**7 DAY FOLLOW-UP PROCEDURE**

<table>
<thead>
<tr>
<th>POLICY NUMBER:</th>
<th>CLPG49</th>
</tr>
</thead>
<tbody>
<tr>
<td>VERSION NUMBER:</td>
<td>1</td>
</tr>
<tr>
<td>KEY CHANGES FROM PREVIOUS VERSION</td>
<td></td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Director of Mental Health</td>
</tr>
<tr>
<td>CONSULTATION GROUPS:</td>
<td>Clinicians, Associate Directors, SMB &amp; SMT Members, MH Operations</td>
</tr>
<tr>
<td>IMPLEMENTATION DATE:</td>
<td>April 2017</td>
</tr>
<tr>
<td>AMENDMENT DATE(S):</td>
<td>-</td>
</tr>
<tr>
<td>LAST REVIEW DATE:</td>
<td>-</td>
</tr>
<tr>
<td>NEXT REVIEW DATE:</td>
<td>September 2019</td>
</tr>
<tr>
<td>APPROVAL BY CLINICAL GOVERNANCE AND QUALITY SUB-COMMITTEE</td>
<td>22nd November 2017</td>
</tr>
<tr>
<td>RATIFICATION BY QUALITY COMMITTEE</td>
<td>14th Dec 2017</td>
</tr>
<tr>
<td>COPYRIGHT</td>
<td>2019</td>
</tr>
</tbody>
</table>

**PROCEDURE SUMMARY**

The Trust monitors the implementation of compliance with this procedure in the following ways:

<table>
<thead>
<tr>
<th>Services</th>
<th>Applicable</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustwide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essex MH&amp;LD</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>CHS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Director responsible for monitoring and reviewing this procedure is Executive Director of Mental Health & Deputy CEO
CONTENTS

THIS IS AN INTERACTIVE CONTENTS PAGE, BY CLICKING ON THE TITLES BELOW YOU WILL BE TAKEN TO THE SECTION THAT YOU WANT.

1.0 PURPOSE
2.0 BACKGROUND
3.0 SCOPE
4.0 IMPLEMENTATION
5.0 WARD PROCEDURE
6.0 IDENTIFIED RESPONSIBLE COMMUNITY TEAM PROCEDURE
7.0 COMMUNICATION
8.0 AUDIT/MONITORING
9.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURE

APPENDICES
APPENDIX 1 – 7 DAY FOLLOW UP FLOW CHART
APPENDIX 2 – 7 DAY FOLLOW UP (DISCHARGE) APPOINTMENT CARD
Assurance Statement
These procedures are necessary to ensure that all service users are given, at the point of discharge, an allocated date for their 7 day follow-up in line with the Department of Health and Monitor requirements.

1.0 PURPOSE

1.1 To specify Trust procedure for the follow up within 7 days of appropriate service users who are discharged from inpatient care.

1.2 To support the requirements of the National Confidential Inquiry Annual Report Oct 2016 ‘Latest Findings’ and the Preventing Suicide in England 2012 on-going guidelines for safer management of those clients at risk.

2.0 BACKGROUND

2.1 One of the specific targets contained within “Saving Lives: - Our Healthier Nation” (DoH 1999) is to reduce the suicide rate by at least 10% by 2020/21. Health and Social Services are expected to play their full part in helping to achieve this, which is reflected in Standard 7 of the National Service Framework for Mental Health.

2.2 One of the particular requirements for preventing suicide among people suffering severe mental illness (SMI) is to ensure that follow up of those discharged from inpatient care is treated as a priority and that care plans include such follow up within one week of discharge.

2.3 This has been reinforced by more recent guidance in the ‘Preventing Suicide in England’ Feb 2015 which highlights the need to include suicide as an indicator within the Public Health Outcomes Framework will help to track National Progress against our overall objective to reduce the suicide rate.

2.4 The National Patient Safety Agency has published Preventing Suicide: A toolkit for mental health services, which introduces a set of standards for management and reduction of suicide following an inpatient episode, including telephone follow up from the inpatient setting (Standard 2) and a follow up visit within 48 hours of discharge from an inpatient setting which is specifically mentioned within the care plan where there is a heightened risk of suicide. Further guidance can be found in the Trust’s Suicide Prevention Clinical Guideline (CG29).
2.5 **Application of These Procedures in Essex Partnership University NHS Foundation Trust:**

These procedures apply to all Essex Partnership University NHS Foundation Trust’s inpatient units when someone is discharged to a community setting. Essex Partnership University NHS Foundation Trust supports this action as part of its commitment to implement the National Suicide Prevention Strategy.

### 3.0 SCOPE

3.1 This Procedure applies to all Essex Partnership University NHS Foundation Trust’s inpatient units including those admitted to Mental Health Assessment Units (MHAU) when someone is discharged to a community setting.

3.2 Community Drug and Alcohol Services will follow up any patient who was admitted to hospital with a dual diagnosis unless allocated a care coordinator within another Community Mental Health Team.

3.3 The Home Treatment Team will be responsible for completing the 7 day follow up for any patient discharged from the MHAU unless the patient already has an allocated care co-ordinator within another Community Mental Health Team.

3.4 Child and Adolescent Mental Health Services (CAMHS) will follow up patients discharged from the CAMHS inpatient unit.

3.5 For patients discharged to Residential and Nursing Homes or known to be travelling out of area following discharge it is more likely that the agreed follow up will be by telephone contact within 7 days. However, this telephone call must be recorded within the clinical records and on the clinical information system.

3.6 For patients discharged to a General Hospital for medical treatment and or end of life care the respective Mental Health RAID Team will be responsible for completing the 7 day follow up.

### Exclusions

This requirement for 7 day follow up includes the following exceptions:

- Patient who dies within 7 days of discharge
- Patients discharged to another NHS hospital for Psychiatric treatment
- Where legal precedence has forced the removal of a patient from the country
- Where a patient leaves the country within 7 days of discharge
- In secure services, in circumstances where a patient is remitted back to prison, the telephone call/face to face follow-up does not apply
3.7 Where a patient is admitted from “out of the catchment area” the in-patient named nurse will contact the identified responsible community team, following the telephone call a fax will be sent to the identified responsible community team in conjunction with the Trust Safe Haven Procedures. This will be recorded both in the patient’s clinical records and on the Trust Clinical Information System.

### IMPLEMENTATION

#### 4.1 Slot Management

Each identified responsible community team will be responsible for identifying the number of baseline slots (appointments for specific days) in accordance with the average number of discharges for their area where this system is in place.

For Early Intervention, CAMHS and Learning Disabilities teams pre-determined slots would not be appropriate due to the minimal number of discharges for these services. In these cases Bed Management will notify the appropriate team at the time of discharge to agree an appointment and confirm the appointment details to the patient, where this system is running. If this system is not in place the identified responsible community team is responsible for confirming the appointment details with the patient.

#### 4.2 Specific Action (also see flow chart attached at Appendix 1):

4.2.1 All patients who are on CPA must be identified during the discharge planning meeting by the ward MDT for a follow up appointment within either 7 days of discharge or requiring 48 hour follow up on discharge as detailed below in 4.2.3 which will be recorded in the MDT minutes and also in the patients clinical record.

4.2.2 The ward will ensure the daily ward discharge list clearly indicates which patients require 7 day follow up and which require 48 hour follow up and notify the identified responsible community team responsible for undertaking the follow up when a patient is discharged. Wherever possible a day and time for follow up, will be agreed with the patient prior to discharge from the inpatient unit.

4.2.3 Patients who have been discharged following a serious self-harm attempt and or where there is a heightened risk of suicide must have this follow up visit completed face to face within 48 hours of discharge from hospital. Such patients must not be discharged on a Friday unless the identified responsible community team is available to undertake the 48 hour follow and or unless an alternative team has accepted this responsibility to facilitate discharge such as the Home Treatment Team. This must be clearly recorded by the ward on the ward discharge list and in the patient’s clinical record.

4.2.4 Team Managers are responsible for ensuring that patients are contacted to confirm the specific details of the appointment (time, venue and practitioner).
For non-face to face contacts e.g. potential telephone contact in the case of individuals discharged to residential and or nursing homes confirmation regarding within what timescale and by which team contact will be made with the home must be given to the patient/carer on discharge.

4.2.5 There may be cases where an individual for 7 day or 48 hour follow up either absconds or self-discharges. The general responsibility for providing follow up does not change in these cases, although the practicality of doing so may be more difficult. In these circumstances the following Trust policies and procedures would need to be implemented immediately:

a) Absent without leave (AWOL) procedures should be followed as appropriate and whilst acknowledging that CPA Care Plans may not be complete, there should nevertheless be efforts made by the in-patient clinical team to make contact and if sufficiently concerned for an individual’s safety necessary request a police welfare check.

b) If the level of risk or degree of vulnerability is thought to be sufficiently high and the patient is informal. It may be appropriate to consider an assessment under the Mental Health Act.

4.2.6 For all patients placed on CPA a face to face contact will be required via a pre-determined appointment with the identified responsible community team in an agreed location.

### 5.0 WARD PROCEDURE

5.1 It is imperative that the ward obtains the correct patient demographic details and in the case of ‘no fixed abodes’ an agreed phone number and / or alternative address needs to be agreed and recorded.

5.2 For all 7 day or 48 hour follow up appointments the ward is responsible for identifying the requirements for individual patients via the ward MDT. It also needs to be considered when planning a discharge that advance contact with the identified responsible community team needs to take place wherever possible. This includes MH RAID Teams in respect of any patients to be discharged to a General Hospital for medical treatment and or end of life care.

5.3 Wherever possible the date of the agreed 7 day and or 48 hour follow up appointment must be entered onto the discharge appointment card (see Appendix 2). And a copy given to the patient (carer / relative as appropriate) upon leaving. A record of this must also be entered into the patient’s clinical record.

5.4 The ward must contact the identified responsible community team responsible via admin to ensure that discharge details are circulated to the appropriate worker. A copy of the completed daily ward discharge list must be sent by admin to the community teams via email to the agreed email account. This list
must be complete and not contain any ‘unknowns’. This list must also clearly identify those patients identified as requiring 48 hour follow up.

5.5 The ward staff will make telephone contact with the patient within the first 24 hours following discharge, and the outcome will be recorded in the patient’s clinical record. If they have been unable to make contact they will discuss with the identified responsible community team wherever possible with the Care Co-ordinator allocated, if unavailable the respective community team’s duty practitioner must be contacted and informed.

6.0 IDENTIFIED RESPONSIBLE COMMUNITY TEAM PROCEDURE

6.1 The Community Team Manager or nominated deputy is responsible for ensuring patients are contacted within 3 working days of discharge to confirm the time, venue and practitioners for the appointment. In the case of telephone contact ensuring it happens and is recorded in the patient’s clinical records and on the clinical information system.

6.2 Patients who have been discharged following a serious self-harm attempt and or where there is a heightened risk of suicide must have this follow up visit completed face to face within 48 hours of discharge from hospital.

6.3 For patients for whom it has been agreed that telephone contact will be made within 7 days of discharge where no phone contact can be ascertained the relevant Team Manager will be advised. The Team Manager will be responsible for undertaking a risk assessment and if necessary, arranging a physical check as required, e.g. a home visit and or a police welfare check and reporting outcomes back to the Bed Management Department to update the Trust 7 day follow up monitoring /assurance report. All actions and outcomes must be recorded in the patient’s clinical record.

6.4 The Team Manager is responsible for ensuring confirmation is sent to the Bed Management Department regarding the outcome of all booked appointments on the list they receive to update the Trust 7 day follow up monitoring /assurance report.

6.5 Team Managers are responsible for the 7 day outcome lists and forwarding to the Bed Management Department.

6.6 Team Managers are responsible for ensuring the 7 day follow-up takes place through the agreed local procedures for cover during absence, should the care coordinator/allocated case worker be absent.

6.7 Where planned contact with a patient is not achieved then this must be immediately escalated for discussion with the responsible community teams MDT, and steps taken to ensure that the patient remains well. Staff should use the Non-concordance and disengagement policy as a guide for the escalation steps which are required and record the failed contact on Datix so that the outcome of the patient contact can be effectively monitored.
7.0 COMMUNICATION

7.1 Appointments for follow up visits will be communicated to the patient in an appropriate format taking into account any communication difficulties they may have either through sensory disability or limited language understanding.

8.0 AUDIT/MONITORING

8.1 Compliance with 7 day follow up requirements will be reported upon regularly via the Trust’s performance reporting framework.

8.2 It is imperative that the outcomes of the 7 day follow up are captured and recorded in a timely manner.

9.0 REFERENCE TO OTHER TRUST POLICIES/DOCUMENTATION

9.1 This policy shall be read in conjunction with the following Trust policies:

- CLP49 7 Day Follow Up Policy
- CLP30: Care Programme Approach
- CLP28: Clinical Risk Assessment and Management Policy
- CG29 : Clinical Guidelines on the Prevention of Suicide
- CLP71: Self Harm Policy
- CG77: Disengagement or Non Concordance Clinical Guideline
- F & C1 System Flow and Capacity Inpatient and Community Care Policy (North)

END