Kent and Medway NHS
NHS and Social Care Partnership Trust

Medway and Specialty Mental Health Services NICE Guidelines Implementation Strategy

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Medway and Specialty Mental Health Services NICE Guidelines Implementation Strategy

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REFERENCES

1. How to put NICE into Practice, A guide to implementation for organisations, NICE 2005
2. Developing guidance-related support tools, Process and Methodology Manual Information for internal NICE teams, NICE 2008
3. National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/06–2007/08, DOH 2004
4. Standards for Better Health, DOH, July 2004

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

NICE Implementation Policy, KMPT	September, 2009
Discussion Document for Internal Audit Report No. KMC080903, NICE Guidelines Implementation at Kent and Medway NHS and Social Care Partnership Trust	December, 2009

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1 INTRODUCTION:

1.1 Guidelines have become an important tool in the practice of health care delivery. These guidelines provide evidence based clinical information for the practitioners. There are many guidelines available. APA guidelines produced by American Psychiatric Association, BAP guidelines by British Association of Psychopharmacology, Texas Medication Algorithm and WFSBP guidelines by World Federation of Societies of Biological Psychiatry are some of the well known guidelines in the field of mental health.

1.2 National Institute of Health and Clinical Effectiveness (NICE) is an independent body responsible for providing national guidance in United Kingdom on the promotion of good health and the prevention and treatment of ill health. These guidelines are popularly known as NICE Guidelines. Organization NICE publishes four different kinds of documents to provide the clinician with evidence based information for their clinical practice. They are:

1.2.1 **Clinical Guidelines (CG)**: these guidelines cover diseases and conditions, and cover all aspects of management from diagnosis to specialist treatment

1.2.2 **Technology Appraisals (TA)**: Advise on the use of new and existing medicines and treatments within the NHS in England and Wales. There is a statutory requirement for the PCT to ensure that within months of the date of publication of a Technology Appraisal that the implications for local implementation are considered and funding to support implementation secured.

1.2.3 **Interventional Procedure Guidance (IPG)**: Advice on whether interventional procedures used for diagnosis or treatment are safe enough to work well enough for routine use.

1.2.4 **Public Health Guidance (PHG):** Guidance on the promotion of good health and the prevention and treatment of ill health. This guidance is for those working in the NHS, local authorities and the wider public, private and voluntary sectors.

1.2.5 **Patient Safety Solution Guidance:** It is a collaborative project between NICE and NPSA addressing the service use safety issues.

1.3 In addition to providing evidence based and cost effective ways of delivering clinical care, the NICE guidelines also offer an opportunity to develop standards for evaluating the clinical practice of health care professionals, for training and education of health care professionals and in empowering and involving service users in the health care decision making process.

1.4 Number of NICE guidelines relating to mental health has been published. Clinical Guidelines on Schizophrenia is one of the earliest guidelines published by the NICE. It is imperative that every mental health professional should be aware of these guidelines and follow the guidelines in their everyday clinical practice. Annexure - A gives details of the NICE guidelines published till January 2010.

2 IMPLEMENTATION OF NICE GUIDELINES:

2.1 Department of Health and various health care professional bodies recognise the importance of implementation of NICE guidelines. Care quality commission's core standard C5(a) observes that 'Health care Organisations should ensure that they confirm to NICE Technology appraisals and where it is available, take into account nationally agreed guidance when planning and delivering treatment and care'.

2.2 Developmental standard D2a states that Patients receive effective treatment and care that conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery. Implementation of NICE Guidelines will also aid meeting the Care Quality Commission standards C3, C16, C22, C23 and D13. Implementation of NICE Guidelines will be one of the important parameter in evaluating the performance of the Trusts. Thrust for implementation of NICE guidelines comes from Department of Health policies / legislation, Care Quality Commission inspections, Quality and Outcomes Frameworks and Practice-based commissioning. In future NICE guidelines will play an important role in payment by results initiatives in mental health.

3 MENTAL HEALTH SERVICES AT MEDWAY:

3.1 Mental health needs of people of Medway are met by the general practitioners, three community mental health teams and psychiatric in-patient services, Crisis Resolution and Home Treatment Team (CRHT), Medway Assessment and Short-term Treatment Team (MASTT) at Medway Maritime hospital. Manpower for the mental health services consists of consultant psychiatrists, psychologists, staff grades, senior house officers, social workers, community psychiatric nurses, ward staff, secretaries and other support staff. In addition to general adult psychiatric services mentioned above there are Mental Health Service for Old Age Persons (MHSOP), Child and Adolescence Mental Health Services (CAMHS), Early Intervention Services (EIS), Assertive Out reach Team (AOT) and Mother and Infant Mental Health Services catering to various needs of the people with mental health problem. Specialist services like Eating Disorder Services and Brenchley Unit for people with Personality Disorder based at Maidstone also serve the Medway community. Annexure-B enlists the various mental health teams serving the people of Medway.

4 IMPLEMENTATION STRATEGY

4.1 A clear strategy will be required to implement these guidelines across number of teams. Implementation guide published by the NICE outlines six components of implementation:

4.1.1 Board support and clear leadership

4.1.2 Provision of a dedicated resource (e.g. a NICE manager or facilitator)

4.1.3 Support from a multidisciplinary team

4.1.4 A systematic approach to financial planning

4.1.5 A systematic approach to implementing guidance

4.1.6 A process to evaluate uptake and feedback

4.2 A strategy to implement NICE Guidelines in Medway locality mental health services is developed taking into consideration of the above mentioned facts. Strategy will include forming main group and subgroup for implementation, creating awareness, imparting training, facilitating practice of NICE, audit, evaluation and reporting.

5 IMPLEMENTATION GROUP:

5.1 It is evident that implementation of the NICE guidelines is prerequisite to delivering quality mental health care to the people of Medway. There are nearly 20 Clinical guidelines and number of Technical appraisals and Public Health guidelines relating to mental health. There are about 10 mental health teams which will expected to implement NICE guidelines in their day to day practice. A main group of professionals will be required to coordinate the implementation of NICE guidelines at Medway. Medway wide implementation group is already in existence. Its functions and performance will be strengthened.

5.2 Consultant and team manager or his/her nominee from the team will form the main group. The group will be termed as Medway General and Specialty Secondary Mental Health Services NICE Implementation Group. Two levels of membership will be entertained. Core group members who are expected to attend every meeting will form one level and other level will be service managers, team managers of teams based out side Medway and specialist services. Second level group members will not be expected to attend all the meeting. But they will be on the mailing list and receive all the minutes and other documents relating to meetings. They are welcome to attend the meetings which they feel relevant to their area of practice. They can also request for inclusion of agenda depending on the need.

5.2.1 Meetings will be held once a month.

5.2.2 Following will be the responsibilities of the main implementation group:

a) To oversee and monitor implementation of relevant NICE guidelines, across all the secondary mental health services.

b) To facilitate and conduct audits and assessments relating to implementation of NICE guidelines

c) To liaise with external agencies including PCTs for implementation of NICE guidelines

d) To form a bridge between trust wide NICE Guidelines Implementation Group and the locality

e) To produce annual and other relevant reports about implementation of NICE guidelines

f) Oversee and facilitate area wide awareness and training programs including sponsorships and funding arrangements

5.2.3 **Subgroups for Implementation:** As mentioned earlier there are more than 20 clinical guidelines and the number is growing. Hence the task of implementation and monitoring will be better served if the responsibilities are shared among the different teams. It will also facilitate involvement of all the teams in the process of implementation. Each secondary mental health team will form a subgroup for implementing certain NICE guidelines. They will champion the Medway wide dissemination and implementation of the certain guidelines. Appendix-C enlists the subgroups and their allocated NICE guidelines. Following will be the responsibilities of subgroup:

a) The subgroup will be responsible for overseeing the implementation of the NICE guidelines designated to their team.

b) Consultant Psychiatrist / Psychologist and a designated team member will work with their team to implement and monitor the NICE guidelines in their team.

c) In addition to designated guidelines the team will also practice other relevant NICE guidelines

d) They will be responsible for conducting Medway wide audits and training/awareness program in the designated NICE guidelines

e) They will provide the necessary information to the main implementation group

6 AWARENESS AND TRAINING:

6.1 Awareness and training form an important aspect of the implementation. Awareness will be created to all the mental health staff including administrative and support staff. Awareness program will aim to impress the staff about the importance and benefits of implementation. To create awareness three annual events will be conducted. Two half a day and one full day program will be conducted for the clinical staff. These programs will use both internal and external resources for delivering the information about recent developments, specific guidelines and relevant audits. It will also aim to install awards system for audits and innovative implementation methods. Poster campaign can be organised to create awareness about any forthcoming or newly published NICE Guidelines.

6.2 Training will be imparted at different levels. New NICE guidelines will be discussed at Consultant CPD meetings. NICE guidelines will be taught in junior doctors teaching programs. Training program on different NICE guidelines will be conducted for each mental health team. Sub groups will be involved in imparting training their designated NICE guidelines.

7 FACILITATING PRACTICE:

7.1 In addition to awareness program and training program each team will be expected to facilitate the practice of NICE guidelines by professionals in their day to day practice. Following measures will be taken to help professionals to practice NICE guidelines:

7.2 Check list will be developed for each relevant NICE guideline to facilitate the implementation. The checklist will be in a simple user friendly format. It can be used

during the CPA or clinical reviews. IT will also be a good tool to collect data on implementation. The practitioner will be expected to fill in these heck is atleast once in 6 months for each service user. Appendix-D and Appendix-E contains checklist for NICE guidelines on Schizophrenia and Anxiety Disorder

7.3 Hard Copies of Guidelines will be made available at clinical rooms. Team manager or designated person from the team will order the required number of relevant NICE guidelines from NICE organisation. A folder can be created with all the relevant guidelines and it can be made available at the clinical rooms.

7.4 Practice of NICE guidelines will be discussed during Supervision or Appraisal of the staff.

8 AUDIT, DISSEMINATION AND MONITORING:

8.1 Periodic audits will be conducted on all the relevant NICE guidelines. Subgroups will be in charge of planning and conducting the audits. They will be supported by main group and the Trust audit and clinical effectiveness group. Completed audits will be presented in the main group and in the annual NICE events. Audit reports will be circulated to all the teams online. Each subgroup will be expected to submit details of implementation in NICE Guidelines Implementation Template for each NICE guideline allocated to them. Appendix F shows the implementation template.

9 OVERCOMING THE BARRIERS:

9.1 Use of checklist and audits will identify areas of non implementation for each NICE guideline. The respective subgroup will collate all the information regarding aspects of non compliance of NICE guidelines. They will make a short report enlisting the barriers to implementation and their suggestion to over come the barriers. This report will be discussed in the main group meeting and suitable recommendations will be made.

10 REVIEW AND ANNUAL REPORTS:

10.1 NICE implementation strategy and implementation of the NICE guidelines will be reviewed annually. Based on the information gathered from sub-groups, audits and visits to different teams, an annual report will be prepared by the main group. Annual report will highlight implementation, non implementation, barriers to implementation, recommendations to overcome the barriers and examples of innovative practices in implementation.

11 PRIMARY AND SECONDARY CARE INTERFACE:

11.1 Most of the NICE guidelines involve implementing NICE guidelines in primary care setting. In the stepped care model, at least the first two to three steps involves primary care. Ideally the practice of NICE guidelines should be initiated at primary care and passed on the secondary care at the appropriate level. It highlights the importance of liaising with primary care in implementation of NICE guidelines. The main group will aim to establish links with primary care groups to share information and methodology. The secondary care can support the primary care professionals in areas of training and awareness.

12 STAKEHOLDER, CARER AND USER INVOLVEMENT:

12.1 Implementation group will have service user and carer representation. Wherever possible service user groups and PAL members will be involved in the implementation process

13 EQUALITY IMPACT ASSESSMENT SUMMARY

13.1 All public bodies have a statutory duty to assess the impact of its policies/strategies on groups (Race Relations (Amendment) Act 2000, Disability Discrimination Act 2005 and Equality Act 2006). Reviewing the information presented in the previous sections: complete the following screening form(Refer to Appendix - G)

14 HUMAN RIGHTS

14.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

15 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	***How will it be monitored***	***Who will monitor***	***Frequency***	***Evidence to demonstrate monitoring***	***Action to be taken in event of non compliance***
Implementation of NICE guidelines Implementation strategy	As detailed in the strategy	Medway NICE Guidelines Implementation Group and Medway Clinical Governance Group	Monthly	Annual report	To assess the reasons for non-compliance and develop ways to overcome the barriers to compliance

APPENDIX A LIST OF NICE CLINICAL GUIDELINES, TECHNICAL APPRAISALS, INTERVENTION PROCEDURES AND PUBLIC HEALTH GUIDELINES RELEVANT TO MENTAL HEALTH

(Both Published and Documents in development as on January 2010)

Completed Clinical Guidelines

1. Antenatal and postnatal mental health
2. Antenatal Care
3. Antisocial personality disorder
4. Anxiety
5. Attention deficit hyperactivity disorder (ADHD)
6. Bipolar disorder
7. Borderline personality disorder (BPD)
8. Dementia
9. Depression (replaced by CG90)
10. Depression in children and young people
11. Depression with a chronic physical health problem
12. Drug misuse: opioids detoxification
13. Drug misuse: psychosocial interventions
14. Eating disorders
15. Medicines adherence
16. Obsessive compulsive disorder (OCD) and body dismorphic disorder (BDD)
17. Post-traumatic stress disorder (PTSD)
18. Schizophrenia (update replaced by CG82)
19. Self-harm
20. Violence
21. When to suspect child maltreatment

Completed Interventional Procedures

1. Soft-palate implants for obstructive sleep apnoea
2. Soft-palate implants for simple snoring
3. Transcranial magnetic stimulation for severe depression
4. Vagus nerve stimulation for treatment-resistant depression

Completed Technical Appraisals

1. Alzheimer's disease - donepezil, galantamine, rivastigmine (review) and memantine

2. Attention deficit hyperactivity disorder (ADHD) - methylphenidate, atomoxetine and dexamfetamine (review)
3. Conduct disorder in children - parent-training/education programmes
4. Depression and anxiety - computerised cognitive behavioural therapy (CCBT)
5. Drug misuse - methadone and buprenorphine
6. Drug misuse - naltrexone
7. Electroconvulsive therapy (ECT)
8. Insomnia - newer hypnotic drugs
9. Sleep apnoea - continuous positive airway pressure (CPAP)
10. Smoking cessation - varenicline
11. Structural neuroimaging in first-episode psychosis

Completed Public Health Guidance

1. Brief interventions and referral for smoking cessation
2. Interventions to reduce substance misuse among vulnerable young people
3. Mental wellbeing and older people
4. Needle and syringe programmes
5. Preventing the uptake of smoking by children and young people
6. School-based interventions on alcohol
7. Smoking cessation services
8. Social and emotional wellbeing in primary education
9. Social and emotional wellbeing in secondary education
10. Workplace interventions to promote smoking cessation

Clinical Guidelines in development

1. Alcohol dependence and harmful alcohol use (Draft Document for consultation in available now on the website)
2. Alcohol use disorders - clinical management (Draft Document for consultation in available now on the website)
3. Anxiety (partial update)
4. Autism spectrum disorders in children and young people
5. Delirium
6. Identification and care pathways for common mental health disorders
7. Nocturnal enuresis in children (bedwetting)
8. Pregnancy and complex social factors
9. Psychosis with substance misuse
10. Self-harm (longer term management)

Technical Appraisals in development

1. Alzheimer's disease (mild to moderate) - donepezil, galantamine, rivastigmine and memantine (part review)
2. Dementia (non-Alzheimer) - new pharmaceutical treatments (suspended)
3. Schizophrenia – aripiprazole

Public health guidance in development

1. Alcohol-use disorders (prevention)
2. Home-based approaches to promoting children's wellbeing
3. Looked after children
4. Personal, social and health education focusing on sex and relationships and alcohol education
5. Pre-school approaches to promoting children's wellbeing
6. Preventing domestic violence
7. Quitting smoking in pregnancy and following childbirth
8. School-based interventions to prevent smoking

APPENDIX B MENTAL HEALTH TEAMS AT MEDWAY

Mental Health Teams at Medway

1. MIMHS	Mother and Infant Mental Health Services
2. CMHT - Rochester	Rochester Community Mental Health Team
3. CMHT – Chatham	Chatham Community Mental Health Team
4. CMHT - Gillingham	Gillingham Community Mental Health Team
5. AOT	Assertive Out-reach Team
6. In- Patient Services	Emerald and Ruby Ward at Medway Maritime Hospital
7. CRHT	Crisis Resolution and Home Treatment Team
8. MASTT	Medway Assessment and Short-term Treatment Team
9. EIS	Early Intervention Services
10. CAMHS	Child and Adolescence Mental Health Services
11. MHSOP	Mental Health Services for Old age Persons
12. Secondary Care Psychology Services	

Trust wide Services available for Medway Population

1. Brenchley Unit for Personality Disorders
2. Eating Disorder Services
3. Forensic Mental Health Services

APPENDIX C MEDWAY SUBGROUPS FOR IMPLEMENTATION OF NICE GUIDELINES

Sub Group	NICE Guidelines / Technical Appraisal	Responsible / Team
I	1. Antenatal and postnatal mental health (CG) 2. Antenatal Care	MIMHS
II	1. Depression (replaced by CG90) (CG) 2. Attention deficit hyperactivity disorder (CG)	MASTT
III	1. Obsessive compulsive disorder (OCD) and body dismorphic disorder (BDD) (CG) 2. Antisocial personality disorder (CG) 3. Anxiety (CG) 4. Depression and anxiety - computerised cognitive behavioural therapy (CCBT) (TA)	Secondary Care Psychology Services
IV	1. Self-harm (CG) 2. Post-traumatic Stress Disorder (PTSD) (CG) 3. Chronic Fatigue Syndrome (CG)	Chatham CMHT
V	1. Bipolar disorder (CG) 2. Medicines adherence (CG) 3. Smoking cessation - varenicline (TA)	Gillingham CMHT /
VI	1. Schizophrenia (replaced by CG82) Schizophrenia (update) (CG) 2. Schizophrenia - atypical antipsychotics (replaced by CG82) (TA) 3. Borderline personality disorder (BPD) (CG)	Rochester CMHT / AOT
VII	1. Eating disorders (CG) 2. Structural neuroimaging in first-episode psychosis (TA)	EIS
VIII	1. Violence (CG) 2. Physical health related Guidelines relevant to psychiatric in-patient Services 3. Insomnia - newer hypnotic drugs (TA)	Emerald/ Ruby / CRHT
IX	1. Depression in children and young people (CG) 2. When to suspect child maltreatment (CG) 3. Conduct disorder in children - parent-training/education programmes (TA) 4. Attention deficit hyperactivity disorder (ADHD) - methylphenidate, atomoxetine and dexamfetamine (review) (TA)	CAMHS
X	1. Dementia (CG) 2. Depression with a chronic physical health problem (CG) 3. Electroconvulsive therapy (ECT) (TA) 4. Alzheimer's disease - donepezil, galantamine, rivastigmine (review) and memantine (TA)	MHSOP

APPENDIX D CHECKLIST FOR NICE CLINICAL GUIDELINES FOR SCHIZOPHRENIA

(Use the following legend to mark the status of implementation: **IMP**- Implemented **TIM -** To be Implemented, **NI** – Not Implemented due to lack of resources, **NA** – Not Applicable)

Service User Name: DOB: Date of Review:

Recommendation	Status	Comments
1. Professionals working with people with Schizophrenia should be Competent 2. Carry out a full assessment in secondary care, including assessment by a psychiatrist. Write a care plan with the service user as soon as possible. Send a copy to the referring primary care professional and the service user.		
3. Before taking each treatment decision, healthcare professionals should ensure that they: ▪ Provide service users and carers with full, patient-specific information about schizophrenia and its management in the appropriate format, to ensure informed consent before treatment starts ▪ Understand and apply the principles of the mental capacity act ▪ Are aware that mental capacity is decision specific (if there is doubt about mental capacity, Assessment of mental capacity should be made in relation to each decision) using the test in the mental capacity act. ▪ Record the indications, expected benefits and risks, and expected time for a change in symptoms and for side effects to occur		
4. Start with a dose at the lower end of the licensed range and titrate upwards slowly within the dose range in the British National Formulary (BNF) or SPC. 5. Justify and record reasons for dosages outside the range specified in the BNF or SPC. 6. Monitor and record the following regularly and systematically throughout treatment, but especially during titration: ▪ Efficacy, including changes in symptoms and behaviour ▪ Side effects of treatment, taking into account overlap with some of the clinical features of schizophrenia ▪ Adherence ▪ Physical health. 7. Record the rationale for continuing, changing or stopping medication and the effects of such changes.		
8. Before starting antipsychotics ▪ Offer an electrocardiogram (ECG) if: Specified in the summary of product characteristics (SPC) ▪ Physical examination shows specific cardiovascular risk (such as diagnosis of high blood pressure) ▪ There is personal history of cardiovascular disease, or the service user is being admitted as an inpatient.		
9. Offer oral antipsychotic medication. 10. Provide information and discuss the benefits and side-effect profile of each drug with the service user. The choice of drug should be made by the service user and healthcare professional		

Recommendation	Status	Comments
11. GPs and other primary healthcare professionals should monitor the physical health of people with schizophrenia at least once a year. A copy of the results should be sent to the care coordinator and/or psychiatrist, and put in the secondary care notes.		
12. Offer Cognitive Behavioural Therapy (CBT) on a one-to-one basis over at least 16 planned sessions to All People with Schizophrenia. 13. Offer family intervention to families of people with schizophrenia living with or in close contact with the service user, for at least 10 planned sessions over a period of 3 months to 1 year 14. Consider offering arts therapies, particularly to help negative symptoms of schizophrenia. 15). Do not routinely offer counseling, supportive psychotherapy, or social skills training as specific interventions. However, take service user preferences for counseling and supportive psychotherapy into account, especially if CBT, family intervention and arts therapies are not available locally.		
16). Do not initiate regular combined antipsychotic medication, except for short periods		
17). Develop advance statements and advance decisions with the person with schizophrenia, especially if their illness is severe and they have been treated under the Mental Health Act.		
18). Support the service user or carer if they seek a second opinion on the diagnosis.		
19). Discuss with the service user and carer if appropriate: ▪ Any non-prescribed therapies (including complementary therapies) the service user wishes to use ▪ Discuss about use of alcohol, tobacco, other prescription and non-prescription medication and illicit drugs		
20). Assertive outreach teams should be provided for people with schizophrenia who: ▪ Frequently use inpatient services, and ▪ Have a history of poor engagement with services leading to frequent relapse or social breakdown (homelessness or inadequate accommodation).		
21). When starting depot/long-acting injectable antipsychotics: ▪ Consider the preferences and attitudes of the service user towards regular intra-muscular injections and their delivery (for example, home visits, location of clinics) ▪ Consider the risks and benefits of the drug ▪ Initially use a small test dose according to the BNF or SPC.		
22). For service users whose symptoms have not responded adequately to treatment: ▪ Review the diagnosis ▪ Check that there has been adherence to antipsychotic medication, prescribed at an adequate Dose and for the correct duration ▪ Check that psychological treatments have been offered according to this guideline and review engagement with these; offer CBT if family intervention has been undertaken; if CBT has been undertaken, suggest family intervention for those in close contact with their family ▪ Consider other causes of non-response, for example co-morbid substance or alcohol misuse, concurrent use of other prescribed medication, or physical illness.		

Recommendation	Status	Comments
23). Offer Clozapine if symptoms have not responded adequately despite sequential use of at least two different antipsychotics, one of which should be a non-Clozapine second-generation antipsychotic.		
24). If symptoms have not responded adequately to an optimized dose of Clozapine, review the ▪ Diagnosis, adherence to treatment, engagement with and use of psychological treatments, other ▪ Possible causes of non-response and measure therapeutic drug levels before offering a second Antipsychotic to augment Clozapine. ▪ The second drug should not compound the common side Effects of Clozapine. ▪ An adequate trial of augmentation may need to be up to 8–10 weeks.		
25). Provide supported employment programmes for those who want to return to work or find a job. ▪ These programmes should not be the only work-related activity offered when people are unable to work or cannot find a job. ▪ Mental health services should work with local stakeholders, including those representing BME Groups, to enable access to local employment and educational opportunities. This support should take into account the person's needs and skill level. It is likely to involve working with Jobcentre Plus, Disability employment advisers and non-statutory providers.		
26). Routinely record the daytime activities and occupational outcomes of service users in their Care plan.		
27). Service users whose symptoms have responded effectively to treatment and remain stable should have the option to return to primary care management. If the service user wishes to do this, record in the notes and coordinate transfer through the CPA.		

APPENDIX E CHECKLIST FOR NICE CLINICAL GUIDELINES FOR ANXIETY

(Use the following legend to mark the status of implementation: **IMP**- Implemented **TIM -** To be Implemented, **NI** – Not Implemented due to lack of resources, **NA** – Not Applicable)

Service User Name: **DOB:** **Date of Review:**

Recommendation	Status	Comments
1. The patient shares decision-making with the healthcare professionals during the process of diagnosis and in all phases of care		
2. The patient with panic disorder or generalized anxiety disorder is unable to participate in an informed discussion with the clinician responsible for treatment at the time, and an advocate or carer is not available.		
3. The patient and, when appropriate, his or her family and carer(s) are offered appropriate information on the nature, course and treatment of panic disorder or generalized anxiety disorder, including information on the use and likely side-effect profile of medication		
4. The patient and his or her family and carer(s) are informed of self-help groups and support groups and are encouraged to participate in programmes.		
5. The patient with panic disorder or generalized anxiety disorder is unable to participate in self-help groups or support groups due to a clinical or other valid reason		
6. All patients prescribed antidepressants are informed that, although the drugs are not associated with tolerance and craving, discontinuation / withdrawal symptoms may occur on stopping or missing doses or, occasionally, on reducing the dose of the drug. These symptoms are usually mild and self-limiting but occasionally can be severe, particularly if the drug is stopped abruptly.		
7. Necessary relevant information is elicited from The patient with panic disorder or generalized		
8. Necessary relevant information can be defined the diagnostic process. Anxiety disorder is unable to participate in a discussion with the clinician responsible for treatment, and an advocate or carer is not available		
9. As personal history, any self-medication, and cultural or other individual characteristics that may be important considerations in subsequent care. The treatment of choice is available promptly		
10. Individuals with panic disorder are not prescribed benzodiazepines		
11. A patient with panic disorder is offered pharmacological therapy (an SSRI licensed for panic disorder; or if an SSRI is unsuitable or there is no improvement imipramine or Clomipramine are considered) and the person's preference is taken into account:		
12. A patient with panic disorder is offered Psychological therapy (CBT) and the person's preference is taken into account:		
13. A patient with panic disorder is offered Self-help (includes bibliotherapy based on CBT principles) and the person's preference is taken into account:		
14. . Patient with generalized anxiety disorder is not prescribed benzodiazepines for longer than 2–4 weeks		
15. A patient with longer-term generalized anxiety disorder is offered		

pharmacological therapy (an SSRI licensed for panic disorder; or if an SSRI is unsuitable or there is no improvement imipramine or Clomipramine are considered) and the person's preference is taken into account		
16. A patient with longer-term generalized anxiety disorder is offered Psychological therapy (CBT) and the person's preference is taken into account		
17. A patient with longer-term generalized anxiety disorder is offered Self-help (includes bibliotherapy based on CBT principles) and the person's preference is taken into account:		
18. A patient is reassessed if one type of intervention does not work, and consideration is given to trying one of the other types of intervention 19. A thorough, holistic reassessment of the individual, his or her environment and social circumstances is conducted by specialist mental health services.		
20. Outcomes are monitored using short, self-complete questionnaires such as the panic subscale of the agoraphobic mobility inventory for individuals with panic disorder.		

APPENDIX F NICE GUIDELINES IMPLEMENTATION TEMPLATE

(To be returned to Implementation group every six months)

Title of guidance:

Type of Guidelines: Clinical Guidelines / Technical Appraisal / Interventional Procedure / Public Health Guidelines

Date of guidance:

Named Implementation Lead Team:

Date of Implementation:

Has Full Compliance Reached: Yes / No

If No, Arrears on non-compliance (Use additional sheet of paper if necessary):

1.
2.
3.
4.
5.

What are barriers to Implementation(Use additional sheet of paper if necessary:

1.
2.
3.
4.
5.

List the Measures taken to overcome the Barriers.

.

Task	Details	Completion date
1.		
2.		
3.		
4.		
5		

Personnel Responsible for Each Task:

Details of resource implication to overcome the barrier (Both Financial and Workforce)

Comments:

Review Date:

APPENDIX G EQUALITY IMPACT ASSESSMENT

EIA Screening form					
	1	**2**	**3**	**4**	**5**
	Which of the 3 parts does it apply to (if any) 1.Eliminating discrimination? 2.Promoting equal opportunities? 3.Promoting good relations?	Is there evidence or reason to believe that some groups could be differently affected? Which groups are affected?	How much evidence do you have? 0-2 None or little 3-4 Some 5-6 Substantial	Is there a public concern that the function/policy is being carried out in a discriminatory way? 0-2 None or little 3-4 Some 5-6 Substantial	Priority (add columns 3 & 4)
Age		No	0	0	0
Disability		No	0	0	0
Gender		No	0	0	0
Race		No	0	0	0
Religion Belief		No	0	0	0
Sexual orientation		No	0	0	0

Conclusions	
If the policy, procedure or practice affects any group differently, can this be legally justified?	**No**
Does the policy/ strategy include opportunities to promote equality?	**Yes/** (See Monitoring table)
Is there a need to gather more information than is currently available to assess the impact of the policy, procedure or practice	**No** (If yes, state what information is needed and how this might be collected)
Is it possible to easily modify this policy, procedure or practice to address any issues highlighted above? Please give details of how and when this could implemented	**Yes**

Considering these questions and information presented in the previous sections you must make a decision as to whether a full impact assessment must be completed. A full impact assessment will include further/extensive consultation with the groups/stakeholders that have been identified

Conclusions	
Based on your answers to the questions in this screening, what is the relative priority of this policy, procedure or practice for full assessment?	**1** ☑ Low* **2** ☐ write within next review date **3** W☐rawn and re-write * Low priority policies, procedures and practices do not have to undergo full assessment.
If you identified this policy, procedure or practice as a 2 or 3 rating, why was this?	☐ It is a major policy, procedure or practice, in terms of its scale or significance for Trust activities. ☐ High relevance to equality, equal opportunities or good inter-group relations/likely to have a significant impact on people from diverse groups. ☐ Possible/actual negative impact identified. ☐ Insufficient information/evidence to make a Judgement. ☐ Other_____
Please indicate the date a full assessment is proposed to commence:	

APPENDIX H ABBREVIATIONS AND DEFINITIONS

Abbreviation	Meaning
AOT	Assertive Outreach Team
CAMHS	Child and Adolescence Mental Health Services
CG	Clinical Guidelines
CMHT	Community Mental Health Team
CPA	Care Program Approach
CPD	Continuing Professional Development
CRHT	Crisis Resolution and Home Treatment Team
EIS	Early Intervention Services
IPG	Interventional Procedure Guidance
MASTT	Medway Assessment and Short-term Treatment Team
MHSOP	Mental Health Services for Older People
MIMS	Mother and Infant Mental Health Services
NICE	National Institute of Health and Clinical Effectiveness
NPSA	National Patient Safety Agency
PAL	Patient Advocacy and Liaison
PCT	Primary Care Trust
PHG	Public Health guidance
TA	Technology Appraisals