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All staff, Salford Royal NHS Foundation Trust (SRFT) |

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In the light of a major change, e.g. legislative, or the document has reached its expiry date, this would see the document reviewed, re-consulted upon and documenting as to version 2.0. For further guidance contact the Integrated Governance Department on 0161-772-3611].
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1. Introduction

The Salford Mental Health Liaison Team (MHLT) provides psychiatric assessment and management of service users referred from Salford Royal NHS Foundation Trust Hospital (SRFT) acute hospital wards, intermediate care (IMC) and service users who present to the Emergency Department (ED). MHLT also have responsibility for all individuals brought to Salford’s identified Place of Safety i.e. service users detained by police on a Section 136 of the Mental Health Act 1983.

The service is PLAN Accredited and aspires to meet the Quality Standards as laid out in the RCP Psychiatric Liaison Accreditation Network (PLAN).

SRFT is a large tertiary care teaching hospital. Emergency Department provide initial treatment to service users with a broad spectrum of illnesses and injuries, some of which may be life-threatening and requiring immediate attention. Standard practice will see individuals arriving at and Emergency Department undergo a brief triage interview to determine the nature and severity of their illness.

It is recognised that considerable efficiencies and improved outcomes have already been delivered across Salford’s Health and Social Care System. This is in relation to a number of managed projects which have addressed such things as reducing unscheduled care attendances and non-elective admissions, increasing deflections from the Emergency Department, reducing duplications and omissions of care, promoting self care (where appropriate) and implementing pathways that seek to prevent use of 999 and unscheduled care services. The specialist focus of the MH Liaison Service developments in relation to those with mental health problems and those with co-morbidity has potential to further enhance these efficiencies.

2. Values and Philosophy of the Service

2.1 The Values and Philosophy

MHLT will assess, manage and signpost service users /carers and provided training/education the staff of SRFT.

MHLT aim to:
- Have a “Can do” attitude
- Be flexible in their approach
- Optimistic
- Ambitious
- Compassionate
- Knowledgeable

MHLT are focused on:
- Having a high standard of knowledge and skills within the team
- Having and maintaining a positive culture
- Encouraging team members to participate in developing the service
- Recording data accurately
- Having high standards of communication with professionals, service users and families.

MHLT will demonstrate efficacy by:
- Responding to referrals in the Emergency Department within 1 hour of referral
- Responding to Routine ward referrals within 24 hours
- Responding to Urgent ward referrals within 6 hours
- Supporting reduction in length of stays within the acute trust
- Supporting service users to access the least restrictive care available
- Reducing mental health Emergency Department 4 hour breaches
- Reducing the duration of section 136 detainee’s detention
- Reviewing feedback from service users, carers, other mental health teams, SRFT & GPs including both complaints and compliments.

2.2 GMMH Trust Vision and Values
Values are the way in which our beliefs are visible through how we behave. They are at the core of the GMMH organisation and what make us unique and special from other organisations.

The trust values are:

**Inspire hope**

Which means:

- Having a positive outlook on the future ahead
- Celebrating achievements, no matter how small
- Staying resilient and optimistic
- Enabling people to reach their full potential
- Being a positive role model

**Work together**

Which means:

- Empowering service users to make informed choices
- Working together to provide seamless services
- Lending a hand to a colleague who needs it
- Setting and maintaining high standards
- Supporting each other to recognise our strengths

**Caring and compassionate**

Which means:

- Showing empathy and understanding to all
- Treating service users, their families and each other with kindness
- Doing the little things that make a difference
- Taking time to engage, support, listen and act
- Putting ourselves in your shoes

**Value and respect**

Which means:

- Seeing the individual in everyone
- Valuing individuality and diversity
- Respecting different people’s needs, aspirations and priorities
- Being considerate and respecting each other
- Challenging behaviour that does not fit with our values

**Open and honest**

Which means:

- Acting with integrity and honesty
- Apologising if we are wrong or if we let you down
- Continually learning to improve
- Doing what we say we will do
- Building a trusting relationship

3. **Aims of the Service**
The overall aim of Salford Mental Health Liaison is to provide the best possible quality assessment, care, treatment and support to service users in Salford Royal Hospital, Intermediate Care, and service users detained on Section 136.

We aim to:

- Provide a timely and flexible response to referrals, to meet the demands of Salford Royal Hospital.
- Provide comprehensive mental health assessment, care planning, risk assessment & management and signposting to service users referred to the service.
- Provide Mental Health related training to staff members of Salford Royal Hospital staff.
- Work in close partnership with others services including but not limited to:
  - Home Based Treatment Team
  - Mental Health Inpatient Wards
  - Adult Community Mental Health Teams
  - Later Life services
  - Early Intervention / EDIT Services
  - Memory Assessment and Treatment Team
  - Urgent Care & Enhanced Care Team within the ICD
  - Hospital Social Work Team
  - Salford Royal Hospital Psychology Service
  - Child and Adolescent Mental Health Team
  - Drug and Alcohol Services
  - Primary Care providers
  - Community Support Organisations
  - 3rd Sector Organisations.
- Work closely with other organisations to contribute to a seamless service of mental health provision. Contribute to and develop appropriate care pathways for onward referral of individuals in need of further assessment and support.
- Support the active engagement of service users and carers at all levels in order to enable participation in the design, planning, delivery, monitoring and evaluation of our services and those of our partner organisations. This will be delivered in line with the GMMH Service User Engagement Strategy and local delivery plan for Salford division.
- To ensure service user information is 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.
- Actively engage service users and carers 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. This 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.
- Service users and carers will be kept informed of their current assessed need and care plan. A copy of the care plan will be provided to the service user where clinically appropriate– in an accessible format appropriate to their needs.
- Seek feedback from service users and carers.
- Treat information with the utmost confidentiality within our service in line with GDPR and the GMMH Information Governance Policy; however, at times it may be necessary to for us to share this information with other parties. This will only happen if there are overriding concerns for the service users or that of others welfare.
3.1 Performance Indicators

A performance and evaluation framework will include as a minimum the following:

- Compliance with agreed KPIs
- Compliance with CQC Standards for Section 136 Suites.
- Completion of the trust wide liaison outcome assessment document
- Patient / carer surveys
- Annual clinical audit of service users /carers and staff satisfaction against the PLAN standards

Mental Health Liaison Service Key Performance Indicators:

- Improve awareness and knowledge of mental health conditions and liaison service across SRFT
- Adhere to agreed response times relating to all referrals – referral to be seen in ED 1 hr (75%) and 2 hrs (95%); assessed, transferred or discharged within 4hrs in ED (95%).
- Increase the identification and diagnosis of mental health disorders in the older adult population of SRFT, including dementia and delirium
- Reduce the number of delayed discharges for over 65s
- Reduce the percentage of new admissions to 24-hour care for service users discharged from intermediate care
- Reduce the percentage of service users over 65 transferred from the emergency village to SRFT wards
- Reduce the length of stay for Section 136 presentations

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.

All these indicators are monitored through Salford Urgent Care Delivery Board, Salford Senior Leadership Team (SLT) and are fed back to the Team Manager and leadership team in the Senior Management Team (SMT) meeting and in individual supervision from the Senior Manager.

3.2 Governance Arrangements

The service’s development is monitored by the Mental Health Liaison Team Leadership Meeting (MHLTLM) which meets every month and includes the discussion of key operational, clinical and governance issues.

All practitioners will ensure that data and information recorded via the Trust’s electronic recording system is accurate and complete, enabling comprehensive profiling of the service in order to inform future development proposals. Monthly activity and outcome data will be provided to service commissioners according to an agreed performance framework.

GMMH have an agreed protocol in place for reporting and responding to safety concerns raised by staff via its Datix reporting system.

MHLT professionals are involved in GMMH organisational and local meetings; which address critical incidents, near misses and other adverse incidents. For example Positive Learning Events, team meetings and SMT.
4. **Model of Service**

4.1 **Operational Hours**

The service operates 24 hours a day, 7 days a week, 365 days a year. Outside of office hours, the staffing structure for MHLT consists primarily of Band 6 Practitioners, who when working out of hours have access to senior advice and support via the GMMH on-call systems.

In the event of staff absence, or where demand exceeds capacity the team have access to the Meadowbrook On-Call Psychiatrist and there is a small core group of Bank Staff; Band 6 mental health practitioners who have been inducted into the service and can cover core work. The Mental Health Liaison Team Manager, Senior Practitioners or Senior Manager, should agree use of bank staff and overtime.

4.2 **Acceptance/Exemptions Criteria**

MHLT receive referrals for service users of all ages who are presenting at Emergency Department, PANDA or are inpatients at SRFT.

4.2.1 **Acceptance criteria**

MHLT will offer an assessment to service users presenting at SRFT with suspected mental health difficulties. Which may include but is not limited to:

- Service users who self-harm
- Service users with co-morbid physical and mental health problems e.g. depression or SMI
- Service users with dementia
- Service users with delirium, with or without dementia
- Service with medically unexplained symptoms
- Service users who express suicidal ideation

4.2.2 **Exemptions**

- Service users who are solely intoxicated with drugs or alcohol without any of the above eligibility criteria.
- Any person subject to police arrest who have been brought to the Emergency Department for their physical health needs. Colleagues within the Criminal Justice mental health services will provide psychiatric assessment, care and advice, within the custody setting.
- The MHLT would provide psychiatric assessment, care planning and advice to anyone subject to arrest who was an inpatient within Salford Royal, as the criminal justice psychiatric services do not provide an in-reach service. MHLT will undertake this role to ensure that the mental health needs of this population are being met whilst they are staying within the hospital.

Appendix 1: Mentally Disordered Patient Pathway

5. **Structure of the Team**

5.1 **Team Compliment and Roles**

The Salford Mental Health Liaison Team will be made up of the following disciplines:

**Senior Operational Manager**

The Operational Manager for Urgent Care and Commissioning is responsible for ensuring the operational delivery of the Mental Health Liaison Team within the Salford Mental Health Directorate. The Senior Manager offers support to the Liaison Team Manager and Leadership team ensuring it meets contracted targets and delivers excellent standards of care to mental health service users and carers across the Acute Trust.
Team Manager

The Team manager will ensure the safe and effective day-to-day management of the team. They will be responsible for ensuring the implementation of the Operational Policy. This includes the implementation of processes for work allocation, communication, performance management, supervision and ensuring the implementation and compliance with all applicable GMMH policy and procedures. They will be responsible for performance review and the implementation of systems which ensure that key performance indicators are being met. The Team manager will follow agreed escalation procedures, develop clinical pathways and liaison protocols including those relating to dementia, substance misuse, self-harm and functional illness. The Team Manager will ensure timely provision of reports, statistics and analysis of service activity in relation to service specification and targets. They will promote collaborative and multidisciplinary team working. Maintain positive working relationships with colleagues in SRFT via attendance at monthly Emergency Village Meetings, joint review of SRFT Datix relating to mental health service users and joint review of ED breech data.

Senior Practitioners

The main duties of the Senior Practitioners are ensuring that senior clinical input is readily available to Liaison Practitioners in order to manage difficult cases and provide support in making robust clinical decisions. Supporting the liaison shift co-ordinator where required during periods of increased clinical demand. The development of clinical pathways and protocols in line with local and GMMH processes. Regular provision of Clinical and Line-Management supervision of Liaison Practitioners. Deputising for the team manager when required

Each Senior Practitioner may also have specific responsibilities for various components of the service in the following areas:

- A&E/EAU/AEC
- Other Acute wards in SRFT
- Section 136 Suite/Police Liaison
- Training
- Children and Young People (CYP)

Consultant Psychiatrist

The Consultants will have clinical leadership responsibility for ED/Emergency Village and the Wards/Older People respectively. The main duties of the Consultants include the provision of clinical leadership. Senior medical input to A&E, wards and intermediate care to ensure diagnosis, effective management plans and early, safe discharge of complex cases, especially in service users with cognitive impairment. Specialist pharmacological advice. High level risk assessments of complex presentations e.g. severe attempts of self-harm, eating disorder, somatisation, and factitious disorder. Working in line with the Mental Health Act, including assuming Responsible Clinician role service users detained to Salford Royal.

Clinical Psychologist

The clinical psychologist will provide highly specialised psychological input to the MHLT across a range of psychology sub-specialisms and across the full-life span. Promote the flexible and responsive development of psychologically informed service delivery. Work in a supervisory and training role with staff, providing consultancy and liaison with other parts of secondary mental health services. Support the clinical supervision of band 6 Liaison Practitioners. Contribute to assessment and effective treatment of service users in the acute hospital setting, carers and service deliverers, and provide facilitation of clinical improvement. Work with service users who frequently attend Emergency Department with the aim of identifying unrecognised need, develop care plans and reduce hospital attendance.
The psychological resource within the team ensures;

- 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
- Psychologically informed case supervision

**Mental Health Practitioner**

The Mental Health Practitioners role includes completing assessment of mental health needs for people referred to the team. For people presenting with both functional and organic issues. Following the assessment, develop a joint care plan with the service users, and where possible, the carer and SRFT/ IMC staff. Support and advise SRFT/ IMC staff regarding the care, treatment and management of service users with mental health difficulties. This will also include participating in the Team training programme. Support and coordinate the assessment of people detained on Section 136 of the Mental Health Act 1983, and facilitate transfer as appropriate to and from the Section 136 Suite. Undertake the shift coordinator role.

**Administration**

The provision of administration support is essential to the success of the service and enabling the clinical staff to focus on patient care.

**Medical Secretary**

The medical secretary will support Consultant Psychiatrists and his/ her medical SHO/ SPR. This support will be provided via a comprehensive secretarial service, which anticipates the needs of the Consultants in the workplace and responds accordingly.

**Senior Administrator**

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

**Team Secretary**

Will facilitate high quality and timely recording of interventions and communication of outcomes provided back to the service user, GP and carers as appropriate. They will be vital to ensuring both smooth interface and communication between practitioners within the teams and across the providers.

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5.2 Accommodation

Salford Mental Health Liaison is primarily based within Salford Royal Hospital. The team also has an office base within the Meadowbrook Unit to support the leadership and administrative functions of the service.

The team have access to a purpose built interview room within the Emergency Department, which meets the standards set in PLAN section 4.4.

Consultant Psychiatrists have access to office facilities within both SRFT and Meadowbrook.

The team have a dedicated, purpose-built Section 136 Suite, which is adjoined to Meadowbrook Unit, where the inpatient mental health wards are situated. Additional mental health staff can be accessed via the Meadowbrook Response Team. All Mental Health Practitioners utilising the suite are allocated a personal pinpoint alarm that will alert the Meadowbrook Unit response team if needed.

6. Systems and Process

6.1 Referral Pathways

Emergency Department

- On arrival in the Emergency Department the triage nurse will contact the MHLT via SRFT Switchboard pager number 3411 and provide required details
- MHLT will attempt to see the patient within 1 hour of referral. Where it is not possible to complete the full assessment within 1 hour of referral, MHLT will make first contact with the service user within the hour in order to explain the waiting process and to complete a brief risk assessment.
- MHLT will attempt to transferred the service user to the designated assessment room or cubicle (where clinical judgement indicates) to await assessment.
- The team will discharged or transfer the service user within the 4-hour standard wherever possible.
- MHLT will endeavor on all occasions to obtain collateral information from family, carers, friends and other professionals in order to formulate a robust plan of care. Where this has not been possible, this will be recorded in clinical notes with a rationale.

Emergency Assessment Unit/Ambulatory Assessment Area

- AAA/EAU/AEC staff contact MHLT via SRFT Switchboard pager number 3411
- MHLT will treat all referrals as urgent and respond within a maximum of 6 hours unless specified by the referrer that a 24 hour response is required.

Salford Royal Hospital Wards

- Routine referrals should be made via “orders” in Sunrise EPR, and patients will be seen within 24 hours.
- Emergency ward referrals should be made via the pager 3411, and will be seen within 6 hours. Should an Emergency referral come through as an order, a telephone call should also accompany this in order to provide MHLT a detailed handover.
- Following assessment a decision will be made as to whether the patient will receive ongoing assessment or intervention from MHLS whilst an inpatient in SRFT.

Salford Royal Intermediate Care

- All referrals will be received via the EPR order system. Although more urgent matters can be discussed by phone.
- All referrals will be seen within 2 working days, excluding weekends and bank holidays.
- Following assessment, the Mental Health Practitioner will decide whether the service user will receive further assessment or intervention from the MHLT.
Blue Light Telephone Triage & Section 136

- Greater Manchester Police (GMP) will contact the MHLT telephone triage when they suspect a member of the public may be mentally disordered and may need to be assessed by a mental health professional. A record of this conversation will be documented by the practitioner taking the call, in either the Paris notes, if the service user is known, or on the specified pro forma for those not known. The aim of this contact to avoid unnecessary detention or conveyance to hospital.

Refer to Appendix 2 for all referral pathways

GMMH Inpatient Wards

When an individual who is currently an inpatient in one of GMMH's inpatient facilities is admitted to a ward at SRFT, the GMMH inpatient team should make a telephone referral to the MHLT. The MHLT will then liaise with the ward at SRFT to ensure the patient's mental health needs are being appropriately managed. Where a service user requires additional support on the medical ward in order to maintain their safety, the GMMH ward responsible for the service user will provide the staff required. The service user's mental health care needs will remain the responsibility of the mental health inpatient ward.

7. Services Offered

7.1 Psychosocial Assessment including Risk Assessment

All service users will be seen as soon as a meaningful conversation is possible with them. The MHLT do not need to wait for the patient to be deemed “medically fit”. Psychosocial Assessments will be carried out using agreed assessment tools, which include approved liaison service assessment documentation Mini ACE, ACE-III, HAD.

MHLT will use the format of the Structured Clinical Note (SCN) in order to document their clinical and risk assessment, formulation and management plans. On completion, a brief note will also be recorded on EPR with the SCN completed in Paris. The SCN will be available on request to clinical staff working in SRFT.

Appendix 14: Structured Clinical Note (SCN) Guidance

Service users may present as acutely agitated, making threats of harm to others, or may have known risk of harm to others. An existing risk assessment may also state that lone practitioners should not see them. In these cases, MHLS practitioners should refer to the High Risk Assessment Pathway.

Appendix 3 - High Risk Pathway

All new referrals to MHLT will have an SCN completed at the point of assessment with the service user. Service users who are identified as regular attenders in the Emergency Department, or have had a full assessment using the SCN within the last 7 days will not need another SCN completing unless there is a significant change in clinical presentation, however, a comprehensive, contemporaneous clinical note and GP letter must still be done in these cases. As a minimum, the clinical note should still contain the following:

- Presenting Complaint
- History of Presenting Complaint
- Mental State Examination
- Risk Assessment
- Impression
- Plan

If a service user is to be admitted to a psychiatric inpatient unit or HBT, MHLT will ensure that their SCN is readily accessible and will provide a comprehensive verbal handover to receiving staff. Detailing clinical reasons for admission/referral and admission plan.
Where needed, MHLT can book interpreters using SRFT Ward booking reference number via Language Line. Alternately, if an appropriate interpreter is not available within a timely manner to support assessment and discharge, the MHLT can use the GMMH service using the MHLT budget code.

For service users detained on Section 136 at Meadowbrook Unit, MHLT, will use Language Empire. Team members should familiarise themselves with the Trust policy on the use of interpreting services.

(GMMH Interpreter policy: http://intranet/integratedgovernance/policies/Lists/PoliciesList/Interpreters Policy.pdf)

Where the service user is already under the care of a Community Mental Health Services, MHLT will inform the appropriate team of the patient’s admission to the acute hospital as soon as possible. MHLT will endeavour to involve the community teams in discharge planning. On discharge, any involved services will be contacted by letter to inform of the assessment outcome, if necessary this can be by telephone in cases where urgent liaison is required.

A comprehensive risk assessment will be completed for all services users referred to the MHLT. Risk assessments will consider risk of harm to self, harm to others, vulnerability, serious self-neglect, adult and child safeguarding, and public protection issues. This will be evidenced within the SCN and the assessment process will be aligned to the GMMH Clinical Risk Policy, which can be found by following the link http://intranet/integratedgovernance/policies/Lists/PoliciesList/Clinical%20Risk%20Policy.pdf

The on-call psychiatrist based at Meadowbrook can be asked by the liaison team, to support in meeting the service demands. Although not exhaustive, these are common reasons why the on-call may be asked to attend:

- Liaison practitioner is seeking a second opinion
- Service user or carer is seeking a second opinion
- High demand on the service
- Advice on medication and prescribing
- Complex cases that would benefit from medical input
- A risk assessment indicates that 2 staff are required to undertake assessment and no other practitioners are available.

7.2 Intervention

Mental Health Liaison Service practitioners will offer a wide range interventions including:

- Nursing care
- Attendance of best interest meetings
- Capacity assessments
- Giving written information on diagnosis
- Investigations advice
- Medication advice/change
- Mental health act assessments
- Making new mental health diagnosis
- Nursing care advice
- Placement/planning advice
- Psychoeducation
- Specialist health needs assessments
- Informal education to non-mental health trained colleagues

NB. All members of the MHLT are required to undergo full training in the Prevention and Management of Violence and Aggression (PMVA) as part of their mandatory training. This means that there may be occasions where they are able to offer direct advice on the management of disturbed service users in SRFT, which may also include
the use of PMVA techniques. Any such interventions must only be carried out as a last resort, following careful consideration and consultation with senior members of the team and DATIX report will be submitted. No member of MHLT will undertake this intervention if they are not up to date with the relevant PMVA training.

There is a specific pathway to support practitioners who need to initiate a mental health act assessment.

**Appendix 4 – Mental Health Act Assessment Pathway**

### 7.3 Outcome/Discharge

At the point of discharge from Mental Health Liaison, service users will be offered a copy of their discharge letter.

All service users will be offered a copy of the Mental Health Liaison Patient Information Leaflet, containing the personalised agreed care plan, and information of how to access emergency help if needed.

All service users who are discharged back to their GP with no secondary care mental health follow up, should have a safety plan completed and receive a copy, unless this is clinically inappropriate e.g the person suffers with severe dementia and delirium. A copy of this should also be shared with the persons GP.

All service users being discharge from the ED will be offered a follow up telephone call from Samaritans, unless this is clinically inappropriate e.g the person suffers with severe dementia and delirium.

Service Users and, or carers will also be offered mental health information leaflets, including but not limited to:

- The Alzheimer’s Society fact sheets
- The Royal College of Psychiatry leaflets
- Information leaflets regarding local services e.g HBT, Salford Council
- Information regarding local and national voluntary services e.g., CAB, Samaritans

Service user and carer satisfaction questionnaires will be offered following assessment, when clinically appropriate.

The service user’s GP will receive a discharge letter summarising the assessment for all service users who are not admitted into a psychiatric inpatient bed. The agreed timeframe for completion of discharge letters are:

- Emergency village (ED/AEC/EAU) or high risk ward cases: within **24 hours** of discharge from Salford Royal Hospital.
- All other wards and cases: Within **10 Working days** of discharge from SRFT

The agreed GMMH DSDS letter format must be completed and recorded in the clinical record by the MHLT practitioner in cases where the service user is not being referred for follow up by mental health services. For those already under services or being referred to services, the GMMH DSCL format must be adopted.

For service users who are already under the care of Mental Health Services the relevant care coordinator, duty worker and Team Manager will be informed of the presentation and outcome of assessment. This should be via the GMMH non clinical e-mail system, to draw the recipients attention to the relevant PARIS note.

Where there is a difference of opinion between the referrer and the assessing practitioner, or there is a significant level of risk the assessing practitioner should endeavour to contact the referrer / other agency in order to agree and inform the most appropriate plan of care.

In the event that the MHLT are informed of a service user’s death and the service user is not known to other services, it will be the responsibility of the MHLT to ensure that the service user’s GP is informed, all relevant actions have been taken within Paris and a DATIX is completed.

**Primary Care Psychology**
Salford Mental Health Liaison Team can make direct referrals to Greater Manchester Mental Health Primary Care Psychology Service via the agreed referral process.

**Community Mental Health Team / Early Intervention Team / EDIT Team**

Salford Mental Health Liaison Practitioners can make direct referrals to Salford Community Mental Health Teams. For urgent or emergency referrals, the referrer should discuss the referral with the duty worker from the appropriate team. Referrals to the Early Intervention team should all be treated as urgent to support the teams RTT target and timely access to services for people with a suspected first episode psychosis.

### 7.4 16 & 17-year-old Service Users

- Service users aged 16 & 17 will be assessed by the Mental Health Liaison Team
- All 16 & 17-year-old service users who are assessed as requiring an inpatient psychiatric admission will be discussed with Local Child and Adolescent Mental Health Services Bed Manager based at the Junction 17 Unit in Prestwich.

**Appendix 6: 16 & 17 Year old Self-harm pathway**

- Service users aged 16 & 17 who have presented following self-harm and are not being referred for a psychiatric admission should be referred to EMERGE 16 & 17-year-old Child and Adolescent Service

**Appendix 7: CAMHS Pathway**

### 7.5 Intoxicated Service Users

There will be occasions when a service user is too intoxicated to engage in a meaningful assessment, these service users will be regularly reviewed by the Mental Health Practitioner. Although a breath sample may be taken as a guide to ascertaining level of intoxication, this will not replace clinical judgement when deciding whether to complete an assessment or not.

**Appendix 8 - Intoxicated Service Users pathway**

### 7.7 Assessment of Under 16 Year Olds

Persons aged under 16 years can be referred from the A & E department or PANDA UNIT to the liaison team for an assessment of their mental health needs. The response times to referrals are the same as all ED referrals.

All assessments for U16 year old young people will be recorded on Paris following the same process as for 16 year olds and over. Consent to share the clinical notes must be sought from the U16’s parents, carer, social worker or whoever is primarily involved in the child’s care. The person with parental responsibility should be consulted at all stages of the assessment where appropriate and they must be consulted regarding risk management and discharge plans.

Salford Child and Adolescent Mental Health Services (CAMHS) must be notified of the referral and assessment within 6 hours of the completion of the assessment by email with a copy of the GP letter attached to ensure CAMHS have the clinical information and plan to ensure appropriate follow up. Please note that CAMHS are currently a Monday – Friday 9-5 service. CAMHS will follow up all U16 year old young people seen by liaison in A & E. CAMHS will decide on appropriate follow up when they receive the notification and assessment from MHLs.

The All Age Senior Practitioner for Liaison will review all assessments of U16s and liaise with CAMHS following each assessment to ensure appropriate follow up has taken place.
### 7.8 Missing and Absconded Service Users

There will be occasions when a service user leaves the hospital prior to mental health assessment. In these circumstances, there will be a discussion between the Mental Health Practitioner and Salford Royal Staff to determine the most appropriate course of action to be taken.

### 7.9 Psychiatric Admissions and Referrals to Home Based Treatment

The decision for patients to be admitted to a psychiatric inpatient unit or referral to the Home-Based Treatment Team, can be made by any clinician in the liaison team. If the service user requires a mental health act assessment the mental health liaison practitioner should co-ordinate the assessment, see Appendix 4.

Where a patient requires Home-Based Treatment, a telephone referral should be made, and where possible follow up should be arranged and confirmed, before the patient is discharged. Where a patient requires a psychiatric admission, the the Home-Based Treatment team should be contacted for a gatekeeping assessment, who will then refer to the GMMH patient flow team if inpatient admission is required.

Where there is a difference of opinion regarding psychiatric admission, this can be escalated to senior staff within MHLT, HBT or Patient Flow for a review of the referral to identify an appropriate solution. If no resolution is found, the case should be discussed between MHLT, Inpatient or HBT consultants.

In the absence of these individuals, the case will be escalated to the operational or service manager.

Differences of opinion which occur outside of office hours should be escalated to the bronze on-call manager and the consultant on-call by MHLT.

Where psychiatric admission is being sought and there is no immediately accessible bed, there is guidance available to practitioners to ensure that service users remain safe and SRFT colleagues are appropriately supported.

### 7.10 Patients Awaiting In-Patient Admission

#### 7.10 12 Hour Wait in the Emergency Department

Within the Emergency Department a 12 hour wait for admission following the decision to admit being made is a “Never Event”. Where it appears that a service user may spend a protracted length of time waiting in the Emergency Department for psychiatric admission the 12-hour escalation protocol must be followed in a timely manner.

### Appendix 11: 12-hour escalation protocol

### 8. Training and Development

#### 8.1 Salford Mental Health Liaison Staff

Staff supervision in the Mental Health Liaison Service will follow the GMMH Trust Supervision Policy with regard to the structure, frequency and recording of both line management and clinical supervision.
The template used to record line-management supervision will follow the format agreed by Salford SLT. A spreadsheet is contained within the Liaison Team shared drive to record the dates of Clinical and Line Management Supervision.

Clinical Supervision of the mental health professionals working in the MHLT will be provided in a manner which takes account of the potential isolation of mental health professionals in a predominantly acute trust setting. This may be individual or peer supervision offered by the relevant professional group.

Within the team structure, the team manager will provided line management supervision to senior practitioners, and identified mental health practitioners. The senior practitioners will provide line management supervision for identified mental health practitioners. Administrative staff will be line managed by the Senior Administrator. This will include authorising leave, sickness monitoring and supporting individual development via the GMMH Appraisal Process.

MHLT will provide all new team members with an induction, based on the MHLT Operational Policy.

GMMH staff training and development will follow the Individual Performance & Development Review (IPDR) process. Staff are able to find out more about this process through ‘My Learning Hub’, located on the GMMH Desktop. This will ensure a consistent approach to each individual having an annual appraisal, and will ensure that each person has clear responsibilities, documented through standard processes. Each team member will have an annual appraisal, which is directly linked to incremental pay progression.

Training will be provided to the mental health professionals working in the MHLT. The training will be based on the Mental Health Liaison CPD Framework. This will include but is not limited to:

- The needs of acute hospital service
- The needs of people who are physically unwell
- The needs of young people
- The needs of older adults
- The needs of people with learning disabilities
- Working with dual diagnosis
- Physical disabilities.

8.2 Training Provided to Salford Royal Hospital Staff

The effectiveness of the MHLT is greatly enhanced through the delivery of formal training and informal advice to SRFT clinical teams. The MHLT is intended to improve understanding and joint working, in both directions between those charged with meeting physical and mental health needs of service-users. Mental Health Professionals in the MHLT will work closely with Emergency Department colleagues to share their expertise on a daily basis and vice versa.

The MHLT will facilitate input to Emergency Department management meetings and specific clinical meetings within the SRFT general acute wards. The team will be expected to contribute to the joint development of patient pathways, protocols and developments of service within the general hospital and Emergency Department, i.e. offering input into the Dementia Strategy.

The Consultant Psychiatrist will work closely with senior medical colleagues to deliver training via established medical and nursing training programmes/ forums to provide a knowledge base for all grades of clinical staff in the:

- Assessment of severe mental disorder
- Appropriate use of pharmacological interventions
- Prevalence of mental disorder within hospital environments, appropriate management strategies and routes of referral.
- Risk assessment of people in high risk situations i.e. self-harm, suicidal intent

The MHLT members will deliver a rolling programme of training to the wider pool of SRFT staff to raise the profile and understanding of the need to:
• Recognise common mental disorders
• Reduce stigmatisation and enhance respect and dignity
• Promote understanding of helpful strategies in interaction with individual users of the service
• Provide SRFT clinical staff with the required knowledge base and competencies to manage mental health service users at the expected level for their services (one example being self-harm and the requirements stated in the Royal College of Psychiatrists Report 2004 “Assessments following Self-Harm in Adults”).

9. Standards for Service Delivery

9.1 Leadership

On each shift, there will be an allocated “shift co-ordinator” who will ensure that the most appropriate practitioner 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. The allocated shift co-ordinator will be identified on the duty rota.

There will be one practitioner allocated per week to dedicate time to the wards and one practitioner allocated per week on a Mon-Fri 9am-5pm basis to work within IMC. Known as the “Ward Practitioner”

The Consultant Psychiatrist will respond appropriately to demand across the whole of SRFT Services, governed by levels of urgency and which specific assessments require their specialist expertise.

The Senior Practitioners will response to requests from the shift co-ordinator to support resource allocation during periods of peak demand. The Senior Practitioners will respond to demand both within the ED and acute inpatient wards.

Appendix 15 – Role of Shift Co-ordinator

9.2 Capacity

Service demand will be variable but MHLT will endeavour to maintain the capacity and capability in order to meet the standard to undertake assessments from all wards and departments at SRFT within the timeframes previously detailed.

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

If MHLT are not able to meet demands, this would further be escalated to senior management both at SRFT and GMMH.

9.3 Lone Working

As indicated in the GMMH Lone Worker policy, there will be times when members of the MHLT will be classed as “Lone Workers”. MHLT will follow the MHLT Lone Working guidance, compiled in accordance with the GMMH Lone Worker policy.

See Appendix 12: MHLT Lone Working guidance

9.4 Record Keeping

MHLT practitioners have responsibility to keep up to date records using 10 Golden Rules of Record Keeping whilst documenting on GMMH Paris system. They will also have access to EPR, and NHS Spine Portal. All practitioners will maintain professional and GMMH policy standards pertaining to record keeping at all times.

Appendix 13: GP Letter Procedure
9.5 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. The MHLS is able to recommend appropriate prescribing for service users referred to the team. Prescribing of these medicines is the responsibility of SRFT for service users receiving care in the ED, IMC or on acute wards. Prescribing recommendations within the service is 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 consistently guided by GMMH Medicines Management and NMP policies, as well as individual professionally defined standards.

The use of honorary contracts for MHLS practitioners from Salford Royal Hospital (SRH) also supports prescribing practice within the general hospital setting for service users who remain under the care of SRH but are also receiving care from MHLS.

9.6 Service User Involvement

All service users 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 service users 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.

Service users and their carers will be encouraged to participate in Service User Satisfaction Questionnaires

Appendix 16: Service User Questionnaire

10. Reference Documents


Department of Health (2014) Mental Health Crisis Care Concordat- Improving outcomes for people experiencing mental health crisis


http://www.rcpsych.ac.uk/publications/collegereports/cr/cr118.aspx


Swift G, Guthrie E (2003) 'Liaison Psychiatry Continues to Expand: Developing Services in the British Isles'
11. Supporting Documents

Policy on Information Governance
As per Trust Intranet

Safety procedures for staff (e.g. what to do if a staff member fails to return from a visit) lone working policy
Guidance taken from GMMH Lone Worker Policy.

Section 136 Policy
As per Local Policy

Mentally Disordered Offenders Policy
As per Trust Policy

Young Person’s pathway
As per Local Authority Policy

GMMH Clinical Risk Policy

Human Resource Contacts

The following corporate lead roles exist within the organisation and can be contacted via Trust switchboard:

- Adult safeguarding
- Child safeguarding
- Health and Safety
- Fire
- Infection prevention
- Physical healthcare
- Information governance

There are local directorate leads, the Team Manager will keep an up to date list of leads.
Appendix 1: Mentally Disordered Patient Pathways

Pathway for Patients Under Police Arrest at SRFT

Patient in Police custody under arrest (Not Section 136)

Patient receiving treatment in SRFT wards with ongoing admission

Concerns raised for mental health of patient

Referral to Liaison Team for Risk Assessment, Assessment of Mental illness and treatment

Information to be shared by GMP & assessing practitioner

Information not shared

Information shared

Unable to complete assessment

Transfer to Cells once medically well for discharge

Patient in A&E, AEC or Assessment Wards. Brought by GP for medical treatment

To receive treatment and return to Cells. Not for referral to Liaison

Patient De-arrested by GMP

Assessment in Police Station via FME Pathway

GMP to leave prior to assessment taking place by Liaison Team

Please Note:
Patients under arrest by GMP are unable to be admitted to Meadowbrook Unit

Appendix 2: Referral and Assessment Pathways

MHLT Referrals

Referrals
1. **Check details on Referral**
   ED Referral – Shift Coordinator to take the details and pass to Admin in hours for Paris input
   Ward and IMC referrals – Admin will input in Paris in hours
   Out of hours Practitioner taking referral will input the referral into Paris. Admin will complete data when next available
   Emergency and urgent referrals to be recorded in the Urgent Referrals Book by shift coordinator in hours. Out of hours by practitioner taking the referral for ALL REFERRALS
   1. Name, DOB, GP details, Address and Next of Kin against NHS Spine.
   2. If details are not matching amend the referral to what is on spine.
   3. If correct place a tick on referral (to indicate this has been searched on Spine)

2. **Search on PARIS & Adding a new person**
   1. Go to Central Index tile
   2. Search just using **NHS number** if no matches search using just **Name** and then **Date of Birth**. If no matches found after 3 **searches**, then ‘add a new person option should appear’
   3. Add person onto Paris,
      - The minimum amount of data required for an ED referral is - Personal details – Name, DOB,
      - when available NHS number
      - For ward referrals the following additional information will be available Address, Gender, Country, GP details, Phone details, CCG

   **ADD - ZZ99 3VZ for No Fixed Abode**
   **Code G9999981 for No GP**
   **No NHS Number – one should be requested via IM&T Helpdesk on the smiley face**

   **THIS WILL PRODUCE A PARIS ID – For ward referrals write this on the Referral form**
   - Additional details – Ethnicity & Religion (on referral)
   - Associated people – Add Next of Kin details (will need to search 3 times on PARIS for person)
   - Identifiers – Add **NHS Number**

3. **Adding A New Referral**
   In Hours Admin will complete the following steps. Out of hours the practitioner taking the referral will do this.
   1. Go to referrals tile – Log new referral.
   2. Type of Referral – Community Mental Health
   3. Add Date and Time
   4. Source –
   5. Priority – Referral Book
      - 1 Hour – ED/Section 136
      - 6 Hours – Urgent ward
      - 24 Hours – Routine - Wards
Salford Mental Health Liaison Service
Operational Policy Version 6.1

- EAU & AEC (24HR) – Routine
- IMC – 48 Hours (excluding Bank Holidays and weekends)

Admin to alert shift coordinator of any urgent referrals not bleeped

Admin to scan the paper referrals into Paris

4. Add Referrals to Whiteboard
   1. Add Name, Date of Birth, Ward, Date & Time, Breach Date & Time and Reason for Referral on to the Referral whiteboard.

   A&E Breach time – 1 hour
   Ward Breach time – 24 hours
   Ward Urgent – 6 hours
   IMC – 48 hours

   2. Place red magnet next to name.

Re-Referrals

1. Re-referrals can be taken verbally or as a print off
2. Check - Is there an ongoing referral already open for MHLS
   Check the Referrals tile on Paris.
   Check the White Boards at the front of the office.
3. Write Re-referral on the paper referral
4. Inbox on Paris & Outlook the practitioner who has assessed this patient
   ** If this person is on annual leave inform Shift Co-ordinator **
5. Place details on the white board
6. Place in the Referrals tray

IMC Referrals

All Service users open to Liaison on transfer to IMC units (or transferred from IMC to SRFT) do not require a separate referral as they remain open to the service.

IMC referrals come through on the fax machine and printer from
Heartly Green
Barton Brook
The Limes
Currently working with IMC and SRFT regarding consistent referral pathway – To be confirmed

**Same procedure on PARIS for Steps 1 and 2**

**Step 3 –**
1. Source – Other
2. Referrer details – The Limes, Heartly Green, Barton Brook).

**Add Referral to IMC Whiteboard, IMC Green folder (pending changes to The Limes using faxes) and Electronic Boardround**

1. Add Name, Date of Birth, IMC, Date & Time, *Breach Date & Time*.
2. Add referral to green folder.
3. Place Referral in the green folder
   - Breach time – IMC referral – 48 Hours.
   - **NOTE** For Referrals sent on a Friday – do not include the weekends
Intermediate Care Referral Pathway

1. IMC identifies mental health issue
2. Referral completed via EPR order system
3. All referrals seen within 48 working hrs
4. Clinical discussion/ prioritisation by IMC Practitioner allocation of appointment for assessment
5. Practitioner to complete assessment/management plan
   - Ongoing advice/assessment from MHLS
   - Discharge to Primary care. EG Primary Care Mental Health/GP
     - Referral for secondary care MH Service e.g. MATS, Mental Health Inpatients
     - Discharge with referral to 3rd Sector Provider e.g. Age UK
Blue Light Triage

Practitioner receives call from Blue Light service via Triage Phone (07824625367)

Electronic proforma is completed for all calls

If the patient is known, this form can be done through Paris so it is attached to the patient's records

In all cases, a copy of the proforma will need to be printed out and placed in the appropriate section of the triage file

Complete the form in the triage file documenting details of the call including the length of time spent

If the patient is not known on Paris, the proforma template will still need to be completed

A copy of the proforma will also need to be e-mailed to the other party.
MHLS Referral Standards

Personal information - Name, patient identifier/DOB
Reason for referral - details of concerns expressed by patient and/or carer
Details of concerns observed by staff - to include behaviours, observations, concerns about risk to self and/or others
Safeguarding concerns - any BIM, planning meeting or discharge planning etc.

Ward Referrals

**6hr/Urgent referrals** - MUST be accompanied by a phone call to discuss risk issues. If no phone call is made the referral will be treated as 24hr. A Clear clinical rationale for the urgency must be identified and agreed with the Liaison practitioner during the verbal discussion.

**NB** Impending discharge later the same day as the referral is made is NOT an appropriate clinical rationale for a six hr referral. MHLT will endeavour to respond the same day to referrals for patients who are due to be discharged, however priority will be given to patients with urgent clinical need. It is SRFT’s responsibility to refer at the earliest opportunity to allow time for MHLT to respond.

**24hr/Routine referrals** - must be made with sufficient time to allow response prior to patient discharge.

**Emergency Village**
**A&E** - All referrals to be made via the bleep system.

**EAU** - Urgent referrals to be made via the Bleep system
Non-urgent referrals requiring 24 hr response to be made via EPR e.g. for Older Adults in the COPE bays
Appendix 3: High Risk

High Risk Assessments

High Risk assessment identified by:
- Alert on Paris
- On SRFT special register
- Concerns raised by triage/MHLS/other informant due to:
  - Known history of violence/aggression towards others
  - Current symptoms/behaviour

Shift Coordinator to review information available on patient and decide if this is a two-person assessment

Alert Security staff on 0161 206 4436 with patient details and information on location of the assessment

Patient to be assessed in suitable location (room 35/EAU Assessment room or at bedside on wards)

Shift Coordinator to alert nurse in charge or Unit Coordinator of location that Service user is currently in

Patient to be assessed with one or two MHLS Practitioners

Assessing Practitioners to liaise with Unit Coordinator or nurse in charge as indicated on completion of assessment
Appendix 4: Mental Health Act Assessment pathway

**Office hours**

Practitioner identifies needs for Mental Health Act Assessment

Case to be discussed with MHLS Consultant Psychiatrist / Senior Practitioner

Make a referral to AMHP Administrator at Cromwell House on 0161 357 1280

Notify MHLS Shift Coordinator

Identify available MHLS Section 12 Psychiatrist

Liaise with AMHP regarding estimated time for assessment

Notify SRFT Department / Ward

**Out of hours**

Case to be discussed with On Call Psych / SPR on call / Emergency Duty AMHP

Make a referral to Emergency Duty Team on 0161 794 8888

Notify Colleagues within MHLS

Liaise with AMHP regarding estimated time for assessment

Notify SRFT Department / Ward

MH Act Assessment

Detained to SRFT

1. Section papers to be given to the nurse in charge on the ward, a copy to be brought to the liaison office and stored in the MHA paper’s file.
2. MHLS to devise care plan for SRFT
3. If detention is out of hours, MHLS Section 12 Psych to be notified the next working day

To be admitted to Mental Health bed

Bed Available

Section papers to remain on ward with nurse in charge

Transport to be arranged by bed bureau

Section papers to be transported with the patient

No Bed Available

Section papers to be kept in MHLS office in MHA paper’s file

MHLS to:
1. Devise Care Plan for SRFT
2. Contact Bed Bureau daily
3. Review patient daily
4. Escalate to MHLS Senior Manager daily
5. Complete datix

**Independent Mental Health/Mental Capacity Advocates**
- GMMH Customer Care: 0800 587 4793
- Citizens Advice Bureau (CAB) and Advocacy: 0161 772 3507 (Fax 3508)
- MIND in Salford Telephone: 0161 839 3030
- Email: info@mindinsalford.org.uk
- PALS (Patient Advice and Liaison Service) Telephone: 0161 206 2003
Salford Mental Health Liaison Service

16 & 17 year olds with self-harm concerns

**Assessment**

- Triage / Assessment in ED
  - Physical Observations Completed

**Intervention**

- Consideration of admission to SRFT AEC to ensure completion of sensitive detection of difficulties and high quality mental health assessment and planning

- Assessment by Liaison Team
  - Include collection of information from GP, family, education establishments, CAMHS

- Provide Written Information
  - Royal College of Psychiatrists information leaflets
  - PAPYRUS, The Samaritans etc

**Outcomes**

- Admission to CAMHS in-patient unit
- Refer to Home Based Treatment Service
- Refer to EMERGE

**ALL 16-18 year old patient who present with self-harm concerns should be referred to EMERGE if they are not admitted to In-patient Unit or HBT**
Appendix 6: CAMHS Pathway

Under 16 Assessment Flowchart

Under 16 referral received from PANDA unit
Liaison practitioner takes details

In hours (Mon – Fri 9 - 5) contact CAMHS duty (0161 211 7260).
Check if known and obtain any relevant details
Contact the Bridge to check SG status

Out of hours.
Check PARIS notes
If no practitioners are CAMHS trained please contact the OOH CAMHS CT and ST at Bolton switch: 01204 390390
Adult on call SHO should not be used for under 16’s.

Complete assessment
For extra discussion / support please contact
Out of hours – Can contact GM on call to discuss plan 01204 390390 Bolton switch ask for ST or CT Child Psychiatry.
In hours – Band 7 and/or CAMHS duty

Young person requires assessment for admission to a mental health bed
Informal
MHA Assessment contact AMHP & ST
Contact gatekeeper at Junction 17 (0161 358 1524)
Complete Tier 4 referral from.
(Once assessment completed confirm DTA and follow escalation for 12 hour wait)
Inform CAMHS
Phone in hours/email out of hours
Email copy of GP letter to update mft.salford-camhs@nhs.net
Checked 9-5
Handover to ....

Young person requires admission to a paediatric medical bed for medical treatment or safeguarding
Inform CAMHS/Liaison
Phone in hours/email out of hours

PANDA find bed

Complete notes on PARIS & EPR

Young person does not require assessment for admission

In hours contact CAMHS for appointment as clinically needed.
(Can be the next day)
Email copy of GP letter to mft.salford-camhs@nhs.net
Band 7 to follow up.

Out of hours email copy of GP letter to mft.salford-camhs@nhs.net
Band 7 to follow up.
Appendix 7: Intoxicated Patient Pathway

Intoxicated Patient Pathway

Referral received from Triage via Pager 3411

Physical observations completed by Triage

First Contact: Initial Risk Assessment
Can patient participate in a meaningful assessment and is the patient alert, not overtly cognitively impaired from alcohol

Yes

No

Assessment
- Full biopsychosocial assessment
- Risk Assessment

Service user waits in Emergency Village
Management plan agreed with SRFT
MHLS Review Service user every 2 hours minimum

If service user does not wait for assessment
phone service user to check on wellbeing &
discuss follow-up needs

Complete full assessment when patient able to participate fully

Outcome
- Inform GP
- Admit
- Referral to substance misuse service via Pathway
- Inform / Refer to CMHT

Outcome
- Inform GP
- Contact Bed Bureau if admission required
- Referral to Substance misuse service via Pathway

Document in Paris i.e.
Referral In, Outcome
Document, Structured
Clinical Note and GP Letter
Appendix 8: Missing and Absconded

Below is an embedded copy of SRFT policy at the time of writing, please ensure you have access to the most up to date policy.

[Missing and Absconded.docx]
Appendix 9: Patients Awaiting Inpatient Admission

Guidance for Mental Health Liaison Practitioners in the Joint Management of Service User, presenting in the Acute Trust who require a Mental Health Admission

The Mental Health Liaison Practitioner to:

- Identify if the service user is deemed medically fit for transfer to an inpatient Mental Health bed or continues to receive medical intervention.
- Identify timescales for completion of medical treatment and possible transfer to Mental Health bed.
- Refer to the local bed manager for the allocation of a mental health bed.
- If the service user is deemed medically fit for transfer and there is no Mental Health bed available, update the shift coordinator, service user and family if present and/or involved in care and follow escalation flow chart for patient awaiting a bed.
- If the service user is in the Emergency Department (ED) review the situation with the Nurse in Charge (NIC) of the ED Department about the appropriateness to move the service user to AEC/EAU, Acute Ward. Follow escalation policy.
- Jointly review with the Ward/ED department NIC if the service user requires observations and determine the level of observations, whilst considering the environment, risk of absconding, risk to self and others.
- Establish if the service user requires a review by the MHLS psychiatrist or the on call CT psychiatrist. If so arrange this and agree at what frequency this should occur.
- Establish if the service user requires PRN medication and if assessing practitioner is non-medical prescriber jointly agree prescribing responsibilities.
- Inform the staff nurse and NIC of the ward/ED about symptoms, needs, risk assessment and management plan.
- Both services agree time scales for review and update service user and family re plans.
- Document assessment, management plan and observations level clearly and concisely on the identified recording systems for the Acute Trust and GMMH.
- Where possible jointly agree a lead nurse contact for the Acute Ward/ED department to be the main point of contact to facilitate co-ordinated communication.
- Verbally hand over to the Mental Health Liaison shift coordinator, Acute Trust Ward coordinator or ED coordinator at regular intervals.
- Continue to liaise with the Bed Bureau in relation to bed identification and follow ‘process guidance for Acute Trust Ward and GMMH Bed Management escalation process’ if delays are past 4hrs from decision to admit and the service user remain in ED, Use ‘12 hr escalation procedure’.
- The Mental Health Liaison Team will continue to review situation until an inpatient bed can be located at a frequency informed by needs of the service user and as a minimum, a review should take place daily.

Below is an embedded copy of SRFT policy at the time of writing, please ensure you have access to the most up to date policy.

SRFT Escalation Process – Acute Trust
Appendix 10: 12-hour breach escalation

Salford 12 Hour Wait Escalation Protocol

**In Hours**

MHLT Shift Co-ordinator to escalate to Operational Manager for Urgent Care. **Action Required**
Liaison with bed manager. Review all options: Use of leave bed, bed state review for discharge, check heads on pillows, ask bed manager to look on wards. Ensure appropriate management plan for patient waiting.

4 Hours

MHLT Shift Co-ordinator further escalation to MHLT Team Manager or Operational Manager for Urgent Care. **Action Required**
Liaison with bed manager. Continue to review all options. Operational Manager to liaise with SBFT Senior Manager – continue liaison as required. Ensure appropriate management plan for patient waiting.

6 Hours

Team Manager or Operational Manager escalates to Service Manager or Head of Operations.
Service Manager or HOPs to review all options and consider discussion/escalation to Head of Operations to resolve potential breach. Ensure appropriate management plan for patient waiting.

8 Hours

MHLT must escalate again detailing the current situation/plan. Escalate every hour until patient is safely admitted.

**Out of Hours**

MHLT Shift Co-ordinator to escalate to Bronze on Call **Action Required**
Liaison with bed manager. Review all options: Use of leave beds, bed state review for discharge, check heads on pillows, ask bed manager to look on wards and review with on-call Dr. Ensure appropriate management plan for patient waiting.

MHLT must liaise with SBFT continuously to ensure there is a management plan for the patient waiting.

MHLT Shift Co-ordinator further escalation to BOC **Action Required**
- Liaison with bed manager
- Review all options
- Liaise with SBFT Senior Manager on Call - Continue to liaise as required
Ensure appropriate management plan for patient waiting.

BOC escalates to SOC.
SOC to review all options and consider discussion/escalation to GO to resolve potential breach.
Ensure appropriate management plan for patient waiting.
Appendix 11: Lone Working Guidance

MHLT Lone Working Guidance

Purpose

As indicated in the GMMH Lone Working policy, there will be times whereby MHLT staff are defined as ‘Lone Workers’. This guidance has been produced in accordance with GMMH Trust policy in order to advise staff on how to lone work effectively, ensuring their own health and safety and the health and safety of others.

Definition of “Lone Worker”

The definition of a Lone Worker is defined by GHHM and The Health & Safety Executive as:

- “Any situation or location in which someone works without a colleague nearby or when someone is working out of sight or earshot of another colleague”
- “Those who work by themselves without close or direct supervision”

This may apply to, but is not limited to, the following:

- Members of the MHLT travelling across the Trust footprint for the purpose of attending meetings e.g. Professional’s Meetings, Operational Meetings, Training Events
- Members of the MHLT visiting Service User’s homes
- Members of the MHLT travelling to and between Intermediate Care settings across Salford
- Members of the MHLT seeing Service Users at other Trust Approved premises or non-Approved premises e.g. GP Surgeries
- Members of the MHLT nursing a patient in the Section 136 Suite

This guidance should apply to all members of the MHLT, to include any practitioners, medics, psychologists and administrators participating in the above activities

Emergency Contact Details

A file containing up to date contact information for all members of MHLT is to be kept in the office at all times, in a readily available location should this information be required in case of emergency. It is the responsibility of individuals to ensure they alert the team’s Senior Administrator if this information
changes, in a timely manner, so that it can be updated accordingly. This file should contain, as a minimum:

- Member of staff’s name, address and primary contact number
- Vehicle make, colour and registration plate
- Contact details for NOK or Emergency Contact

When staff are lone working, it is their responsibility to ensure that they have on their person a mobile phone that is charged, so they are contactable and can contact others at all times. Should staff not wish to use their personal phones, a team phone is available for use. If this is taken, it is the responsibility of that member of staff to ensure that it is returned and charged ready for use by the next person.

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**Lone Working Outside of SRFT/MBU**

This section of guidance applies to anyone lone working away from the usual site of operation e.g. Salford Royal Hospital/Meadowbrook Unit

- When working away from the usual work base, it is the responsibility of the individual to ensure that they have communicated their intended whereabouts to the designated shift co-ordinator for that shift, along with an estimation of the time they are expecting to take.

- The location of the intended visit, Paris ID of associated patient (if relevant) and time of departure should be documented on the whiteboard located immediately to the right of the main office door, so that details of visit can be quickly accessed if required.

- If more than one location is being visited, details of all locations should be provided as above.

- Upon returning to the office, it is the individual’s responsibility to remove the details from the whiteboard and inform the shift co-ordinator that they have returned.

- When attending a planned home visit at a service user’s home or any other location away from usual work base, it is the responsibility of the member of staff to call in before and after the visit to inform the shift coordinator that they have arrived/left safely.

- If a member of staff is planning on going home from a visit without returning to base, it is their responsibility to ensure that the shift coordinator is made aware of this and that all the above details have been handed over before the member of staff leaves the location.

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NB. Prior to any visits with service users away from usual work base taking place, a thorough risk assessment should be undertaken by the member of MHLT and discussed with line-manager/senior practitioner in order to identify whether it is appropriate and safe to visit alone. If not, consideration **must** be given to visiting in pairs or meeting at a more appropriate location.
It is accepted that there will be occasions whereby members of the MHLT will be classed as “lone working”, despite being in their usual place of work. This may include, but not be limited to, the following:

- Completing assessments with service users in A&E or on the wards in a private area, not readily accessible to other members of staff
- Completing assessments with service users in A&E or on the wards when it is particularly quiet and there are fewer staff around than usual
- Being out of the office for a prolonged period of time e.g. visiting more than one ward or patient

In these instances, the following guidance should be adhered to:

- It is the responsibility of the individual member of staff to ensure the shift coordinator is aware of where they are intending to go and write this on the white board immediately to the right of the office door, along with the time of leaving the office. This can then be removed upon the member of staff returning to the office
- For all new referrals picked up within the hospital, the name of the practitioner intending to see them should be written next to the patient’s name on the referral boards
- It may be useful for members of the team to carry a mobile phone with them around the hospital, however, as a minimum, the ward locations should be identified to the shift coordinator prior to the member of staff leaving the office so that they can be contacted in the event of an emergency
- When seeing service users on the wards/in A&E, it is good practice to inform the nurse coordinator/ward sister that you are from the MHLT and intend to see the service user to complete an assessment. This is particular pertinent when seeing service users in private rooms

If the shift coordinator is not available to hand information over to, a designated member of the team must be identified to take the responsibility for overseeing the lone worker’s activity.

**NB.** Prior to any service users being seen alone in any part of the hospital, a risk assessment must be completed to check the appropriateness of this or to identify whether additional precautions e.g. a buddy, security, alarm are required

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**Safe Phrase**

In the event that a lone worker may be experiencing difficulties and/or are feeling threatened, they should contact the MHLT office and repeat the following phrase:
“Please can you let Mr Cryer know that I am running late for our appointment as I have been held up at (service user’s name/address/establishment/ward)”

All MHLT staff should be familiar with this phrase and have an awareness that they should raise an alert should they receive this phone call. If this phone call is received, it should be assumed that the member of staff is in trouble and the following actioned:

- If the member of staff is calling from a location somewhere within SRFT, hospital security should be contacted and an urgent request should be made for them to attend the ward the member of staff is known to be on

- If the member of staff is working away from the usual site of operation e.g. SRFT/Meadowbrook unit and this call is received, the police should be contacted and an urgent concern for welfare request should be made

**Cause for Concern**

There may be cause for concern should the following occur:

- The member of staff does not call in to inform shift coordinator of their safe arrival/departure from a visit
- The member of staff does not return back to the office at the approximated time they were due back
- The member of staff cannot be located on the ward(s) they were expected to visit
- A telephone call has been received from the member of staff using the Safe Phrase NB. In this instance, the ‘Safe Phrase’ guidance should be followed

In the event of any of the above or anything else that gives cause for concern, the following guidance should be adhered to:

- In the first instance, the shift coordinator should attempt to make contact with the member of staff by calling their mobile phone
- If unsuccessful, the shift coordinator should attempt to make contact with the service user/establishment of where member of staff was visiting (where appropriate). If more than one location, the route of the individual should be tracked
- If both of the above are unsuccessful, the shift coordinator should contact the staff member’s NOK or Emergency Contact
- If none of the above are successful, the shift coordinator should discuss with Senior Practitioner or Team Manager and a decision should be made as to whether the police are contacted
Supporting Documents and References

Lone Worker Policy (GMMH)
Preventing and Managing Violence and Aggression Policy (GMMH)
Mobile Telephone Policy (GMMH)
Health & Safety Policy (GMMH)
NHS Protect guidance for lone workers
Appendix 12: GP Procedure


WARD REFERRALS

Boardround Admin
1. Board Round highlights that patient has been discharged.

2. Admin to add decision to discharge in PARIS following the Board round using the formula below following:
   - Select the progress notes tile
   - Select create new case note
   - Select Community Note (Not a contact)
   - In the Reason box, select Administrative
   - Enter boardround Discharge Note (Discharge destination and date) as stated by Practitioner
   - Go down to the Progress Notes Reason and Select Summary
   - Admin to add ‘Decision to Discharge’ in PARIS for DSDS ONLY using the formula below following:
     - Select the progress notes tile
     - Select the Progress Note (date) that relates to that letter
     - Go down to the Interventions and insert a row
     - Intervention box: Decision to Discharge (DTD is the code if you prefer to use this) and double click
     - Duration (minutes): 60
     - Staff: Your name
     - Click Save at the bottom

3. PARIS inbox (Notify) practitioner/medic

Practitioner/Medic
1. Complete and authorise Liaison Outcome document (Please ensure one has not already been open)

2. LETTER – (Must be sent within 10 day period from Decision to Discharge.)
   - DSDS
     Produce a letter type of “GMW – DSDS to GP” from the referral closure tile by selecting your referral from the left hand side and then selecting “produce letter”
   - DSCL
     To produce a DSCL follow the old procedure of opening the DSCL template from the letter tile
       Add name into GP letter list in office.

Admin (Ward Letter)
1. Print off letter –
2. Create fax header (If urgent)
3. Send letter must be marked ‘Sent’ and have a ‘Printed’ date within the 10 day period from decision to discharge
4. Review Liaison Outcome document for accuracy and completion. Authorise the document if you can or email practitioner if incomplete

   ONLY after LTOD and decision to discharge is completed the referral can be closed.

All Referrals must be closed:
DSDS –
OUTCOME: DISCHARGE TO PRIMARY CARE (GP)
REASON: ASSESSMENT COMPLETED

DSCL –
OUTCOME: TRANSFERRED TO OTHER GMW SRV
REASON: ASSESSMENT COMPLETED

EMERGENCY VILLAGE REFERRALS

Practitioners

1. Complete outcome document, do not authorise
2. Practitioner to generate Letter In PARIS
   - DSCL
     Produce a letter type of “GMW – DSDS to GP” from the referral closure tile by selecting your referral from the left hand side and then selecting “produce letter”
   - DSCL
     To produce a DSCL follow the old procedure of opening the DSCL template from the letter tile
3. Add name into GP letter list in office.

Admin (A&E Letter)

1. Pick up name from GP letter list.
2. Check for spelling mistakes and formatting.
3. Print off letter
4. Create fax header
5. Send letter must be marked ‘Sent’ and have a ‘Printed’ date within the 24 hour period from decision to discharge
6. Admin to add ‘Decision to Discharge’ in PARIS for DSDS ONLY using the formula below following;
   - Select the progress notes tile
   - Select the Progress Note (date) that relates to that letter
   - Go down to the Interventions and insert a row
   - Intervention box: Decision to Discharge (DTD is the code if you prefer to use this) and double click
   - Duration (minutes): 60
   - Staff: Your name
   - Click Save at the bottom
7. Review Liaison Outcome document for accuracy and completion. Authorise the document if you can or email practitioner if incomplete
8. ONLY after LTOD and decision to discharge is completed the referral can be closed.

All Referrals must be closed:

DSDS –
OUTCOME: DISCHARGE TO PRIMARY CARE (GP)
REASON: ASSESSMENT COMPLETED

DSCL –

OUTCOME: TRANSFERRED TO OTHER GMW SRV

REASON: ASSESSMENT COMPLETED
### Mental Health Liaison Structured Clinical Note

#### Presenting complaint/reason for referral

#### History of presenting complaint

#### Collateral Information
Gain consent to contact family/significant others/services involved
Discuss previous personality, any changes, support network and ability to continue current level, carer stress
If family/significant other was not contacted, please detail why

#### Psychiatric history
Currently under secondary care? If yes, whom, most recent diagnosis, recent changes to treatment/management
Previous contact with secondary service, i.e. inpatient admission, dates, diagnosis, reason for admission, dx plans.
Previously under HBT, dates, diagnosis and reason for referral and dx arrangements.
If not under MH services, has this person had contact with primary care i.e. GP. Are they on any mental health medication, if so when were they started, when were doses changed.
Any contact with psychology?
Any contact with drug or alcohol services?

#### Physical Health/Medical history
Current/previous illnesses/chronic conditions
Current medications: drug, dose, frequency, concordance
Any allergies/sensitivities

#### Social History
Current living arrangements
Support networks
Package of care
ADLs

#### Personal History (for patients not known to services) including:
Born/Raised, developmental milestones, family history, sexual orientation, relationships (both supportive relationships and abusive), marital status, education, employment
Family history of mental illness
GMMH policy to ask “Have you experienced physical, sexual or emotional abuse, including domestic abuse at any time in your life or currently”. Document if this question has been asked, and if so the answer. If not asked there should be a rational why it has not been asked.

**Addiction**
Drugs/Alcohol
Gambling
Current use
Past use
Explore readiness for change
Impact on current presentation

**Current presentation (Mental State Examination):**
Appearance and Behaviour
Description, reaction to interview, motor activity
Speech - Speed, quality, continuity
Mood
Thought content
Discuss any negative cognitions i.e. thoughts of worthlessness, guilt, hopelessness, nihilism
Discuss any other relevant symptoms i.e. sleep disturbance, changes to appetite, anxiety, stomatising
Evidence of any paranoia, persecutory ideas, abnormal beliefs, thought disorder
Perception - delusions, hallucinations, depersonalization.
Cognitive Function - report any formal testing done (MMSE, ACE-R with breakdown of scores)
Insight - do they recognise that they have a mental health problem? Are they willing to start/continue with treatment or care? Are they able to identify that unusual mental/psychological events (e.g. delusions and hallucinations) are illness related?

**Risk Assessment**

**Risk to self**
History
Current thoughts, hopelessness, protective factors, future plans, predisposing factors - age, recent separation, isolation, recent discharge from mental health inpatients, serious physical illness (chronic pain), family history of suicide
Significant issues likely to reduce/increase risk

**Risk to others**
History
Current thoughts, symptoms/behaviours to indicate risk
Significant things likely to reduce/increase risk, i.e. alcohol use, poor pain management etc

**Fire**
History of deliberate or accidental fire setting

**Neglect**
Any aspects of care needs not being met

**Unintentional harm**
Any accidental injuries impacted on by mental health

**Falls**
History of falls
Walking aid used
Risks associated with mental health to be considered

**Forensic**
Any current/spent convictions/include any current restrictions
Any anti-social behaviour reported

**Safeguarding**
Discuss any current/past abuse
Police involvement
Access to victim
Risk of neglect
Recent end of domestic abuse relationship
Support network
Access to children – record child details, any specific risks to children, any services involved
Capacity

**Impression and formulation:**
What are your views of what is happening?
Answering the questions made by the ward/A & E in the referral
Why do you think this?
Precipitating factors
Maintaining factors

**Plan**
Record if a level of observations required, if so what level and what is the rationale; with reference to any specific needs to be met through the 1:1, including risk. This resource should be routinely be considered if a person is waiting for a mental health bed
Record a plan in relation to frequency of review by the mental health liaison service. Any person waiting for a mental health bed should receive a review of mental state, risk and management on a shift basis as a minimum.

Record specific management plan in relation to ongoing mental health care or actions being undertaken by the service to enable care to be completed (e.g. referrals made or pending, liaison with other parties, request for a mental health act assessment etc).

Record recommendations about interventions, treatments, management as required by the acute trust e.g. delirium measures, monitoring pain, use of medication whether regular or PRN (prescribers only).

Record any communication of this plan with Acute Trust Team.

Record how team can be contacted urgently and routinely if required to return before planned review.

Record any escalation that has taken place and outcome of this.
Appendix 14: Shift Coordinator

Summary- Role of shift coordinator

Purpose of the role

The Mental Health Liaison Team needs to have an identified shift co-ordinator at all times so that other team processes can work effectively. Overnight the practitioners on duty will decide who carries the bleep and police triage phone depending on service demands. However, between 8am and 8pm the co-ordinator will be office based in order to prioritise clinical demands and allocate staff to meet these.

Responsibilities of the co-ordinator

The co-ordinator is responsible for holding the bleep and police triage phone. If the bleep and police triage phone are temporarily given to someone else (to allow the co-ordinator to take a break), this does not mean the co-ordinator has relinquished the role.

The main elements of the role include:

1. Ensuring referrals from both the emergency department and the wards are being allocated and patients are being seen within the appropriate time frames
2. Undertaking or allocating the morning EAU board round handover
3. Allocating workload to practitioners in a fair and equitable way, taking into account breaks, cut off points and other commitments such as supervision
4. Knowing where staff are at all times in accordance with lone working procedures
5. Being able to account for care management and delegation during shifts for which they are co-ordinating
6. Allocate who will complete the 136 Suite checks
7. Follow the 12 hours escalation for service users awaiting a mental health inpatient admission in the emergency department, and escalation procedure for patients elsewhere in the hospital waiting admissions.
8. When a MHA assessment is requested by a practitioner the coordinator will have oversight of the process- check on progress, liaise with AMHPs and medical staff about times etc for assessments.

Responsibilities of the co-ordinator

The co-ordinator is responsible for holding the bleep and police triage phone. If the bleep and police triage phone are temporarily given to someone else (to allow the co-ordinator to take a break), this does not mean the co-ordinator has relinquished the role.

The morning co-ordinator will aim to have the working day start in the most organised way possible. This will involve:

1. Taking hand over from the night practitioner and arranging for any outstanding duties to be followed up (e.g. contacting community teams)
2. The members of the MDT will inform the co-ordinator at the beginning of the shift via telephone of their availability throughout the day to enable the co-ordinator to plan resources.
3. Noting any sickness and making provision for cross covering diary or board round actions. The shift co-ordinator must inform the senior practitioner and team manager of any staff sickness.

4. Prompt allocation of those referrals for patients waiting for assessment in the ED but which arrived after the night time practitioner’s cut off time.

5. Checking the board and diary for any commitments, and allocating duties with sufficient time for the practitioner to prepare (e.g. BIMs)

6. Allocating a practitioner to check the emergency equipment in the S136 suite.

7. Making provisional arrangements for breaks for those practitioners working long days.

8. Taking into account other duties that practitioners want to complete and factoring them into the daily workload (e.g. supervision, specific ward reviews).

9. Ensuring referrals and LTODs are completed when service users have been assessed by locums and/or duty psychiatrists, and for S136 assessments that take place in the ED.

10. Have an oversight of the whereabouts of staff, including IMC, for safety purposes.

11. Subsequent co-ordinators during the day will need to continue with these duties and in addition:

12. Ensure team administrators are aware which cases can move from the top board by writing M when a patient has been seen so that the team secretaries can add the information to the team case load.

13. Check the printer for new referrals when the admin team are no longer on duty.

14. All information is to be recorded on the co-ordinator daily planner and handed over to the next person taking on the co-ordinator role.

15. The coordinator must cover ward work offer to see patients if there are no other practitioners available to respond and the co-ordination aspect of the role is in hand. During exceptionally busy shifts, it is expected that all other available practitioners will be deployed so the coordinator can keep on top of all the work coming in and prioritise response to emergency referrals from the ED and the wards.

**Triage of referrals to prioritise workload**

1. The reason for the referral. Sometimes the team may receive multiple referrals regarding the same service user, therefore it is necessary to establish what is being requested of the team.

2. Current risks relating to the service user. The referrer is not a mental health professional, however it is possible to gain some basic information regarding the service user’s appearance, behaviour and the content of the information they have provided to the ward/A & E.

3. Decide level of clinical priority. From the information gathered the co-ordinator will decide the level of clinical priority for the case.

4. Current capacity within the SMHLS and expected time to the person being seen. The co-ordinator should advise the referrer of the current capacity within the team and the current estimated time to when the service user will be seen, also advising the referrer that the response time may be subject to change if urgent referrals are received from A&E. The co-ordinator will advise the referrer of a management plan for the service user if there will be an extended delay to them being seen.

5. Record the plan on EPR. This will assist the staff at SRFT regarding the progress of the referral and reduce the need for follow up contact with the SMHLS.

6. If an Urgent referral does NOT come with the phone call, the coordinator will phone the ward to discuss before taking it as a 6-hour response. If there is a delay in responding to a referral the coordinator will contact the referring ward or department to gain additional clinical information.

**Allocating work to practitioners**
Allocation of work must take into account the task required and the relative complexity of the case.

The IMC practitioner should not be routinely asked to leave IMC work, given that the service is commissioned to provide a resource to IMC. The IMC practitioner must only be asked to take an ED referral in exceptional circumstances when to delay assessment may risk the safety of the patient. Neither should the ward practitioner be routinely asked to leave their ward duties. However, during exceptional circumstances as described above, the ward practitioner may be asked to assist with the completion of an assessment in the ED as a contingency plan.

As a general measure, non-complex, full assessments can take up to three hours including documentation; ward reviews can take up to 90 minutes including documentation and SHNAs can take up to four hours including family liaison and documentation. Use of think pads, dict8 and quiet working in the PANDA or MBU offices are to be encouraged as ways to assist with the efficient completion of work.

It is not unreasonable for co-ordinators to forward plan the allocation of work but this must be done with professional courtesy.

The practitioner completing the full assessment with the service user will open the outcome document, the co-ordinator is not expected to do this. If an initial assessment is required in cases viewed by the co-ordinator as urgent, the person carrying this review out is not expected to open the outcome document but document the time they saw the service user within EPR and Paris.- I'm not sure what this means

**Identifying the co-ordinator**

Handing over of information must be fair, thorough and with completeness (figure 1). The co-ordinator role is allocated for each early shift and handed over to the practitioner on the late shift. Hand over is usually around 1.30pm during the daily huddle. The night-time practitioners will have a handover between them during the early hours of the morning at a time suitable for both practitioners.

**Co-ordination on night duty**

Assessment of workload and care delivery overnight will be a dynamic process, influenced by several factors which may include, the volume of referrals, the clinical acuity of service users waiting to be assessed in the ED and the number of practitioners on duty.
Practitioners on duty must be clear who is holding the bleep and Street Triage telephone at any given time during the night shift. There will not be an identified co-ordinator on duty, however it is expected that practitioners will work collaboratively to share responsibilities.

On busy night shifts, it may be helpful for the practitioners to regularly provide updates to the co-ordinators in ED with updates regarding the number of service users waiting to be seen and the estimated time to assessment with the SMHLS.

To avoid service users waiting in the ED, time owing must only be taken at the end of a shift when the workload can be adequately accommodated by the practitioner who remains on duty. Cut off times must not be brought forward in the anticipation of taking time owing at the end of a shift.

The role of SMHLS administrators to support co-ordination

At times of peak demand, the role of the co-ordinator can be challenging. Therefore, the role of administrators is important to assist the co-ordinator in prioritising telephone calls. If the co-ordinator is involved in prioritising referrals or managing a 12 hr escalation, it is expected that the team administrators will support the co-ordinator by taking messages or directing telephone calls to the most appropriate person.

The administrators should answer telephone calls made to the team office as quickly as possible and gather the following information to establish the most appropriate action:

1. Who the caller is and where they are calling from.
2. Which service user the call relates to, including full name, date of birth and NHS number (if known).
3. If the service user is currently open to the SMHLS and which SRFT ward/department they are under.
4. What the purpose of the call is – follow up relating to a referral made regarding when an assessment is to be completed, the outcome of an assessment, update relating to discharge planning or the discharge of a service user from a ward, request from a GP for the full assessment information following the discharge of a service user.
5. Telephone number and person’s availability if a call back is required.

To support administrators in providing information to callers, it is expected that clinical plans are documented clearly within EPR and Paris by the practitioners involved. For ward assessments, this plan should include whether the liaison team need to see the person before they leave the ward or whether any follow up can be put in place following discharge.

If the information requested is available on EPR and the caller is from an SRFT ward/department, the team administrator should politely direct the caller to this entry. It is should not be necessary for the co-ordinator to be asked to deal with this type of query.

If the information requested is not available on EPR and relates to a new referral where the caller is requesting an update regarding the time to assessment. The co-ordinator should be able to provide the administrator with this information to pass onto the caller. However, it may be necessary for the co-ordinator to speak with the caller depending on the particular clinical needs of the service user.
Where the call relates to the outcome of an assessment, where the service user’s discharge is being delayed and the information is not available on EPR or Paris, the administrator should seek the support of the staff member who completed the assessment or the co-ordinator.

Where a ward is calling to inform the team of a service user discharge, the team administrator should check which practitioner has been involved in the case to inform them of the discharge. The team administrator should check the team rota to establish if the staff member is available in work due to annual leave, going onto nights or sickness. If the staff member will not be available to complete the necessary discharge processes, the administrator should take the details of the service user and pass these onto the co-ordinator for this to be reallocated.

If a GP or their secretary calls requesting the full assessment document following receipt of a discharge letter. The team administrator should provide this information. It is not necessary to discuss this with a practitioner or the co-ordinator.
Mental Health Liaison Service

Service User and Carer Satisfaction Questionnaire

Service User PARIS ID Number ..................................................

Date of Interview ..........................................................................

Time of Interview ..........................................................................

Name of Interviewer .................................................................

Yes  No

Semi structured interview with: Service User

Carer

1. Do you remember being seen by a member of the Mental Health Liaison Service

   Yes  No

   If yes continue.

   If no, please feel free to leave a comment at the bottom.

2. Did the Mental Health Staff member explained to you why he/she was talking to you?

   Strongly Agree  Agree  Neutral Disagree  Strongly Disagree  No Opinion
3. Did you feel the Mental Health staff member understood your difficulties?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>No Opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

4. Were you involved in the discussions regarding your care? / Or the person you care for?

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>No Opinion</th>
</tr>
</thead>
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</tbody>
</table>

5. Were you satisfied with the length of time spent with you?

Yes [ ] No [ ]

If no, please give details.

...................................................................................................................................................................
...................................................................................................................................................................

6. Were you provided with relevant and useful information (including how to access services in an emergency?)

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>No Opinion</th>
</tr>
</thead>
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</tr>
</tbody>
</table>
7. Did you receive written information regarding the ongoing plans for your care?

Yes ☐ No ☐

8. Were you asked if you wanted copies of letters written by the Mental Health Service to your GP?

Yes ☐ No ☐

9. If “yes” did you receive a copy?

Yes ☐ No ☐

10. Did you find the Mental Health Services supportive and helpful?

Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree ☐ Strongly Disagree ☐ No Opinion ☐

11. Was your Carer given advice and support regarding supporting the service user?

Yes ☐ No ☐ No Carer ☐

Thank you for your time.
Do you have any other comments you would like to make regarding the Mental Health Service?

Comments:

........................................................................................................................................

........................................................................................................................................

........................................................................................................................................

........................................................................................................................................

........................................................................................................................................

........................................................................................................................................
Appendix 16: U16 Structured Clinical Note

**CAMHS structured Clinical Note Template – Under 16’s**

Date / Time of referral:

Referred from:

Reason for Referral:

Date / Time of review:

**Management plan:**

Record if a level of observations is required, if so what level and what is the rationale; with reference to any specific needs to be met through the 1:1, including risk. **This resource should be routinely be considered if a person is waiting purely for a mental health bed**

Record a plan in relation to frequency of review by the mental health liaison service. **Any person waiting for a mental health bed should receive a review of mental state, risk and management on a shift basis as a minimum**

Record specific management plan in relation to ongoing psychiatric care or actions being undertaken by the service to enable care to be completed (e.g. referrals made or pending, liaison with other parties, request for a mental health act assessment etc.)

Record recommendations about interventions, treatments, management as required e.g. delirium measures, monitoring pain, use of medication whether regular or PRN

Record any communication of this plan with Acute Trust Team

Record how team can be contacted urgently and routinely if required to return before planned review

**Impression/ Summary**

**Presenting complaint/reason for referral**

**History of presenting complaint**

**Psychiatric history**
Are/are not currently under CAMHS, EIT, Emerge (Man/Salf), EXIT (CSE team), RUNA (missing from home team). If yes, allocated worker (with contact details), most recent diagnosis, recent changes to treatment/management, any significant matters i.e. live in supported accommodation/community placement

Contact with school nurse/pastoral/counselling services, 42nd street or GP
Previous admission to tier 4 inpatient unit, (location, dates, reason for admission, dx plans)
Any contact with drug or alcohol services?
Psycho-tropic medication
**Physical Health/Medical history**
Current/previous illnesses/chronic conditions
Any periods of hospitalisation (extended stays away from family)
Current medications: drug, dose, frequency, concordance
Any allergies/sensitivities

**Social History**
Family composition (Close and extended family? Who do they get on well with, who supports them, looks after them, who do they find scary/worrying? Is anyone missing? Recent losses)
Personal Circumstances, including:
  i. Transitions (where born, raised, moved house, schools)
  ii. Developmental milestones (walking, talking, speech)
  iii. Family history, (mental health, domestic violence, transitions, losses)
  iv. Mental Health
  v. Relationships (peers, romantic relationships, sexual orientation)
  vi. Education (school, part-time working, apprenticeships, relationships with teachers)
  vii. Abuse question: “Has anyone ever hurt you, made you feel scared or uncomfortable, or done anything to you and asked you not to tell anyone”. Follow up with “Is anyone hurting you now” Always ask these.

**Social Care Involvement / Professional involved**
Do they have an allocated social worker or family support worker (are they a child in need or on a child protection plan, or is family open to ‘early help’)

**Drugs/Alcohol**
Current use
Past use
Who with, how did it start, how purchasing it?

**Current presentation:**
Appearance and Behaviour - Description, reaction to interview, motor activity
Cognitive function - Report any formal testing done, E.g. WISC (IQ assessment)
Speech - Speed, quality, continuity
Mood – Subjective and objective
Sleep -
Appetite -
Motivation -
Concentration –
Anxiety -
Thought content - Evidence of paranoia, persecution, abnormal beliefs, thought disorder
Perception - Illusions, hallucinations, depersonalization.

Insight - Do they recognise that they need some support? Are they willing to accept help?

**Family perspective/attitude to problem -**
**Ensure that you have seen the young person & parent/carer to be seen separately & clearly document this**
Perspective/understanding of the young person & difficulties
Confidence in providing support and containment
Own mental health and support systems
Attitude towards risk/safety
Risk Assessment

Risk to self

Suicide

History
Current thoughts, intentions, hopelessness, future plans, understanding of death/lethality of approach
Predisposing factors (i.e. age, bereavements, isolation, recent dx from psych unit, physical health problems, family history (mental health, domestic violence, suicide), poor problem solving)
Significant things likely to reduce/increase risk, i.e. substance use, relationship break downs (friends/partner), school pressure (exams/coursework), experiencing humiliation/shame, ‘googling’ suicide techniques, witnessing domestic violence
Protective factors (supportive peers, insight into problems, optimistic, valued in the family, increased problem solving, resilience)

Self-harm

History
Method
Function (coping, calming, communicating distress, chastisement, control, contagion, cleansing, to feel something/nothing)
Contributory factors (abuse, neglect, trauma, relationship problems, bullying, parental criticism, dysfunctional home environments)
Significant factors likely to reduce/increase risk of harm (harming in isolation, using dangerous methods, harming frequently, in the context of substances)

Risk to others

History
Current thoughts, symptoms/behaviours to indicate risk
How do others feel about safety or risk of harm towards them (e.g. parent/carer)
Significant things likely to reduce/increase risk, (substance use, relationship breakdown, pro-criminal peers, positive attitudes to violence, low frustration tolerance, conflict in family)

Other Risks

Safeguarding matters
Risk of vulnerability, neglect
CSE risk/exploitation
Significant things likely to reduce/increase risk,

Safe & Well Check
Provide fire safety advice & ask about health &wellbeing
To make a referral – get consent of the person being referred
Ring GMFRS contact centre on 0800 555 815 or go to www.manchesterfire.gov.uk

5 P’s Risk Formulation

Problem
Precipitating – (Factors / Triggers)
Predisposing (History)
Perpetuating (Maintaining Factors)
Protective
Integrating Information in the 5 P’s Formulation

Although risk assessments cannot be based upon demographic factors alone, the factors listed below have been particularly associated with an increased risk of suicide and self-harm.

**Predisposing / History**
- Trauma (e.g. sexual abuse)
- Problems in early attachments (e.g. growing up in care)
- Family history of suicide
- Family history of mental illness
- Past deliberate self-harm (especially with high suicide intent)
- Individual clinical history

**Perpetuating / Maintaining factors**

<table>
<thead>
<tr>
<th>Demographic</th>
<th>Increasing age / younger ages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low socioeconomic status</td>
</tr>
<tr>
<td></td>
<td>Unmarried, separated, widowed</td>
</tr>
<tr>
<td></td>
<td>Living alone</td>
</tr>
<tr>
<td></td>
<td>Significant physical health issues</td>
</tr>
</tbody>
</table>

| Individual Context | Suicidal ideation – at what level of imagination, how often, how long, emotional response? |
|                    | Suicide plans                  |
|                    | Availability of means          |
|                    | Lethality of means             |

| Psychological / Psychosocial | Expressions of hopelessness |
|                             | Impulsivity                  |
|                             | Low self-esteem (self-attacking thinking) |
|                             | High levels of guilt / shame |
|                             | High levels of anxiety       |
|                             | Extreme black and white thinking |
|                             | Limited availability to regulate emotions |
|                             | Significant life events causing ongoing distress |
|                             | Relationship instability     |
|                             | Lack of social support       |
|                             | Command hallucinations (beliefs of power / control of voices, ability to ignore them / not respond). |

**Precipitating Factors / Triggers**
- Why now?

**Problem**
- Nature – Type of harm to self?
- Severity – How far may it go?
- Frequency – How often?
- Imminence – How soon?

**Protective**
- Effective clinical care and positive engagement with services
- Access to a variety of clinical interventions (services there when help seeking)
- Support through ongoing medical and mental health care
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Positive relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Resilience in the face of adversity
- Positive interpersonal attributes
- Hopefulness (belief in the capacity to change, evidence of this in the past)
Appendix 17: Contact Numbers

CAMHS outpatient:

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salford CAMHS</td>
<td>0161 221 7260</td>
</tr>
<tr>
<td>Bolton</td>
<td>01204 390 659</td>
</tr>
<tr>
<td>Trafford</td>
<td>0161 716 4747</td>
</tr>
<tr>
<td>North Manchester- Winnicott Centre</td>
<td>0161 701 6880</td>
</tr>
<tr>
<td>South Manchester- Carol Kendrick Centre</td>
<td>0161 902 3400</td>
</tr>
<tr>
<td>Bury</td>
<td>0161 716 1100</td>
</tr>
<tr>
<td>Rochdale</td>
<td>01706 676 000</td>
</tr>
<tr>
<td>Oldham</td>
<td>0161 770 7777 (referrals) / 0161 716 2020 (queries)</td>
</tr>
<tr>
<td>Ashton</td>
<td>0161 716 3600</td>
</tr>
<tr>
<td>Stockport</td>
<td>0161 716 5858</td>
</tr>
<tr>
<td>42nd Street</td>
<td>0161 228 7321</td>
</tr>
<tr>
<td>Emerge (16-17 Salford)</td>
<td>0161 226 7457</td>
</tr>
</tbody>
</table>

CAMHS Inpatient:

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gatekeepers (GMMH patients) 9-5 mon-fri (OOH will go through to ward.)</td>
<td>0161 358 1524</td>
</tr>
<tr>
<td>Junction 17</td>
<td>0161 358 1740</td>
</tr>
<tr>
<td>Hope unit (Bury acute admission Gatekeeper for Pennine care)</td>
<td>0161 716 1168</td>
</tr>
<tr>
<td>Horizon unit (Bury long term complex needs)</td>
<td>0161 716 1145</td>
</tr>
<tr>
<td>Cygnett (Bury)</td>
<td>0161 762 7200</td>
</tr>
</tbody>
</table>

Paediatric inpatient / A&E

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>PANDA</td>
<td>0161 206 0600</td>
</tr>
<tr>
<td>Bolton inpatient (E5)</td>
<td>01204 390 405</td>
</tr>
<tr>
<td>Stockport Rainforest (surgical)</td>
<td>0161 419 2158</td>
</tr>
<tr>
<td>Stockport Acorn</td>
<td>0161 419 2157</td>
</tr>
<tr>
<td>Stockport Brambles</td>
<td>0161 419 2155</td>
</tr>
<tr>
<td>Stockport Mulberry (Day case)</td>
<td>0161 419 2153</td>
</tr>
<tr>
<td>MRI children’s hospital switch</td>
<td>0161 276 1234</td>
</tr>
<tr>
<td>Wythenshawe F8</td>
<td>0161 291 2269 / 2248 / 5458</td>
</tr>
<tr>
<td>Wythenshawe observation 7 assessment unit</td>
<td>0161 291 2620</td>
</tr>
<tr>
<td>North Manchester</td>
<td>0161 625 8273</td>
</tr>
</tbody>
</table>
## Salford 1:1 Staffing Issues Escalation

Service users who are assessed and detained to medical wards in SRFT whilst solely awaiting admission to a mental health beds (e.g. no medical needs) are the responsibility of Greater Manchester Mental Health Trust. These service may require 1:1 observations, this will be agreed between the host ward, mental health act team & MHLT. This does not include patients transferred from inpatient mental health wards as they remain the responsibility of the parent ward.

### In Hours Escalation

- **Shift co to request Senior Practitioner / Team Manager to book staff via NIP.**
- **Team Manager must be kept informed.**

### Out of Hours Escalation

- **Shift Coordinator identifies the need for 1:1 staffing & the duration of expected stay.**
- **Inform GMMH Bronze on Call.**
  - If no staff available — consider use of agency staff, SRFT / Reallocation of resources.
  - If unable to secure staffing: Bronze on Call BOC to liaise with patient flow to try and expedite admission.
  - Discuss with other divisions if able to re-allocate resources from outside of Salford.
  - If no other option then MHLT staff can be used to undertake observations. Consideration must be given to A&E waiting time, and the potential risk of increased demand on the service and reduced access to assessments.

- **No staff available — Practitioner / Team Manager to review agency staffing.**

- **If no agency staff available to liaise with SRFT to identify if any staff from SRFT bank are able to cover shifts.**

- **If unable to secure staff — Team Manager to escalate to operational manager.**

  Liaise with Bed Manager, and A & E Senior Manager. To try and expedite admission. Review with other services to consider reallocation of resources e.g. HBT / Inpatient staff.
Appendix 19: Ward Practitioner Role

**Guidance for Ward Practitioner role**

**Overview:**

Each week, a practitioner will be allocated as the designated Ward Practitioner (WP) with a view to ensuring a timely response to the wards for those patients awaiting further input from the MHLS. The practitioner will be identified in advance on the rota. The WP may be allocated to work over any of the 7 day period, however, the role is likely to be particularly useful at the beginning of the week and towards the end of the week, to correspond with the demands on the service.

A Board Round is completed every Monday by a Senior Practitioner and a Consultant. During this process, reviews will be identified for the WP and will be highlighted on the weekly review list for them. This list will then be e-mailed to the WP following the completion of Board Round and can also be located in the office. The rationale for reviews can be located within the Paris notes following from Board Round. Wherever possible, the Ward Practitioner will be a protected role, treated as supernumerary and not routinely called upon to pick up assessments in the A&E department or to staff the 136 Suite. In exceptional circumstances e.g. dangerously low staffing within the team, this may need to occur, however, it will be the Shift Co-ordinators responsibility to ensure that all other options have been explored prior to approaching the WP.

The Ward Practitioner will be responsible for:

- The Board Round will indicate any urgent reviews to be prioritised and suggested timescales, however, the WP will then be responsible for co-ordinating and prioritising the remainder of the workload

- Alongside regular reviews, the Ward Practitioner may also be required to complete outstanding Specialist Health Needs Assessments and attend Best Interest Meetings/Discharge Planning Meetings, where indicated

- Liaising with the Shift Co-ordinator and attending huddles in order to identify any urgent ward-based work that has not been allocated elsewhere

- Communicating, via their Plan in the Clinical Note, whether there is any ongoing review required, either for the next WP or another Clinician. This can then be identified and allocated at the next Board Round

- Demonstrating a degree of flexibility in responding to work that may be unplanned or of an urgent nature

- Whilst it is expected that the majority of WP’s work will be in completing reviews, there may also be times when new ward referrals need to be picked up and a full assessment completing. Where this is the case, the WP will be mindful of breach times and of offering a timely response
Appendix 19: Gatekeeping Template

Gatekeeping blank template.docx