NHS
Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
MENTAL HEALTH CRISIS INTERVENTION TEAM

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Author/Lead **Job Title**	Kerrie Harrison Service Manager
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VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*Feb-22*	*New SOP* *Approved through MH Divisional Practice network meeting 2-Feb-22*
1.1	*May 2022*	*Updates to reflect implementation of Epma (no ratification required due to a process implemented across the Trust)*
1.2	*September 2022*	*Updates following SI 2022-3400. Updates to safer staffing escalation procedures.* *Additionally, arrangements for crisis intervention at Goole hospital included.* *Approved at MH Division Clinical (Practice) Network (07.09.2022).*
1.3	*November 2023*	*Minor amend to:* *4.2 Referral/access into the service/for very urgent /urgent referrals* *4.4 working and supporting families addition – 'where an individual's ongoing report…'* *4.25.1 Interface with crisis pad – updated* *Approved by Divisional Clinical Lead sign-off (Kayleigh Brown – 22/11/23).*
1.4	*September 2024*	*Reviewed and updated to reflect change in how the team support Frequent attenders by Sian Johnson (Senior Clinical Lead). Approved by Divisional Clinical Lead sign-off (Kayleigh Brown – 13/09/24).*

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1. INTRODUCTION

The Mental Health Crisis Intervention Team (MHCIT)is a multi-disciplinary team of mental health professionals providing a 24 hour, 7 day per week service to people experiencing an acute mental health crisis, for individuals (and their families/carers) who are registered with a Hull or East Riding GP.
MHCIT work alongside the Mental Health Advise and Support Team (MHAST) which offers 24/7 access for mental health support.
We provide crisis interventions through telephone support, triage and assessments, plus intensive community-based treatment via the Home Treatment Team. Assessments and interventions can take place virtually via phone and video call, or in an appropriate community setting such as an NHS site, or an individual's own home.
The team focuses on immediate risk management and rapid stabilisation of a person's mental health and provides a short period of care to help manage the person's crisis. We work with individuals and their family or carers to help resolve the individual's current mental health crisis and to assist with the process of recovery.
If the individual is considered to lack the ability to make an informed choice and/or there are concerns about their safety and risk, team members may request an assessment under the Mental Health Act 2007.

The team works to provide people with safety, recovery and social inclusion, and adheres to the principles of honesty, openness and integrity. The service user's experience should be central to the workings of mental health services and the team provides personalised care that recognises each person's unique path to recovery.

The nature of the team is such that it is not possible to cover all eventualities within this policy. MHCIT will need to consider the principles of this policy and other Trust policy and guidance when making decisions to best meet the needs of individual service users.

MHCIT form an integral part of the Care Services that are integrated within Mental Health Acute Care. These include Mental Health Liaison Services. MHCIT also have strong links and networks with Inpatient Services, Community Services, Police, Addiction services, GP surgeries and Social care services. This integrated approach aims to ensure a comprehensive and seamless service to users and their carers during periods of mental health crisis and:

- To support an individual through a mental health crisis to aid their personal recovery. MHCIT will provide individuals with safe, effective, compassionate, high quality care throughout the duration of their input.
- To provide timely, responsive triage, assessment, intensive home-based treatment and alternatives to admission, to service users and their carers.

Key Objectives.
Our commitment is to ensure that MHCIT is delivered in a person-centred, compassionate, and supportive way, promoting safety and wellbeing at the forefront. The MHCIT aims to be needs led, responsive and delivered in a way that empowers people to build on their strengths, promotes recovery, supports families and carers, and ensures equality and fairness for all.

MHCIT work alongside the Mental Health Advise and Support Team(MHAST) which gives 24/7 easily accessible, timely and appropriate support; which is essential for ensuring the best outcomes for people with mental health problems.

What is a mental health crisis?

A mental health crisis is a situation that the person or anyone else believes requires immediate support, assistance and care from a Crisis mental health service.

There are various possible causes or triggers of a crisis. For example, many people experience adverse life events that include a psychological, physical or social element, which leads to a need for an urgent or emergency response from mental health services. All crises will be different in their cause, presentation and progression. It is important to identify the trigger (for example, abuse, trauma or homelessness), associated risks and options for ongoing care, and respond to the crisis according to the individual's need and circumstances.

Crisis is best defined by the person experiencing it. For this document, crisis is defined as the interruption of an individual's normal life.
Crises may vary in form- they may be developmental, situational, or as a result of severe trauma. Crisis services have been historically concerned with those crises associated with severe mental illness (Rosen, 1997-cited in Mental Health Topics, Crisis Resolution, Sainsbury Centre for Mental Health).

Crisis is often a normal response to abnormal situations and events, distress if often the outcome of a crisis regardless of its source.
The primary objective for MHCIT is to minimise harms including harm to self, harm to others, harm from others and potential unintended harms from our intervention and to help support the individual in their recovery and minimise distress using a bio psychosocial model. MHCIT (See HBT SOP) can enable people to be transferred earlier from inpatient wards and receive treatment within their homes (alternative) whilst still experiencing an acute phase of an illness, high risk period or ongoing distress.

Most service users and carers prefer community-based treatment and research has shown that clinical and social outcomes achieved by community based' treatment are at least as good as those achieved in hospital. 'Intensive' home treatment can be provided in a range of settings MHCIT consider all the options available and consider work collaboratively to find the best outcome. with patients and carers to help the individual to support their recovery, promote stabilisation of mental health and address potential risk.
We recognise that complex dynamics occur within relationships and different parties can have different views on needs and care/intervention required. However, it is important to give space to patients and carers to gain a clear understanding of the needs of both.
For some, hospital could have a detrimental impact on wellbeing, whereas for others it may be the most appropriate option.

It is vital that the functioning of MHCIT takes place within the context of effective partnerships with service users and their carers, all other community care providers, as detailed in the Five Year Forward View, (NHS England October 2014) The NHS Long Term Plan (January 2019) such as Emergency Departments (Accident and Emergency), General
Practitioners, Primary Care Services, Community Mental Health Services, IAPT services, Liaison Psychiatry Services, Early Intervention Services, Inpatient Services, Police, statutory and non-statutory services in order to ensure smooth care pathways

MHCIT have improved pathways within inpatient, urgent and community models as part of the Right Care Right Place Programme (2019/2020), Recovery and Trauma focussed agenda and wider Trust Pathways and remain congruent with the principles within the Mental Health Crisis Care Concordat.

2. SCOPE

This document should be used for the daily running and procedural support of the MHCIT and is for all employees of Humber Teaching NHS Foundation Trust who work within the MHCIT substantively and temporarily via the trust bank. The document will cover all staff working within this area including admin (band 2 and 3), healthcare assistants (band 3 & 4), specialist registered clinicians (band 5 & 6) clinical leads (band 7) and service manager.

3. DUTIES AND RESPONSIBILITIES

Service manager – They will have overarching responsibility for the running of the service and ensuring key performance indicators are met. The service manager will oversee any incident investigation and complaints procedures associated with the service. The service manager will delegate day to day running of the service to the clinical leads.

Team manager – Working with the service manager, the team manager will support with performance indicators and holds responsibility for recruitment, staff absence monitoring and training requirements for the individuals working in this team.

Clinical leads – The clinical leads will be assigned to oversee the MHCIT on a daily basis and support the general running of the team from a clinical perspective. They will ensure direct robust multidisciplinary discussion and decision making and be able to escalate and problem solve when the service is unable to provide the service as agreed.

Specialist registered clinicians – They will be responsible for the managing incoming crisis referrals the triage process, any 136 or voluntary assessments plus supporting with wider crisis interventions as well as the delivery of the planned initial mental health assessments via virtual and face to face appointments. They will be responsible for the completion of all documentation associated with an initial assessment, the identification of care needs and onward referrals to appropriate services. They will be responsible for, in consultation when required with the clinical lead, to agree outcomes for non-attenders and communicate all outcomes and required tasks to the administration team.

Healthcare assistances –The healthcare assistants will be responsible for managing incoming crisis calls/referrals, supporting 136 ,voluntary assessments and mental health assessments

Administrators
The administration team are responsible for completion of electronic referrals indicated following the outcome any crisis triage or assessment. They will ensure all Lorenzo and monitoring processes are completed and complete ad-hoc administrative duties as required by the team.

To support all Staff the service ensures everyone has an allocated supervisor, have access to weekly reflection sessions, informal and formal incident reviews and a service specific induction pack and competencies pathway. The service also facilitates weekly staff meetings and ensure staff have access to additional meetings to meet their professionals needs.

4. PROCEDURES

The MHCIT will:

- Assertively engage individuals, carer's and professionals with referrals to the MHCIT
- Appropriately triage individuals who are experiencing a mental health crisis.
- Provide appropriate assessments within 4-72 hours according to need.
- Involve significant others in the triage and assessment process.
- Complete a Care and Risk management plan and outcomes from the urgent triage and assessment process
- Provide multi-disciplinary community-based support 24 hours a day, 7 days a week.
- Remain involved with the service user until the crisis is resolved and there is no longer a role for the MHCIT. The MHCIT will facilitate contact/referral with services that promote recovery
- Where hospitalisation is necessary, be actively involved and at the earliest possible stage aim to provide intensive home treatment at the earliest opportunity .(HBT SOP)
- Offer short-term relational support that buffers individuals in distress who may not otherwise have access to such support. These may include skills training and selfmanagement techniques
- Work collaboratively with all Community Teams and referrers regarding all support available.
- Undertake facilitation and attendance to Section136 detentions (See 136 SOP)
- Liaise/with MHAST taking incoming urgent referrals
- GPs take incoming urgent referrals
- Mental Health Act Assessment referrals- See AMHP SOP

4.1. Safer staffing and escalation procedures

Appendix 1 identifies the minimum safe staffing establishment for the MHCIT per shift. Should these numbers and skill mix not be met, escalation of staffing concerns should commence.

Staffing concerns should initially be escalated to the band 7 clinical leads and team managers within MHCIT, who subsequently can further escalate these concerns to the Service Manager, should they have not been adequately addressed.

Business Continuity Measures should be put in place to manage demand and resources effectively, prioritising those with the highest need and risk.

Additionally, MHCIT team members should refer to the HTFT Safer Staffing Escalation Policy for Inpatient Services, to categorise impact on the service for staffing related issues and to appropriately escalate the concerns through various levels of management.

As part of these escalation procedures, a datix should be completed every shift where the establishment is not met, to allow for formal escalation and patterns to be identified.

4.2. Referrals/Access into the Service

For Very urgent/Urgent referrals

- These should always be made via phone and come via MHAST, GPs, other professionals who have direct crisis team access by the clinician/worker
- Very urgent/Urgent referrals can also be raised via the triage team when indicated
- Patients cannot direct refer for urgent referrals
- Lorenzo should be checked for any current team working with the patient to help inform who supports them/responds to the crisis.
- All referrals should be taken on the referral form from phone calls received
- An agreed outcome with the referrer should be made to either continue as an urgent referral, ask them to refer as a routine referral or signpost elsewhere

Other info:

- Professional enquiry (01482 216624) is transferred to the crisis team for consideration of the pathway required, unless admin can direct it accordingly initially. These can go to urgent or routine referrals depending on the need.
- MHAST (0800 138 0990) will only take referrals where the patient is present and able to complete a self-referral with consent. Professionals must not be directed here to make a referral. This line is for patients and public.
- GPs have access to the PCMHN for support with their patients also and can direct refer to them
- Patients can direct refer to IAPT, however if we have completed a triage it is good practice for us to refer them on (as with other services unless a self-referral is required)

4.3. Crisis telephone support via MHAST. Patients do not have direct access to MHCIT.

MHCIT staff are trained and experienced in communicating with people in distress, and providing support and guidance helping people to manage their feelings when in a mental health crisis. If staff assess there to be a need for very urgent/urgent support, they will act/respond accordingly to the needs of the service user. (see appendices 3,4,4a UK MH Triage Scale)
The overall aim during the management of a crisis is to help the service user to return to a more stable level of mental functioning as quickly as possible without inducing any harmful effects which might prolong the problems. The service user's autonomy should be maintained as far as possible, their safety and that of others assured, and their emotions, impulses, and behaviours reduced to a manageable level. Supportive, empathic comments are necessary in the first instance and these may be particularly beneficial if the initial contact in the crisis is by telephone. In some circumstances, it may be that’s this initial phone contact alone is sufficient to support the person, manage or resolve the crisis without them needing additional care. The team may agree that a short-term local support plan is commenced which may involve additional support calls or a more comprehensive Care and Risk management plan or maybe agreed within the team. Care and Risk management plans will be developed in an MDT and may be an outcome from a professionals meeting or a Team MDT.

High Risk Calls

When dealing with difficult, high risk calls, staff have access to a range of support options in obtaining appropriate assistance. This includes:

- Informing the caller that the staff member may need to speak (for advice) to a colleague while they stay on the phone.
- Flag (wave arm etc.,) with a colleague/Co-ordinator that they need support/advise.
- Staff may need support from another member of staff to take over the call.
- Have a clinical discussion and develop a Crisis/safety plan.
- Consider a mental health assessment.
- If the call handler wishes for the police to be contacted, they will be required to either inform another member of staff (see above) or contact the police themselves.

Staff will use their clinical judgment to make use of the above options and record as appropriate.

If the staff member is an unregistered member of staff, and during a call there is a clear imminent risk of suicide please follow the UK MH Triage Scale appendices 3,4,4a.

Staff are to ensure they seek supervision and time to reflect after such calls. Further support can be found in the staff induction pack

4.4. Working and Supporting Families/ significant others

(Information sharing and suicide prevention -Consensus statement (gov.uk,2014))

We strongly support working closely with families. Obtaining information from and listening to the concerns of families are key factors in determining risk. We recognise however that some people do not wish to share information about themselves or their care. Practitioners should therefore discuss with people how they wish information to be shared, and with whom. Wherever possible, this should include what should happen if there is serious concern over suicide risk.
We want to emphasise to practitioners that, in dealing with a suicidal person, if they are satisfied that the person lacks capacity to make a decision whether to share information about their suicide risk, **they should use their professional judgement to determine what is in the person's best interest.**
Part of the assessment should always take place without the carer of family member present. This is to enable the Service User to disclose information that they do not wish others to know.
Following assessment all paperwork is required to be completed on Lorenzo, a mental state assessment, risk assessment, and an immediate plan of care plan. Clustering must also occur following assessment, outcomes could be:

1) Transfer of care to an in-Patient Unit for mental health care
2) Home Based Treatment
3) Referral to Locality Team Community Mental Health Team(CMHT) or Early Intervention Team(EIT)
4) Referral to primary care, third sector, Improving Access to Psychological Therapies (IAPT),
5) Service user is signposted to other self-help resources relevant for the location (Hull/East Riding)

Assessments should provide sufficient information to all of the services or agencies involved with the Service User, to reduce duplication or the requirement for superfluous assessment.'

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 service user 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 service user in managing their own care/self referral, in those instances a rationale for not liaising with the external agency must be documented.

4.5. Frequent callers/users of the service

Some of the service users that have contact with the service on a regular basis often present with complex needs and at times the service can find it challenging to effectively support them.
Frequent callers to MHAST will be monitored via the call handlers at MHAST.
MHCIT staff will develop therapeutic and collaborative Care and risk management plans with this group of service users.

Frequent users will be identified via a monthly BI report which will identify any service user who has had 7 or more referrals to MHCIT in the last month. This report will be sent to the Senior Clinical Lead, Team Leader and Clinical Leads. The report will be reviewed as part of the leadership meeting and a plan identified for each service user.

Consideration will be given to:

- Does the service user require MDT discussion
- Does the service user have a risk management/crisis plan. If they do not then a Clinical Lead or designated other will be allocated to complete this
- Does the service user have a formulation. If they do not they will be taken to the Complex Case meeting
- Is a professionals meeting required

- Who else is involved with the service user
- Do we need a multi-service MDT or a multi-agency meeting

The monthly Complex Case meeting will have a chair and co chair and the meeting will be attended by the chair plus 4 other MDT members.

MHCIT also review frequent users of 136, MHA assessments and the Humber Bridge this data is used for multi-agency clinical and professional discussions.

4.6. Out of Hours support for the HBT

MHCIT support HBT service users out of hours and this may include additional calls or visits which have been developed collaboratively with the service user and the service.

4.7. Crisis Triage process

Triage is an essential function of the team to ensure that needs are effectively prioritised, and assessment / interventions are appropriately prioritised, the triage will also determine how urgently the response is required. The triage involves an initial, brief risk assessment that aims to determine whether the service user is a risk of harming self or others because of their mental state, and to assess other risks related to mental illness. This will determine how resources are allocated and prioritised and will often take place over the telephone or face to face. All MHCIT clinical staff are required to document their clinical reasoning and include their purpose and rationale for triaging the referral on the triage/Referral form.

With complex referrals requiring face to face triage, this should be agreed with the shift coordinator and allocated as required. The service user and assessment details including response time needs to input onto the electronic board.

Please refer to the Clinical Triage Risk Decision Guide **UK Mental Health Triage Scale** (appendix 4) and Red Flags (appendix 3).

The triage process needs to be followed for all service users who have self-harmed with an assessment of intent (NICE Guidance).

The triage process must consider the nature of repeat attendances to services.

Outcomes of Triage

Following referral information, a triage outcome must be established. This outcome should meet the service users' needs in accordance with the priority status identified.
Following the triage being completed, the finalised triage and any additional clinical notes are to be distributed via Lorenzo to the . For people who are referred to the MHTAT (See MHTAT SOP)

4.7.1. Service user under the influence of substances

The service users who present intoxicated or following an overdose (both prescribed and non-prescribed) should be determined at the earliest point in the triage process. The clinician carrying out the triage (see appendix 4,4a) should conduct the triage process as per standardised template When the service user is presenting as intoxicated/overdose with substances (prescribed and non-prescribed), the Intoxication Pathway must be consulted and the Symptoms and Signs of drugs involved in poisoning or overdose, must also be consulted. The pathways should be utilised within the triage process to support clinical decision making and ongoing management of the service user. See above.

4.8. Clinical Triage Risk Decision Guidance (UK Mental Health Triage Scale)

Prioritise response based on the presenting need and level of urgency. See below and appendix 3 & 4

A-Emergency immediate blue light 999/ A&E
Immediate response - denotes emergency situations in which there is imminent risk to life or serious harm to themselves or others, and will require a ‘999’ response, potentially within minutes

B-Very Urgent – within 4 Hours
For all 136 and MHA assessments.

For those who present a **very high risk** of harm to themselves or others, acute suicidal ideation with clear plan and intent, who have a rapidly worsening mental state, who do not require immediate physical health medical intervention, are not threatening violence to others.

These referrals require a very urgent assessment with a specialist mental health crisis practitioner within four hours.

C-Urgent-within 24 hours
The types of typical presentations in this category include **high risk** behaviour due to mental health symptoms, new or increasing psychiatric symptoms that require timely intervention to prevent full relapse and/or significantly impaired ability for completing activities of daily living or vulnerability due to mental illness, expressing suicidal ideation but no plan or clear intent.

These referrals require an urgent assessment with a specialist mental health crisis practitioner within 24 hours.

D-Semi-urgent -within 72 hours
The types of typical presentations in this category include **moderate risk** behaviour due to mental health symptoms, new or increasing psychiatric symptoms that require timely intervention to prevent full relapse and/or significantly impaired ability for completing activities of daily living or vulnerability due to mental illness, expressing suicidal ideation but no plan or clear intent.

These referrals require a semi-urgent assessment with a specialist mental health crisis practitioner within 72 hours.
The assessment should be discussed in an ad hoc MDT, including the shift coordinator, triage coordinator, person completing triage (if different), the clinical lead on duty and any other professional as required i.e., AMHP or Medic. If a very urgent, urgent assessment or semi-urgent is then agreed, the referral priority should be assigned; either up to 4 hours for Very Urgent or up to 24 hours for Urgent and 72 hours for a semi-urgent. The referral should then be uploaded and created on Lorenzo by the admin team, with the correct priority inputted for accepting the referral against. The name and NHS, including any other relevant information, then update the electronic boards.

The service user and/or referrer should then be contacted to arrange an appropriate time and place for the assessment to take place. Decision as per discussion with the service user and carer should be clearly documented on a clinical note in Lorenzo. There may be a need for the assessment to be arranged at an NHS site or other place of safety due to personal or environmental risk. Should this need to occur this will be highlighted on the electronic boards and an alert created on Lorenzo to indicate the risk situation.
If the outcome of triage indicates a more urgent need, an assessment is arranged with the service user or carer. This assessment will need to be discussed with either the shift coordinator or clinical lead on duty to ensure correct allocation of the workload for the shift and facilitate any discussion required around risk management. The referral will need to be re-graded to either very urgent for a 4-hour

response, urgent for a 24hr response or semiurgent for a 72-hour response The referral will then need referring on Lorenzo to the MHCIT- urgent team and electronic board updated with the allocation of assessor.
In some circumstances the assessment may need to be arranged at either a local GP practice or at Miranda House for safety reasons. If the referrer is the police, then complete the police handover form. (Webley form-136 Policy)

There may be a need for a follow up assessment to take place. This could be due to not managing completion of the assessment due to complexity, or further specialist assessment is required e.g., Substance misuse issues, eating disorders ,memory problems or needing urgent physical health checks or treatment The assessment process will incorporate an initial assessment and a MHCT (*a needs based assessment tool designed to rate the care needs of a service user)*, that will give a care cluster outcome, as well as any other clinically appropriate assessment tools. These will be required by the accepting followon agency.
What needs to be completed for every assessment:

- The initial assessment form
- The FACE for adults
- AUDIT
- Brief substance screening tool
- Cluster
- ReQol
- A contact needs to be recorded on Lorenzo
- Assessment/risk assessment needs to be distributed to GP
- Admin informed so they can action anything that needs to and close the referral to MHCIT

If making a referral to Let's Talk/EWS the following are also required:

- PHQ-9
- GAD 7
  Front sheet for Let's Talk

When another professional from within Humber Teaching Foundation Trust services and in certain instances, outside of Humber services is making a referral for a crisis assessment, the professional (see gatekeeping process for services who are not keyworkers) should have ideally seen the service user face to face and be referring them within 24 hours of this contact, but as a minimum the referring professional should be able to provide a good working knowledge and a clinical rationale for the referral to have been made and what the referral is expected to achieve.

Please refer to the Gatekeeping guidance(4.9.1) on the requirements from different types of services.

Clinical judgement must be used regarding the best approach to assessing urgent presentations according to clinical need and demands upon resources

4.9. Interpreter Requirements

The team have access to Language Line-Insight which is a real time video interpretation services. Staff have access 24/7 to iPad which can be used in Miranda House and the community. Should there be a preference or requirement of face to face in person interpretation services that this can be arranged.

4.10. Decision making process following assessment

After the assessment staff will have a discussion, prior to a plan being made with the Service User and where possible family or/and significant others to consider possible outcome and support options where required.

If staff are unable to agree on an appropriate plan for the Service User then this is to be escalated to the Clinical Lead for the MHCIT, during their working hours, outside of these hours there may be a need to consult with on-call managers or Medics. Outcome of this discussion is to be clearly documented on the assessment paperwork and name of persons discussed with is recorded. Attempts to be made/considered to consult with other clinicians/professionals involved in the care of the service user.

The following list is not exhaustive, but some possible assessment outcomes may be:

- Provide advice and signpost to external agency, ensuring referrals are carried out where required.
- Referral to CMHT
- Referral to Home based treatment or acute Inpatient bed.
  Gatekeeping process should be followed, see below.
- Medical or prescribing appointment always to be discussed with an appropriate medic, ACP or NMP prior to any agreed outcome. (See NMP SOP)

Once a decision has been agreed on the outcome of assessment, the documentation must be updated on Lorenzo and on MHCIT electronic boards. Referrer and GP should be informed of the outcome of assessment and any follow up care offered. If the service user remains under the care of the MHCIT triage and urgent medical team, they should be transferred to the 'Outpatient' electronic board until the medical team has completed their interventions. This process must always be in consultation with the medics, ACP or NMP They are still subject to discussion in MDT unless stated otherwise.

If under medical review within the setting of MHCIT, the prescriber should utilise electronic prescribing and medicines administration (ePMA) module of Lorenzo, if required to do so. This would be required in instances where the service user is being provided directly with a prescription (FP10) from the service, or administration of medicines will be taking place by MHCIT registered nursing team. The use of ePMA is also required when utilising Patient Group Directives (PGDs).
ePMA use is not required if following the review, no medication changes are made, or if the GP will be responsible for prescribing the medications at the request of the MHCIT prescriber.

Policies and procedures relating to the use of ePMA for prescribing and administration should be utilised as required to support the delivery of this intervention. As a minimum, all service users requiring the use of ePMA in this setting will need adding into the electronic prescribing clinic for MHCIT on Lorenzo by the admin team (clinician if admin unavailable) and their 'health issues' recording on their electronic patient record (EPR on Lorenzo) prior to any prescribing and administration of medicines. The responsibility of recording 'health issues' should be agreed at MDT discussion and whether this is the duty of the clinical team/assessing clinican (if they have appropriate scope of practice, skills and knowledge) or if the prescribing team will be responsible for this.
Additionally, it will be at the discretion of the prescriber, should they choose to 'clerk in' the medications the service user is already prescribed onto their EPR, prior to prescribing and medications administration. It should be noted, if the medicines are not clerked in, warnings regarding prescribed medications will not be made available to the prescriber via ePMA for any possible interactions.

4.10.1. The Gate keeping process (Also refer to the Bed Management and HBT SOP for further details)

Providing a compassionate, supportive, and least restrictive response
In the Mental Health Division of HTFT it is good practice for MHCIT to lead on the process of gatekeeping and, in the first instance HBT will be at the forefront of these decisions as ultimately, they need to decide if a community alternative is safe and viable.
Gatekeeping is the process of a clinically focussed intervention completed by clinicians in order to facilitate the most appropriate, least restrictive outcome to meet the needs of the patient. The Bed Management Team can be involved in the process in respect of balancing capacity and demand. The process is in place to ensure equity to access appropriate care in the correct setting which supports the patient, their family & carer(s).

Aim of Gatekeeping process
The primary objective for MHCIT is to minimise harms including harm to self, harm to others, harm from others and potential unintended harms from our intervention and to help support the individual in their recovery and minimise distress using a bio psychosocial model. MHCIT (See HBT SOP) can enable people to be transferred earlier from inpatient wards and receive treatment within their homes (alternative) whilst still experiencing an acute phase of an illness, high risk period or ongoing distress. Many service users and carers prefer community-based treatment and research has shown that clinical and social outcomes achieved by community based' treatment are at least as good as those achieved in hospital. 'Intensive' home treatment can be provided in a range of settings.

Consideration of options MHCIT consider all of the options available and consider work collaboratively to find the best outcome. with patients and carers to help the individual to support their recovery, promote stabilisation of mental health and address potential risk. We recognise that complex dynamics occur within relationships and different parties can have different views on needs and care/intervention required. However, it is important to give space to patients and carers to gain a clear understanding of the needs of both.

Families & Carers
We strongly support working closely with families and carers. Obtaining information from and listening to the concerns of families and carers (where identified and consent from patient provided) are key factors in determining risk and gatekeeping the appropriate service. For some, hospital could have a detrimental impact on wellbeing, whereas for others it may be the most appropriate option.
Care must be individualised, collaborative and based on everyone's needs, and consideration to active care or crisis management plans and Advanced Statements should also be considered in the Gatekeeping process where available. A consideration of mental capacity to understand the need and options available as part of the gatekeeping process should be also identified and recorded if required.

In some circumstances, it may be that an initial contact alone is sufficient to support the person, manage or resolve the crisis without them needing additional care. The team may agree that a short-term crisis support plan, which may develop into a more comprehensive mutually agreed management plan.
Management plans will be developed through a Multi-Disciplinary Team setting (MDT) which extends to the involvement of the patient, significant others, family, and carer (s).

The process to consider
It is good practice to contact HBT(MHCIT) early as possible when an escalation of care needs is evident for a patient. The Home-Based Treatment Team (HBT) can formulate a plan to address short term interventions in conjunction with any pre-formulated care plans that may already be in place. The aim being to promote the recovery from crisis, support the patient, family & carer(s) with the common

aim of stabilisation from the point of crisis, and reengagement with current services. This may include inpatient services and community services.

There may be circumstances where the face to face gatekeeping process is not required, as community treatment is not deemed as a viable alternative to inpatient care. Examples of these could be:

- Service users recalled on Community Treatment Orders
- Service users on leave under section 17 of the Mental Health Act (MHA) 1983
- Planned transfer of cares from Specialist Units.
- Where a Mental Health Act assessment has already taken place.
- If a Doctor has commenced the recommendations of a MHA section and then the service user agrees to an informal transfer of care. As the Doctor has already begun to carry out an assessment and has felt that formal transfer of care would be appropriate it would not be clinically appropriate for the Service User to be seen by MHCIT staff and may delay the service user receiving appropriate care and treatment.
- Planned transfer of cares for service users who are returning from out of area (their initial transfer of care will have been expected to have been gate kept).
- Planned transfer of cares for service users who are returning from a short transfer of care to the acute trust from one of our wards, where the plan was for the service user to return to the ward once treatment was completed by the acute trust.

Exceptions

In all care events, assessment of need is required however there may be some instances where this may not have been completed. In these circumstances a statement explaining the rationale for transfer of care and the reason why a face-to-face assessment was not deemed necessary should be recorded in the electronic records. This will involve a comprehensive clinical discussion between MHCIT (where possible a HBT clinician to be involved) Clinician and the referrer to ensure all options/possible outcomes have been considered, providing a supportive, compassionate and least restrictive outcome for the patient.

Outside of normal working hours

The services that MHCIT incorporating HBT offer a 24/7 service response, therefore the gatekeeping discussion and outcome formulation can fall across both parts of the service depending on time of day and requires a common sense approach to ensure swift and timely actions are undertaken, and that patient safety is recognised. In gatekeeping formulation, a holistic and realistic outcome should be sought.

Expectations from Referral Routes:

MHLS

It is expected that a conversation between MHLS assessing clinician will occur with HBT/MHCIT to explore the reasons for referral for admission and to explore all least restrictive options, providing an opportunity to assess for HBT interventions. A further face to face gatekeeping assessment will not be required, as the patients has already been assessed by an appropriately skilled clinician, during their crisis situation. The receiving clinician should not insist on awaiting completion of all paperwork before this discussion is had, as this can cause unnecessary delays to the patient’s care, identification of intervention and impact on capacity/waiting times in A&E. The patient will have completed any treatment and therefore either medically fit or expected to be medically fit for discharge when this contact occurs.

The gatekeeping triage form should be completed by the receiving clinician, ensuring all least restrictive options have been considered and the expectations of what the referral for an admission would achieve from the patient and professional perspective. If the patient is known to a treatment team, it would be expected the MHLS clinician would have had a discussion with their keyworker (in working hours) if practicable to do so, to explore escalation of care within this service before discussion with HBT or possible admission takes place.   Should there be any disagreements between the clinicians, they should follow the escalation protocol.

CMHT / Psypher(EIT)

Patients who are known to a key worker and under the care of the community mental health team often present with escalating needs in the days leading up to an admission. Should the needs of the patient become more intensive, or concerns are expressed by family/carers, it would be expected the for the key worker or duty clinician (if the key worker is unavailable) to contact HBT to discuss the escalating situation, following their own review of the patient and situation. A planned joint face to face review can be planned with the HBTT, CMHT, patient & family, in the coming days to determine a collaborative plan of care, identifying the least restrictive options first, but with parameters agreed for further escalation to admission if required. There may be more than one joint meeting which occurs during this time of increased need and acute presentation.
The gatekeeping triage form should be completed by the receiving clinician, ensuring all least restrictive options have been considered and the expectations of what the referral for an admission would achieve from the patient, family and professional perspective. The key worker (or duty clinician) would be responsible for updating the FACE risk assessment, cluster tool, ReQoL and the care plan (as required) and this should be reflective of the current level of need and presentation.

Service user under secondary mental health services other than CMHT/MHLT/Psypher/CENS

There are a number of services within secondary care who case manage patients/are the only allocated workers, but their role does not extend to unplanned contact with those under their service. This includes (but is not limited to):

- Dialectical Behaviour Therapy (DBT) Team
- Specialist Psychotherapy Service (SPS)
- Humber Traumatic Stress Service (HTSS)
- Liaison Psychiatry
- Structured Clinical Management

In these cases, the clinician will not (due to the remit of their provision, either clinically or operationally) take an active role in the arrangement of unplanned care contact. Where this is the case, the clinician may refer into MHCIT/HBT, or the patient might self-refer, and
MHCIT will take a referral and organise for a triage of their needs as a crisis
response. Once the triage has been completed, normal processes within the MHCIT SOP will be followed. It is good practice to consult the relevant involved clinicians in decision making where practical, this should not delay decision making where contact has not been possible.

Any exceptions will be considered on a case-by-case basis for services with a specialist remit (see also HBT SOP).

PCMHN

Patients known to PCMHN should be escalated to the CMHT as their needs increase, for a higher level of intervention to take place. If there has been no evidence of escalation in care needs and the patient is presenting in crisis, the PCMHN should discuss with HBT to determine an appropriate way forward and formulate the least restrictive options of care provision.

If it is determined that HBT cannot safely manage the patient needs and an admission may be required, the MHCIT should complete a crisis assessment to determine the patient needs, ideally with the key worker of the PCMHN if possible.
If the patient has received a crisis assessment, the MHCIT clinician should discuss with HBTT the outcome of the assessment for a gatekeeping triage (if outside of normal hours of work for HBT, MHCIT would be responsible for completion of this document).

Others
If a patient is unknown to services or has no open referrals, they should follow the MHCIT SOP pathway for assessment.
If the patient has received a crisis assessment, the MHCIT clinician should discuss with HBTT the outcome of the assessment for a gatekeeping triage (if outside of normal hours of work for HBT, MHCIT would be responsible for completion of this document).

MHA
If a patient has been assessed under the MHA (including Section 136 assessments) , or has a CTO recall in place, the HBTT/MHCIT clinician should completed the gatekeeping triage to reflect the outcome of the assessment and identification of the admission.

4.11. Providing a Crisis/safety plan (also known as Care and risk management plan

People who have experienced a mental health crisis and had contact with the MHCIT should always have a jointly developed Crisis/safety care (Care and Risk management plan) in place as an outcome. The plan should include:

- Advice and instructions for both the person, family/Significant others and the supporting healthcare professionals when the person is experiencing a mental health crisis.
- Phone numbers for the people to be contacted in the event of mental health crisis.
- Coping strategies.
- Details of self-management.

4.12. Disengagement and DNA process for assessment (this also includes disengagement during an assessment and an assessment of risk if patient wishes to leave the building for a smoke):

The process for Service users not attending assessments or leaving before completion of assessment will depend on 'reason for referral',' level of risk',' presentation during assessment' and the 'required time of response '
In the event a service user DNA's or disengages from a 4 hour/24 hour/72-hour assessment or 136 follow up appointment then the following action should be taken:

- Immediate review of risk and concerns around mental health.
- If face to face at time of disengagement, then encourage service user to stay and complete the assessment process.
- Consider MCA and best interests of the service user.
- Attempt to contact service user via phone, risk and mental health presentation at triage will determine the urgency of this.
- If unable to make contact via telephone (depending on risk/areas identified on the TAG score/concerns at triage) an unannounced home visit to be conducted. If risk is considered 'very severe' then to consider police welfare check.
- Also consider contacting nearest relative/significant other, initial referrer and GP to be completed.
- All clinical decision making to be discussed within MDT/Band 7.

If further attempts are required, then a *contact* letter to be sent to the service user to contact the MHCIT, then placed on an access plan. If the service user does not respond, transfer of care process to be completed and GP

For all assessments:
If a service users care is transferred following a DNA/disengagement then the referrer is to be informed, with the rationale for clinical decision making and admin informed to follow Lorenzo transfer of care process.

4.13. Management of violence and aggressive (See Management of Violence and Aggression Policy).

Always discuss and agree response to individual needs within the MDT.
There should always be plans, led by MHCIT staff, to manage de-escalation, summoning additional staff, transporting or escorting of patients and health staff use of DMI techniques; must be considered before police are requested.

4.14. Mental Health Act Assessments (See AMHP SOP and Mental Health Act Policy)

The Hull Approved Mental Health Professional (AMHP) day duty rota is an integral part of the MHCIT, allowing dedicated AMHPs to triage any requests for Mental Health Act Assessments.
Mental Health Act Assessments are considered and coordinated in Hull through MHCIT and in East Riding through Adult Social Care.
(Please note ER AMHPs accept referrals from Goole District Hospital)

4.15. Re-Assessments

Some service users re-present after the initial assessment. In these instances, the process of assessment needs to be the same.
However, documentation doesn't need to be on an initial assessment form. Should nothing have changed substantially from the initial assessment, then document the contact on a clinical note (or use the back pages of the assessment form) with clear rationale why it isn't on an initial assessment form, clear information on current presentation and mental state. A
FACE and cluster must be updated

4.16. Referrals from emergency services (includes voluntary attendance requests to Miranda House)

A dedicated emergency services phone line is in use at the MHCIT (see appendix 9 for YAS and Hull MHCIT & YAS SOP). This line can be accessed 24/7 by all emergency services and will be prioritised. Referrals received from emergency services will be triaged as per Appendix 4.
At the point that emergency services consider a need for mental health input/advise the police office or paramedic must contact MHCIT first to discuss their concerns and decide on the best course of action. To ensure a meaningful discussion, discuss alternatives and other options:

- It maybe that staff can/should speak to the service user and agree a collaborative plan on how to best support the service user.
- Staff to check Lorenzo and any existing Plans (Crisis/Safety/Care/Intervention/Risk)
- Ascertain if known to services and liaise/link in with coordinator as appropriate.
- Consider if Crisis Pad is appropriate. • No further action maybe appropriate
- Signpost to other services.
- If the decision is made to see the service user voluntarily at either Miranda House once the handover is completed by the receiving clinician, normal assessment procedures apply.
- Under some circumstances the ambulance service may consider using the Mental Health Capacity Act to bring people to Miranda House for the purpose of assessment/intervention. The principals of the Act including how this decision has been reached i.e. Best Interests

decision should be clearly established and communicated to MHCIT in order to accept this, with evidence of any physical health issues being ruled out.

If the Police Officer or ambulance technicians (in conjunction with the police) have conveyed the service user to Miranda House are required to provide a full handover to the receiving clinician and complete the voluntary handover form (This is the Webley form for the police and Handover form for other professionals) for Miranda House.
The police can leave after handing over to MHCIT staff (RCRP Process)

If the service user is not medically fit the Police Officer should be advised of calling an ambulance to the scene or conveying to ED.

People can only attend with the explicit agreement of MHCIT
If the police disagree with the plan, then they may proceed to a 136 detention.

Information sharing should be in line with the Trusts Information Governance policy, information sharing procedures and in line with GDPR.
Please refer to the Standard Operating Procedure Sharing Personal Data with the Police

4.17. Mental Capacity Act

As per the Mental Capacity Act 2015, it is assumed that every adult over 16 has full legal capacity to make decisions for themselves at the time that the decision needs to be made.

However, where capacity is doubted, or following assessment deemed to be absent, we need to capture this decision making. The best way of doing this is by completing the Mental Capacity Assessment form. This is located in the Mental Health Act and Legal Tab, then notes, in Lorenzo. Whilst documenting in a normal communication form can at times capture this, we are still prone to just stating that patient lacks capacity, rather than being more explicit in reasons for lack of capacity and more importantly with regards to which decision in particular the patient lacks the capacity to make.

There have been a series of SEA's and investigations where we have made this error, and this has led to further issues and complications.

By completing a Capacity Assessment form, we can fully capture if someone has or lacks capacity for a specific decision, this will give the individual practitioner a lot more cover and security in the event of an untoward incident. Here are a few examples when we should consider undertaking a capacity assessment and documenting it on the relevant form.

1. If making a decision to admit someone informally, but there was some doubt as to whether the patient had the capacity to consent to that admission or not, the Capacity Assessment form can be completed, with the decision being 'Should patient A be admitted informally to inpatient unit B". The decision maker is the person undertaking the assessment. The form is actually quite straightforward but means that we can capture the specifics of how you came to confirm the patient had capacity or indeed lacks it. One can also consider use of copy and paste into any communication sheet being completed as well.

A completed capacity form will help when there is a risk that the admitting unit are querying capacity when the bed is initially being arranged. Remember that the capacity assessment is time and decision specific, so it would not be an issue if when assessment is carried out, they have capacity but this changes in the future.

2. If the police or ambulance service bring in someone to Miranda House on an informal basis, but on arrival we have concerns about their capacity. This can also help with documentation of what we tried to do to support a person, especially if they are trying to leave Miranda House. A capacity

assessment may help with a best interest's decision to try and persuade / stop someone leaving the unit, but obviously there are no hard and fast rules attached to this, and consideration of discussing use of section 136 with officers may be an alternative option.

If a patient is placed on section 136 but is intoxicated, then a capacity assessment can be carried out to determine if the patient is fit / able to be assessed under the Mental Health Act. Bear in mind that our standard operating procedure is clear that '***Breath testing is not appropriate to use to assess the value or necessity of clinical assessment. No arbitrary level should be used as a reason to not undertake a clinical assessment.'*** A formal assessment of capacity will determine if the service user is fit for assessment under the Mental Health Act. The documentation of this on the Mental Capacity Assessment form will provide a robust rationale for delaying the assessment if this is required. Given that it is the AMHP's role to coordinate the process of assessment under the Mental Health Act (14.41 MHA 1983 Code of Practice), then the decision to either undertake or delay the assessment lies with the AMHP. Under the Mental Capacity Act 2005, it is the decision maker that completes the Mental Capacity Assessment form; therefore, it will fall to the AMHP making the decision to complete this form. Again, an assessment of capacity is time and decision dependent, and it is to be expected that the service user will regain fitness for interview in due course. Once fit for assessment this can be arranged. Given the presumption of capacity in the MCA, there may not need to be the requirement for a further MCA form to be completed, as long as the reasons for the change in decision are noted fully in any communication sheet.

4.18. Interface with Section 136 (Refer to 136 Policy):

During each shift at MHCIT, a 136 coordinator is allocated. Their role is to ensure there is a designated, registered individual for the requirements of the 136 suite. Their duties can be identified in appendix 24 (136 Suite Coordinator Responsibilities).

2 x HCA Band 3 are to be allocated to the 136 process 24/7 to support the 136 co-ordinator. To ensure a meaningful discussion with the police discuss alternatives and other options, see above. If possible, the 136 co-ordinator will be present during the MHA assessments and for any outcomes to be discussed with the AMHP and medics to ensure a comprehensive handover of information. All referrals to HBT will be triaged by MHCIT to ensure the service user receives a timely and appropriate outcome. (See 136 Policy)

4.19. MHCIT Frequent users of the Service

The service monitors service users who frequent need the MHCIT/136. Either collaborative care plans or MHCIT management plans will be in place and implemented by the service.

4.20. MHCIT & Hospital Mental Health Team (MHLS)

There is a dedicated 24-hour A&E Hospital Mental Health Team who provide a service to services users presenting at Hull Royal Infirmary (HRI) or Castle Hill Hospital with self-harm behaviour, acute mental illness or emotional distress.

Service users who are 'open' to both MHLS and MHCIT requires a discussion between the services to establish the most appropriate pathway for the service user.
This discussion and rationale for the decision is to be recorded in the service users clinical notes on Lorenzo

When a referral to MHCIT and indicates an immediate and urgent physical health need, i.e., overdose, the service user should be directed to the Accident & Emergency Department (A&E). MHCIT should then contact MHLS and advise of a service user who will be attending A&E and provide a handover to the team member.

Service users should not routinely be advised to attend A&E if MHCIT cannot provide a timely response as per the assessment time frames.

Do Not Waits (DNW) at MHLS

If a DNW comes to the attention of MHCIT staff are to follow the normal referral and triage procedure. Discussion with MHLS would be good practice to inform them the service users is in the care of MHCIT.

4.21. Referrals and crisis contacts from service users under the care of a CMHT/recent transfer of care

- When a call is received by the MHCIT and that individual is open to a CMHT, the usual process of triage will still take place. If the call is received within working hours of the locality CMHT, the call should be directed to the service user's locality CMHT and care coordinator or duty worker.
- If the call is received outside of usual working hours of the CMHT, the call handler will follow usual triage procedures of information gathering in the first instance. The call handler must consult with the Lorenzo documentation, including care plan, risk assessment and any other relevant information on management of crisis situations. Any plan that is established as an outcome of the call, must take into account the care plan, preferences of the service user/carer and advanced directives. The service user may require phone interventions, the setting up of a safety plan, or may need to be seen to manage the crisis.
- It is not required that a triage and referral form is completed for service users who are receiving care under the CMHT and instead a thorough clinical note can be created on Lorenzo, documenting the situation and outcome.
- Follow up to CMHT following crisis contact:
- It is at the discretion of the clinical team at MHCIT as to whether a verbal handover to the CMHT is required, at the earliest opportunity after the assessment. If this is not required, the admin team at MHCIT will create a task, via Lorenzo and inform the admin team at the locality. Following this, local procedure for managing these tasks takes over, as per locality
CMHT
- For service users who's care from a CMHT, ended in the past 12 weeks the 'Transfer of care and re-entry to CMHT' pathway (CMHT Policy) should be followed

4.22. Referrals and support/advise for Goole District Hospital

- Goole District Hospital does not have a MHLS team.
- There is an agreement that on the occasion that GDH staff require support and advise the MHCIT/CITOP will be the first point of contact for any patient staying at GDH.
- When a call is received by MHCIT from Goole District Hospital it will be from one of the following wards: *Neuro rehab unit*
Ward 3 -medical rehab
Ward 6- surgery
Ward 7- day surgery
Maternity
- Staff at GDH (these are not mental health practitioners) will contact the Professional enquiry line (01482 216624) , the call will then be transferred to the Crisis team if adult or CITOP (within working hours 8-12) if an older adult.
- The band 7 or co-ordinator will ensure a meaningful discussion and consideration of what support/advise or pathway is required. See also section 4.1 of this SOP
- The patients may not be resident in the Hull and East Riding area but will still require our input and support. (This will be needs led and may require a discussion with the clinical lead)
- If a Mental Health Act assessment is required please refer to sec 4.14 of this SOP

4.23. Lone working procedure on and off site

Risks should be identified at the point of receipt of referral, in regard to risk to the member of staff. These risks can be personal (directly from the service user) from a carer or known associate or may be environmental. Due to risks posed by service user contact within a hospital and community setting, lone working procedures should always be adhered too.

Please see HFTT Lone working policy.
Local protocols from lone working are as follows:

- When risk to visiting is identified, this should be recorded as an alert on Lorenzo and the sections of the referral (appendix 8) and triage (appendix 15) should be completed to document the risk identified and what protocols will be put in place to manage this.
- Service users name should be placed in red writing on any whiteboards in the MHCIT/HBT office to indicate risk to visiting.
- When service user is being booked for a routine appointment, the admin team will use the information placed on the triage to identify risk to visiting and ensure this information is recorded on the outlook diary of the assessor and inform the assessor by email that the risk exists and requires management.
- When risks to visiting are identified, the preference would be to see the service user at a team base and where possible, Miranda House. This is not always possible due to presentation and in these instances the following should be adhered to:
- The staff member should indicate on the staff signing in/out boards in the MHCIT/HBT offices at Miranda House, the address of where they are going, the service user whom they are going to see, time of departure, time of expected arrival back at base, and a contact number they will be available on. Where there is no whiteboard to place this information onto, the staff member should contact the shift coordinator, or designated other person, and inform them of the information listed verbally. The person receiving the information should document this for their records. The shift coordinator should always be made aware of a staff member leaving site and attending a service users' home/another site.
- The shift coordinator should then contact the staff member on the contact number provided if they do not return/contact you by the time estimated.
- The staff member should make every effort to contact the coordinator to inform them if the plan changes/time changes or there is new information that has come to light.
- In certain circumstances, the staff member may not be able to contact the coordinator due to presentation of the service user and in these instances should follow the trusts Lone Working Policy and escalate the situation as required.
- All staff members are to keep in their mobile phone under the name AAA the MHCIT emergency phone number which is 01482 336145. If unable to contact someone on this number, the staff member should contact 999 in an emergency situation.
- Local procedure dictates that when the emergency phone rings, that staff on shift immediately cease other activity and answer the phone as soon as possible, as this is an emergency situation.
- Should the staff member not return to site and be uncontactable, the coordinator is to raise this to clinical lead on duty or on call manager and consider the use of contacting next of kin and the police.
- When seeing a service user on a trust site, lone working procedures should continue to be adhered to.
  - Service user should be seen in an appropriate room on the site.
  - Staff member should ensure they have surveyed their environment before inviting in the service user and take note of exits, chair positioning and alarm systems.
  - Staff member should always remain in close proximity to the entrance to the room and any alarm points available
  - Should risk escalate, the staff member should attempt de-escalation if appropriate and/or remove themselves from the room to protect their safety. Staff to use the alarm points to contact for help as required.
  - When seeing a service user at Miranda House; the 136 suite and interview rooms are fitted with the pinpoint alarm system. Staff should ensure they have acquired a pool alarm kit from reception before seeing the service user. The staff member should ensure they test the key fob to ensure it is working correctly and carry this with them at all times during their consultation. This fob is to be activated as required and assistance will be provided from MHCIT and

Avondale staff. Once the consultation is complete, the key fob should be returned and signed back in at reception for further use.
  - Staff should ensure they have enquired about and adhere to all local procedures at other sites they may be working from.
- Staff should always consider the use of a second person attending visits and assessments with the staff member and arrange this accordingly.

Any incidents of aggression should be documented on Lorenzo, including creating an alert, inform the shift coordinator/clinical lead, report via Datix, consider report to the police as required. Staff who witness or are subject to physical or verbal aggression should be offered supervision and a de-brief session at the earliest opportunity.

4.24. Alcohol and Substance Misuse

Alcohol screening procedure (See Policy Identification of Alcohol Misuse P197) So prevalent is alcohol misuse that NICE (2010) recommends that NHS professionals should routinely carry out alcohol screening as an integral part of practice. Short, validated screening tools (i.e., questionnaires) should be utilised to identify those who misuse alcohol and should be integrated into assessment and review documentation
Humber NHS Foundation Trust services will systematically screen for alcohol misuse using validated screening tool/questionnaire chosen from the following:

- Alcohol Use Disorders Identification Test - Consumption scale (AUDIT – C; Bush et al, 1998)
- Alcohol Use Disorders Identification Test - Interview Version (AUDIT, Saunders et al, 1993)
- All those who score positively for alcohol misuse should be:
  - Notified that they are, or recently have been, drinking at levels or in a pattern which may have increased their risk of health or social problems
  - Advised that cutting down on drinking will reduce risks associated to alcohol
  - Offered further information on the risks of alcohol (leaflets, websites) and where to get further advice/help
  - Considered for needing a referral to alcohol services for further assessment, advice and/or treatment.
- Those positive for alcohol misuse using shorter screening AUDIT-C should be offered the Full AUDIT.
- All those thought to be alcohol dependent (e.g., AUDIT score 16 or more), or who typically drink more than 15 units of alcohol daily, should be:
  - Considered at risk of alcohol withdrawal symptoms and should be assessed by a competent clinician, particularly when restricted from alcohol (i.e., on transfer of care to hospital) as the individual may require medication to manage alcohol withdrawal symptoms and parenteral vitamins to avoid complications associated with abrupt cessation of alcohol (See Guideline - G349 Alcohol Withdrawal on Psychiatric Wards).
  - Considered in need of specialist comprehensive assessment and possible need for structured treatment and referred to alcohol services where the service user service user agrees.

Adults Scoring: Maximum score of 12 with a score of 5 or more indicating hazardous/harmful drinking
Young People: A score of 3 or more may indicate hazardous/harmful drinking and a score of 5 or more consider comprehensive assessment – with positive alcohol use in young people always consider safeguarding
Positive Score: If trained, and feasible, consider application of Full AUDIT and follow guidance.

Comprehensive Assessment
Those service users who score 16 or more on the AUDIT or who are suspected of experiencing complex alcohol misuse should receive a comprehensive assessment of their alcohol misuse by a trained healthcare professional. The comprehensive assessment should consider multiple areas of

need, be structured in a clinical interview, use relevant and validated clinical tools, and cover the following areas:

- Alcohol use, including consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
- Dependence, including history of:
- evidence of tolerance (needing more alcohol over time to get the same effect)
- withdrawal symptoms (nausea, tremor, sweats, anxiety, delirium tremens, seizures, sleep problems, make use of the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar))
- strong desire/compulsion to take alcohol (i.e., craving/urge to drink)
- inability to control the use of alcohol
- preoccupation with the obtaining, using and recovery from alcohol – other activities/priorities diminished
- Persistent use of alcohol despite evidence of harmful consequences and problems.
- Supplement the assessment with the use of the Severity of Alcohol Dependence Questionnaire (SADQ)
- Alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
- Other drug misuse, including over-the-counter medication
- Physical health problems: particularly attention should be paid to a history of recent falls, head injuries, possible neurological problems, nutrition and dietary intake
- Psychological and social problems
- Cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- Readiness and belief in ability to change.
- Alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
- Other drug misuse, including over-the-counter medication
- Physical health problems: particularly attention should be paid to a history of recent falls, head injuries, possible neurological problems, nutrition and dietary intake
- Psychological and social problems
- Cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- Readiness and belief in ability to change

Breath test

Breath tests can form part of assessment and safety/management plans, however in isolation do not define level of dependence. Caution should be taken with severely dependant persons, as they may have a high breath reading when they begin to experience withdrawal symptoms.

Substance use

- So prevalent is drug use that all healthcare professionals, wherever they practice, should be able to identify and carry out a basic assessment of people who use drugs (National Institute for Health & Care Excellence (NICE) 2007).
- NICE recommends that mental health and criminal justice settings, routinely ask service users about recent legal and illicit drug use, including type, method of administration, quantity and frequency.
- People who misuse drugs may present with a range of health and social problems other than dependence, which may include (particularly with opioid users):
  - Physical health problems (for example, thrombosis, abscesses, overdose, hepatitis B and C, HIV, and respiratory and cardiac problems)
  - Mental health problems (for example, depression, anxiety, paranoia and suicidal thoughts)
  - Social difficulties (for example, relationship problems, financial difficulties, unemployment and homelessness)

All service users* on assessment and/or transfer of care should be asked about recent legal and illicit drug use, including:

- type

- Method of administration
- Quantity
- Frequency

- All service users must be made aware that asking them about drug use is a routine part of the care we offer. This is required as drug misuse informs the treatments that we offer and where indicated may influence the medications prescribed.
- The Brief Screen for Drug Misuse has been adapted from an international tool (ASSIST: WHO, 2010) to support services undertake a basic assessment of drug misuse. This tool has been incorporated into mental health assessments across the organisation

Complete the Brief screening for substance misuse

Outcome of the brief drug misuse questions must be shared with the service user and reported to all those responsible for their care.

The precise interventions to consider will need to take account of other factors:

- Outcome of mental health and risk assessment
- Age of the service user
- Pregnancy
- Parental responsibility
- Safeguarding advice

This action may require seeking specialist advice, assessment and/or treatment. The outcome of the screening tool should not be used in isolation, but health and social care staff should consider:

- All those service users reporting use of a substance once or more over the last year should receive feedback on the risks of use and information on where to access further help and support if needed
- All those reporting intravenous (I.V.) use should receive information on the risks of injecting behaviour
- All those reporting monthly or more frequent use should be asked about their drug misuse routinely as part of their care plan
- A health or social care professional should consider seeking a specialist comprehensive assessment of drug misuse where a service user reports, monthly or weekly use of drugs.

A specialist comprehensive assessment should be obtained where drug use is:

- daily or almost daily
- less frequent than daily but there are additional specific concerns (i.e., young person, pregnant, high-risk behaviour)
- involving I.V. or high-risk routes of administration

Ciwa-b benzodiazepine withdrawal schedule rating scale
Clinical Opiate Withdrawal Scale (COWS)

4.25. Handover to next shift- 08.00hrs and 20:00hrs

- HBT coordinator to be present at 08:00hrs handover and where required at 20:00hs handover. Bed Management staff to be present at 08;00 handover.
- Outgoing shift coordinator highlights outstanding assessments (MHA,136 and very urgent/urgent providing brief overview of presenting issues and risks, whilst incoming coordinator notes all relevant information. Coordinator to handover any pertinent information from the outgoing shift in regard to clinical activity or service issues that the oncoming shift requires knowledge about.
- Any outstanding triage referrals requiring further discussion to be provided to Incoming coordinator.
- A member of staff should be allocated to MHCIT phones to manage any incoming calls whilst handover takes place

- Outgoing AMHP highlights outstanding assessments, providing an overview of presenting issues and risks. Gives an update on completed Assessments and also any other issues /processes that are ongoing requiring attention form the incoming AMHP.

Record MDT in Lorenzo, using the SOAPP framework (appendix 7): all staff involved in MDT and includes risks, decision making risk management and plan of action.

4.25.1. Interface with the crisis pad (see Crisis Pad Service Aims and Objectives)

The crisis pad (managed by MIND) operates out of Wellington House, 7 evenings a week between 18.00hrs and 02.00 hours

The service is for adults. Children and organic presentations have been considered as exclusions to the service. No other exclusions have been identified although risk factors need to be considered as does degrees of intoxication before consideration to refer.

4.26. Interface with External Agencies/Stakeholders

MAVA is a multi-agency meeting to discuss vulnerable adults who come into contact with various services on a regular basis. These include mental health services, social services, police, DAP etc. It's a forum to share information about input from each service and approaches to managing individuals. It's a way in which services can work together to provide consistency and hopefully reduce level of contact/need.

All individuals discussed must not already be an open case in the MAPPA & MARAC meetings. The MAVA meeting is held once a month.

MARAC has been in place since January 2006 in Hull and filled the void in relation to supporting victims of domestic abuse that are deemed to be High Risk. MARAC is now recognised nationally as an effective way of reducing risk for high-risk victims affected by domestic violence and abuse.

In addition to domestic abuse cases being heard at MARAC, cases that involve Honour Based Violence can be referred if deemed to be high risk.

Is a victim focused meeting, whereby agencies legally share necessary information in order to develop a safety management action plan to help protect the victim and their children. Hull MARAC is held every 4 weeks; emergency meetings can be called by an agency if it is believed that a victim is at imminent risk of serious harm.

The aim of MARAC is:

- To share information to increase the safety, health and wellbeing of victims – adults and their children
- To determine whether the perpetrator poses a significant risk to any particular individual or to the general community.
- To construct jointly and implement a risk management safety plan that provides professional support to all those at risk and that reduces the risk of harm.
- To reduce repeat victimisation.
- To improve agency accountability.
- Improve support for staff involved in high-risk Domestic Abuse cases.
- To identify those situations that indicate a need for the Local Safeguarding Children Board's Child Protection Procedures to be initiated

MHCIT MARAC lead attends the monthly two-day meetings.

Hull Domestic Abuse Partnership (DAP)-

MHCIT have a DAP worker within the team one day a week

Hull DAP is a multi-agency team; it aims to improve the safety of survivors and children in Hull through a co-ordinated and effective inter-agency response.

The Hull DAP team is a group of professionals experienced in the field of domestic abuse who work together to provide support for victims of domestic abuse. The team consists of Specialist Domestic Abuse workers, housing officers, and specialist Police Officers. The team provides a range of tailored support options to enable survivors and their children to live safer lives without fear.

Support can include:

- Sanctuary Scheme Measures, i.e., support to stay in their own home with; increased home security; home fire safety check completed by Humberside Fire and Rescue Service, Lifeline panic alarm, new mobile phone / SIM card, personal alarm, CCTV, etc;
- Risk Identification and Safety Planning.
- Emotional support, legal advice, specialist housing advice, health related advice, advice with regards to child contact, support through the civil and criminal justice routes.
- The support workers also link in with the other disciplines in the team to ensure all the needs of victim's woman and any children are met.

Hull DAP works in partnership with many agencies to provide information, training, advice and guidance to other professionals working in this field.

Strength to Change

Strength to Change service is for men who are concerned about their abusive behaviour. It aims primarily at enhancing the safety of women and children whilst giving men an opportunity to change their behaviour.

Calls to Strength to Change are confidential and men are encouraged to self-refer. Whilst professionals' providing basic information and the helpline number to potential clients is useful, essentially the men themselves need to want to change their behaviour and be prepared to engage consistently over a year long programme. In return the project will work with them to encourage and motivate them to stop their abuse and to understand how their behaviour affects their family and friends.

Ultimately, Strength to Change strives to keep women and children safe by providing a holistic approach to domestic abuse that encompasses support for all family members within a non-judgemental supportive framework.

MAPPA (See HTFT SOP-MAPPA)

MAPPA are a framework of statutory arrangements introduced by s.325-327 Criminal Justice Act (CJA) 2003 and operated by criminal justice and social care agencies. MAPP Arrangements enable these agencies to work together to reduce the risk to the public of further offending presented by sexual and violent offenders. This is done by sharing information to produce a coordinated risk management plan that will allow offenders to be effectively managed in the community.

There is a statutory duty on the Police, Probation and the Prison Service, in each of the 42 MAPPA areas of England and Wales to establish arrangements for the assessment and management of risk presented by specified sexual and violent offenders. These agencies comprise the MAPPA Responsible Authority. In addition, a range of other agencies that have dealings with offenders are under a duty to co-operate with the Responsible Authority. These Duty to Co-operate agencies include social services, health services (including NHS Trusts), housing authorities, education authorities, youth justice services, work and pensions services and immigration services.

Identification and Notification - The first stages of the process are to identify offenders who may be liable to management under MAPPA as a consequence of their caution or conviction and sentence, and later to notify the MAPPA Co-ordinator of their impending release into the community, or the commencement of a community order or suspended sentence, as appropriate. This responsibility falls to the agency that has the leading statutory responsibility for each offender. Offenders are placed into one of three MAPPA categories according to their offence and sentence.

Levels of management - MAPPA offenders are managed at one of three levels according to the extent of agency involvement needed and the number of different agencies involved. The great majority are managed at level 1 (ordinary agency management). This involves the sharing of information but does not require multi-agency meetings. The others are managed at level 2 if an active multi-agency approach is required (MAPPA meetings), and at level 3 if senior representatives of the relevant agencies with the authority to commit resources are also needed.

RAMM (Risk Assessment Monitoring Meeting)The 6 weekly meeting is a multi-agency meeting attended by representatives from various Hull City Council departments including Housing, Neighbourhood Nuisance and Environmental Protection: representatives from Humberside Police and myself.
I bring to the meeting cases of anti-social behaviour or Hate Crime that have been referred through to Victim Support, mainly by the Police or Council using the attached Risk Assessment referral form. Acting as Victims Advocate, I seek an update on each case and we discuss progress, needs of the victim and what further action is proposed/can be offered by the collective to support the victim and reduce the crime or anti-social behaviour impacting on them

MEAM (Making Every Adult Matter)
People facing multiple disadvantages experience a combination of problems including homelessness, substance misuse, contact with the criminal justice system and mental ill health. They fall through the gaps between services and systems, making it harder for them to address their problems and lead fulfilling lives.
The MEAM Approach helps local areas design and deliver better coordinated services for people experiencing multiple disadvantages considering the seven principles, which they adapt to local needs and circumstances.
Operationally, we attend a multi-agency meeting to discuss cases on a monthly basis. In addition to this, the partnership has a bi-monthly meeting specifically for the MEAM client group, to give partners the opportunity to discuss and identify the more systemic issues that are arising through this work and to share good practice.

4.27. Interface with CAMHS

See transitions procedure and CAMHS SOP

4.28. Out of Area presentations of Hull/ER service users

Should a Hull/ER service user present out of area either requiring assessment, transfer of care or treatment it is the team's responsibility to support the out of area service with information and guidance around the care required for our service user. In regard to an assessment, it is the responsibility of the out of area care establishment to facilitate this as it would be if an individual presented within our boundaries from another area. The clinical decision concerning a Hull/ER service user should be made by the out of area service and shared with MHCIT who will triage the clinical information and jointly decide on the care requirements. If this decision is a transfer of care to Hospital, we should support the out of area service with this and attempt to return the service user to a Humber Foundation Trust Bed, if this is not possible it is the responsibility of the out of area service to conclude their assessment and provide urgent care. Should the out of area service decide to admit to a bed out of their area we need and ensure regular contact occurs with the out of area service providing the treatment, returning the Hull/ER service user as soon as possible to a HFT bed.

If MHCIT is contacted by an out of area service requiring information about on-going care due to the service presenting out of area while visiting the local area, support should be provided by the best person that may be either a crisis team member of a community member of staff.

It is not the responsibility of HFT staff to travel to the out of area service to assess the service user. if an out of area Trust contacted MHCIT then the details to be passed to the bed management team at the earliest opportunity.

4.29. Bed Management -See Bed Management SOP

5. REFERENCES

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- UK Mental Health Triage Scale Guidelines January 2015 Authors: Sands, N., Elsom, S. & Colgate, R.14 *UK Mental Health Triage Scale*
- Whitby S, Ieraci S, Johnson D, Mohsin M. Analysis of the process of triage: the use and outcome of the National Triage Scale. report to the Commonwealth Department of Health and Family Services. Liverpool, NSW. Liverpool Health Service; August 1997.

Appendix 1 – Staffing Establishments

At the start of each day shift, one qualified member of staff will be allocated as shift coordinator.

Shifts commence at 08.00hrs and 20.30hrs

Handover occurs from shift coordinator from the previous shift; only the relevant information should be handed over including risk related concerns

Minimum staffing **Days**

In MHCIT-

1 x band 7

1 Medic

4 x band 6

2 x band 5

4 x band 3(1 x TL) *This includes the 2 x B3 RCRP (1 Humbercare)*

1 AMHP (9-5) day rota & 1 on T

On Nights –

1 x band 7 9 - either a CL Nurse or CL AMPH

2 x band 6 (1 and AMPH if band 7 is already an AMPH)

1 x band 5

3 x band 3 *This includes the 2 x B3 RCRP (1 Humbercare)*

Coordinator uses team diary/shift log to support the day's clinical demands

The Electronic board handover log should support allocation of crisis assessment work (Gatekeeping assessments, S136, Triage)

The coordinator allocates the work and can change the roles of the clinicians on shift to meet service demand

The use of the electronic boards should be kept up to date at all times

The Shift Co-ordinator will:

- Manage the morning review ensuring calls continue to be answered and all relevant clinical decisions are agreed with the Consultant
- Keep the electronic board up to date and input agreed visits.
- Record all referrals and MH Act assessments including s136 on the electronic boards.
- Allocate s136 coordinator to be present throughout s136 detention
- To ensure all staff are present at the start of the shift
- To screen call boards for increased activity and appropriate allocation.

- To discuss all referrals and arrange assessments
- To ensure all referrals are regularly reviewed for urgent assessment needs
- To ensure that all assessments are spread evenly throughout the day
- To ensure that all clinical activity has been recorded on Lorenzo by clinicians on shift
- To ensure resources are allocated according to demand
- To consult the team clinical diary/shift log and ensure all tasks are allocated and completed
- To ensure that all staff are safe and accounted for at the end of a shift
- Ensure all clinical notes and the electronic boards are up to date at the end of each shift

Appendix 2 – Roles of staff

Role of the Admin staff

- Answer phones and act as first point of contact for routine enquires and referrals
- Collect demographic / Mental Health Minimum Data Set details for enquiries and referrals
- Process emails and manage non urgent clinics
- Collect clinical/audit data as required
- Input information onto IT systems/ spread sheets/databases
- Support the Clinical Staff working as required

Role of HCA

- Answer phones and act as first point of contact for urgent enquires and referrals
- Collect demographic / Mental Health Minimum Data Set details for enquiries and referrals
- Collect clinical/audit data as required
- Input information onto IT systems/ spread sheets/databases
- Support the Clinical Staff working as required
- Adhere to the Triage panel information
- Adhere to the Clinical Triage Referral Pathway
- Act as first point of clinical contact for urgent enquiries and referrals
- Follow Clinical Triage Risk Decision Guide
- Obtain further information at point of triage from both referrers and service users to support clinical decision making.
- Allocate assessments to appropriate service using agreed criteria/decision guide. If necessary discussing with qualified staff/clinical leads to aid decision making.
- Provide feedback and information to referrers and stakeholders
- Escalate delays and blockages to Clinical Leads

Role of the band 5

- Adhere to the Triage panel information
- Adhere to the Clinical Triage Referral Pathway
- Act as first point of clinical contact for urgent enquiries and referrals
- Follow Clinical Triage Risk Decision Guide
- Obtain further information at point of triage from both referrers and service users to support clinical decision making.
- Allocate assessments to appropriate service using agreed criteria/decision guide. If necessary discussing with other qualified staff/clinical leads to aid decision making.
- Provide feedback and information to referrers and stakeholders
- Escalate delays and blockages to Clinical Leads
- Provide clinical and operational leadership
- Engages in Triage and assessment roles
- Acts as point of contact for clinicians and Admin staff
- Support MHRS Shift Coordinator in balancing workload demand
- Support clinicians in resolving differences in clinical opinion with referrals and where necessary takes a lead.

Role of the band 6

- Adhere to the Triage panel information
- Adhere to the Clinical Triage Referral Pathway

- Act as first point of clinical contact for urgent enquiries and referrals
- Follow Clinical Triage Risk Decision Guide
- Obtain further information at point of triage from both referrers and service users to support clinical decision making.
- Allocate assessments to appropriate service using agreed criteria/decision guide. If necessary discussing with other qualified staff/clinical leads to aid decision making.
- Provide feedback and information to referrers and stakeholders
- Escalate delays and blockages to Clinical Leads
- Provide clinical and operational leadership
- Engages in Triage and assessment roles
- Acts as point of contact for clinicians and Admin staff
- Support MHRS Shift Coordinator in balancing workload demand
- Support clinicians in resolving differences in clinical opinion with referrals and where necessary takes a lead

Role of the Clinical Leads (see below for more detailed list)

- Provide clinical and operational leadership
- Engages in Triage and assessment roles
- Acts as point of contact for clinicians and Admin staff
- Support MHCIT Shift Coordinator in balancing workload demand
- Support clinicians in resolving differences in clinical opinion with referrals and where necessary takes a lead.

Role of the shift coordinator

- Must be a band 6/7 practitioner
- To be available at all times to support the team with clinical decision making
- To provide clinical leadership and liaise with the clinical lead as required (if different)
- To delegate roles; triage coordinator, 1st responder, 136 coordinator, triage panel, ILS trained nurse
- Delegate breaks
- Provide handover to oncoming shift
- Ensure completion of shift log
- In the event of a response to an alarm, the coordinator may wish to send a second responder to the area due to intelligence regarding the situation. If the alarm sounds in the 136 suite or in the upstairs rooms at Miranda House, it would be good practice to send a second person and ideally the ILS nurse in case this alarm relates to a medical emergency.

Role of the 136 coordinator-See 136 SOP

Role of the 'responder' in the MHCIT (see below)

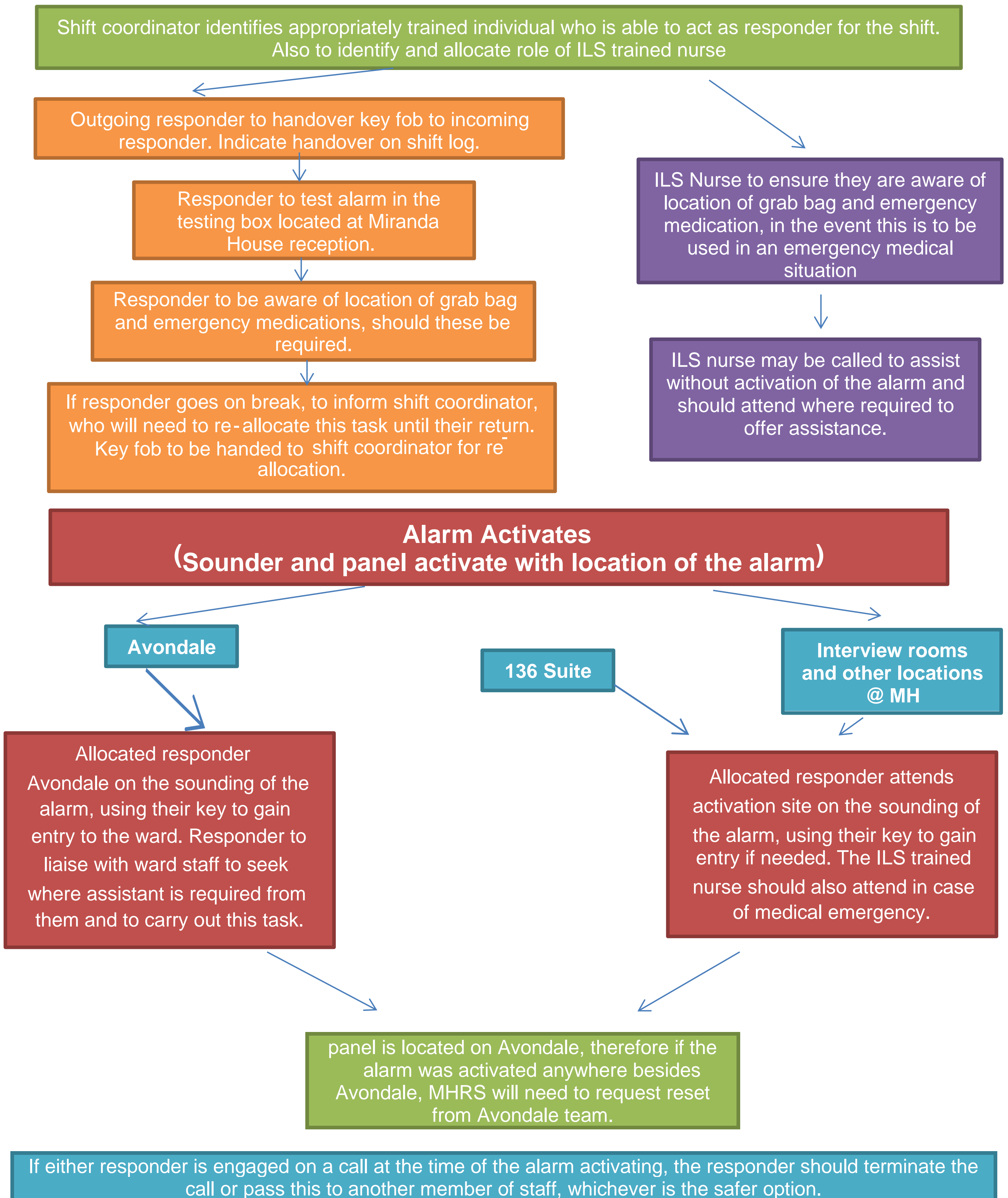
- The role of the responder is to provide support to Avondale and the 136 suite, including any other areas that are pinpoint alarmed at Miranda House, should alarm be activated
- The responder is required to be identified on every shift
- The responder should be an appropriate trained individual with DMI training in date
- The responder should at all times, carry an alarm and key to Avondale and the 136 suite on their person, when in this role.
- The responder key fob should be passed over to the new responder on each shift and logged as completed on the shift logs. It is the duty of the responder at the start of each shift to test the alarm in the system, located at Miranda House reception.
- When the designated responder is due to take a break, they should inform the shift coordinator who will re-assign this role as required.

- When the alarm is activated and the information panel and sounder activate to indicate this, the responder should attend the area the alarm has been activated as quickly as possible.
- Should there be a requirement for more than one responder from MHCIT, due to clinical demand or staffing requirements, the Avondale shift coordinator and the 136 coordinator should inform MHCIT coordinator of this requirement, so another responder can be identified.
- The responder may be required to manage the situation and delegate to other members of the team and take a leader role.
- The responder should be aware of the location of the grab bag and emergency medication, should they be asked to collect this for a medical emergency.

Role of the ILS Trained Nurse (see below)

- An ILS trained nurse should be identified on each shift.
- They will be required to respond to any medical emergency that may arise at Miranda House.
- Should the pinpoint alarm sound for the 136 suite or the upstairs interview rooms, the ILS nurse should always attend as a matter of precaution in case of a medical emergency

MHCIT Responder and ILS nurse flow chart



Role	Clinical Lead	Team Leader
Recruitment and Retention		
Vacancy Monitoring		Y
Appointing Officer	Y	Y
Job Purpose and Function	Y	Y
Prepare Job Description	Y	Y
Recruitment process	Y	Y
Shortlist Applicants	Y	Y
Interview Candidates	Y	Y
Service/Staff contract changes i.e. Leavers & retirement		Y
Registration/ Initial introductions to new staff – smart card etc		Y
Occupational health referral/liaison		Y
Induction: professional	Y	
Induction : team	Y	Y
Administrative and Organisational		
Budget Management		Y
Reviews of Service SOPs, BCPs etc,.	Y	Y
KPI/performance monitoring		Y
Annual leave monitoring and sign off		Y
Sickness and absence reporting	Y	Y
Sickness and absence monitoring	Y	Y
Special Leave		Y
Training and supervision monitoring		Y
Operational Service cover	Y	Y
Management and Monitoring of IT systems	Y	Y
Travel Expenses	Y	Y
Environment/Facilities	Y	Y
Purchase of Equipment – team		Y
Monitoring and request of Equipment – specific resources (test equipment, books)	Y	Y
Team objective and business planning	Y	Y
Contributing to service development, business plans, Trust strategy, etc	Y	Y
Quality of service user satisfaction	Y	Y
Individual Performance		
Managerial Supervision	Y	Y
Adherence to team Operational Policy	Y	Y
Implements professional strategy	Y	
Complaints/SI's/SEA/Investigations	Y	Y
Disciplinary Matters – professional practice	Y	Y
Disciplinary matters – general	Y	Y

Standards of professional practice	Y	Y
Professional registration – re-registration	Y	Y
Training and Professional Development		
KSF, Appraisals, training needs analysis	Y	Y
CPD training with budgetary cost or time cost		Y
CPD training with budgetary cost: defining training content, careers advice, professional development	Y	
Job plans and objective setting	Y	Y
Mandatory training	Y	Y
Links with training establishments	Y	Y
Student allocation, co-ordination and accreditation of places	Y	Y
Clinical practice/standard setting		
Caseload management	Y	Y
Management of medicines	Y	
Professional role issues	Y	
Clinical supervision	Y	Y
Activity recording	Y	Y
Record keeping	Y	Y
Risk Assessment and Management	Y	Y
Therapeutic Approaches	Y	
Clinical Audit and Outcomes	Y	Y
Clinical Governance	Y	Y
Professional Issues		
Professional supervision	Y	Y
Professional Networks	Y	Y
Professional Pathways	Y	Y
Registration monitoring	Y	Y
Research activity	Y	Y
Promotion of the professions	Y	

Appendix 3 – RED FLAGS:		
Demographic and social factors	**Personal History**	**Clinical Factors & Mental state**
Demographic- Middle aged men Women aged 75 and over Men over 75 Marital status-Separated, 1st year after separation, divorced, widowed. Pregnant women and new mothers. **Unemployment:** Initially high then decreases after 3 months. Poor work record in last 4 years (age 40-60) **Minority groups –** Refugees, first generation immigrants, living in the UK for less than 5 years. **Lack of social capital-** Social isolation, Living alone, Loss of attachment, Lack of social support, Institutionalisation, Recently leaving the armed forces, Loss of privilege **Economic –** Economic adversity Changes to Economic status Homelessness	**Family history-** Suicide Mental illness Alcoholism Pain Sleep problems Abuse / Trauma Previous suicide attempts Significant life events **Certain professions-** Building construction, truck drivers, farmers, doctors (female) dentists, pharmacists, veterinary surgeons and female nurses **Access:** Access to lethal means Use of suicide promoting websites	**Current mental illness;** Recent relapse, repeated relapses, transfer of care/transfer of care from in-service user unit, self-neglect, agitation, depressive symptoms, anhedonia and insomnia, severe anxiety, panic. PTSD. Pattern of repeat attendance to services. **Traumatic development and resulting;** emotional instability, impulsivity, recklessness, increased risk taking, frantic attempts to avoid abandonment, interpersonal regulation fractured sense of self. **Medication;** Prescribed and over the counter. Hording of meds. **Substance misuse-** High level of dependency, long history of drinking or binging. **Health:** Poor physical health & chronic medical illness (1 in 10 completed suicides). **Primary care** Recent increase in consulting behaviour, changes to medication. **Psychotic phenomena;** Distressing psychotic phenomena, persecutory delusions, nihilistic delusions, command hallucinations, omnipotent perception. **Cognitive phenomena /insight** Delirium, Low IQ, previous high pre-morbid functioning and fear of deterioration, early stages of illness.

Should the service user present with any of the above please ensure that the referral is discussed with a senior clinician/clinical lead & that this is documented and a plan of action agreed.

Appendix 4 – UK Mental Health Triage Scale

UK Mental Health Triage Scale-permission to use this given on 11/11/2021 by N Sands(email)				
Triage Code /Description	**Response type/ time to face-to face contact**	**Typical presentations**	**Mental health service action/response**	**Additional actions to be considered**
A Emergency	**IMMEDIATE REFERRAL** **Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS** **Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means. Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS** **Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period

D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS** **Semiurgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS** **Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider (with or without formal written referral)**	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only** **OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

Appendix 4a – Additional Guidance for staff in MHCIT to support the UK Mental Health Triage Scale (above)

Response Time/Description	Typical presentations	Mental health service action/response	Additional considerations
A EmergencyIMMEDIATE REFERRAL Emergency service response	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	Staff member to notify ambulance, police and/or fire service	Keeping caller on line until emergency services arrive / inform others Telephone Support
B **Very Urgent-4 hours response** **Very high risk of harm to self or others and/or high distress, especially in absence of capable supports.** **Significant deterioration in mental health, which is highly likely to deteriorate without imminent intervention or treatment**	Acute and Active suicidal ideation with plan/partial plan and/or history of suicidal ideation. Ongoing history of self harm or aggression with intent. Rapidly increasing/developing symptoms of psychosis and/or severe mood disorder Very High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control, including risk of harm to self or others Unable to care for self or dependents or perform activities of daily living due to acute mental health presentation Known service user requiring very urgent intervention to prevent or contain relapse Where peoples physical health is significantly at	Urgent assessment under Mental Health Act Ensure a qualified member of staff is involved in the call and supporting the staff member and a plan of action is agreed. If the staff member is a band 3 and cannot access a qualified member of staff then they are to call 999. Assessment maybe required within 4 hours. Develop a collaborative safety plan	Recruit additional support Telephone support Point of contact if situation Changes Are they Known to services-Liaise with relevant team. Safeguarding Physical screening required Substance misuse Obtain additional/corroborating information from relevant others including family, friends other services.

	risk due to their mental health i.e. not eating/drinking due to belief food is poisoned.		
C **Urgent response 24 hour response** **High risk of harm to self** **or others and/or high distress,especially in absence of capable supports**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent. Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	Assessment maybe required within 24 hours. Develop a collaborative safety plan	Contact same day with a view to following day review in some cases. Obtain additional/corroborating information from relevant others including family, friends other services Point of contact if situation Changes. Telephone support and advice to manage wait period Are they Known to services-Liaise with relevant team
D **Semi-Urgent response within 72 hours** **Moderate risk of harm and/or significant distress** **evidence of mental illness which is likely to deteriorate without intervention/treatment in a timely manner.**	Significant service user/carer distress associated with serious mental illness (including mood/anxiety disorder) but not actively suicidal. Absent insight/Early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	Assessment maybe required within 72 hours Develop a collaborative safety plan	As above

E **Non urgent 30 days response** **Low risk of harm in short term or moderate risk with high support/ stabilising factors** **evidence of mental health needs that are not manageable/treatable within a primary care setting long term**	Requires specialist mental health assessment and treatment but is stable and at low risk of harm in waiting period Other service providers able to manage the person until MHS appointment (with or without MHS phone support) Known service user requiring non-urgent review, treatment or follow-up Early cognitive changes in an older person Has long term complex needs, which require multiple professionals/service involvement.	Follow up review Non-urgent assessment	As above Ensure service required is provided in area such as ADHD assessment.
F **Referral not requiring face-to-face response from MHS in this instance** **Advice or information only/ Service provider consultation**	Other services (e.g. GPs, primary care, voluntary sector) more appropriate to person's current needs such as prescribing of antidepressants when need is not complex. Symptoms of mild to moderate depression, anxiety, adjustment, behavioural disorder, particularly when primary care hasn't already been accessed.	**Not appropriate for secondary MH services:** Signpost to MHAST, primary care, IAPT, voluntary services Professional/advice from MHCIT Staff.	Assist and/or facilitate transfer to alternative service provider. Telephone support and advice

	Service user/carer requiring advice or opportunity to talk Service provider requiring telephone consultation/advice Issue not requiring mental health but require other services such as housing, finances, benefits.		

Appendix 5 – Police Model of Thrive

All Trust Areas – Communication to Police

There are occasions staff need to contact Police, for example:

- Emergency assistance required at a community base due to violence;
- Safe & Welfare Checks on vulnerable people at risk of **immediate** harm;
- Emergency assistance to inpatient wards with weapons use;
- To report a crime following an incident etc.

Trust staff will always ensure it is necessary, proportionate and all other options are exhausted as well as a legal remit, for Police to be involved.

This is a communication aid for those calls.

101 – Non urgent matters reporting, advice and/or support	999 – Emergency Police assistance required now

Making the Call – Based on Police Model of THRIVE

Basics		• Ensure non jargon language, clear Communication, and no acronyms are used. Provide accurate, factual and detailed information. • Ensure your location is given clearly and fully , the type of location, if applicable. • Give your full name, role and then using below details of why Police are required.
T	**THREAT**	What is the threat? Is it on-going? Details of intent and capability. Location of where the person is now in relation to where they have stated that will cause the harm.
H	**HARM**	Who could be harmed; the subject or other? What is the likely level of harm that could be caused e.g. is there a weapon involved? Is potential for harm imminent, pattern of behaviour or new presentation? **"We have tried/considered all we can do without harm"**
R	**RISK**	What actions have you done to minimise the risk, and why are Police now required to assist with the risk? Consider previous risk history of person, previous contact with Police/MH services, actions taken previous contact with Police/MH services, actions taken
I	**INVESTIGATION**	What Investigation has taken place prior to police being informed? Phone calls, CCTV, enquiries with neighbours, letters sent / left? Evidence must be provided to assist in police assessment of request
V	**VULNERABILITY**	What vulnerability exists? Are they alone or is there someone with them who can protect them from harm? Is the support person vulnerable, e.g. is the person in crisis armed with a weapon and threatening to harm others?
E	**ENGAGEMENT**	Is the service user amenable to engaging with Police or other support services offered? Who do they best engage with?

There should be an agreed exit plan for police and agreed handover/communication back to the service that makes the call.
Ensure there is an agreed point of contact for police communication and updates

Appendix 6 – If medication thought to be taken in excess of the recommended maximum BNF dose

If medication thought to be taken in excess of the recommended maximum BNF dose, intentionally or otherwise, the following steps should be considered: *NICE Clinical Knowledge Summaries: Poisoning or overdose*

Immediate assessment/support:
Advice should be given to access medical attention following a poisoning or overdose to all service users for observation and possible treatment. Alternatively staff may need to consider alerting emergency services

- Location of the service user and are they alone
- What has been taken and the amount (e.g. number of tablets, strength/dose) • Has anything else been taken? (e.g. alcohol, illicit substances, household products) • When was it taken?
- Route of use (e.g. orally, intra venous)
- Is the person experiencing any adverse effects? (See table contents)
- Has the service user any underlying physical health problems?

Most people should be seen (in person) after a poisoning episode or overdose. Advice may be offered over the telephone (without seeing the person) if the healthcare professional feels confident that the poisoning episode is not serious. For sources of information regarding the management of poisoning see table contents below; **Useful resources:**
The 24 hour UK national poisons information service should be contacted for information regarding risk management if required e.g. If it is unclear whether the amount represents a significant overdose. It should never be assumed that a small amount of tablets are safe as this varies greatly depending on the medication.

Report the incident
Any incident of overdosing behaviour should trigger a Datix.

National poisons Information service – 24 hours - **0344 892 0111**
This is a telephone service that can offer advice and information on overdoses. They can advise whether or not a person should attend a&e as well as management and monitoring that should occur after an overdose.
The service is free and you should not hesitate to call them!

Healthcare professionals seeking poisons information can also access www.toxbase.org
Team access:
It is advised all staff access the eLearning package on the toxbase website

Appendix 7 – The SOAPP aide memoire for Clinical Notes and MDT

SUBJECTIVE	• What are you hearing • What is the patient telling you • Background/family • Patients experience of symptoms and condition • What do they perceive they need
OBJECTIVE	• How are we hearing this • What are the mental health needs • Clinical observation
ASSESSMENT	• How can we help • What services can be utilised • Other agencies? • Clinical impression based on information gathered • Risk/safety • Rationale • Assessment should only contain the information required
PLAN	• What happens now • Who will be involved
PLAN B	• What if we cannot get in touch • What course of action takes place

The SOAPP aide memoire has been developed to aid critical thinking about the information to be discussed in the daily MDT meeting. The use of this tool can be utilised by all team members and allows for clinical discussion to be relevant and easily documented. All or part of the model can be used to document key decisions made within the MDT, with a focus placed upon clear rationale for planning of care

Appendix 8 – YAS Pathway with MHCIT