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STANDARD OPERATING PROCEDURE COLLABORATIVE WORKING BETWEEN FORENSIC INPATIENT WARDS AND COMMUNITY FORENSIC TEAMS

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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Oct-21*	*New SOP, approved by Clinical Netrwork 16 October 2021*
1.1	*Sep-22*	*Format changes, changed to up to date language regarding acccess assessments and changes in the Provider Collaborative Clarity regarding the collaborative approach to planning care. Approved at Forensic Clinical Network (12 September 2022).*
1.2	*Jan-24*	*Reviewed. SOP title changed to “Collaborative Working Between Forensic Inpatient Wards and Community Forensic Teams”. Updates and amendments made throughout entire document. Approved at Forensic Clinical Governance Meeting (22 January 2024).*

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1. INTRODUCTION

This procedure has been written to support collaborative working between Community Forensic Teams and medium and low secure inpatient wards at Humber Centre and Pine View. All teams are supported and managed within the Forensic Division of Humber Teaching NHS Foundation Trust.

The following procedure should be considered within the context of the Trauma Informed Diamond Clinical Model, please see below.

There are service specification documents outlining service provision for both community and inpatient services, these documents are available from the respective teams.

The national agenda is to reduce the admissions and length of stay for patients in secure inpatient care. In forensic services we move towards responsive, timely and appropriate interventions that support individuals to live safe and satisfying lives in community settings.

2. SCOPE

This procedure applies to all employees of the Trust, including all staff who are seconded to the Trust, contract and agency staff involved in the provision of health and social care.

The procedure refers to the relationship between Community Forensic Teams and secure inpatient services within HTFT, the procedure does not apply to in-reach services provided outside of HTFT.

3. DUTIES AND RESPONSIBILITIES

The procedure will be reviewed within the Division Clinical Network. Team Managers will ensure that all team members within the services are familiar with the procedure.

Team members from respective teams are responsible for the delivery of the procedure. Operational and clinical leads within Forensic Community and Inpatient Services are accountable for overseeing the implementation and review of the procedure.

Team and service leads will ensure that the implementation of the procedure is delivered within the context of team contractual arrangements and service specifications.

4. CLINICAL MODEL: CLARITY – THE DIAMOND MODEL

Service delivery in the Forensic division of Humber NHS Foundation Trust is underpinned by the Clarity clinical model. Clarity is a trauma-informed clinical care approach. Many service users have experienced trauma in their lives, and the teams

recognise that a trauma-informed way of working benefits all, even if they have not experienced a specific trauma. At its core, trauma-informed working involves understanding that people's life experiences impact on them in their current life, the model provides ways to support people with potential negative impacts of this. The model is underpinned by the five core-principles of trauma-informed care: Safety, Trustworthiness, Choice, Collaboration, and Empowerment.

Inpatient and community forensic teams will possess the knowledge and understanding of a trauma informed approach and integrate into all practice areas.

Inpatient and community forensic teams will embed the model throughout their care through the following means:

Values and Principles – Trauma informed theory and principles guiding practice.
Stages of Treatment – Safety and Stability, Understanding and Change, Strengthening and Applying.
Practice Domains – assessment, formulation, therapeutic interventions, and service culture.
Integrated Pathways –Inpatient, In-reach, ONCF, transition, discharge, community.
Quality Standards – service users experiences, need, risk, public safety, treatment, management, relapse, care planning collaboration, supervision, multi-disciplinary working, governance
Outcomes Measures and Evaluation – including (but not limited to) HoNOS, ReQoL, EssenCES, Core 10, NHSE data and Inequality data, service data, individualised outcome measurement.

5. PROCEDURES

5.1 Referral to Secure Inpatient Services

The Humber North Yorkshire Single Point of Access team (HNY SPA) will identify all referrals to inpatient provision. Where the referral is made to low secure provision the Community Forensic team will join the assessment to ascertain if a community alternative to inpatient care can be identified. Referrals will be discussed in the Humber Inpatient referral meeting.

The Single Point of Access team (HNY SPA) will identify all referrals for community forensic teams, referrals to the community will be discussed in the Humber Community referral meeting.

A senior clinical representative from the Community Forensic Teams will also attend HNY Pathway meetings, within this meeting patients placed out of natural clinical flow (ONCF) are identified. Community Forensic Teams will retain a knowledge of the ONCF caseload and monitor the requirement for Community Forensic Team involvement pending identification of potential discharge dates/plans.

The Community Teams will work with providers, service users and carers to retain a community focus to pathways of care.

The HNY SPA accepts referrals from a consultant psychiatrist or their delegated clinician, who has assessed the patient in their current setting (e.g., the local mental health unit or community setting) and who considers there is a clinical need for a referral to secure care. Community Forensic Teams will provide support to the current care team if required, to ensure that the referrer and SPA have all relevant information.

5.2 Access Assessment and Pre-Admission Planning

Referrals for an Inpatient Forensic access assessment will be received via the SPA into the Referral and Bed Management meeting, if appropriate for medium security, then the referral will be further discussed at the inpatient Multi-Disciplinary Team meeting (MDT). The MDT will allocate a minimum of two members of the inpatient MDT, one of whom will be the responsible clinician for the ward, the inpatient clinicians will complete the assessment. Where the referral is for low security the third assessor for the access assessment will come from a Community Forensic Team. The Community Forensic Team leader and low secure ward manager will ensure that the assessment is completed avoiding duplicate assessment times for the service user. All members of the access assessment panel will contribute to a clinical access assessment report with the aim of agreeing an outcome and plan. The timescales and the access assessment process is outlined within Adult Secure Mental Health and Learning Disability Inpatient Services, Access Assessment Guidance, (NHSE, January 2019).

The Community Forensic Team will bring a community perspective to the access assessment ensuring that discharge and step-down plans can be considered as part of the admission.

The Community Forensic Team will not usually have a role in pre-admission ward-based planning, the inpatient team will undertake this.

5.3 Admission

The Community Forensic Team will be made aware of the admission via the inpatient referral meeting, where the community team are in attendance. Community team members will not routinely be involved in the ward-based admission process.

5.4 Inpatient Assessment

Unless specifically requested from the inpatient MDT it is acknowledged that the community teams will not routinely be involved in the initial assessment period on the ward

5.5 Planned Intervention

It is acknowledged that the community teams will not be involved in providing intervention whilst an inpatient unless this is planned as part of a discharge process.

5.6 Crisis Intervention

Community staff have undertaken security training to support patient escorted section 17 leave from the ward where the need is identified, as part of a plan for community integration/discharge or as part of business continuity.

5.7 In-reach, Transfer and Discharge

All HNY patients with an Estimated Discharge Date of 12-6 months should be referred to the HNY SPA for consideration of Community Forensic team consultation. The SPA

will process the referral for the most suitable community team (locality based). The Community Forensic Team will then complete a consultation process, this will result in recommendations for the inpatient team in establishing a discharge plan. Not all service users leaving secure inpatient services will require a Community Forensic Team.

Where it is indicated an in-reach service for service users with an EDD or ETD of 12-6 months will be provided, this will be care planned and will involve joint working arrangements between the inpatient and community teams. Humber Community Teams will only provide in-reach to service users who are being discharged to the Hull and East Riding locality.

The in-reach process will be collaborative with inpatient staff and the service user, supporting a readiness for discharge from secure services. Individual in-reach care plans will be written by the Community Forensic Team in collaboration with the inpatient MDT. In-reach will include:

- Bringing a community perspective to the review of risk assessments and management plans
- Contribution to formulations and care plans with a community focus
- The production of an in-reach interim care plan to identify the support offered by the Community Forensic Teams
- Attendance at MDT to support a review of transfer and discharge plans
- Providing support to the ward with reference to criminal justice processes; MAPPA and victim related issues specifically in relation to discharge and transfer plans
- Spending 1:1 time with the service user to support the development of a therapeutic relationship and integration into the community, this can include facilitation of leave
- Identifying and supporting service user engagement with community groups.
- Enhancing skills of independence
- Spending time with family and carers to facilitate a successful transition to the community
- Community Forensic Teams and inpatient staff to liaise with partner providers in the community to facilitate an understanding of the service user needs.
- Working alongside the inpatient team to co-produce and review the relapse prevention /staying well plans before discharge.
- Working alongside inpatient team to complete the Integrated Care Pathway (ICP) and Discharge checklist.

- Support during extended period of leave (within the scope of the 9-5 Monday-Friday) in the context of the agreed care plan

Community Forensic Teams and the inpatient teams will work closely together with the service user and carers to facilitate a positive experience of discharge and transition.

6. COMMUNITY AND INPATIENT COLLABORATION IN MDT AND CARE PLANNING

Once it is agreed that the patient will be supported by the Community Forensic Team upon discharge, the community team will attend inpatient MDTs. Inpatient and Community teams will work collaboratively utilising inpatient and community experience and expertise to support the patient pathway. The specialist knowledge of community services will aim to support patient pathways to community care packages and services. The teams will work collaboratively to bring alternative perspectives to traditional step-down pathways.

7. LEAVE FACILITATION

Where it is established that the Community Team will be supporting the patient upon discharge, the Community Team can facilitate leave. Community staff will require security training to support the facilitation of unescorted section 17 leave. Service users can be supported on leave in staff vehicles where this is identified as safe by the MDT and where individuals are happy to transport the service user in accordance with the relevant Standard Operating Procedure Forensic Patient Leave and Movement.pdf (humber.nhs.uk).

8. TRAINING AND CLINICAL SUPERVISION

Community Forensic Teams and inpatient team leaders/ managers will work together to support team access to training and supervision. Opportunities to develop in-house training opportunities will be identified by team and clinical leads. All training needs will be identified in appraisal or by the service and accessed via applications to the Divisional Workforce meetings.

There will be a strength in development of supervision structures which span both teams in reciprocal clinical supervision arrangements.

9. COMMUNICATION AND ESCALATION

The care coordinator from the inpatient team and the planned care coordinator from the Community Forensic Teams will be responsible for maintaining timely and thorough communication regarding individual service users. This will include timely invites to meetings and notification of changes to care plans, for example in the event of a cancelled intervention or developments with a community plan.

It is accepted that Community and Inpatient teams will bring different perspectives to care planning, this should be encouraged and will facilitate a dynamic approach to individualised care planning. However, it is acknowledged that differing opinions can, on occasion lead to unresolved challenges. In the first instance an escalation will be resolved by discussion between the care co-ordinator on the ward and the care coordinator from the Community Team. If required, this can be further escalated to team leaders and further to respective inpatient and community clinical leaders and/or managers when required. Consideration should be given to holding a professionals meeting inviting key members from the MDT. Formal escalation procedures should be adhered to if the scenario is unresolved.

10. RECORD KEEPING

It is important that all actions and communications are recorded in the patient's electronic clinical record. Both inpatient teams and Community Teams utilise the electronic patient record.

11. REFERENCES

NHS England Adult Secure Mental Health and Learning Disability Inpatient Services, Access Assessment Guidance, 2019/20, (NHSE, January 2019)