

# **Standard Operating Procedure**

## **General Hospital-Based Mental Health Liaison Teams**

### **May 2014**

Author:  
Anthony Harrison – Consultant Nurse  
(Liaison Psychiatry)

Date:  
6 May 2014

Scrutinised by:  
AWP Senior Management Team (SMT)

Review date:  
May 2015

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## 1. Purpose

### 1.1. Policy Context

The 2011 national Mental Health Outcomes Strategy, "No Health Without Mental Health", sets out six objectives to improve mental health outcomes for individuals and the population as a whole:

- More people will have good mental health.
- More people with mental health problems will recover.
- More people with mental health problems will have good physical health.
- More people will have a positive experience of care and support.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination.
- All Trust Standard Operating Procedures reflect the values and aims of this Strategy. They also reflect wider mental health policy development in recent years, including the Care Programme Approach, mental health legislation, and the development of clustering, as well as guidance from the National Institute for Health and Clinical Excellence (NICE).
- There are eight developmental standards relating to dementia care published by the South West Dementia Partnership (2010) and a majority of these are expected to be delivered via and supported by effective mental health liaison provision for older people in the acute hospital.

### 1.2. Trust strategic context

"Whether service users, staff, GPs, commissioners or third sector groups, you matter to us and we care how we listen and respond to your needs, views and ambitions".

#### Values

<b>P</b>	<b>Passion</b>	Doing our best, all of the time
<b>R</b>	<b>Respect</b>	Listening, understanding and valuing what you tell us
<b>I</b>	<b>Integrity</b>	Being open, honest, straightforward and reliable
<b>D</b>	<b>Diversity</b>	Relating to everyone as an individual
<b>E</b>	<b>Excellence</b>	Striving to provide the highest quality support

### 1.3. Delivery unit context

The following local delivery units (LDUs) provide mental health liaison services to the following acute hospital trusts across Avon and Wiltshire:

- B&NES – service to the Royal United Hospital Bath NHS Trust
- North Somerset – service to Weston Area Health NHS Trust
- Swindon – service to the Great Western Hospitals NHS Foundation Trust
- Wiltshire – service to Salisbury NHS Foundation Trust

A complex historical arrangement exists in Bristol whereby AWP contributes psychiatric medical input to the mental health liaison team at University Hospital Bristol NHS Foundation Trust, but the

other multi-professional team is provided directly by UHB. A similar arrangement is in place with North Bristol NHS Foundation Trust who provide their own mental health liaison service within Frenchay and Southmead hospitals.

Commissioning of general hospital mental health liaison services is through the relevant local CCGs, either as part of existing block contracts or individual hospital liaison contracts. At hospital sites where highly specialised regional services are located, separate funding and contractual arrangements will need to be developed to ensure appropriately targeted resources and corresponding service provision.

#### **1.4. Vision, aims and activities of the mental health liaison service to the general hospital**

##### **1.4.1. Service vision:**

To ensure that patients who attend or who are admitted to an acute (general) hospital have prompt and effective access to expert mental health care, and that general hospital colleagues are supported to contribute effectively to mental health care<sup>1</sup>.

##### **1.4.2. Service aims:**

1. To provide a comprehensive psychosocial assessment service throughout all clinical departments of the acute general hospital (and associated community hospitals where contractual arrangements specify the provision of a mental health liaison service).
2. To take the lead in undertaking, managing and evaluating clinical risk in relation to the care and treatment of people with mental health needs in the acute hospital.
3. To contribute to effective, holistic and person-centred care delivery within the acute hospital.
4. To provide expert mental health advice, information, support, supervision and sign-posting for acute hospital staff.
5. To act as an effective communication channel between the range of secondary mental health services (including those not provided by AWP) and the acute hospital.
6. To contribute to the review, evaluation and further development of mental health services within the general hospital.

##### **1.4.3. Core service activities:**

- Provide a mental health (psychosocial) assessment service to each clinical area within the acute hospital.
- Actively manage the organisation and delivery of the mental health liaison service through the most effective use of liaison service personnel.
- Provide a short-term (time-limited) mental health support and consultation service to individual patients, as appropriate.
- Undertake liaison and communication with the full range of secondary mental health services, in respect of individual patients, as appropriate.
- Contribute to the development, implementation and evaluation of treatment and care plans in respect of individual patients, as appropriate.
- Convene and facilitate multi-disciplinary professionals' meetings regarding individual patients, as appropriate.
- Participate in Care Programme Approach (CPA) review meetings, as appropriate.

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<sup>1</sup> A number of acute hospital trusts deliver a range of clinical services in smaller community hospitals, and this SOP applies equally to these areas.

- Actively contribute to the identification and development of clinical management plans for those individuals identified as 'repeat attenders', liaising and collaborating with other care providers, as necessary.
- Convene and facilitate acute hospital-based supervision and review meetings regarding individual patients within the acute hospital, as appropriate.
- Participate in the operational and strategic development of mental health care within the acute hospital by active attendance at relevant meetings and forums.
- Participate in the delivery of education and training for acute hospital staff.
- Contribute to the development and implementation of person-focused care pathways relating to specific conditions or patient groups.
- Provide clinical/professional placement opportunities for health and social care students and other learners.

#### **1.5. Safeguarding children and young people and vulnerable adults:**

The service will ensure that policies and procedures relating to safeguarding are adhered to, that staff have undertaken training appropriate for their professional role and should be represented on the local safeguarding boards. All staff working with children and young people will have received an enhanced Disclosure and Barring Service check.

## 2. Service scope

### 2.1. Service user groups covered:

- The general hospital mental health liaison service is for people who are aged 18 years and over. A separately commissioned and provided service is in place for children and young people (CAMHS) in each of the respective acute hospitals. Flexibility is required regarding those people aged 17-18 years, and there may be occasions when it is appropriate for the MHLT to undertake an assessment; such decisions will be based on the needs and best interests of the individual patient. There is no upper-age limit.
- All individuals who either attend or who are admitted to the acute hospital, regardless of home address, accommodation status or GP registration.
- All clinical teams (wards and departments) across the acute hospital site, including those services delivered by other on-site providers (excluding occupational health services, where separate commissioning and service delivery arrangements will apply).

### 2.2. Geographical populations served:

Service delivery is across four acute hospital sites:

1. Royal United Hospital Bath NHS Trust (RUH)
2. Weston Area Health NHS Trust (Weston General Hospital)
3. Great Western Hospitals NHS Foundation Trust (GWH)
4. Salisbury NHS Foundation Trust (Salisbury District Hospital)

### 2.3. Specific service functions:

The following definitions will apply in relation to 'emergency' and 'urgent' referrals (RCPsych. PLAN Standards 2011)

**Emergency:** An acute disturbance of mental state and/or behaviour which poses a significant, imminent risk to the patient or others.

**Urgent:** A disturbance of mental state and/or behaviour which poses a risk to the patient or others, but does not require immediate mental health involvement.

**Routine:** all other referrals, including patients who require mental health assessment, but do not pose a significant risk to themselves or others, and are not medically fit for discharge.

It is not possible to specify exact response times for every single mental health referral, as this will be influenced any number of other local factors; clinical urgency and potential risk will always be the most important determinants with regard to agreeing response time in individual cases. The following response times are those advocated by the Royal College of Psychiatrists (2013), and will be used as benchmark standards. The MHLT will respond to referrals within the following timescales:

- Emergency – liaison team response within 60 minutes of referral. Depending on clinical urgency and potential risks, consideration may be given to classifying ED referrals as 'urgent'.
- Urgent – liaison team response within 5 hours of referral – same working day. This is likely to include all patients referred from the ED Observation Ward/Unit or Clinical Decision-Making Unit (CDU) and those referred from other hospital teams (unless classified as 'emergency').
- Routine – liaison response within 2 working days of referral – usually within 10 working hours.

Monitoring of response times will use the following metrics:

- ED (including Observation Unit and Medical Assessment Unit): time from referral to commencement of mental health assessment.
- Hospital wards and internal clinical departments (excluding occupational health services): time from referral and commencement of mental health assessment.

Undertake, record and communicate the outcome of a full psychosocial assessment, covering the following domains:

- Reason for referral and presenting problem(s).
- History of mental health and related personal and social problems.
- Alcohol and substance use.
- Mental state examination.
- Risk assessment – focusing specifically on risks associated with self-harm and suicide.
- A recommendation for the initiation or on-going prescribing of psychotropic medication, if appropriate.
- A recommendation for the immediate, short and medium-term clinical management of the patient in order to ensure the safe and effectively delivery of care, and the management of risk.
- Advice regarding the possible use of the Mental Health Act, including its implementation (eg: completion of a medical recommendation), if appropriate.
- Advice, screening, assessment, diagnosis, referral to and liaison with other services for people with dementia.
- Further assessment for people with dementia who develop non-cognitive symptoms that cause distress, or who present with behaviours that others find challenging.
- Communication and liaison with family/significant others and carers, as appropriate.
- Summary and clinical formulation.
- A recommendation regarding discharge or transfer from hospital.
- Communications attempted and completed with other services – eg: mental health services, primary care, etc.
- A person-centred discharge and, if appropriate, follow-up plan – this plan will include any specific actions that will be undertaken by the liaison practitioner.

In addition, ward-based assessments will include the following domains:

- Any clinical or individual clinical management problems, as defined by the ward team.
- Specific requests for advice on clinical management (including discharge planning).
- Sources used and information obtained from others (collateral history), as appropriate.
- Specific advice on mental capacity and any possible restrictions of liberty, if appropriate.

Initiate and coordinate the input of other mental health services – eg: additional elements to the current assessment, such as the need for inpatient psychiatric admission, Mental Health Act assessment, etc.

All patients and carers (if appropriate) will be provided with written patient information, appropriate to the situation and presentation, and their cultural and individual learning needs.

All relevant clinical documentation will be completed using the RiO electronic patient information system, although a professional decision will be made as to the exact detail length of the information recorded; this will be commensurate with the complexity of the presenting clinical complaint, degree of urgency and level of risk. A summary of the contact will be recorded in the acute hospital clinical record.



Maintain a detailed knowledge of all local relevant resources and to work effectively with other partners to identify and develop new and innovative services with people with mental health problems.

Work to gain a detailed understanding of the local population, its mental health needs and priorities and to provide a service sensitive to this and any religious and gender needs.

Work with other partner agencies and other teams to support people, including housing, local authority, public health, employers and the police.

Work to ensure the repetitive or unnecessary assessments and interventions are avoided.

Work collaboratively with acute hospital-based alcohol (and substance misuse) liaison practitioners, as appropriate.

## **2.4. Team structures**

### **2.4.1. Skill mix:**

The skill mix for each team will include:

- Team Manager
- Mental Health Liaison Practitioners
- Consultant and specialist/trainee psychiatrists
- Team administrator

**Multi-professional skill mix within the general hospital-based mental health liaison team may include the following:**

- Consultant psychiatrist x 1 WTE – to undertake the Responsible Clinician (RC) role
- Registered nurses (mental health) x 6 WTE
- Social worker x 1 WTE
- Occupational therapist x 0.5 WTE

A minimum of two practitioners will be 'on duty' at any one time. Only in exceptional circumstances – eg: sudden staff sickness – will a lone practitioner be on duty in the hospital.

## **2.5. Working with families/friends/supporters ('carers'):**

AWP recognises the role of the carer (supporters, relatives, and friends), and values the important role that carers play towards supporting a person's recovery. The responsibility for defining and facilitating services to carers for individuals will sit with one of the following:

- AWP care coordinator (if known to mental health services)
- Acute hospital named nurse
- All AWP services will adhere to the good practice guidelines when working with carers.
- All liaison practitioners will ensure that patients are invited to have someone of their choosing (or their nominated carer) to be present for a part of the psychosocial interview, if appropriate.
- All liaison practitioners will ensure that social networks are discussed in any assessment.
- All carers will be encouraged to share their knowledge of the person as a way of contributing to the assessment and care delivery processes, and to provide potentially important risk assessment and management information.

- All carers will be offered an opportunity to discuss their role in more detail.
- The MHLT will communicate with carers to screen and identify their potential needs and signpost and refer on, as appropriate.
- If the carer declines an invitation to talk more about their role then this should be recorded in the appropriate section of RiO.
- There is a clear understanding between AWP, carers and service users in relation to the limits of confidentiality and the sharing of information.

### 3. Service delivery

#### 3.1 Location of service:

The mental health liaison team (MHLT) will be located at an appropriate space within the acute hospital complex. Their main administration based may be relatively distant from the majority of clinical teams within the hospital, so a smaller (satellite) office space or 'hot-desking' arrangement may need to be made. Acute hospitals should, through their appropriate executive and operational management teams, actively contribute to the effective functioning of the service by:

- Facilitating the provision of effective satellite office space where confidential clinical matters can be discussed.
- Provide access to IM&T (PCs and appropriate mobile electronic devices) services, telephones and hospital bleeps.
- Ensure that on site IM&T services enable trouble-free access to AWP's electronic systems.

Patients will be seen and assessed within an appropriate part of the ward/department. This facility will comply with national guidance on the provision of quiet spaces and interview rooms in clinical settings, in order to ensure the provision of dignified care.

#### 3.2 Hours of operation/availability:

- The MHLT will be available 365 days a year. The core hours of operation will be: 09.00 to 17.00 daily, working flexibly to meet the needs of patients within the general hospital.
- All liaison services (with the support of local commissioners and acute hospital partners) will develop aspirational plans to implement extended hours operation of 08.00 to 20.00 daily.
- Outside of these operational hours access to urgent mental health input will be via AWP locality intensive teams. LDU/acute hospital interface and other operational issues will be addressed in Section 4, below.
- General hospital-based liaison services will be non-stigmatising and non-discriminatory, providing fair and equitable access.
- General hospital-based liaison services will work in a way that it does not discriminate against its individual service users or potential service users on the grounds of gender, race, disability, sexual orientation, age, or belief system and will ensure that all applicable legislation is adhered to.
- The service is accessible to people who have had difficulties accessing appropriate mental health services, including people from black and minority ethnic communities, people who are deaf, and people with learning disabilities.
- The service will offer interventions in a manner which the user of the service, and their carers, finds easy and timely.

#### 3.3 Referral processes

Referrals will be received by the mental health liaison team via one of the following routes:

- For patients attending or admitted following an episode of self-harm, the team will identify these individuals by checking the bed status of the following units by 08.30 each day – emergency department, observation ward/unit, medical assessment unit. On other

wards/units, they will receive the referral by telephone.

- Ward-based referrals – acute hospital colleagues will complete a standard electronic referral form.
- A new referral will be logged and opened on RiO.

### **3.4 Referral routes**

- Patients will be referred directly to the MHLT using the agreed referral documentation, accessible to clinical staff via the acute hospital's intranet.
- Referrals will be sent to the nominated MHLT's NHS Net email account. The inbox for this account will be accessed daily to check for referrals received.
- A copy of this referral form will be uploaded to the relevant section of RiO.
- For those patients who have attended or who have been admitted following an episode of self-harm, a telephone referral is sufficient to alert the MHLT to the need to undertake a psychosocial assessment.
- A 'Call-Back Clinic' will be provided each weekday (excluding weekends and public holidays), at a time negotiated and agreed with the acute hospital trust. This facility is for the ED clinicians to directly book patients in for a mental health assessment. Up to two clinic slots will be available each day.
- The MHLT practitioners can be contacted via the acute hospital bleep system.

### **3.5 Assessment**

- All assessments will be undertaken according to the standards laid out in AWP CPA Policy.
- Gender, cultural issues and personal preferences will all be considered within the process.
- A full psychosocial assessment, including a risk assessment, will be completed and will assess the domains identified in section 2.4.2, above.

### **3.6 Assessment outcomes**

All assessments will have a recorded outcome. Possible outcomes are:

- Referred back to GP with appropriate advice and suggestions for primary care or third sector management. A written summary, addressed to the patient, will be provided alongside the CPA documentation (where appropriate) and sent within 72 hours of discharge. A copy of this summary will also be sent to the patient's GP. Professional discretion will be exercised regarding the appropriateness of forwarding summary documentation when the MHLT intervention has consisted solely of signposting and/or advice to clinical colleagues.
- Where a discharge letter contains specific advice to another health professional (eg: GP), this should be written to the professional, and a copy forwarded to the patient.
- Transferred across to one of the following AWP services:
  - Intensive Recovery
  - Specialist service – eg: EI, secure services, specialist drug and alcohol services
- All patients seen will be provided with appropriate suggestions regarding self-help and access to a range of other third sector organisations. These organisations will usually require the person to self-refer in order to access their service.
- Assessments undertaken on one of the acute hospital wards may remain open cases to

the MHLT on RiO, as further assessment/review consultations may be required whilst the person remains an inpatient at the hospital. Any plans for the MHLT to re-assess and review during the patient's stay will be documented in the RiO progress notes and the acute hospital's clinical record.

- For patients detained in the acute hospital under a section of the Mental Health Act a care plan will be developed regarding the patient's mental health management during their admission. This care plan will be recorded in RiO and in the acute hospital's clinical record.

### **3.7 Documentation and information**

- The MHLT will record all relevant referral, assessment, formulation, discharge planning, and follow-up information in the relevant sections of RiO within 24 hours of completion of the relevant clinical contact or episode of care.
- For assessments carried out following an episode of self-harm, a short summary of the assessment – usually consisting of one paragraph – will be documented in the relevant acute hospital record (eg: ED clinical record, patient's main health record). This summary will detail:
  - Outcome of the mental health assessment, including any short and medium-term risks identified and any interventions or strategies to manage these.
  - Plans for follow-up or on-going mental health care, whichever is appropriate.
  - Recommendations regarding discharge once the patient is medically fit to leave hospital.
- For assessments carried out following a hospital attendance/admission as a result of an undifferentiated mental health problem, a short summary of the assessment – usually consisting of between two and four paragraphs – will be documented in the relevant acute hospital record (ie: ED clinical record, patient's main health record). This summary will detail:
  - Outcome of the mental health assessment, including any short and medium-term risks identified.
  - Plans for follow-up or on-going mental health care, whichever is appropriate.
  - Any recommendations for the short-term management of the patient's mental health needs whilst in hospital - eg: advice regarding psychotropic medication and its management, nursing management (including the management of any short-term risks relating to potential self-harm/suicide, wandering/absconding, and whether any additional nursing staff are required).
  - Recommendations regarding discharge once the patient is medically fit to leave hospital.
  - Plans for follow-up and on-going care, if appropriate.
- Written information – in a format appropriate for the person's intellectual, developmental, cultural and sensory needs – will be provided on the completion of the mental health assessment or episode of care.

### **3.8 Individuals who attend frequently**

A person who attends frequently is defined as a patient who re-presents to the acute hospital on three or more occasions with the same presenting complaint, within a 12-month period. The MHLT will collaborate in the of identification those individuals who meet this definition and will participate in:

- Maintaining an up-to-date register of patients who attend the acute hospital frequently.

- Reviewing any existing arrangements for their mental health care with the relevant mental health staff – eg: inpatient services, recovery services, third sector services.
- Actively coordinating the development of mental health crisis, contingency and relapse plans, and ensure that these reflect the fact that the patient is presenting to acute hospital on a frequent basis.
- Assisting existing AWP care coordinators to develop and share contingency plans which identify the most appropriate clinical responses from general hospital staff in the event of re-presentation.
- Collaborating with AWP care coordinators, initiate CPA reviews, as appropriate.
- Coordinating and chairing/co-chairing professionals' meetings in order to review a person's frequent attendances and to develop coordinated plans to reduce the frequency of attendance, as appropriate.

### **3.9 Clinical responsibility and duty of care**

The MHLT and all AWP staff attending and assessing patients within the acute hospital are providing a liaison-consultation service and will be accountable for their professional practice, including the clinical advice provided. However, until discharge, the patient remains the overall responsibility of the acute hospital.

### **3.10 Mental Health Act within the acute hospital**

Full details of the operational aspects of the MHA within the acute hospital are contained within the hospital's *Mental Health Act Policy*, available to staff via the intranet.

The MHA allows for the detention and treatment of persons with mental disorder where admission is considered necessary for their health and safety or for the protection of others, and where they are unable or unwilling to consent to such an admission. The MHA does not apply to the detention and treatment of patients for physical illness for which they must give informed consent or for whom treatment should be considered given reference to the Mental Capacity Act 2005. The MHA may apply where physical disorder contributes to mental disorder or is otherwise inextricably linked with the mental disorder. In legal terms, it is an 'enabling' act which means it need not be used in all possible instances of the above but its use provides legal safeguards for patients and for staff responsible for patients subject to the MHA.

When the MHLT is operating (see section 3.2, above) acute hospital staff should contact the MHLT as a matter of urgency if they are considering the use of the Mental Health Act. Outside of these hours they should contact the AWP Intensive Service.

When an assessment is required for the purpose of the MHA [with the exception of Section 5(2)] this will need to be carried out by the duty MHA Section 12 approved doctor. The Section 12 doctor will then make the appropriate recommendations based upon that assessment. The involvement of any other mental health professionals for the purposes of the MHA assessment will be coordinated by the Approved Mental Health Professional (AMHP).

### **3.11 Responsible clinician (RC):**

The legal responsibility for patients detained under a section of the MHA remains with the acute hospital trust. An RC (as defined by the MHA) needs to be identified to oversee and coordinate

the detained patient's mental health care whilst they are in hospital and this role can only be undertaken by an appropriate consultant psychiatrist. The RC is an AWP employee but acts in this capacity on behalf of the acute hospital trust; all AWP psychiatrists undertaking the RC role are required to have a valid honorary contract (or local equivalent) with the acute hospital trust in order for them to fulfil this function with the appropriate indemnity.

The RC will, by default, be the consultant liaison psychiatrist within the MHLT. In situations where the MHLT consultant is absent (eg: annual leave), then cover for this role will be undertaken by accessing the locality duty consultant on-call rota. If the patient being detained is currently known to and in receipt of mental health care from AWP, the RC role is most appropriately undertaken by the respective team's consultant psychiatrist – even if they are outside of the host locality.

### **3.12 Training, education and research activities**

The MHLT Manager will, through the AWP staff appraisal and supervision procedures, identify the training and development needs of the staff, and ensure all statutory and mandatory training requirements are met.

The MHLT will contribute to the ongoing training and professional development of acute hospital clinical staff by contributing to:

- Induction of new staff, in particular medical and nursing staff from the ED
- Providing observational/shadowing opportunities for new employees
- Providing placement opportunities for health and social care students and other learners

### **3.13 Clinical and managerial supervision arrangements**

Supervision is regular protected time within work to reflect on and discuss a range of issues which together contribute to maintaining standards and ensure that the service delivers the highest quality of care to service users and carers.

There are different types of supervision and the trust sets out standard and expectations in respect of each.

Team managers will ensure supervision is provided according to the Trust's current Supervision Policy.

### **3.14 Management of untoward incidents**

There will be occasions when serious untoward incidents (eg: an unexpected death) occur regarding a patient who is receiving care by both the acute hospital trust and AWP. In order to ensure that effective learning is identified, A Memorandum of Understanding will be developed and agreed (with appropriate Executive-level scrutiny and sign-off) such incidents will be investigated/reviewed, managed, reported and shared.

### **3.15 Governance, quality and effectiveness**

A structure and system of governance and quality monitoring of the overall delivery of mental

health care within the acute hospital will be established at each site. It will consist of the following structures.

- Strategic Mental Health Group/Mental Health Act Committee
- Operational Mental Health Group

**Strategic Mental Health Group/Mental Health Act Committee:**

Hosted and convened by: Acute hospital trust

Chaired by: Acute hospital executive – eg: Director of Nursing/Quality, Medical Director.

Serviced by: Acute hospital trust

Accountable to: Trust Board/Clinical Executive

Purpose: Develop and monitor the strategic organisation and delivery of mental health care within the acute hospital.

Minimum meeting frequency: Quarterly

Core membership:

- Executive director
- Mental Health Act lead for the acute hospital
- Senior operational manager – eg: directorate manager
- AWP senior operational manager – eg: Clinical Director, Managing Director, or Head of Profession & Practice (HoPP)
- Commissioner(s)
- Senior clinical representation – eg: ED consultant, Matron/clinical manager
- Acute hospital clinical lead for mental health/learning difficulties
- AWP social work manager/lead
- Mental Health Act administrator (or representative, if externally commissioned)

**Operational Mental Health Group:**

Hosted and convened by: Acute hospital trust

Chaired by: Senior operational manager – eg: directorate manager, or deputy

Serviced by: Acute hospital trust

Accountable to: Strategic Mental Health Group

Purpose: Provide a forum for identification and resolution of ongoing operational and interface issues and problems relating to the provision of mental health care within the acute hospital.

Minimum meeting frequency: Bi-monthly

Core membership:

- Senior operational manager



- MHLT manager
- AWP clinical team representation – eg: Intensive Service, Primary Care Liaison Service (PCLS), social work, etc.
- Acute trust clinical team representation – eg: ED, medical admissions, etc.
- Mental Health Act lead for the acute hospital

### 3.16 Developmental standards

The core functions and delivery of the mental health liaison service within the acute hospital will be monitored and reviewed using the national liaison standards developed by the Royal College of Psychiatrists (2011) in their PLAN Standards. These standards address the following five core domains:

- **Core standards for all teams**, including ease of referral, relationship with the wider hospital and external agencies, and staffing, training and support within the liaison team.
- **Meeting emergency mental health needs throughout the hospital (adults of all ages)**, including services to people who self-harm, people brought in under Section, people who may be psychotic, and people on general wards who develop urgent mental health needs.
- **Meeting routine mental health needs throughout the general hospital**, which includes people admitted to general wards who have a psychological reaction to physical illness or injury, people with medically unexplained symptoms and people where psychological factors may be affecting their capacity to consent or refuse medical treatment.
- **Providing routine mental health care to older people**, such as those with dementia, delirium and depression.
- **Providing training and support to non-mental health colleagues**, such as emergency department colleagues, ward staff and so on.

It will be for local determination as to whether the service formally participates in PLAN by joining the accreditation network, or whether a bespoke review and audit process is developed locally to monitor quality against the PLAN Standards.

## **4. Locality specific operational issues**

### **4.1. Bath & North East Somerset (B&NES) (Royal United Hospital Bath NHS Trust)**

#### **4.1.1. Clinical interface**

- i. Response times and the standards associated with these will be monitored against national standards and good practice guidance.
- ii. A local 'team handover'/communication process will be developed and agreed between the B&NES Intensive Service and the MHLT; this will include a standardised handover sheet, detailing any outstanding or agreed clinical activities and interventions on a day-to-day basis.
- iii. MHLT to identify a 'shift-coordinator' on a daily basis, facilitating ease of communication between ED and liaison team.

#### **4.1.2. Operational and managerial interface**

- i. Operational mental health group to develop a training/professional development template regarding the MHLT contribution to education of medical and nursing staff within the ED.
- ii. Breaches to the 4-hour standard to be monitored and reported on weekly – RUH Business Intelligence Unit to forward details to MHLT manager, who will review and summarise learning.
- iii. Both organisations will commit to the development and implementation of a self-harm monitoring and review process ('Self-Harm Register').
- iv. RUH will develop and maintain an up-to-date register of AWP staff provided with, and working to, honorary contracts within the hospital.
- v. Both organisations to work collaboratively in contributing to the delivery of mental health training.

#### **4.1.3. Mental Health Act**

- i. Mental Health Act administration to be provided through a separate contractual arrangement with AWP Corporate Services.
- ii. RUH to undertake monthly monitoring of the use of Section 136 via the ED.
- iii. RUH to ensure effective interface between their Quality Improvement Lead for Safeguarding, Learning Disability and Mental Health, via both strategic and operational mental health groups.

## **4.2. Salisbury**

### **4.2.1. Clinical interface**

- i) A local pathway between intensive services, ED and the MHLT will be developed and agreed.
- ii) An ageless referral form will be developed and disseminated across SDH. This will be sent to the MHLT by secure fax or NHS Net, in line with both Trusts' information governance procedures.
- iii) Explore the possibility of a baseline educational needs survey for SDH staff to guide development and outcome monitoring of educational interventions.
- iv) Initiate partnership working with SDH and others regarding people who attend frequently.
- v) Follow-up of people presenting with self-harm and who have been discharged by ED staff – will be followed-up by telephone contact by the MHLT through the normal referral process.

### **4.2.2. Operational and managerial interface**

- i) Regular 4-6 weekly EDMHLT interface meetings, including SWIDS and AMHP representation, as required, will be established to develop care pathways and to review complex cases, or where an incident or near-miss has occurred. This will be reported to the Strategic Mental Health Group.
- ii) Participate in the development of ToR and a work plan for meetings of the AWP/SDH Mental Health Operational and Strategic meetings.

### **4.2.3. Mental Health Act**

- i) Mental Health Act administration provided by AWP.
- ii) Responsible Clinician (RC) role for patients detained by SDH, and over the age of 18 years, will be provided by the liaison psychiatry consultant (with cover for periods of leave), except when the patient is transferred from a mental health inpatient unit, when the RC will remain with the transferring RC.
- iii) For the purpose of the MHS the liaison psychiatry consultant will have an honorary contract with the SDH. An agreement between SDH and AWP will be developed to provide similar indemnity cover to other AWP employed psychiatry consultants undertaking this role.

### **4.3. Swindon (Great Western Hospital NHS Foundation Trust)**

#### **4.3.1. Clinical interface**

- i. A local pathway between the intensive service and the MHLT will be developed and agreed; this will include a protocol for the transfer of patients requiring home treatment and/or psychiatric hospital admission.

#### **4.3.2. Operational and managerial interface**

- i. Operational Mental Health Group to develop a training/professional development template regarding the MHLT's contribution to the education of GWH medical and nursing staff.
- ii. Both organisations will commit to the development and implementation of a self-harm monitoring and review process ('Self-Harm Register').
- iii. MHLT will ensure effective interface between the team and the GWH Safeguarding Lead via the Operational Mental Health Group.
- iv. MHLT Manager and the emergency department mental health lead nurse and ED consultant to meet monthly to identify and resolve operational and care pathway issues; this will include links/interface with other local AWP services.
- v. MHLT weekend hours of operation are 08.00 – 13.30.

#### **4.3.3. Mental Health Act**

- i. Mental Health Act administration is provided by the GWH.
- ii. GWH to ensure effective interface between their Quality Improvement Lead for safeguarding, Learning Disability and Mental Health, via both strategic and operational mental health groups.

#### **4.4. North Somerset (Weston General Hospital)**

##### **4.4.1. Clinical interface**

- i. A local pathway between the intensive service and the MHLT has been developed and agreed; which includes a protocol for the transfer of patients requiring home treatment and/or psychiatric hospital admission. In these cases joint assessments between the MHLT and the Intensive Team take place.
- ii. The MHLT has 3.6 WTE nursing staff only with no dedicated medical input and operates a service from 09.00 to 17.00 over 7 days. Two staff are on shift weekdays and one member of staff at weekends. Outside of these hours, by local agreement, the Intensive Team will give advice to Weston General Hospital (WGH) and assess those who are classified as red on the Mental Health Assessment Matrix. Medical input to the team is currently provided by the local mental health teams on an ad hoc/goodwill basis.
- iii. For older people (focussing on dementia and delirium) the Mental Health Liaison Service will be able to provide limited advice, depending on demands from other areas but not a specialist older people's assessment, diagnostic and advisory service (focussing on dementia and delirium). The Mental Health Liaison Service will not be able to provide assistance with discharge planning to older adults on wards at WGH.

##### **4.4.2. Operational and managerial interface**

- i. The service includes the provision of psychosocial assessment, fast tracking into secondary services, risk assessment, short term intervention and follow up, referral on and facilitation of discharge to the ED and other wards. Priority to referrals from the emergency department (ED) for those who present following a suicide attempt or episode of self-harm. The team also provide some limited education sessions.
- ii. The team manager attends the North Somerset Urgent Care Network consisting of N Somerset CCG, AWP, SWAST, Local Authority Social Services, Care UK. Community Partnerships and Weston Area Health and participates in a daily conference call including the above and NHS 111 to manage demand into Urgent Care and to ensure effective interface between services.

##### **4.4.3. Mental Health Act**

Mental Health Act administration is provided by the WGH. The MHLT and the local AMHP team are currently in discussion with plans to liaise with WGH to ensure that local interface around MHA issues is robust.

## 5. References

Psychiatric Liaison Accreditation Network - PLAN (2011) *Quality Standards for Liaison Psychiatry Services*. London: Royal College of Psychiatrists.

Royal College of Psychiatrists (2013) [\*Liaison Psychiatry for every Acute Hospital: Integrated mental and physical healthcare \(CR183\)\*](#). London: RCPsych.

South West Dementia Partnership (2011) [\*South West Hospital Standards in Dementia Care\*](#)