

STANDARD OPERATING PROCEDURE BRIDLINGTON, DRIFFIELD & HOLDERNESS COMMUNITY MENTAL HEALTH TEAM FOR OLDER PEOPLE

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

CHANGE RECORD

Version	Date	Change details
1.0	5 July 2023	<i>New SOP. Original document written 12 December 2018 and frequently updated but formally approved as a Trust SOP at MH Division Practice Network Meeting on 5 July 2023.</i>

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1. Team Vision

The Bridlington, Driffield & Holderness Community Mental Health Team for older people collectively share a commitment and passion in caring for patients, their families and carers (formal and informal).

We are clear about the values that we share which are in line with our various codes of practice and conduct for all professional bodies:

- Innovating patient safety
- Enhancing prevention, wellbeing & recovery
- Fostering integration, partnership & alliances
- Developing an effective and empowered workforce
- Maximising efficient & sustainable organisation
- Promoting people, communities and social values

Trust Values - Caring, Learning, Growing.

Trust Vision: We aim to be a leading provider of integrated health services, recognized for the care, compassion and commitment, of our staff and known as a great employer and valued partner.

2. Context

Our Team is part of a multi-speciality provider Trust working toward providing excellence in primary, community care and secondary mental health services through both integration and joint working. Our Older People's Mental Health Services are a sub-speciality group of clinical, managerial and support staff working specifically with older people (to include providing advice or expert clinical input into younger people with dementia or associated frailty) within the wider mental health service. The service is delivered in conjunction with other services within the Trust, including Mental Health Response Service, Crisis and Intervention Team for Older People, Inpatient Units, and Psychological Wellbeing services.

Bridlington, Driffield & Holderness OP CMHT is based at East House, St Johns Avenue, in Bridlington and Rosedale Community Unit in Hedon. The team provides community mental health services for adults aged 65 years and over who are experiencing severe and complex mental health problems. The team also provide care to those patients under 65 who have a diagnosis of a cognitive impairment and/or recognised frailty that contribute to or complicates the management of their mental illness. Further information can be found in the Transition of Care between Working Age Adult and OPMH Services procedure.

The team works closely with key stakeholders internal and external to the organisation which includes; service users, carers and if required family members, primary care services, and other local statutory and non-statutory agencies, to deliver responsive and high quality care.

The Trust is committed to providing high quality care delivered in a timely and responsive manner to our local communities. In doing so we will also make the most effective and efficient use of resources.

3. Commissioning Arrangements

The service is commissioned by the East Riding Clinical Commissioning Group (ER CCG).

4. Partnership Working

The team covers a wide area and provides services for people living within the boundaries of several NHS Trusts.

4.1. Key Partners

General Practitioners, acute medical trusts (this may include Hull and East Yorkshire Hospital) local authorities, ER CCG.

4.2. Additional Partners

Voluntary sector; residential care homes; nursing homes; Alzheimer's Society; Red Cross; Humberside Fire and Rescue Service; Humberside Police and many other local and other services.

5. Overall Purpose

The team's purpose is to provide a caring, supportive and holistic service to promote recovery and improve the lives of patients who are experiencing either functional mental health problems or neurological conditions (e.g. dementia), and their families. We aim to provide comprehensive assessment of health and social care needs allowing shared interventions and treatment that are agreed collaboratively with our patients, in their best interest and in the least restrictive manner.

We aim to promote independence and care in the community wherever possible taking into account the needs, wishes and advanced statements of our patients and carers.

6. Team Aims

To improve the lives of older people with functional mental health problems or neurological conditions (e.g. dementia) by:

- Providing comprehensive assessment and treatment.
- Education and advice to care providers formally and informally.
- Promote a recovery focused approach and utilise the least restrictive option.
- Consideration of pharmacological / non-pharmacological interventions, recovery-focused approach and psychosocial interventions relative to patient need.
- Working collaboratively in partnership with other health and social care professionals and carers.
- Recognition of the needs of the carer, as well as the person they care for.
- Enabling carers to develop their skills and expertise as caregivers.
- Facilitating a seamless transition between services when needed.
- Continue to promote continued personal and professional development with our staff group.

7. Staffing and Resources

7.1. Staffing

Discipline	Grade	WTE
Locum Consultant Psychiatrist Bridlington		0.6
Consultant Psychiatrist Holderness		1
Team Leader covering both Bridlington/Driffield & Holderness OP CMHT's	B7	1
Clinical Lead covering both Bridlington/Driffield & Holderness OP CMHT's	B7	1
Registered Mental Health Nurse covering both Bridlington/Driffield & Holderness OP CMHT's	B6	2.8
Occupational Therapist covering both Bridlington/Driffield & Holderness OP CMHT's	B6	0.8
Registered Mental Health Nurse covering both Bridlington/Driffield & Holderness OP CMHT's	B5	4.6
Assistant Practitioner Occupational Therapist covering both Bridlington/Driffield & Holderness OP CMHT's	B4	1.0
Healthcare Support Workers covering both Bridlington/Driffield & Holderness OP CMHT's	B3	2.6

The clinical staffing group work across both Bridlington/Driffield OP CMHT and Holderness OP CMHT to ensure timely response to patient referrals and to support staff skill mix. The team also includes other professionals to ensure we can meet the holistic needs of our patient group. This includes psychiatry, psychology, physiotherapy, and administrative staff to include medical secretaries and domestics.

Profession Role

Nurses Community

Physical and psychiatric nursing care; community assessments and interventions; care coordination; Mental Health Act / Mental Capacity Act assessments; nurse prescribing; clinical leadership; initial assessment; ongoing assessment; support planning; follow-up; care programme approach (CPA) coordination/case management, discharge planning, safeguarding.

Specialist Occupational Therapists

Areas of work include: Providing specialist assessment of function including where necessary to support diagnosis; Writing specialist treatment plans; Assessment for and provision of aids and adaptations to enhance independence, where the patient needs are such that local authority occupational therapists would not be as well placed to meet the need; Work as a care co-ordinator (as per protocol).

Consultant Psychiatrists

Provide: Mental Health Act / Mental Capacity Act assessments; complex assessments and interventions; prescribing; supervision and advice to team members; clinical leadership; Consultant assessments and reviews, advice on difficult clinical issues; ensuring seamless transition when junior medical staff change; other doctors' initial assessment; ongoing assessment; specialist assessment/management and follow-up advice on difficult clinical issues and diagnosis.

Psychologists

Provide clinical leadership; initial assessment; specialist assessment and management follow-up; discharge planning; will be involved with a range of psychological interventions based on the initial formulation and activities, including neuropsychological assessment and rehabilitation; from face-to-face patient work with individuals and families, group work; co-working; skills-sharing; teaching; supervision; audit; research and service developments.

Primary Care Network Clinicians

Provide primary level mental health interventions for anxiety and low mood (functional patients). Attend weekly MDT's to ascertain the appropriateness of referrals to their service ("step down referrals") and they can also "step up" to CMHT input where appropriate.

Nursing Associates

The nursing associate role contributes to the core work of nursing, freeing up senior nurses to focus on the more complex elements of clinical care.

Provide clinical tasks such as depots, blood retrieval, supporting patients and their families when patients are diagnosed with significant diagnoses. They also complete information gathering from care home settings and can act as the initial contact within the team.

Associate Practitioner Occupational Therapy (APOT)

The Band 4 APOT role is a relatively new role within teams and, as such, is still developing.

Support workers

Provide essential physical health care; therapeutic interventions; monitoring role functioning; providing emotional and practical support; encouraging social participation and inclusion through time limited interventions which are care planned; occupational therapists initial assessment; specialist assessment / management follow-up, contribute to MDT discussions in relation to their patients, escalating concerns to qualified staff members in relation to patient's presentation.

Physiotherapy provision

Offer individual patient centred care to people who, due to complex mental health problems, are unable to access mainstream physiotherapy services. We are able to provide assessment and treatment to people in their own homes (including residential and nursing homes) and during admission to mental health inpatient units, within Hull and East Riding of Yorkshire. Physiotherapy staff can assist in discharge planning from hospital and can provide follow up treatments once the patient is at home.

The general aim is to work proactively with other professionals / local authorities to ensure the patient is receiving appropriate and necessary care. These teams include, the Falls Team, primary care services, Community Rehabilitation Team, Intermediate Care Team, Long Term Conditions Team and end of life teams, including Dove House Hospice.

Occupational Therapists (OTs)

Are an essential part of both community and inpatient teams working as integrated members of the teams. The function is to assess and treat complex patients with functional and organic mental health problems in a holistic way addressing physical as well as mental health needs. Then work as part of the team providing individualised evidence based assessment in their homes, care homes and in community locations. OTs also work very closely with families, home carers,

residential and care homes, involving them in assessment and interventions to ensure the best outcomes for the patient.

OTs also aims to enable the person to participate in their valued routines and occupations enabling and protecting their recovery which improves quality of life and prevents or slows down return to services.

OTs work in partnership with a wide variety of professionals and third sector partners including GP's the local authority, care homes, wheelchair services, NRS, Alzheimer's society, MIND, Age UK, leisure services, to name but a few.

7.2. Resources

The team is based across both East House in Bridlington and Rosedale Unit, Hedon. Out-patient clinics are held in these buildings, in addition to Alfred Bean Hospital in Driffield and ground floor rooms are available to see patients on site. We can also offer carer support and education on site if not possible to facilitate within the home environment or should patients exercise personal choice.

8. Hours of Operation

The team primarily operates Monday to Friday between the hours of 9am to 5pm (excluding Bank Holidays) but flexibility of working hours around patient carer need can be accommodated.

9. Service Model

The clinical model is to manage the care of older people experiencing either functional mental health problems or neurological conditions (e.g. dementia).

The service will provide appropriate and comprehensive assessment. In the case of a determined and identified functional mental health need, the patient will be provided with regular evidence-based interventions relevant to their condition and an individualised care plan will be completed and reviewed every six months. Examples of assessments that can be completed are: Recovering Quality of Life (REQOL), Generalised Depression Scale (GDS), Short Anxiety Screening Tool (SAST), Liverpool University Neuroleptic Side Effect weighting Scale (LUNSERS).

Those with functional complex emotional needs will be supported in conjunction with psychology, who offer support in the development of management and containment plans. These plans will ensure that patients get an appropriate and consistent response from OPMH services. In the event that the support identified within the developed plan is not available for a patient for a period of time (for example, should the allocated care co-ordinator be on leave), a clear plan will be discussed in the MDT, regardless of the impact on risk to ensure consistency and ongoing support to the patient in their absence. 'MDT Care Planning: Good Practice Guidelines' should be utilised, which prioritises the inclusion of others with additional skills/knowledge where clinically useful (this may include specialist therapies, the Complex Emotional Needs Service (CENS), for example.

Whereas in the case of the identification of an organic and complex need, Stokes Model of unmet need could be a possible indicator for care delivery and advice, as can the Pool Activity Level Assessment. The Addenbrookes Cognitive Examination (ACE) is also completed in cases where levels of cognition need to be measured and a diagnosis of dementia is being sought.

Non-pharmacological interventions that are delivered are anxiety management, sleep hygiene, coping with emotions, pain management, relaxation techniques, behavioural activation, self harm management and suicidal ideation distraction techniques.

With pharmacological treatments we provide regular face to face, Microsoft Teams and telephone reviews of patient's to monitor for any adverse effects and this information can then be brought to MDT for discussion and actioned accordingly.

We provide information to carers/families/relevant others to support care in the community whilst maintaining the patients' quality of life and respecting their values and beliefs. The service will share information where appropriate with other agencies to assist in interventions and support discharge back to primary care services.

Treatment decisions will be fair and transparent. This translates into the adoption of the following key principles:

- Patients/service user's will be seen according to clinical priority and then in chronological order, subject to operational limitations.
- Patients/service user's choice will be facilitated where appropriate
- Patients/service user's referral to treatment pathway will be defined by the service specification agreed with commissioners.
- Management of patients/service user's will be fair, consistent and transparent and communication with patient/service user's and/or carers will be clear and informative and decisions taken regarding treatment will be based first and foremost on clinical need which will be agreed within a robust multi-disciplinary approach.
- Patients/service user's will be advised as to whom to contact at the CMHT in relation to discussing the progress of their referral.
- If the patients/service user's chooses to wait longer for a particular service, this choice will be considered and all parties informed.

We support patients who are being initiated on, and who are already established on Clozaril, and undertake the additional level of monitoring this requires (see Clozapine SOP for further details). Bloods are collected by our trained phlebotomists either at patients home or at suitable clinic base in purple vials. Patients name, NHS number and DOB label to be attached to the vial and placed in clear plastic specimen bag. Vial will then be transported that same morning to Adult CMHT in Bridlington for them to process sample in Pochi machine. Adult services then email clinical leads to inform of result in addition to the East House Mail Box address: HNFTR.EastHouseMailBox@nhs.net.

Duty worker role

There is an allocated duty worker and back-up duty worker each day that are qualified members of staff, available throughout the day to receive and screen referrals, pick up emergency visits, cover sickness and depot injections, and assist in coordinating the day in terms of staff safety and lone-working.

Wait list management

In delivering the aspirations of 'right care, in the right place at the right time' we must do all we can to keep waiting times and the numbers waiting for a service to a minimum and manage this in a clear and structured way.

A reduction in and management of waiting times are important because:

- The patient/service user's condition may deteriorate while waiting and in some cases the effectiveness of the proposed treatment may be reduced.
- Risk to self and others may increase
- The very experience of waiting can be extremely distressing in itself.
- The patient/service user's family life may be adversely affected by waiting.
- The patient/service user's employment circumstances may be adversely affected by waiting.

All accepted referrals are allocated on a weekly basis within the team MDT across all disciplines Band 5 and above. In situations where our wait list time exceeds the 4 week expected waiting time for allocation and intervention, we would then attend the 2 weekly wait list management meetings facilitated by the Service Manager to discuss rationale for the excessive waiting times and develop a plan to address this. All unallocated patients will be contacted on a regular basis (timeframe determined by risk and circumstances) by the duty nurse to enable any patients to be reprioritised if required in order to ensure patient safety.

Should patients/service users be added to a waiting list, this would be monitored, in partnership with the Performance Team and reported accordingly detailing the current position for the waiting lists for their service. It will be the responsibility of the Team Leader/Clinical Lead to review and update the Trusts electronic waiting list reports on a weekly basis.

10. Referral Procedures

The team receives referrals from the Older People's Mental Health Triage Service. These are then screened and if appropriate accepted for allocation on a weekly basis following MDT.

Referrals will be accepted into CMHT within three months of discharge without a patient needing to go through the triage service.

The services that can refer directly into CMHT

- Memory Service
- HTFT Inpatient/Community services
- Out area CPA transfers
- Humber Prison Services
- Mental Health Liaison
- Primary Care Network

The OP CMHT will accept clinical referrals electronically through Lorenzo from the above.

Referrals from teams within HTFT must include the following as a minimum standard:

- Risk assessment
- Cluster review where relevant
- Mental Health assessment form including formulation and identified treatment plan and for social care referrals relevant background and reference to complexity.

In the case of out of area referrers, out of area services, Prisons and Forensics, the specific assessments listed may be replaced by service specific documentation.

All referrals will be reviewed by the receiving Duty Worker before being accepted.

Management of New Referrals

All new referrals to the team will be reviewed on a daily basis by the Duty Worker. A discussion will be undertaken regarding all new referrals via the weekly Multi Disciplinary Team Meetings. These are attended by a Consultant Psychiatrist, Nursing staff, Physiotherapy, Psychology and Occupational therapy. This is to ensure the patient/service user's needs are acknowledged and that any differences in clinical/professional opinion in relation to the referral are discussed. Any urgent referrals and or clinical/professional disputes will be addressed by the Team Leader. There may be occasions where it is felt the team require additional referral information that cannot be gathered, or is difficult to gather by telephone. In these circumstances it can be difficult for the

MDT to identify a clear plan of care and the Duty Nurse and/or Consultant Psychiatrist may wish to do a face to face triage either in clinic or at the patients home. This can also reduce inappropriate referrals reaching the point of assessment should there be no mental health need identified.

All referrals received by OP CMHT will be recorded by administrative colleagues and allocated to the access plan. Following receipt of the referral the patient/service user will be forwarded correspondence to advise of the position of the referral and contact telephone numbers for routes to safety. In the majority of cases, referrals will operate under a 'next on list' allocation system however, they will be reviewed upon clinical/presenting need and priority should they not receive an assessment within the time frame of 4 weeks they will be reviewed by telephone. From the point of acceptance of the referral the individual is classed as being under the care of the identified team and can contact the Duty Worker between the hours of 9am-5pm Monday to Friday (excluding Bank Holidays) should they need to discuss their care further.

Once-only assessments

Should a patient be assessed and it deemed that they are not appropriate for secondary CMHT, a comprehensive GP letter is required to explain the rationale for this and signposting should be completed where appropriate.

Referrals to CITOP

Should it be felt that a patient is at risk of significantly deteriorating mental health, CMHT are able to refer to the CITOP for additional support. Referrals to CITOP are required when CMHT need to consider inpatient admission as CITOP are the gatekeepers for admission. Admin would create a referral on Lorenzo to CITOP after a preliminary discussion has taken place. The care coordinator would update the FACE, care plan and complete a face to face visit with the patient where possible, prior to referral to CITOP.

Once intervention and treatment within CITOP is near to completion, the patient is placed in the Amber/Green zone. The CITOP worker contacts the Care Co coordinator by telephone to arrange a joint visit for a discharge meeting where possible. The CITOP will contact the patient to confirm the meeting time and date.

Where possible, all parties attend the joint discharge meeting; if it is agreed by all that the patient can be discharged completely from the service they will be transferred back to the care of their GP. The Nurse from CITOP will update the FACE, Cluster and sends a letter to the GP within the agreed KPI of 72 hours.

If it is agreed by all that the patient will remain in the care of the CMHT the patient is handed back to the Care Coordinator. The nurse from CITOP will update the FACE, Cluster and sends a letter to the GP within the agreed KPI of 72 hours.

The Care Coordinator will update the care plan and agree with the patient a visit by a qualified member of staff within 72 hours of discharge from the CITOP.

11. Contact and Accessibility

The team can be contacted at the following address/telephone numbers:

Bridlington and Driffield CMHT
East House
38 St Johns Avenue
Bridlington
YO17 4NG
Tel: 01262 458220

Staff can be contacted on the above numbers between 9:00 and 17:00 Monday to Friday. An answerphone is available for out of hours' messages it also gives redirection details for emergencies/crisis.

12. Discharge

Patients are discharged following a multi-disciplinary review meeting when their treatment is complete and their care transferred back to primary care. Their care can be "stepped down"/transferred to the Primary Care Network (PCN) where necessary. This would entail an MDT discussion with the PCN worker.

In cases where a complete discharge from mental health services is appropriate, the care coordinator will update the FACE, care plan, cluster and complete a GP letter stating the CMHT interventions that have been provided and the follow up that will be required from the GP.

13. Involving Patients, Carers and Families

Patients who have experienced our services at first hand, their families and carer(s) are best placed to help us develop, monitor and improve services. To help us better understand the quality and effectiveness of our services we collect information about the service including; complaints, compliments and contribute to the national Friends & Family Test surveys. The organisation has a complaints service, which helps us to listen to patients, their relatives, carers and friends.

The team carries out bespoke surveys, at the initial meeting and reviews and on discharge. The Care Group takes opportunities in its developmental work to assess patient, carer and family feedback through a specific Patient and Carer Experience Group.

14. Training and Staff Development

All staff Employed by Humber Teaching NHS Foundation Trust receives regular Clinical Supervision and an annual Performance and Development Review (PADR). This incorporates statutory and mandatory training as a means to support continuous professional development. Medical staff in particular has access to regular weekly Continual Professional Development (CPD) and annual job planning meetings.

Our organisation views clinical and professional development as essential and continues to work pro-actively with higher and further education establishments to plan for and review pre-and post-registration requirements for all professionals. Training can also be accessed via a mixture of profession specific update courses, conferences and internal multi-agency developments, workshops and training sessions.

Training cards are being developed via the Functional Pathway working party under the umbrella of the NHS 5 year plan for service development; this covers all bands of staffing.

Staff are encouraged to participate in and attend Continuing Professional Development days.

All staff have established link roles within the team to develop their skills and knowledge and subsequently improve patient outcomes and care.

Appendix 1 – Clozapine Clinic SOP

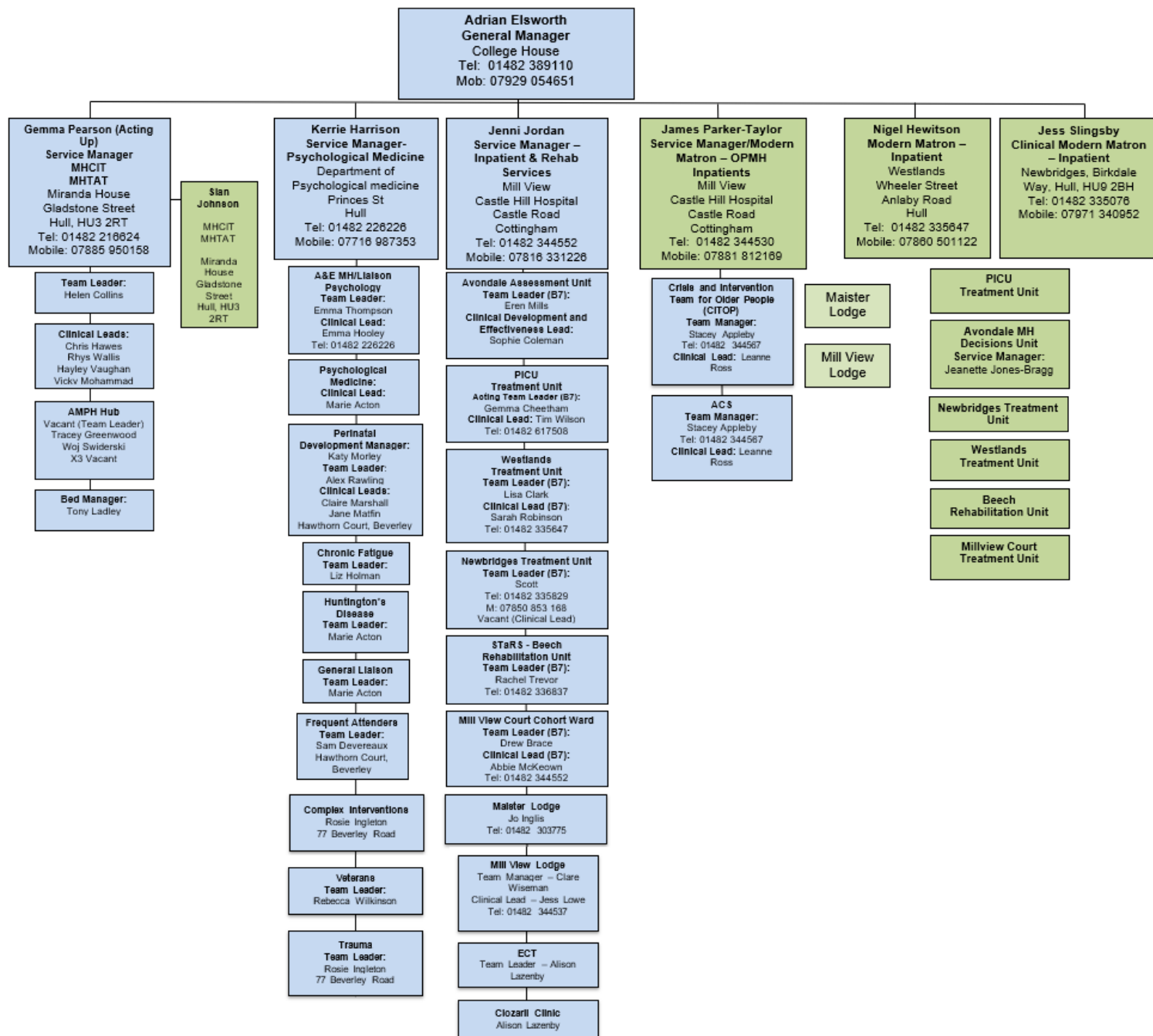
[Clozapine Clinic SOP \(SOP19-011\)](#)

Appendix 2 – Divisional Structure

[Humber Divisional Structure](#)

Appendix 3 – OPMH Unplanned Care Services Structure

Unplanned Care - Mental Health Services Division



Appendix 4 – OPMH Planned Care Services Structure

Planned Care – Older Peoples Mental Health Teams

