Re-access Plans (re-access to service plans): Guidance for Practitioners

Why has this guidance been developed?

To provide practitioners with baseline information on the meaning of the term 're-access plan', alongside guidance on how such plans should be developed, recorded and shared. processes involved in the development, implementation and evaluation of crisis, relapse and contingency plans.

Who is it meant for?

All practitioners who undertake, or contribute to, care coordination, care planning and evaluations (reviews) of care. This document applies to all clinical teams and services within AWP, with the exception of specialist drug and alcohol services (SDAS)

Does it contain everything I need to know?

This guidance covers the fundamental, or essential, elements of developing, using and recording re-access plans. It is not an exhaustive guide to the subject. This guidance should be read in conjunction with AWP's CPA Policy and Access to Mental Health Care Assessment and Treatment General Policy P114 Access to Mental Health Care Assessment and Treatment General Policy P114. Additionally, the Practitioner Guidance for Crisis, Relapse and Contingency Planning in the Clinical Toolkit will also be of relevance.

What does it contain?

An outline of the core aspects of addressing the issue of re-access to services for individuals who have been discharged from AWP care co-ordination following a period of treatment and care.

Where should I record the information?

In the relevant section of the core assessment area of RiO – this is titled "Crisis, Relapse and Contingency Plan" and is separated into the following headings:

- Constructing the crisis plan
- Who will be caring for any dependent children
- Relapse indicators/warning signs
- Contingency plan

Complete the free-text boxes systematically.

What does the term 're-access plan' mean?

A re-access plan is information that has been developed and agreed between service users and

professionals, and then recorded in RiO, regarding the future route back into AWP services, should this be indicated.

What information supports this guidance?

The references for this guidance are:

- Good practice guide to care planning – AWP guidance (2013)
- Refocusing the Care Programme Approach (Department of Health guidance 2008)

Where can I obtain further information?

You should access further information from the following sources:

1. Your clinical/professional supervisor and/or line manager.
2. Your professional organisation – eg: BMA, RCN, etc. – and check whether they have published guidance for their members.
3. A useful video made by the Institute of Psychiatry and in association with Rethink Mental Illness, on the principles of care coordination and the role of the care coordinator is accessible here: Care coordinators and care planning

When was this guidance produced?

It was developed throughout 2013 and approved for use on 09/12/2013

When will it be reviewed?

On a three yearly cycle (2016), or earlier if necessary

Who developed this guidance?

This guidance was written by: Chris Ellis – Consultant Nurse (Nursing & Quality Directorate).
Contributions from:
Anthony Harrison – Consultant Nurse (Nursing & Quality Directorate)
Sarah Jones – Lead Nurse (Nursing & Quality Directorate)
Daniel Badman – RiO Clinical Lead (Nursing & Quality Directorate)

Introduction

Prior to discharge from AWP services, practitioners should agree an individualised re-access plan with the service users and their carer/s, if appropriate. In most circumstances, the greater number of services involved with the individual prior to discharge, or the more complex their mental health and social care needs, then the more comprehensive and detailed their re-access plan will need to be.

When and how to develop a re-access plan

When an individual is discharged from AWP services – ie: stops receiving AWP service(s), then all parts of the care plan except the Crisis, Relapse and Contingency plan will be closed down. The care co-ordinator is responsible for ensuring that all elements of this discharge process (including liaison with other agencies and administrative tasks) are completed. In most instances the care coordinator will undertake these tasks, but they can be delegated to an appropriate individual within the team, although it remains the care coordinator's responsibility to *ensure* that they have been completed.

A re-access plan will not be clinically appropriate for every situation, and the risks and benefits of this should always be considered, for example, weighing-up the advantages of trying to make contact with a practitioner who is personally known to person, but who may not be immediately available at the point when the service user or carer requires re-contact.

The usual route back into AWP services will be via the PCLS. However, there may be occasions when it has been agreed that the service user will re-access services by another route, for example, directly back into one of the recovery or intensive services. The clinical rationale for direct re-access must be clearly documented within the re-access plan. In all cases the following issues must be addressed in the plan, and communicated to the service user, and carer, where appropriate:

- Name of the service/team – be specific, and include full postal and email addresses, where appropriate.
- Access hours and team opening times – what steps should be followed if the service user or carer needs to make contact outside of core team operating hours?
- Contact telephone numbers and email addresses.
- Specify the length of time that the option of direct re-access to the named service is an active option for the service user and/or carer – eg: an end date when this option ceases and access returns to the usual route. Ensure that *exact* dates are used – ie: from dd/mm/yyyy to dd/mm/yyyy. Avoid vague statements such as "for six months", and "contact the team if necessary".
- Details of the sorts of circumstances where waiting for example, for their care co-ordinator to be available to talk with them would be best, and circumstances where they should not wait but ring their general practice or the intensive team.

In addition to the re-access plan, the service user may have an "Advance Decision/Advance Statement" recorded within the MCA part of RiO. This is an optional plan and will not be appropriate for all individuals. If such a statement has been completed, then you must ensure that any additional re-access plan clearly spells out that it exists, so that staff know to refer to it.

The final written re-access plan should be communicated to the service user/carer/GP/other agency/care home, etc. via a discharge letter, a copy of the re-access plan contained within the Crisis, Relapse and Contingency plan can be printed from the Clinical Portal.