STANDARD OPERATING PROCEDURE
HULL INTEGRATED CARE 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	*Dec 2022*	*New SOP. Approved at MH Division Practice Network (07/12/2022).*
1.1	*7 June 2023*	*Minor amend - Additional paragraph in section 9 regarding those with functional complex emotional needs; updated appendices Organisational chart and links to intranet. Approved at MH Division Practice Network (07.06.2023).*

Contents

1. TEAM VISION

The Hull Integrated Care Team for 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, aligned with the Trust strategy:

- 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, recognised 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.

Humber Teaching NHS Foundation Trust (HTFT) provides the Mental Health Services via The Hull Integrated Care Team for Older People (HICTOP) as part of a pathway of community based mental health services across the City.

HICTOP is based at Townend Court Block A 298 Cottingham Road Hull. 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 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.

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 that meets the needs of the population of Hull.

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 Humber and North Yorkshire Integrated Care Board (Humber ICB).

4. PARTNERSHIP WORKING

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

4.1. Key Partners

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

4.2. Additional Partners

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

5. OVERALL PURPOSE

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

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

6. TEAM AIMS

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

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

7. STAFFING AND RESOURCES

7.1. Staffing

Discipline	Grade	WTE
Consultant Psychiatrist		1.00
Locum Consultant Psychiatrist		1.00
Team Leader	B7	1.00
Social Work Lead	B7	1.00
Clinical Lead	B7	1.00
Specialist Mental Health Nurse	B6	7.00
Specialist Social Worker	B6	4.77
Registered Mental Health Nurse	B5	0.40
Nursing Associate	B4	1.60
Social Worker	B5	1.00
Social Work Assistant	B4	0.43
Support workers / STR	B3	2.65

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

PROFESSION ROLES

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

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

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

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

Social workers
Provide significant and essential social perspectives which enhance the MDT model through initial assessment of complex cases; negotiating care and support; ongoing assessment; risk management, specialist assessment and advice/management follow-up; discharge planning,

safeguarding, act as care coordinator of patients within the team to include risk assessments and care plans, assessments in relation to the Mental Capacity Act/Deprivation of Liberty Safeguards and Mental Health Act assessments. Some may also be Approved Mental Health Practitioner (AMHP) trained and be on the rota to complete AMHP assessments

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; occupational therapists initial assessment; specialist assessment / management follow-up, contribute to MDT discussions in relation to their patients, escalating concerns to qualified staff members in relation to patient's presentation.

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

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

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

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

7.2. Resources

The team is based at Townend Court. 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 mental health problems or neurological conditions (e.g. dementia).

The service will provide appropriate and comprehensive assessment. In the case of a determined and identified functional mental health need, the patient will be provided with regular evidence-based interventions relevant to their condition and an individualised care plan will be completed. The team will work holistically in supporting patients and their families by involving them in the care planning process. 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.

In the case of the identification of an organic and complex need, Stokes Model of unmet need could be a possible indicator for care delivery or advice or the Pool activity model etc. Humber-approved assessments such as the Addenbrookes Cognitive Examination (ACE) can be utilised in cases where levels of cognition need to be measured and a diagnosis of dementia is being sought.

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

With pharmacological treatments we provide regular face to face 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/transfer back to primary care services.

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

- Patients/service user's will be seen according to clinical priority and then in chronological order, subject to operational limitations.
- Patients/service user's choice will be facilitated where appropriate

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

We Support patients who are being initiated on, and who are already established on Clozaril. This requires an additional level of monitoring and intervention (see Clozapine SOP for further details).

ACS Pilot Scheme Pathway
We are currently in collaboration with the Acute Community Service (ACS) running a pilot treatment programme for community patients within HICTOP. The programme is designed to help patients better understand their mental health and build on coping skills and managing emotions. The programme is a 7-week course spread across a 12 week period, and draws upon several psychological treatment models including Cognitive-Behavioural therapy, Dialectical Behavioural therapy and Acceptance and Commitment therapy. There is a focus on improving quality of life and helping patients to work towards their personal goals. The course sessions include topics such as:

- Understanding emotions
- Relaxation and mindfulness
- Good sleep practices
- Distress tolerance skills
- Relationships and communication

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.

The criteria for acceptance is dependant on risk and presentation of the patient. All referrals are screened and further triaged, if required by the qualified duty practitioner in preparation for the weekly MDT discussion/allocation. Should a second opinion be required this can be sought by the band 7 on shift.

Should a referral be rejected/redirected this is discussed with the patient/care giver, if appropriate. Comprehensive communication sheet is then completed to reflect this decision accompanied by a clear rationale as to why.

The services that can refer directly to CMHT

- Memory service
- HTFT Inpatient/Community services
- Out of area CPA transfers
- Mental Health Liaison
- Primary Care Network

All triages are screened by a Band 6 practitioner while on duty. Within this process risks are assessed and appropriateness for the CMHT service is discussed and measured against our referral criteria, such as risks to self or others, severe self-neglect, deterioration in mental health, memory impairment, medication reviews plus interventions, suicidal ideation plans and/or intent.

All accepted referrals are allocated on a weekly basis within the team MDT across all disciplines Band 5 and above. Over the past 7 months we have established that this is a sustainable way of working for HICTOP and has resulted in no wait list and patients being assessed on average in 2 weeks from the date of referral.

In situations where our wait list time exceeds the 4 week expected waiting time for allocation and intervention, we would then attend the 2 weekly wait list management meetings facilitated by the Service Manager to discuss rationale for the excessive waiting times and develop a plan.

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 to review and update the Trusts electronic waiting list reports on a weekly basis.

As HICTOP is an Integrated Service, referrals can be directed to any professional but also to the appropriate professional when necessary e.g. to a Social Worker when a Care Act Assessment is required.

10. REFERRAL PROCEDURES

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

Exceptions
Out of area Care Programme Approach (CPA) transfers where the individual is already under the care and treatment of specialist mental health services or as a minimum who have a robust treatment plan in place will be accepted subject to review by the MDT. It has to be acknowledged between the transferring team to the accepting team the level of priority in terms of allocation taking into consideration capacity of workloads within the teams.

Receiving referrals
HICTOP receive electronic referrals via the Triage Service. These are then screened and if appropriate accepted for MDT discussion and allocation on a weekly basis (Wednesday).

Referrals are also received from internal sources following telephone discussion with duty and referrals tasked to the team via the Lorenzo system. Internal sources include:

- Mental Health Liaison Service
- Inpatient units
- CITOP (to be allocated within 72 hours not including weekends)

- Transfers from other CMHT's
- Memory Assessment Service

Referrals from HICTOP 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.

Admin would create a referral on Lorenzo to CITOP for 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 with CITOP is near completion CMHT support will be resumed, if required. If discharge is appropriate at this stage, all parties attend a 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.

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

The care co Coordinator will update the care plan and agree with the patient a visit by a qualified member of staff within 3 working days of discharge from CITOP.

Primary Care Network referrals; stepping up and stepping down.
A representative from the PCN network attends the weekly MDT during the initial slot. Referrals that are appropriate for PCN interventions are discussed with the team. Patients who are low in mood, anxious , socially isolated and have very low suicidal risks can potentially be accepted. A patient who is experiencing memory loss would not be suitable for this service.
Similarly the PCN practitioner can step their patients back up to the CMHT during this slot, should their mental health be deteriorating and their risks increasing.

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.

11. CONTACT AND ACCESSIBILITY

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

Hull Integrated Care Team for Older People
Townend Court Block A
298 Cottingham Road
Hull
HU6 8QA
Tel: 01482 335795/303570 Fax: 01482 303561.

Emails can also be sent and accessed via the HICTOP duty inbox - hnf.tr.hictopduty@nhs.net

Staff can be contacted between 9am and 5pm 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. 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 assigned to the Hull area.

In cases where a complete transfer of care from mental health services back to the care of their GP is appropriate, the care coordinator will update the FACE, care plan, cluster and, if required, an accompanying comprehensive GP letter would follow to ensure that all parties are aware of possible relapse indicators that may be associated with any future deterioration in mental health to be identified by the GP.

13. INVOLVING PATIENTS, CARERS AND FAMILIES

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

Patient feedback groups have been commenced at Townend Court and we have worked in collaboration with the Trust Patient Feedback Team to provide us with relevant feedback to contribute towards team and wider service development and improvement.

14. TRAINING AND STAFF DEVELOPMENT

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

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

Training cards are being developed via the Functional Pathway working party under the umbrella of the NHS 5 year plan for service development; this covers all bands of staffing.
Staff are encouraged to participate in and attend Continuing Professional Development days, and HICTOP hold 6 weekly Development Meetings which all staff are encouraged to attend.
All staff have established link roles within the team to develop their skills and knowledge and subsequently improve patient outcomes and care.

Appendix 1 - Divisional Structure

For updated Divisional structure please follow the link - Mental Health Services Division (humber.nhs.uk)

Appendix 2 - OPMH Inpatient Units Operational Structure

For updated Divisional structure please follow the link - Mental Health Services Division (humber.nhs.uk)

Appendix 3 - OPMH CMHTs Operational Structure

For updated Divisional structure please follow the link - Mental Health Services Division (humber.nhs.uk)

Appendix 4 - MH Division Clinical Governance Structure