



**Greater Manchester
Mental Health**
NHS Foundation Trust

Mental Health Liaison Service Operational Procedure – Manchester and Trafford Services

Greater Manchester Mental Health NHS
Foundation Trust



Improving Lives

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

Title of Standard Operating Procedure:		Mental Health Liaison Service Operational Procedure – Manchester and Trafford Services			
Document Summary:		Details the pathways, role and responsibilities that support the operation and function of the mental health liaison services operating within North, Central, South Manchester and Trafford divisions.			
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Target Audience:		Acute Trust partners, mental health liaison service practitioners, managers, service managers and heads of operations.			
Consultation:		Divisional SLTs, Urgent Care Clinical Leads, GMMH Liaison Clinical Lead, MHLS Clinical Leads, Professional Leads, Governance Lead, CAMHS Leads.			
Approval Committee:		MHLS Urgent Care Forum			
Cross Reference Document(s):					
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Minimum Monitoring Requirement	Frequency	Process for monitoring	Evidence	Responsible Individual(s)	Response Committee(s)
01.11.2020	12 month review	MHLS UCF	Minutes	D. Robinson	MHLS UCF

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 1 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

Contents

	Content	Page
1.	Introduction	3
2.	Definitions	4
3.	Service aims, objectives, values and philosophy	4
4.	Service model	5
5.	Systems, processes and procedures	13
6.	Training	29
7.	Service evaluation	30
	APPENDICES	31
1	A&E Triage pro forma and risk assessment	
2	A&E Referral pathway	
3	Urgent Ward Referral pathway	
4	Routine Ward Referral pathway	
6	Intoxication pathway	
7	High risk pathway	
8	Integrated care pathway (Wythenshawe)	
9	Missing or Absconded person	
10a	Manchester Clinical Risk Management and Assessment Tool Guidance, Version 5, Section 6	Need update on correct versions
10b	Trafford Structured Clinical Note guidance	
12	Manchester Later Life Operational Procedure (interim)	
13	Children and Young People's Community Pathway	
15	Acute mental health and learning disability escalation pathway	
16	GMMH Perinatal services referral form	
17	12 Hour Breach Escalation	
18	Initial assessment delay	
19	Medical Ward escalation	
20	Lone Working Guidance for mental health liaison	
21	Service evaluation questionnaire	

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 2 of 36

Introduction

The CORE 24 service model for mental health liaison services promotes the integration of specialist mental health care, within the local and wider health and social care systems in which they operate.

Based within the acute hospital, mental health liaison services enable 24/7 access to specialist mental health care. This is delivered by a clinically led multidisciplinary team who operate 24/7, to provide specialist psychiatric assessment, advice and treatment for anyone with a known or suspected mental health need in the acute hospital.

This document explains how Manchester and Trafford Mental Health Liaison Services will operate in order to deliver CORE 24 mental health liaison services on the following hospital sites:

- North Manchester General Hospital
- Manchester Royal Infirmary and St Marys Hospitals
- Wythenshawe Hospital
- Trafford General Hospital (Urgent care Centre 8.00-2200hrs)

It is intended that where standardised practices exist that these will remain, although local variations are also defined within this document.

1.1 Purpose

This procedure will provide all staff groups working within mental health liaison services with understanding on how to deliver care aligned to the evidence based CORE 24 service model.

Principles, processes and practice standards will be defined for all staff groups that articulate the components of the model to support translation into practice:

- Service model aims and objectives
- Referral pathways
- Assessment
- Interventions
- Discharge
- Training and education
- Governance

1.2 Scope

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 3 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

The scope of this procedural guidance incorporates the day-to-day operational delivery of Manchester and Trafford mental health liaison services and how the services interface with other agencies, systems and processes. This guidance will also reflect local procedures and pathways that may also exist at each site.

2. Definitions

MHLS – Mental health liaison service

MHA – Mental Health Act

AMHP – Approved mental health professional

AT – Acute trust

GMMH – Greater Manchester Mental Health NHS FT

DTA – Decision to admit

KPI – Key Performance Indicators for mental health liaison services

1hr Breach KPI –MHLS have not commenced assessment within 1hr of referral in A&E

2hr Breach KPI - MHLS have not commenced assessment within 2hrs of referral in A&E

4 Hour Breach KPI – A person has not been discharged from A&E within 4 hours of their attendance

12 Hour 'Trolley Wait 'Breach - A person has not been discharged within 12 hours of a decision to admit and this is a Never Event

Decision to Admit (DTA) – Where a decision has been made to admit a person to hospital by a professional with the legal power and framework to do so. Where a MHA has been undertaken the DTA occurs when the application (or intention to do so where there is no bed) has been made

3. Service aims, objectives, values and philosophy

The overall aim of Manchester and Trafford mental health liaison services is to provide the best possible quality and comprehensive assessment, care, treatment and support to people experiencing known or suspected mental health problems within the four hospital sites.

The overarching service objectives are:

- Provide a timely and flexible response to referrals, to meet the demands of the Manchester and Trafford Hospitals
- To work with the following groups of people who may attend or be admitted to the acute hospital setting (not an exhaustive list):
 - People who have self-harmed
 - People with physical and psychological consequences of alcohol/substance misuse
 - Frail elderly people with possible delirium/depression/dementia

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 4 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- People with known severe mental illness particularly when in relapse
 - People admitted with primarily physical health symptoms which may also have a psychological/social cause
 - Vulnerable groups including people who are homeless, experience personality difficulties, subject to domestic abuse/violence, children and young people at risk
 - People with general medical and surgical presentations including people who are peri and post-partum
- Provide comprehensive mental health assessment; assist with diagnosis, care and specialist discharge planning, risk assessment and management, including signposting to people referred to the service.
 - Provide Mental Health related training to staff members at the hospital sites to raise awareness of mental health conditions.
 - Work closely and in partnership with other services and organisations to contribute to a seamless service of mental health provision and the development of appropriate care pathways for onward referral of individuals in need of further assessment and support.
 - Support the active engagement of people and carers at all levels, to enable participation in the design, planning, delivery, monitoring and evaluation of our services and those of our partner organisations.
 - Ensure information is presented in a manner that is clear, concise and of a good quality. As far as possible, provide the right information at the right time suited to their personal needs.
 - Actively engage people to participate in their assessment and care planning. This will follow a commitment to equality, inclusion, recovery and diversity that supports people in living independent and valued lives. The approach puts the individual person's strengths, goals and aspirations as well as needs and difficulties at the centre, builds confidence and promotes social inclusion and recovery.
 - Inform people referred to the service of their current assessed need and care plan. A copy of the MHLS care plan will be provided to the person where clinically appropriate– in an accessible format appropriate to their needs.
 - Seek feedback from people using the service and their family/friends and carers.
 - Treat information with the utmost confidentiality within our service; however, at times it may be necessary for us to share this information with other parties. This will only happen if there are overriding concerns for the people or that of others welfare

3.1 Service values and philosophy

Mental health liaison services aim to be:

- Helpful
- Proactive
- Flexible
- Optimistic
- Ambitious
- Compassionate

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 5 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- Knowledgeable

This is achieved through recognition of the service's central role in:

- Raising standards of knowledge and skills within the team
- Developing and maintaining a positive culture
- Encouraging team members to participate in innovating and developing the service
- Continue to be warm, welcoming and supportive during times of change
- Improve our ability to demonstrate value by accurate recording of data
- Improve communication standards with professionals, people and families in letters, note entries and verbal communication

Mental health liaison services will demonstrate their efficacy by:

- Responding to 75% of referrals in the Emergency Department within 1 hour of referral
- Responding to 95% of Routine ward referrals within 24 hours of referral
- Responding to 95% of Urgent ward referrals within 6 hours of referral
- Reducing Emergency Department attendance for people identified as 'frequent attenders'
- Reducing length of stays within the acute trust
- Demonstrating an increase in people being able to return to their own homes
- Reducing the percentage of mental health attributable A&E 4 hour breaches
- Reducing duration of section 136 assessments
- Receiving positive feedback from people /carers/system partners

4. Service model

4.1 Team structure and roles

The service operates through a divisional line management structure. Medical line management aligns to the divisional lead consultant with responsibility for MHLS.

Operational Lead for Urgent Care

The Operational Lead for Urgent Care is responsible for ensuring the operational delivery of the Mental Health Liaison Team within the Mental Health division. Supporting the Team Manager and Clinical Leadership team in ensuring contracted targets are met and it delivers excellent standards of care to mental health people and carers across the Acute Trust.

Consultant Psychiatrist

The Consultants will have clinical leadership responsibility for the service delivery in all areas within the acute hospital. The main duties of the Consultant includes the provision of:

- Senior and overarching Clinical Leadership for the service, MHLS led by the Lead Consultant

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 6 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- Senior medical input to A&E and the wards, to enable access to diagnosis, effective management plans and early, safe discharge of complex cases
- Specialist pharmacological advice
- Senior clinical input (direct or closely supervisory) into complex presentations e.g. severe attempts of self-harm, dementia, eating disorder, somatisation, factitious disorder
- Mental Health Act work, including assuming Responsible Clinician role for people detained to the host acute hospital
- Review of people who are detained in the acute hospital under MHA

Team manager

- To ensure and effective day-to-day management of the team. They will be responsible for ensuring the implementation of the Operational Procedure. This includes the implementation of processes for work allocation, communication, performance management, supervision and ensuring the implementation of GMMH policy and procedures.
- Day to day managerial responsibility for the Service and will report directly to the Operational Lead for Urgent Care (GMMH).
- To manage the overall workload/rota of the service ensuring that appropriate systems and staffing levels are in place for timely and effective assessment of people within acute trust
- To ensure that the team is compliant with Trust policies, procedures, protocols and guidelines.
- To be responsible for performance review and the implementation of systems which ensure that key performance indicators are being met.
- To demonstrate clinical expertise via interventions, supervision and modelling good practice.
- To ensure that the team comply with the agreed timescales for the service in relation to the assessments of people and report any breaches to senior management and provide reports in relation to this.
- To work with the team in developing clinical pathways and liaison protocols including those relating to dementia, substance misuse, self-harm and functional illness.
- To ensure timely provision of reports, statistics and analysis of service activity in relation to service specification and targets.
- They will promote a positive learning environment and support the professional development of the team.
- To will promote collaborative and multidisciplinary team working.

Clinical psychologist

- To provide highly specialised psychological input into the service across a range of psychological sub-specialisms and across all ages
- To promote the flexible and responsive development of psychologically informed service delivery

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 7 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- To work in a supervisory and training role with staff, providing consultancy and liaison with other parts of the secondary mental health services
- To contribute to assessment and effective treatment of people in the acute hospital setting who may be experiencing mental health problems
- To work with people who attend A&E frequently, with the aim of identifying unrecognised need, develop care plans and reduce hospital attendance

A psychological resource within the service ensures:

- Robust case formulation
- Complex case formulation and management of frequent attenders
- Brief interventions (e.g. CBT informed interventions and solution focussed therapy)
- Enhances MDT working
- Accordance with the Stepped Care Model
- Psychological informed case supervision

Senior Practitioner/ Clinical Lead

The main duties of the Senior Practitioners/ Clinical Leads include:

- Ensuring that senior clinical input is readily available to Liaison Practitioners to manage difficult cases and provide support in making robust clinical decisions.
- The development of clinical pathways and protocols
- Clinical and Line-Management supervision of Liaison Practitioners

Each Senior Practitioner/Clinical Lead may also have specific responsibilities for various components of the service, for example:

- Urgent and Emergency Care
- Medical wards
- Police Liaison
- Training with the Acute Trust
- Safeguarding
- Perinatal mental health
- Older adult mental health
- Dual Diagnosis

CAMHS Senior Practitioner

- Ensuring that senior clinical input is readily available to Liaison Practitioners to manage children under the age of 16 and provide support in making robust clinical decisions.

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 8 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- The development of CAMHS clinical pathways and protocols with our other CAMHS agencies.
- Monitor and report on the CAMHS data
- Provide training to assessing young people to mental health practitioners
- Clinical and Line-Management supervision of Liaison Practitioners

Mental Health Practitioner

Mental Health Practitioner role includes:

- Complete assessment of mental health needs for people referred to the team. These will include people presenting with both functional and organic problems.
- Following the assessment, develop a joint care plan with the people, and where possible, the carer and acute trust colleagues
- Support and advise acute trust colleagues regarding the care, treatment and management of people with mental health difficulties. This will also include participating in the Team training programme.
- Support the assessment of people detained on Section 136 of the Mental Health Act
- Take a lead in shift coordinating where required

Clinical Support Worker

The clinical support worker's role includes:

- Assisting the team in the assessment and management of mental health needs
- Support the team in delivering brief interventions to people under the service
- Contribute to discharge planning process
- With appropriate supervision, provide formal and informal training to acute trust colleague around mental health problems and their positive management

Administration

Medical Secretary

- Medical secretary to a Consultant Psychiatrists and the medical team.
- To provide support via a comprehensive secretarial service, which anticipates the needs of the Consultants in the workplace and responds accordingly.

Senior Administrator

- To provide comprehensive administrative support and to manage and co-ordinate the administrative support function in the MHLS, ensuring the most efficient and effective use of resources.
- The post holder will have line management and supervisory responsibility for the secretarial staff within the service.

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 9 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

Team Administrator

- To facilitate the achievement of effective high quality and timely recording of interventions and communication of outcomes provided back to the person, GP and carers as appropriate.
- To contribute to both a smooth interface and communication between practitioners within the teams and across the providers.

4.2 Hours of operation

The service is delivered 24 hours a day, 365 days a year throughout the entire hospital site.

Band 6 and Band 7 practitioners will work over a 24/7 rota and the remaining staff groups, 9am-5pm Monday to Friday.

Senior medical supervision and advice will be available via the team consultants, within the working hours of the MHLS Consultants and via the On-call Speciality Trainee and Consultant rotas outside of this.

4.3 Key Performance Indicators

There are a number of outcomes associated with successful delivery of CORE 24 mental health liaison services, by which GMMH will be measured and also evaluate themselves.

- Improve awareness and knowledge of mental health conditions and liaison service across the acute trust
- Improve response times relating to all referrals
- Increase the identification and diagnosis of mental health disorders in the elderly population of the acute trust, including dementia and delirium
- Reduce the identified frequent attenders in the Emergency Department
- Reduce the number of delayed discharges for over 65s
- Reduce the number of mental health breaches in the Emergency Department
- Reduce the percentage of people over 65 transferred into to acute trust wards
- Reduce the length of stay for Section 136 presentations
- Ensure that 75% and 95% of Emergency Department referrals are responded to within 1 and 2 Hours of referral, respectively
- Ensure that 95% of people that are referred from Emergency Department will be assessed and discharged within 4 hours of attendance
- That 95% of people referred on a routine basis from a medical ward are seen within 24 hours of referral

Performance standards will be modified to reflect future development of nationally agreed standards for the input of mental health services into the Emergency Department, general acute wards and the wider community.

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 10 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

All these indicators are monitored through divisional Senior Leadership Team (SLT) meetings and are fed back to the Team Manager via line management supervision and to the teams via monthly Team Business Meetings.

4.4 Interfaces

The mental health liaison service will maintain close working relationships and ensure robust communication pathways are in place with a number of services and providers.

- Community Mental Health Teams.
- Approved Mental Health Professionals (AMHP)
- Emergency Duty Service
- Child & Adolescent Mental Health Services
- Learning Disability Services
- Drug and Alcohol services
- Acute trust clinical and operational partners
- Homelessness services.
- Non-statutory crisis service.
- Home based treatment teams
- Primary Care Mental Health Services
- Psychological Services.
- Statutory services including Social Services and Police.
- CAMHS CYP Services

4.5 Governance

Every member of staff working in MHLS must understand and comply with GMMH policies as listed below.

GMMH also operates an Urgent Care forum within which aspects of service governance are reviewed and monitored; together with wider service development.

The aspects of governance are detailed in the table below together with the responsibility expected of mental health liaison services

Aspect of Governance	Mental Health Liaison Services
Incident reporting, management, investigation and learning	<p>GMMH have an agreed Incident Accident and near Miss policy in place for reporting and responding to staff and patient safety concerns raised by staff across the Trust via its Datix Incident reporting system.</p> <p>GMMH have established systems, via 3 Day Review and Root Cause Analysis investigations, and more recently the development of Structured Judgement Case record Reviews (SJR) in line with the national learning from Deaths Guidance 2017, to understand reasons why incidents occur, recognise good practice and identify and share learning.</p>

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 11 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford
Services

	<p>GMMH services follow an established process for undertaking Positive Learning Events with MDTs, to support the robust dissemination of learning from incidents and also inquests and Preventing Future deaths Reg 28 reports issued by coroners</p> <p>Supporting policies:</p> <p>GMMH Incident, accident and near miss policy</p> <p>GMMH Being Open and Duty of Candour Policy</p> <p>Inquest policy</p>
Audit and data collection	<p>The information management arrangements within electronic records systems will ensure that data and information collected via the Trust's electronic recording system enables the reporting of performance standards and the accurate profiling of the service in order to inform future proposals.</p>
Safeguarding	<p>GMMH have an agreed policy in place to discuss, report and escalate safeguarding concerns.</p> <p>GMMH has close working relationships with acute trust safeguarding teams and there are communication pathways that enable the sharing of information.</p> <p>All services have named safeguarding link practitioners and within each division staff are aware of who can provide specialist safeguarding advice and guidance should the need arise, both within and outside of normal working hours.</p> <p>All staff receive training in relation adult and child safeguarding to level 3. Staff should follow local procedural guidance embedded within the below policies available on the intranet, when a Safeguarding concern arises</p> <p>Supporting policy:</p> <p>GMMH Safeguarding Adults at Risk</p> <p>GMMH Safeguarding Adults Procedures and Practice document</p> <p>Safeguarding Children Policy</p>
Performance	<p>Monthly activity and outcome data will be provided to service commissioners according to an agreed performance framework and reporting system.</p> <p>Performance activity is monitored within divisional SLTs, Network Hub and individual team business meetings.</p>
Customer Care	<p>GMMH have an agreed protocol in place for the reporting, investigating, and responding to</p>

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 12 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

	<p>concerns/compliments/complaints raised in relation to the service.</p> <p>Recording and monitoring at a Divisional and trust level takes place via the DATIX system.</p> <p>Supporting policy: Customer Care Policy</p>
CPD/Training	<p>GMMH have an agreed and defined scope of required mandatory training that is essential for team members.</p> <p>GMMH have a system of monitoring and evaluating compliance with mandatory training for all staff through corporate workforce development systems and local line management supervision arrangements</p> <p>Supporting policy: Induction and mandatory training policy Individual and Personal Development Review policy</p>
Information governance	<p>There are information sharing agreements in place that support the sharing of information pertinent to the delivery and evaluation of mental health liaison service's business</p> <p>Supporting policy: GMMH Information governance policy GMMH Confidentiality policy</p>
Joint working	<p>Mental health liaison consultants, service managers, Urgent Care Operational Leads and Team managers sit on the acute trust led Mental Health Operational meetings.</p>

4.6 Acceptance into the service

Referrals are received for people of all ages, who present at Emergency Department or are inpatients within the acute hospitals.

The service will offer an assessment to people presenting with suspected or known mental health needs. This can and should be undertaken in conjunction to any physical health care assessment or intervention that they require.

4.7 Exceptions

People who are solely intoxicated with drugs or alcohol, without any known or suspected mental health needs.

A person under police arrest and who has been brought to the Emergency Department for their physical health needs, would not be seen by the service. Colleagues within the Criminal Justice mental health services will provide psychiatric assessment, care and advice, within the custody setting.

Our service however, will provide psychiatric assessment, care planning and advice to anyone subject to arrest who was an inpatient within an inpatient medical ward.

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 13 of 36

5. Systems, Processes and Procedures

5.1 Referral Pathways

In line with the service philosophy, values and aims of the service, a person does not need to be 'medically fit' to be referred or receive an assessment.

It is accepted that an assessment should be completed when it is possible for a person to fully engage and their ability to do so is not adversely compromised due to their physical state or needs. To establish this position, an assessment should always be attempted.

Where there is a disagreement between the service and referrer about the urgency of a referral, the clinical prioritisation of the referral should be led by the mental health liaison service. Where the matter cannot be agreed upon, it should be passed to a senior clinician within the respective services to resolve.

5.1.1.A&E Referrals

- Referrals can be made by any professionally qualified person in A&E
- Contact is made via bleep or direct verbal handover to the mental health liaison service

	Contact bleep/Telephone number
North Manchester	0161 720 2560/ Bleep 4226
MRI	5279/0161 701 0313
Wythenshawe Hospital	Air Bleep #6492
Trafford General	Bleep 0149

- The service will commence an assessment within 1 hour of the referral being made
- Where it is unlikely that an assessment will commence within 1 hour of referral, contact will be made with the person to advise them of the delay and briefly review any immediate needs and risks to ensure that they can be managed whilst awaiting assessment (e.g. to ensure the place within which they are waiting is appropriate). This contact will be documented by the practitioner involved within the GMMH and Acute Trust clinical records systems.
- The date and time of referral, time that a person's assessment commences and timing of their discharge will be recorded by the service within the Liaison Team Outcome Document
- Where in use, the A&E triage pro forma should also be completed by the triage nurse, to ensure that physical health needs are identified and managed by A&E clinicians, in parallel to the MHLS assessment.
- The triage risk assessment should also be completed by the triage nurse, to ensure immediate risks are identified, communicated to MHLS and managed until assessment can commence

Appendix 1a: Triage Pro-forma

Appendix 2 A&E Referral Pathway

5.1.2. Urgent ward referrals

- Referrals can be made by any professionally qualified person
- Contact is made via bleep or direct verbal handover to the mental health liaison service

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 14 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

	Contact bleep/Telephone number
North Manchester	0161 720 2560/ Bleep 4226
MRI	5279/0161 701 0313
Wythenshawe Hospital	Air Bleep #6490
Trafford General	Bleep 0149

- The service will commence an assessment within 6 hours of the referral being made, unless a more urgent response is indicated
- The date and time of referral, time that a person's assessment commences and their discharge will be recorded by the service within the Liaison Team Outcome Document

Appendix 3: Urgent Ward Referral Pathway

5.1.3. Routine ward Referrals

- Referrals can be made by any professionally qualified person
- Referral is made via the electronic hospital referral system or bleep (See referral routes table below for site specific guidance)
- The service will commence an assessment within 24 hours of the referral being made
- Where it is unlikely that an assessment will commence within 24 hours of referral, contact will be made with the person to advise them of the delay and briefly review any immediate needs and risks to ensure that they can be managed whilst awaiting assessment (e.g. to ensure the place within which they are waiting is appropriate)
- The date and time of referral, time that a person's assessment begins and their discharge will be recorded by the service within the Liaison Team Outcome Document

	Referral route	Bleep/Telephone Number
North Manchester	Pennine Acute Trust Intranet	NHS.Net email
MRI	ICE electronic referral system	0161 276 8866
Wythenshawe Hospital		Air Bleep #6490
Trafford General		Bleep 0149

Appendix 4: Routine Ward Referrals Pathway

5.1.4. Section 136

- The reception of a person detained subject to Section 136 will be led by the mental health liaison service in line with the Section 136 policy and procedure
- All actions undertaken by the mental health liaison service will be documented
- The Section 136 Monitoring/Recording Form will be completed and collated by the mental health liaison service
- The mental health liaison service will follow the GMMH Section 136 procedural guidance when a person is brought to A&E subject to Section 136

Manchester Services Section 136 policy: [https://newintranet/services/social-care/manchester/amhp/Documents/Section 136 operational procedure.docx](https://newintranet/services/social-care/manchester/amhp/Documents/Section_136_operational_procedure.docx)

Trafford Services Section 136 policy:

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 15 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

<https://newintranet/procedures/trafford/Documents/Section 136 Local Procedure March 2017 - Review Due Jan 2020>

5.1.5 Intoxication

- The service will attempt to assess a person who is thought to be intoxicated
- There will be occasions when a person is too intoxicated to engage in a meaningful assessment, these people will be regularly reviewed by the service and advice around the management of the person's needs during the intervening time will be recorded by the service within both clinical records systems and verbally communicated to the acute trust staff member responsible for the clinical area where the person remains

Appendix 6: Intoxicated person pathway

5.1.6. High risk referrals

People may present as acutely agitated or making threats of harm to others. Equally, some people may have known risk of harm to others and their risk assessment states that they should not be seen by lone practitioners.

In these cases, practitioners should refer to the High Risk Assessment Pathway or Integrated Care Pathway (ICP) at Wythenshawe.

Appendix 7: High risk assessment pathway

Appendix 8: Integrated Care Pathway (ICP)

5.1.7 People who do not wait to be seen

There will be occasions when a person leaves the hospital prior to mental health assessment. In these circumstances, there will be a discussion between Mental Health Practitioner and acute trust staff to determine what is the most appropriate course of action that may need to be taken. This may not always require a Concern for Welfare to be made to the police.

For people known to GMMH community services, it may be more appropriate for the respective community team to be informed to contact the person. Where appropriate contact the local HBT service to request urgent follow up visit.

Decisions not to call the Police must be informed by absence of immediate risk to self or others, as far as is known.

Appendix 9: Missing/ Absconded Patients Procedure

5.1.8 People sent to A&E by other professionals or agencies

In the event of another service, health provider or agency contacting the mental health liaison service to inform them that they have advised a person to attend A&E for a mental health assessment.

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 16 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

The Mental Health Liaison practitioner should:

- Take the name and contact details of the advising person/service
- Take a handover of the concerns and any potential risks on presentation. On receiving this information,
- Use their clinical judgement to also consider informing the respective triage nurse in ED.
- Should the person not attend A&E within 1 hour, the referring team and the mental health liaison service will discuss and agree the most appropriate course of action.

If a person who is already under a GMMH mental health service such as CMHT or Home Based Treatment team present to A&E, the mental health liaison should contact the respective team and request they attend to support the assessment process. Should this not be possible within 1 hour, then the MHLS assessment will continue and the GMMH service informed of the conclusion and be involved in planning next steps.

5.2 Assessment

5.2.1. Biopsychosocial assessment

Anyone referred to the service will receive an assessment as soon as a meaningful assessment can be held with him or her.

Biopsychosocial assessments will be carried out using agreed assessment tools, which include approved liaison service assessment documents.

In order to complete a robust assessment, the following steps will be undertaken within the assessment process:

- Review the person's AMIGOS / Paris records if they exist
- Review the person's acute trust medical notes
- Speak to a member of the clinical team looking after the person (ideally the referrer if available)
- Engage the carer/supporter, if they are present, in the assessment

Then the staff member will:

- See the person
- Undertake a biopsychosocial assessment within the defined assessment framework of the mental health liaison service as per Appendices 9a or 9b
- Consider the use of further assessment tools which may include HAD, ACE as indicated by the clinical presentation
- Attempt to gather further information (e.g. collateral history from family, GP) dependent upon circumstance (e.g. time of day, urgency of decision making)
- Share the findings of the assessment with the person, their carer and other relevant agencies involved in their care

Appendix 10a: Manchester Clinical Risk Management and Assessment Tool Policy and Procedure, Version 5, Section 6

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 17 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

Appendix 10 b. Structured Clinical Note Guidance

5.2.2. Clinical risk assessment, formulation and management

In conjunction with and informed by the biopsychosocial assessment, a comprehensive risk assessment, formulation and management plan (including safety planning) will be completed for anyone referred to the service. This will include a clear plan to positively manage a person's mental health needs and any associated risks, whilst a person remains on an acute hospital ward or in A&E.

Risk assessments will consider risk of harm to self, harm to others, vulnerability, self-neglect, adult and child safeguarding and public protection issues.

This will be recorded within the defined clinical documentation detailed in Appendices 10a and 10b and the process of assessment will be aligned to the GMMH Clinical Risk Policy.

5.2.3. Collateral information

Wherever possible and with due regard to confidentiality, collateral information should be obtained from sources such as other agencies, friends, families or carers to inform the assessment and care planning process. Where this has not been possible or attempted then this should be documented by the assessing clinician and a rationale given.

5.2.4 Mental Health Act assessment

Manchester A&E Departments:

- The decision made to refer for a mental health act assessment should occur following discussion with the Speciality Trainee doctor on call by the assessing clinician, if they are no Section 12 approved
- On agreement of the need for an assessment, the assessing clinician will contact the Manchester AMHP hub to request attendance of the AMHP
- Confirmation of the time of attendance will be sought by the assessing clinician who will ensure that the person is kept informed and supported whilst they wait in the department

Manchester Ward areas:

- The decision made to refer for a mental health act assessment should occur following discussion with the service consultant psychiatrist or their nominated deputy who is Section 12 approved, by the assessing clinician if they are not Section 12 approved
- On agreement of the need for an assessment, the assessing clinician will contact the AMHP hub during office hours and Emergency Duty Service (EDS) outside of this, to request attendance of the AMHP
- Confirmation of the time of attendance will be sought by the assessing clinician who will ensure that the person is kept informed and supported whilst they wait for the assessment

Trafford Urgent Care Centre:

- The decision made to refer for a mental health act assessment should occur following discussion with service by the assessing clinician, if they are not Section 12 approved

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 18 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- On agreement of the need for an assessment, the assessing clinician will contact the AMHP to request attendance
- Confirmation of the time of attendance will be sought by the assessing clinician who will ensure that the person being assessed is kept informed and supported whilst they wait in the department

Trafford Ward areas:

- The decision made to refer for a mental health act assessment should occur following discussion with service consultant psychiatrist by the assessing clinician, if they are not Section 12 approved
- On agreement of the need for an assessment, the assessing clinician will contact the AMHP to request attendance
- Confirmation of the time of attendance will be sought by the assessing clinician who will ensure that the person being assessed is kept informed and supported whilst they wait

5.3 Interventions

The service will offer a range of interventions, including:

- Collation of collateral information
- Biopsychosocial assessments
- Investigations advice
- Making new mental health diagnosis
- Medication advice, change and review
- Clinical risk assessment
- Clinical management advice and planning
- Ongoing evaluation of MHLS care delivery and interventions provided
- Mental Health Act assessments
- Giving written information on diagnosis
- Psychoeducation
- Nursing care advice to acute trust colleagues
- Informal and formal education to non-mental health trained colleagues
- Develop and implement discharge plans
- Support to decision-makers in undertaking capacity assessments where capacity is thought to be fluctuating or complex
- Contribution and attendance at Best Interests meetings
- Undertake and specialist health and nursing needs assessments to inform discharge planning
- Placement/planning advice following specialist health needs assessments

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 19 of 36

5.4 Discharge

Discharge from the service can occur following completion of a biopsychosocial assessment and development of an ongoing plan of care. Discharge for many people may not be appropriate following an initial assessment, as their clinical needs are complex or evolving. It is essential therefore, that MHLS maintain contact with their caseload, to ensure that there is oversight into how care is progressing, the efficacy of MHLS interventions and so that discharge planning can remain as proactive as is possible and also relevant to the changing needs of the person, as their admission progresses.

The discharge outcomes following assessment may include referrals onwards to services/agencies::

- To primary care with referral/signposting to additional services.
- To substance misuse services.
- To Mental Health Primary Care Services.
- To Secondary Care or Specialist Services.
- To Home Based Treatment Teams.
- To Inpatient treatment, including Safire.
- Local CAMHS

At the point of discharge from the service, a person will be offered a copy of their discharge GP letter to be sent to them also and refusal of this should be documented.

Where appropriate, a person and/or their family/carer will be offered a copy of the mental health liaison service Information Leaflet, containing the personalised agreed care plan, and information of how to access emergency help if needed (i.e a Safety Plan).

A person and/or their carers may also be offered mental health information leaflets, including:

- The Alzheimer's Society/ Age UK fact sheets
- The Royal College of Psychiatry leaflets
- Information leaflets regarding local services
- Information regarding local and national voluntary services e.g. Citizen's Advice Bureau, Samaritans

Person and carer satisfaction questionnaires will also be offered following assessment, when clinically appropriate.

5.5 Onward referrals

5.5.1 Communication standards

Communication with a person's GP in writing should be sent **within 24 hours of discharge from A&E**.

GP letters for people who have been discharged from other areas of the hospital should be sent within a maximum of **10 days of discharge**, this may need to be earlier if critical clinical information needs to be communicated with a GP or other relevant agency (e.g. medication

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 20 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

advice, changes or other guidance that requires immediate action). There may also be circumstances where verbal communication should take place that is then followed by a letter.

GMMH PARIS clinical records system will automatically populate a **GMMH DSDS** GP letter template for completion (**M61**).

The GP letter will contain a summary of the assessment, ongoing advised plan of care and risk assessment and formulation.

A safety plan should be shared with the person who has been assessed at the same time as the GP letter.

A copy of the GP letter should be offered to the person who has been assessed and with their consent, their relative/carer/friend.

Other agencies involved in a person's care should also receive this letter. This may include, but is not limited to:

- Named social worker (children's or adult's)
- CAMHS professionals
- Safeguarding leads
- CMHT professionals
- Drug and alcohol workers
- Psychological therapists and other health, social care and wellbeing professionals.

5.5.1.1 Information required within onwards referrals

Services may require different amounts of detail from the mental health liaison service.

As a minimum and contained within the required relevant clinical assessment documentation, the mental health liaison service should provide the following information within their verbal and written handover of the referral:

- Reason for referral
- Anticipated outcome of the referral being sought
- Rationale for the stated urgency of a referral

Where possible, the referrer will ensure that all demographic, address, telephone and carer contact details are recorded within the GMMH electronic records system and confirmed with the person being referred as accurate.

5.5.2 Urgent Care Services Referrals

5.5.2.1 Home based treatment team

- The mental health liaison service will refer by telephone, to the appropriate Home Based Treatment Team (dependent on locality of a person's registered GP in the first instance)
- The Home Based Treatment Team will provide the referrer with the date and time of their initial assessment and the necessary contact details of the service

5.5.3 Community Mental Health Teams

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 21 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- **Routine referrals** to CMHTs/EIS will be made via telephone by the mental health liaison service referrer to the CMHT/EIS duty worker within working hours and in writing outside of working hours the same or next working day following assessment
- **Urgent follow up requests** to CMHT/EIS services who may already know a service user would be by telephone discussion with the duty worker the same or next working day following assessment

5.5.4. Older Adult services

Care pathways for Manchester Later Life services are defined within appendix 12.

5.5.4.1 Community mental health team

- **Routine referrals** to CMHT will be made via telephone by the mental health liaison service referrer to the CMHT duty worker within working hours and in writing outside of working hours the same or next working day following assessment
- **Urgent follow up requests** to CMHT services who may already know a service user would be by telephone discussion with the duty worker the same or next working day following assessment

5.5.4.2 Older Adult Inpatient admission

- Gatekeeping occurs via discussion with Consultant Lead for Older Adults or Older Adults Service Manager within hours/On call Consultant for Older Adults outside of hours
- Bed identification then occurs via GMMH Manchester bed management team after agreement for admission is confirmed by the gatekeeper above

Appendix 12: Later Life interim operational procedure

5.5.6 Children and Young People

5.5.6.1 Community referrals for Children and Young People

The mental health liaison services receive referrals for people aged 16 years upwards who may go on to require community-based care, following discharge from the mental health liaison service.

Some young people will already be involved in services and so contact details for CAMHS services for under 16s in Manchester and Trafford are detailed below:

	Location	Hours of Operation	Contact details
North	The Bridge	9am-5pm Monday-Friday	0161 203 3250
Central	Winnicott Centre		0161 701 6880
South	Carol Kendrick Unit		0161 902 3400
Trafford	Healthy Young Minds Trafford		www.healthyyoungmindspennine.nhs.uk 0161 716 4747

For any young person presenting with self-harm, consideration of an automatic referral to EMERGE (16-17 Community Service) should be made and a rationale recorded if this pathway

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 22 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

is not followed. Any young person who it is felt would benefit from ongoing care in the community can be referred to EMERGE.

All of the above services operate a duty officer system who will respond to urgent/emergency calls to the team that requires a same day response.

EMERGE is a service operated by Manchester University Hospital Foundation Trust (MFT) for Manchester and Salford services. They are a multidisciplinary team that can be contacted to make urgent or routine referrals or for advice Monday- Friday 9am-5pm: 0161 226 7457.

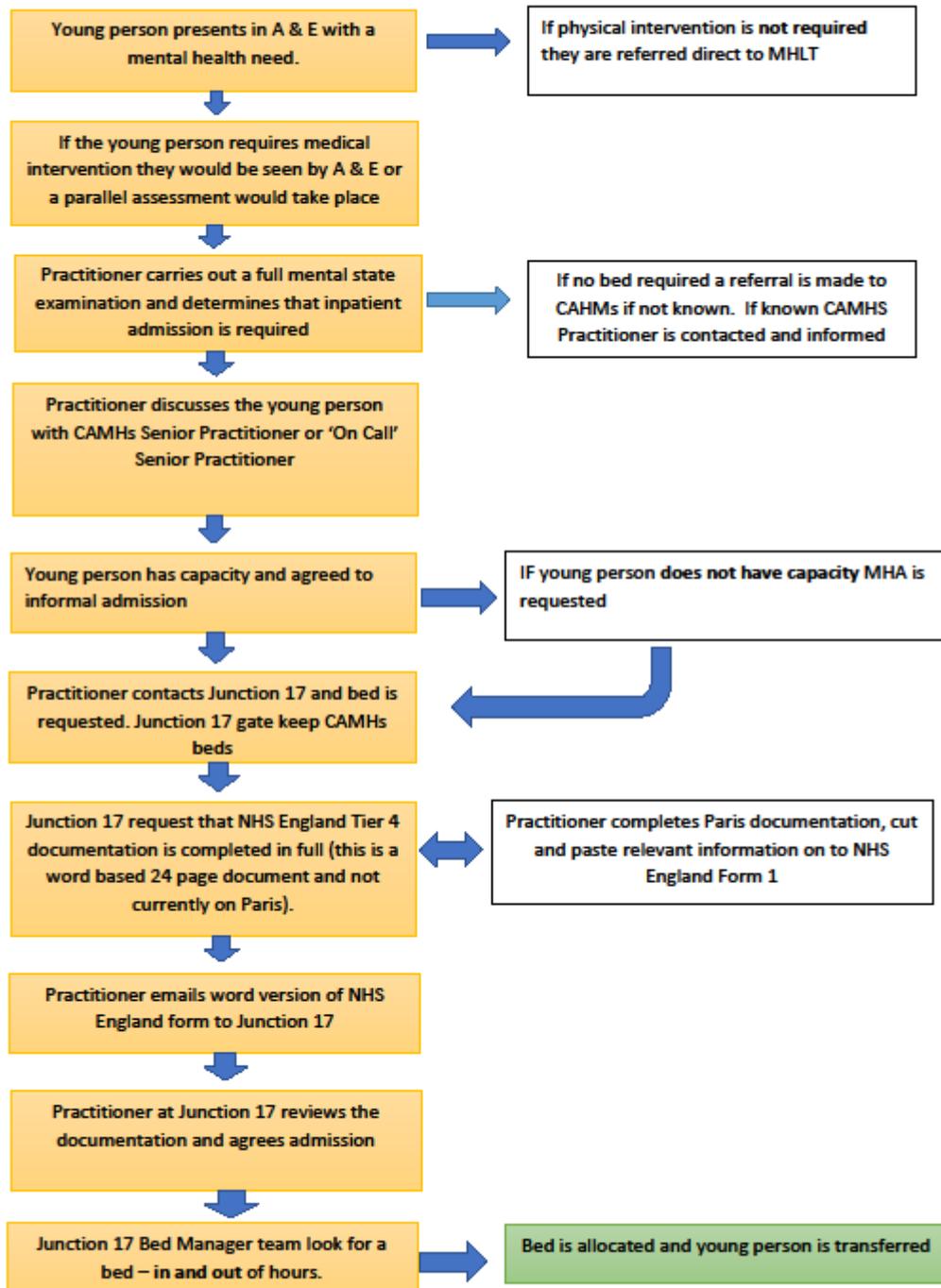
Healthy Young Minds is a service operated by Pennine Care NHS Foundation Trust (PCFT) that provides CAMHS services for children and young people in Trafford.

Urgent Care provision for young people would be via GMMH acute home-based treatment teams and so the pathways for these services should be followed.

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 23 of 36

5.5.6.2 Admission for Children and Young People

CAMHS Assessment and Bed Process – 16+ years only



Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

To enable admission:

- The CAMHS T4 Children and Young People's assessment documentation (Form 1) will be completed by the mental health liaison service referrer when it is felt that an inpatient admission is indicated
- The referrer will contact the on call CAMHS consultant to discuss the admission
- The T4 referral document is then sent (via encrypted email) to Junction 17 who will commence gatekeeping and bed identification process within working hours
- The clinical assessment and plan should also be recorded within both GMMH and the Acute Trust patient records systems

	Telephone	Fax
On Call CAMHS consultant	0161 276 1234	n/a
Junction 17	0161 772 3649	0161 772 3593

5.5.7 Learning disability service access

In line with the acute mental health and learning disability escalation pathway, the mental health liaison service should undertake an initial biopsychosocial assessment to inform onward care planning and action required to support a person who is referred to the service and may also have a learning disability.

Appendix 15: Acute mental health and learning disability escalation pathway

5.5.8 Frequent Attenders

Frequent attenders to the A&E department are identified by review of data obtained from the Acute Trust and partner agencies, using agreed parameters to identify the cohort of people who may benefit from a focused intervention to support them in identifying alternative positive ways to access and elicit care.

Complex cases are discussed within divisional multiagency forums and collaborative care planning will take place to support a reduction in frequent attendances.

The interventions of the mental health liaison services in relation to supporting people who attend frequently are detailed below, although this is not exhaustive:

- Coordination of Professional's Meetings
- Delivery of psychologically informed interventions
- Development of individualised care plans

5.5.9 Inpatient admission

Where the referrer has identified a need for hospital admission, the following steps should be taken by the referrer:

- Refer for a gatekeeping assessment/ discussion –For Manchester services this is face to face and in Trafford it is by phone via the Admission and Discharge clinician
- Advise bed management of need for a bed
- Verbally handover all relevant clinical information
- Contemporaneously record their full clinical assessment and management plan using the defined clinical assessment framework, within the GMMH clinical records system

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 25 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

On identification of an inpatient bed, the mental health liaison service should support the safe transfer of the person; this would include the following actions:

- Clinical handover to receiving area
- Confirmation of legal status and necessary paperwork (in the absence of the local mental health act administrator undertaking this function)
- Obtain assurance from medical team that the person is medically optimised to leave the ward
- Advise on the most suitable form or transport
- Ensure a review of presentation takes place as close to the timing of transfer

If there is a delay in identifying a bed; the service should follow the medical bed escalation procedure in Appendix 19.

5.5.10 Perinatal referrals

Referrals are accepted by the mental health liaison service from the inpatient maternity wards for women experiencing known or suspected perinatal mental health problems.

These referrals may:

- Form part of an already developed care plan to have a mental health review immediately post-delivery/at admission **and/or**
- Occur following a known or suspected need becoming evident to the maternity/obstetric team that arises within the perinatal period

It is recognised that the nature of perinatal presentations may warrant a more urgent or even emergency response by the service. Consequently, consideration of this should be made in receipt of such referrals by the shift coordinator and clinical lead where the prioritisation is not clear from the information received.

Following the initial assessment, access to specialist perinatal mental health clinical advice and onward referrals to perinatal services should be via the GMMH Perinatal Outpatients and Community services or GMMH Mother and Baby Unit (Anderson Ward, Wythenshawe Hospital) that provides inpatient care for mothers and babies.

Service	Contact details
Perinatal Outpatients	0161 291 6930
GMMH Mother and Baby Unit	0161 291 6829

Appendix 16 Perinatal referral form

5.6 Escalation

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 26 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

The degree and nature of demands experienced by mental health liaison services vary. At times of pressure escalation procedures provide a systematic and defined approach to inform how pressure can be responded to and how the service can be supported to respond safely and effectively.

GMMH has procedural guidance for staff at all levels to support proactive ways to manage and respond to pressures, this is called the Operational Pressures and Escalation Framework (OPEL): <https://newintranet/GMMH-Policies/Lists/PolicyDocs/CL32%20Operational%20Pressures%20Escalation%20FW.pdf#search=opel>

The examples of positive escalation actions below are not exhaustive and may be required at different points in **any** GMMH escalation process, depending on the nature of delay.

They seek to provide those staff likely to be involved with escalation with an understanding of potential actions, expected roles and responsibilities within this process to ensure that a person remains safe and their needs met whilst they are within an acute hospital setting.

- **Liaison Practitioners**

- Ensure service user, family and carers are kept updated about progress in the event of any delay
- Ensure service user's needs are met as far as is possible within the acute trust hospital ward/A&E Department and their dignity maintained
- Review need and source of resources to support delivery of additional mental health interventions within acute trust hospital ward/A&E Department e.g. PRN, 1:1 observations, situation of person in department, access to regular medications
- Update Acute Trust lead for the area (e.g. shift leader/ward manager) of the needs and risks associated with supporting the person, as well as progress towards discharge/transfer
- Confirm if psychiatrist review is necessary and facilitate this by liaison with the appropriate clinician
- Review the presentation and needs of the service user at least once per shift
- Escalate outside of the timescales defined within this protocol if concerned or further support is required
- Undertake actions agreed with supporting managers as part of escalation and feedback progress

- **MHLS Shift Coordinators**

- Provide on-site direct leadership to support proactive resolution of delays, in the absence of the team manager or senior practitioner e.g. overnight
- Responsibility for progressing actions to resolve delays
- Maintaining contact and provide updates to the service user, acute trust clinicians and their management around progress

- **Senior Practitioner/Team Manager/SOC/BOC**

- Provide leadership and ownership of the situation in order to ensure proactive resolution of delays

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 27 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- Responsibility for progressing actions to resolve delays
- Contact Patient Flow Team/Admission and Discharge Clinician/Gatekeeper to understand reason for delay in bed identification, steps required to resolve and timescales anticipated.
- Confirm what steps are being taken to increase bed capacity within the division and timescales anticipated.
- Contact transport providers to understand reason for delays in transport, ensure all GMMH-based or NAWAS transport options have been exhausted before considering private providers
- Consider timescales within which earlier escalation to Area team manager/Service Manager/SOC may be indicated e.g. escalating acuity/risks in acute trust hospital ward/A&E Department
- Contact AMHP hub/EDT to establish reasons for delays of AMHPs and ask that workload be reviewed and if possible reprioritised
- Contact CT/ST doctor on call to establish reason for delay in attendance and explore possibility of ST/Consultant attending if a delay of more than 2 hours is anticipated and this would be the main cause of delay.
- When re-contacting confirm steps taken and their efficacy in resolving delays and what further actions are required
- Handover actions undertaken to date to more senior manager as timescale requires
- Consideration of reallocation of resources from within the division to support delivery of care in A&E department if required e.g. 1:1
 - **Area team manager/Service Manager/SOC/BOC:**
 - Provide leadership and ownership of the situation in order to ensure proactive resolution of delays
 - Responsibility for progressing actions to resolve delays
 - Confirming steps taken, their efficacy in resolving delays and what further actions are required to establish understanding of likely timescales for their resolution
 - Contact leads for Patient Flow/Admission and Discharge Clinician/Gatekeeper roles to increase bed capacity locally and to review GMMH-wide bed capacity and consider inter-divisional admission feasibility
 - Consideration and provision of authorisation for funding e.g. For out of area placement, transport, interventions within the department
 - Consideration of reallocation of resources from within the division to support delivery of care in acute trust hospital ward/A&E Department if required e.g. 1:1
 - Liaison with CCG to advise of risk of 12hr breach and actions that may require their support
- **Head of Operations/Assistant Director/SOC/GOC:**

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 28 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- Provide leadership and ownership of the situation in order to ensure proactive resolution of delays
- Responsibility for leading the progression of actions to resolve delays
- Liaison with CCG to advise of risk of 12hr breach and actions that may require their support
- Liaison with partner organisations/providers e.g. to identify bed capacity, transport, resources

5.6.1 A&E 12 hour escalation procedure

Where a decision to admit (DTA) has been made by a mental health liaison practitioner or mental health act assessment team, and there is a delay in identifying a bed, the mental health liaison service will ensure a proactive approach is taken to resolve barriers to discharge or transfer from the department.

A wait of 12 hours from decision to admit is a 'Never Event' and is reported as such.

Where it is recognised that a person is likely to spend a period of longer than 2 hours from decision to admit, the '12 Hour escalation procedure' should be followed without delay.

GMMH 12 Hour Escalation Procedure: https://newintranet/departments/nursing-governance/risk-and-safety/emergency-planning/bronze-on-call-resources/Documents/A&E_GMMH_Escalation.docx

5.6.2 Initial assessment delay escalation

Demands placed on the service can vary and the capacity of the service to respond can be compromised for a number of reasons. The MDT will be supported by operational managers to manage and respond to the demands placed on it.

Where it is recognised that the capacity of the service is being exceeded therefore the initial assessments of those referred are likely to be delayed, the 'Initial assessment delay' escalation procedure should be followed by the mental health liaison service.

Appendix 18: Initial Assessment Delay escalation

5.6.3 Medical ward escalation

A person who is awaiting transfer into a psychiatric bed must continue to receive care from the mental health liaison service, who will remain responsible for maintaining contact with GMMH bed management and Patient Flow team on a minimum of a daily basis until transfer has taken place.

The level of contact will be informed by an MDT-led clinical decision.

Should the situation arise where it is not possible to transfer a person into a psychiatric ward from an acute trust bed, due to no bed being identified, the mental health liaison should follow the 'medical ward escalation procedure'.

Appendix 19: Medical Ward escalation

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 29 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

5.6.4 Staffing escalation

In the event of staff absence, or where demand exceeds capacity the services have access to a small core group of Bank Staff; Band 6 and Band 7 mental health practitioners who have been inducted into the service and can cover core work such as A&E.

The practitioner staffing resources may be required to move between Manchester and Trafford sites to support periods of acute pressure.

5.7 Shift coordinator role

On each shift, there will be an allocated co-ordinator who will ensure that the most appropriate clinician is allocated to each referral, in order that referrals can be dealt with in a timely and responsive manner, and reduce the risk of delays in any area of the hospital.

The main elements of the role include:

1. Ensuring referrals from both the emergency department and the wards are being allocated and persons are being seen within the appropriate time frames
2. Allocating workload to practitioners in a fair and equitable way, taking in to account breaks, cut off points and other commitments such as supervision
3. Knowing where staff are at all times in accordance with lone working procedures
4. Being able to account for care management and delegation during shifts for which they are co-ordinating

5.8 Standards for service delivery

5.8.1 Leadership

Day to day Clinical leadership of the service will derive from the senior leadership team which comprises of:

- Consultant psychiatrists
- Team manager
- Senior practitioners
- Clinical psychologists

Actions of the clinical leadership team on a day to day basis includes:

- Triage of referrals where there is uncertainty
- Advice or direct involvement in clinically complex cases
- Service case load review and management

5.8.2. Capacity

There will always be a practitioner resource assigned within the agreed shifts, to deal with any referral demand, regardless of the location.

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 30 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

Case allocation will be to the most appropriately skilled practitioner available, clinical priority and also time of referral. The allocation of cases may require reprioritisation as changing needs and demands arise within the whole service.

The Consultant Psychiatrist will respond as necessary to demand across the whole of the acute hospital services, informed primarily by which specific assessments require their specialist senior expertise.

Service demand may be variable but the service will endeavour to maintain the capacity and capability in order to meet the standard to undertake assessments from all wards and departments within the timeframes detailed earlier in this document.

In circumstances where there are multiple referrals which have a significant impact on capacity, discussion may take place between senior members of the team and the shift co-ordinator in order to effectively and safely prioritise the workload.

If the service is not able to meet demands, this will be escalated to senior management at the acute trust and GMMH for consideration of proportionate actions. More detailed guidance on response to challenges around capacity and demand are referenced within the escalation section of this policy.

5.8.3. Lone working

As indicated in the GMMH Lone Worker policy, there will be times when members of the service will be classed as "Lone Workers". On these occasions, staff will follow the GMMH mental health liaison Lone Working guidance, compiled in accordance with the GMMH Lone Worker policy.

Appendix 20 GMMH Mental Health Liaison Service Lone Working Guidance

5.9 Medicines Management

The scope of medicines management is to ensure the use of medicines is optimised by considering and promoting cost effective, evidence based prescribing practice and effective risk management.

Prescribing (whether active, via advice or recommendation) within the service is primarily undertaken by team consultants and on-call doctors. Following development and implementation of a Non-Medical Prescribing (NMP) strategy, there will also be NMPs operating within the team.

Any prescribing and practices relating to medicines for any professional group within the service would be aligned to GMMH Medicines Management and NMP policies, as well as individual professionally defined standards.

The use of honorary contracts for practitioners from acute trust also supports prescribing practice within the general hospital setting, for people who remain under the care of the acute trust but are also receiving care from the service.

5.10 Record keeping

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 31 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

All members of the service have a responsibility to maintain clinical records in line with GMMH Record Keeping policy, relevant legislation, and professional standards.

Clinical records will be maintained by team members within the GMMH electronic records system, to which all staff will have access, and the acute trust record system.

Adherence to record keeping and clinical assessment documentation standards will be monitored and reported through a quarterly audit of clinical documentation against GMMH trust policy, undertaken by the team manager or a nominated deputy and reported back at a service level and via individual line management supervision.

6. Training

6.1. Acute trust staff training delivered by MHLS

The mental health liaison team will develop and deliver a mental health programme of training, including bespoke training, for acute trust colleagues from all backgrounds. This training will cover areas such as:

- Recognition of common mental health problems
- Reducing stigma
- Promote understanding of helpful strategies to promote positive interactions with individual users of the service
- Provide acute trust staff with the required knowledge base and competencies to enable to positive and effective care of people experiencing mental health problems in the acute hospital

The service will also engage with acute trust mental health and associated policy development, to promote the collaborative development of policies, protocols and strategy.

6.2. MHLS training and Continuing Professional Development (CPD) support

This operational procedure should inform the local induction of new starters to the service.

The service operates an academic programme from within the team. Training needs analysis for the service has been informed by the Mental Health Liaison Nurse Competency Framework developed by Eales et al 2014.

Access to wider CPD opportunities is also supported by GMMH Learning and Development strategy and would be informed on individual goal planning arising from the appraisal process, as well as service development priorities.

6.3 MHLS Practitioner Line management supervision

In-service line management supervision delivered by the team manager and senior practitioners is provided in line with the GMMH Trust Supervision policy. This policy informs the structure, frequency and recording of both line management and clinical supervision.

- Band 7 senior practitioners will provide line management supervision to the Band 6 practitioners and will be line managed by the team manager.
- Administrative staff will be line managed by the Senior Administrator.

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 32 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- Medical line management responsibility sits with the divisional Lead Consultant, unless otherwise stated.
- The team manager will provide line management supervision to the clinical psychologist and advanced nurse practitioner.

These line management structures will include responsibility for authorising leave, sickness monitoring and supporting individual development.

6.4 MHLS Clinical supervision

Access to individual clinical supervision will be supported for all members of the team from clinical supervisors of their choosing and in line with GMMH Supervision policy.

Group and case supervision opportunities will be supported by the MDT for retrospective case discussions.

6.5 Appraisal

The defining and monitoring of achievement against individual development goals and plans is undertaken in line with the GMMH Appraisal Process. The service and trust are committed to support and promote the development of the staff within the service. Staff are able to find out more about this process through 'My Learning Hub', located on the GMMH intranet. Each team member will receive an annual appraisal.

7. Service evaluation

7.1. Person and carer involvement

All people will be actively encouraged to be involved in their care. Information regarding their care and treatment will be presented in a manner that is clear, concise and of a good quality. In so far as possible, provide the right information at the right time suited to their personal needs.

All people and their carers (where appropriate) will be actively engaged to participate in their assessment and care planning. This will follow a commitment to equality, inclusion, recovery and diversity that supports people in living independent and valued lives. The approach puts the individual person's strengths, goals and aspirations as well as needs and difficulties at the centre, builds confidence and promotes social inclusion and recovery.

People and their carers will be encouraged to participate in Patient Satisfaction Questionnaires.

Appendix 21: Service user and carer experience questionnaire

7.3. Reporting systems

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 33 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services

- Service activity and performance are monitored and reported on a monthly basis, against service KPIs.
- Performance is monitored within service level team meetings, divisional Senior Leadership Team meetings, network hub meetings and the GMMH Urgent Care forum
- Mental health liaison services are not within the scope of Payment by Results (PbR)

8. Appendices

1. Manchester Triage Pro-forma



REFERRAL TO THE
MENTAL HEALTH LIA

2. A&E referral pathway



A&E Referral
pathway.docx

3. Urgent Ward referral pathway



Urgent Ward
Referral pathway.do

4. Routine referral pathway



Routine Ward
Referral pathway.do

6. Intoxication pathway



INTOXICATION
Protocol Chart V6 re

7. High risk assessment pathway (North and Central Manchester)

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 34 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services



High risk pathway
v1.docx

8. Integrated care pathway (Wythenshawe)



ICP Self Harm.doc

9. Missing or absconded person

10.a Manchester Clinical Risk Management and Assessment Tool Guidance: Version 5, Section 6



Manchester Clinical
Risk Management an



RiskAssessment2016
Blank.doc

10.b Trafford Structured Clinical Note Guidance



Guidelines For
Recording An Initial



Initial

Assessment_Pro Form

12. Later Life operational procedure guidance (interim)



Later Life Inpatient
SOP V6 interim draft

13. Children and Young People T4 (Inpatient) Referral Form 1

15. Manchester Acute mental health and learning disability escalation pathway



LD Pathway v0.8.pptx

16. GMMH Perinatal Services Referral form

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 35 of 36

Mental Health Liaison Service Operational Procedure Manchester and Trafford Services



PRAMMBS-referral-form-sept-2017.docx

19. Medical Ward Escalation



Medical Ward Escalation.docx

20. Lone working procedure of mental health liaison service



Liaison Lone Working Guidance v1

21. Service user experience questionnaire



Experience questionnaire V1.doc

Ref:	Issue date: 22.11.2019	Version number: 1.0
Status: Ratified	Next review date: 22.11.2020	Page 36 of 36