STANDARD OPERATING PROCEDURE
EAST RIDING INTEGRATED COMMUNITY MENTAL HEALTH TEAMS AND PRIMARY CARE MENTAL HEALTH NETWORKS

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

CHANGE RECORD

Version	Date	Change details
1.0	*Aug 2022*	*New SOP. Approved by MH Division Practice Network (03.08.2022).*
1.1	*03/01/2024*	*Reviewed. Amends made re: SI 2023-3491 Action 13 (page 32) and SEA 2023-10 Action 3 (page 34). Approved at Mental Health Practice Network (3 January 2024).*
1.2	*17/4/2024*	*Minor change to clarify 'Step ups' needs to be at the point of agreement/clinical discussion not a future date due to the escalation of need/risk. (page 30) SI 2023 18270. Amends made to adress PSIA 2023-03 action 1 (Update on paragraph 4.9 on page 35) action 2 (Update on paragraph 4.9 page 33), action 3 (Update on paragraph 4.3.1 pages 19, 20, 21), SI2023-15948 action 2 (Update on paragraph 4.3.1 pages 19, 20, 21, paragraph 4.15 page 39, 40, 41), action 4 (Update on paragraph 4.3.9 page 24) and SI 2023-11201 action 5 (Update as above).* ***Also to note:** PSII 2023-19764 action 3 (SOP to be reviewed twice a year or following significant change to processes).* *Approved at Mental Health Practice Network (1 May 2024).*

Contents

1. INTRODUCTION

Nationally, Community Mental Health Teams (CMHT) have been recognised as a vital part of mental health services. For many people with mental health needs and their family and carers, they are essential.

The Community Mental Health Framework for Adults and Older Adults 2019 sets out a new place-based community mental health model providing multidisciplinary services across health and social care aligned with primary care networks. This new model breaks down the current barriers between: (1) mental health and physical health, (2) health, social care, voluntary, community and social enterprise (VCSE) organisations and local communities, and (3) primary and secondary care, to deliver integrated, personalised, place-based and well-coordinated care.

The service will enable people with mental health problems to be supported to live well in their communities, to maximise their individual skills, and be aware and make use of the resources and assets available to them. This will help them stay well and enable them to connect with activities that they consider meaningful, which might include work, education and recreation.

The service works closely between professionals in local communities to eliminate exclusions based on a person's diagnosis or level of complexity and avoid unnecessary repeat assessments and referrals.

The East Riding Integrated Community Mental Health Teams (CMHT) and Primary Care Mental Health Networks (PCMHN) Standard Operating Procedure (SOP) aims to support the delivery of care for community-based service-user/clients.

Humber Teaching NHS Foundation Trust (HTFT) and East Riding of Yorkshire Council (ERYC), provide an integrated health and social care service in the CMHT to individuals with a Serious Mental Illness (SMI).
SMI is a smaller and more severe subset of mental health problems with SMI defined as; one or more mental, behavioural, or emotional disorder(s) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (NIMH).

Humber Teaching NHS Foundation Trust (HTFT) and East Riding of Yorkshire Council (ERYC), will work in partnership with the Primary Care Networks (PCNs), the Local Health Trusts and voluntary sector providers to deliver seamless support for people with primary mental health conditions and their families/carers, ensuring delivery of improved service user/client outcomes.

Care will be centred around an individual's needs and will be stepped up or down based on need and complexity, and on the intensity of input and expertise required at a specific time. provide an integrated health and social care service in the PCMHN.

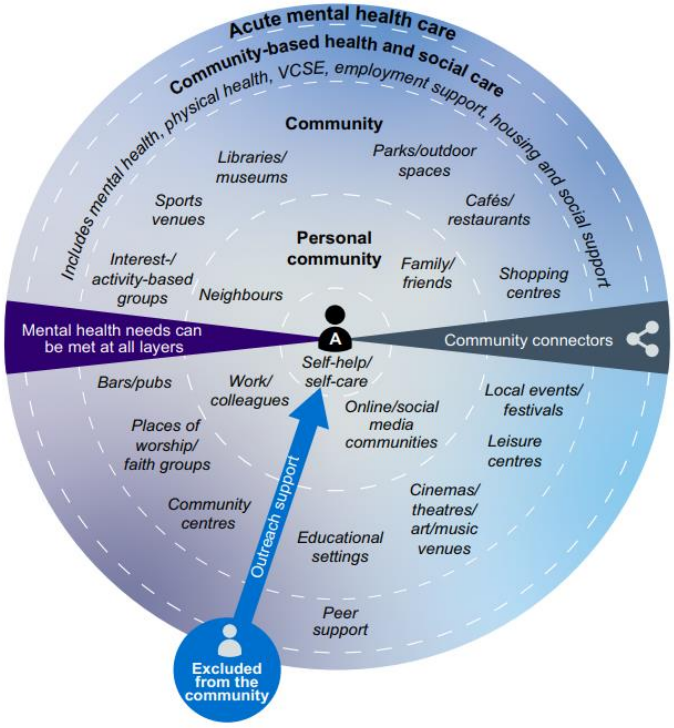
This document aims to provide operational procedures for the safe and effective day to day running of the service, ensuring equity across locality, and puts collaboration with the service user/client and their family at its heart.

The Community Mental Health Framework for Adults and Older Adults (2019), sets out the ambitious transformation of community mental health care with the objectives of:

- Delivering care in a place-based way
- Tackling health inequality
- Utilising the power of communities
- Reducing barriers and variations in care
- Improving access to appropriate care
- An ease of moving between services as required

This document aims to support the delivery of these objectives, alongside other implementation initiatives including the replacement to Care Programme Approach (CPA), the Four Week Wait (4WW) to intervention guidelines and integration of additional Service user/client Recorded Outcomes Measures (PROMs) into the service user/client journey.

The importance of a collaborative health and social care integrated model is demonstrated in the figure below, taken from the Community Mental Health Framework for Adults and Older Adults (2019).



This shows how mental health needs can be met by many layers, from the personal resources of the individual to their local community of friends, family and networks, up to acute level mental health care. The person moves between their layers of support depending upon their needs at the time, and as a community mental health provider, the aim is to provide care and support when required, but to also link individuals into community support which will help with their recovery and long-term wellbeing, helping to keep people well for longer.

The British Medical Association (2014), Closing the Gap (2014) and The Kings Fund (2016) suggests that integration with Primary Care can play an important role in ensuring that people with mental illnesses receive equitable access to care across the system and that building relationships with Primary Care is a crucial component to build a closer connection between mental and physical health. Implementing a new service model will be an effective way of supporting the large number of people presenting with mental health needs, often

alongside a mixture of physical illness, substance abuse problems and complex social circumstances.

The teams are underpinned by the requirements, responsibilities and principles of The Care Act 2014, and the introduction of a care and support system aimed at being clearer, fairer and fit for the future. The focus is on people's wellbeing, and on supporting them to live independently for as long as possible. Existing policy objectives around prevention, early intervention and personalisation have been consolidated, and new statutory responsibilities around individual well- being, prevention, information and advice, advocacy and carers will inform the structures process and practice in the team.

The Care Act 2014 details that the Local Authority have a duty to make enquiries, to safeguard any 'vulnerable adult' living in their area or cause out this duty. This relates to adults living in the area, who have care and support needs, and due to those needs (whether the Local Authority are meeting the needs or not), cannot protect themselves from abuse or neglect. The Care Act 2014 also details that the person who knows the person well, is best placed to conduct enquiries. Whereas Social Workers can lead on championing safeguarding within the CMHT, this is not exclusive to social care staff, and is a responsibility of any workers within the CMHT.
It ensures holistic and supportive interventions and promotes wellbeing, a preventative approach to reduce reliance on formal care and considers the whole person utilising their strengths, communities, support networks to be able to achieve positive outcomes that are person centred, and encourage people to live independently for as long as possible.

When looking at person centred and holistic care, staff need to ensure that they 'Think Local Act Personal'. The person should receive the right support at the right time with planning to manage change and emergencies and be supported to access other services and be transitioned safely and with joint working approaches before closure.
If the person referred into the Adult CMHT refuses to engage or presents with contributing factors i.e., alcohol, substance misuse, hoarding presentation etc but presents a 'risk' to self/others, a VARM needs to be considered. This can be discussed with the safeguarding team and managed within the CMHT. Humber also have a safeguarding team for advice however the LA is the responsible body for sharing safeguarding concerns. This needs to be done, to ensure the Safeguarding Adult's Board have oversight into all concerns in the area.

Existing policy objectives around prevention, early intervention and personalisation have been consolidated, and new statutory responsibilities around individual well- being, prevention, information and advice, advocacy and carers will inform the structures process and practice in the team. This includes completing assessments, support plans, and reviews under The Care Act, and also includes the safeguarding of vulnerable adults, again under The Act

The Accreditation for Community Mental Health Services (ACOMHS) Standards for Adult Community Mental Health Services (2015) embraces the diversity represented by the range of community mental health services and is designed to be applicable to all adult community mental health services. ACOMHS facilitates quality improvement and supports teams to achieve accreditation.

ACOMHS standards refer to three categories:

- Type 1: criteria relating to service user/client safety, rights, dignity, the law and fundamentals of care, including the provision of evidence-based care and intervention.
- Type 2: criteria that a service would be expected to meet

- Type 3: criteria that is desirable for a service to meet, or criteria that are not the direct responsibility of the service.

The overarching principles of the ACOMHS Standards have been used within the aims and objectives of the service. The suggested Standards have been utilised within the setting of this standard operating procedure.

The integrated nature of the community mental health services across East Riding of Yorkshire provides increased flexibility to meet the needs of our local populations and reduce the need for internal referrals between services, with a reduction in service-user/client having to have unnecessary assessments when moving between primary and secondary care mental health services.

Adult Social Care's unique contribution to an integrated CMHT and PCMHN teams ensures holistic and supportive interventions that are in line with Care Act 2014 which promotes wellbeing, preventative approach to reduce reliance on formal care and considers the whole person utilising their strengths, communities, support networks to be able to achieve positive outcomes that are person centred

This SOP aims to support the service to meet the health and social needs of individuals with mental health problems, and their families, to improve their lives and to enable their personal recovery. This will be achieved by a multidisciplinary, community-based model of service, with a clear aim of working closer with other agencies and partners including Voluntary, Community and Social Enterprise (VCSE). It is fully integrated with health and social care staff and delivered as part of a whole system of community mental health care.

The key aims of the service are:

The teams will work as a dual sided service with PCMHN's focusing on wellbeing, prevention and mental health concerns of a mild to moderate level and the CMHT focusing on the population who present with moderate to severe mental health challenges. There will be a fluid approach to service user/clients being able to move between the two parts of the service via a step up/step down process that will reduce the waiting times and need for repetitive assessments.

- The CMHT/PCMHN will be a needs led, recovery focussed, intervention and intervention service and therefore is not limited by specific diagnostic criteria.
- The clinical team will strive toward the achievement of clinical excellence, service user/client safety and regulatory assurance.
- Provide a multi-disciplinary service, which will provide timely bio, psycho-social assessment, diagnosis, and intervention for people with complex mental health needs.
    a. Service-user/client can be stepped up/down between the primary/secondary care elements of the team as their needs change to ensure we provide the most effective and appropriate service for them.
    b. With this approach, service-user/client only 'step up' to more intensive/specialist services if it is considered the right thing to do clinically.
- Provide a person-centred approach that advises on appropriate intervention, information, care and support and empowers people with complex mental health difficulties and their carers to make informed decisions about care which helps maximise quality of life
- Provide family inclusive interventions.

- Provide advanced assessment & interventions based on the analysis and formulation of the individual presentation and diagnosis. Interventions will follow local care pathways and evidence-based practice.
- Provide expert risk formulation and robust safety plans that are person centred and family inclusive. Promote positive decision making as part of a therapeutic approach.
- Provide intensive case management of service-user/client with severe mental illness who are deemed high risk and have significant safety issues who may also have Mental Health needs. This may include Ministry of Justice restrictions or be managed under the Multi-Agency Public Protection Arrangements
- Work within the expectations of relevant legal frameworks such as the Mental Health Act and the Mental Capacity Act
- Understand and work in partnership with all local resources relevant to the service-user/client group and to promote effective interagency working. This will include commissioning services through individual/personal budgets, promoting access to the Recovery College, and working with a range of third sector providers(VCSE)
- Provide effective assessment and care management and access to social care services, in line with the requirements of the Care Act (2014), through personalisation and self-directed support, promoting choice and control
- Use a range of approved outcome measures, review service user/client feedback and promote positive service user/client experience. To ensure systems are in place to monitor quality of the services.
- The service will aim to promote recovery and support the maintenance of a person's wellbeing and promoting good psychological health strategies to reduce the risk of relapsing to poor mental health by making sure people are referred to appropriate services in a timely manner
- Reduce the reliance on institutionalised care and empower people to live independently, emphasising the least restrictive option. Enabling the service user/client to be cared for at home or within their community.
- Improve the physical health of service-user/client to reduce premature mortality in people with severe mental health needs.
- Work in partnership with GP and Primary Care, to develop a seamless service
- Continually review the development of service specifications, business plans and service level agreements with service-user/client, commissioners and other providers to ensure responsive, flexible, cost-effective quality service within a culture of competing priorities
- Offer service-user/client, their carers and families the opportunity to take part in research studies they may be eligible for

The key objectives of the service are:

- Ensure the service emphasis is on inclusion rather than exclusion criteria.
- Ensure that the practice of team members is Recovery focused and aligned to Trauma Informed care
- Integration of services resulting in an ease of access facilitated by a streamlined, responsive referral pathway. Facilitate ease of access to an integrated service using a streamlined and responsive referral pathway
- Focus on the needs of service-user/client, their carers and families as opposed to an emphasis on exclusion. Self-harm, substance misuse, social background, criminal history, learning disability or personality disorder are not barriers to acceptance by the service.

- Ensure the service is readily accessible and meets the range of needs of the service-user/client group
- Provide appropriate evidence-based interventions in line with national guidelines and intervention pathways
- Ensure service-user/client and, if required, their carers have appropriate information that allows them to manage their care more effectively along the pathway and understand how to access other assistance
- Ensure service-user/client and, if required, their carers are supported to access local sources of advice and community support through social care and the voluntary sector
- Ensure that services are responsive to the needs of service-user/client whose partners / family members are also in receipt of mental health services
- Engage service-user/client in decisions about the care options available to them, including the development of Personalised Care Plans and Personal Budgets
- Ensure continuity of care across the pathway and integration with other health and social care providers
- Ensure the service is delivered in a considered, timely and co-ordinated manner
- Ensure service-user/client, carers and families are informed about research available to them

2. SCOPE

The Humber Teaching NHS Foundation Trust and East Riding of Yorkshire Council provide an integrated health and social care, community mental health service. This SOP covers all community mental health teams in East Riding of Yorkshire, offered in collaboration by the providers. The scope of the SOP aims to address the following:

The teams are based on the following underpinning principles:

- Prevention and personalised support for all.
- Recovery focused principles aim to ensure better service user/client outcomes and improved service user/client safety so enabling service-user/client to reach their potential and live well in their community.
- Right Care, Right Quality, Right Place, Right Time
- Clinically Led – Operationally Managed
- We aim to be recognised as a leading provider of integrated health services, recognised for the care, compassion and commitment of our staff. We want to be a trusted provider of local healthcare and a great place to work. We want to be a valued partner with a problem-solving approach.

The fundamental standards of the Care Quality Commission, including the five key questions:

1. Are they safe? - People are protected from abuse and avoidable harm
2. Are they effective? - People's care, intervention and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
3. Are they caring? - Staff involve and treat people with compassion, kindness, dignity and respect

4. Are they responsive to people's needs? – our services are organised so that they meet people's needs
5. Are they well-led? - Leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture

The service is for individuals who are 18 years of age or older; in some cases, CMHT/PCMHN support may commence for individuals prior to their 18th birthday who are in the process of transitioning from Child and Adolescent Mental Health Services (CAMHS), in line with the Trust's CAMHS transition guidelines. Furthermore, transitions to and from adult and older adult community mental health service will be on a needs led basis, but generally speaking the services named in this SOP operate for individuals to the age of 65, or no upper age limit for PCMHN.

The Care Act 2014 places a duty on the Local Authority to offer an Adult Care and Support Assessment where it appears that an adult may have needs and to promote wellbeing and independence. The eligibility threshold for adults with care and support needs is set out in the Care and Support (Eligibility Criteria) Regulations 2014.

In East Riding of Yorkshire, there are five distinct CMHTs which include; Haltemprice and North Bank Villages, Goole, Beverley, Holderness, and Bridlington & Driffield. In addition, there are seven PCMHNs: Harthill, River and Wolds, Yorkshire Coast and Wolds, Holderness, Beverley and Cygnet.
The PCMHN's are aligned to PCNs (acting as a catalyst for a direct link between the PCN and mental health services) and CMHT's and should work as a united unit as part of those teams. Some PCMHN's cross barriers of different CMHT's however this should not be a barrier to collaborative team working.

Mental Health Services in the East Riding are commissioned to provide services to residents within the boundary of the East Riding Local Authority and registered with an East Riding GP.

Each locality team will be aligned to designated GP practices within the areas. Overlap can occur as teams will be mindful of the service user's address.

This SOP should be used to support the day-to-day delivery of safe and effective care for all substantive, bank or agency team members and students who are working alongside team member. This SOP is aimed at individuals working on behalf of HTFT and ERYC.

There are specific guidance manuals which support this SOP (one for the CMHT and one for the PCMHN)which provides specific instructions, and additional advice on processes, systems and support for policies, standards or procedures.

The following list of professionals in not exhaustive but cover general staff groups the SOP should support the practice of, within the area of CMHT/PCMHN:

- Leadership and Management team
- Administrative team
- Social Workers/Social care team
- Medical team
- Nursing team
- Occupational Therapy team
- Psychological professions
- Pharmacy team

- VCSE team
- Peer support workers

These individuals may be employed by HTFT or the VCSE sector. Individuals will cover a range of bandings and this SOP is for those from band 2 to band 8a, depending on their function within the team. Additionally, other staff members who are providing care may not be on an Agenda for Change contract and therefore will not be banded.

3. DUTIES AND RESPONSIBILITIES

The teams are managed through a single integrated management structure and comprises a variety of disciplines across both primary and secondary care mental health service provision.

The Trust is committed to the value of leadership, recognising the significance of leadership in all care settings. This is reiterated in recent reports into the failings of various health systems (Francis, 2013, Berwick 2013) and has resulted in calls for more effective leadership. See mental health brochure for more details on roles as this list is no exhaustive.

Service managers – The service manager is the budget holder and responsible for the service meeting their performance indicators. The Service Manager will act as line manager for band 7 team leaders and clinical leads, providing management supervision as per the supervision structure and operational management with the support of the Senior Clinical Lead as appropriate.
The service manager holds ultimate responsibility for the operation of the service, working closely with the team manager to facilitate and enable this. The service manager will report directly to the general manager of the division.

Senior clinical leads – The senior clinical lead works closely with the service manager to ensure the service area is meeting the aims and objectives of the service, providing high quality, safe and effective care to the population. The Senior Clinical Lead will provide Clinical Supervision to all Clinical Leads within the CMHT's and PCMHN's as per the supervision structure.
The senior clinical lead will work directly with the clinical leads to deliver the service and will report to the divisional clinical lead.

Team Managers/Leaders/Clinical leads & Senior Social Workers – Responsible for the day to day operational and professional/ clinical management of the CMHT/PCMHN. Promoting a clinically led, operationally supported approach. They shall also share in the responsibility of supporting KPI management, performance, accountability and assurance with the Service Manager.
The Clinical Lead Practitioners and Team Leaders have different roles and responsibilities but will be jointly liable for the accountability and assurance of the service. It is important that the line management structure has clear lines of accountability within the service, and it is essential they work alongside each other to achieve the aims and objectives of the service, with the clinical lead focussing on Professional/clinical delivery, effectiveness and safety, and the team manager focussing on the wellbeing of the workforce and team performance.
The Senior Social Workers- are the social care leaders within the CMHT localities. They oversee allocations to social care staff with the manager and clinical lead, and manage complex caseloads. They will provide supervision for social care staff, and ensure a strong social care presence within the multi-disciplinary teams. They work alongside the manager and clinical lead to ensure the effective running of the team.

The Leadership team will ensure the service meets the needs and requirements for both the HTFT and ERC.

Administrative team – The administration team provides administrative and clerical support to the team and is often the first point of contact for service-user/client and family when contacting the service. The admin team will be responsible for the data quality and caseload management on the electronic service user/client record, in conjunction with the team managers, clinical leads and service managers.

Consultant psychiatrist/medical team - The consultant psychiatrist does not carry their own caseload of service-user/client and have clinical oversight for the service-user/client open to the team. The role of the consultant psychiatrist in the CMHT/PCMHN is to provide clinical leadership and expertise from a clinical medical perspective. Duties include, but not exclusively:

- Involvement in the team MDT discussion about service-user/client who are open to the team and input into their individual plans of care
- Involvement in the transfer of care discussions for any service user/client open to the team
- Review of medications or to provide medical consultation on individuals accessing the teams, providing urgent appointments where required for relapse prevention or crisis mitigation
- Apply a triumvirate approach to Clinical Leadership and quality with the CMHT's, working closely with the Service Manager and Senior Clinical Lead as part of the Senior Leadership team to achieve this.
- To provide clinical involvement with CTO requirements, ministry of justice requirements, Court reports and other relevant legislation and to ensure a 3 month Consultant follow up appointment is made with the service user/client following transfer of care of CTO.
- To provide care with colleagues in partner agencies in line with Trust Shared care protocols i.e. General Practitioners

Registered nursing team – Registered nurses provide a key worker role, in promoting and delivering evidence-based care for service users with mental health conditions within CMHT/PCMHN. The nursing team will follow their code of conduct and professional remit to provide well-coordinated care and therapeutic interventions based upon a collaborative and individual care plan.

Nursing Associates
Will work supporting particularly with physical health-based interventions, acting as a link between primary and secondary general health care teams.
Will support with mental health interventions within the remit of their capability and knowledge and according to their own registered standards and professional code.

Refer to Scope *of Practice for Registered Nurse Associates SOP23-036*

Social workers - Social workers place a strong focus on prevention and early intervention using a strength-based approach that considers all aspects of a person's life using the principles of the Care Act (2014) and supporting people's choice, control and human rights. Social workers are experts in the application of relevant legislation and have statutory responsibilities in relation to the Mental Health Act 1983, Mental Capacity Act 2005, Care Act 2014 and Human Rights Act 1998 and safeguarding. Social workers are integral to multi-disciplinary teams and provide a range of interventions to support people to achieve

sustainable recovery, through effective transfer of care pathways, where they have independence and their transfer of care from services is long term.
Social workers should refer to the guidance and procedures relevant to their work and the ASC operating manual below.

Social Care Officer– Care officers also have a strong focus on The Care Act principles as above. They hold the role of a Care-coordinator/Keyworker and plan and provide an effective range of social care services and interventions for adults, their families and carers, who are impacted by mental health difficulties and issues. They also complete Care Act 2014 assessments and reviews, and They work alongside the other MDT members to ensure people have holistic support. They work with a person centred and strengths based approach.

Psychological professions – Psychological professions include psychologists, mental health and wellbeing practitioners who are responsible for providing evidence based psychological assessments, formulation and interventions for people accessing CMHT/PCMHN. They will also provide psychological intervention and psychoeducation groups as part of their core function within the community service.

Approved Mental Health Professionals (AMHP) - AMHP's are mental health professionals who are approved by the Local Authority to carry out certain duties under the Mental Health Act.

They may be:

- Social Workers,
- Nurses,
- Occupational Therapists,
- Psychologists.

Please refer to the AMHP Agreement in relation an AMHP's commitment to the AMHP Service and in relation to Training and Approval.
AMHP's in the East Riding are employed by the East Riding of Yorkshire Council. They work closely with the CMHTs, and attend MDTs within the locality they work.

Also refer to National workforce plan for approved mental health professionals (AMHPs) (publishing.service.gov.uk) which also contains the National AMHP Service Standards.

Occupational Therapists (OT)
An Occupational Therapist is a registered member of the Health and Care Professionals Council (HCPC) which, along with the Royal College of Occupational Therapists (RCOT), sets standards of practice to maintain registration. Occupational Therapy staff can include qualified therapists as well as Occupational Therapy Technical Instructors, Assistants and Support Workers.

The focus of occupational therapy is the human need to engage in meaningful activity of all kinds and the interaction of this with a person's health. Occupational Therapists believe in the power of engaging in occupations as a means of change: what we do alters who we are. The 'doing', that is the basis of therapy, can be any occupation, whether that be self-care, leisure or productivity.

Occupational therapists are skilled in assessing activities and an individual's ability to engage in them, including their physical, emotional, psychological, cognitive and perceptual skills. This knowledge is combined with assessment of the social and physical environment in which an activity is taking place to help individuals move towards a better fit between what

they can/want to do and the context in which it is undertaken. This leads to better functioning, satisfaction and recovery.

Non-Medical Prescribers (NMP) – NMPs are individuals with a core profession who have completed additional training in the area of medicines prescribing. NMPs can provide additional medicines review resources into teams, within their scope of practice and competence. All NMPs are governed by local NMP policy and SOP.

Pharmacists/pharmacy technicians - Pharmacy support within the CMHT/PCMHN is a developing role to support with safe and effective use of medicines and a key role in ensuring appropriate medicines use and addressing needs of polypharmacy and inappropriate medicines use.

Mental Health Wellbeing Coaches (MHWBC) - The role of the MHWBC is a hybrid role taking elements of a health trainer along with building community links to address and focus on the mental health and wellbeing needs of service-user/client, whilst using the recovery star to support the intervention. The role will support individuals to move from 'surviving to thriving' through non-clinical interventions.

Support, Time and Recovery (STR) worker – STR workers support and provide interventions to individuals under the guidance of a registered clinician. STR workers take an active and lead role in facilitation of the groups programme in CMHT/PCMHN.

Peer Support Workers - Peer Support Workers provide support, encouragement and signposting based on their lived and learned experience. Their role is to establish the Mental Health recovery needs of the individual they are working with to enable them to continue on their recovery path to become an integrated member of the community. They will provide this support on an individual centred basis. They are not there to provide clinical care.

4. PROCEDURES

This is detailed instruction which must be followed, or steps which must be taken to implement the document.

4.1. Team structure, purpose and inclusion

The aim of the teams is to provide a seamless, integrated health and social care, community mental health service. Community mental health services have different levels of intervention, providing a range of intervention options at primary and secondary care level. Community services in East Riding work collaboratively and are fully integrated with the ER LA . The CMHT and PCMHN work closely together and are strongly interwoven. The community mental health services covered within this SOP are part of a wider offering of mental health care in the locality, including via other statutory providers, NHS Talking Therapies, specialist mental health services, third sector and VCSE.

This SOP relates to a service which provides interventions and support to individuals with a Serious Mental Illness (SMI). SMI is a smaller and more severe subset of mental health problems with SMI defined as; one or more mental, behavioural, or emotional disorder(s) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (NIMH).

For individuals to be eligible for interventions and care via the community mental health services, they should demonstrate needs which are covered by the definition above and needs which are not best met by other providers. For example, and individual may have a history of SMI, but be seeking talking therapy for a co-occurring anxiety problem without

complex needs which would be eligible for care via NHS Talking Therapies. Furthermore, an individual may have a history of SMI, but the problem they are seeing support for is for substance misuse without a core mental health element or complex need, therefore their needs are best met by the local substance misuse agency.

The service user/client should be registered with a local GP or live and have ties to the local area, to be eligible for support with the local team. However, there may be times when a service user/client is not registered or living in the local area but remains under the service for social care needs as they have 117 entitlement or eligible care needs under the Care Act. Additionally, the service user/client may be accessing a specialist placement out of the local area, where the continued provision of community mental health service is required from the team.

The community mental health service will not hold an exhaustive list of inclusion or exclusion criteria, however each referral will be considered on its own basis, taking into account current presentation, historical information, the service-user/client wishes and risk assessment. Local community mental health services are often best placed to know what services are in the local area to meet the needs of the population, using best evidence to support with decision making.

The service offers two degrees of intervention, both at primary and secondary levels. Both levels of service are designed and commissioned for those individuals who display having a serious mental illness, the difference in which level is more appropriate to meet the needs of the service user/client links more into their individual and identified needs, the complexity of the needs and presentation, and the risk associated with this.

- The primary care level would usually be more appropriate for those individuals who have less complex presentation, have a lower level of risk and have limited identified needs which can be treated consecutively rather than concurrently. Furthermore, the level of engagement of someone accessing the primary care level intervention needs to be demonstrated as the team is unable to provide an assertive outreach approach. The PCMHN provides short term and brief interventions over roughly 12 sessions in a 3-month time frame.
- The secondary care level would usually be more appropriate for those individuals who have more complex presentations with interplay between different symptoms, moderate to more severe risks, and those who have multiple needs which require concurrent interventions and a warp around service. The secondary care level can provide a more assertive approach over a longer period of care.
- Both levels of service require the identification of needs which can be met by the team and not met by another, more appropriate agency.

The service will operate in the main Monday to Friday between 9 am and 5 pm. Outside of these hours, service-user/client can be supported the Mental Health Crisis Intervention Team (MHCIT). A service offer leaflet is available on the intranet and internet for service-user/client and carers clearly outlining the Trust's MHLT offer. This is suitable for learning disabilities, sensory impairment and is available in different languages.

All bases have their own contact details and team email addresses, including staff having their own smartphone for work use also.

4.2. Referral into the service

Referrals into the community mental health services may come from several pathways. Referrals may be received by the primary or secondary care intervention teams (PCMHN/CMHT); however this should not pose a barrier to intervention and service-

user/client care should step up or step down through the intervention level as per their presentation, risk and care needs, without the need for additional assessment or unnecessary delays to their care.
For further detail please see the CMHT or PCMHN Service guidance

4.2.1. Referrals from MHTAT/MHLS/MHCIT

The majority of referrals received into the community mental health services come via the Mental Health Triage and Assessment Team (MHTAT), Mental Health Liaison Service (MHLS) and Mental Health Crisis Intervention Team (MHCIT). The MHTAT service is a routine triage and assessment service, whereas MHLS and MHCIT are unplanned services who respond more urgently to service user/client needs. It should be acknowledged an assessment is an snapshot of information in the context of the time and place the assessment happens, therefore the assessment may be more about understanding needs and risk to inform the intervention plan, rather than the full history and presentation of the service user/client being comprehensively assessed an understood at this initial stage.

All three services will complete a collaborative and holistic assessment of mental health needs and consider what support is required for individuals to meet their needs. Consideration will be given by the assessing clinicians for services who may be best placed to meet the needs of the service user/client which are outside the community mental health service. However, if the service user/client is presenting with an SMI and complex needs of which there is a core mental health element, which require community mental health services, they can refer to the local community mental health service via the following procedure, which replaces the 'trusted assessor model'.
This revised pathway puts more emphasis on collaborative working between the referring and receiving teams and also on collaboration with the service user/client to review their needs prior to alteration of the agreed outcome from assessment.

- The assessors identifies needs through the assessment which are not best met via another service and require intervention through the community mental health service. Specific interventions should not be offered to the service user/client at the assessment stage, but should focus on need and why the community mental health service is best placed to meet this need.
- The service user/client is consenting and agreeable to a referral to the community mental health service
- The assessor has considered historical information, intervention and engagement within service
- Up to date and relevant documentation is completed by the assessor including the; initial mental health assessment, FACE risk, mental health clustering tool, AUDIT, DAST, ReQoL and other tools identified as appropriate at the assessment stage. If the documentation is not completed or to an acceptable and defensible standard, the receiving team may decline the referral until this has been addressed.
- An electronic referral will be made via the electronic service user/client record to the receiving team
- The receiving team will review the assessment documentation within their MDT and consider what pathway the service user/client should be placed on according to their needs identified. This discussion and outcome should be captured on the service user/client record to accurately recount the decision-making process and rationale for such.
- If the receiving team agrees with the outcome/plan of the assessment, the referral is accepted and allocated to the right pathway
- If the receiving team does not agree with the plan/outcome of the assessment, the receiving team will make contact with the referring team to discuss the referral prior

to acceptance. This is to gain further information and to enable to a clinical discussion to take place to aide the decision making.

- If the receiving team does not agree with he plan/outcome of the assessment and wishes to redirect to a more appropriate service, this must be completed in consultation with the service user/client and outcome shared with the referrer to support learning.
- Decision making should primarily occur on a team to team basis with escalation to team managers, Senior Clinical Leads and Service Managers should no resolution be reached.

If a service user/client comes to the attention of the MHCIT/MHLS or MHTAT within 12 weeks of transfer of care from the community mental health services, a full assessment may not be required, but a review of the needs and update of the risk assessment, mental health cluster tool and ReQoL may be sufficient to support a referral back to the team. It should always remain at the discretion of the assessing clinician if a full assessment is required based on the change in needs and presentation since last engagement, however outside of 12 weeks the episode of care should be treated as new and complete assessment should be completed.

The local community mental health teams are completing routine referral screening for MHTAT, which may yield an outcome of the team agreeing to open a referral without the need for initial assessment taking place. This should be completed at the discretion of the team, but would be considered good practice for people who have been recently transfer of cared who's needs remain largely the same as the previous care episode, or where the team is best placed to offer intervention/signposting and going through an assessment is deemed unnecessary or causing delays to care.

4.2.2. Referrals from inpatients/home based intervention (HBT)

Service-user/client may be admitted to inpatient services or offered home based intervention following an assessment and may not be currently receiving care from the community mental health service. During this period of care, the acute care team will consider if a referral to the community mental health service is required. .

In East Riding, the inpatient and HBT services will contact the team to discuss a potential referral, where the internal transfer form will be completed to capture this discussion. If the referral is accepted, an electronic referral should be made to the receiving team via the electronic service user/client record. Once received, the receiving community mental health service should complete acceptance and allocation within 2 working days.

Due to the recent acute mental health needs of this group of service-user/client and the heightened risks they may continue to present with, referrals to the community mental health service from acute services should be prioritised for allocation to the individual who will be providing their main intervention.

If a referral is declined from the community mental health services, this should be clearly documented in the service user/client notes including the rationale for the decision making. If there continues to be disagreement regarding the referral, this should be escalated to the clinical leads initially and then further to the modern matron/senior clinical lead.

The 3 day follow up is a vital component of transfer of care planning, which is in response to increased risk following transfer of care from inpatient services. Responsibility for completion of the 3 day follow up should be carefully considered if the service user/client is unknown to community mental health services and engagement may be improved if the inpatient team held responsibility of this. For service user/clients with a risk of suicide, this must be carefully

considered due to the known increase in risk in the days that follow transfer of care from an inpatient services
In most cases, unless directly stipulated otherwise by the service user/client, 3 day follow ups should be completed face to face, particularly if there is a risk of suicide.

4.2.3. Transfers from internal CMHT and other HTFT teams

Internal Transfers between CMHT and other HTFT teams
Internal transfers should be from other community mental health services due to the service user/client moving areas or reaching the end point of intervention in the case of Early Intervention in Psychosis, should not cause a delay or break in their intervention.
The referring team should contact the appropriate community mental health service to discuss the transition of care and complete an internal transfer form to support the discussion and decision making. The receiving team withhold the right to challenge the referral and use their local knowledge to support with alternative care plans which may be more appropriate to meet the service user/client needs. Should the two teams disagree about appropriate care, escalation should occur to the clinical leads and then senior clinical leads as required.

Please refer to MDT Care planning Guidelines C425

For transfer of care to take place, the referring team should be able to clearly demonstrate a continued need for community mental health service, have an up to date care plan, FACE risk, mental health clustering tool and service user/client recorded outcome measures.

The referring team should inform the receiving community mental health service as soon as possible so the transition of care can be appropriately planned, with a period of shared care agreed upon in the best interest of the service user/client and completion of interventions. Service-user/client should be allocated directly to their new clinician, without re-entering a waiting list. There should be no set time frame on transition, but this would be expected to be completed in most cases within 3 months.

Where someone is in receipt of a social care package/provision, the original team may retain responsibility over the care package or 117 entitlement, but the healthcare provision is transferred to the new team. This aspect should not delay the transition of healthcare but should be clearly identified in the transition process who has the responsibility for what aspects of the service user/client's care plan.

4.2.4. Transfers from external mental health providers

If an external community mental health provider is seeking to transfer care to the local community mental health services, the referral should not go via an initial assessment service such as MHTAT. Referrals from these services should be made directly to the local community mental health service and a transfer of care organised between the teams in the best interest of the service user/client.

For transfer of care to take place, the referring team should be able to clearly demonstrate a continued need for community mental health service. Should the two teams disagree about appropriate care, escalation should occur to the clinical leads and then senior clinical leads as required.

If a transfer of care is agreed from an out of area provider, the service user/client may be unknown to local mental health services, therefore will require registering onto the system, new care plan, FACE risk and mental health clustering tool be completed by the receiving team within 4 weeks. The receiving team should request and upload relevant information from the previous team onto the system for historical accuracy.

4.2.5. Referrals from GP to PCMHN

GPs can directly access mental health wellbeing coaches and clinical leads within their PCMHN, aligned to the PCN. The MHWBC or clinical lead will arrange the first appointment and determine if their/PCMHN intervention is appropriate, or if they are to step up into the CMHT or signpost into other services. Further details of processes are in the PCMHN Guidance.

4.3. Interventions in the service

If a referral is appropriate for intervention via the community mental health service, the service user/client will be allocated a team member to work with as soon as possible, in their allocated care pathway. Interventions in the service should always be collaborative, service user/client centred, involving the family, non-judgemental and trauma informed.

Evidence supports how appropriate interventions delivered as soon as possible enable the best outcomes. The organisation is committed to the four week wait to intervention, therefore an individual should be engaged in their intervention within 4 weeks of the referral to the collaborative care plan completed with the appropriate SNOMED code to stop the clock.

Intervention should be provided by the most appropriate clinician for the intervention required either at primary or secondary care level, with adequate levels of supervision.

Primary care level intervention – The PCMHN model is to provide proactive and preventative mental health support and care to people who present with mild to moderate mental health concerns. The care needs of the service user/client accessing this support should be defined, have lower levels of complexity with low to moderate levels of risk. The PCMHN will provide brief interventions for the identified care need and look to step into other community resources which can support the service user/client in their community longer term. The aim of the PCMHN is to work into primary care, providing interventions for those with reduced levels of need, providing lower level interventions for a higher number of people.

Secondary care level intervention – The CMHT model is to provide an intervention for individuals with a serious mental illness, who present with complex and multiple needs who require more wrap around care. Individuals accessing CMHT will likely have moderate to high levels of risk and require a longer period of intervention from multiple professionals. The aim of the CMHT should be to treat identified needs, providing episodic care to empower the service user/client to live as functionally and independently as possible, rather than life long care.

In both levels of intervention, the clinical leads will provide clinical oversight and recommendations of which level of intervention a person will require from their identified needs and risk. Allocation of intervention level should always be based upon their presenting problem and what their goals of intervention are.

4.3.1. Initial Allocation-

<u>Supportive intervention contacts</u>

Intervention should never be unnecessarily delayed and should commence as soon as possible. If a service user/client cannot be allocated for intervention initially, they should be allocated to a registered clinician within 5 working days, for commencement of supportive intervention contacts. The clinician will complete a collaborative care plan and arrange the care and support required with the service user/client, prior to intervention commencement, at a minimum of a contact every 4 weeks, up to weekly. This contact can be completed by the registered clinician or an unregistered clinician with appropriate supervision and guidance from a registered staff member. The registered clinician should agree appropriate review points during this phase of intervention with the service user/client but should be

completed at a minimum of every 4 weeks. The care plan should be shared with the service user/client and family and include appropriate safety netting information to support the service user/client and family with any deterioration in their mental health or possible crisis.

Should the needs of the service user/client change whilst awaiting intervention, the registered clinician will urgently review the needs and the risks of the service user/client and based upon clinical priority either expedite the allocation to intervention or arrange acute care. Prioritisation must be in response to the level of presenting need and risk. Conversely, should the needs and risks of the service user/client decrease, formal review of this should take place, with appropriate plans to meet the needs put in place. The reviewing clinician should use the MDT where needed to support with any decisions about escalation or reduction in care required, documenting clearly in the service user/client record the rationale for the decision to change priority status of the care and updating the core documentation i.e. FACE risk and care plan.

Within the first 4 weeks of a referral being accepted by the team, the following should be completed:

- Review of assessment information and any unidentified or unmet needs
- A review and if required, update of the FACE risk assessment
- A collaborative and comprehensive care plan
- Completion of service user/client recorded outcomes measure baselines
- Long term goals and routes out of service/transfer of care planning
- Agree a frequency of contact, safety plan and review of the needs of the family/carer with appropriate signposting/onward referral
- Review and update of the next of kin and service user/client protected characteristic information

4.3.2. Caseload

In terms of care co-ordination responsibilities, staff may carry a caseload of 30+ (in the CMHT) this is based on capacity, productivity information linked to roles and job planning, which may indicate a higher or lower number on caseload.
Caseload sizes, however, should not be based purely on a number, but consideration given for additional roles such as AMHP/NMP/Family Interventions/Therapy etc,., complexity of cases and any other additional duties the staff member has such as running groups, supervision, statutory work on behalf of the local authority and mentoring.
Regular clinical and professional supervision should aim to identify those people on caseloads who are appropriate to transfer following intervention being completed or the service user/client disengaging, people who require additional support or different intervention, and identify the capacity each service user/client needs, which will help determine case allocation.

The care coordinator/key worker will be responsible for (but not limited to) the oversight of the service user/client's care journey in service, identifying, with the support of the MDT, other interventions which may be appropriate, making onward referrals, and ensuring care plans, FACE risk assessments, mental health clusters and other appropriate documentation remains up to date and relevant at all times.

In allocations, Consider the rationale and specific functions that a Social Care member of staff will discharge in this allocation. Namely, is the allocation appropriate for Social Care staff and can they lead with Care Act statutory responsibilities and demonstrate Care Act outcomes? Can they combine the requirements under Care Coordination to meet social outcomes for people.

Reallocation of cases – if the main allocated worker of the service user/client is absent from work due to sickness for 14 calendar days or more, the service-user/client on this caseload will be reallocated to other team members to continue providing the care plan and prevent a break in intervention. If the absence is short term, up to 14 days, the service-user/client on the caseload will be notified of the absence, either via direct telephone contact or letter, alongside the routes into the team for support whilst their worker is unavailable. Planned absence of 14 calendar days or more will be discussed directly with the clinical lead for consideration of reallocation according to individual needs and associated risks of the service user/client.

4.3.3. Access plans

The use of access plans are available for service-user/client awaiting a specific intervention option. Service-user/client should be placed on this access plan, notified of this and plans in place for review as required, considering earlier sections of this SOP.

4.3.4. On going CPA/Care planning/Documentation standards

CPA

As per national standards all community mental health service service-user/client will be offered an annual review of their care if they are managed under the provision of the Care Programme Approach (CPA). Care co-ordinators are expected to empower the service user/client to be fully involved in care planning and also to prepare for the review of their care and intervention plan. The allocated worker will be responsible for maintaining an up-to-date caseload and appropriate and timely review of documentation, in collaboration with the service user/client, family and other professionals involved.

The service user/client will have access to independent advocates to provide information, advice and support, including assistance with advance statements and CPA Reviews. Outcome of CPA Reviews will be discussed with all parties, recorded and circulated to the GP.

At the time of publication of this SOP(January 2024), the Care Programme Approach (CPA) remains the framework used in the community mental health service and wider organisation to review and plan appropriate care for this on the secondary care caseload. Not all service-user/client on the caseload of the community mental health services, receiving secondary care level interventions are required to be monitored on CPA, however those who are and are not held on CPA should be regularly reviewed in line with the CPA standards SOP/policy.

Further CPA guidance and assurance this is completed at a minimum of annually is located in appendix one.

Please see CPA policy for further information

The organisation is making steps to move away from CPA and towards person centred care planning, under the community mental health framework initiative. This move will be one of the most significant policy changes to occur in mental health in recent times and aims to ensure holistic needs and met in collaboration with the service user/client and their family. Outside of the minimum expectation for CPA review annually, CPA review should also take place when clinically indicated through step up or step down in care provision.

<u>Care planning and FACE risk</u>

Furthermore, care plan and FACE risk review should take place at all transitions in care, annually (minimum standard) and when the service user/client and family may request this.

The care plan is the foundation to provide a narrative as to what the service user/client wants to address, what this will look like and how they will get there, therefore this document must be up to date and relevant to the service user/client and the community setting, with an associated relevant safety plan in the event of a crisis. The care plan should be co-produced and a copy of this should always be offered to the service user/client, as it is their care plan. A copy of the care plan should also be shared with key individuals involved in the person's care, with their consent.

Additionally, the FACE risk provides a comprehensive review of actual and possible risk to self (service user/client) and to others, and therefore is a key document to ensure the appropriate provision of care in both planned and unplanned care settings.

Clinical records

A contemporaneous record of the interactions with the service user/client, family and key professionals is paramount in ensuring safe and effective care, therefore all records should be made in line with the trust defensible documentations standards. A clinical contact is required for all activity completed on behalf or with the service user/client, as well as adding appropriate SNOMED codes for the interventions delivered.
All MDT discussions, whether these are conducted in the formal MDT meeting or another clinical meeting, should be recorded on the CMHT MDT clinical note template on the service user/client record.

Updates to general details

Protected characteristics and next of kin should be routinely checked and updated on the service user/client record at every care plan/CPA review point.

4.3.5. Mental Capacity

It is important to assess whether the person has capacity in respect of their care and support requirements and whether this restricts or places controls on the person's life which deprive them of their liberty. This includes any informal or formal requirements. All practicable steps must be taken to ensure a person is supported to make an informed choice.
Mental Capacity needs to be assessed decision and time specific. It has to be assessed for specific decisions as part of the assessment, reviewing and support planning process, for instance, if a person has capacity in respect of their care and support needs, where they may live, who they have contact with, whether they need to enter into a tenancy or manage financial affair. Practitioners must ensure they have followed all reasonable and practicable steps to ascertain capacity for specific decisions. Decisions are time specific therefore capacity must be assessed on or near the point where a decision needs to be made.

For Local Authorities the types of decisions we should be assessing under Mental Capacity Act 2005 can include decisions in respect of care and support needs, residence; where to live, entering into, managing and ending a tenancy, managing finance and property affairs, contact with others, sexual relationships, internet and social media use.

Some decisions will need Court of Protection oversight for a Community Deprivation of Liberty and/or where the person lacks capacity, for contact with others whether this is face to face or on line, sexual relations must all be referred to the Court of Protection regardless if there is an LPA/Deputy for Health and Welfare.

It is important that Social Care professionals record defensible decisions and complete Mental Capacity Assessments for specific decisions where the person has been assessed to lack capacity. It is also best practice to record a Mental Capacity Act assessment where there is a dispute as to whether the person has capacity for a specific decision, a history of safeguarding, risky behaviours which could be leading to significant safeguarding concerns

or when there is a dispute between the person, advocate and or practitioner, in particular, where this would lead to legal action.

Legal advice can be sought around the Mental Capacity Act from the East Riding legal team. For Deprivation of Liberty advice can also be sought from the DOLS coordinator in East Riding Safeguarding team. For more information please refer to the Mental Capacity Act 2005 Code of Practice.

4.3.6. Social work Interventions

Social Workers place a strong focus on prevention and early intervention using a strength-based approach that considers all aspects of a person's life using the principles of the Care Act and supporting people's choice, control and human rights. Social workers are experts in the application of relevant legislation and have statutory responsibilities in relation to the Mental Health Act 1983, Mental Capacity Act 2005, Care Act 2014 and Human Rights Act 1998 and safeguarding.
Social Workers are integral to multi-disciplinary teams and provide a range of interventions to support people to achieve sustainable recovery, through effective transfer of care pathways, where they have independence and their transfer of care from services is long term. As part of their work to assess, arrange and review support packages funded by East Riding Council they are required to work to their operating model and record information on their operating system.

4.3.7. Nursing Interventions

Community Mental Health Nurses are a vital resource within our CMHT's and PCMHN's of whom the value cannot be overstated. Community Mental Health Nurses work with other professionals, statutory services and VCSE's to support those people who experience a mental health condition. This accounts to around a third of the population, building trusting relationships with them, helping them to adhere to treatment programmes, lifestyle choices and advising on and facilitating therapies that support good mental health. They will support with medication management and assessment of efficacy. They may be responsible for giving depot injections. Community Mental Health Nurses will facilitate referrals, identifying risk and vulnerabilities and collaborating with safeguarding both in the trust and in the local authority to ensure the wellbeing and safety of the people within their care. They will work alongside MARAC and MAPPA frameworks to identify and manage risk. Community mental health nurses will work autonomously but also as part of the MDT, bringing their significant skills and knowledge to support with case management and collaboration. They will assess and treat service users promoting a recovery based, person centred approach with focus on early intervention and support with relapse management. They will work with an applied understanding of relevant legal frameworks such as Mental Health Act 1983, Mental Capacity Act 2005, Care Act 2014 and Human Rights Act 1998. Community Mental Health Nurses work in a variety of settings including clinics and service user/clients homes. They will manage a caseload of service user/clients according to the needs of their service and population. They will work with a 'think family' approach and co-produce careplans with service users, their families and other members that may be important to the service user to involve, with their consent. PCMHN Community Mental Health Nurses will play a vital role in closing the gap between GP's and mental health services, working within GP surgeries to provide assessment and treatment of service users and consultation and support to GP's.

4.3.8. Medical

Psychiatry forms a vital and integral part of the community mental health service provision. Psychiatrists bring with them significant skills, knowledge and experience, which can support the service user/client's care plan and the team with management of the needs and risk. Psychiatrists may provide medication reviews for individuals who require this however, are

clinicians with skills far beyond this and should routinely be involved with complex case discussion and reviewing the needs of deteriorating service-user/client.

Non-medical prescribers are a complementary role to support with the intervention initiation, change and cessation of medicinal products for people who have lower levels of complexity and do not require the expertise of the psychiatrist. NMPs are a vital part of the modernisation of community mental health services, enabling quicker access to medicines and as a resource to the wider service to support holistic needs management.

Pharmacists and pharmacy technicians are also key roles in the delivery of medical care, ensuring the safe and appropriate use of medicines. Pharmacy technicians can provide level 1 reviews of medications, which allow for the review of the efficacy, use and side effects of medications, including any barriers to adherence.

Any medical review should include appropriate documentation completion including but not limited to a clinic letter and intervention recommendation form. An outcome from the review should routinely be shared with the GP for their records and rationale for prescribing arrangements. Any significant medication changes should result in the community team providing adequate follow up, either via the prescriber, or via the team to monitor for efficacy and side effects, as this is best practice. A transfer of care to the GP should only take place once all treatable needs have been identified and met where possible, and the effects of the medication have identified.

Medicine adherence in service-user/client with a mental health difficulty can be a significant problem; particularly in service-user/client with severe mental illness (SMI) as they may believe they are mentally unwell. Other reasons for poor adherence are concurrent alcohol or drug abuse and/or a poor relationship between the healthcare professional and the service user/client. Clinicians working in the community should have discussions regularly with service-user/client regarding their medication as determined by the service user/client risk factors if prescribed medication is be taken. For this approach to have the maximum effect it is vital clinicians involve service users/service-user/client in their care and develop supportive, trusting relations with service users/service-user/client. Any issues with intervention adherence, especially where adherence has been an issue previously steps should be taken to help the service-user/client improve adherence and prevent relapse whilst maintaining their own autonomy and agency within their own care, in an environment of safety and empowerment to prevent relapse.

Please refer to the Safe and Secure Handling of Medicines Procedure

4.3.9. Psychological Professions

Currently the team consists of:

- Clinical Psychologists/ HCPC Practitioner psychologists
- Assistant Psychologists
- Clinical Associate Psychologists (often referred to as CAPs)
- Staff trained in the delivery of specific psychological interventions e.g., Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation Reprocessing (EMDR) Therapy.
- Trainee Clinical Psychologists/Therapists
- Family Therapists
- Family Intervention Practitioners

Accessing the Psychology provision in ER CMHT involves the following steps:

1. Client is allocated a Care Coordinator or Key Worker within the team.

2. The Care Coordinator/Key Worker builds a relationship with the client and identifies that Psychology work might be appropriate.
3. The Care Coordinator/Key Worker arranges a consultation with a psychological profession, either directly or via the weekly MDT meeting.
4. During the consultation, the psychological professional will consider options for psychological input including intervention within the CMHT (e.g. Assistant Psychology, 1:1 therapy, groups), referral to external and specialist services (e.g. DBT, MBT, Humber Traumatic Stress Service).
5. If input from the CMHT psychological professions is identified, a Therapy Screening Appointment is offered to the client. This is a one-off assessment to gain a psychological understanding of the client and their difficulties, as well as to assess suitability for intervention. Clients may continue to receive support from their Care Co-ordinator/Keyworker depending on their individual needs.
6. Upon commencement of psychological intervention, there should be communication between the member of the Psychological professions, the client and the Care Coordinator/Key Worker to create a collaborative care plan, which reflects the degree of support required from the Care Coordinator going forward.
7. Client completes the Psychology intervention and either their care is transferred to the most appropriate agency (with the collaboration of the key worker or care co-ordinator) or their care remains with the care co-ordinator/ key worker.

N.B – it is the case that some service users/clients are case managed by psychological professions presently, when there are no other needs requiring a care coordinator/key worker elsewhere in the service, at both primary and secondary care level. In this circumstance, psychological professions members will continue to have access to other team members and duty to support with any additional needs which may become apparent. If input from the Psychological professions is not deemed appropriate, the Psychologist may recommend resources and interventions that could be used by the Care Coordinator with their client. Further consultations or support can be offered by the Psychologist professional to aid this work or to reconsider accessing Psychology in the future.
At any stage in this process, if there is uncertainty about the most appropriate course of action, the case will be discussed within the multidisciplinary team meeting. The outcome will then be communicated to the Care Coordinator.
Assessment proformas, tools, and outcome measures may be used on a case-by-case basis. These are uploaded to the service user/client record.

<u>Interventions:</u>
The Psychological professions provide both direct (with the client) and indirect (with staff) interventions. Members of the team will provide some or all of these, dependent on role and experience. See below for more details about the difference in roles within the Psychological professions.

Direct	**Therapy screening assessment** **Extended assessment and formulation** **Individual therapy** **Individual skills-based work** **Skills group** **Group therapy** **Neurocognitive assessment** **Family therapy and Family Interventions**
Indirect	Consultation Complex case discussions File review Supervision Formulation group

	Reflective practice group Staff well-being work Training

Role/Band	Interventions delivered	Supervision arrangements
Clinical Psychologists Band 7/8a/ 8b	Therapy screening assessment Extended assessment and formulation Individual therapy (model varies between clinician and client) Individual skills-based work Facilitation of groups Group therapy Neurocognitive assessment Consultation Supervision of other Psychological professionals. Facilitation of formulation group Facilitation of reflective practice group Staff well-being work Staff training Clinical audit and research	Monthly Clinical Supervision from another Clinical Psychologist. Clinically responsible for own work.
Therapists (e.g. EMDR, CBT) Band 7	Therapy screening assessment Extended assessment and formulation Individual therapy (model varies between clinician and client) Consultation Staff training Supervision of others	Clinically responsible for own work. Suitable clinical supervision which is modality specific. Frequency to be determined based on caseload and complexity.
Clinical Associate Psychologists (CAPs) Band 6	Therapy screening assessment Extended assessment and formulation Individual therapy (short term, focussed therapeutic work) Co-facilitation of skills group Consultation Facilitation of formulation group Staff training SCM Group	Weekly supervision with Clinical Psychologist. Supervisor holds clinical responsibility.
Family intervention practitioner Band 6	Contribute to Family Therapy Family Interventions Supporting decision making and making recommendations for working with families Supporting Family Inclusive Practice Supervision (including Live supervision) Staff Training Consultation Joint working	Monthly Supervision with Family Therapist Monthly Family Interventions Supervision Group facilitated by Family Therapists Live supervision within Family Therapy Clinics by Family Therapists Clinically responsible for own practice.
Assistant Psychologists Band 4/5	Individual skills-based work (low intensity, time-limited, manualised work) File reviews Neurocognitive assessment administration Supporting the running of groups Supporting the running of team-based groups (E.g. Formulation/Reflective Practice)	Weekly supervision with Clinical Psychologist. Supervisor holds clinical responsibility.

4.3.10. Occupational therapy

An Occupational Therapist is a registered member of the Health and Care Professionals Council (HCPC) which, along with the Royal College of Occupational Therapists (RCOT), sets standards of practice to maintain registration. Occupational Therapy staff can include qualified therapists as well as Occupational Therapy Technical Instructors, Assistants and Support Workers.

The focus of occupational therapy is the human need to engage in meaningful activity of all kinds and the interaction of this with a person's health. Occupational Therapists believe in the power of engaging in occupations as a means of change: what we do alters who we are. The 'doing', that is the basis of therapy, can be any occupation, whether that be self-care, leisure or productivity.

Occupational therapists are skilled in assessing activities and an individual's ability to engage in them, including their physical, emotional, psychological, cognitive and perceptual skills. This knowledge is combined with assessment of the social and physical environment in which an activity is taking place to help individuals move towards a better fit between what they can/want to do and the context in which it is undertaken. This leads to better functioning, satisfaction and recovery.

In the Trust, Occupational Therapist operate using the Model of Human Occupation (MOHO) to underpin their practice, and use formalised assessments, tools and outcome measures based on this model. MOHO considers the interrelations between the client's motivation, habits, roles, skills and their environment.

Occupational Therapists work with service-user/client through a shared-decision making approach to plan realistic, outcomes-focused goals. As a profession OT work holistically using a person-centred approach in partnership with the multi-disciplinary team. They can help service-user/client to adapt to, manage and overcome their physical and mental health long-term conditions through;

- supporting people to alter what they do, and how they do it
- the teaching of skills to successfully undertake activities
- adapting to personal limitations and barriers in the environment
- helping people change their self perception, hope and confidence by what they do
- advising on/issuing equipment and adapting environments

OT's develop, implement and evaluate a seamless occupational therapy support service across the CMHT/PMHCN, working with community and secondary care where appropriate, and aimed at continuously improving standards of service user/client care and wider multi-disciplinary team working.

Access to the occupational therapy team is completed via discussion in the MDT if the discussion sits within the PCMHN level of the service. Although there is no current direct provision of OT within the PCMHN, the ambition is to grow this service via the OT resource within the integrated CMHT. If the service user/client sits in the secondary care level of the service this can be completed via completion of the OT referral form and forwarding on to OT email inbox.

4.3.11. Peer support work

Peer support workers offer an invaluable link for service-user/client to work with someone who has lived experience. This can not only support their mental health and intervention generally, but provides a vital support regarding social inclusion.

The peer support workers sit as part of the primary care level intervention and can be accessed via the PCMHN or through step down from the CMHT into the PCMHN.

When identifying a service user/client for possible peer support intervention, the following gold standard should be following as closely as possible:

- If the service user/client is new to the PCMHN, the clinical lead to identify possible intervention through the MDT in discussion with the peer support workers and the lead for this part of the service.
- Discussion for allocation to a peer support worker should be completed via discussion with the peer support worker manager.
- Once allocation is identified, the clinical lead or other allocated worker (if the service user/client has been working with another staff member) should arrange a joint appointment between the peer support worker, clinical lead/other staff member and the service user/client.
- A care plan should be completed in collaboration with the service user/client for the peer support work intervention.
- The peer support worker would carry out their intervention and report back through clinical supervision and the MDT on progress or escalation of any concerns.
- The case will be reviewed by the clinical lead providing the peer support workers clinical supervision and completion of further care plans, FACE risk reviews, PROMs and other documents will be completed.

4.3.12. Groups

The delivery and facilitation of groups are a key objective within the community mental health service. When delivered appropriately, groups are a way to deliver therapy within a supportive environment of peers where that setting enhances the delivery and efficacy. This can also provide additional capacity as the intervention can be run for several people at once, but also provides a peer support element and other potential benefits to the service-user/client who are accessing them.

It should be noted that group work is not for everyone and the team may need to work with the person to recognise and manage any negative feelings and experiences associated with past group work. If the service user/client does not engage with this intervention or starts to disengage over time, the team should identify with them the reason for this and work collaboratively with them to overcome any concerns they have with this. If the service user/client chooses not to take up the group offer, but this is the most appropriate care pathway for them, the reasons for not wishing to undertake a group intervention should be considered by the team and whether an alternative treatment can be provided.

If the group is the main intervention for the service user/client, the group facilitator should hold overall caseload responsibility whilst they are accessing this intervention pathway. If the group is alongside other care ongoing with someone else holding the case, the group facilitator should work alongside as a co-worker.
A review of the effectiveness of the group and ongoing care needs should be completed as standard for all group participants, with discussion in the MDT meeting for allocation of further care if required, or transfer of care from the service following intervention completion.

A review of the effectiveness of the group and ongoing care needs should be completed as standard for all group participants, with discussion in the MDT meeting for allocation of further care if required, or transfer of care from the service following intervention completion and review by a registered clinician or agreement within the MDT. Any discharge from non-attendance at the group should be undertaken as a direct review with the service user/client.

MBT

Service Users/Clients undertaking MBT are required to have a care coordinator in the CMHT to access the therapy programme. Care is reviewed jointly at the end of the psychoeducational group (after 12 weeks) to determine if clients have engaged with the material, require further MBT therapy and a referral to the experiential group or if there is no further treatment from an MBT perspective. If a client misses more than 2 psychoeducational group sessions, they are not allowed to continue with MBT sessions and would be discharged from the MBT service (unless there is an

exceptional circumstance which is agreed with the care coordinator and they would be allocated to the next available group). Clients are aware of this boundary when they agree to start MBT.

4.3.13. CMHT Duty

There is a duty rota within each CMHT to which one staff is allocated per day (Some CMHT work with 1 duty worker and 1 duty back up).
There will always be a qualified practitioner on duty. Duty is to be covered for either a one day period or a half day period. Staff must always complete their availability for duty cover. Whilst the rota is devised, the rostered duty worker is responsible to promptly notify admin if they cannot work allocated their allocated duty session due to any unforeseen absence. The staff member is responsible for ensuring that this duty is allocated to another worker.
Individual staff are responsible for swapping the duty worker role in good time if they know in advance that they will be unable to fulfil the role on a specific day.

Role and responsibilities of the designated Duty Worker and Shift Co-ordinator

- It is the duty worker's responsibility to ensure that each member of staff communicates their safety at the end of the day via phone, as per lone working policy. The cut off time for phoning to confirm safety is 16.45 unless a prior arrangement has been made.
- The duty worker, at the end of the day will ensure that the building is safe to be left and is secure.
- The duty worker will manage clinical calls(for the CMHT and PCMHN) in the absence of the service-user/client designated worker in a timely fashion and follow up any actions and ensure any outstanding work is handed over to the next duty person.
- The Duty Worker will record all clinical contact in the clinical record and make the relevant care co-ordinator aware of any significant issues
- The duty worker will be responsible for handover of specific clinical issues to Care Co-ordinators, Team Manager/Clinical Lead and ensure follow-up to the next day duty worker if appropriate.
- The duty worker must seek additional support/guidance/advice from the Back up duty worker in the first instance if they require additional support or advice in this role.
- The Back up duty worker will provide support to the Duty Worker to facilitate face to face contact with service-user/client when necessary and will also support the management of the Lone Working Policy.

<u>ER PCMHN Duty Clinical Lead</u>

The ER PCMHN have an assigned clinical lead daily. The Duty CL will ensure they are available during the core hours of the service and are there to direct and support other team members as required.
This is not a replacement for duty and service users/clients who are receiving primary care level interventions who may need the support of CMHT duty still.

4.3.14. Escalation in care needs

Needs and risks very rarely remain static and therefore the clinical team, other professionals, service user/client and family (where appropriate) should remain vigilant to changes and act accordingly.

'Red flags' and key risk indicators should be used to support identification of changes in clinical presentation and risk status, where these support real time understanding, formulation and onward planning on care. An exhaustive and up to date list of 'red flags' cannot be provided within this SOP, however relevant guidance can support the use of these in practice including; NICE, NCISH, RCPSYCH and the use of emerging evidence in mental health research.

Risk and need does not fluctuate in just mental health, but also in a person's housing, finances, family situation, social support, physical health to name a few. Therefore, the clinical team should consider all areas of destabilisation in planning of escalation of care needs. Cases with increasing

needs and risks should routinely be discussed in the MDT meeting and the outcome documented on the service user/client's records, with clear actions and plans/timescales for review. Clinical prioritisation may alter based upon escalation of care needs and should be based upon presenting needs and risk, with clear rationale documented in the clinical record as to the actions taken or not taken in relation to increasing care needs.

See section 4.4 for further details on step up of care needs as required.
See MDT Care planning Guidance G425

4.3.15. Physical health

People with a serious mental illness have higher rates of mortality than their general population counterparts. This is due to a combination of factors including (but not limited to) higher prevalence of tobacco use, substance use, the negative effects of medication and the exclusion from services to support health and wellbeing.

As such, it is of the upmost importance to identify unmet physical health needs and support the person to access the appropriate intervention in a timely manner, which befits the concern. All clinical staff, to varying degrees, have a responsibility in this area and to escalate concerns regarding physical health issues if they identify them.

SMI service user/client's should be offered an annual review of their physical health to support with early identification of physical health needs. Community mental health services should ensure this has been completed and support the service user/client to be empowered to understand why this is important and to access it.

Furthermore, physical health checks should be completed by the team, under the advice of a prescriber, when initiating, stopping or changing medicines. The prescriber may also request additional physical health checks in the form of bloods and ECG from the GP when required.

If a service user/client presents with a potentially urgent or life-threatening physical health concern, this should be escalated to the appropriate agency including GP, urgent intervention centre or emergency services. If the clinician is unsure if there is an urgent or life-threatening need or they lack the skills and knowledge to make a judgement on this, they must urgently seek out advice from an appropriate clinician to support the decision making.

Should any plans or agreements be made with the service user/client or family regarding escalation of physical health concerns, an appropriate follow up plan should be put in place to ensure this has occurred.

Please see *additional guidance on managing the deteriorating Patient Policy N0-62 & Protocol Prot257*

4.4. Steps within the service

The community mental health services, following the community mental health transformation framework, now have tiers of service for offering different levels of intervention for people with primary level and secondary level needs.
A service user/client should be able to transition between tiers of the service as per their clinical needs and risk status, without reassessment and with ease of access and no break in intervention. This is also true of individuals stepping across into similar services of stepping up and down in acute services.

4.4.1. Steps between primary and secondary care level interventions and out into other Humber services.

In all cases: a clinical discussion agreeing timescales needs to be agreed between services

Steps between primary and secondary care level interventions and out into other Humber services.

In all cases: a clinical discussion agreeing timescales needs to be agreed between services.

> ***However*** when **stepping up** as shown below, this needs to be at the point of agreement/clinical discussion not a future date due to the escalation of need/risk.

- Step-up – when a service user/client has escalating needs in respect of their health problems
  E.g. – Primary/Secondary support following "Assessment intervention" to MHCIT
  E.g. – Primary to Secondary support within the integrated community mental health services

- Step-down – towards the end of a specific piece of care, a service user/client led review will be completed and will inform the next step when a less intensive level of care is required,

  - E.g. HBT to community mental health services
  - E.g. Secondary care to Primary care element of community mental health services
  - E.g. Psypher to Primary care element of community mental health services
  - E.g. Community mental health services to PCN (GP service) or VCSE

- Step-across – this would reflect when a service user/client is sign posted to another service either within the community mental health services or to external services, but there is a specific piece of care interventions that is required

  - E.g. – community mental health services following "Assessment intervention" to "MHWBC intervention"
  - E.g. – community mental health services following "Assessment intervention" to VCSE or other external provision such as ERTT

- Step-out – once a period of brief intervention has been offered the expectation is that a service user/client can step-out of the community mental health services

  - In order to facilitate recovery the service user/client must have ease of access back to the community mental health services should their needs change significantly
  - Care can be reviewed with the service user/client and MDT at point of contact if accessing services again

We will aim, where possible, to make clinical decisions in accordance with current NHSE Guidance ensuring that all step ups and step downs are based on the service user/client need/ level of complexity and the expertise required to deliver the NICE-approved intervention.

SI 2023 18270

4.4.2. Joint Working between ERTT and ER Community Services

ERTT provide evidence-based treatment for people with anxiety and/or depression in line with NICE guidelines.

As the service user/clients' needs and level of complexity are likely to be more fluid and changeable, the requirements of the Network interface meetings essential.

The function of the weekly Network Interface meetings(Case discussion) between PCMHN/CMHT/MHTAT and ERTT is to:

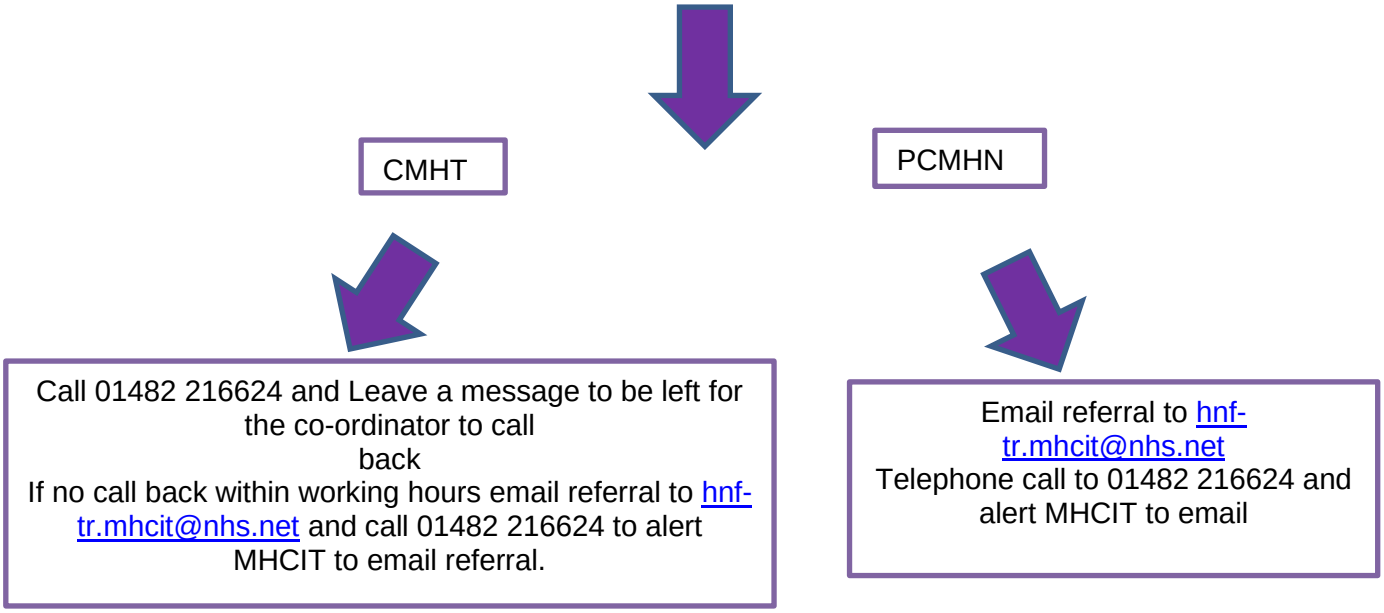
- Discuss referrals between services and agree the most appropriate pathway within the meeting.
- Improve appropriate referrals to ER PCMHN and ERTT for anxiety and depression.
- Improve ability for people to 'move' between services where appropriate.
- Avoid duplication of service provision.

Refer to: *Community Mental Health and NHS Talking Therapies for anxiety and depression National guidance to support seamless and person-centred access to appropriate mental health care July 2023 ERTT SOP*

4.4.3. Step up to acute services

Temporary Process For making a referral into MHCIT/HBT(Agreed January 2024)

CMHT/PCMHN/GP's call professionals' line on 01482 205555
If waiting longer than 30 minutes



Please ensure that when emailing a referral, please use the appropriate referral form and ensure full details are provided, including contact numbers, requested method of contact and contingency plan if contact cannot be established.

Referrals to the Mental Health Crisis Intervention Team-CMHT

Where intensive care is required beyond the normal expected support from community mental health services, service-user/client will be referred to the Mental Health Crisis Intervention Team (MHCIT). See above flowchart.

This service gatekeeps all inpatient beds and provides alternative acute care through Home Based Intervention (HBT), ensuring where feasible and safe to support service-user/client and their family/carers to remain in the community. Prior to any discussion with the MHCIT for either HBT or inpatient admission, the community mental health service worker should gain consent for the this to occur and explain to the service user/client what a HBT or inpatient admission involves, including the offering of the service. This discussion should be realistic and explain all aspects of this intervention including practices which may appear restrictive including access to personal items and smokefree policy.

The MHCIT service will only accept referrals from the community mental health service where there has been contact with the service user/client by the team on the same day.

All referrals to MHCIT will be reviewed and triaged by MHCIT who have their own process. MHCIT is not the service for weekend support; unless there are clear intervention requirements and not being provided care through MCHIT would lead to an admission. A telephone call to MHCIT to notify the potential contact by the service would be expected to ensure the team are aware and therefore facilitate a safe intervention.

All paperwork should be completed and accessible, to include the following:

- Internal referral form (completed by MHCIT)
- Up to date FACE.(due to change in presentation and a different pathway is being considered)
- Up to date Care and Intervention plan to reflect the changes and requirements in care.
- Clinical note reflecting the clinical decision, reasons for referral, gatekeeping considerations and expectations + any other relevant clinical information.
- Up to date MHCT completed

Attempts should be made to involve carers where permission has been given. It will also be highlighted to the service user/client that where carers are involved MHCIT staff can accept information from the carers even if permission is not given to share information.

Please see the MHCIT and Bed Management SOP for further specific details on inclusion criteria and internal processes

Upon step down back to the community mental health service from acute service, and within the first 4 weeks of returning to the community, a review of the following should take place:

- A review and update of the FACE risk assessment
- A collaborative and comprehensive community-based care plan
- Completion of service user/client recorded outcome measures
- Long term goals and routes out of service/transfer of care planning
- Agree a frequency of contact, safety plan and review of the needs of the family/carer with appropriate signposting/onward referral

<u>Referrals to the Mental Health Crisis Intervention Team-PCMHN</u>

If a person presents in Crisis and is open to the PCMHN including Peer support and Wellbeing Coaches, then they will escalate this to the appointed clinical lead. The Clinical Lead/band 6 will provide the appropriate advice to manage the immediate situation/safety.
The Clinical Lead/Band 6 will then take over responsibility (if required) of managing the situation to a safe and effective outcome. The clinician would then liaise with the appropriate service to transfer care to the most appropriate service. If this was to refer to the MHCIT, see above flow chart.

4.5. Transfer of care from the CMHT/PCMHN service

Transfer of care from the community mental health service must be a planned process in collaboration with the service user/client and carer.

When being transfer of cared from service, service-user/client will receive a letter and be offered a plan, which will indicate clear routes back into the service for that individual if needs be. Relapse prevention work will, at all times, seek to empower the individual and their family with the confidence and the skills to manage their mental health.

The Trust CPA Policy and Procedural Guidance (page 19) states that:

Transfer of care from Mental Health Services Where it has been agreed at review that transfer of care from secondary care services is appropriate then this decision should be recorded on the appropriate documentation. The only criterion for transfer of care from the Trust is that the service user/client no longer needs support from any part of the Mental Health Services. Where the service user/client requests that care be discontinued against the advice of the MH care coordinator and/or multi-disciplinary team, then every effort must be made to develop/present a care plan that is acceptable to that individual. This could mean delivering only part of the original plan or making substantial modifications. (See also service users requesting self-transfer of care within Transfer of care/transfer Policy.) Where compromise cannot be reached, support should be offered to the service user/client and/or carer, and they should be given full details of how to contact the Mental Health Services for future reference.

Where an individual's ongoing support or intervention plan is to be delivered by an external agency (whether that is an established relationship or a new referral), the discharging clinician is responsible for liaising with that service to ensure that the provision is clinically appropriate and available to meet the identified needs. This allows the clinician and service user to formulate an alternative plan, prior to transfer of care, if required. There may be circumstances under which there is a strong clinical rationale to facilitate the service user in managing their own care/self referral, in those instances a rationale for not liaising with the external agency must be documented.

SI 2023-3491 Action 13
When an individual does not require on going support or clinical intervention but requires ongoing social care support they will remain on the team caseload.

The transfer of care of any service user/client from the community mental health services with a history of violent and aggressive behaviour towards others should be discussed and considered by the MDT prior to transfer of care and recorded in the clinical record and transfer of care paperwork.

Also care coordinators/Keyworkers should ensure they notify the service user's GP and other services/agencies that the service user is either involved with or may come into contact with, as it may be that some individuals may quickly relapse in their mental health without the level of service they have been receiving previously. Consideration should also be given to arranging a VARM (Vulnerable Adult Risk Management) meeting if the individual is thought to be vulnerable. Withdrawal of a particular service or intervention should only take place with the agreement of the team following full discussion with those persons/agencies involved in the service user's care. Unilateral withdrawal of services or transfer of care from caseloads will be avoided at all times

This will be followed with every service user/client open to the team, including those on a waiting list, attending a group, on CPA or being case managed. This will support the safe transfer of care of service-user/client and will allow for a full discussion about the most relevant way to progress for any individual by the full multidisciplinary team.

Transfer of care must always include the considerations of carers, family and other identified people who may support the service user/client with a holistic view of the persons social situation and means of support.
The transfer of care will also be discussed at the team MDT discussion where all clinical disciplines review ongoing care and cases. This includes representation of the team clinical leadership too i.e. Clinical Lead, Consultant Psychiatrist, Clinical Psychologist.

If the service user/client and family do not agree with the transfer of care and plan, their views must be taken into consideration and presented in the MDT meeting. The service user/client and family should also be given the opportunity to meet with and discuss the transfer of care with the clinical lead of the service to informally manage the disagreement. Should disagreement still continue, escalation to the senior clinical lead would be appropriate. Transfer of care should always be

based upon clinical information/evidence, NICE/care guideline and the needs of the service user/client.

Transfer of care to Social Care only
It may be appropriate to discharge from a clinical caseload based on NHS criteria but social care professionals are still involved in the care. Rationale and consideration of the Care Act eligible needs and an assessment must be considered.

4.6. Disengagement and DNA

Sometimes, service-user/client will disengage from the support the team is providing. Should this be the case, the worker/team should consider the reason for this and what barriers may be in place to deter engagement. Where possible, understanding of the disengagement should be sought by the service user/client and family, or other professionals who may be involved. The ethos for managing disengagement should always be to consider how we can better engage with the service user/client; rather than how can they better engage with us.

The team will proactively follow up service-user/client who have not attended an appointment or who are difficult to engage. Service-user/client should not be transfer of cared back to their GP simply because they have missed, cancelled or rearranged appointments. Any decision to transfer of care should always be a clinical decision, based on the individual service user/client's best clinical interest and ratified through a minuted discussion at a MDT meeting. Transfer of care via disengagement should never be a punitive action.

The following steps to good practice will be adhered to in safely managing missed appointments, did not attends and no access visits.

- Recognising non-attendance. This may be non-attendance at clinic appointment or not available at a planned or urgent home visit.

- The individual recognising the non-attendance must take action. If this individual is a non-qualified practitioner they must discuss the case with a supervisor and/ or clinical lead practitioner.

- Identify and take action to minimise risk to the service user/client and/or others.

- If the service user/client is known all relevant information relating to risk should be used to formulate an action plan. This may involve existing care plans, contingency and crisis plans. This may also include formal approaches to assessment under the Mental Health Act 1983 or assistance/engagement with other agencies such as Approved Mental Health Professionals (AMHP).

- If the service user/client is not previously known to services or additional information may be required to formulate an action then the referrer/GP must be contacted to identify potential risks and to agree any actions.

- After discussion, if agreed within the MDT, service-user/client who do not attend (DNA) will be sent a letter inviting the person to contact the team within 14 days. The named worker or duty officer will document all action taken on the service-user/client electronic record. Where no action is considered to be necessary this should also be recorded with a clinical rationale as to how this has been concluded.
  SEA 2023-10 Action 3

- If no contact is made within the time frame a communication is required to the referring agent, the service user/client and the GP notifying them the service user/client is now transfer of cared.

- If the service user/client is subject to a Community Intervention Order or Home Office Conditional Transfer of care arrangements the Responsible Clinician should be made aware at the earliest opportunity in line with the details of the after-care plan.

4.7. Agile working

The community mental health services are working in an agile manner with staff will using laptops, smartphones and hot desking when required at base.

Wi-Fi is available at all Trust premises so staff are able to 'drop in' to use available desks to access Lorenzo and other applications rather than having to return to their office base to update the Electronic Service user/client Record (EPR) after they have seen service-user/client. Additionally, the ability to access these applications from home is available and the Trust also has partnership arrangements with many other organisations, for example GP Practices thus enabling staff to use many locations across Hull and East Riding.

4.8. Lone working

The safety of workers is paramount to the ability to provide an effective service. Staff frequently work alone in the community and face a variety of challenging situations. Team members should comply with the Trust lone working policy. Social care staff also have access to Orbis fobs which are security devices. Staff record the location of visits and can press to alert the manager for danger.

It is the duty worker's responsibility to ensure that each member of staff communicates their safety at the end of the day via phone, as per lone working policy. The cut off time for phoning to confirm safety is 16.45 unless a prior arrangement has been made. If no contact is made the duty worker needs actively contact the staff member by telephone initially to check safety. If they do not answer the phone then this is escalated to senior member of the team (Clinical Lead orTeam leader).

A decision will then be made to (via assessment of risk).

- Contact the last known address by telephone.
- 2 x members of staff to visit the address listed.
- If contact cannot still be established contact the police.
- Contact NOK.

The duty worker, at the end of the day will ensure that the building is safe to be left and is secure.

4.9. CAMHS transitions

Transition for young people approaching their 18th birthday will be managed in accordance with the relevant CAMHS Transitions Policy and Protocol. Referrals to the adult community mental health services in such cases will be accepted for young people aged 17 and half years old in accordance with good practice and opportunities for preparation and joint working.

The Children and Young People (CYP) services key worker will coordinate transition with the identified adult clinician with support from both team managers if required.

The CYP services clinician will be the lead professional in a young person's care until the age of 18 and take the lead in overseeing and co-ordinating the appropriate level of support needed within adult services. This may require a multi-agency approach to ensuring all aspects of care are recognised and supported. This remains the case even when an adult service is providing an intervention prior to the age of 18 if the young person remains open to CYP services. A CPA review or other planning meeting, involving the young person, should take place as soon as possible, and this should document clearly the transition plan and the date upon which the adult services clinician becomes the lead professional instead of the CYP services clinician.

Please see the CAMHS transition policy and passport for further details

4.10. Forensic transitions

The community mental health service will support the appropriate step down from forensic services for those whom no longer require this level of care. The Humber and North Yorkshire Provider Collaborative provide a Single Point of Access for all referrals for forensic inservice user/client and community services in the area. The Humber Specialist Community Forensic Service (SCFT) works with people in community settings who have a needs which can only be met via forensic services, however these needs will not remain static and therefore transition to mainstream services will be required at some point within their care journey for most.

The SCFT provide a series of points in the care journey including, consultation, assessment, intervention and care coordination. If a service user/client is open to the community mental health service who may have needs of a forensic nature, the SCFT is available for consultation and support should the team wish to access this. Consultation should not purely be based on completion of a forensic risk assessment but should indicate the underlying need and advice which is being sought to work with the person. Furthermore, if the team are looking to transfer of care or move someone's care to another provider and the service user/client has forensic history, the SCFT can also provide consultation and transfer of care planning advice in this circumstance. The team can also provide advice on MAPPA and signposting where appropriate.

Transitions to mainstream services will be considered as soon as possible by the SCFT. Most service-user/client will require transfer of responsible clinician and care coordinator, plus some will require an element of social supervision. A transition from SCFT to mainstream community mental health services should aim for the following principles:

- Transfer should commence 2 months prior to planned transfer date
- An internal transfer form should be completed by SCFT, a call placed to the community team to discuss the transfer and an electronic referral made if this is the agreed outcome
- If the service user/client has needs which require the ongoing input from the community mental health service, they should be allocated a care coordinator and responsible clinician
- If the patent does not appear to have needs which require the ongoing input from the community mental health team, this should be escalated to the clinical leads of the services to discuss and to the MDT. If this does not resolve the dispute, further escalation to the senior clinical leads may be required.
- The care coordinators should meet to discuss transfer arrangements and joint visits
- The responsible clinicians should meet to arrange handover
- A joint care plan should be developed with the service user/client to support the transition period
- Full transfer should take place on the agreed date

An interface meeting between community mental health and SCFT should be established to support joint working and transitions but should not supersede the elements of good practice for the transition as stated.

4.11. Older adults transitions

Where appropriate and in accordance with local commissioning arrangements and service configuration, transition into Older People Services for people around the age of 65 should be managed on a needs-led basis through CPA using established protocols to plan care and provide continuity.

Please refer *to Older People's Mental Health and Working Age Adults transition SOP*

4.12. Interface between CMHT and Complex Emotional Needs Service (CENS)

Patients care co-ordinated by CENS do not require an open referral to be maintained to the CMHT.

If a patient who is open to CENS requires a medication review or other intervention provided by the CMHT that CENS are not commissioned or able to provide (for example CMHT psychology, occupational therapy), then a referral into the CMHT can be made directly by creating a referral to the relevant CMHT on Lorenzo, alongside the completion of a clinical note/letter detailing the

request. After the identified request has been completed, the CMHT would then close the referral and direct them back to the referring service.

CENS will initially provide indirect support to the CMHT in working with patients. If CENS agree to assess a service-user, the CMHT remain the lead team with responsibility for all tasks e.g. FACE, care plan, follow-up, unplanned care liaison, until the point that CENS agree that they will take care co-ordination responsibility, if appropriate.

As East Riding patients require social care functions to be completed by the East Riding of Yorkshire Council (ERYC), CENS is unable to complete social care functions for East Riding patients, even when they are care co-ordinated by CENS. In such cases, CENS would offer support to the assessing social worker if desired e.g. in collation of information.

Interface between CMHT and Humber Dialectical Behaviour Therapy (DBT)
Patients referred to DBT require an open referral to a CMHT during the initial group phase of treatment, and should be allocated to caseload of an worker. During this time, the CMHT remains responsible for tasks e.g. FACE, care plan, follow-up, unplanned care liaison, until the point that DBT agree that they will case manage the patient, if appropriate. This will typically not occur until at least 12 weeks into individual DBT. Discharge from the CMHT should not be initiated unilaterally for patients within DBT; this should be a joint decision between DBT and the CMHT, with any disagreements escalated via clinical leads.

If a patient who is case managed by DBT requires a medication review or other intervention provided by the CMHT that DBT are not commissioned or able to provide (e.g. occupational therapy), then a referral into the CMHT can be made directly by creating a referral to the relevant CMHT on Lorenzo, alongside the completion of a clinical note/letter detailing the request. After the identified request has been completed, the CMHT would then close the referral and direct them back to the referring service.

Humber DBT is a psychological therapy service and does not have a social work function. As such, social care needs for patients case managed by Humber DBT would be met via CMHT social workers or the local authority, following a referral from Humber DBT to the relevant agency.

4.13. Clinical audit

Clinical audit is one of the components of clinical governance. The team participate in Trust wide audits where appropriate or required. Team managers/clinical leads are responsible for working with staff to ensure collection of the required information.

Case note record audits will be completed as part of ongoing supervision and other additional audits, such as audits of clinical supervision may be undertaken as appropriate as part of service evaluation. The sharing of any audits should be completed via the clinical lead to the team to support learning and development.

It is essential that teams incorporate the learning from serious incidents (SIs) and serious events (SEs), complaints and audits into clinical practise. Team Managers and Clinical Leads will work closely with the Service Manager and Senior Clinical Lead to oversee the application of learning outcomes in consultation with trust structures e.g. The Clinical Governance, Clinical Networks and Risk Management Team.

4.14. Incident reporting

The community mental health services (HTFT and ERC) are committed to an open and just culture at work. An open and just culture is vital to ensure learning takes place, and to develop a safe and effective service.

The HTFT is currently rolling out the Service user/client Safety Incident Response Framework (PSIRF), with a focus on learning from service user/client safety incidents , using a systems based

approach and no blame culture. An open culture is vital to ensuring a safe and effective service, a culture without the fear of reprisals or blame.

Therefore, all staff are strongly encouraged to ensure they are aware of safety incident reporting procedures, the use of DATIX and their awareness of the risk register.

Should any operational or clinical issues requiring escalation be identified by any team member, these should be escalated through appropriate structures including individual supervision, business meetings and MDTs. Service user/client safety concerns should routinely be escalated to the service manager and senior clinical lead. Should any staff member feel unable to report concerns to their immediate supervisor, they should go to a more senior person to report their concerns, or utilise the 'Freedom to Speak Up' process/guardian to raise the issues.

ERC will be informed if any issues/concerns are escalated through the HTFT processes if they involve ERC staff.

Please refer *to Datix FAQs(Intranet)*
Service user/client Safety Incident Response Policy NO75
Engaging Service user/clients and Families Policy NO74

4.15. Supervision

The Trust is committed to ensuring that all staff engages in supervision as part of their continuing development, organisational and professional accountability. Supervision is included in the terms and conditions of all posts and is a requirement of national standards within care quality commission quality standards and guidance from a range of professional regulatory bodies. The Trust supervision policy differentiates management, clinical & professional supervision and lays out recommended frequency of the various types of supervision. The Supervision structure within the CMHT's and PCMHN's will be overseen by the Service Manager, Senior Clinical Lead and the relevant Professional Lead.

Supervision is a key element in maintaining wellbeing at work and as such, it should be prioritised to ensure this, and safe and effective care delivery.

Supervision is an opportunity to discuss issues arising from service-user/client on the staff members caseload and comes in several forms both informally and formally. Whether supervision is sought on an informal or formal basis, if any discussion is had with another clinician regarding a service user/client's care, this should always be documented on the service user/client record, alongside the outcome from the discussion. Furthermore, any discussion from MDT meetings, peer support, case formulation etc. should be documented on the service user/client records also. This information is vital to support a contemporaneous record of the service user/client's journey through services.

Managerial and clinical supervisors will routinely use available reports to monitor the activity of the staff member, last contacts with service-user/client on caseload, 4 week wait to intervention targets and the review of key documentation (CPA, FACE risk, care plan). These reports should be utilised on a 1:1 basis with staff members directly to support supervision discussions and monitor quality of care.

Supervision is an opportunity for staff to explore issues at work which may be affecting their wellbeing and resources which may be able to help manage this, including a referral to occupational health, a stress at work assessment, a back care assessment, using VIVUP benefits, or accessing the resilience hub. All staff are strongly encourage to engage with and complete their wellbeing at work passport.

Refer to *Supervision Guidance (G312) to support Supervision Policy (For Clinical Practice and Non-Clinical)*

4.16. Training and Development

Training and development will reflect local and national drivers including NICE guidance, the needs of the trust/local authority and individuals who use services. These development needs will be identified and reviewed in line with the Trust Appraisal Policy. All staff will be appraised annually as per the Trust Appraisal Policy.

The Trust recognises that continuing professional development is a key element of ensuring the delivery of evidence-based quality services and maintaining staff confidence, optimism and hope. Role development and scope of practice is also increasingly relevant to the provision of staff training and supervision.

All staff will keep up to date with their individual statutory and mandatory training requirements either through e-learning or by attending relevant face to face or video conference based training sessions.

Team managers and clinical leads will facilitate staff and team development as required, liaising with the training and development department or Professional Lead Educator as appropriate. Training necessitates the absence from normal duties of the team. Cover arrangements will apply wherever possible and should be discussed in advance with the team. Full team training days will necessitate specific cover arrangements from other locality teams and will be decided well in advance in order to ensure service continuity

The Trust aims to provide the highest standards of pre-registration and post-registration training and development. Students from various disciplines are regularly attached to teams as part of their training. All such students will be advised of the operational policy of the teams and will understand the supervision arrangements within the team. All disciplines are required to provide practice supervision to students. Service-user/client have the right to choose if students are present for their appointments.

4.17. Complaints, Issues and concerns will initially be dealt with at a local level to a satisfactory outcome.

Trust Complaints and PALs department will co-ordinate all complaints, concerns and compliments within the newly adopted integrated guidelines. All team members are responsible for adhering to the Trust complaints procedures and for ensuring that service-user/client and carers know how they can complain or offer a compliment if they wish to do so.

Serious allegations and complaints which cannot be resolved informally will be dealt with according to the Trust complaints procedures, and concerned parties will be advised to contact the PAL's Team for support in the process.

A key part of the process of complaints is identifying themes and learning, to develop a safer and more effective service in the future. Outcomes from complaints will be routinely shared with the team in the business meeting, where reflection and discussion will be encouraged. The team manager will coordinate complaints and feedback to the clinical leads, service manager and senior clinical lead with outcomes.

Refer to *Complaints and Feedback Policy (N-047)*

4.18. Involvement of Service-User/Client and Carers

Service user/client and carer involvement is a high priority for the MHLT and the Trust. Service-user/client should always be involved in the planning and provision of their care. Service-user/client and their carers are given the opportunity to feed back about their experiences of using the service by the use of the Friends and Family Test (FFT) which is available in all team bases and offered to all service-user/client using the community mental health services. Their feedback will be used to improve the service.

All care coordinators/named workers have a responsibility to offer Carer's assessments in line with the Care Act. These should be routinely offered at every review or sooner if circumstances change. The teams social care staff can complete carer's assessments or alternatively carers are supported to access local carer's services.

Anyone who considers themselves to be a carer and provides regular care, paid or unpaid is entitled to have a carer's assessment. This is an assessment of their own wellbeing and how caring has affected them. It does not matter whether or not you live with the person you support.

The service shares information about any Serious Incidents involving a service user/client with the service user/client and their carer's, in line with the Duty of Candour Agreement.
Family inclusive care coordination, family interventions & family therapy are integral components of the community mental health service.

Refer to Information sharing with Carers SOP 16-007

Patient and Carer Experience Team

Appendix A: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: East Riding Integrated Community Mental Health Teams and Primary Care Mental Health Networks (SOP22-031)
2. EIA Reviewer (name, job title, base and contact details): Jeanette Jones-Bragg, Service Manager HTFT
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? SOP

Main Aims of the Document, Process or Service
The East Riding Integrated Community Mental Health Teams (CMHT) and Primary Care Mental Health Networks (PCMHN) Standard Operating Procedure (SOP) aims to support the delivery of care for community-based service-user/clients
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender re-assignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. This procedural document is in relation to adults over the age of 18 and considers specific areas of need for people who are older. Additionally the procedures include contact with younger people to include their impact. Additional documents related to these groups have been referenced in the text as required.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not on those with a disability and procedures account for reasonable adjustments where required. Copies of relevant documentation can be made into accessible formats where required.
Sex	Men/Male Women/Female	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon sex.
Marriage/Civil Partnership		Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon marriage/civil partnership

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Pregnancy/ Maternity		Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon pregnancy/maternity.
Race	Colour Nationality Ethnic/national origins	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon race. Documents can be made accessible and translated into other languages if English is not a first language.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon religion or belief.
Sexual Orientation	Lesbian Gay men Bisexual	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon sexuality.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	The procedure has been reviewed by a range of clinical and operational staff, committees and forums to ensure that no person is adversely affected by these procedures. The procedures do not discriminate based upon gender reassignment.

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The procedures listed in this document will have low impact on those with protected characteristics and will be adopted by the team members within the service area. Special attention should be ensured when applying procedures listed to groups with protected characteristics, especially the groups of race, sexual orientation, gender reassignment, sex, age and disability. Procedures are listed as a guideline to staff, but awareness of flexibility in procedure to ensure non-discriminatory practice should be observed.	
EIA Reviewer: Jeanette Jones-Bragg	
Date completed: 28.12.2023	Signature: J Jones-Bragg