formulation and to consider level of the intervention. i.e.:
    -Consultation to the service user/referrer/system
    -Provision of therapy with consideration for modality and interventions
    -Referral to an appropriate service
2. Create a Risk-Management plan with the service user based on risk and clinical need.
3. Share with the service users the therapist's understanding of the service user's difficulties.
4. Establish the service user's preference for therapy and any specific requirement (e.g. restrictions on their attendance, therapist's gender, language need, etc.) and discuss support options.
5. Decide with the service user which therapy modality may be most appropriate and discuss expected waiting time.
6. Allocate to modality where appropriate according to the team's criteria.
7. Enable clients/patients to make informed choices and give informed consent at all stages of the referral, allocation, assessment and therapy process.
8. Minimise waiting lists and waiting times as far as possible within available resources.
9. Develop methods as far as possible within available resources for minimising the negative impact of waiting lists on clients/patients.
10. Communicate clearly and appropriately with referrers and others who have a need to know about the referral and outcome process. Referrers are informed of the outcomes of assessment, beginning of therapy and the end of therapy within the 4 weeks of end of assessment, beginning of therapy and the end of therapy.

Assessment Process

1. Service users who opted in will be offered a telephone or video assessment within 11 weeks of date of acceptance.
2. Assessors to contact service user at the time of assessment and again after 10 minutes if the service user did not respond. A 'Contact-Us' Letter will be sent if the service user does not respond both times.
3. If Service user DNA's the second assessment, they will be discharged from the service. They can be re-referred in three months if they are able to attend.
4. Assessment will determine if service users are able to use therapy and if this is the most appropriate service for their current needs. If the service user and assessor agree that therapy in the Psychological Therapies Service is not appropriate, the service user will be discharged.
5. Follow-ups: service users who have been accepted will be booked for a routine follow-up appointment within 18 weeks of the referral acceptance date. If they DNA, a 'Contact-Us' letter will be sent. If the service user does not respond to the letter, they will be discharged from the service.
6. Service users will be informed about the follow-up appointment and three monthly phone calls following this, should they still wait for therapy at that point. If they don't respond to two phone calls, a 'Contact-Us' Letter will be sent. If they don't respond to the letter, they will be discharged from the service. Service users will be informed about this policy in their assessment and the information will be included in the Assessment Letter.

Allocation Process

1. Allocating assessments

- During the Screening Meeting a decision is made about the type of assessment, either generic or modality-specific, to be offered.
- Administration team support this decision by checking the referral-assessment data base to identify suggested modality to book the assessment.
- Clinicians will ensure they prepare the list of available assessors for the administration team.

2. Assessing for groups

- Clinicians need to use available support such as Supervision and Team Meetings to discuss complex assessments.
- Clinicians will be encouraged to ensure assessment decisions are appropriate for presenting needs and discuss with supervisor and/or the team where suitability of modality is not clear.

4. Standardised assessment format

- An Assessment Form adapted for group and online therapy delivery will be used to guide this process for all staff.
- All assessments are standardised to ensure consistency of approach
- The Assessment Form will be used as a prompt during the assessment, decision making process and afterwards to document it on RIO.
- Assessments must include an up-to-date risk assessment.
- All assessments are to be written up into letter format and forwarded to service user, referrer and GP.

6. Outcome measures

- CORE 10 and Dialog will be e-mailed/posted with an assessment invite letter.
- Assessor must complete these outcome measures with service users in the assessment if they has not been completed by them beforehand.

7. Follow-ups

- The Assessment and Follow-Up appointments will constitute the initial 11 and 18 weeks targets respectively.
- The follow-up will be booked by the clinician within the 18 week target. The follow-up will include re-administering the CORE 10 outcome measure.

3.6 DNA/Cancellation & Waiting List Policies

DNA/Cancellation Policy

This Policy has three main aims:

1. To minimise lost appointments through DNAs and cancellations.
2. To give new Service users reasonable notice of their first appointments.
3. To maximise capacity by reducing wastage and enhancing efficient throughput.

For consistency across the service due to each stage of the care pathway being different regarding what is offered and due to expectations about engagement, we have created bespoke processes at each Step (1) Assessment and Step (2) Online Therapies. At Step (1) where appointments are one-offs/stand alone, the same DNA and Cancellation criteria apply for all Service users. In Step (2) where interventions are longer and differ, the standard DNA and Cancellation criteria does apply but it is implemented in relation to a case formulation based approach which is essential with secondary care Service user presentations and the nature of the Online Therapies offered.

Waiting List Policy

This Policy has three main aims:

1. To provide clarity with expectations about waiting and contacts between the Service user and the service.
2. To ensure engagement is maintained where waits occur
3. To facilitate risk management throughout the care pathway

It is the responsibility of modality leads to ensure that adherence to this policy occurs and that oversight of all Service users waiting for therapies is managed safely. Service users are always encouraged to contact the service for updates on the waiting list or other support needs.

3.7 Discharge Process & Re-Referrals

Discharge Process

Following an initial consultation, a contract for a specified number of sessions is agreed between the therapist and the Service user as per each team's duration of therapy and review guidance. On

completion of this contract, a further contract may be negotiated using the service guidelines for therapy provision. All discharges will be clearly recorded on relevant systems and communicated to referrers as per the service standards.

Discharge from Psychological Therapy Services may be:

a) At the end of an agreed brief time-limited piece of work.
b) At the end of an agreed period of longer term work.
c) If a client drops out during therapy and fails to re-engage. This will be discussed in supervision. Also see DNA, Cancellation & No Longer Wish to be seen policy.
d) Planned for more complex situations where resolution is unclear or person is not engaging. Decision to involve other agencies as per the service user's needs.

Re-engagement with the Psychological Therapy Services teams may be:

a) Part of planned process (discussed in management and clinical supervision).
b) Agreed following a Clinical Review in clinical and management supervision.

Re-Referrals

It is acknowledged that the chronicity of some Service users' presentations can span for years needing multiple if not prolonged interventions from a range of professionals. The service needs to balance this genuine need with the fact that more therapy is not necessarily the best option (such as in creating dependence) and that there are many Service users newly referred to mental health services for the first time.

After completing a course of therapy, Service users can be re-referred for further therapy after one year for a group treatment and after three years for individual therapy. There will be exceptions and this will always be on a case by case basis. Online Group Therapies are the current intervention offer and as such the policy will be one year.

Where possible, suggestions of options of private therapy will be given and/or consultation can be provided for re-referred Service users to find out why the previous therapy wasn't helpful and how more can be different. Should a Service user be open to an MDT, the 'Getting There' Community Group Programme will always be advocated.

3. GOVERNANCE STANDARDS & ACCOUNTABILITY

3.1 Clinical Governance

To ensure the delivery of high quality Psychological Services, clinical governance structures will be adhered to ensuring that the service is delivered appropriately by all staff. Clinical governance is a systematic approach to maintaining and improving the quality of patient care within a health system (NHS). Clinical Governance is a way for organisations and individuals to make sure they deliver safe high quality healthcare. It is designed to help organisations and staff monitor and improve standards of care. Drawing on the five Care Quality Commission (CQC) principles to ensure that services are high quality, the Service user will be placed at the centre of our psychotherapeutic work. The five key domains will ensure and evaluate that a high quality service is provided:

1. **SAFE**: Service users are protected from abuse and avoidable harm.

2. **EFFECTIVE**: Service users' care, treatment and support, achieves good outcomes, helps to maintain quality of life and is based on the best available evidence.

3. **CARING**: Staff involve and treat Service users with compassion, kindness, dignity and respect.

4. **RESPONSIVE**: Services are organised so that they meet Service users' needs.

5. **WELL-LED**: The leadership, management and governance of the organisation make sure it's providing high-quality care that's based around Service users' individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

3.2 Professional Standards

Professional & Operational Accountability

All psychological professionals are accountable to Lead Borough wide Psychological Services who is accountable to the Clinical Director and Borough Directors. Lines of professional and operational accountability are in place for all psychological professionals to ensure that clinical practice is safe, sound and supported according to principles, guidelines and standards that are relevant to the professions of psychiatry and Newham Psychological services. The aim is to set up a framework for the clinical governance of practitioners and the services that they deliver.

Professional Standards, Protections & Responsibilities

a) All qualified practitioners in the service are autonomous clinicians who carry clinical and legal responsibility for their own work and the work of any trainee practitioners whom they may be supervising.
b) All psychological work is undertaken during normal working hours (9.00 am – 5.00 pm). Evening clinics take place on Mondays and Thursdays (5.00pm – 8.00pm) and offer limited capacity to accommodate clients who are unable to attend daytime clinics due to work commitments.

c) Psychological practitioners hold clinical responsibility for case(s) seen by trainees on placement. They will co-sign all clinical correspondence and clinical forms including assessments, reviews, discharge summaries and risk assessment/management protocols.
d) Psychological practitioners do *not* hold clinical responsibility for the work of those from other professions to whom they may be offering training or consultation.
e) All psychological practitioners are required to undertake an appropriate level of continuing professional development (CPD) activity in order to ensure that their skills and expertise continue to meet the highest standards. Approximately a minimum of 70 hours (or 10 working days) per annum for a full time post should be allocated for this purpose.
f) All psychological practitioners in the service must be accredited by the appropriate body (i.e., British Psychological Society (BPS), British Association for Counselling & Psychotherapy (BACP), British Confederation of Psychotherapists (BCP), United Kingdom Council of Psychotherapy (UKCP), Association for Family Therapy (AFT), British Association of Behavioural and Cognitive, Psychotherapy (BABCP) Royal College of Psychiatry (RCPsych), and General Medical Council (GMC)).
g) All Psychological staff in the service are required to have Health Professional Council registration.
h) All qualified non-medical practitioners are advised but not required to join UNITE or another suitable Trades Union for additional professional support.
i) All practitioners are required to receive regular clinical supervision from suitably qualified colleagues. Peer supervision from suitably qualified practitioners (on an individual or group basis) is acceptable if it facilitates constructive feedback on clinical work and creates an opportunity for regular reflection on clinical practice in the context of psychological theory. Contracts will be in place for all external Consultations with joint annual reviews with the line manager (See service policy on Supervision & Consultation).
j) All psychological practitioners will abide by the policies issued by the Trust Psychological Therapies Committee and by the policies of the Borough wide Psychological Services.

3.3 Risk Management & Safeguarding & Incidents

Management of Risk

a) Clinical risk assessment skills are built into the training and continuing professional development of qualified and accredited psychiatrists, psychologist, psychotherapists and counsellors. Clinical risk assessment is an inherent part of the role and routine practice of these professional groups. Clinical risk will always be carefully considered at assessment and continuously reviewed during any subsequent intervention.
b) All psychological practice is designed to prevent or minimise risk. This can be measured, for example, by the reduction of incidents of self-harm, admission frequency, length of admissions etc. during and/or following psychological interventions.
c) There will be occasions for psychological practitioners where risk goes beyond what can be contained in “stand alone” psychological work (i.e., patients who are not on CPA). In these cases clients should always be explicitly reminded about additional sources of support that are available to them and their psychological practitioner will always work in liaison with other professionals and agencies as appropriate to form a co-ordinated and individually tailored response to risk.
d) Assessment and management of risk will be in line with the Trust Risk Management Policies.
e) A crises management plan will be activated when risk is identified including contacting with relevant professionals involved in the users care to ensure safely, liaison and fluid communication.

f) If there is an indication of risk at the point of referral intake, risk assessment information must accompany a referral.
g) Referrals that indicate high risk or complex dual diagnosis will be accepted only as part of a multi-agency approach for the management of risk. For the care coordinated cases, psychological therapists will liaise closely with the care coordinators to keep the care provision joined up and well-coordinated. This will require psychological Therapists to be invited to care planning meetings.
h) The risk assessment will be carried out at the assessment stage and where risk is indicated, assessors will be responsible to put a risk management plan in place with clear documentation on Rio as well as liaison with relevant professionals. This will be discussed in clinical supervision and the service manager will be notified.
i) If increased risk is identified during therapy, this will be discussed in clinical supervision and the service manager will be notified. Records of risk management plans will be recorded in the case file on Rio.
j) Psychological Therapists will call professional meetings for those users where needed. This included users who are difficult to engage and/ present with risk during the course of their treatment requiring multi-professionals approach to engagement and risk management.
k) All appointment cards will have crisis line numbers and information will be provided to service users for out of hours services for support in crises.

Safeguarding Children and Vulnerable Adults

All psychological therapists are responsible to assess risk and set out an alert when there are concerns about the actual or possible abuse or neglect of an adult and children. All safeguarding concerns about children and vulnerable adults are discussed in supervision. The service head will be consulted and notified when an alert is raised. Trust policies on Safeguarding Children and Vulnerable Adults are followed for guidance. The service does not provide any crèche facilities.

Management of Untoward Incidents

Untoward incidents will be recorded, discussed and investigated as per Trust Serious Untoward Incidents (SUI) policy.

3.4 Information Governance

Confidentiality, Record-Keeping, Sharing of Information and Consent Issues

a) All Psychological practitioners are required to adhere to Trust policy in Record keeping, Data protection, Confidentiality, Sharing of Information and Consent.
b) All psychological practitioners are required to keep written records to a standard that would enable a legal defence of their professionalism. Written case notes should be legible and identifiable, demonstrating at the very least a clinical rationale for work undertaken and an evidenced sequence of assessment, formulation, intervention and outcome.
c) Trust policies and professional guidance will be adhered to for electronic records.
d) RIO entries following a meeting with the users will be made at the end of the clinics. The minimum information on RIO will contain main themes of the session, mental state and risk issues where identified and the date of next appointment.
e) All psychological practitioners should communicate their work to referrers and other colleagues both informally and in written form to a standard that is sufficient to enable multi-professional co-ordination of care. Written communication about work undertaken

would be expected at the very least after assessment, reviews of therapy and at the completion of the work. Such communication should provide at least a brief clinical formulation, a brief rationale for the approach adopted and some idea of current outcome or recommendations for the future. All therapy teams will have standards for letters to referrers reflecting the service baseline standards.

f) All psychological practitioners will preserve and uphold the general principle of patient/client confidentiality but this will also be balanced against the need to share patient/client information when appropriate as per the Trust policies.
g) Where the explicit consent of the client/patient is given for the disclosure or withholding of information, the wishes of the client/patient in this respect will generally be followed, unless in the judgement of the psychological practitioner this would significantly increase risk to the client/patient or others.
h) Clients are asked for consent to be seen by trainees at the stage of assessment. All trainees in the service will meet stringent standards of qualification, experience and practice at the stage of recruitment. Structure for appropriate clinical supervision will be in place for all trainees in accordance with the requirement of their training organisation. Where a client/patient raises concerns about being seen by a trainee this needs to be thought through and dealt with on an individual basis. This is the same as for other issues that may from time to time be of concern to clients/patients, for example the gender or therapeutic approach of their psychological practitioner. In all of this, there is an important underlying principle of respecting the wishes and needs of all our clients and sensitivity to clinical issues.
i) All case files will be secured in locked cabinets. For clinicians operating from satellite sites, it is the clinicians' responsibility to place a yellow tracer cards at the service main operational base for cases where files are kept at satellite sites. On each site, same standards for file security apply.
j) Case files will be held in accordance with Trust Policies on Case File Management and Access to Files.
k) Transfer to electronic records will be in line with the Trust Policies and professional guidance.

3.5 Evidence-Based and Practice-Based Psychological Intervention

The service prides itself on **Evidence-Based Practice**. Psychological therapists are skilled in the use of recognised interventions recommended for complex cases. NICE guidelines advocate the use of a range of interventions for individuals who have been given specific diagnoses. These diagnoses are frequently given to Service users seen at 409 and therefore, the approaches advocated are incorporated into the psychological provision. They include:

a. Psychosis and Schizophrenia (NICE: 2014)
b. Bipolar Disorder (NICE: 2020)
c. Depression (NICE: 2009)
d. Anxiety, GAD and Panic Disorder (NICE: 2011)
e. Obsessive Compulsive Disorder and Body Dysmorphic Disorder (NICE: 2005)
f. Eating Disorder (NICE: 2004)
g. Post-Traumatic Stress Disorder (NICE: 2005)
h. Self-Harm (NICE: 2013)
i. Borderline and Antisocial Personality Disorder (NICE: 2009)

a) All psychological practitioners are required to be aware of the published evidence and literature relating to their field and to keep up to date with this through an ongoing process of CPD activity.

b) The role of the psychological practitioner requires innovation, improvisation and integration of techniques, methods and approaches for development of the theory and practice. It is recognised that the research literature is incomplete and evidence can be contradictory. Clinical practice needs to be informed by the social, cultural and political context of the client group and the service will aim to develop local evidence to contribute to the national research.
c) Psychological practitioners are committed to an approach that looks at the concept of evidence in the full complexity of the different contexts within which that term is used. "Evidence" may refer to national/international published empirical research, the wider clinical literature, local research/audit and individual professional experience.
d) At all times the individual experience of the client must be paramount in considering the concept of "evidence-based practice". In all forms of psychological work the view and perspective of the client must be actively sought and clarified on an ongoing basis in a constant endeavour to gather the clinical "evidence" as to what is and is not working in that individual clinical context. The literature in the area of effectiveness and efficacy suggest that psychological practitioners should aim to deliver the best and most suitable approach available in the individual context. The rationale for treatment decisions by psychological practitioners should be evidenced at least in broad outline terms from clinical records, documentation and correspondence.
e) Psychological practitioners take account of evidence at various levels in making judgements about best practice in all aspects of their work. The concept of evidence is complex and involves interplay of objective and subjective factors within the context of the severity and complexity of the psychological difficulties. Clinical judgement can never be entirely objective. However, clinical judgement must always be tested and validated against other sources of evidence that when taken as a whole can provide a more objective benchmark of the quality of work undertaken. These other sources include supervision, research evidence, available written guidance on best practice, consultation with peers and most importantly of all the ongoing perspective of the client and significant others in their social network. Clinical methods are not advised to be just based on 'objective evidence' that go against clinicians sincere and reasonable convictions derived from clinical experience with the SU, experience, clinical judgement and professional training.

The service additionally prides itself on **Practice-Based Evidence**. This entails the application of integrated models based on a formulation of individual Service user's needs. Through experience, expertise and an understanding of the Service user group, this sophisticated approach can be developed and implemented and offered where NICE Guidance is not indicated. Complex problems require creative solutions and so we promote individualised formulation-based approaches in secondary care. This is an essential way of intervening when comorbidity and complexity are frequent in presentations and as such are not covered in current NICE Guidance.

3.6 Service Evaluation

Evaluation & Outcomes

The service aims to:

1. Provide routine clinical activity data.
2. Provide clinical governance data as part of a specific psychological services profile.
3. Monitor client satisfaction routinely.
4. Apply appropriate and scientific measures of clinical outcome (e.g., CORE).
5. Take a proactive stance towards clinical audit and service-based research.

6. Each service will take responsibility for fulfilling the various outcomes and reporting requirements (CQUIN) placed upon them by service commissioners.

The service will provide a choice of a range of effective therapies. Recommendations regarding an appropriate treatment (e.g., their modality and length) will be based on clinical judgements informed by NICE guidelines and are validated against best practice guidelines, clinical experience, outcome and efficacy literature and case discussions in supervision.

The service will need to generate more practice-based evidence to consider "what works for whom within the local context" and this will require the setting up of robust audit and evaluation systems.

Outcomes

Outcomes are routinely collected in our psychotherapy services and evaluated to guide practice. We pride ourselves on good results and effect sizes with outcome data indicating that we have effective interventions. We use a range of measures to reflect Service user complexity, Trust directives and local needs. Our outcomes include:

PROM **Patient Reported Outcome Measures**
DIALOG and Clinical Outcomes in Routine Evaluation (CORE) administered monthly

PREM **Patient Reported Experience Measures**
Tablet with Trust-wide measure in Waiting Area
Yearly paper and pen evaluation that is more bespoke to service offered at 409.

CROM **Clinician Reported Outcome Measures**
Clinician Rated Clinical Outcomes in Routine Evaluation (CORE)

Quality Improvement & Strategic Service Development

The Quality Improvement (QI) Initiative within ELFT is developing staff to think and practice more innovatively with the aim of increasing quality and the cost effectiveness of services. QI is successfully demonstrating adherence to a quality agenda and showcasing the work of staff in teams and is shaping staffs' perception of healthcare for the better as staff are thinking more analytically about the work they do to achieve a high quality service.

We pride ourselves on the range of QI Projects in psychological services that incorporate improvement methodologies to better our work. There are a range of completed and ongoing and new projects to develop our care pathways. Trainee clinical psychologists are particularly embedded in this Trust wide as they complete Service Research as part of their doctorates.

Partnerships and professional links will be established with the Research Department to ensure innovation in research practice and continuation of research expertise.

3.7 Performance & Targets

Performance and outcome targets and systems

The Unit objectives and targets will be drawn up as part of Newham Psychological Services commissioning contract & service planning. The service will aim to set up structures and processes for service planning and regular reviews are based on the principles of staff and service user involvement. All psychological practitioners will have their appraisals and annual reviews in line with the Trust policies.

The service performance and outcome targets will be monitored as required. Gaps in the service will be communicated to the head of the service/commissioning.

Current Targets are for the first two contacts:

- Assessment 11 weeks
- Assessment Follow up 18 weeks

Service Capacity

Each clinical team has their capacity figures for a number of new cases per year, expected caseloads and specified activities which are reviewed on yearly basis.

Psychological Trust-Wide Targets will be achieved based on Job Plans of psychological staff and regularly reviewed to ensure staffing productivity.

Staffing Job Plans, Supervision & Appraisals

All staff will have an expectation to negotiate their time in accordance with a Job Plan:

a) Direct clinical care: This includes face-to-face contact with the identified users for the purpose of assessment and treatment), attendance at CPA meetings, family and group work, consultation and case reviews. (Indirect clinical work: Within the service this includes supervision to others, case discussion, consultation, report writing, communication to referrers/service users/colleagues and personal supervision.
b) Limited indirect clinical work is also offered to other services in the form of supervision, reflective practice groups, case consultation, staff development, support and training. The level of this work is limited by the resources available.
c) Service maintenance and development: These activities include team meetings, liaison meetings, audit and research, clinical governance activities, away days, service planning meetings and staff training as agreed though IPR and CPD.
d) Service management: This includes staff and service management related activities i.e. IPRs, management supervision, activity monitoring, service planning and development, general operational management.

Staff spend on average 40-50% of their time in direct face to face contact with service users. The exact proportion of time spent in clinical work by each staff member (to the recognised maximum of 60%) is determined by the range of their responsibilities.

a) All members of the team receive regular group and individual supervision and six monthly Annual Appraisals and Appraisal Reviews to ensure high-quality working practice Psychological practitioners may provide training, consultation and supervision for members of other disciplines and professions (including the voluntary sector) in order to enhance the psychological aspects of their existing role within appropriate limits and boundaries.

b) All practitioners are required and will be supported to update and develop their own knowledge and skills through an ongoing process of continuous professional development (CPD). This will be monitored annually via the appraisal process.
c) Psychological practitioners will routinely share knowledge and skills with each other at appropriate internal meetings across their department/team, the directorate and across the Trust as a whole.
d) Appraisals will be carried out on regular basis as per Trust guidance to ensure that psychological practitioners are performing to adequate standards and receiving adequate support and training to deliver high quality services and further develop skills and expertise.
e) .All members of the team keep up to date with relevant literature and current interventions for people with severe and enduring mental health difficulties, and attend relevant training courses regularly.

Meetings, Liaison and Communication between Services

The service will ensure that it works in close collaboration with other mental health services. The service teams will have representation in relevant forums to address interface issues. The relationship with psychological practitioners working in other specialities will need to be flexible to ensure that a seamless access to therapeutic help can be offered across the service. Meetings include:

1 *DMT Meetings*
2 *Newham Management Meetings*
3 *Crisis, Community and Acute Healthcare Clinical Governance Meetings*
4 *Performance Meetings*
5 *Community Transformation Meetings*
6 *Trust-wide PTS Strategic Meetings*
7 *Business Meetings*
8 *Interface and Mainstreaming Meetings*

3.8 People Participation & User Involvement

a) The user involvement policy of the service will be in line with the national, regional and local initiatives to ensure service user involvement in service delivery, strategic planning, recruitment and monitoring and evaluation of services.
b) Comments, compliments and complaints will be invited in order to improve the quality of the service. Informal 'Comments, Compliments and Complaints' forms and the suggestion box will be available in reception/waiting areas, clearly indicated. These forms /suggestions will be directed to the Service Head who will bring feedback to relevant forums for discussion and decisions on appropriate service response when needed.
c) Service users will be provided information on the Patient Advocacy and Liaison Service and complaint procedures when required. Formal procedures will be followed if required using the Trust complaints procedures.
d) Feedback on satisfaction with the services will be invited at the end of the service user contact with the service.
e) Relevant forums will be put in place for service user consultation.