Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
HUMBERSIDE COMMUNITY FORENSIC SERVICES

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1. BACKGROUND

This procedure is written to support regional delivery of community forensic services for adults across the Humberside region.

Prior to 2019 there was a national picture of inequality of provision for community forensic services, with some localities well served and others without a specific resource. From 2019, NHS England commenced with national focus and impetus on reducing inequitable service delivery and development of adult Forensic Community Services in the national pilot scheme for Specialist Community Forensic Teams (SCFT's; along with the continuing development of Learning Disability Forensic Outreach Liaison Services (LDFOLS).

As Humber and North Yorkshire Specialised Provider Collaborative we recognise the impact of the NHS England work which has been ongoing since 2019 and has overall reduced inequalities. However, across Humber and North Yorkshire we are aware there continue to be some variation in provision and inequality of access and subsequently this Standard Operating Procedure (SOP) has been developed to start to address current regional inequalities and support teams in the delivery of a high-quality specialist community forensic service.

As a Collaborative we recognise the importance of continued development across all forensic services, as community services continue to develop the standard operating procedure will require regular review.

The introduction of a new community Single Point of Access (SPA) will enable community teams to collate and analyse referral data. The implementation and function of the community SPA will be outlined within a Standard Operating Procedure (see Appendix 1)**.**

2. SCOPE

This SOP procedure applies to all providers of adult age community forensic teams within the Humberside region.:

- **Care Plus Group (CPG)** – LD FOLS (North East Lincs)
- **Humber Teaching NHS Foundation Trust (HTFT)** – SCFT & LDFOLS (Hull & East Riding)
- **NAViGO** – SCFT (North East Lincs)
- **Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH)** – SCFT & LDFOLS (North Lincs)

The SOP provides an agreed regional framework for community forensic services, it is acknowledged that each provider will require additional local guidance to support implementation.

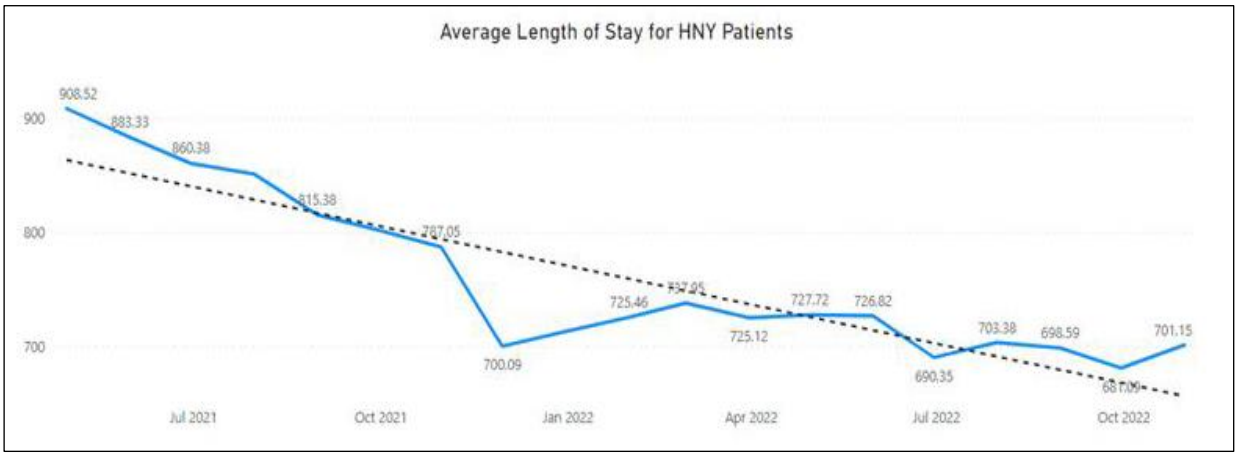
3. OVERALL AIM OF THE COMMUNITY FORENSIC TEAMS

The Community Forensic Teams will work in collaboration with partners, service users and carers to provide in-reach and specialist community support to reduce admissions and referrals to secure inpatient care as well as reducing length of stay in inpatient secure care.

Community Forensic Teams across Yorkshire & Humber have successfully supported the step down of service users to local communities from inpatient secure care settings. Community teams have contributed to the reduction in length of stay within Humber and North Yorkshire (HNY) inpatient services and aided in repatriating where is it has been clinically safe to do so service users who were in secure care services outside of HNY.

Discharge Destination	Discharges HCV Patients who were placed out of area	Discharges Patients who were placed within area	Total Number of Discharges
Local Authority residential accommodation	3	7	10
Non NHS Care Home	1	0	1
Prison	3	7	10
Temporary Residence	1	2	3
Usual Residence	12	22	34
Total	**20**	**38**	**58**

3.1 Table 1. Repatriation Data – October 2022.



3.2 Table 2. Average length of secure inpatient stay for HNY patients.

Since the introduction of the Specialised Provider Collaborative in 2021 a review has been undertaken and it has been agreed by all partners that the Community Forensic Teams will work together to address the inequalities in service delivery across the region.
The overall aims of the community forensic teams are:

- To provide specialist forensic consultation, assessment, intervention, and care coordination
- To provide an equitable and good quality service across the region
- To create timely transitions for service users from secure inpatient services to local communities
- To reduce the length of stay for those leaving secure services, through effective in-reach

- To develop effective relationships with partner agencies including the criminal justice system, mental health services, social care, housing, and the voluntary sector

- To evaluate the efficacy of the teams to support continuing service development

4. COMMITMENT TO TRAUMA INFORMED CARE DELIVERY

Most service users have experienced some trauma and adversity in their lives, and the teams recognise that a trauma-informed way of working leads to high quality services, based on 'doing with' service users and not 'doing to', this is helpful for everyone.

The community teams will seek to continue to develop and delivery community forensic services through co-production with involvement from people with lived experience. We are committed to further developing Peer Support Worker roles in our teams.

Community forensic services will adapt based on feedback and will develop to improve user experience and outcomes. We will focus service delivery on the needs of individuals as well as continuing to develop our trauma informed practice.

5. MODEL AND FUNCTION OF THE COMMUNITY FORENSIC TEAM

The model will ensure that non-forensic mental health services and service users are able to access timely specialist forensic advice and guidance. Where possible referrers will seek to gain consent from service users, this will require teams to consider and make a record of risk issues and the consequences of sharing/not sharing the referral with the service user.

The model will safeguard specialist resources whilst providing a high-quality service to service users, carers, referrers, and partner providers.
The teams will utilise a gate kept staged model:

A - Screening (A)

B - Consultation (B)

C - Specialist Assessment (C)

D - Specialist Intervention (D)

E - Care co-ordination (presently only SCFT) or Case Management (LDFOLS) (E)

The teams will receive all referrals through the community SPA. On receipt of the referral the community team may screen the referral as being inappropriate, in this event the receiving community team will send a letter to the referrer closing the referral and offering advice.

5.1. Screening (A)

All referrals received from the community SPA will have been administratively and clinically screened, this process will be outlined in the community SPA SOP (see Appendix 1). Referrers will retain overall clinical responsibility for the person they refer and assume a care coordination role from stage of A-D.

5.2. Consultation (B)

All referrals screened by the SPA will enter a consultation period, this will include referrals made for in reach (see in reach section below). Following receipt of the referral the consultation will be allocated to a clinical team member who should meet with the referrer **within 7 working days**. The purpose of the meeting will be to undertake the initial case consultation, feedback will be provided to the referrer with immediate advice.

The initial advice (consultation) process will focus on care and treatment planning to manage immediate and imminent risk alongside information gathering. Emphasis should be placed on imminent concerns and short-term risk mitigation, which can be supported by the referring professional. Based on the outcome of the initial advice and discussions it may be necessary to complete an enhanced level of consultation which will include:

- Revised or new formulations regarding risk, and the problems generally that the person, and the systems around them are posing.
- An opinion and recommendation about risk management from a specialist service.
- The opportunity to consider whether the person would benefit from direct assessment or intervention from the Forensic Community Team.

The consultation should then be presented back to a forensic community multi-disciplinary forum to decide as to whether further specialist assessment and/or intervention is required.

For all referrals at this stage a consultation report will be completed **within 4-6 weeks of the consultation being allocated**. If no further specialist forensic input is indicated a letter should be sent to the referrer and service user where appropriate, detailing the outcome of the consultation and any advice offered.

5.3. Specialist Assessment (C)

Specialist risk assessment will be considered when the consultation process has indicated that a forensic case formulation is not sufficient in understanding risk / need, and so further assessment work is required. The consultation recommendations and multi-disciplinary forum will identify appropriate assessments to be undertaken. These may include (but are not limited to):

- HCR-20
- VRS
- RSVP
- SVR-20
- ARMIDILO
- SAPROF
- SARA
- SRP
- PCLR
- IPDE
- MCMI

The specialist risk assessment will be allocated to a clinician to undertake the assessment. This will be based on training, experience, and capacity of the clinicians within the team(s).

The assessing clinician will review consultation documents and hold a discussion with the colleague who undertook the consultation if this would be of benefit. It may be that the consultation process has obtained a significant amount of the background information that is relevant to the case and will support the timely completion of the specialist risk assessments.

The assessing clinician will progress the assessment in line with the assessment procedure, meeting with both the client, family/carers (where appropriate) and other professionals. The assessing clinician will respond to any requests for updates on progress with the assessment and would be expected to raise at the earliest opportunity if there is a risk that they will not meet with the agreed timescales. The outcome of the assessment will be collated in a report within **16-24 weeks of the assessment being allocated.**

The specialist risk assessment should then be presented back to the referrer and service user where appropriate. A forensic community multi-disciplinary forum will decide as to whether further intervention, care coordination or case closure is required.

5.4. Specialist Intervention (D)

Intervention may need to be allocated to a different clinician, allocation will be based on training, experience, and capacity of the clinicians within the team(s). The aim will be to deliver intervention in partnership with the current care coordinator. Intervention will be limited to **6-12 months** and may comprise of, psychological intervention, Psychiatric treatment advice and/or occupational therapy. Specialist intervention will aim to reduce risk whilst supporting the service user to fulfil their aspirations. Intervention will seek to increase confidence in risk management for the service user, care coordinator and other community service providers.

On the completion of the intervention period, a decision will be made by the multidisciplinary forum as to whether longer terms case management (LDFOLS) or care coordination (SCFT) is indicated.

A formal report will be completed which summarises the intervention period and recommendations made; this will be completed within **6 – 8 months of the intervention being allocated. Easy read reports will be available dependent on service user needs.**

5.5. Care Co-ordination and case management (E)

Each provider will adhere to local guidance for care coordination and case management. A decision to discharge a service user from the community forensic teams will be made within a forensic community multi-disciplinary forum.

6. DISCHARGE FROM CARE COORDINATION

Prior to discharge the following should be completed:

- A full review of the HCR-20 (or similar structured professional judgement risk assessment dependent on risk profile)
- Full review of any other relevant risk assessments
- Care plan fully reviewed, and interventions completed

- Formulation completed and discussed at MDT
- GP information sent
- Outcome measures completed
- Discharge summary report completed – this should include information from each professional discipline involved as well as a summary of the formulation and risk management information.
- Transition plan between services completed
- CPA meeting held within 1 month of discharge

7. IN-REACH

Referrals for in-reach will be managed through the same model as described above. As the service user will be an inpatient it is important that their readiness for active in-reach support is assessed through a formal consultation process and a review of existing risk assessments and intervention. If the patient is not ready for discharge within 6-12 months, the consultation process should make clear recommendations to ensure readiness prior to the service user being re-referred. For patients identified as having a learning disability or autism, it is suggested that an in-reach period may need to be longer than 6-12months dependent on service user need and complexity.

8. DATA COLLECTION, ANALYSIS AND PRESENTATION

Since 2019 data regarding the community teams' function has been limited. It will be the role of the Data Manager within the community SPA to provide the teams with data which reflects demographic and case stage data. The data will support service development providing information which will identify training needs, workforce development and identify trends in terms of locality needs.

The data will be collected by the SPA team and will be reported to the HNY Operational Group, the data will also be available to all providers for governance and audit purposes. Each team will utilise internal audit processes to ensure all services are provided to a high quality.

9. TEAM SUPPORT AND TRAINING

There will be a whole system approach to accessing staff support and training across the region. Teams will facilitate opportunities to share lessons learnt from clinical cases. There will be an opportunity to explore clinical supervision and reflective practice across the wider region. It is acknowledged that accessing training as a regional group is likely to reduce costs and encourage cross team learning as well as ensuring there is a sustainable approach to maintaining core skills across the region.

10. STAKEHOLDER EVENTS

There will be 6 monthly regional stakeholder events to ensure that stakeholders are informed about the team's function and development. Data will be presented in this forum

as well as presentation of case studies and information about referral processes. The events will be evaluated and will develop to meet stakeholder needs.

11. SUMMARY OF DESIRED OUTCOMES

The model described in the SOP will bring a consistent and high-quality service for service users across the Humberside region. Forensic Community Teams will provide specialist advice and guidance to community and inpatient providers. It is anticipated that the model will provide data which informs service and workforce development. It is assumed that the model will continue to develop through regular review and stakeholder feedback. The model seeks to provide a high quality and consistent service to patients with complex needs.

12. SOP REVIEW

The SOP will be reviewed at 6 monthly intervals, this will be informed by operational meetings, contract discussions and learning from clinical cases. As the community teams are relatively new it is anticipated that the SOP will need to develop dependent on the experience of service users and regional teams. The SOP is authored by the host provider and owned by the teams within the provider collaborative.

Appendix A – Forensic Single Point of Access (SPA) SOP

Forensic - Single Point of Access (SPA) SOP23-016