Northamptonshire Healthcare
NHS Foundation Trust

OLDER PEOPLE'S COMMUNITY MENTAL HEALTH TEAMS OPERATIONAL POLICY

OP.OPCMHT

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Why we need this Policy

Northamptonshire Healthcare NHS Foundation Trust (NHFT) provides comprehensive mental health services for the 117,400 aged 65+ (2015 JSNA) population in the Northamptonshire region, requiring close partnership working with local health, social care and voluntary/community sector. NHFT's Older People's Community Mental Health Teams (OPCMHT) provide a range of services, including assessment, treatment and support for those diagnosed with complex and severe mental health difficulties emotional disorders, psychosis and dementia.

OPCMHT's form part of an integrated whole system approach that is delivered in conjunction with Urgent Care and Treatment Team's and Inpatient mental health services.

Throughout Northamptonshire, there are four OPCMHT's, which serve the localities in which they are based. These are Multi-Disciplinary Teams which exist to provide a needs-led, evidenced based service. People referred to OPCMHT will receive a comprehensive assessment taking into account their mental health and physical health. Carers will be offered a carers assessment via Northamptonshire Carers which may enable them to receive additional support in their role. Following assessment, appropriate services are offered for their mental health needs and sign posting for specialist social care and physical health needs

The Trust is committed to treating people with dignity and respect in accordance with the Equality Act 2010 and Human Rights Act 1998. Throughout the production of this policy due regard has been given to the elimination of unlawful discrimination, harassment and victimisation (as cited in the Equality Act 2010).

What the Policy is trying to do

The aim of this policy is to set out the standards and expectations for Older People's Community Mental Health Teams within Northamptonshire Healthcare NHS Trust.

Key duties

- The Northamptonshire OPCMHT's are multidisciplinary groups of professionals working together to provide specialist, community-focused, mental health services to adults over the age of 65 years with mental health problems.

- The OPCMHT's are committed to ensuring that all health care needs and risk are assessed and that service users are managed within the Care Programme Approach and an appropriate treatment/care plan and risk management plan is agreed. The plan will include the views of the service user and relevant carers and a copy will be provided

- The OPCMHT's will provide services that are accessible to all sections of the local population in compliance with equality and diversity principles, including access to interpreters as required.

- They will work with service users within a model of care that aids recovery and enables the service user to return to their full potential in day to day life and, when appropriate, discharge from secondary services.

- The OPCMHT's will work collaboratively with and referring appropriately to other NHFT services such as the Urgent Care and Assessment Team, (UCAT), Inpatient Services, Forensic Services, Community Teams for People with Learning Disability (CTPLDs), Liaison Psychiatry for Older People (LPOP), Personality Disorder Service and any other new services as they develop.

- OPCMHT's are committed to the continued development of effective partnership and collaborative working with the primary care services as well as other statutory and voluntary organisations ensuring the needs of the service user are taken into account.

- The OPCMHT's will enable service users to have access to advocacy services.

- Carers will be support as per the Trust's Carer's Charter and carers assessments will be arranged via Northamptonshire Carers to ensure appropriate support is given..

- The OPCMHTs are committed to actively involving service users and carers in planning and delivering mental health services by working together in co-production and countywide meetings.

Feedback will be sought by service users and carers through I Want Great Care (IWGC) to ensure we review the services we deliver.

The Older People's Community Mental Health Team has the following management team:

- Service Manager
- Operational Manager (two – one north and one south of the county)
- Band 6 Clinical Leads
- Psychology Lead

The Service Manager has overall responsibility for the Mental Health Services for Older People, both in-patient and community.

The two Operational Managers are responsible for the day to day operation of the OPCMHT, for the delivery of the services it provides and to ensure the delivery of an effective clinical pathway for the service users. This includes the day to day line management of the constituent team members of all disciplines although each discipline will continue to have its own professional lines of accountability.

The Operational Manager will have responsibility for ensuring effective waiting list management of all parts of the OPCMHT business and reporting on performance management.

Identified clinical leads and senior members of each profession, usually at Band 6, in the Team are responsible for professional and clinical leadership and supervision. They also have a key responsibility to contribute to the service development and forward planning in the Team.

The clinical team is made up of Consultant Psychiatrists, Specialist Psychiatric and Trainee Doctors, Registered Mental Health Nurses, Community Support Workers, Clinical Psychologists, and Occupational Therapists, supported by an administration team. At times students also work within the teams; these can be medical students, nursing students or other professions within healthcare.

All disciplines will contribute both professional and generic skills to the team. Each team member is professionally responsible for clients under their care and for recognising the limits of their own competence and job description. This includes the responsibility to seek appropriate supervision both within the team and within their own professional structure.

Non-registered staff will work under the clinical guidance and direction of appropriate professionals.

Each OPCMHT will have weekly multidisciplinary clinical meetings to facilitate the allocation of referrals, discussion of assessment outcomes, and review of on-going cases, case formulation and those for discharge. Meetings will also facilitate input from all members of the Team and will ensure that concerns and differences of professional opinion are fully discussed and a course of action agreed.

Policy detail

Philosophy of the Service

The OPCMHT's will use their resources efficiently and effectively to provide a comprehensive and community-focused service that includes the following:

- Assessment, formulation, planning, treatment, care, support, monitoring and review of individuals' mental health problems and condition to minimise experiences of impairment and disability and to empower them to lead a fulfilling

and meaningful life, this will focus on recovery principles and promoting living well with dementia.

- To ensure pathways are clear and that service users are referred quickly and efficiently to the appropriate services.

- Support carers in their caring roles and help them maintain their health and wellbeing jointly with voluntary/community sectors (Northamptonshire Carers and The Alzheimer's Society).

- Giving advice, information and support to primary care services and other local agencies in the management of people with mental health problems

Objectives of the OPCMHT

- Provide a high quality mental health service to older people and their carers living in the community who are experiencing severe emotional distress or psychotic experiences. Or who have a dementia and are experiencing significant distress/risk/ complex needs that cannot be managed within primary care.
- Provide memory clinic and outreach services for those service users on cognitive enhancing medications.
- Provide a service which is flexible and has the ability to support, change, adapt or reinforce peoples' quality of life in the treatment of the condition, by offering personalized advice tailored to suit individual needs.
- Improve awareness amongst the public and professionals.
- Ongoing monitoring of caseload at clinically agreed milestones.
- Offer support in coping with symptoms, providing information about medication and side effects
- Take an evidence based approach to delivering cost effective treatment programs or interventions which contribute to improving or preventing further Cognitive Functioning Impairment and difficulties experienced by service users diagnosed with a mental health difficulty
- Manage and support service users with in their home setting where necessary, feasible and appropriate
- Ensure care pathways and care plans are in place following assessment to ensure appropriate effective interventions
- Support admission avoidance wherever clinically possible

- Work on a one to one basis or with groups, with service users, carers, health professionals and other agencies
- Provide expert advice and education to other NHFT Health Care professionals on approaches to cognitive impairment management and difficulties encountered by emotional distress and psychotic experiences
- Refer and delegate within the team to maximise resources and utilise expertise of other skilled professionals
- Have in place and implement prioritisation, dependent on clinical need
- Make available a range of psychosocial interventions designed to prevent relapse
- Deliver services and be available to respond to contacts in core hours of Monday-Friday 9am-5pm (out of hours, service users can contact 111 or Crisis and Telephone Support Service (CATSS) 08009170464
- Have in place electronic clinical records and an electronic reporting system and provide accurate and timely reports as requested by the Commissioner
- Actively seek and use feedback from IWGC from service users and carers to evidence the use of feedback in order to improve services

Team Locations and Hours of Operation

Throughout Northamptonshire there are four localities and each locality has a dedicated Older People's Community Mental Health team and a Memory Assessment Service. The localities are:

- Daventry/South Northants
- Kettering/Corby
- Northampton
- Wellingborough/Rushden

The service operates five days per week, Monday – Friday, 09.00 – 17.00. Out of Hours cover is provided by the Service Users local GP arrangements, unless a Crisis Contingency Plan has been agreed with the service user and carer when alternative arrangements may apply.

Service Access Criteria

The OPCMHT's will provide a service to adults aged 65 years and over who are experiencing mental health problems. The service is for service users as follows:

- Individuals with first presentation to Mental Health Services, (whose needs cannot be met via primary care and for whom Changing Minds IAPT Services (Improving Access to Psychological Therapy) is not appropriate), or referrals who require

specialist interventions from a multi-disciplinary team will be treated by the OPCMHT's for periods of weeks or months until their conditions stabilise after which they will be referred back to their GPs or relevant practitioners in primary care.

- Individuals who are transferred from Memory Assessment Services as have been diagnosed with dementia and treated with a cognitive enhancing medication that requires on-going monitoring by the Memory Clinic Team with OPCMHT.

- Individuals who have severe and enduring mental health difficulties (this will include servicer users with dementia) who need on going treatment, care and monitoring for periods, including those with:

    a. Severe and persistent mental health problems and those service users under Section 117 (Mental Health Act) aftercare.

    b. Longer-term mental health problems characterised by poor treatment adherence and as such will benefit from proactive follow-up.

    c. Any mental health difficulties where there is significant risk of harm to themselves and/or to others or where the level of support required exceeds that which can be offered by primary care.

    d. Complex mental health difficulties that require multi-disciplinary input to provide skilled or intensive treatment and care that are not generally available in primary care

    e. Complex problems of management and engagement.

    f. Those service users who are prescribed cognitive enhancing medication who require a period of additional support from the OPCMHT until their condition stabilises.

Referrals not appropriate for OPCMHT are

Service users who turn 65 years of age whilst receiving care and treatment by Adult Community Mental Health Teams (ACMHT), or who have been under the care of the ACMHT within the last twelve months, will remain with the Adult Mental Health Services.

- Service users under the age of 65
- Service users with a primary diagnosis of Learning Disability
- Service users with a head injury or other significant physical health conditions as a primary cause such as delirium or end stage malignancies
- Service users whose needs would be better met by drug and alcohol services

Direct Clinical Services

- Comprehensive Assessment of mental health needs for service users with complex and longer term needs
- Diagnosis of mental health difficulties, its clinical management and/or recommendation for management.

- Case management and Care co-ordination – comprising needs assessment, risk screening/assessment, care planning with service users and carers; support and relapse prevention; monitoring; crisis management; regular review and liaison with individuals and services involved.

- Provide follow-up to service users discharged or on leave from hospital as per policy in line with 7 day 48 hour Inpatient Discharge Follow Up Policy.

- Psychological assessments, formulations and interventions – according to the assessed need of the service user.

- Medication management – in liaison with primary care, OPCMHT's will prescribe, administer depot medication, monitor medication and its side-effects, and encourage concordance with prescribed medication.

- Occupational therapy.

- Assessment and support with Activities of Daily Living.

- Liaison with Approved Mental Health Professionals (AMHP) Services for Mental Health Act Assessments.

- Assistance to Service Users to develop Advanced Statements

- Carers' assessments, signposting to relevant services, support and education

- Annual physical health checks

Referral Process

Northamptonshire Healthcare NHS Foundation Trust provides a single point of access for referrals to mental health services for each locality.

Information required from General Practitioners (GPs) will be specified by the Service and are imperative for the assessment process to commence.

Copies of the most recent and up to date blood and urine examinations should be sent with the referral

Any known risks to self or others should also be included in the referral.

Referrals will not be actioned until all the required information is received.

All referrals received will be screened by the allocated staff member/duty staff member who will review the referrals that come into the service throughout the day.

Referrals that are inappropriate, have missing information or are relevant for another service will be either sent back to the referrer with outcome and timescales required for further information to be returned or forwarded onto the relevant service.

Following referral acceptance:

- First contact for routine referrals to be attempted within 2 working weeks – this could be by telephone.

- Urgent referrals will be dealt with within 2 working days.

- Where an admission to a mental health unit is being considered or where an Emergency (same day) Assessment is required the referral should be made to the Urgent Care and Assessment Team (UCAT) for those Service users experiencing an emotional or psychotic presentation. For those Service users experiencing a dementia-type presentation the OPCMHT will arrange a visit and liaise directly with the service users/carers (within the hours of 9-5 Monday – Friday, outside of these hours referrals will go to UCAT). Alternatives to Hospital admission should be explored at all times.

- The OPCMHT's main referrers are the Primary Care Services (General Practitioners), Acute Mental Health Hospitals and Memory Assessment Services.

- Referrals are also accepted from Acute General Hospital Liaison Services (Liaison Psychiatry for Older People; LPOP) – Urgent cases from LPOP (patients with high suicide risk) should always need discussion and referral to UCAT teams for feasible support in the community or inpatient admission for treatment. However referrals from LPOP will be accepted for patients with complex needs that require a multi-professional input to minimise risks on discharge from the Acute Hospital.
- Other NHFT Teams

- There may also be referrals for Service users following their discharge from Inpatient Services.

- Within the weekly MDT meeting, professionals will discuss the specifics of the referral and outline an initial management plan which will include an initial assessment. This may include:

    - Out-Patient appointment with Doctor for initial assessment
    - Domiciliary Visit by the Doctor to complete the initial assessment
    - Initial assessment by clinical nursing staff
    - Initial assessment by clinical therapy staff
    - Advice to be provided to referrer by MDT

Allocation and Prioritisation

Once the assessment process has taken place, the case will be discussed within the multi-disciplinary team. Allocation for Care Coordination will be determined at this point.

Priority for allocation will be given to:

- Individuals considered or posing a significant risk to themselves or others, on the basis of information provided by the referrer.

- People being discharged from in-patient services and in particular those who have expressed suicidal ideation whilst an inpatient, in accordance with the– 7 day 48 hour Inpatient Discharge Follow Up.

- Service users who require depot medication administered by the team.

- People with complex needs , including those on Section 117 of the Mental Health Act.

- Other referrals will be prioritised according to relevant severity of their identified need and will be seen within 13 weeks as per referral to treatment time performance indicator.

Care Programme Approach (CPA)

The term CPA is used to describe the approach, which is fully explained in – Care Programme Approach Policy, used in NHFT Mental Health services to assess, plan, review and co-ordinate the range of treatment, care and support needs for people who have complex characteristics.

There is a clear expectation in NHFT mental health services that professional staff will positively encourage mental health service users and their carers to participate in the CPA process where appropriate. This is essential if individual care programs are to be effective

Service users will:

- Have their needs and problems assessed by a professionally qualified person
- Service users/carers will "be provided with encouragement and support" to complete their CPA Care Plan "my life story" which is their individual story to share and inform on the treatment they want. It is coproduced with their Care Co-ordinator.
- Ensure the Service User understands the purpose of their CPA care plan and any risks of not engaging in CPA.
- Be encouraged to sign their CPA care plan
- Have a copy of their CPA care plan
- Know they can request the support of a friend, relative or advocate at any time.
- Be given information about their condition and treatment, the risks of the treatment and information about alternatives.
- Have a choice who their CPA care coordinator will be (within the limits of resources and clinical appropriateness)
- Be informed who their CPA care coordinator is.
- Be informed who to contact in the absence of their CPA care coordinator and out of hours.
- Have the role of the CPA care coordinator explained to them.
- Have a crisis and contingency plan
- Be aware that they can ask for a CPA review at any time.
- Be told the reasons why if it is decided a review will not be held.
- Be informed that any information they give may be passed to other members of the team and other agencies if they have a need to know this information.
- Be informed that information will be kept about them in an electronic patient record (EPR).
- Be informed that they have a right to access their clinical records.
- Be given a leaflet explaining to them what CPA is.
- Have specialist communicators arranged if they have communication difficulties, including where their first language is not English

Risk Assessment

Practitioners should refer to NHFT CLP021 – Working with Risk Policy and where appropriate abide with the requirements of the policy

HoNOS

All practitioners should ensure HoNOS is completed on initial assessment, as clinical needs change, as per guidance for clustering reviews and on discharge from services.

Loss of Contact

There may be occasions when a service user chooses not to maintain contact with the CPA care coordinator and/or other members of the care team. Loss of contact will be deemed to have occurred when the service user fails to keep appointments, either as an OPA or in their own home, and no explanation is received.

Staff should follow the DNA/No Access Protocol and also take guidance from the NHFT CLP003 – Policy for Missing Service Users.

Safeguarding

Safeguarding is about raising concerns and protecting children and adults from abuse. Northamptonshire County Council is the lead authority for Northamptonshire, however NHFT has a "Safeguarding Adults Team" however all staff are trained within this area and aware of how to raise concerns.

Discharge

The aim of the Older People's Services is to provide interventions that will maximize the individual's mental health and independence and enable them to return to Primary Care Services promptly.

The service will develop discharge planning as a planned element of the service.

Discharge plans will be developed with the service user and any other professionals or organisations involved in the Service users care.

Service users will be discharged to Primary Care when their condition has stabilised and /or alternative support arranged, as their need for specialist mental health care ceases.

Wherever possible, this will be discussed with the individual and their relatives and carers where consent has been given to do so.

Record Keeping

All electronic and paper records are bound by confidentiality protocols and the Data Protection Act.

The Service adheres to Professional Codes of Conduct and NHFT policies and procedures

Operational Managers and Clinical Leads monitor good practice in record keeping and records are audited to ensure standards are maintained

Service users can request access to information related to themselves and their care.

Lone Working

In line with NHFT Lone Working Policy, CMHT's will ensure that local strategies are in place to ensure safe working.

Staff induction

All new staff will attend a Trust Induction and will also receive a local induction programme individual to their respective area. This will include orientation to the unit and also an individual programme of visits.

Management Supervision

The provision of an effective OPCMHT service can best be achieved by ensuring that staff are supported and feel enabled to deliver the service safely and efficiently.

The team will follow NHFT's for Supervision ensuring that:

- Staff receive regular individual structured supervision by a senior member of staff.
- Team members who come from different professional backgrounds to that of their supervisor have access to professional supervision from a senior within their own discipline. Joint supervision should also be undertaken.
- There will be regular multidisciplinary forums/symposiums to discuss topics of interest.
- There are regular team meetings and STAR days which focus on development and day-to-day business issues

Clinical supervision

All clinical staff will actively engage in clinical supervision. All team members will be provided with an up to date description of their job and role, will be clear about their responsibilities and who they are accountable to.

All staff will have an appraisal annually.

Clinical supervisors will be expected to provide junior clinical staff with regular supervision which will be a minimum of 2 supervisions per quarter (3 months) or as specified by their training requirements.

Students, trainees and learners

All students on placement will be provided with an induction, an assigned assessor and on-going experiential learning, including time with other disciplines. Students will be closely monitored and supported. Each OPCMHT completes a profile of learning opportunities available to Student Nurses. Following their placement, feedback will be sought to ensure that the placements have been positive experiences.

Service users have a right to decline student involvement in their care

Performance management

OPCMHTs recognise the importance of monitoring performance the in order to identify areas of strengths and weakness and assist in future developments of the service.

OPCMHTs will work with users and carers, to collect data and feedback about the activity and quality of the service.

Staff working within OPCMHTs will be encouraged to actively participate in audit and clinical governance.

Workforce development

OPCMHT's are committed to improving the quality and effectiveness of the service by supporting staff to maximise their skills and strengths, ensuring a robust, resilient and forward thinking workforce.

Some of the elements that contribute to this are:

- Supervision and Appraisals
- Regular countywide directorate reflection events
- Protected time to attend non mandatory training such as leadership modules
- Protected monthly STAR days
- Flexible working arrangements where required
- Employee carer passports where required
- Access to Work assessments and provision of specialised equipment where required
- Utilisation of Retire and Return options
- Positive feedback opportunities for all staff within Thank you's and staff quality boards
- Supporting the implementation of apprenticeships within the directorate

Service user and carer involvement

OPCMHT's will promote co-production with service user and carer involvement as it results in better outcomes for individual care, provision of more locally responsive services and greater ownership of health services.

OPCMHT's will involve service users and carers in the following:

- Decisions about their own treatment and care.
- Giving feedback about the quality or type of health and social care received.
- Planning and development of future services.
- Patient stories – support for service users and their carers to share their story with staff and others service users within a variety of methods
- Involvement in recruitment process for all staff roles

PALS - Patient Advice and Liaison Service

There is a Patient Advice and Liaison Service (PALS) in the Trust. PALS focuses on improving services to Service Users. It aims to provide "on the spot" resolution of concerns, advice, information and support for Service Users, their families and carers. All Service Users have the right to access independent advocacy. The Clinical Commissioning Groups have commissioned Total Voice Northamptonshire to provide advocacy within inpatient services provided by NHFT. Service Users can choose to use alternative advocacy services if they wish to do so.

Complaints

OPCMHTs will maintain and follow the complaints procedure in accordance with the current policies and procedures of NHFT.

Serious incidents (SI's)

Where available, learning and recommendations from critical incidents or reports from National Confidential Inquiries will be discussed during weekly team meetings and incorporated into practice in order to improve care and service delivery.

Training requirements associated with this Policy

Mandatory training is not a requirement of this policy.

How this Policy will be monitored for compliance and effectiveness

The Operational Policy is a working guide for all team members. It also serves to inform primary care services, local statutory and voluntary services, service users and carers about the OPCMHT.

This Operational Policy will be reviewed three yearly to reflect major changes in national policy and practice and feedback from local stakeholders and service user experience.

The updated version of the policy will be available on the Trust Intranet and brought to all staff's attention through the staff room.

In addition the Operational Manager's will bring the policy and any revised additions to the attention of all staff with in the Team.

Equality considerations

Equality Statement

The Trust aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Action 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no-one receives less favourable treatment due to their reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to gender identity, socio-economic status, immigration status and the principles of the Human Rights Act.

In carrying out its functions, the Trust must have due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the Trust is responsible, including policy development, review and implementation.

Due Regard

This policy has been reviewed in relation to having due regard to the Public Sector Equality Duty (PSED) of the Equality Act 2010 to eliminate discrimination, harassment, victimisation; to advance equality of opportunity; and foster good relations. Due regard comprise two linked elements: proportionality and relevance. The weight given to equality should therefore be proportionate to its relevance to a particular function. It should also be noted that there will policies/proposals that have no impact and little relevance to equality. This policy is specific to a target group defined in the eligibility criteria namely those people who are over the age of 65 who require mental health services. The potential of any negative impact on those outside of the age criteria is limited as services are provided for those Service users through other pathways such as Adults of a Working Age Planned Care and Recovery Teams (PCART). The target group for individuals who do not have English as their first language will be supported through interpreter services.

The OPCMHT additionally promotes and encourages service user and carer involvement co-production and feedback as this informs better outcomes of care. This policy also states that the Trust will promote effective liaison and collaborative working partnerships with local voluntary and non-statutory agencies that will be of benefit to service users. The team will liaise with and as necessary refer to other specialist teams e.g. Brain Injury team, Leaning Disability Teams, MS nurses, Parkinson 's Disease Nurses, Mentally Disordered Offenders Services, and services to meet the physical needs of Service users (such as District Nurses, Fall Service and ICT).

The Trust works in accordance with its Equality, Inclusion and Human rights policy and its Equality, Inclusion and Human rights strategy.

Document control details

Author:	Jackie Collins in consultation with Dawn Rosen, Bridget Egan, Alexis Berry, Katie Bates, Patient Experience Group (PEG)
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