Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
MENTAL HEALTH - 72 HOUR FOLLOW UP

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Ratified and Quality Checked by: **Date Ratified:**	Director sign-off (Kayleigh Brown) 26 June 2024
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	

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

CHANGE RECORD

Version	Date	Change details
1.0	*Apr-2024*	*New SOP. Approved at MH Division Practice Network (3 April 2024).*
1.1	*Jun-2024*	*Reviewed. Minor amend on page 7 due to PSIA 2023-15. Approved by director sign-off (Kayleigh Brown – 26 June 2024).*

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1. INTRODUCTION

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) have identified the period of time following discharge from psychiatric inpatient care as a time of increased risk for completion of suicide. Between 2010 and 2020, there were 2,394 suicides within 3 months of discharge from inpatient care, where the highest number of suicides occurred on day 2 after leaving hospital (NCISH, 2023), and day 1 and 2 identified as the days with highest risk of suicide following discharge (RCPsych, 2022). The Suicide Prevention Strategy for England 2023-2028 identified that 48% of people who died by suicide in England between 2010 and 2020 had been in contact with mental health services in the 7 days prior to their death.

Following the evidence gathered by NCISH, their recommendation to follow up all patients within 72 hours of discharge from inpatient care is now included in the standard NHS contract in England (NCISH, 2023).

NCISH have identified 10 key elements to improve safety and quality, of which early follow up from discharge is a fundamental step. This key element aligns with the other 9 to provide greater clinical and organisational safety and care to the patient. Other key elements which relate directly to follow up are:

- 24-hour crisis teams
- Family involvement
- Personalised risk management
- Reducing alcohol and drug misuse

These areas are related to the follow up as having support from the family around you, having care personalised to your needs, getting help when experiencing crisis, and the reduction in substance misuse which may increase impulsivity and decrease rational decision making, are all key factors in the risk of suicide and can be appropriately considered at the point of inpatient discharge, when planning the follow up.

Other key factors for consideration for increased risk of suicide on discharge from inpatient services are:

- Housing problems
- Financial problems
- Employment problems
- Discharge from a non-local inpatient unit

Although as professionals and an organisation, the above problems may not be rectified at the point of discharge from inpatient services, consideration of their impact on suicide risk can be considered within discharge planning and the completion of the 72 hour follow up (NCISH, 2023).

National Institute for Health and Care Excellence (NICE) have developed guidance on the 'Transition between inpatient mental health setting and community or care home settings' (NG53). The overarching principles of this guidance include:

- Person centred and recovery focussed care
- Work with people as partners in their own care and transition planning
- Least restrictive options
- Identify support networks
- Support to maintain community links
- Joined up working with other agencies
- Non-discriminatory practice

Furthermore, this guidance identifies key areas for consideration during preparation for discharge and follow up, which include:

- An assessment of the person's personal, social, safety and practical needs to support discharge should be undertaken
- An assessment on the risk of suicide should be undertaken
- Involvement of family and carers
- Agree follow up support before discharge with a completed safety plan
- Booking of a GP appointment within 2 weeks of discharge
- Discharge letter to be sent to the GP within 24 hours of discharge, with a copy provided to the person. A follow up discharge summary to be provided to the GP within a week.
- A copy of the person's latest care plan to be sent to all people involved in their care within 24 hours of discharge
- If the person is being discharged to a care home or supported living environment, information about the person should be exchanged
- **Follow up to be completed within 72 hours** (7 days within the guidance but this has been reduced to 72 hours following NICHE findings)
- **Follow up within 48 hours if risk of suicide has been identified**

This list is not exhaustive and should be read in conjunction with NG53, available here: Recommendations | Transition between inpatient mental health settings and community or care home settings | Guidance | NICE

Additionally, the 72 hour follow up is now included in the Suicide Prevention Strategy for England: 2023-2028. The strategy identifies that patients receive good quality follow up support, in line with NICE guidance, within 72 hours of being discharged from inpatient mental health care. The strategy identifies that 82% of people who died by suicide in England between 2010 and 2020 were assessed to be of 'no risk' or 'low risk' of suicide. Due to this, in 2022 NICE published updated guidelines which reiterate the importance of risk assessment tools and scales not being used to predict future suicide risk in the guidance 'Self-harm: assessment, management and preventing recurrence' (NG225), which is available here:
Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

The 72 hour follow up has directly come into use to provide care and support to people following an inpatient discharge, as a way of supporting people who may be at risk of suicide. The evidence provides a compelling narrative for its use and NICE guidance identifies how discharge planning and follow up should consider a range of factors which may influence a person's mental health, relapse and suicide risk. The follow up should not be a transactional process but one of assessment, support, care and safety planning. Furthermore, NHS England put forward a discharge challenge in 2022 identifying how follow up should be completed to ensure the right discharge support is in place, again cementing the position of the follow up being a robust mental health intervention, with real life benefits if completed robustly and in line with NICE guidance.

2. SCOPE

This document is to support the safe and effective application of the 72 hour follow up directive when a patient is transitioning from a mental health inpatient setting, back to their community.

This SOP is for all Humber Teaching NHS Foundation Trust staff who are involved within the process of 72 hour follow up and they may be from different service areas including inpatient mental health wards, home based treatment teams and community mental health services.

3. DUTIES AND RESPONSIBILITIES

Divisional clinical lead and general managers – The divisional clinical lead and general managers will have divisional oversight over the key performance indicator of the 72 hour follow up. They will be informed of possible breaches through escalation procedures and will report back to the executive management team on adherence to the follow up indicator.

Business intelligence (BI) team – Business intelligence will hold oversight over all 72 hour follow ups and monitor for compliance of their completion. The BI team are not responsible for communication of the follow up to the designated worker, but provide a check and balance to ensure the follow up is met. The BI team will also collate all incident reports via DATIX of breached follow ups.

Senior clinical lead, modern matrons and service managers – The senior clinical leads, modern matrons and service managers will hold responsibility for monitoring for compliance of 72 hour follow up for their service areas and support the facilitation of safety huddles and escalation procedures when required. Pathway and communication issues will be investigated and managed by these individuals.

Bed management – The bed management team as responsible for oversight of all patient's in out of area beds, therefore, hold a key position in ensuring follow up is arranged for patients transitioning from out of area beds back to their communities, locally.

Inpatient team – The inpatient team are responsible for identifying when the patient is moving towards discharge from the inpatient ward to the community. The inpatient team will organise a discharge meeting where the individual plan for 72 hour follow up will be agreed and the person identified to complete it allocated, with notification sent to BI. The inpatient team will complete the 72 hour follow up if this is deemed clinically appropriate as discussed later in this document.

Community team – The community team are responsible for identifying when the patient is moving towards discharge from the inpatient ward to the community. The community team will attend the discharge meeting where the individual plan for 72 hour follow up will be agreed and the person identified to complete it allocated. The community team will be responsible for the completion of the follow up if the patient has been transitioned to their care following discharge and if the follow up is to be completed in core office hours (Mon-Fri 9-5).

Home based treatment team – Patients might be discharged to the home based treatment team when still presenting with significant needs and/or risk which requires a more intensive community support. In this instance, the home based treatment team will complete the 72 hour follow up if they are the most appropriately placed team to do so and the patient is not receiving care from a community team, or the follow up is outside of core office hours.

4. PROCEDURES

This is detailed instruction which must be followed, or steps which must be taken to implement the document. The procedures listed are to ensure and support with the safe and effective completion of the 72 hour follow up.

All processes detailed in this section should be considered within the scope of trauma informed principles, alongside the ongoing work within Humber Teaching NHS Foundation Trust (HTFT) to integrate further trauma informed ways of working.

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual well-being. The working definition of trauma informed practice is:

"Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development." (Office for Health Improvement and Disparities. 2002. Working Definition of Trauma Informed Practice. Gov.UK)

The principles of trauma informed practice are:

- Safety
- Trustworthiness
- Choice
- Collaboration
- Empowerment
- Cultural consideration

Practitioners should be aware of the personal and wider societal effects of trauma, focus on accessibility of services and aim to present re-traumatisation by being sensitive to the needs of the person.

4.1. Discharge and 72 hour follow up planning

During inpatient admission, discharge planning and community treatment should be carefully considered by the inpatient team and any other providers involved with the patient's care. As part of this process, a discharge CPA is organised where the requirements of the 72 hour follow up must be discussed and planned for. A thorough risk assessment should be completed prior to and at the discharge CPA, which can highlight additional risks or needs which may impact on the completion of the follow up or needs and risks which identify a requirement of an expedited follow up to be completed.

When assessing risk prior to arrangements for the follow up, the clinical team should be aware that NCISH have identified through their research that the 48 hours following discharge have the highest levels of risk for completed suicide. Furthermore, NHS England have made a recommendation during their discharge initiative work in 2022 where discharges should be planned for earlier in the day to enable a greater level of wrap around support to the patient, family and carers.

Where an individual's ongoing support or intervention plan is to be delivered by an external agency (whether that is an established relationship or a new referral), the discharging clinician is responsible for liaising with that service to ensure that the provision is clinically appropriate and available to meet the identified needs. This allows the clinician and patient to formulate an alternative plan, prior to discharge, if required. There may be circumstances under which there is a

strong clinical rationale to facilitate the patient in managing their own care/self-referral, in those instances a rationale for not liaising with the external agency must be documented.

Discharge planning must be patient centred, ensuring the voice of the patient, their family and carers are heard and considered. For patients who have a diagnosis of an organic illness and are unable to engage directly in the follow up contact, this can be completed via an identified proxy, during the discharge planning stages. All efforts should be made by the care team to facilitate and encourage direct patient involvement in this process, however for some people this may not be possible due to their organic illness. Please note, the use of a proxy for any other patient group not permitted.

The planning for 72 hour follow up must include:

- Identification of the care team who is to complete the follow up -
    - Consideration should be given for which team is best placed to complete the follow up and the provision of time in relation to when the discharge occurs, i.e if the patient is discharged Thursday or Friday, the follow up might need to be completed by the discharging ward and not the community team as there is limited time for completion of the follow up by the community service. Furthermore, if the patient is unknown to the community mental health service, the ward team might be the best option for completion of the follow up.
- The identification of the follow up individual -
    - The person carrying out the follow up should be someone which whom the patient feels able to openly and honestly speak to, but also someone who has the appropriate skills and knowledge of assessment of risk and need to complete the follow up to an appropriate standard.
    - *HCAs/Students should not be completing 72 hour follow up, however where a student or an HCA is completing the 72 hour follow up, for this to be done under the direct and strict supervision of a registered professional with knowledge of the patient.*
- If the care team or the identified individual who will complete the follow up will not be in attendance at the discharge CPA, contact must have taken place prior to the CPA between the inpatient team and the team/individual completing the follow up, to confirm arrangements for follow up and agree a date, time and venue for this to take place. This will then be documented as the agreement for follow up during the discharge CPA and provided to the patient and family (if applicable).
- Consideration by the clinical team of the presenting risk and the evidence which identifies the 48 hours post discharge having the highest risk for completed suicide
- The initial plan for completion of the follow up, also known as plan A
- The secondary plan for completion of the follow up, also known as plan B, should plan A be insufficient to complete the follow up
- Agreement of the way the follow up will be completed.
    - The default for follow up contact should be face to face, though care teams in consultation with the patient/proxy and family can deviate from this with an appropriate rationale for doing so.
- A date and time for the follow up appointment to be provided to the patient/proxy, along with the agreed venue
- A check and update to the clinical record of contact numbers for the patient/proxy, family members (with consent) and other workers involved with their care. Furthermore, a confirmation of the address the patient will be discharged to, or a care of address if they are currently no fixed abode.
- An up to date record of the patient's next of kin/emergency contact
- A safety plan agreed and established between the care team, patient/proxy, family/carers and other support services in place
- Completion of the 72 hour follow up form on the patient Lorenzo record and submission to BI for monitoring

When agreeing follow up arrangements, care teams should recognise the follow up is a patient safety intervention and as such planning for it should be patient centred. Follow up is not the sole responsibility of one individual or team and the mental health division has a shared and collective responsibility to ensure completion of the follow up is attained. Thus, care teams should work with one another with the aim of reducing barriers, to facilitate high quality care for the patient during this higher risk period.

Patients who chose to take their own discharge against medical advice are still entitled to 72 hour follow up and arrangements should be made with them where possible, regarding the above considerations.

4.2. Completion of the 72 hour follow up

The follow up is a safety critical, patient centred intervention which requires completion and/or oversight from a registered clinician with the appropriate skills and knowledge in risk assessment and safety planning.

The clinician completing the follow up should demonstrate professional curiosity when meeting with the patient/proxy, whereby the follow up should not be a transactional process with a defined list of questions, but an opportunity to explore any current problems and their impact on the risks/presentation of the patient. This being said, the follow up should include discussion and assessment of the following areas:

- How they have been since discharge
- Current risks
- Any thoughts, intent, plans or preparations of suicide
- Medication adherence
- Any follow up actions agreed at the discharge planning stage
- Consolidation of the safety plan
- Confirmation of next planned contact (if applicable)
- Any other areas which are important to the patient/proxy and family/carers

If the follow up indicates further contact is required, this should be agreed and planned with the patient at the time of the follow up contact. As part of the follow up contact, the clinician may also be required to liaise with other teams or agencies, both internal and external to HTFT.

Once completed, the follow up should be documented on the patient's electronic record, ensuring a thorough overview of the follow up is included as well as their current risks, the safety plan and arrangements for next planned contact (if applicable). **The follow up must also be recorded as a care contact on the patient record as the follow up will not be officially logged on the system's reporting mechanisms unless this has been completed.**

4.3. Escalation procedures should 72 hour follow up not be completed

During discharge planning, a primary and secondary (A & B) plan were established for completion of the follow up. Should plan A fail to complete the follow up, the clinican/care team should move forward with the use of plan B. All attempts made to complete follow up should be clearly documented on the patient's electronic records.

If the carrying out of plan B still does not allow for completion of the follow up, the clinician/care team should move forward with the escalation procedures listed here.

If the patient has taken their own discharge against medical advice and there has been reduced opportunity for robust follow up arrangements to be made, resulting in failed follow up completion, the clinical team should still complete the following steps of the escalation procedures within the context of the patient's wishes and considerations, as well as the inpatient team, at the time of the discharge.

Safety Huddle/MDT discussion

The clinician/care team should call an urgent safety huddle/MDT discussion as soon as possible/urgently following the failed attempt of plan B.

The membership of this group should include:

- The clinician(s) who have made the attempts at follow up. It is noted this may not always be possible in teams which have shift patterns and the clinician is not available, therefore in this instance the clinical notes from the attempted follow ups should be used
- The Clinical Lead
- The Modern Matron/Senior Clinical Lead or other senior clinical operations representative
- A medical representative (where possible within service structures)
- Other workers involved in the patient's care, or consultation with them prior to the meeting

The group should consider the following in their discussion and planning:

- The risk assessment of the patient on discharge
- The risk of suicide
- Their presentation recently
- Their medication and adherence
- Any factors which may impact on engagement and risk such as; housing, financial or employment issues, and substance misuse
- Their networks – family, friends, social contacts or people they see regularly
- The context of the failed attempts to follow up

The frequency of the huddle/MDT:

- The huddle/MDT should meet daily until the follow up is completed or the group agree to stand down the requirements for follow up

All discussions, actions and rationales for these following the safety huddle/MDT must be recorded on the patient's electronic patient record on an MDT meeting clinical note.

Actions from the safety huddle/MDT discussion
Various actions will be agreed following the safety huddle/MDT as it should be based upon patient needs and risk, therefore being individual to them. Therefore, there is no prescriptive list of actions which should be undertaken following the failed attempts at follow up, but some considerations may be:

- Contact with the patient's emergency contact
- Contact with the patient's next of kin
- A welfare check by HTFT staff to their home address
- Attendance at other planned appointments they may have with other professionals or agencies

It is at the discretion of the safety huddle/MDT to how many times further attempts are made at follow up and the mechanisms used to try to facilitate it. Once a set of actions have been completed and this has not yielded success of the follow up, further discussion in the safety huddle/MDT should take place.

All attempted actions and their outcomes must be recorded in the patient's electronic records.

Emergency response
If there is a significant concern for the safety of the patient and HTFT staff have already conducted a welfare check at the address, the team should consider if an emergency service response is required.

Due to the initiative ‘Right Care, Right Person’, HTFT staff must have made reasonable attempts to engage and account for the patient’s safety prior to any escalation to emergency services.

Escalation of a welfare check to emergency services must be based on immediate risk to the patient or others.

Failed 72 hour follow up completion
If the deadline has passed to complete follow up, the clinical team must complete a datix incident report noting the failed 72 hour follow up. The datix should include all attempts made at contact for the 72 hour follow up, and the plan for contact/care after this.

If the safety huddle/MDT membership have determined no further attempts are to be made following the 72 hour window closing, a letter should be sent to the patient’s address detailing attempts have been made to contact them as part of their discharge arrangements, alongside the plan for contact and their care, unless there is a robust clinical rationale for not doing so which is/has been discussed and agreed in a multi-disciplinary forum. Liaison with external agencies may also need to be completed and the outcome of the follow up process should be shared with the patients’ GP.

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

4.4. Monitoring and reporting

The completion of the 72 hour follow up will be monitored by BI, who will feed this into the wider reporting structures of the mental health division and HTFT. The completion rates of the 72 hour follow up will be monitored by senior leaders and be part of the overall clinical governance procedures within the division.

Any failed 72 hour follow up must be reported via datix incident reporting, detailing all attempts made to complete the follow up and plan for ongoing care/contact. The datix report will be discussed in the corporate safety huddle meeting to determine if further investigation needs to take place or a narrative obtained regarding any exception reporting.

Appendix 1: Equality Impact Assessment

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

1. Document or Process or Service Name: Mental Health - 72 Hour Follow Up (SOP24-026)
2. EIA Reviewer (name, job title, base and contact details): Kyle McInnes, Senior Clinical Lead
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? SOP

Main Aims of the Document, Process or Service
This document is to support the safe and effective application of the 72 hour follow up directive when a patient is transitioning from a mental health inpatient setting, back to their community.
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

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

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	N/A
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	Low	N/A
Sex	Men/Male Women/Female	Low	N/A
Marriage/Civil Partnership		Low	N/A
Pregnancy/ Maternity		Low	N/A
Race	Colour Nationality Ethnic/national origins	Low	N/A
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	N/A
Sexual Orientation	Lesbian Gay men Bisexual	Low	N/A

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	N/A

Summary

Please describe the main points/actions arising from your assessment that supports your decision. The 72 hour follow up has directly come into use to provide care and support to people following an inpatient discharge, as a way of supporting people who may be at risk of suicide. It has been developed to support staff in line with NICE guidance which identifies how discharge planning and follow up should consider a range of factors which may influence a person's mental health, relapse and suicide risk. The follow up should not be a transactional process but one of assessment, support, care and safety planning.
EIA Reviewer: Kyle McInnes
Date completed: 03/04/24 | Signature: K. McInnes