Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
SPECALIST TREATMENT AND RECOVERY SERVICE (STaRS)

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

CHANGE RECORD

Version	Date	Change details
1.0	*15/03/22*	*New SOP. Approved at Mental Health Practice Network (CNG) 6 April 2022.*
1.1	*01/03/23*	*Amended to reflect service changes leading to amendments in duties and responsibilities, procedures and the pathways in the appendices 1-6. Approved at MH Practice Network (1 March 2023).*

Contents

1. INTRODUCTION

This document will provide operational details relating to the Specialist Treatment and Recovery Service (STaRS).

STaRS is a complex recovery service, focussing on the rehabilitation of adults, in the Hull and East Yorkshire area, who have complex and challenging mental health needs. The service has a 5 bedded recovery unit that can hold a mixed gender patient group and a community outreach service which provides rehabilitative interventions in the community. STaRS also provide a focus on the repatriation to Hull and East Yorkshire of out of area patients

The service has multi-disciplinary approach to ensure the guidance recommended by the National Institute of Clinical Excellence (NICE) is adhered to and these may include:

- NG181 Rehabilitation for adults with complex psychosis
- CG82 Schizophrenia. Core interventions in the treatment and management of Schizophrenia in adults in primary and secondary care.
- CG78 Borderline Personality Disorder. Treatment and Management.
- CG38 Bi-Polar Disorder, The management of Bi-polar disorder in adults, children and adolescents in primary and secondary care.
- CG77 Anti-social Personality Disorder. Treatment, Management and Prevention.
- CG22 Anxiety (Amended) Management of Anxiety(Panic disorder with or without agoraphobia and generalised anxiety disorders in primary, secondary and community care.
- CG23 Depression (amended) management of depressions in primary and secondary care.
- CG 120 Psychosis with coexisting substance misuse. Assessment and Management in adults and young people.
- QS34 Self-Harm
- QS101 Learning Disabilities: challenging behaviour.
- NICE guidance and public health outcomes

2. SCOPE

The scope of this operational (SOP) guidance is to provide transparency of the procedures; roles, responsibilities, and the expectation of the rehabilitative service and includes both aspects of the STaRS in-patient and community outreach service to guide staff of the safe and effective service provision to the patient group. The SOP is communicated and available to anyone who comes into contact and requires an awareness of STaRS rehabilitation service.

3. DUTIES AND RESPONSIBILITIES

The purpose of STaRS is to work with individuals, with complex needs, to improve their day to day functioning, support their continued recovery and increase their social inclusion. STaRS work in addition and collaboratively with other teams, providing intensive support to both inpatients and community patients who use their service, using a biopsychosocial model. STaRS speciality allows for a focus on rehabilitative goals for individuals whose recovery is complex. The focus would include unmet needs in relation to, mental health, physical health, employment, accommodation, leisure, social networks, personal safety, education around medication, prompting for medication and some practical support, alongside any other individual needs and goal-based outcomes identified within the person-centred care plans.

STaRS staffing consists of:

Team Leader
B8c Approved Clinician
B7 Psychologist
Clinical Lead
Deputy Charge Nurses
Registered Mental Health Nurses
Health Care Assistants
Specialist Social Workers
Social Worker
Advanced Occupational Therapist
Specialist Occupational Therapists
Assistant practitioners of OT
Occupational Therapy Assistants
Nursing Apprenticeship
Peer Support Worker
Administrators

4. PROCEDURES

The day to day running of the unit and community outreach service adheres to national and local policies and procedures as well as NICE guidance. All of these can be accessed via the Humber Teaching NHS Foundation Trust intranet site.

STaRS provide a multi-disciplinary team approach to ensure delivery of evidence-based interventions (NICE as above) and care through the provision of other dedicated health staff which includes; Responsible Clinician, Junior Doctors, Registered Mental Health Nurses, Psychology, Occupational Therapy, Social Work, Modern Matron and Service Management.

STaRS utilise a value based Compassion Focused Approach to each other and their patients, as well as ensuring the inpatient unit uses a Psychologically Informed Environment (PIE) model, in order to support safe and secure relationships and environments for both staff and patients. Least restrictive practice is promoted and adhered to by all staff. STaRS inpatient unit operates a 24-hour 7-day service, and the shifts consist of Long Days (07:45-20:30), Early (07:45-15:45 hrs) Late (12:30-20:30hrs) and a night shift (20:15-08:00hrs) these are the core shifts to ensure continuity of care and a safe and nurturing environment to promote recovery. The Registered Mental Health Nurse completes shift lead roles and holds responsibility, any areas of concern are escalated to senior members in the team. To manage environmental risk, there is a controlled and contraband items list.

STaRS community outreach service is staffed between the hours of 08:00-20:00, 7 days a week. Psychology, Social Work, Peer Support Workers and Allied Health Professionals working hours are set to support clinical effectiveness, which may change subject to clinical requirements and the safe management of the environment. The community outreach service has a designated Duty Officer who is responsible for completing the roles and responsibilities of coordinating, planning, and delegating all outreach visits, as well as ensuring all lone working procedures are followed and completed to support and ensure staff safety.

STaRS staff are expected to work across both the in-patient unit and community team to support skill sharing, safer staffing, consistency, and continuity across both services. The staff are allocated and informed of their working environment on a weekly basis; these are dictated based on staffing, safety and skill set and weekly staff allocation. Staff are required to be flexible to accommodate sickness and staffing shortfalls. The Health Roster electronic system is to support management of staff working requirements.

Staff are responsible for following the Humber Trust policies when reporting any sickness absences or return to work, as this is required to support safe staffing and support effective management of the service.

Staff are bound by confidentiality and duty of candour and are required to adhere to all other policies and procedures to support them in their role.

STaRS staff have allocated specialist link roles to support sharing of skills and knowledge to support the patients in our care and ensure safe and effective running of the service.

STaRS staff have access to regular supervision and reflective space to support clinical effectiveness. All staff are to take personal responsibility for their actions and are required to ensure all training is undertaken, either mandatory or specific, to ensure they are competent.

Registered staff are required to work in relation to their registration requirements and provide role modelling to junior staff.

STaRS community outreach service can offer highly intensive and low level interventions in a person's environment or as an inpatient. The RAG rated model is used to assess patients' outreach need, with outreach intervention being provided for up to 18 months in the community.

STaRS referrals are triaged individually and in line with the team's inclusion and exclusion tool and within the Trust required time limits. All referrers will be provided verbal and written outcomes. At times there may be a need for an extended assessment period to best establish treatment needs and goals as well as therapeutic relationships. This period could be for up to 4 weeks with an aim to reduce this length of time for inpatients due to be discharged to the community.

A holistic and whole systems approach is used by all staff to ensure a patient's recovery journey encompasses every aspect of their life.

STaRS patients will be provided specialist assessments based on their identified needs. Recovery focused and evidence-based interventions will be provided either in a group or 1:1. These will be planned in collaboration with patients using Goal Based Outcomes and the DIALOG scale. As well as specific discipline assessments dependent on needs and goals.

All patients will have an up-to-date formulation, individual recovery led care plan and risk assessments that are reviewed as required by the Trust.

All staff are required to report any risk factors and manage these according to the Trust policies.

All patients on STaRS caseload will be supported by the Care Programme Approach or be Case Managed from Social Care staff. A Care Coordinator will be provided by STaRS for repatriated OOA patients whilst an inpatient. When long term support needs are identified in the community, Care Coordination will be transferred to the CMHT.

STaRS community patients will be provided Care Coordination by their identified Community Mental Health Team. Referrals will also be considered from other pathways including the Dual Diagnosis Service, providing that medical input in available to them. STaRS community outreach/in reach interventions will be reviewed via a weekly referral meeting and the identified STaRS key workers will attend the relevant CMHT MDT meetings as needed, to support risk management. A member of the STaRS team will also link in fortnightly with the inpatient units to identify any potential referrals at the earliest opportunity. A discussion will be had between the referring inpatient unit and the relevant community mental health team prior to referral.

STaRS inpatients are overseen by a Responsible Clinician, MDT and weekly key worker sessions and will have access to a twice monthly face to face MDT review. This will be increased if needed and supported by the MDT Criteria for Zoning RAG rated Model (appendix 9).

Staff are required to work in line with the patient's care plan. All patients assessed to lack capacity will be provided care based on their best interest and least restrictive approach.

Staff will be actively engaged with patient and carer involvement, and they will be provided support as needed and inclusive in intervention planning when consented by their family member/friend. Assessments under the Care Act will be completed and supported, please see Friends and family support pathway for full details (appendix 15).

Staff are required to use defensible documentation in line with Trust policy.

5. APPENDICES

These are detailed instructions which must be followed, or steps which must be taken, to implement the document using the following STaRS procedures:

1. Community Inclusion/Exclusion Criteria (see appendix 1)
2. Inpatient Inclusion/Exclusion Criteria (see appendix 2)
3. Inpatient Referral Pathway (see appendix 3)
4. Community Referral Pathway (see appendix 4)
5. Referral form (see appendix 5)
6. Recovery Care Pathway (see appendix 6)
7. Criteria for Zoning (see appendix 7 and 8)
8. Does not meet criteria letter template (see appendix 9)
9. Service User Assessment (see appendix 10)
10. Discharge Letter (see appendix 11)
11. Letter of Out of Area providers prior to assessment (see appendix 12)
12. Current Placement Assessment for out of area use (see appendix 13)
13. Family and Carer Information (see appendix 14)

Appendix 1: Community Inclusion/Exclusion Criteria

Aim of Community Outreach – To offer practical, functional, and psychological interventions to maintain community living for service users with severe and enduring mental illness. STaRS also offer consultation and advice to professionals for patients known to the service.

Inclusion criteria:

1. Adults aged 18 plus, who have complex and enduring mental health difficulties with a history of complex needs with an impact on their ability to function independently in the community
2. Currently placed out of area and consenting to transfer back to Hull and East Riding
3. People who have unmet needs that are impacting on their recovery, that require high levels of support to improve their skills and independence. Including to their mental health, physical health, employment, accommodation, leisure, social networks, personal safety, education around medication, some prompting for medication and some practical support, alongside any other individual needs and goal-based outcomes.
4. Those living in Hull or East Yorkshire area, or in hospital and transitioning back into the community, supported living or independent living
5. those who can consent to working with us and opt into the service.
6. Those whose previous community placements have required additional support not currently offered by other services
7. Cluster 5-9 and 11-17
8. People with an allocated CMHT or support from a team who can provide medical input and care coordination.

Exclusion criteria:

1. People not living in Hull or East Yorkshire (unless identified for repatriation)
2. people who do not have any identified unmet needs or do not wish to work with the service
3. People whose primary need is crisis support/substance misuse/emotional dysregulation where alternative services would be better suited to offer support
4. Cluster 1-4 and 10 and 18 plus
5. No allocated CMHT

Appendix 2: Inpatient Inclusion/Exclusion Criteria

Aims of Inpatient – To offer interventions to service users with severe and enduring mental illness to support them in achieving or maintaining community living where there is an identified impact on level of functioning.

Referral Criteria

1. Adult aged 18 plus
2. Currently placed out of area and assessed as being appropriate for the rehab service and environment
3. Currently in a local inpatient ward, assessed as being appropriate for the rehab service and environment and established on a treatment plan
4. Cluster 5-9 and 11-17

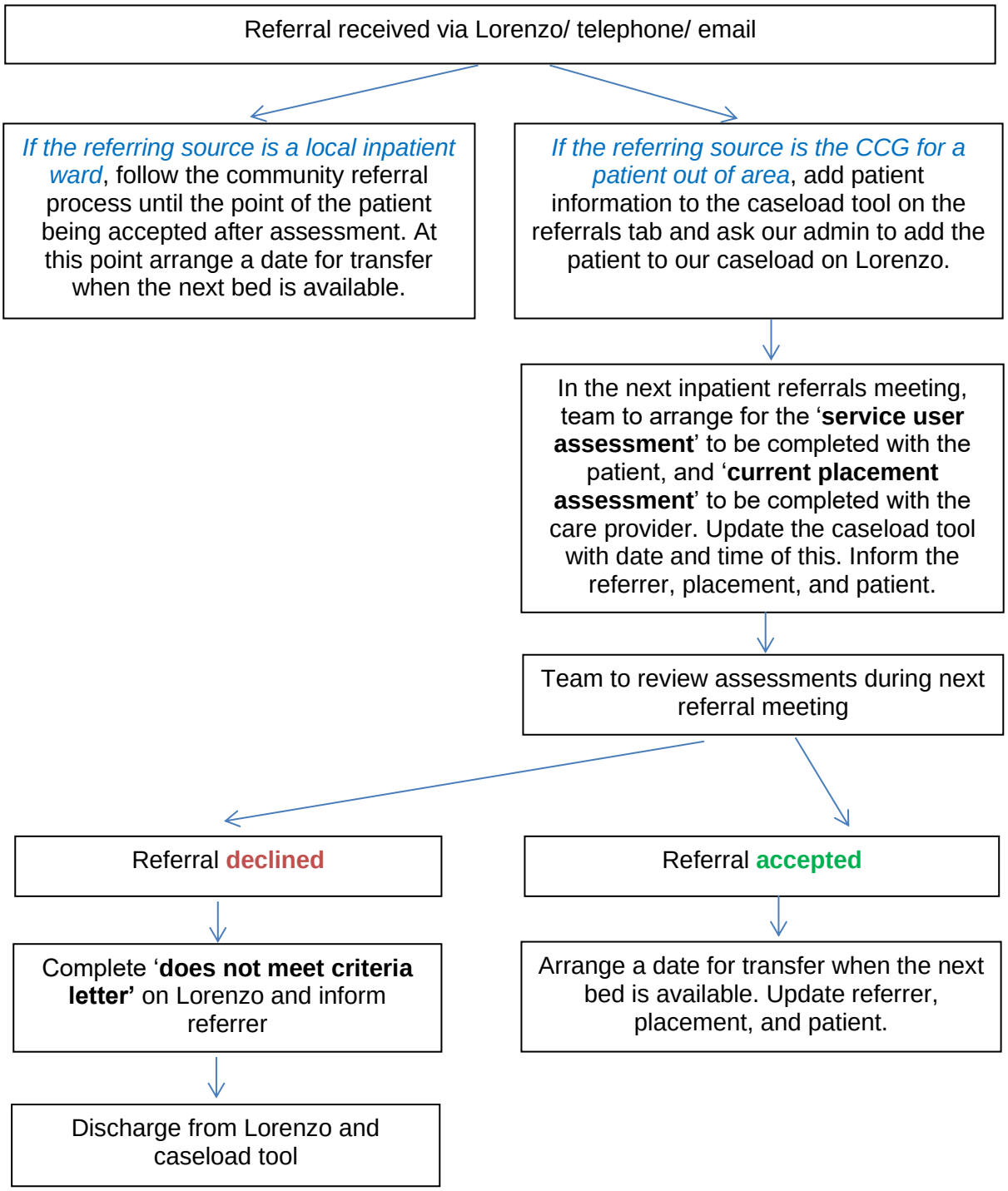
Inclusion Criteria

1. Adults aged 18 plus
2. Currently placed out of area and consenting to transfer back to Hull and East Riding
3. Currently residing in a Humber Teaching NHS Foundation Trust Mental Health unit
4. Severe and enduring mental health illness with a history of complex needs
5. People requiring rehabilitate interventions to improve their level of independent living
6. Those living or previously lived in Hull or East Yorkshire area
7. Those whose previous community placements have required additional support not currently offered by other services
8. Cluster 5-9 and 11-17
9. People with a CPA Care Coordinator identified from the CMHT
10. People in low secure services who require repatriation, are under the Forensic Outreach Service and have completed identified therapies to manage risk, as well as having unescorted leave and working towards a discharge plan.

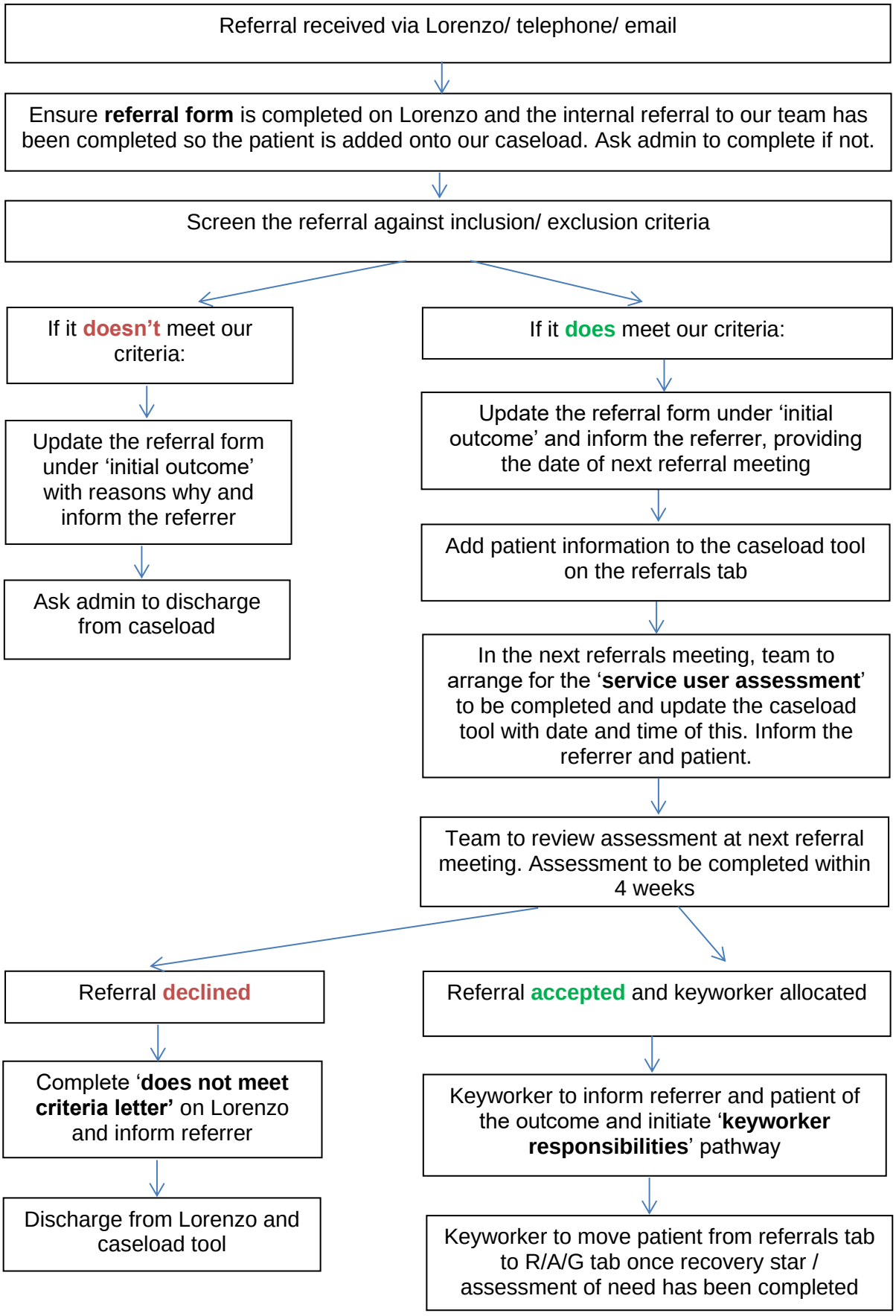
Exclusion criteria

1. Currently in high or medium secure services, or under MOJ restrictions
2. Has a primary diagnosis or presentation that requires a specialist service i.e. eating disorder or brain injury?
3. Not currently in an inpatient setting
4. Where there are safety concerns around being on a mixed sexed ward
5. Cluster 1-4, 10, and 18 plus

Appendix 3: Inpatient Referral Pathway



Appendix 4: Community Referral Pathway



Appendix 5: Referral form

Specialist Treatment and Recovery Service (STaRS)
Referral form

Dear colleague,
Thank you for making a referral to STaRS. Please complete this form and then create an internal referral to the team on Lorenzo. After the triage process, a member of the STaRS team will arrange to assess the service user with an aim to provide an outcome at the earliest convenience. Please indicate by ticking below which service you are referring to:

Inpatient Service	
Community Service	

Referrer Details

Referrers name	
Referring team	
Referring contact details	
Date of referral	

Patient Details

Name	
DOB / Age	
NHS Number	
Address	
Contact number	
GP	
CMHT and Care Co-ordinator	
Accommodation status	

Mental Health and Risk

Diagnoses	
Cluster	
Medication	
Mental Health Act status	
Physical health needs	
ReQol score and date	
Summary of risk to self/others	
Safeguarding	
Does the person have capacity to consent to the referral? If not, has a best interest decision been reached around this?	
Does this person need short term support to manage crisis?	

Reason for Referral

Reason for referral	

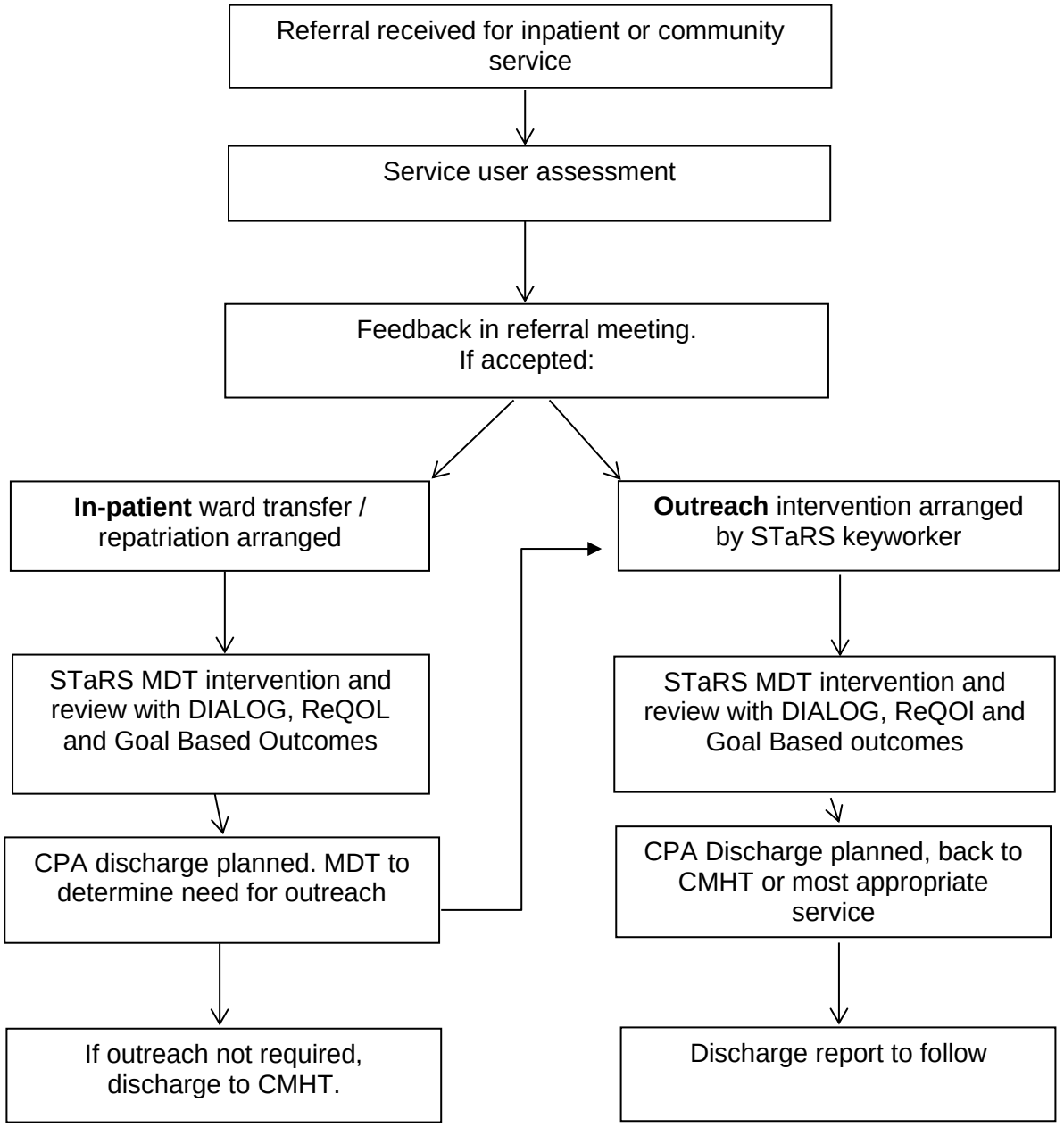
What are you hoping we can achieve?	
Recovery goals	
Details of benefits and finances	
Past living arrangements	
Social networks and relationships with others	
Discharge plans (area/type of accommodation)	
Anticipated duration of time with STaRS / level of required input (daily/ weekly)	

Initial Outcome – for STaRS duty worker to complete

Need more information (please specify):	
Initial referral accepted for further assessment:	
Initial referral not accepted with reasons noted:	

Authorised by:
Role:
Date:
Time:

Appendix 6: Recovery Care Pathway



Appendix 7: Criteria for Zoning (MDT inpatient model)

CRITERIA FOR ZONING

- High level of risk to self or others including absconding.
- Engagement levels – intermittent or constant.
- Newly admitted/transferred and unknown – first 72 hours
- Unmanaged physical illness
- On Sec 5(2) or 5(4).
- High levels of distress related to mental health
- Isolative/non engagement with staff.
- No treatment plan in place/patient not concordant with plan/treatment
- No CPA meeting arranged
- Awaiting completion of baseline assessments.

- Risk issues reduced on unit – needs to be considered if off unit
- Remains vulnerable.
- HIP part two and Recovery Star review completed
- Starting to gain insight – 'Accepting Help' on Recovery Star, evidence of acknowledging need to address social issues (Relationships, Housing and Benefits)
- Accepting medication without coercion
- CPA arranged

- Recovery/response to treatment in evidence - 'Believing' on Recovery Star
- Informal (or CTO pending)
- Independent leave – may be day or overnight
- Concordant with medication.
- CPA/117 processes in place - Information sought from family and carers

Appendix 8: Criteria for Zoning (MDT community model)

CRITERIA FOR ZONING

- Transitioning from an inpatient setting
- Engagement issues that require a higher level of intervention
- High level of self-neglect
- High level of occupational deprivation
- High risk of social isolation
- At risk of losing tenancy due to lack of functional living skills
- High levels of skill deficits to meet mental health needs
- Patient not concordant with recovery plan/treatment
- Currently undergoing assessments
- Recovery Star identifies higher level of intervention
- ReQoL scores identifies a higher level of intervention
- Occupational Therapy/Psychological assessments identify higher level of intervention
- Change in presentation (not crisis management)

- Engagement issues that require a lower level of intervention
- Low level of self-neglect
- Low level of occupational deprivation
- Low risk of social isolation
- Lower level of skill deficits to meet mental health needs
- Some concordance with recovery plan/treatment
- Currently undergoing assessments
- Recovery Star identifies lower level of intervention
- ReQoL scores identifies a lower level of intervention
- Occupational Therapy/Psychological assessments identify lower level of intervention
- Minimal changes noted in presentation (not crisis management)

- Engagement issues that require a lower level of intervention
- Recovery Star identifies minimal level of intervention
- ReQoL scores identifies a minimum level of intervention
- Occupational Therapy/Psychological assessments identify minimal level of intervention
- Social inclusion intervention only

Appendix 9: Does not meet criteria letter template

Date:

Specialist Treatment and Recovery Service
Townend Court
298 Cottingham Road
HULL
HU6 8QR
Tel: 01482 336846

Specialist Treatment and Recovery Service (STaRS)

Re:
DOR:
Referrer:
DOB:
NHS No:
GP:

Thank you for your referral to the Specialist Treatment and Recovery Service (STaRS).
The service user was recently discussed in our referrals meeting. We feel that (person's name) is not appropriate for our service at this time for the following reasons:

Following MDT discussion and accessing (person's name) professionals meeting it was deemed that their primary needs were not within the STaRS remit.

If you feel that their circumstances change in the future, and you feel they are more appropriate for this service please feel free to re-refer.

Yours sincerely

On behalf of
Specialist Treatment and Recovery Service

Appendix 10: Service User Assessment

Service User Assessment

Service user:		DOB:	
NHS Number:		Date of assessment:	

What are your strengths/things that you are good at? What do you think you need help with? What are you currently receiving help with?
What changes do you want to make to your life? What are your current goals? What are your hopes for the future?
How do you manage your living skills and what support do you receive for this? I.e. managing finances, personal care, cooking, accessing the community?
Has there been any change whilst staying in your current placement? Could you tell me about this?

Assessment summary:
Assessment action plan:

Completed by:
Designation:
Date:
Completed by:

Appendix 11: Discharge Letter

Specialist Treatment and Recovery
Service (STaRS)
Townend Court
298 Cottingham Road
Hull
HU6 8QR
Tel: 01482 336830/6 (inpatient)
01482 336846 (community)

DISCHARGE SUMMARY

SERVICE USERS NAME:

NHS NUMBER: D.O.B:

ADDRESS:

DATE OF ADMISSION OR START OF INVOLVEMENT WITH STaRS:

DATE OF DISCHARGE FROM STaRS:

REASON FOR REFERRAL TO STaRS:

OVERVIEW OF INTERVENTIONS AND ASSESSMENTS COMPLETED:

- NURSING:
- OCCUPATIONAL THERAPY:
- PSYCHOLOGY:

SUMMARY COMPLETED BY (Name & Designation):
CC:

Appendix 12: Letter to Out of Area providers prior to assessment

Date:

STRICTLY PRIVATE & CONFIDENTIAL

Dear

A member of the Specialist Treatment and Recovery Service (STaRS) will be accessing your service in order to complete a repatriation assessment of **INSERT PATIENT NAME** on **ENTER DATE.**

The STaRS service is a hybrid multi-disciplinary rehabilitation service which comprises an in-patient unit and a community outreach service and offers a bespoke recovery focused intervention package. The service has been developed within the Humber Teaching NHS Foundation Trust in order to support the safe and secure repatriation of out of area patients back into their local areas to meet the requirements of the NHS England Long Term Plan (2020).

The assessment may take up to three hours and will include a discussion with the clinical team, review of the patient clinical notes and a face to face assessment with the patient and any relevant others. The information generated in the review will be discussed further within the STaRS Multi-Disciplinary Team Meeting with any outcomes and recommendations provided in writing within 28 days.

If you would like any further details about the STaRS service or clarity around the review please contact us on the above telephone number.

Yours sincerely

Name
Designation
Cc:

Appendix 13: Current Placement Assessment (for out of area use)

STaRS Current Placement Assessment

INPATIENT REFERRAL		COMMUNITY ONLY REFERRAL	
Service User name		NHS Number	
Current placement and contact details		DOB	
Next of Kin, contact details, and consent to contact?		Lasting Power of Attorney details	
Date of admission		Diagnoses/ MHA status	
Care Coordinator/Key worker and contact details		Current involvement	
Service User consent to referral:		Planned discharge date and address :	

Does the person have any identified capacity issues? If yes please provide details
Please provide a brief history leading up to admission
What is the person's current presentation? What engagements and interventions are being offered, and what progress has been made with this? What would staff say it is like to be around this person?
Are there any ongoing or historical safeguarding issues? How are these managed currently?

Does the person have a social support network? How supportive or helpful are these relationships?
What are the person's interests? (work, leisure, education, vocational)

Does the Service User have:		
Any other medical conditions? If YES, please describe and include any ongoing involvement with other services regarding this.	YES /NO	
Medication If YES, please describe and include concordance with this. Do you have a medication timeline for this patient?	YES/NO	

Physical Impairment (e.g. mobility, sensory problems etc) If YES, please describe. Do they require any aids/adaptations or ongoing support from another provider?	YES /NO	
Cognitive Impairment (e.g. concentration, attention, memory, initiation problems, impulsivity) If YES, please describe. Have they had any scans or investigations? If yes, please attach with this document. Has this been assessed?	YES /NO	
Communication difficulties If YES, please describe.	YES /NO	
Suicide/self-harm history If YES, please describe	YES/NO	

Challenging/ Inappropriate Behaviour If YES, please describe. Is there a management plan for this behaviour? How frequently does this occur, and when was the last incident? Have there been any incidents of seclusion or restraint? If yes, what where the triggers and circumstances, frequency and duration of these and is there anything that prevents incidents occurring and anything that helps the service user during or after an incident?	YES /NO	
History of offending behaviour? Are there any ongoing conditions or criminal proceedings? If YES, please describe	YES/NO	
Substance Misuse, Including history of? If YES, please describe including ongoing treatment or support being offered for this.	YES/NO	
Is your environment smoke free? If not: Do they smoke? If YES, what support/treatment does the patient receive for this?	YES/NO	

Level of supervision required for:	
Dressing	
Personal Hygiene	
Activities of daily living: • Laundry • Meal preparation • Shopping • Road safety	
State any specific transport requirements: Do they have a bus pass?	
Assessment formulation and identified rehabilitation goals:	

Please attach relevant supporting information			
	Tick		Tick
Care plan		Formulation	
Risk assessment		Time line /chronology including presentation and treatment	
OT report Psychology report Social Worker report		CPA review form	
S17 leave form			
OTHER:			

Completed by:

Name: **Job Role:**

Date & Time:

Appendix 14: Family and Carer Information