Southern Health and Social Care Trust

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# Mental Health and Disability Directorate
# Case Management Standard Operating Procedure

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| Document Owner | [redacted] |
| Document Author(s) | [redacted] |

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| Version | Final Version 2.0 |
| Date | 10.01.2024 |
| Review date | 10.01.2026 *(or upon implementation of new external guidance or electronic information systems)* |
| Electronic location | *MHD Case Management SharePoint* |

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## Version Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

| Version | Date Implemented | Details of Significant Changes |
|---|---|---|
| 1 | 20.11.2023 | • Amended throughout for clarity to include the requirement to update the Case Management Monitoring Form and complete the Care Review [illegible] on PARIS following implementation of or Changes to services.<br>• Summary table of Monitoring and Review visits amended to reflect all requirements |
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## Contents

## 1. Introduction

The Department of Health and Social Services Northern Ireland Circular HSC (ECCU) 1/2010 Care Management, Provision of Services and Charging Guidance sets out guidance for HSC Trusts in the delivery of Care and Case Management. The terms 'Care Management' and 'Case Management' are increasingly used interchangeably and for the purposes of this standard operating procedure, the term 'Case Management' will be used to describe all activity in the co-ordination of care for people with complex or frequently or rapidly changing service needs.

## 2. Purpose

The purpose of this document is to describe the procedures to be followed by staff in the provision of Case Management within the Southern HSC Trust Mental Health and Disability Directorate in line with the Care Management Provision of Services and Charging Guidance Circular HSC (ECCU) 1/2010 *(2010 Circular)*

## 3. Scope

This standard operating procedure applies to all staff in Mental Health and Disability Services involved in the delivery of Case Management activity and processes, including but not limited to the following staff groups;

- Heads of Service
- Service Co-ordinators
- Team Leaders/ Locality Managers
- Social Workers
- Nurses
- AHP Staff – Physiotherapists/ Occupational Therapists/ Speech and Language Therapists/Podiatrists
- Social Work Assistants
- Financial Support Officers
- Administration Staff

In the event of an infection outbreak, flu pandemic, major incident or unforeseen circumstances, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety.

## 4. Abbreviations & Definitions

| | |
|---|---|
| MHD | Mental Health and Disability Directorate |
| SOP | Standard Operating Procedure |
| Case Management | The focused activity of supporting, advocating and effectively coordinating timely services for "...people with complex, or frequently or rapidly changing needs or for people with more straightforward and stable needs where services or service providers need to be co-ordinated." (DHPSSNI, 2010) |

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|---|---|
| Keyworker | Person with professional responsibility for Case Management. |
| Carer | A nominated relative, friend or responsible person |
| Service User | Person in receipt of care and services |
| Service User Advocate | A spokesperson who supports a person who is in receiving or who is eligible to receive Health & Social Care Services |

**Duties and Responsibilities**

The Keyworker retains professional responsibility for Case Management however, duties may be delegated by the Keyworker to other team members e.g. Social Work Assistants/ Administrative Staff as per the competencies of their job role. All staff involved in the delivery of Case Management activity and processes should follow the SOP within the scope of their job role and level of delegated professional responsibility.

**Associated Documentation**

The documents referred to within this document for the purposes of Case Management administration are subject to change. Links are available within the SOP to the most recent version of documentation available.

## 5. Process

The processes of Case Management are set out in the Care Management Provision of Services and Charging Guidance Circular HSC (ECCU) 1/2010 *(2010 circular)* in stages as per *Table 1* below; See also page 22 for MHD Case Management Flow Chart.
*(MHD Case Management flow chart)*

***Table 1:*** **Case Management Stages**

| STAGE | NAME OF STAGE |
|---|---|
| 1 | Case Finding |
| 2 | Screening and Allocation |
| 3 | Assessment of Need |
| 4/5 | Care Planning and Implementation |
| 6 | Initial Review |
| 7 | Annual Review |

### 6.1 Stage 1 - Case Finding

Case Finding is the process of proactively publicising the Case Management process with Referrers, Service Users and Carers. Information on arrangements for assessment and service delivery are available to assist those who are likely to need them and to Referrers to assist with making appropriate referrals

All Trust Staff can give and explain, relevant (user friendly) accessible information to Service Users, Carers and referral agencies about the Case Management process and the support available

## 6.2 Stage 2 - Screening and Allocation

6.2.1 All referrals received into services will be screened as per PARIS processes by a Registered Professional Staff Member against Service criteria and criteria for Case Management

**NB Not all Service Users will meet the Case Management Criteria but they may still require services e.g. referral for healthcare intervention, short term intervention or a non-complex uni-professional case**

**Criteria for Case Management**
As per the DHSSPSNI Care Management, Provision of Services and Charging Guidance Circular (ECCU) 1/2010, people who should be considered for Case Management across all programmes of care and service user groups will include individuals who;

- Require, or are at risk of, permanent admission to Residential Care, Nursing Homes or long-stay care settings
- Are in need of care and protection
- Are assessed as being at a high level of risk
- Are experiencing severe mental or physical ill health and loss of independence
- Have complex needs or challenging behaviour where high level support is necessary
- Care arrangements are at risk of breaking down
- Experiencing rapidly or frequently changing needs
- Are highly dependent on the input of a carer
- Are people with complex needs whose carer's needs mean they are having difficulties in maintaining their caring role
- Require a range of professional input and services to manage their needs
- Have a chronic long term condition
- Are high intensity users of unplanned secondary care (frequent hospital admissions)

6.2.2 If the referral is to be considered for Case Management as per the criteria, a Keyworker must be identified

6.2.3 Record the screening outcome on PARIS

6.2.4 Requests to the MHD Directorate for services for a resident from England, Scotland or Wales or a Non-UK country should be discussed with Team Leader/Locality Manager/Head of Service. Funding for Social Care services must be agreed in advance with the first authority (or placing authority) as they will retain financial responsibility for the resident. *(Extra Statutory Authority and Entitlement Aid)*

For Visitors/non-residents not ordinarily resident to Northern Ireland they may only be entitled to immediately necessary treatment within the Emergency Department without charge. This does not include emergency services that are provided once the visitor has been accepted as an inpatient or at a follow-up outpatient appointment. It is therefore, essential to ensure confirmation of a person's

"Ordinarily resident" status has been validated before providing services. If there is any doubt regarding an individual's permanent residency within Northern Ireland please refer to the Business Services Organisation's information via the link Entitlement to NHS services and first time registration (hscni.net)
For further queries regarding Non-UK nationals please contact the Access to Health & Social Care Team, Daisy Hill Hospital

[redacted]

## 6.3 Stage 3 - Assessment of Need

6.3.1 If a Case Management Assessment is required following screening of referral, a visit for assessment should be scheduled by the Keyworker

6.3.2 The following information should be provided to the Service User and Carer **as relevant to them.** Record provision of information on PARIS case notes; *(Case Management Information Pack)*

- Contact details for relevant Service/ Keyworker
- SHSCT We Value Your Views Leaflet
- SHSCT Case Management Leaflet
- Carer(s) Assessment Information Leaflet Feb 2016
- Carers Needs and Support Plan Leaflet Jan 2022
- Self- Directed Support: The User Guide February 2016 (if relevant following assessment)
- Guidance on Paying for Care in Residential/Nursing Home Information Booklet (if relevant following assessment)
- MCA Leaflet (where appropriate)

6.3.3 The Keyworker will initiate the assessment-with the Service User/Carer by;

- Explaining the Case Management Process
- Explaining the Keyworker role

6.3.4 The Keyworker will **seek and record** the Service User's informed consent (where capacity allows) both to assessment and the sharing of relevant information with Carers and other professionals in line with General Data Protection Regulation (GDPR)

Consent can be recorded in the case notes under the first Case Management note under activity/reason. Staff may also complete the NISAT Consent form for the sharing of information *(eNISAT)*

Service users should be advised of the following;

- Information shared may be used for the purpose of providing a service or care to him/her and further assessment may be required

- He/She may withdraw his/her consent to assessment, care or the sharing of information at any time, but that this may affect ability to provide full services for him/her
- He/She has the right to restrict what information may be shared and with whom, but that this may affect ability to provide full services for him/her

6.3.5 The Service User may choose not to avail of Case Management. The reason for opting out of the Case Management Process should be recorded in the Service User's Initial Assessment/Short Term Intervention record and the Service User/Carer should be advised he/she can choose to avail of the Case Management Process at a future date

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6.3.6 All professionals involved in provision of care and support should give full consideration to the Mental Capacity Act (2016) DOLs whereby capacity is in question. *(Mental Capacity Act)*

6.3.7 The Keyworker will commence assessment;

- Disability and Memory Services - NISAT Initial Assessment and/ or Core and Complex (as required) *(eNISAT)*
  **OR**
- Mental Health Services - Mental Health Services Assessment *(MH Assessment)*
  **AND**
  Commission and collate specialist/multi-disciplinary assessments as appropriate to each individual service user

6.3.8 Service Users and their Carers should be directly asked during assessments, care planning and reviews about any other person that co-habits with them that is also in receipt of domiciliary care services and/or other support services, ensuring any interdependency is documented, giving consideration to imminent and future care planning and the utilisation of statutory and voluntary support services

6.3.9 If there is a significant change in the Service User needs/circumstances following the initial assessment, e.g. a Service User moving from Residential Home placement to Nursing Home placement, a Case Management reassessment is required

6.3.10 Where NISAT is used, Regional eNISAT Business Rules should be adhered to;

- An eNISAT Assessment cannot be used for any person under the age of 18 years
- An Initial Assessment/Short Term Intervention Assessment (IA/STI) does not have to exist or be completed for each Service User before moving to a Core/Complex or Specialist Assessment

- More than one IA/STI may be open concurrently (within a Team or across Teams)
- A second Core/Complex Assessment cannot be opened if an open Core/Complex Assessment already exists
- A staff member in a different Team will be able to open a Specialist Assessment Summary
- Multiple Specialists Assessments Summaries can be opened at any time
- The Keyworker must ensure completion of the Complex NISAT Assessment within 28 days from commencement date

6.3.11 A holistic Risk Assessment must be completed by the Keyworker as per the Service requirement where specific risks have been identified in either the Core or Complex Assessments *(Risk Assessment)*

6.3.12 The Keyworker should collate completed multidisciplinary team assessments which may inform the Care Plan such as: Moving and Handling Risk Assessment (MHRA), Falls Risk Assessment Tool (FRAT), Malnutrition Universal Screening Tool (MUST), Restrictive Practice Plans

6.3.13 If a Carer is identified the Keyworker must offer and/or complete a separate Carers Assessment using;
The Carer's Conversation Wheel *(note this is the Southern Trust's preferred method)* *(Carers Assessment)*
**OR**
The NISAT Carer(s) Support and Needs Assessment (Version 4)

6.3.14 The Carers Assessment Status section must be completed in PARIS and document uploaded

6.3.15 Complete the Case Management Monitoring Form on PARIS *(CM Monitoring Form)*

6.3.16 Only one Case Management Monitoring Form should be open at a time

The form should be updated following assessment and implementation of a package

A new Case Management Monitoring form is required at review or reassessment

**NB: If completing a hard copy of the Case Management Monitoring Form this must be forwarded immediately to Administration staff for input to PARIS. The Keyworker retains overall responsibility for the case management monitoring information recorded on PARIS**

6.3.17 The following Checklists can be completed by the Keyworker to support each option; *(Checklists)*

- Checklist 1: Self Directed Support
- Checklist 2: Commencing a Domiciliary Care Package
- Checklist 3: Admission to a Residential Home
- Checklist 4: Admission to a Nursing Home
- Checklist 5a: Bed Based Short Breaks/Respite
- Checklist 5b: Flexible Short Breaks/Respite
- Checklist 6: Day Care
- Checklist 7: Supported Living

6.3.18 If consideration is being given to the need for a long term care placement the Keyworker should provide and discuss the Information Booklet titled 'Guidance on Paying for Care in Residential/Nursing Home', as found in the Case Management Information Pack *(Case Management Information Pack)*

6.3.19 All requests for services to be approved by Team Lead (Disability)/ Locality Manager (MH) as per Service requirements *(Request for Services and DC1)*

**NB Approval for complex and/or specialised packages of care or placements to be escalated to Co-ordinator (MH)/ Head of Service (Disability) level**

6.3.20 Adult Learning Disability and S&R Mental Health Service - All new applications for Supported Living will be submitted to the appropriate Panels within their services for approval *(Supported Living)*

6.3.21 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

6.3.22 Should the Service User change Keyworker and/or locality, **all forms/assessments** should be end dated by the current Keyworker and re-started by the new Keyworker

## 6.4/5 - Stage 4/5 Care Planning and Implementation

6.4.1 The Keyworker will contact the Service User/Carer and arrange to share the assessment outcomes and agree the Care Plan *(Care and Risk Management Plan)* with the Service User/Carer. This may involve the attendance by some/all professionals involved if required

6.4.2 **The Trust has a statutory duty to use a Self-Directed Support approach. Direct Payments should be considered and offered as the first option**

**where appropriate. Offers of Direct Payments should be recorded on PARIS** *(SDS)*

6.4.3 All Service Users in receipt of domiciliary care packages, direct payments, managed budgets and day care should have, at a minimum a 1 page SDS support plan which is required to be reviewed annually. This document should be attached to PARIS as an external document titled "SDS Support Plan". Guidance is included within this SDS link *(SDS)*

6.4.4 The Care Plan must clearly identify the care needs of the service user and specify how those needs should be met by providers of commissioned services

6.4.5 The Care Plan, for service users, must explicitly detail how person-centered care must be delivered over a 24-hour period, particularly when 1:1 supervision/ support is required on a continuous basis by a member of staff

6.4.6 The Keyworker **must** ensure a copy of the Service User Care Plan is shared, discussed with and signed by the Service User/Carer and discussed/ shared with other relevant Professional staff and Service Providers as appropriate

6.4.7 A detailed care plan must be provided to the Service Provider, which explicitly describes how such care should be delivered on an individualised basis over the entire 24-hour period

6.4.8 Record the date and method of sharing the Assessment Outcomes and Care Plan on the Service User Case Notes

6.4.9 Where a copy of the Service User Care Plan is declined by the Service User/Carer, that decision together with the reasons should be recorded clearly on the Service User Case Notes. This decision should be revisited periodically (at least annually) reminding the Service User of his/her entitlement to receive a copy of the Service User Care Plan. A record of reminders offered and their outcomes should be maintained within the Service User case notes

**Direct Payments**

Direct Payments should be the first commissioned service offered where appropriate to meet assessed needs *(SDS)*

6.5.1 If Direct Payments is the option chosen by the Service User, the Keyworker must complete Direct Payment documentation and forward to their manager for review and forwarding to: [redacted]

6.5.2 The Keyworker must ensure forms are completed for Direct Payment; Managed Budget or Trust Arranged Support Options

6.5.3 Ensure that relevant assessment documentation is forwarded to the Provider i.e. Risk Assessments, Manual Handling Assessments, Care Plans, PQC and record what has been provided on PARIS

6.5.4 Where Emergency Direct Payments are utilised on discharge from hospital, it is the responsibility of the Keyworker to review the arrangement and care plan within 4-8 weeks. Please see information on ESDS Emergency Direct Payments. *(SDS)*

**NB For Discharges from both Acute and Non Acute Hospital, the Hospital care plan and associated risk assessments can be in place for up to 72 hours**

6.5.5 Service Users and their Carers should be directly asked during assessments, care planning and reviews about any other person that co-habits with them that is also in receipt of domiciliary care services and/or other support services, ensuring any interdependency is documented, giving consideration to imminent and future care planning and the utilisation of statutory and voluntary support services

6.5.6 Eligibility criteria and application of decision making tools for Domiciliary Care must be evidenced against the 4 Bands (Critical, Substantial, Moderate or Low need) to prioritise those most at risk. The Trust is currently working to CRITICAL Levels of Need Only as per ECCU 2 2008 Dom Care Access Criteria *(External Guidance)*

6.5.7 Unmet need and risk management strategies should be recorded and implemented as required

- Services using NISAT – Record on eNISAT Needs Identification Grid *(eNISAT)*
- Mental Health to record unmet need on the contingency planning section of the Mental Health Risk Screening Tool *(Risk Assessment)*

The circumstances of the case **must** be kept under regular review

6.5.8 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

6.5.9 Complete/Update the Care Review section on PARIS *(Reviews)*

**Domiciliary Care Support**

6.5.10 Where domiciliary support is required, all Staff must negotiate and mobilise support from family, friends and community/voluntary sector agencies before

considering provision of Domiciliary Care Services. Consideration should be given to the involvement of family support for Weekend & Bank Holiday cover, so reducing demand on Trust Services

Staff have a responsibility to document discussions and outcomes during the assessment process

6.5.11 Service Users and their Carers should be directly asked during assessments, care planning and reviews about any other person that co-habits with them that is also in receipt of domiciliary care services and/or other support services, ensuring any interdependency is documented, giving consideration to imminent and future care planning and the utilisation of statutory and voluntary support services

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The circumstances of the case **must** be kept under regular review

6.5.14 Procurement of Domiciliary Care Services should be initiated via existing Southern Trust processes by completion of eDC1/DC1, approval as per Service requirements and sent to Care Bureau. Where there is a care plan initiated or a change to the existing care plan this must be approved by a Professional Staff member. *(Request for Services and DC1)*

6.5.15 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

6.5.16 Complete/Update the Care Review section on PARIS *(Reviews)*

**Day Care Placement**

6.5.17 The Keyworker in conjunction with other appropriate Professionals will agree a suitable Day Care Setting

6.5.18 The Keyworker should seek approval for placement as per Service procedures

6.5.19 Complete the Day Care Screening Tool *(Day Care and Transport)*

6.5.20 Consider transport requirements and complete transport documentation as required *(Day Care and Transport)*

6.5.21. Complete/Update the Care Review section in PARIS

6.5.22 The Keyworker must ensure eDC1/DC1s reflect the day/s care provision provided *(Request for Services and DC1)*

6.5.23 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

**Admission to Residential/Nursing Homes**
(Includes Temporary Placement/Bed Based Short Breaks)

**NB** When a Service User is assessed by relevant Trust multi-disciplinary professionals as requiring a bed-based short break, temporary placement or permanent placement, the Service User has the option of signing a non-disclosure in relation to their finances and to self-fund the placement but they continue to be supported via the Case Management process with the appropriate monitoring and review. A Service User may also disclose their finances and undergo a means-tested financial assessment and be deemed as obligatory to self-fund. **This is not the same as a private arrangement.**

If a Service User organises a placement or bed based short break in a Care Home as a private arrangement between the Care Home and the Service User/Family; this is not considered a Trust facilitated placement and would not be subject to Case Management processes, monitoring and review and financial assessment or contract management. This has to be fully explained to the Service User and family by the Keyworker. The Trust can only facilitate and review a placement that has been assessed by the Trust and identified in collaboration with the Service User as the required support to meet their assessed needs. **The Service User/Carer should be informed that they can avail of the Case Management process at any time if they so choose and are entitled to a Case Management Assessment**

6.5.24 The Service User/Carer must be directed/informed of the following;

- To view Information on available homes on the RQIA Web site, please click the following link: *RQIA*
- The availability of SHSCT contracted beds from the most recent 'Bed List'. Please advise the Service User/Carer that this 'Bed List' is updated daily

6.5.25 The Keyworker or Team Leader/Manager as per Service, will check with the Community Contracts Team to ensure that the Trust has a contract in place with chosen Residential/Nursing Home *(Residential and Nursing Homes)*

6.5.26 The Keyworker will check bed availability with the chosen home and liaise with the Home Manager to organise a pre-admission assessment (PAA) to ensure that the home can effectively meet the individual needs of the Service User

6.5.27 All Care Home placements require a record of confirmation from Care Home Managers that;

- Assessments relating to the Service User's current needs and support requirements have been received
- The Care Home can accept the Service User and meet the particulars of the care being commissioned
- All pre-admission documentation has been read

6.5.28 The Service User/Carer will be assisted by the Keyworker to complete; *(Residential and Nursing Homes)*

- Admission/Discharge and Financial Referral Form
- Agreement to Pay Form
- Top-up Undertaking to Pay Form (where applicable)
- Choice Assurance – If the first choice Home is not available at the time of admission.

6.5.29 Where there appear to be issues in relation to any Service User independently managing their own finances or lacking capacity to appoint someone to manage finances, the Trust are required to consider if appropriate arrangements are in place. This includes consideration of the need for a Financial Capacity Assessment, Power of Attorney, Enduring Power of Attorney or a Corporate Appointee. Consult with line manager to seek support with this process as required. Record on Service User Case Notes

6.5.30 The Keyworker in conjunction with other appropriate Professionals will agree the appropriate category of care

6.5.31 The Finance Department should inform the Keyworker if the Service User is a Self-Funder

6.5.32 Financial Assessment Officers will make contact with the Service User/ Service User's financial representative to complete the relevant financial information once a referral has been received from the Keyworker. Appointments to complete financial forms are available only at Ghana House, Daisy Hill Hospital, Newry. If unable to attend, the Financial Assessment Officer will either arrange

a telephone appointment or forms will be emailed/posted out to the Service User/Service User's financial representative

6.5.33 The Finance Department will inform the Keyworker via referral, if a Nursing Needs Assessment Tool (NNAT) is required. The NNAT needs to be completed by a Registered Nurse who has completed NNAT Training *(Residential and Nursing Homes)*

6.5.34 The Keyworker will agree the date for admission with the Service User/Carer and Residential/Nursing Home

6.5.35 Complete/Update the Care Review Section in PARIS with the Placement Name/Type/Date

6.5.36 The Keyworker will ensure all relevant information is forwarded to the Residential/Nursing Provider e.g. eNISAT Core/Complex Assessment; Recovery Care Plan; Risk Assessment; Safe Systems; Service User Care Plan and List of Medication; equipment needs

6.5.37 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

**Emergency Placement**

6.5.38 Emergency Placement to a Residential/ Nursing Home during normal working hours should be approved as per Service by Team Leader/ Locality Manager/ Co-Ordinator/Head of Service

6.5.39 An Emergency Placement outside working hours can be made by the Regional Emergency Social Work Service *(Emergency Social Work Service)*

6.5.40 Thereafter, refer to the Admission to Residential/Nursing Home Section within this document (see page 12) (includes Temporary/Bed Based Short Breaks)

**Bed Based Short Break/Respite**

6.5.41 The Keyworker (or Short Breaks Co-ordinator in ALD) will check bed availability with the chosen home and liaise with the Home Manager to organise a pre-admission assessment (PAA) to ensure that the home can effectively meet the individual needs of the Service User

6.5.42 Care Home placements for Short Breaks/Respite require a record on the Service User Case Notes of confirmation from Care Home Managers that;

- Assessments relating to the Service User's current needs and support requirements have been received by the Care Home.

- The Care Home can accept the Service User and meet the particulars of the care being commissioned
- All pre-admission documentation has been read

6.5.43 The following forms should be completed as required; *(Residential and Nursing Homes)*

- Charging for Respite Form - to be completed on the first episode of Respite/Short Break in each Financial Year
- Admission/Discharge and Financial Referral Form
- Agreement to Pay Form
- Respite Admission Form – This form must be completed for all FIRST time Respite/Short Break Service Users
- Top-Up Undertaking to Pay Form

6.5.44 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

6.5.45 Complete/Update the Care Review section on PARIS *(Reviews)*

**NB Advise Service User/Carer that if the placement exceeds 56 nights a 'declaration of means' will be completed as required for additional financial arrangements**

**Flexible Short Breaks**

6.5.46 Flexible Short Breaks should be explored with Service Users and Carers following the identification of the need for a Carer to be afforded a short break from their caring responsibilities *(Short Breaks, Respite, Flexible Short Breaks)*

6.5.47 For Flexible Short Breaks the following must be completed and recorded on PARIS;

- The Keyworker must ensure with Line Manager (Team Lead/Locality manager/ Head of Service) that the agreed Finance Forms are completed for Flexible Short Breaks which includes the necessary insurance documents and bank account arrangements and one-off direct payment form
- The Keyworker must complete Direct Payment documentation and forward /cc to Team Lead for approval before being forwarded to: [redacted]

6.5.48 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

6.5.49 Complete/Update the Care Review section on PARIS *(Reviews)*

**NB Where the short break is taken outside of a residential/ nursing home setting, the contribution charge should not be deducted from payments towards short breaks provision**

**Temporary Placements**

6.5.50 The Keyworker must ensure that all Temporary Placements have an exit strategy recorded on the Service User Care Plan/ Service User Recovery Plan

6.5.51 Temporary Placements must be approved as per Service requirements *(Residential and Nursing Homes)*

6.5.52 The Keyworker will ensure and record monitoring and review of Temporary Placements

6.5.53 **Monitoring and review of temporary placements should be completed every 2 weeks** with a view to implementing the package of care determined as required at assessment or confirming a permanent placement as needed

6.5.54 The Finance Department will issue a list of Service Users with a temporary status to Heads of Service each month

6.5.55 The cost of Temporary Placements in the absence of availability of the assessed package remains the responsibility of the Service

6.5.56 The Keyworker should work with the Service User to identify how available personal resources can be incorporated to enhance an individual's quality of life. The Finance Department will provide the Keyworker with relevant updates on SHSCT held Patient Private Property account balances and any changes in benefits received. The sharing of information with 3rd parties, which includes family members, should be considered in line with the Data Protection Act 2018

6.5.57 The Finance Department will notify the Keyworker when invoices due to SHSCT are not paid and/or where there is concern around finances. In relation to concerns relating to financial abuse consideration should be given to the Adult Safeguarding Operational Procedures (September 2016) *(Adult Safeguarding)*

6.5.58 **For Memory Services**, following any review of temporary admission to a Nursing Home, if a permanent placement is agreed the Service User needs to be transferred to the Care Home Support Team (CHST). Refer to CHST Referral Checklist *(Residential and Nursing Homes)*
The Keyworker should advise the appropriate Care Home Support Team (CHST) practitioner of monitoring or review date. It is expected that the CHST practitioner will attend this meeting to meet the Service User/Carer and assume responsibility for the case

6.5.59 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

6.5.60 Complete/ Update the Care Review section on PARIS *(Reviews)*

**Notification of Change Form**

6.5.61 When there is a change in the Service User's placement in a Residential/Nursing Home e.g. admission to hospital, the Provider should complete a Notification of Change Form which details the Reason for Absence and forward within one working day of any change to the Finance Department at Ghana House Daisy Hill Hospital, Newry (includes Permanent/Temporary/Bed Based Short Breaks Placement)
Email Address: [redacted]

If the Service User is absent from the Residential/Nursing Home (e.g. admitted to Hospital) the weekly rate will continue to be charged to ensure the bed is held pending a return. Should the Service User wish to terminate their placement, the Keyworker should support the Service User/Carer to explore the reasons for termination and alternative options. The Keyworker must support the Carer to ensure the bed is cancelled should the Service User not wish to return to the Residential/Nursing Home and advise that it is their responsibility to notify the Keyworker

**Supported Living**

Supported Living supports Service Users to live as independently as possible in their own home. Supported Housing is funded by NIHE and has a number of service which enable people to develop & maintain skills to live in the community.
SHSCT Supported Living services are provided by both the Trust and independent providers. Services may be linked to the accommodation that the person resides in or provided in the Community as floating/peripatetic support.

6.5.62 When the outcome of Assessment/s is to seek a **Supported Living Tenancy** for the Service User the Keyworker will consider the Criteria for Supported Housing/ Accommodation applicable to the service *(Supported Living)*

6.5.63 The Keyworker will support the Service User/ Carer/ Advocate to identify options in regards to prospective tenancy/ accommodation and to explore their understanding of holding a tenancy and the financial implications involved

6.5.64 Keyworker will request a date / time on the relevant Supported Living Panel / Accommodation Panel to discuss the service user's needs and any suitable accommodation options for their service user;

- In S&R Mental Health Service the Panel is called 'The Supported Living Panel' as it deals only with applications for Supported Housing and services linked to maintaining the individual in the community
- In Adult Learning Disability services the panel is referred to as the Accommodation Panel'. The panel in ALD also receives referrals for complex needs / bespoke placements / Nursing and Residential homes. Refer to "Accommodation Panel Pathway" currently in draft form (August 2023) *(Supported Living)*

6.5.65 Mental Health Services complete the 'Supported Living Panel Application form and forward with all assessments in Electronic form to [redacted]

[redacted] Adult Learning Disability Services complete the Accommodation Panel Summary Report' for review by Team Lead and forward with all assessments one week prior to the Panel date to the Supported Living Administrator

6.5.66 The Panels take place in Adult Learning Disability and Mental Health Support and Recovery services and are held on a monthly basis but Urgent Cases may be discussed outside of the normal panel arrangements.
The Keyworker and where appropriate the Service User's Advocate will be expected to attend the panel meeting to answer any questions arising and to provide feedback to the Service User, Carer and MDT

The Panel decision will be communicated to the referrer by letter

6.5.67 The prospective Tenant/ Service User may also need to be presented to the providers own panel

6.5.68 Keyworker may be required to complete the Supported Living Screening Tool *(Supported Living)* for individuals obtaining a tenancy in shared supported Living facilities.

6.5.69 Keyworker completes Housing application to NIHE under 'Complex Needs'

6.5.70 Update/Complete Service User Care Plan/ Recovery Care Plan

6.5.71 In ALD Service it may be necessary for the Keyworker to check with the Contracts Department that there is a suitable contract in place to meet complex needs.

6.5.72 The Housing Officer will share with the prospective applicant the terms of their tenancy and agree/sign the 'Contract and Tenancy Agreement' with the applicant

6.5.73 Keyworker will discuss the financial implications with the Service User and where appropriate the Carer / Service users' Advocate

6.5.74 The Keyworker will, where appropriate, refer the service user to the Benefit Agency for advice with regards to accessing Housing benefit as these benefits are means tested. When a client is not eligible for Housing benefit they will incur the costs of the housing and supported people costs in relation to their placement

6.5.75 Keyworker will ensure that the Service User completes and signs the Financial Support Agreement where capacity allows *(Supported Living)*

6.5.76 Keyworker will ensure that the Individual Service Agreement is completed. This should include commencement date, type of care being provided, arrangements for financial transactions, explanation of the service provision and other additional charges which may be applied by the provider e.g. food, heating, electricity, transport, service charges

6.5.77 If the Service user is in receipt of any Social Services support the Keyworker may need to Update /Complete DC1 and Inform Domiciliary Care Providers, if involved, of any Placement

6.5.78The Key Worker will ensure that all relevant documentation is forwarded to the Provider and provide a detailed care plan which explicitly describes how such care should be delivered on an individualised basis over the entire 24-hour period as required.

6.5.79 Monitoring visits should be completed as often as is required and recorded on PARIS Case notes to ensure that the care plan continues to meet the needs of the Service User and that service providers continue to follow contractual arrangement for the provision and quality of care commissioned

6.5.80 At a minimum, a formal review should take place once a year

6.5.81 Update the Case Management Monitoring Form on PARIS *(CM monitoring form)*

6.5.82 Complete/ Update the Care Review section on PARIS *(Reviews)*

### 6.6 Stage 6 - Review of Services - Monitoring and Review of the Service User Care Plan. *(Reviews)*

"Monitoring of the Service User Care Plan will be an ongoing task and where Service User's needs are changing rapidly or frequently, adjustments may have to be made to the Care Package. The main focus should be on whether the quality and appropriateness of the provision meets the agreed outcomes for Service users and, where appropriate, their carers" (Page 7 - 2010 DHSSPSNI Care Management Circular). *(2010 Circular)*

6.6.1 Following the commencement of the Service User Care Plan, at a minimum, contact in the form of a monitoring visit MUST be made at or before 12 weeks post commencement to ensure that the care plan continues to meet the needs of the Service User and that service providers continue to follow contractual arrangement for the provision and quality of care commissioned. Keyworker must ensure that a PARIS Case Note is completed stating "Monitoring visit/contact has taken place

6.6.2 Hospital discharge Nursing/Residential Home placements via the Intermediate Care Service must be followed up with monitoring within 2 weeks to plan future care for the Service User

6.6.3 A formal review is required at any time should there be any significant changes to the Service User's care and support needs. Any changes should be reflected in the care plan following review

6.6.4 **A formal review is required at a minimum annually**

6.6.5 As good practice, the Keyworker must ensure that the date of the next formal review is set at least 12 months ahead of the current review and confirmed 3 months in advance. If a formal review is required ahead of this date, re-set the next formal review date for at least 12 months ahead

6.6.6 All reviews must be recorded on the Care Review section on PARIS and the Case Management Monitoring form should be updated
*(CM Monitoring Form)* *(Reviews)*

6.6.7 Additional monitoring visits should be completed as often as is required and recorded on Service User Case Notes to ensure that the Care Plan continues to meet the needs of the Service User and that service providers continue to follow contractual arrangement for the provision and quality of care commissioned

**Table 1: Monitoring/Reviews**

| Time Scale | Contact | By Whom | Where to Record |
|---|---|---|---|
| **As required** due to needs of Service User | Formal Review | Keyworker must co-ordinate the Formal review with involvement of MDT | PARIS Case Note and update Care Review section |
| **2 weeks –** Temporary Placements **and/or** Hospital discharge Nursing / Residential Home placements via Intermediate Care Service | Monitoring Home visit/contact | Keyworker can delegate this task to other staff members, as appropriate.<br><br>Keyworker to coordinate future care plan and complete formal review as required | Keyworker **must** ensure that a PARIS Case Note is completed stating **"Monitoring visit/contact has taken place"** |
| **4-6 Weeks –** Service Users in receipt of Emergency Direct Payments on discharge from hospital | Monitoring Home visit/contact | Keyworker can delegate this task to other staff members, as appropriate | Keyworker **must** ensure that a PARIS Case Note is completed stating **"Monitoring visit/contact has taken place"** |
| **Within 12 Weeks –** For All Case Managed Service Users following the commencement of the Care Plan | Monitoring Home visit/contact | Keyworker can delegate this task to other staff members, as appropriate | Keyworker **must** ensure that a PARIS Case Note is completed stating **"Monitoring visit/contact has taken place"** |
| **Annually –** All Case Managed Service Users | Formal Review | Keyworker must co-ordinate the Formal Review with involvement of MDT | PARIS Case Note and update Care Review section |

6.6.8 Ensure the views of the Service User/Carer or Independent Advocate as relevant remain central to the process

6.6.9 For any changing needs that would require a change in Service Provision the Keyworker must consider referrals to other services

6.6.10 The Keyworker must complete/update PARIS eDC1/DC1 to capture all changes in Service Provision *(Request for services and DC1)*

6.6.11 The Service User Care Plan should be updated to reflect that the review has taken place

6.6.12 The Keyworker must update the Mental Health Assessment OR eNISAT Core /Complex Assessment, as appropriate. If using NISAT, the eNISAT Core/Complex Assessment must be updated/completed within 28 days from commencement *(MH Assessment)* *(eNISAT)*

6.6.13 The Care Review section on PARIS must be updated with the new review date

6.6.14 Updated and relevant documentation to be shared with Service Users, Carers, Providers and other relevant stakeholders

## 6.7 Stage 7 – Annual Review *(Reviews)*

6.7.1 **"As a minimum, a formal review should take place once a year**. However, more frequent reviews may be required in response to changing circumstance or at the request of the Service User/Carers or agencies involved in their care" (Page 8 - 2010 DHSSPSNI Care Management Circular) *(2010 circular)*

6.7.2 Any updated and relevant documentation to be shared with Service Users, Carers, Providers and other relevant stakeholders as consent allows

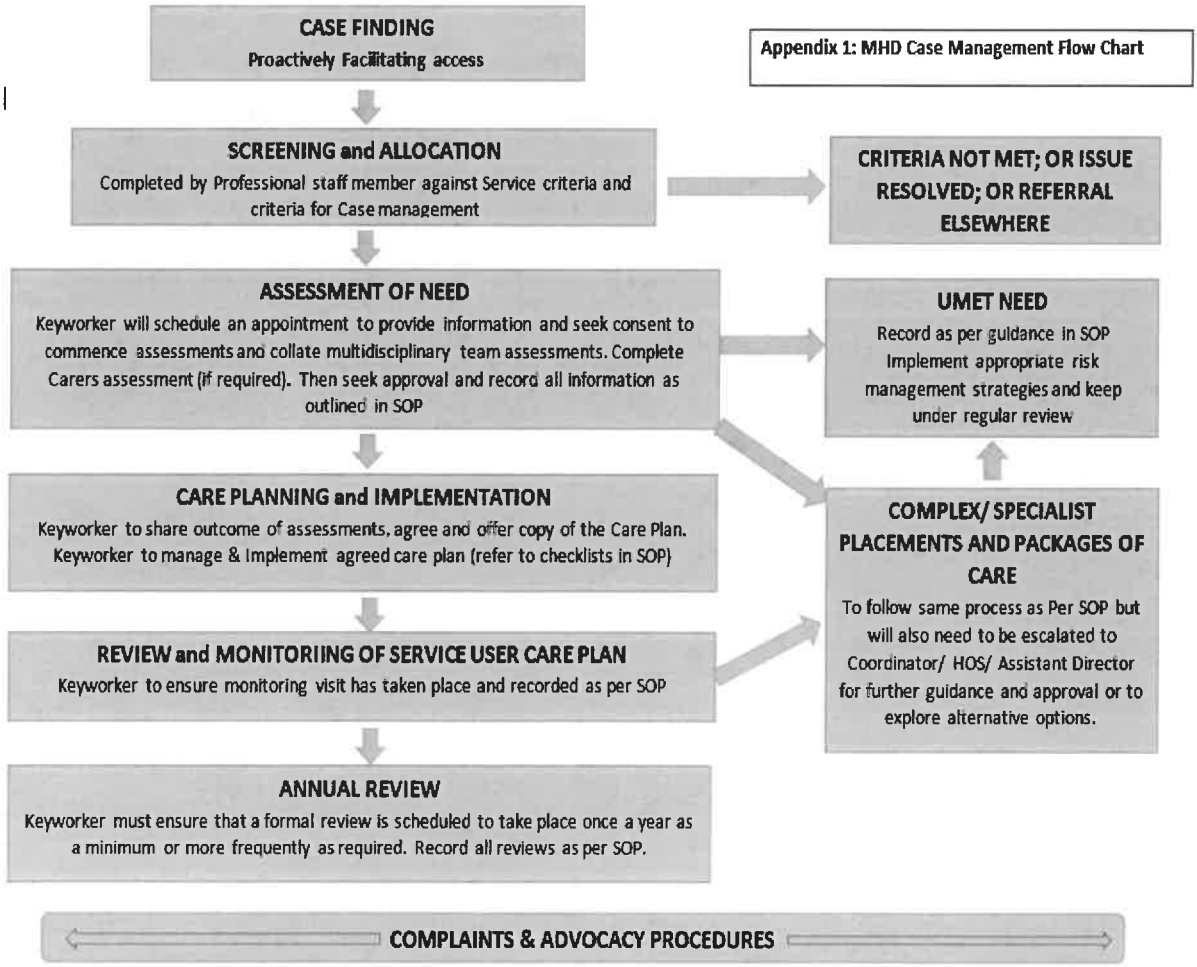
6.7.3 A financial review must be completed as part of the Annual Review for Service Users in residential placements.

- Service Users in Supported Living require review and completion of the Financial Support Agreement. *(Supported Living)*
- Where applicable, the Key worker must ensure contact with Finance for a balance of PPP account prior to the annual review taking place. *NB This financial information is provided for the purposes of the financial review of client needs. Under GDPR, the Trust is not permitted to disclose personal financial information to a 3rd party eg client family members.*
- Service Users in Residential/ Nursing Facilities require review and completion of the 'Financial Review Record for MHD Service Users in Residential/Nursing Facilities' *(Reviews)*

6.7.4 As good practice, the Keyworker must ensure that the date of the next formal review is set at least 12 months ahead of the current review and confirmed 3 months in advance. If a formal review is required ahead of this date, re-set the next formal review date for at least 12 months ahead

6.7.5 Update the Care Review section in PARIS and the Case Management Monitoring Form *(CM Monitoring Form)* *(Reviews)*

## Flow Chart – MHD Case Management Processes




## Associated Documentation

See MHD Case Management SharePoint page *(MHD Case Management)*