Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
GOOLE
COMMUNITY MENTAL HEALTH TEAM
FOR OLDER PEOPLE

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

CHANGE RECORD

Version	Date	Change details
1.0	*02/08/23*	*New SOP – (based on document created 10.10.2018). Approved at MH Practice Network Meeting (2 August 2023).*

Contents

1. TEAM VISION

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

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

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

Trust Values - Caring, Learning, Growing.

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

2. CONTEXT

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

Goole OPCMHT is based at Bartholomew House, Boothferry Road , Goole. The team provides integrated community mental health services for adults aged 65 years and over who are experiencing severe and complex mental health problems. The team also provide care to those patients under 65 who have a diagnosis of a cognitive impairment and/or recognised frailty that contribute to or complicates the management of their mental illness. Further information can be found in the Transition of Care between Working Age Adult and OPMH Services procedure.

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

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

3. COMMISSIONING ARRANGEMENTS

The service is commissioned by the East Riding Place.

4. PARTNERSHIP WORKING

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

4.1. Key Partners

General Practitioners, acute medical trusts (this may include North Lincolnshire and Goole , York, Hull and East Yorkshire Hospitals,) local authorities, ER Place

4.2. Additional Partners

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

5. OVERALL PURPOSE

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

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

6. TEAM AIMS

To improve the lives of older people with functional or organic mental health problem by:

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

7. STAFFING AND RESOURCES

7.1. Staffing

Discipline	Grade	WTE
Consultant Psychiatrist		0.90
Team Leader covering across both Goole OPCMHT and Beverley and Haltemprice OPCMHT	B7	1.00
Clinical Lead covering across both Goole OPCMHT and Beverley and Haltemprice OPCMHT	B7	1.00
Advanced Occupational Therapist working across OPMH	B7	1.00
Registered Mental Health Nurse	B6	2.00
Registered Mental Health Nurse	B5	1.60
Associate Practioner	B4	0.8
Occupational Therapy APOT	B3	2.40
Support workers / STR	B3	1.00
Senior administrator		

The team also includes other professionals to ensure we can meet the holistic needs of our patient group. This includes psychology, physiotherapy, occupational therapy and domestics. The team also are actively involved and supported by local authority staff.

PROFESSION ROLE

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

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

Advanced Occupational Therapist
The Band 7 Advanced Occupational Therapist is a qualified occupational therapist with substantial specialist experience and knowledge, providing professional and clinical leadership to occupational therapy staff across the whole the planned and unplanned OT service. They ensure the workload of the service is covered when there are absences and assist with recruitment. They are a key point of liaison with Team Leaders, the service development lead for the service and the AHP leaders for Humber regarding the whole OPMH OT service. Responsible for the developing of staff members through identifying relevant training, completing of objectives and identify strengths and needs through the trust appraisal system.

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

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

Nursing Associates
The nursing associate role contributes to the core work of nursing, freeing up senior nurses to focus on the more complex elements of clinical care.
Provide clinical tasks such as depots, blood retrieval, supporting patients and their families when patients are diagnosed with significant diagnoses. They also complete information gathering from care home settings and can act as the initial contact within the team.

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

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

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

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

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

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

Reference: https://www.jcpmh.info/wp-content/uploads/jcpmh-olderpeople-guide.pdf

Assistant practitioner occupational therapy (APOT)
To deliver high level, quality care and evidence-based interventions within a multi-disciplinary team
• To work collaboratively across a range of disciplines, developing knowledge and expertise to enable them to perform non-complex, protocol limited, clinical tasks with minimal supervision
• To supervise/support identified healthcare assistants
• To apply skills to working in a team providing assessment and support to people under 136 of the Mental Health Act.1983

7.2. Resources

The team is based at Bartholomew House in Goole. Out-patient clinics are held in this building and ground floor rooms are available to see patients on site. We can also offer group work, carer support and education on site if not possible to facilitate within the home environment or should patients exercise personal choice.

8. HOURS OF OPERATION

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

9. SERVICE MODEL

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

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

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

Whereas in the case of the identification of an organic and complex need, Organic illness Model is Stokes Model.

Stokes Model of unmet need could be a possible indicator for care delivery or advice, or the Pool activity model (PAL) is an additional assessment tool used to inform patient centred care at the

appropriate level for their functioning as affected by dementia. In cases where levels of cognition need to be measured and a diagnosis of dementia is being sought cognitive assessment using a standardised cognitive assessment may be used , relevant to the person's level of cognition and functioning.

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

With pharmacological treatments we provide regular face to face, video conferencing including the Trust advised Upstreaming and telephone reviews of patient's to monitor for any adverse effects and this information can then be brought to MDT for discussion and actioned accordingly.

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

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

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

10. REFERRAL PROCEDURES

OPCMHT receive referrals via the Older People's Mental Health Triage Service. These are then screened and if appropriate accepted for allocation on a weekly basis

Referrals are also received from internal sources such as:

- Mental Health Liaison Service
- Inpatient units
- CITOP (to be allocated within 72 hours not including weekends) and therefore may need to be allocated before screening meeting is held
- Transfers from other CMHT's
- Memory Assessment Service
- Primary Care Network
- Out of area CPA transfers

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

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

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

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

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

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

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

Management of New Referrals
All new referrals to the team will be reviewed on a daily basis by the Duty Worker. A discussion will be undertaken regarding all new referrals via the weekly Multi Disciplinary Team Meetings. These are attended by a Consultant Psychiatrist, Nursing staff, Physiotherapy, Psychology and Occupational therapy. This is to ensure the patient/service user's needs are acknowledged and that any differences in clinical/professional opinion in relation to the referral are discussed. Any urgent referrals and or clinical/professional disputes will be addressed by the Team Leader. There may be occasions where it is felt the team require additional referral information that cannot be gathered, or is difficult to gather by telephone. In these circumstances it can be difficult for the MDT to identify a clear plan of care and the Duty Nurse and/or Consultant Psychiatrist may wish to do a face to face triage either in clinic or at the patients home. This can also reduce inappropriate referrals reaching the point of assessment should there be no mental health need identified.
All referrals received by OP CMHT will be recorded by administrative colleagues and allocated to the access plan. Following receipt of the referral the patient/service user will be forwarded correspondence to advise of the position of the referral and contact telephones numbers for routes to safety. In the majority of cases, referrals will operate under a 'next on list' allocation system however, they will be reviewed upon clinical/presenting need and priority should they not receive an assessment within the time frame of 4 weeks they will be reviewed by telephone. From the point of acceptance of the referral the individual is classed as being under the care of the identified team and can contact the Duty Worker between the hours of 9am-5pm Monday to Friday (excluding Bank Holidays) should they need to discuss their care further.

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

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

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

- The patient/service user's family life may be adversely affected by waiting.
- The patient/service user's employment circumstances may be adversely affected by waiting.

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

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

Referrals from CMHT to CITOP
Should a patient's presentation deteriorate and result in increased risks, it may be appropriate to access additional support from CITOP, a discussion would then take place between the teams and a patient focused plan would be established to maintain that patient's safety using a collaborative approach. Referrals to CITOP are required when CMHT need to consider inpatient admission as CITOP are the gatekeepers for admission

Admin would create a referral on Lorenzo to CITOP after the preliminary discussion has taken place. The care coordinator would update the FACE, care plan and complete a face to face visit with the patient where possible prior to referral to CITOP.

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

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

If it is agreed by all that the patient will remain in the care of the CMHT the patient is handed back to the Care Coordinator. CITOP will update the FACE, Cluster, complete a GP letter and liaise with the CMHT allocated worker regarding discharge from their team. A visit will be arranged by the CMHT care coordinator within 72 hours of discharge from CITOP.

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

Advice and Guidance request
Should the GP write to the team for advice and guidance around medication this will be responded to by the Consultant Psychiatrist and documented on the MDT sheet.

11. CONTACT AND ACCESSIBILITY

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

Goole OPCMHT
Bartholomew House
Boothferry Road
Goole
DN14 6AL
Tel: 01405 608288 .

Staff can be contacted on the above numbers between 9a.m. and 5p.m. Monday to Friday. An answerphone is available for out of hours' messages it also gives redirection details for emergencies/crisis.

12. DISCHARGE

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

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

13. INVOLVING PATIENTS, CARERS AND FAMILIES

Patients who have experienced our services at first hand, their families and carer(s) are best placed to help us develop, monitor and improve services. To help us better understand the quality and effectiveness of our services we collect information about the service including; complaints, compliments and contribute to the national Friends & Family Test surveys. The organisation has a Patient Experience Team which helps us to listen to patients, their relatives, carers and friends. The team carries out bespoke surveys, at the initial meeting and reviews and on discharge. The Care Group takes opportunities in its developmental work to assess patient, carer and family feedback through a specific Patient and Carer Experience Group.

14. TRAINING AND STAFF DEVELOPMENT

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

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

Training cards are being developed via the Functional Pathway working party under the umbrella of the NHS 5 year plan for service development; this covers all bands of staffing.
Staff are encouraged to participate in and attend Continuing Professional Development days.

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

15. CLOZAPINE

We support patients who are being initiated on, and who are already established on Clozaril, and undertake the additional level of monitoring this requires (see Clozapine SOP for further details). Bloods are collected by either our trained phlebotomists , District Nurses or primary care either at patient's home or at suitable clinic base in purple vials. Patient's name, NHS number and DOB label to be attached to the vial and placed in clear plastic specimen bag which is then posted to CPMS.

APPENDICES

Appendix 1 - Clozapine SOP

Clozapine Clinic SOP19-011

Appendix 2 - Divisional Structure

Humber Divisional Structure

Appendix 3 - OPMH Unplanned Care Mental Health Service Structure

Unplanned Care – Mental Health Services Division

Appendix 4 - OPMH Planned Care Mental Health Service Structure

Planned Care – Older Peoples Mental Health Teams

Appendix 5 - Humber Clinical Divisions

Clinical Divisions (humber.nhs.uk)

Appendix 6 - MH Division Governance Reporting Structure

Page 19 – MH Division Clinical Governance SOP21-009