STANDARD OPERATING PROCEDURE PERSONALITY DISORDER & COMPLEX NEEDS MDT

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The Trust monitors the implementation of and compliance with this operational procedure.

OPERATIONAL POLICY SUMMARY

This is a Standard Operating Procedure (SOP) for the Trust-wide Personality Disorder and Complex Needs Multidisciplinary Team It describes the composition, practice and provision delivered by this team across Essex. This Standard Operating Procedure ensures that the clinical services provided are underpinned by robust governance mechanisms to ensure patient safety, positive patient experience and clinical effectiveness. However, any SOP needs to reflect evidence-based clinical practice based on principles in NHS, NICE and professional body guidance and thereby responsive and flexible to required change in service provision and practice.

Equality and Diversity Statement

The Trust is committed to ensuring that equality, diversity, and inclusion are considered in our decisions, actions and processes. The Trust and all trust staff have a responsibility to ensure that they adhere to the Trust principles of equality, diversity, and inclusion in all activities. In drawing up this policy all aspects of equality, diversity, and inclusion have been considered to ensure that it does not disproportionately impact any individuals who have a protected characteristic as defined by the Equality Act 2010

STANDARD OPERATING PROCEDURE
FOR THE
SPECIALIST PERSONALITY DISORDER AND COMPLEX NEEDS MULTI-DISCIPLINARY TEAM

CONTENTS	PAGE
TITLE	1
REFERENCE NUMBER	1
CONTENTS	2
INTRODUCTION	3
BACKGROUND	3
SERVICE DESCRIPTION	3
PRINCIPLES OF CARE	4
OBJECTIVES	4
KEY FUNCTIONS	5
DAYS/HOURS OF FUNCTION	5
ELIGIBILITY CRITERIA	6
REFERRAL PROCESSES FOR INVOLVEMENT WITH PD&CN MDT	6
SERVICE DELIVERY	6
REFERRAL PROCESS FOR DISCUSSION IN MAF	7
RISK ASSESSMENT AND MANAGEMENT	7
DISCHARGE PROCESS AND PLANNING	8
REVIEW AND MONITORING	8
CLINICAL PARTNERSHIP WORKING	8
SERVICE USER NETWORK (SUN)	9
TRANSITIONS FROM ADOLESCENT TO ADULT SERVICES	9
SERVICE STANDARDS	9
POLICY GUIDENCE	10
SERVICE DEVELOPMENT	10

INTRODUCTION

The Specialist Personality Disorders and Complex Needs (PD&CN) Multi-disciplinary Team (MDT) has been created as part of service transformation for service users (SUs) living with/who might meet criteria for a diagnosis of Personality Disorder (PD). It constitutes one part of the multi-provider/multi-service complex needs care pathway. The function of the MDT can be seen as threefold:

- Clinical (direct and indirect), including: consultancy function to colleagues from EPUT and other partner organisations; working alongside colleagues to support their work with SUs with complex needs and/or presenting with high risk; maintaining a selected individual caseload which might be considered with some clients to have a tertiary function.
- Teaching, including; PD awareness training programme; bespoke training; development of Knowledge and Understanding Framework for PD programme.
- Convening Multi-Agency Fora.

The team has an Essex-wide reach and includes Psychotherapists, Psychologists, a Social Worker, a Psychosocial Nurse Practitioner, a Service User Network Manager and facilitators.

BACKGROUND

As stated above the development of this team is a constituent of the wider transformation agenda for services working to better meet the needs of persons who have a diagnosis of EUPD/PD or are living with traits consistent with a diagnosis of PD. The developments in EPUT are aligned with the NHS transformation agenda as described in documents such as: Personality Disorder: No Longer A Diagnosis of Exclusion (2003); and The Personality Disorders Capabilities Framework (2003). The NHS Long Term Plan (2019) and Community Mental Health Framework (2019) provide further direction for meeting the needs of this population.

SERVICE DESCRIPTION

The team has an Essex-wide reach and includes Psychotherapists, Psychologists, a Social Worker, a Psychosocial Nurse Practitioner, Assistant Psychologists, Service User Network Manager and admin support.

The function of the Specialist PD&CN MDT is not restricted by traditional team, service or locality boundaries. Consequently it can provide a unique contribution in the specialist care pathway, but is one part of a more comprehensive pathway of care for patients with PD and Complex needs. It fulfils both direct and indirect functions in the pathway, including 1:1

therapy, specialist consultation and supervision, joint working, and 'working alongside' both staff member and service user in the event of rupture (thus supporting relational continuity or providing an option if local relations have broken down). It has capacity for increased intensity or frequency of support and can work with service users whose presentation and needs may not be a 'good fit' for other services.

It is usual for service users to have received care in other teams/elsewhere on the complex care pathway before input is sought from the Specialist PD&CN MDT. Input may be requested when e.g. intervention has been attempted elsewhere and there is ongoing unmet need due to the complexity/severity/multi-agency nature of the service user's presentation; there have been engagement difficulties with intervention; there is a lack of progress following group intervention; there has been a rupture or breakdown of relationships; risk has escalated and an alternative to admission is sought; care has been fragmented and there is a need for continuity and oversight.

PRINCIPLES OF CARE

Clinical principles of care are based on the above policy documents, training needs documents and developments in clinical understanding. All these documents in some way describe working from a "trauma informed" perspective that understands the emotional disturbance and distress of most SUs presenting with EUPD as resulting from early trauma or "Adverse Childhood Experiences (ACEs). The aspiration is that this thinking will inform all interventions across the partnership networks.

Procedural principles of care are based firmly on the recognition of the importance of good multi-disciplinary and multi-agency working, with structures to support better communication with partner organisations across the wider care system (e.g Voluntary, Care and Social Enterprises (VCSEs), social care, 'primary' and 'secondary' mental health care, police, acute hospitals) facilitating an integrated approach to care that meets the multiple and complex needs of this client group and supports transitions.

OBJECTIVES

To support the quality and improvement and transformation agenda.

To provide consultations to colleagues that support understanding, interventions and working relationships between colleagues and their clients.

To work alongside colleagues and SUs to support delivery of care especially in instances of rupture (in relationship with team or Trust) or heightened risk.

To facilitate or provide (bio)-psychosocially informed formulation and intervention plans that both inform care for the individual and guide intervention from the MDT.

To facilitate collaborative complex risk assessments and the development of safety plans that can be shared across services and agencies.

To provide 1:1 interventions for proportion of SUs referred to the Specialist MDT for whom it is clinically indicated and following team discussion, recognising the need to retain capacity to be responsive, and provide optimal intensity and frequency of contact for SUs with complex needs. Each clinician will manage a small caseload.

To deliver training to staff in the health, social care and VCSE sectors to enhance understanding of the development of EUPD and its association with trauma, to support interventions that are compassionate, validating and trauma-informed and to reduce stigma (The Personality Disorders Capabilities Framework (2003)).

To lead in the development of interventions across the system that support psychological provision to this client group, including Structured Clinical Management (SCM) and Family Connections.

To lead in establishing Multi-Agency Fora across localities, supporting the development of a culture of 'joined up' working with local partners such as VCSEs, housing, social care, GPs etc. to deliver successful interventions that are as seamless and coordinated as possible.

To deliver and develop the Service User Network (SUN) for PD&CN.

To facilitate the smooth transition of young adults moving from CAMHS or EWMHS to adult services.

To provide a structure and clinical working networks with PD leads in the Adult Community Psychological services and the Transitioning Team.

To work collaboratively and effectively with psychotherapy colleagues to deliver a single pathway for therapeutic interventions for SUs with PD&CN.

KEY FUNCTIONS

- To support integrated work through Multi-Agency Fora
- To support the continued development of the transformation agenda
- To support partnership working
- To support complex transitions from adolescent to adult services
- To scaffold relationships between SU and locality staff
- To hold a caseload, utilising the MDT to provide holistic support to the client
- To enhance Trust-wide understanding of services for clients with PD or who might attract this diagnosis
- To provide training to further develop psychological mindedness across services and partnership agencies in understanding of the development of EUPD from a trauma-informed perspective
- To work with and support services on the PD&CN care pathway working with clients who are appropriate for tertiary care management
- To support integration and collaboration of new provisions on the PD&CN pathway including PD Lead Psychologists, Transition Psychologists and Psychotherapy Lead.
- To provide staff hours to the PD leads in ACP to support therapies provided by ACP on the PD&CN pathway
- To develop and support the Service User Network
- To develop opportunities for co-design and co-production with SUs
- To contribute to the development of Peer Support Worker roles in Essex
- To provide supervision and reflective practice opportunities to staff working with people with PD

DAYS/HOURS OF FUNCTION

Monday through Friday 9:00am to 5:00pm.

ELIGIBILITY CRITERIA

Referrals to the PD&CN MDT are considered for persons of (17 ½) 18 years of age and older who are registered to a GP in Essex and have a diagnosis of PD or are living with personality traits that may attract this diagnosis.

It is expected that clients will present with significant complexity, risk or ruptures in their relationships with care professionals.

To be considered for ongoing engagement or treatment with the PD&CN MDT the client must be held within the complex care pathway (formerly regarded as 'secondary level care' services) including CMHTs and wards.

Clients who are referred for discussion in Multi-Agency Fora do not need to be open to services in EPUT.

REFERRAL PROCESS

The Specialist PD&CN MDT is not a 'refer on' service. Decisions about the MDT's contribution to a SU's care plan are collaborative, and made after consultation with referrer.

Referrals/requests for consultation are made via email to the PD&CN MDT [redacted]. These can be unstructured, or can use the PD&CN MDT referral form. All referrals are recorded.

All referrals are discussed in the PD&CN MDT weekly meeting (Thursday mornings). The most appropriate team member is identified to make contact with referrer to discuss request.

The team member can negotiate the MDT's involvement independently at first contact, but further multi-disciplinary case discussion is usually indicated, to support the development of a preliminary formulation and facilitate effective case management.

The case is brought back to the MDT for discussion. If the MDT does not identify a role for involvement in the SU's care, this will be communicated to the referrer with an opportunity to discuss and offer further information.

On-going clinical engagement is discussed in supervision.

The SU is opened to the service on the appropriate system by the administrator.

SERVICE DELIVERY

The initial consultation with a colleague may involve the development of a preliminary formulation that will include an understanding of the client and client's needs, and the relationship the client has with the service and the referrer (and significant networks, including family).

From this tentative or working formulation, recommendations for a possible role for the PD&CN MDT is considered as part of a robust care plan.

Outcomes may include: working with the referrer and/or other services involved with the SU; working with the referrer and the client; or providing a direct intervention to the SU.

REFERRAL PROCESS FOR MULTI-AGENCY FORA (MAF)

Colleagues from across the provider network (e.g. EPUT, Adult Social Care, VCSEs, housing, police, A&E) can request use of the MAF to convene a multi-disciplinary/multi-agency discussion.

Requests are placed via email to the relevant locality MAF email address. The MAF Administrator and Chair review the referral to ensure it meets criteria.

The referrer is requested to identify and submit contact details for colleagues and partner agencies who are working/have worked with the client, or whose involvement with the client is sought.

The MAF Administrator will invite requested participants to the MAF.

The referrer is asked to seek consent from the client; a document to be signed by the SU is provided. Although consent is not necessary for a MAF to be convened, it is considered best practice as a result of its impact on the relationship between the client and clinicians/Trust currently and moving forward.

Client are usually scheduled for discussion at a MAF two weeks from the point of referral, to allow for diary scheduling and support attendance.

Actions derived from the MAF discussion are recorded, and further discussion time can be booked to support and monitor the actions.

The SU is opened to the Specialist PD&CN MDT by the Administrator on appropriate system; and discharged when appropriate.

RISK ASSESSMENT AND MANAGEMENT

Risk is held jointly with the referring service.

A risk assessment is developed collaboratively with the client and relevant locality colleague, and is informed by psychological formulation. The risk assessment is person-centred,

reflects the needs of the individual, and includes safety planning that is meaningful for that person.

Risk profiles will identify and focus on suicidality, self-harm, impulsivity, drug and alcohol use, safeguarding, violence and aggression, physical health status and offending behaviours.

The PD&CN MDT clinician cannot be the first response in a crisis. Care-co in locality must stay involved when there is active risk or escalating risk.

This is a 'live document' and must be reviewed with the client in the course of treatment.

DISCHARGE PROCESS AND PLANNING

Discharge from the consultation process is negotiated between the PD&CN MDT clinician, the locality colleague and client. A clear understanding of the intention of the consultation process will inform the appropriateness and timing of discharge.

The client should be involved with and aware of the plan following discharge from the PD&CN MDT.

Risk assessment/safety plan and recommendations recording future involvement should be included in discharge report.

The discharge must be communicated to the PD&CN MDT Administrator who will ensure the client is discharged according to Trust process.

Discharge should not occur from the referring locality team; leaving the PD&CN MDT 'holding the case'.

Clinical communication to GP, Consultant Psychiatrist, other involved professionals is the responsibility of each clinician.

Discharge following discussion in the MAF must be communicated to the MAF Administrator when involvement of the MDT is concluded.

Discharge from a 1:1 psychological intervention is managed by the therapist and discharged from the relevant Trust system by the PD&CN Administrator. The clinician must ensure liaison with colleagues and other relevant stakeholders and that the relevant clinical report is entered on Mobius/Paris as appropriate.

REVIEW AND MONITORING

All activity is recorded on Mobius, Paris, SystemOne and non-patient Daily Diary Sheet (DDS) as appropriate.

The PD&CN MDT is developing feedback and outcome monitoring methods appropriate to the work of consultancy and joint working as is provided by the MDT.

Outcome measures for clinical work will be implemented in accordance with Trust and Directorate recommendations, and will include Goal Attainment Scaling and?

Condition-specific outcome measures, and service user satisfaction measures, will be utilised as necessary.

Pre- and post-training questionnaires are completed by all training delegates and the outcomes collated by Assistant Psychologists in the PD&CN MDT.

CLINICAL PARTNERSHIP WORKING

Where necessary for service continuity and delivery, PD&CN MDT members will join with other colleagues or teams in delivering a clinical intervention; this might include Dialectical Behaviour Therapy (DBT), Mentalisation Based Therapy (MBT) and Systems Training for Emotional Predictability and Problem-solving (STEPPS).

SERVICE USER NETWORK (SUN)

This network is provided under the auspices of the PD&CN MDT but operates independently and has its own Operating Procedures. To note, the SUN facilitates peer-led support interventions and provides resources for people with PD, but is not a refer-in or standalone service.

TRANSITIONS FROM ADOLESCENT TO ADULT SERVICES

EPUT and partner providers of services for adolescents/young adults have an agreed procedure for managing transitions of young people to working age adult services. However, it is recognised that such transitions can prove challenging for the young person, especially when from an adolescent ward to adult ward or community team.

A Specialist Psychotherapist in the PD&CN MDT supports the transition of adolescents to adult services through the provision of dedicated support to the young person, involved teams and the family.

The MAF can be used to convene a discussion between all clinicians and teams involved in the young person's care.

The dedicated psychotherapist will work with the local MDT to determine the appropriate level of involvement with the young person, team and family.

Individual psychotherapy, and/or consultation to the family, young person and team can be offered. Family Therapy can be provided by the PD&CN MDT's Family Therapist.

SERVICE STANDARDS

The PD&CN MDT was established as part of transformation of services for people with complex needs of the personality disorder type. All ll members of the MDT are aware of policy drivers.

All members of the MDT must adhere to Trust standards and professional codes of conduct.

All members of the MDT must be registered with their appropriate registering body.

All members of the MDT must practice in line with Trust core values: Learning, Caring, and Empowering.

All staff are responsible for maintaining 'mandatory training' and management/clinical supervision, and all must participate in yearly appraisals.

Clinical supervision to be arranged as appropriate to the profession.

All members of the MDT are responsible for maintaining clinical notes. Communication with others involved in the client's care must demonstrate adherence to codes of confidentiality and professionalism in communications.

All are responsible for attendance at team meetings and other meetings required for the delivery of the service and the functioning of the MDT.

All members of the MDT should make themselves aware of the Freedom to Speak Up Policy. Concerns regarding good practice should initially be brought to the managers of the team. However, concerns can be identified and reported to the Freedom to Speak Up lead who is in the position to address issues.

All members of the MDT should make themselves aware of the DATIX reporting process and events to be reported.

POLICIES INFORMING THE WORK OF THE TEAM:

https://www.nice.org.uk/guidance/conditions-and-diseases/mental-health-and-behavioural-conditions/personality-disorders

http://personalitydisorder.org.uk/wp-content/uploads/2015/06/personalitydisorders-capabilities-framework.pdf and http://personalitydisorder.org.uk/wp-content/uploads/2015/04/PD-No-longer-a-diagnosis-of-exclusion.pdf

https://www.rcpsych.ac.uk/expertadvice/problemsdisorders/personalitydisorder.aspx

http://www.newhamlscb.org.uk/wp-content/uploads/2016/11/Meeting-the-Challenge-Making-a-Difference.pdf

SERVICE AND STAFF DEVELOPMENT

Service and staff development is intrinsically linked.

All members of the MDT are required to participate in appraisal process, including preparing for the meeting, identifying appropriate objectives with managers, and working to achieve these goals.

All members of the MDT should be aware of service goals and consider how their personal development aligns with service development objectives. This provides an opportunity to enhance service development and take on new opportunities.

All members of the MDT will have a Job Plan that is developed in accordance with their role, banding and expectations of the service. This will be reviewed in the appraisal

Maintenance of Continuing Professional Development (CPD) as required by professional bodies is the responsibility of each member of the team. Appraisals should be used to identify training needs and areas of growth that align with the service.

All team members should understand Trust and profession requirements of supervision and adhere to this. Supervision needs to be recorded on the Trust 'tracker.' Records should also be kept in line with professional requirements.