Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
MENTAL HEALTH LIAISON SERVICE

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VALIDITY – All local SOPS should be accessed via intranet

CHANGE RECORD

Version	Date	Change details
1.0	*6 July 2022*	*New SOP – Approved at MH Division Practice Network (06.07.2022)* *06/12/23 – Review date extended until Jan 2024 (Divisional Clinical Lead sign-off - Kayleigh Brown).*
1.1	*7 Feb 2024*	*Reviewed with the following amends made:* • *Update instigated as part of of SEA 2021-34.* • *Update instigated as part of SEA 2021 29 and further to SEA 2021 34 following final sign off. Amendments made in relation to patients in police custody (Page 15) and Inappropriate referrals (page 13). Update made also to Page 6, service model with additional information regarding ED Streaming.* • *SI 2023-3491 Action plan with regards to utilising Intepreters.* • *SI 2023-3491 actions following assessmet with external providers.* • *Did Not wait procedure review.* • *CAMHS Crisis Referral Flowchart.* *Approved at MH Division Practice Network Meeting (7 February 2024).*
1.2	*13 Feb 2024*	*Minor amend to the end of section 16.1 re: MHA assessment completion. Approved by director sign-off (Adrian Elsworth – 13 February 2024). Review dates kept the same.*

Contents

1. INTRODUCTION

The Mental Health Liaison Service (MHLS) are a specialist team based in the Emergency Department (ED) at Hull Royal Infirmary. They provide a valuable role in supporting people in a crisis, as well as adults and older adults who have both mental and physical health problems in a general hospital setting. Support is provided to clinicians working in general health pathways, enabling EDs and wards at Hull Royal Infirmary (HRI) and Castle Hill Hospital (CHH) to assess and manage mental health problems as they present or arise among people being cared for in the general health pathway which can help people to avoid lengthy stays in hospital and can speed up discharge.

2. SCOPE

The purpose of this policy is to provide operational guidance for the MHLS operating within the Humber Teaching NHS Foundation and should be followed accordingly.

This document describes the aims, objectives, service model, service criteria, pathways, referral processes, response times & prioritisation, staff supervision, outcome measures and training in MHLS.

It is the responsibility of the service manager to ensure that this policy is effectively implemented and escalate any issues, as necessary.

3. STAFFING

Having the right workforce with the right skills is essential to delivering care in line with NICE guidance (NICE, 2016).

Staffing
Consultant Psychiatrist (Adult)
Consultant Psychiatrist (Older Adult)
Band 7 Team/Clinical Leads
Band 7 Clinical Shift Leads
Band 6 Specialist Liaison Practitioners
Band 5 Development Liaison Practitioners
Older Adult Band 6 Specialist Liaison Practitioners
Band 3 Support Time & Recovery Workers
Band 5 Data Analyst
Band 3 Medical Secretaries
Band 2 administrative assistants

4. AIMS & OBJECTIVES

To work collaboratively with Hull University Teaching Hospital (HUTH) staff in the assessment and management of patients admitted/attending HRI or CHH who require support from MHLS.

To provide Biopsychosocial assessment of all Urgent and Emergency referrals to determine patients' mental health needs and presenting risk to themselves or others.

Following completed assessment an Urgent and Emergency Mental Health (UEMH) care plan will be in place within four hours and the patient will be en-route to the next location as appropriate.

To document outcomes of any assessments undertaken in patient notes including a clear management plan.

To work closely with all community services and teams including the voluntary sector to ensure the patient receives safe and timely support in the community that responds to the level of risk identified within the assessment.

Provide training to other healthcare professionals who may need to respond to mental health crises (for example, training ED and general hospital ward staff on local protocols, legal frameworks, mental health awareness, and responding compassionately and appropriately).

Offer care planned interventions within the service where appropriate or signpost to other services, including voluntary sector and other community groups/services.

5. SERVICE MODEL

The MHLS are a 7 days a week, 24 hour service based at The Department of Psychological Medicine, Gladstone Street, Hull and have office space within HRI. From June 2023 we will also have a Mental Health Emergency Department Streaming area named 'The Humber Suite' which is situated adjacent to the Emergency Care Area. Please refer to the ED Streaming Standard Operating Procedure.
We accept a referral to the service for any patient of any age (see referral criteria) referred by HUTH regardless of the patient's place of residence. Referral will be accepted from Emergency Departments at HRI and any inpatient ward across HRI or CHH.

The service works closely with other mental health teams across the Trust area – this includes primary care, secondary mental health services, Child and Adolescent Mental Health Service (CAMHS) crisis teams and inpatient units.

The team also works closely with key stakeholders including service users and carers, primary care services, and other local statutory and non-statutory agencies, to deliver responsive care that meets the need of the population.

6. SERVICE CRITERIA

6.1. Inclusion:

- Suspected acute mental illness
- Self-harm
- Suicidal ideation/and or attempts
- The consequences of alcohol and drug use when co-occurring with a mental health problem
- Dementia where advice is sought regarding safe management of risk and commencement of treatment.
- Cognitive Impairment where advice is sought regarding safe management of risk and commencement of treatment.
- Delirium presentation where advice is sought regarding safe management of risk and commencement of treatment.
- Acute emotional distress associated with a mental health problem
- Medially unexplained symptoms that are causing significant distress and/or functional impairment which is hindering with the ability for HUTH medical team to deliver care.
- Advice and assistance with regards to assessing Mental Capacity

6.2. Exclusion:

- Where a patient is admitted to a ward due to physical health concerns and they are active to a Secondary Mental Health Service and have an allocated Key worker, we will not complete an assessment but rather liaise with their Key worker/team and provide a liaison role if required, unless the patient presents with increased risks such as self-harm or harm to others in which case mental health assessment may be offered.
- Where a patient is active and receiving care from Mental Health Crisis Intervention Team, Home Based Treatment Team, Crisis Intervention Team for Older People, CAMHS Crisis Intervention Team and CAMHS Home Treatment Team, MHLS will undertake a liaison role only unless it is negotiated that MHLS are best placed to complete a review of their Initial Mental Health and Risk Assessment.

Referrals for any patients under 18 years of age, will only be accepted where there is clear evidence of the current presentation to hospital for reasons of:

- Suicidal ideation/and or attempts
- Deliberate Self-harm

For all other referrals for patients under the age of 18 who present with mental health difficulties or distress, will be forwarded by the MHLS to the appropriate CAMHS Team and the role of MHLS will be to liaise only.

7. REFERRAL PROCESSES

Referrals should be made via the single point of contact on Telephone: 01482 226226. The referral will be taken by a member of the administration team between the hours of 09:00hrs-17:00hrs 7 days per week, outside of these hours a member of the clinical team will take referrals or enquires. Once a referral is made, service users remain under the overall responsibility of HUTH.

8. RESPONSE TIMES AND PRIORITISATION

As defined by NICE: “An emergency is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response.

An urgent situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life threatening” (NICE 2016).

The Team provides:

- A one hour response service to all of the ED within HRI and for ‘Emergency’ referrals throughout HRI and CHH.
- 24 hour response to all ‘urgent’ referrals from all wards within HRI and CHH

For all referrals received from the ED, the Clinical Shift Lead will respond to a referral within one hour with the purpose to screen for appropriateness to transfer to the ED Streaming unit ‘Humber Suite’. For all patients transferred to the Humber Suite, please follow the ED Streaming SOP MH - ED Streaming SOP23-015.pdf (humber.nhs.uk) .
For cases where the CSL doesn’t have the clinical capacity to respond within the timeframe or identifies that the referral would clearly not meet the ED Streaming Inclusion Criteria, this can be delegated to another member of the team to complete which can be a member of the STR Team.

For all other referrals outside of the ED and where an assessor is unavailable to respond within the above time frame to complete an initial mental health assessment, a Support Time and Recovery (STR) worker can respond by completing a face-to-face ‘first Response’ with the patient. If the patient is experiencing high levels of distress, it may be appropriate for arrangements to be made via the Clinical Shift Lead, for a STR worker to provide support while the patient awaits their assessment.

For all referrals into MHLS during the first contact, the attending practitioner/STR worker will use this opportunity to gain additional information from the referrer such as current and up to date demographic information, fitness to engage in assessment, any outstanding physical investigations and any additional concerns. If a patient is presenting as intoxicated with alcohol this opportunity will also be used to perform an Alco-meter reading, if the patient consents. The patient will also be provided with verbal and written information on MHLS and other relevant mental health support services based in the local community.

The Clinical Shift Lead will review all incoming referrals and prioritise accordingly based on clinical need; consideration of practitioners’ skill and competence will be a

factor in order to deliver care in line with NICE guidance. Whilst every effort will be made to avoid breaches in the ED, this alone will not make the patient a priority. If a patient referred is not appropriate for the Humber Suite and is required to wait for assessment or treatment they should be offered an environment that is safe, supportive and minimises distress, where possible. For many patients, this may be a separate quiet room with supervision (if required) and regular contact with a named member of staff to ensure safety. This member of staff could be a member of the HUTH staff, HUTH security staff or MHLS staff.

Communication between MHLS and HUTH staff is pivotal and will help to maintain patient safety. MHLS are not fully integrated with the information governance arrangements of HUTH and therefore do not have full access to electronic patient records, therefore all written correspondence needs to be entered onto patients' 'hand-held' notes, along with a verbal handover to the nurse/medic in charge of the patient's care. This will need to be replicated in the patient's mental health electronic patient record.

9. HANDOVER PROCESS

Due to the fluidity of shift patterns in operation within the MHLS, the collation and handover of all referrals is the responsibility of the Clinical Shift Lead (night and day).

All referrals shall be recorded on the referral electronic board and the allocated assessor or STR worker will be identified. The board will also allow for contemporaneous updates/prompts.

10. THE ROLES OF THE MHLS CLINICAL SHIFT LEAD

These are as follows:

- To prioritise all referrals received by MHLS.
- To allocate patients who require assessment in a timely manner, taking into account the varying shift patterns that exist within the MHLS.
- To regularly update the electronic referral boards (on V-drive) and ensure referral logs are up to date and accurate.
- To lead the case discussions ensuring all patients are discussed within the MDT.
- To co-ordinate other activities within the MHLS.

Whilst every effort will be made to adhere to the 1 hour response, the challenges that face a busy ED department may result in a breach of this guidance. Where ED staff have concerns about the response times of the MHLS or where a patient remains in the ED department awaiting transfer to or involvement with other Mental Health Services, then they will need to liaise with the Clinical Shift Lead who can then seek the assistance where required, from a Band 7 Team/Clinical Lead.

11. ASSESSMENTS

Patients will be assessed as soon as possible or when they are physically able to undertake a mental health assessment. The MHLS does not require the patient to be medically fit for discharge to commence or undertake an assessment. The assessment of patients should be completed in a suitable environment. This should ensure that privacy and dignity is maintained for the patient and that staff safety is also assured. Privacy and dignity should include as a minimum the confidentiality of the setting and the availability of environments in which patients with physical limitations can be accommodated.

The assessment process should be conducted in a 'whole system' context and as such should include key information collected from all appropriate sources (Electronic Patient Record, family, Carers, other professionals and agencies where appropriate and available). This may also mean that on occasion it is appropriate for the assessment to be carried out by some other professional e.g. the patient's Key worker.

When there are circumstances whereby the patient is not medically fit for discharge, there is potentially an opportunity for a 'parallel assessment'. A parallel assessment process is the expectation that a mental health assessment can take place at the same time as a medical assessment. The aim is to ensure patients are triaged or assessed without unnecessary delay. If medical concerns are identified further into the mental health assessment, then the patient should be review as required by the HUTH responsible medic.

Patients under the influence of alcohol and/or illicit substances, who are presenting with co-morbid mental health problems must be given sufficient time to actively engage in the assessment in a manner where they are deemed to have capacity to engage in the assessment, meaning they have the ability to use and understand information to make a decision, and communicate any decision made. An alcometer reading may be taken to support this decision making however the patient's mental capacity to engage in the assessment should be the overall deciding factor.

Following assessment, a summary will be recorded in the medical notes. This will include as a minimum the formulated action/ care plan based on any identified risks. Following assessment/review and in guidance with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD, 2017) there should be clear and concise documented plans in the hospital notes at the time of assessment/review. As a minimum the review should cover:

- What the problem is (diagnosis or formulation)
- The legal status of the patient and their mental capacity for any decision needing to be made if relevant
- A clear documentation of the mental health risk assessment – immediate and medium term
- Whether the patient requires any further risk management e.g. observation level
- An action/ care plan including medication or therapeutic intervention

- Advice regarding contingencies e.g. if the patient wishes to self-discharge please do this '…'
- A clear discharge plan in terms of mental health follow-up

The MHLS has a daily MDT/case discussion along with handovers at the start and end of the shift with well-established mechanisms of case discussion which aim to convey high-quality clinical decision making by the team. The case discussion is always recorded within the patient's notes, this is a two-way process to provide and receive information and gives an opportunity to members of the MDT to ask questions and challenge clinical decision making.

12. THOSE WHO DO NOT MEET MHLS INCLUSION CRITERIA.

For all patients referred to MHLS they will receive face to face contact with a MHLS staff member to gain further collateral information, obtain current demographic information and provide crisis support leaflets to patients for future support if required. It will be from there that a decision will be made on the appropriateness of the referral and this will also be agreed within the daily multi-disciplinary team meetings.

13. THOSE WHO REQUIRE AN INTERPRETER.

Creating the best communication possible is a priority whilst engaging with service users and their carers to ensure a person's language needs are fully met if they do not use spoken English. This happens through spoken language and sign language interpreters.

The optimal means of communication would be with an independent face to face interpreter however if this is not available, the use of translation programmes and language line is the next appropriate means of communication.
Family and friends of the patients should not be used as interpreters unless in exceptional circumstances whereby the rationale to do so is clear and justifiable. All other means of interpretation should be attempted first from independent sources.

14. PRISONERS

Clinical guidelines (NICE, 2004) have recommended that all people who attend a general hospital following an episode of self-harm should be offered a psychosocial assessment at an appropriate time which includes those from the prison population as evidence would indicate that there are increased risks amongst this group of people.

The following should be followed:

- All prisoners that attend HUTH general hospital following an episode of self-harm will be offered a psychosocial assessment.
- Determining the timing and environment of this psychosocial assessment will depend upon the patient's physical health, current distress and immediate risk of harm to self.

- Equally due regard should be given for the patient's security and therefore undue delay prior to return to the prison should be avoided, if it is anticipated that there may be a delay in assessment or it is felt more appropriate from a clinical perspective for the patient to be assessed by their Mental Health In-Reach Team (where available), negotiation needs to take place and agreement reached. The decision as to who undertakes the assessment will be based upon who is best able to identify the potential risk and ensure that risk management plans are put in place.
- For all patients that have attended the hospital following an episode of self-harm, consideration should be made as to whether or not opening an ACCT (Assessment, Care in Custody and Teamwork) plan is appropriate (Pike & George, 2019). ACCT is the care planning process for prisoners identified as being at risk of suicide or self-harm. The ACCT process requires certain actions are taken to ensure that the risk of suicide and self-harm is reduced, some of these actions will include prison staff to completing an Immediate Action Plan (IAP) following a conversation with the prisoner to ensure the prisoner is safe from harm and completing a 'Concern and Keep Safe' form. There is also the requirement for Prison Staff to hold a multidisciplinary case review meeting within 24 hours of the ACCT being opened.

15. POLICE CUSTODY

For patient's at HUTH in the custody of the police they will be offered an assessment should they meet the service criteria. If the patient is remaining in custody and/or being transferred back into custody following their attendance to HUTH, MHLS will liaise with the Liaison and Diversion Team to ensure information sharing is completed following assessment. If, however the patient did not meet MHLS referral criteria or declined to engage in an assessment and an assessment was not completed, MHLS will also feed this information back to the Liaison and Diversion Team. The Liaison and Diversion Team can be contacted via Telephone however if this is not successful following the first attempt, MHLS will leave an answerphone message if possible and will then Email Liaison and Diversion via their teams Email address to ensure the necessary information is communicated in a timely manner.

16. MANAGEMENT AND IMPLEMENTATION OF THE MENTAL HEALTH ACT

The consultants in the MHLS will act and fulfil all responsibilities as a Responsible Clinician for service users detained in the acute hospital under a section of the Mental Health Act, when these patients are detained to HUTH unless there is a Sector Consultant already identified. An exception to this will be those patients that are below 18 years of age and restricted forensic patients.

In the event that a patient is detained under the MHA to a ward within HUTH, it is the responsibility of the named HUTH nurse caring for that patient to inform them of their rights, including the right to appeal against the decision to detain them. This is an obligation under Section 132 of the Mental Health Act and it is the responsibility of the staff within HUTH as the detaining authority.
Patients need to be informed of their right to appeal to an Independent Mental Health Review Tribunal and HUTH staff need to record that they have informed the patient of

their rights and to have taken steps to help facilitate this. Part of this responsibility will be to ensure they have been given their rights in written form as well as providing the patient with a statutory leaflet relevant to the section they are detained under. Section 132 rights form should be completed and given to the patient and must be documented in their electronic patient record. The form should then immediately be scanned and emailed to her-tr.MentalHealthLegislation@nhs.net and the original will be collected by the Mental Health Legislation Team.

16.1. Requesting Mental Health Act (MHA) Assessments

While conducting an assessment, if it is felt that a Mental Health Act (MHA) assessment is needed due to a concern of the assessor that the patient has a mental disorder and is a risk to their own or others health and safety but are unwilling or unable to agree to an informal admission, a MHA assessment would need to be made via the Mental Health Crisis and Intervention Team (MHCIT) who would give the request to the Duty Approved Mental Health Practitioner (AMHP).

To ensure the request of a MHA assessment is appropriate the assessor must be confident that alternative least restrictive options such as; further support from HBTT, respite, or changes to a care and support package already in place, is not suitable or available.

If it is believed that a patient lacks capacity to make informed choices regarding their care and treatment, it is important to document this and any decisions made regarding the clinical judgment by utilising the Mental Capacity Assessment (MCA) documentation on Lorenzo.

For those patients that are an inpatient at HRI or CHH and whereby an assessment under the MHA is required, consideration should be given by the ward doctor regarding whether a holding power (section 5(2) of the MHA) is necessary.
It is widely acknowledged that the acute trust is not the best environment for someone who is acutely mentally ill/distressed, therefore MHLS are best placed to provide good care to the patient until they leave the hospital setting and this will need to be organised by the Clinical Shift Lead.

The Clinical Shift Lead or allocated person will ensure there is clear communication between the AMHP, patient and HUTH staff, informing them of any potential delays or expected time of assessment (if known). However, the responsibility for ensuring that the assessment takes place rests with AMHP.

To assist with the process within normal working hours and if deemed appropriate and reasonable to do so by the AMHP, the MHLS consultants can be approached to see if they can support the AMHP in the MHA Assessment, however if this is not the case the AMHP will continue to co-ordinate two doctors.

Following completion of MHA assessment, it is expected that the attending AMHP updates the Clinical Shift Lead (or nominated member of MHLS Staff team) a verbal update as a minimum as to the outcome of the assessment and recommended actions. If the attending AMHP is from East Riding queries can be made via telephone or alternatively via email to : amhp.outofhoursteam@eastriding.gov.uk, or for Hull AMHP contact can be made via hnf-tr.dutyamhpservice@nhs.net.

17. MENTAL CAPACITY ACT

Referral to assess capacity to consent to physical health intervention

The MHLS will often receive requests to assess a patient's capacity to accept or decline particular physical health interventions. This can become a very complicated area and guidance in the Standard Operating Procedure will have to be interpreted with clinical judgement on how best to proceed. Principles however stem from the Trust's own Mental Capacity guidance and the General Medical Council/NMC guidance.

It is very clear that the team or consultant offering a particular treatment is the ultimate arbiter of whether or not a patient has capacity to consent to that intervention. In the first instance it is therefore expected that an attempt by the referring team will be made to assess that patient's capacity. It may be that the team require some support in how to do this, but this does not necessarily need face to face review of the patient and may be a discussion about the MCA and how capacity is assessed with relevant sign-posting to the statutory guidance or other appropriate agencies. HUTH do have their own Mental Capacity Lead who can be contacted via switchboard for advice.

There will be circumstances when a MHLS practitioner has to see the patient to support the ward in trying to assess the individual's capacity. It is difficult to outline every circumstance where this may be the case; examples include where an individual has an existing mental illness and there are concerns that this may be interfering in their ability to make decisions about their care; or where the physical intervention arises due to the consequences of a mental illness such as the effects of an overdose.

It may be that the support in the capacity assessment is not best done by the MHLS but there may be other services within HUTH who may be best placed to support a Mental Capacity assessment. For example, an individual with profound learning disabilities who requires a complex capacity assessment may be best supported by the Learning Disability Specialist Nurse. A patient well known to another service may be best supported by a team member from that service who knows the patient well.

Where MHLS practitioners agree it is appropriate to support the referring team with the capacity assessment, then ideally this should take place jointly with a member of the treating team who has a full understanding of a particular procedure or intervention that is being offered. It should be noted that the patient remains under the care of HUTH and the documentation of capacity should usually be done in the HUTH notes and following HUTH's own policies. However, duplication should be made in the patient's Humber Teaching NHS Foundation Trust mental health notes. In order to help assess the patient's capacity, it may also be appropriate to complete a full biopsychosocial assessment depending on the circumstances around the referral.

In the event of disagreement or the need to further support this should be escalated through HUTH's internal escalation to the Mental Capacity Lead and then potentially to the court of protection.

18. FOLLOWING ASSESSMENT BY MHLS:

The assessment summary will be emailed to the GP within 24 hours or the next working day. The whole assessment must be completed by the end of that working shift. Where the patient is transferred to a mental health inpatient unit following assessment, the complete assessment and FACE risk assessment must be completed on Lorenzo prior to admission.

For all assessments that involve other identified healthcare professionals (including all secondary Mental Health Care such as MHCIT or Community Mental Health Team (CMHT) we will endeavour to liaise with them and provide an update of the assessment and any potential outcomes required by the supporting healthcare professional/team. This will need to be documented within the patient's Humber electronic notes regarding the discussion and agreed outcome.

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), liaison must take place with that service to ensure that the provision is clinically appropriate and available to meet the identified needs. If the external agency feels that they can no longer meet the needs of this patient then this will need to be fed back into the MHLS MDT to formulate an alternative plan and discussed with the patient as soon as practically possible to confirm that the patient is in agreement. Given the retrospective nature of this revised plan of care, the patient will need to be contacted via the telephone in the first instance or if this fails then the patient will need to be contacted via letter asking them to contact the team to discuss their onward care needs. This letter will be a bespoke letter and will request contact within 7 days. Whilst MHLS await contact over the next 7 days the patient's case will be placed onto the internal 'Zoning Board' in red which will allow for frequent review and MDT discussion. If no contact is made by the patient then discharge will commence with no onward referrals, however details will be sent to the patient for potential self-referral to the identified agencies, as agreed within the MDT.

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.

Liaison with other professionals will be endeavoured to be done within 24hrs of the assessment been completed (excluding Bank holidays and weekends where services are often closed) and this can be completed by the STR workers based in the team as well as the qualified practitioners. All required liaison tasks will be identified on a 'Liaison Log' and it is the responsibility of the daily Shift Co-ordinator to allocate this to members of the team.

18.1. Inpatient admission

If the assessment indicates that an admission may be required to a psychiatric Inpatient bed, the MHLS will liaise with MHCIT/Crisis Intervention Team Older People/ CAMHS Crisis. A clinical discussion (Gate keeping assessment) will take place to ensure that all options including admission are explored (see relevant pathways in Appendices). Where an agreement is reached that an inpatient bed is required every effort will be made to complete this in a timely manner; whilst sourcing a bed is not the

remit of the MHLS, MHLS staff are expected to regularly update HUTH staff at frequent intervals on the progress of this.

The team will take responsibility from a mental health perspective until the patient is transported to the named unit. Clinical judgement will be needed to establish if the patient requires further review and/or support during this time. The review will consider if the person continues to need an inpatient stay (if this is an informal admission) and the rationale for this. An action/care plan may be required for HUTH staff and consideration given around the need for medication, environment, need for security, Enhanced Care Team or STR support.

The shift co-ordinator or allocated Liaison Practitioner will ensure there is clear communication both verbally and written between the bed manager, patient and HUTH staff, informing them of changes and expected time of transfer.

18.2. Referral to a Secondary Mental Health Service

For all assessments that indicate a referral needs to be made to a CMHT or Secondary Mental Health Service, it is a requirement that an Initial Mental Health Assessment, a cluster and a FACE be completed. In the case of all referrals to MHCIT/HBTT these will need to be verbally discussed with the receiving team in order to agree on acceptance. If there is a clinical disagreement with the referral being made, this will need to be discussed with the Band 7 Clinical Lead for resolution/escalation. All discussions and actions will be documented on Lorenzo.

19. REPEAT PRESENTATIONS- “CLUSTER ATTENDANCES”

Repeat presentations require additional attention; it is crucial to understand the circumstances for the patient. Practitioners must establish the risks associated with repeated attendances and discuss next steps of support for this cohort of patients. Updated risk assessments and care plans are paramount, ensuring clear communication of the patient’s needs to other relevant clinicians.

Prior to assessment whilst completing background checks, if it becomes evident that the patient has attended on more than three occasions in 7 days to the ED, the patient is required to be discussed in-depth at the MDT.

There is also a daily automatic generated report from Lorenzo which will also identify any ‘cluster attendance’ for patients being referred to the service. The daily report is reviewed by Clinical Leads from MHLS and Frequent Attenders Service (FAS) and a professionals’ meeting will be arranged involving all relevant community services. Where it transpires that a patient is already active to Secondary Mental Health Services liaison will take place with this service to determine whether there is an understanding of the frequent presentation and a plan already in place, and whether a professionals meeting might be appropriate, and who should organise/chair this.

20. PEOPLE WHO WISH TO LEAVE BEFORE A MENTAL HEALTH ASSESSMENT / 'DID NOT WAIT'.

Following referral to MHLS, if the patient leaves the hospital prior to the completion of an assessment, there are one of three pathways to be followed dependent on their presentation during the first contact (if completed) and /or the immediate risk to life or serious harm to an identified person. Please refer to the pathways in APPENDIX 8 which determine which pathway will be followed dependant on presenting risks.

21. CASE DISCUSSION/MDTS

Every referral made to MHLS will require a formal discussion within the daily MDT to discuss allocation and outcome following assessment of which will be documented on the team's MDT documentation on Lorenzo. The documentation will either be documented by the assessor or an allocated team member. The purpose of the MDT is to ensure best practice and support in decision making, especially around risk.

22. DISCHARGE

Whilst the MHLS is involved in a consultancy capacity, it remains the sole responsibility of the Consultant in charge of the patient's care at HRI or CHH, to make a decision to discharge the patient from hospital.

Any patient who requires admission to a mental health Inpatient unit will only be transferred when they are considered fit for medical discharge.

This will always be the case unless agreement is reached with the admitting Consultant Psychiatrist.

Patients who are referred on to mental health services outside Humber Teaching NHS Foundation Trust are given a copy of the full assessment and the risk assessment either by email (through secure accounts).

23. OUTCOME MEASURES

Patient and clinician-reported outcomes

NICE recommend that the Clinical Global Impression Improvement Scale (CGI-I) should be used as a Clinical Rated Outcome Measure (CROM) to measure the person's condition at the end of every assessment along with the Patient Rated Experience Measure (PREM). These will be carried out following an assessment by MHLS and will remain the responsibility of the Specialist Liaison Practitioner conducting the assessment (see Appendix 9).

24. TRAINING

The service will offer bespoke training to staff at HUTH either specific to a particular service and need, or generic training on Mental Health and common presentations.

The staff working within the team will undertake mandatory training and potentially other identified training, ensuring they are competent in line with the Competence Framework for Liaison Mental Health Nursing (Eales, Wilson, Waghorn, 2014).

25. STAFF SUPERVISION

Clinical or practice supervision provides a cornerstone of effective practice to support delivery of safe, high-quality care and maintenance of good clinical practice.

All staff are required to have supervision both one to one and in a group setting on a regular basis to encourage self-reflection, development, and the maintenance and revision of clinical skills.

There is a supervision structure in place which is regularly reviewed by the Band 7 Clinical Lead to ensure ongoing appropriateness and compliance which is reported to the Trust on a monthly basis.

26. REFERENCES

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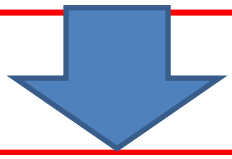
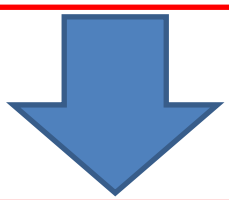
APPENDIX 1: MENTAL HEALTH ACT REQUESTS PATHWAY

Whilst conducting an assessment, if it is felt that a Mental Health Act (MHA) assessment is needed due to a concern of the assessor the assessor will make the required arrangements via the Mental Health Crisis Intervention Team.



Telephone the Mental Health Crisis Intervention Team on 205555 and make this request

The MHCIT will take details and contact the AMHP on duty who will make telephone contact to discuss further and following consideration will confirm whether an assessment will take place.



<u>Should there be a delay in the assessment under the Act taking place</u>

It is the responsibility of the MHLS to update both the Patient and HUTH and establish whether support in the interim is required to ensure safety of the patient.

APPENDIX 2: GATE KEEPING / ADMISSION PATHWAY

Telephone Mental Health Crisis Intervention Team on 205555
a discussion will take place including outcome of assessment and a request for an admission will be made.

Mental Health Crisis Intervention Team will take details and will co-ordinate and discuss with the bed manager

(N.B – the time the request is made should be clearly recorded in both medical and mental health documentation)

Once the referral has been accepted and if you are advised that there are no beds available within this geographical area –

An Out of Area Bed Consent Form MUST be completed by the patient

Should there be a delay in sourcing a bed

It is the MHLS responsibility to keep the patient, HUTH and the bed manager updated

AND

Provide regular reviews of the patient to assess ongoing need for a bed and/or change in presentation.

APPENDIX 3: HOME BASED TREATMENT TEAM REFERRAL PATHWAY

Decision making following assessment

The patient is in crisis and unable to manage their circumstances, presenting a risk to themselves or others, however HBTT would be an acceptable alternative to inpatient admission. During working hours, there needs to be liaison with any allocated Key worker (or duty worker) to ensure an agreement is reached that HBTT is the safest way forward to meet the needs of the patient.

Telephone 336699 (8am – 8pm) to discuss and verbally make referral

Outside of these hours telephone Mental Health Crisis Intervention Team on 205555

Once a verbal referral has been made and accepted, create referral via Lorenzo

There will need to be a clear plan of treatment, updated cluster, Initial Mental Health and FACE assessment.

A discussion will take place with the team ensuring the request for HBT is purposeful and time limited.

APPENDIX 4: REFERRAL TO HULL/EAST RIDING CAMHS CORE (VIA CONTACT POINT)

Assessment to be completed and discharged from MHLS with an internal referral via Lorenzo to CAMHS

MHLS administrator to create a Task via Lorenzo to CAMHS Admin to highlight the new referral to their service.

APPENDIX 5: MHLS TO CAMHS REFERRAL PATHWAY

APPENDIX 6: HULL & EAST RIDING COMMUNITY MENTAL HEALTH TEAMS (9AM-5PM MONDAY TO FRIDAY) REFERRAL PATHWAY

MHLS practitioner receives referral and completes:

-Initial Mental Health Assessment

-FACE Risk Assessment

-Cluster

MHLS administrator to create a Task via Lorenzo to Admin to highlight the new referral to their service.

APPENDIX 7: PATHWAY FOR MENTAL HEALTH LIAISON SERVICE (MHLS) INTO NHS HULL TALKING THERAPIES OR NHE EAST RIDING TALKING THERAPIES

MHLS practitioner completes a Full Biopsychosocial Mental Health Assessment along with an appropriate Referral Form.

Save Referral Form to the V-drive and instruct MHLS admin to email to:

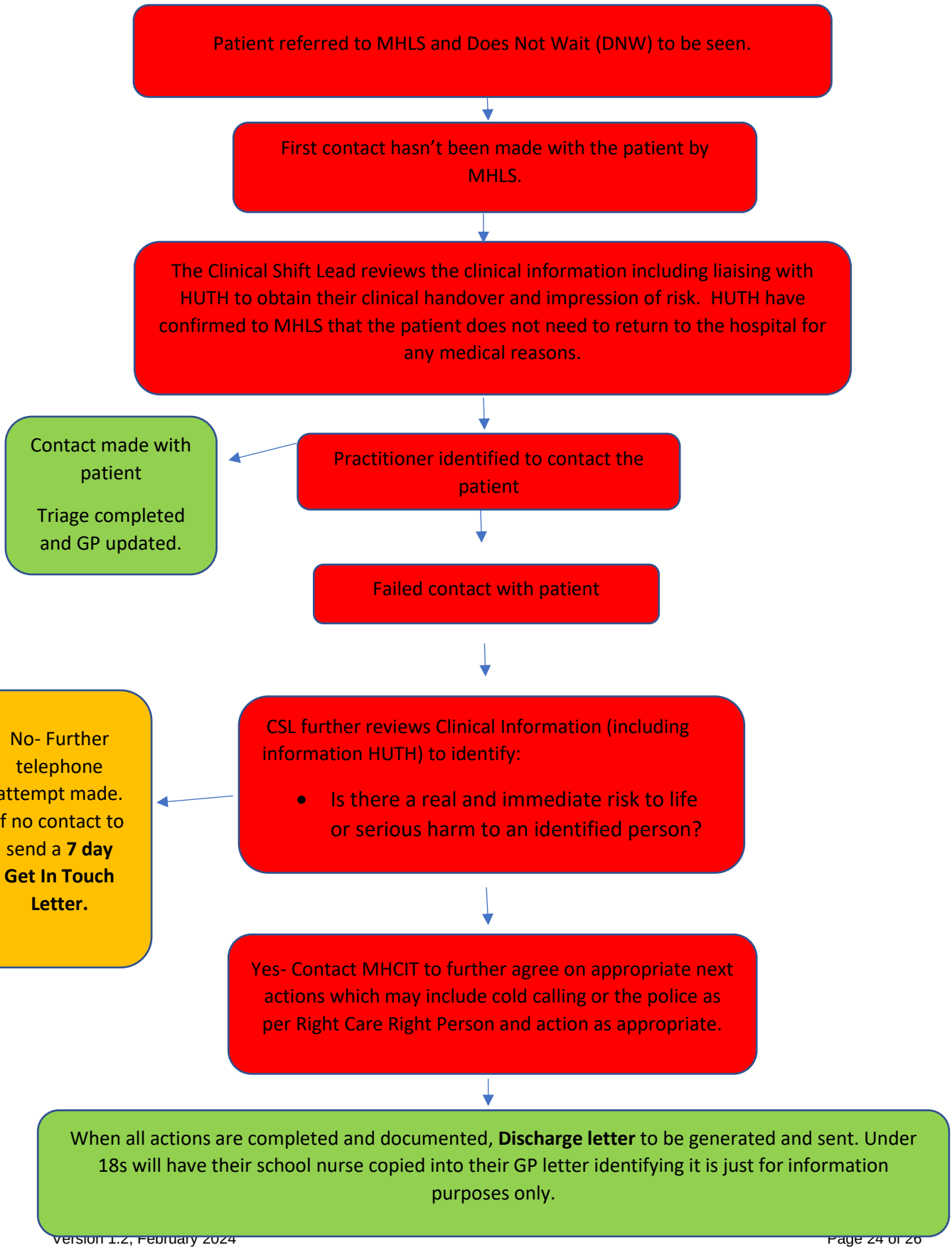
Hull patients: pws-letstalk.hull@nhs.net

East riding Patients: HNF-TR.ABService@nhs.net

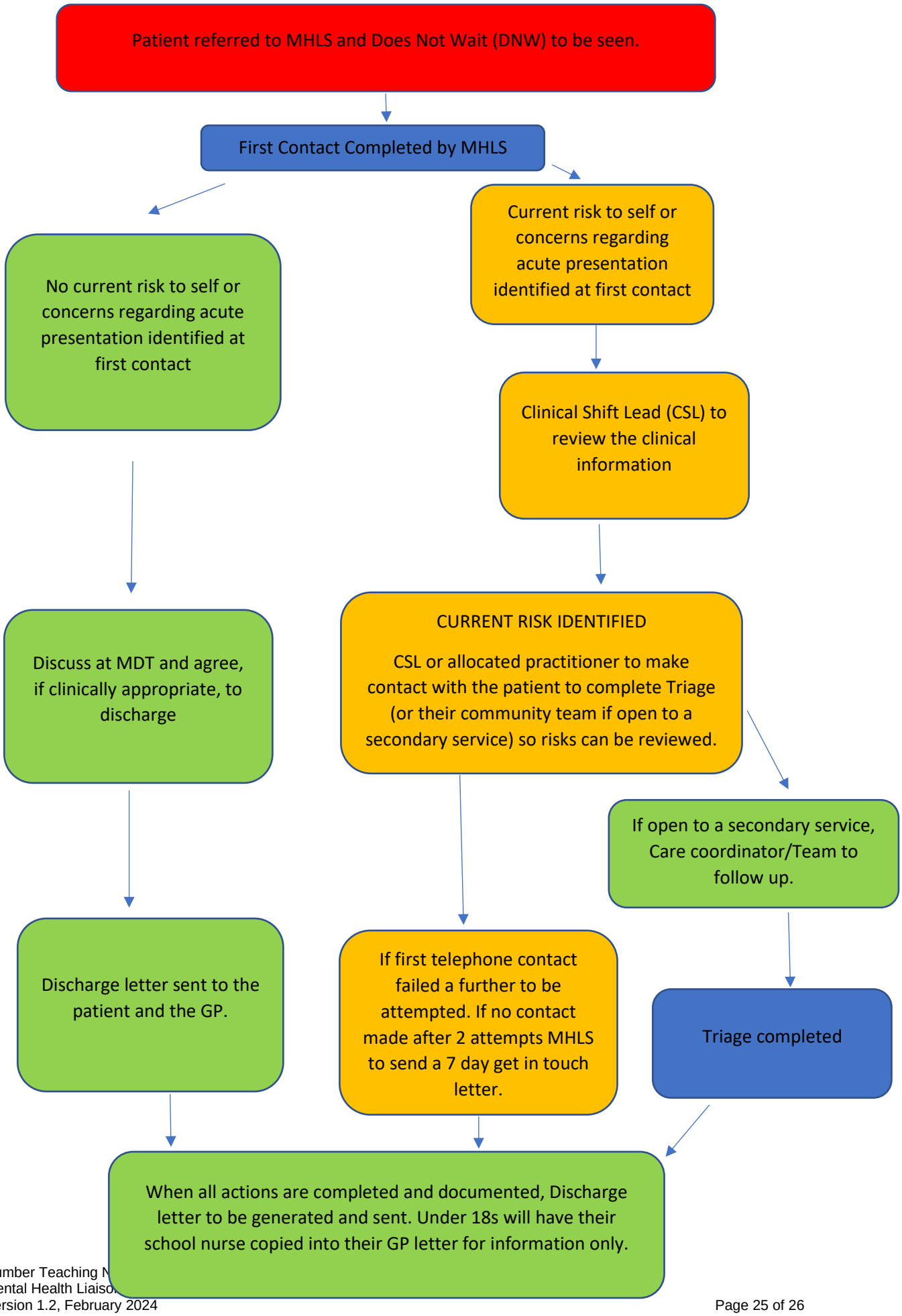
APPENDIX 8: PROCESS FOR THOSE PATIENTS THAT DO NOT WAIT FOR AN ASSESSMENT

DID NOT WAIT PATHWAYS

MHLS Did Not Wait- Red Pathway.



MHLS Did Not Wait- Amber and Green Pathways.



APPENDIX 9: OUTCOME MEASURES

Patient Rated Experience Measure (NICE, 2016) used for each assessment completed.

	Statement	Please circle one number				
1	If I experience a mental health crisis again, I feel optimistic that care will be effective.	1	2	3	4	5
2	During the treatment for my crisis, I was treated with empathy, dignity and respect.	1	2	3	4	5
3	During the treatment for my crisis, I felt actively involved in shared decision-making and supported in self-management.	1	2	3	4	5
4	I feel confident that my views are used to monitor and improve the performance of mental health care for crises.	1	2	3	4	5
5	I can access mental health crisis services when I need them.	1	2	3	4	5
6	During the treatment for my crisis, I understood the assessment process, diagnosis and treatment options, and received emotional support for any sensitive issues.	1	2	3	4	5
7	During the treatment for my crisis, I jointly developed a care plan with mental health and social care professionals, and was given a copy with an agreed date to review it.	1	2	3	4	5
8	When I accessed crisis support, I had a comprehensive assessment, undertaken by a professional competent in crisis working.	1	2	3	4	5
9	The mental health crisis team considered the support and care needs of my family or carers when I was in crisis. Where needs were identified, they ensured that they were met when it was safe and practicable to do so.	1	2	3	4	5

Clinical Global Impression Improvement Scale (CGI-I) to be completed by the practioner for each assessment completed.

Compared to the person's condition at the start of assessment, his/her condition is:

Very much improved	Much improved	Minimally improved	No change	Minimally worse	Much worse	Very much worse
1	2	3	4	5	6	7