MENTAL HEALTH LIAISON OPERATIONAL PROCEDURES
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Membership of the policy development/review team:

- Michael Dunning (Operational Service Manager)
- Liaison Team Managers
- Liaison Consultant Psychiatrists

Consultation:

- Mental Health Liaison Team members
- Senior Service Managers and their teams

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1. Introduction

Background

This Operational Procedures provide a framework for the Mental Health Liaison Teams to work within and specifies actions which may be required.

This document includes procedures which provide standardised methods by providing a series of actions to be conducted in a certain order. This is with the aim of achieving a safe and effective outcome in a consistent method by all concerned.

Camden and Islington NHS Foundation Trust is commissioned to deliver Mental Health Liaison services to the following Acute Trusts. Our staff are required to follow the policies and procedures of their employing Trust and to be aware of, and comply with relevant polices from:

Royal Free London NHS Foundation Trust

Pond Street  
London  
NW3 2QG  
Tel: 020 7794 0500

University College London Hospitals NHS Foundation Trust

University College Hospital  
235 Euston Road  
London  
NW1 2BU  
Tel: 020 3456 7890

And Whittington Health

Whittington Health NHS Trust  
Magdala Avenue  
London  
N19 5NF  
Tel: 020 7272 3070
This policy was approved by the Camden and Islington NHS Foundation Trust Quality Review Group in May 2017 to ensure that the actions recommended are a reflection of best practice within mental health services.

Policy Statement

Camden and Islington NHS Foundation Trust provides Mental Health Liaison Services for the three local acute trusts. This policy aims to provide an effective, streamlined operational overview that applies to these three areas.

The purpose of these procedures is to provide operational guidance for the Mental Health Liaison Teams operating within the Camden and Islington NHS Foundation Trust. This operational guidance is informed and supported by Camden and Islington NHS Foundation Trust policies, procedures, and practice guidance. We strive to achieve standards of care and direction in response to national standards and local need.

This policy encapsulates the values, standards and procedures of Camden and Islington NHS Foundation Trust and is informed by the practice standards of University College London Hospital, Royal Free and Whittington Health Acute Trusts.

2. Our Vision

Our vision for Mental Health Service provision is for an integrated, multidisciplinary team approach that can proactively manage both Service Users’ mental health needs and physical care needs.

The service will work jointly with Service Users, ensuring partnership in the decision making for their care and treatment. We also include carers in the Service Users’ treatment, recognising their skills and knowledge.

There are three core components at the heart of this vision:

a. Integration

Historically, mental health services in the NHS have been integrated well with community-based services but less fully with acute providers. Camden and Islington NHS Foundation Trust has a joint commitment with hospitals to ensure seamless integration between the Mental Health Liaison Service, the Emergency Department (ED), the ward teams, and services both in our local communities and those further afield.
b. **Service User Need**

All Service Users experiencing a mental health crisis should receive a mental health assessment from a highly trained Mental Health nurse or doctor as soon as possible, regardless of the time of day. However, the Mental Health Liaison Service should be more than a reactive service to meet the needs of Service Users presenting in crisis.

With evidence to suggest up to a third of people who access NHS services have a Mental Health need, we aim to make it easier for staff and Service Users to access suitable and appropriate treatment and support.

c. **Workforce**

The backbone of any service is formed by the staff who work within it. We will invest in our staff and advocate for the necessary resource to achieve Core24 standards. Investment will allow the service to meet the demand in ED and to also deliver a proactive service that works more closely with wards to identify Service Users who need psychiatric or psychological input.

Furthermore, it will enable the Mental Health Liaison staff to provide a full training programme to ED and ward staff, developing all Trusts to be psychologically informed environments.

As a clinical-facing policy, this document is intended for all staff within the Acute Division specifically the Mental Health Liaison Teams. It should be referred to by all acute hospital staff, clinical staff, and operational staff, whether permanent, temporary, volunteers or agency staff.

3. **Feedback**

We encourage comments, suggestions or concerns about the care and experience of care that Service Users receive. Information gathered via the Friends & Family Test will inform service improvement activity.

**FRIENDS AND FAMILY TEST LINK**

CSQ (Client Satisfaction Questionnaire)


Complaints or concerns should in the first instance be raised with the assigned clinician. If the Service User is not satisfied with the initial response, the Team Manager can be contacted to address the concern informally. If the Service Users’ concerns are still not resolved these can be raised using the Complaints Policy for Camden and Islington NHS Foundation Trust. Details of this can be obtained from the Team Manager or by contacting the Advice and Complaints service directly. (see Appendix i)

3a. Service Users and Carers - can also be directed to the PALS (Patient Advice and Liaison Service), telephone numbers of which can be found on each acute Trust website, or local Service Users Forums.

C&I will work in a coordinated way with acute trust Complaints and PALS services, including joint response where this is indicated.

Our Service Users’ service/interventions; we have Service user volunteers who from time to time attend the Teams and assist the service – this may be to conduct surveys or to provide input such as providing refreshments or providing self-occupying packs for assessed service users awaiting transfer to another department – these volunteers have full DBS clearance and have been recruited specifically to work within the Trust.

3b. Service User Groups and Forums

Communication and engagement with service users is really important to us. We want to improve our services and ensure that we provide the best care possible. The key to achieving this is through feedback and involvement with service users, families and carers.

There are many ways in which service users can get involved with The Trust and voice their experiences and ideas. They can become a Trust member or join one
of the groups or forums such as the Camden Borough Users Group (CBUG) or Islington Borough Users Group (iBUG) or the Nubian User Forum for example; representatives from all of the groups meet regularly under the Service User Alliance. Contact details for the entire group can be found.

Please note - these services are only open to residents of Camden & Islington boroughs, for out of area residents, please signpost to their respective mental health Trusts as required.

3c. Information for Carers:

Carers play an important role in supporting people who use our services. Carers provide both emotional and practical support which can help others to live a more rewarding and independent life. C&I is committed in making sure that with carers; their views are heard, they get the support that they need and all the necessary information which may help them.

- Whilst under the care of the MHLT - each service user and carer is to be given an information and advice leaflet: (Appendix ii)

4. Service Aims

Mental Health Liaison aims to ensure all Service Users, regardless of diagnoses, specialty, age, or physical locations within the Acute Hospital Trusts receive care and treatment that considers their mental and physical health together. Service aims to be holistic in approach; outcomes based; community led and driven by best practice.

Holistic in Approach

- To promote recovery through the appropriate care and support to prevent the development of mental illness
- To improve the physical health of mental health populations
- Reduce stigma by recognising that physical and mental health are interrelated
- To provide a positive experience of care and support in general hospital setting
- To offer advice and education to the general hospitals clinical staff regarding the assessment, care, and treatment of people with mental health difficulties
To provide a holistic psychosocial assessment to determine Service Users’ mental health needs and presenting risk

Outcomes Based

- To reduce the number of people who experience harm by identifying risk
- To ensure care is given within the least restrictive environment by diverting from acute psychiatric admission wherever possible.
- To provide a timely Mental Health Liaison Service to ED and inpatient wards of the Royal Free, Whittington and UCL Hospitals seeing service users within 1 hour of referral in ED and 24 hours of referral from Wards
- To initiate an immediate plan of care

Community Led

- To liaise with community services, non-statutory services, in-patients services and the third sector as required
- To facilitate effective discharge from the general hospital such that the risk of readmission is reduced
- To include the Service Users’ social network (including relevant family, friends, and carers) in planning outcomes and care where indicated and with full patient consent
- To enable safe discharge within 4 hours from the ED.

Committed to Driving Best Practice

- To provide education and advice to hospital staff, other Camden and Islington NHS Foundation Trust colleagues and other key stakeholders;
- To incorporate the relevant standards from the National Service Framework (1999), primarily Standard 3: to provide an accessible service and Standard 7 to reduce and prevent suicides;
- To incorporate the NICE guidelines for self-harm (2004);
- To incorporate the Psychiatric Liaison Accreditation Network (PLAN) Standards and Core 24;

5. Duties and Responsibilities

All Trust staff are responsible for ensuring that they:

- Are familiar with the content of the relevant policy and follow its requirements;
- Work within, and do not exceed, their own sphere of competence.

6. Clinical Processes
Please also refer to associated documents section for list of relevant policies

6a. Referrals

The Mental Health Liaison Team accepts referrals for all service users over the age of 18 where there are mental health concerns. This includes adults of working age and older age service users with frailty and cognitive problems. Referrals are received from the ED and all in-patient wards. Advice and support is also provided for Service Users/families/carers and health professionals wishing to make a referral or simply for case discussion, which may or may not lead to referral.

Once a referral is made, service users remain under the overall responsibility of the Acute Trust.

Service Users are referred and accepted, regardless of the proximity of the patient’s home address.

Referrals are usually made by direct telephone contact from the referrer; they are connected to the following bleep numbers:

University College London Hospital: 4505
Whittington Hospital: 1106
Royal Free Hospital: 1784

Within normal office hours (9am – 5pm), the Child and Adolescent Mental Health Services (CAMHS) provide an urgent response liaison service for those under 18. Out of hours, there is an on-call service provided by a CAMHS Registrar and Consultant.

Referral Information Required

- NHS number
- Name
- Date of birth
- Address
- Ethnicity
- Status (either voluntary, or under a section of the Mental Health Act)
- Name of referrer
- Department/Ward of referrer
- Contact details for referrer
- Location of patient.
Reason for referral

- Brief outline of Service Users’ main concern, symptoms, need for mental health assessment at this time.
- Brief outline of health professionals or carers felt need for mental health assessment at this time.

History of presenting problems, difficulties, or concerns

A detailed description of the presenting problems will be collated. This should include the time of onset, the duration, and the progression, including how it affects relationships, work and other aspects of life, possible triggers, or exacerbating factors.

This should also include any details of any treatment already received for this episode of illness, with information about the person’s response to this. Any current care provision should be recorded, with key contact details noted.

6b. Collateral Information: Gathering collateral is a key component to successful liaison work. Every member of the Liaison Team is reminded that; robust collateral information gathering is crucial before conducting any psychiatric assessments. Permission to obtain collateral is needed first from the service user, and the importance of this conveyed to them as part of establishing a care plan. Information about a patient who is about to be assessed should be gathered from anyone who has had involvement with the service user but in particular from:

- Family and Friends
- Neighbours
- Police
- Triage Nurses
- GP’s
- Ambulance crew
- Acute Trust
- Social services
- Electronic patient record systems (EPR).
- Community Mental Health Teams
- Any institution or individual who has been involved in the patient’s care.

6c. Parallel Assessment procedures: A parallel assessment process is in place with all acute Trusts and C&I with the expectation that a mental health assessment can take place at the same time as a medical assessment within the
ED. The aim is to ensure service users are triaged and assessed without unnecessary delay. If medical concerns are identified further into the mental health assessment, then the service user should be re-referred back to the Emergency Department for an additional review as required. (Appendix iii)

6d. Management of Intoxication: Service Users under the influence of alcohol and/or drugs; who are presenting with co-morbid mental health problems must be given sufficient time to become assessable.

6e. Sharing of key clinical information:

Sharing amongst professionals: When a member of the Liaison Team or other partner acute service such as the Crisis Resolution Team receives important clinical information about a service user who is currently being assessed in a crisis or emergency situation, or who is already under the care of another mental health team, the team members should immediately or at the earliest opportunity seek to share this information with the assessing service by telephone. This is to aid risk management and decision-making ‘in situ’ as well as documenting on the electronic patient record system.

Sharing amongst external agencies and/or carers/family/friends: An Information sharing and consent form is included, together with a flowchart to aid decision-making (Appendix iv) to facilitate this process. It should be scanned and uploaded to the EPR system once completed.

6f. Exclusion Criteria: Service users who exclusively present with substance misuse difficulties and no co-morbid mental health problems.

A Referral Log template is included in the appendices (Appendix v) and should be used to record the referral which must then be transferred to the EPR system.

Response times for referrals are currently: 1 hour for all ED referrals and 24 hours for those from medical wards.

7. Section 136 Referrals

The Metropolitan Police and British Transport Police may detain people under Section 136 of the Mental Health Act. People detained under Section 136 may be brought to the designated Health-Based Place of Safety (HBPoS) for a mental health assessment. The Royal Free, Whittington and UCLH are all designated
HBPoS. Please refer to the joint policy and procedure for Section 136 referrals (Appendix vi).

There is a pan-London Section 136 policy which all teams must adhere to, this can be found at https://www.healthylondon.org/latest/publications/mental-health-crisis-care-londoners

8. Management and Implementation of the Mental Health Act, the role of the RC for detained patients, the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) concerns

8a. The Mental Health Act: Service users may be considered for assessment under the Mental Health Act (MHA) as part of the admission process. Once a service user has been identified as needing a MHA assessment, medical recommendations are initiated by the most appropriate member of the psychiatric medical team. Reading of rights to service users detained under the MHA and recording of this is an expected part of this process.

8b. Management and Implementation of the Mental Health Act
The consultants in the Mental Health Liaison Teams will act and fulfil all responsibilities as a Responsible Clinician for service users detained in the acute hospital under a section of the Mental Health Act, when these patients are detained to the said acute hospital. The liaison psychiatry team will provide clinical care to all other service users detained to mental health institutions and briefly conveyed to the acute hospital for the treatment of their medical/surgical needs.

Section 12 doctors working in the Liaison teams will conduct Mental Health Act reviews in the ED or the wards, in a timely manner, according to existing guidelines and under the supervision of the respective Consultant Liaison psychiatrists.

Completion of the MHA assessment and MHA assessments at unsocial hours will be performed by the MH trust in line with C&I Trust procedures (Appendix vii).

The administration of the MHA will be provided by each acute hospital or provision will be made within the mental health trust (C&I). Regular support for teaching and training of the relevant administrative staff in the acute hospital is detailed elsewhere (in the respective SLAs for the MHA administration).
The transfer of patients placed under the MHA from the acute hospital to other hospitals would be conducted under agreed operational procedures and in accordance to local guidelines.

In the event that a service user is detained to any of the acute trusts, under Section 2 or 3 of the Mental Health Act, it is the responsibility of the named nurse caring for that service user to inform them of their rights, including the right to appeal against the decision to detain them. This is an obligation under Section 132 of the Mental Health Act and is the responsibility of the staff within the hospital that is providing care.

Service users need to be informed of their right to appeal to an Independent Mental Health Review Tribunal and staff need to record that they have informed the service user of that right and to have taken steps to help facilitate this. Part of this responsibility will be to ensure they have been given their rights in written form. Section 132 rights form should be completed and given to the service user and also must be documented in their notes.

8c. The Mental Capacity Act (MCA) Mental health liaison teams can provide a second opinion on mental capacity for patients if there is a concern about an individual’s capacity to make decisions about their medical treatment. All clinicians are able to conduct capacity assessments and these should be documented in the relevant part of the EPR system. However, the initial mental capacity assessment must be completed by the treating medical/surgical team. The Mental Health Liaison team will also offer an opinion on complex issues of mental capacity in accordance with the requirements of the Act, in a timely manner and in conjunction with the treating team, the legal team from the acute hospital, other agencies and external legal structures as required. The required seniority of the assessor will be determined by the complexity of the question and the clinical need on a case by case basis and determined by the multi-disciplinary team.

8d. Deprivation of Liberty (DoLs) The liaison psychiatry team will offer an opinion on the requirement for an application of a DoLS, if necessary but will not be directly involved in the process which is escalated through the acute hospital structures.

All service users who are placed on enhanced observations by the liaison team by reason of incapacity or under the section of the MHA will have their
management plan reviewed on a daily basis, in accordance with current practice and policies.

All Mental health Liaison teams will adhere throughout to the Camden & Islington NHS Foundation Trust Mental Capacity Act 2005 (incorporating the Deprivation of Liberty Safeguards) policy.

9. **Informal Admission to a C&I acute in-patient bed:** When assessing patients for informal admission to a C&I bed, Liaison team clinicians will complete the record of Informed consent for voluntary admissions in mental health units (Appendix viii). If admitting to other trusts clinicians will adhere to procedures requested by the relevant bed managers.

10. **Escalation processes:** In the event of there being delays to admission and discharge, there are formal escalation protocols in place. These are RAG-rated and the various stages are triggered by time. Liaison staff are expected to regularly update the acute staff at frequent intervals, the minimum requirement being 4 hourly intervals (appendix ix).

11. **Discharge from the Liaison service** is marked with a clear entry in the EPR documenting outcome of assessment and rationale for ongoing care. There should be one of four outcomes clearly recorded:

   1) **Admission to hospital** - details of ward, time, etc, whether voluntary or on section - reasons for this with recommendations for first 24 hours in relation to ongoing care.
   2) **Admission to crisis house** – name of crisis house, name of accepting clinician, care plan for first 24 hours. Consider need/availability of medications.
   3) **Referral to crisis team**, reasons for this, the Mental Health Liaison teams can refer directly into the CRT via the Crisis Call Centre within C&I and as such a full and detailed assessment must be completed and demographics and contact details to be confirmed as accurate prior to the service user leaving the department.
   4) **Discharge home to care of GP and/or follow up by community team.** A letter of discharge is to be sent to GP and community services. This must take place within 24 hours.

12. **Clinical Documentation:** For all documentation relevant to clinical processes, the Trust EPR system (CareNotes) is to be utilised. All referrals are entered straight on to CareNotes, a Referral Log template is included below for use in assisting in recording referrals - all information must be added to the CareNotes system. The following documentation is required to be completed by all clinicians:
A robust and detailed assessment within the Core Assessment template to include a full mental state examination, and detail on past history, family and social circumstances, physical health, substance use and forensic history.

A risk assessment must be completed and documented in the Risk Assessment section within CareNotes.

Care Plans: There is also a Care plan template for use within ED which helps inform acute trust staff. A suggested template is attached for use for all liaison teams to provide up to the minute care planning in conjunction with ED staff and should be used to support care delivery (appendix X).

Progress notes are used for contemporaneous information and must not be used to the exclusion of other CareNotes documents.

Service users who are referred on to mental health services outside CIFT are given a copy of the full assessment and the risk assessment either by email (through NHS.NET accounts) or a hard copy.

13. Prescribing/Medication Policy (Liaison Teams):

13a Responsibilities
The liaison psychiatry teams do not store medications. This is the responsibility of the acute hospital. In addition to this, the pharmacy service is also provided by the hospital. Prescribing can be done either by advising ward or A&E medics on the most appropriate psychiatric medication. Liaison psychiatrists with honorary contracts prescribe directly. Prescribing by psychiatrists with honorary contracts is only via the acute hospital’s medication charts. Liaison psychiatry medics should only prescribe in conjunction with documentation within the patients’ acute hospital medical notes, this in addition to the mental health trust notes.

13b Other prescribing and Advisory Considerations
Prescribing considerations must be done in line with both the C&I and the acute hospital prescribing policies e.g. all sections of medication chart to be completed i.e. known allergies or drug sensitivities etc.
13c Honorary Contracts
Liaison psychiatrists will only advise the acute hospital medics if the honorary contract is not yet in place and cannot directly prescribe.

13d. Administration of Medicines
Medicines are not routinely administered by members of the liaison Psychiatry team. This is primarily the responsibility of acute hospital medical or nursing staff.

On occasions, the liaison psychiatry nurses may be asked to administer oral medications where staff have been unsuccessful or they may support acute hospital staff to give medicines. All practitioners are accountable for their actions in this respect. This should only be done within the boundaries of the Royal Free Hospital and C&I medication administration policy.

13e. Monitoring of Side Effects of Medications
Liaison psychiatry staff should always advise acute hospital staff of any potential side effects or contrary indications. Liaison psychiatrists will usually have more experience around this area, but ultimately the acute hospital staff will have responsibility.

Side-effects of long-term antipsychotics for instance may be assessed by using the Glasgow Antipsychotic Side-Effects Scale (GASS) or the Liverpool Unwanted Side Effect Rating Scale (LUNSERS) it is essential that the liaison team share any historical information with the acute hospital staff e.g. history of addictive behavior in the case of benzodiazepines or previous adverse reactions etc.

Pharmacy services are available 24 hours a day for advice around contraindications between different medications being taken for mental and physical problems, including over-the-counter products, which may adversely affect cognitive functioning. The age of the patient is always considered e.g. older adults metabolise medications more slowly, therefore lower doses to be considered.

This policy on medication within the liaison teams compliments the Trust wide medicines management policy.

Factors to take into consideration

- Establish Collateral Risk History/previous management plans
- Diagnosis
- Triggers/relapse indicators
- Forensic History
- Substance Misuse
- Absconding (Risk history/likelihood)
- Legal status (MCA/MHA/Sec 136)
- Sedation and prescribing
- Physical Health Checks
- Security/1:1 nursing observation/ Emergency Dept. Assistants

Clearly documented plan of action in the event of service user leaving before being fully assessed or before completion of assessment

- Inform Police (description, clothes/appearance/CCTV information)
- Search hospital grounds/locality
- Attempt to contact patient (whereabouts, likely destination)
- Contact Next of Kin
- Alert local Mental Health Services and other ED Depts (AMHP Service/EDT/CMHT)
- Inform GP
- Datix

14a. High Risk Assessment Processes

Environment

- Identify safe assessment space: MH cubicle/Triage area/ordinary ED examination cubicle, consider fixtures, fittings and removal of furniture.
- Security Present (security personnel must be informed of the nature of an assessment, its potential risks and briefed about potential assistance needed or likely interventions that may be needed including the searching of patients property for potential weapons or methods of self-harm
- Consider the need for sedation or the need for physical restraint (If either are necessary patients physical observations must be clearly recorded)
Liaison staff should not assess high risk patients alone
- Alarm systems (PIN point/wall strip/skyguard)
- CCTV
- Consider the need for Police assistance

**Communication**
Clear documentation of risk factors and plan of action
Documented handovers between ED staff, liaison team and Security
Clearly documented liaison with internal and external agency

**Conveyance**
Upon determining level of risk appropriate transport should be arranged in order to convey the patient safely including the use of secure vehicles for detained patients and the use of nurse escorts

Please refer to the Clinical Risk Assessment and Management Policy

14b. Communication of risk to acute trust.

Risk assessment is electronically updated via patient records (care notes) which is available to all CIFT teams.
Risk alerts and plans for management form a fundamental part of each assessment. Plans are verbally handed over to acute colleagues and the written assessments are printed from Care Notes and placed in the acute trusts medical notes. If this is not practicable, handwritten documentation within the acute Trusts notes is acceptable.

15. Management of absconding from care: In the event of a service user under assessment absconding from ED/wards, it is the responsibility of the liaison team to try and establish contact with the service user by telephone. Discussion should be held between acute Trust staff and liaison staff as to what appropriate action should be taken including the need to request police assistance to conduct a welfare check.

*If the mental health act has been applied* (including Section 136) or is in the process of being applied – service users must be prevented from leaving. Police should be notified immediately if this happens. If awaiting admission and are
voluntary then a police welfare check must be considered following a risk assessment.

If a service user is informal and making attempts to leave the department then a clinician must carry out a capacity assessment before a decision can be reached to allow the service user to leave of their own accord.

16. Safeguarding children and vulnerable adults: The Safeguarding of children and vulnerable adults must be managed through the respective acute Trusts. For service users being discharged from the general hospitals e.g. via ED; all safeguarding alerts will then be investigated by the local authority. For any alerts raised for those service users who remain within medical wards, each acute Trust has a Safeguarding lead who manages this. There are weekly safeguarding meetings which managers are invited to.

17. Quality and Governance

There will be an ongoing process of both clinical and quality audit and evaluation in relation to the quality of service delivered, the results of which feed into the Trusts’ governance structures and strategic planning. This will involve the production of demographic data, Service User feedback, carer and staff feedback and admission/treatment/discharge data.

The results of audits will be disseminated to staff and management of the service including Service Users groups and appropriate senior managers. Policies, protocols standards etc. will be amended based on information and evidence from audits and incidents.

Individuals working in clinical teams providing NHS services are at the frontline of ensuring quality of care to Service Users. Many of these frontline staff work within a framework of professional regulation that makes them personally accountable for the quality and safety of care they provide to individual Service Users. However, ultimately, it must be the board and leaders of Camden and Islington NHS Foundation Trust that take final and definitive responsibility for improvements, successful delivery, and equally failures, in the quality of care.

Each MHLT must also comply with clinical governance forums within their respective Acute hospitals and all appropriate acute hospital policies.

Evaluation feedback and further service development will also be obtained from and fed back to the following forums:
- C&I Clinical Governance Group
- Acute Community Service Users and Carer Involvement Forum
- Carer Experience Meetings
- Service Users Views via comment cards/tablets
- Team meetings
- Clinical Audit
- Monthly joint operational meetings for RFH, UCLH and Whittington Liaison Teams

Performance Reports will be produced monthly detailing activity and response time’s data. All staff are responsible for contributing to continuous improvement in data quality.

Mental Health Liaison staff will record incidents using the C&I Datix system and/or local acute incident reporting systems as required. C&I and acute trust clinical governance leads will work together to establish if the threshold has been met to undertake a serious incident investigation and coordinate activity if a joint investigation is indicated.

C&I Risk & Patient Safety Manager: Samantha Barclay, Tel: 020 3317 6560, Email: Samantha.barclay@candi.nhs.uk

UCLH named lead?
RFH: Nick Wright: 020 375 82155
WH: Post vacant

Learning from serious incidents and near misses will be shared across Liaison Services via Team meetings and individual supervision.

Camden and Islington NHS Foundation Trust will be expected to play a full part in monitoring their compliance with the standards set out by the Care Quality Commission.

17a. Record keeping

- Each Acute Trust is responsible for keeping records in patient notes;
- The Mental Health Liaison Service will keep assessment records on the Trust’s Electronic Record System called CareNotes and also Medway/CERNER/CareCast
- The Mental Health Liaison Service will make use of clinical and data quality dashboard to ensure that record keeping is compliant with C&I Trust standards;
- The Mental Health Liaison Service participates in Audit/Quality Improvement Projects so that evidence of action and feedback from any negative comments and complaints made about the liaison team can be evidenced and discussed. These projects also address critical incidents, near-misses and other adverse incidents, where relevant to the liaison team
- Documentation and data management; - the MHLT need to record a log of all referrals, this assists the service with performance management. Clinicians must also use the CareNotes diary for recording all patient

18. Training Requirements

External: The provision of mental health training for acute Trust staff is an expected part of service delivery and is highlighted in the monthly performance reports for each acute Trust. This varies according to individual Trust needs but all training will include components on managing risk, deliberate self-harm and the Mental Health Act. A list of suitable topics can be found at Appendix 1: Examples of Training Provided to Acute colleagues Quality Standards for Liaison Psychiatry Services, 4th ed. PLAN (Psychiatric Liaison Accreditation Network, Royal College of Psychiatrist

Internal: Skills development and continuing practice development is a joint responsibility between all staff and their managers. Staff must ensure that core skills training is up to date including any mandatory training needs. Managers will ensure that other training opportunities are cascaded down to staff via the Learning and Development team.

Through supervision, staff appraisals and Performance and Development Reviews individual learning needs will be identified and a personal development plan formulated and reviewed.

https://intranet.candi.nhs.uk/policy/overview/563/clinical-professional-and-practice-supervision

Clinical supervision is a crucial part of the development and maintenance of good clinical practice. All staff are encouraged to have supervision both one to one and in a group setting on a regular basis to encourage self-reflection, development, and the maintenance and revision of clinical skills.
Management supervision allows a person in a supervisory position to manage, direct and oversee the performance and operation of another member of staff, enabling the individual to achieve a satisfactory level of competence and promote their potential within the organisation. All staff employed within the trust will receive regular management supervision in line with the trust’s agreed standards and procedures.

Camden and Islington NHS Foundation Trust has training structures in place to ensure that the Liaison Team has access to training, education, and guidance.

This includes:

- Annual training reviews;
- Rolling training programme for liaison professionals;
- Liaison staff access to online journals, reference guides or text books;
- A comprehensive Induction to new liaison team members;
- Opportunities for liaison staff to shadow mental health colleagues from outside of the hospital.
- Education and weekly supervision of psychiatric trainees overseen by each teams Consultant Psychiatrists

For training requirements please refer to the Trust’s Mandatory Training Policy (accessible from the Trust intranet) and Learning and Development Guide (accessible from the Trust intranet).

The Mandatory Training Policy and Learning and Development Guide will be regularly updated (yearly, or in line with latest legislation) by the Policy Lead.

19. Dissemination and Implementation Arrangements

This policy will be circulated to all staff within the acute division via email, and will be discussed and reviewed annually in team meetings, or more often as appropriate.

For clarification or support in the implementation of this policy, please contact:

Michael Dunning
Operational Service Manager for Mental Health Liaison Teams within Camden and Islington NHS Foundation Trust.
Email: Michael.dunning@candi.nhs.co.uk
Tel: 07768 507 587
20. Monitoring and Audit arrangements

This policy will be audited and reviewed by Camden and Islington NHS Foundation Trust annually to ensure that it is compliant with relevant legislation and that it is fit for purpose.

Michael Dunning, Operational Service Manager and Policy Lead, is responsible for carrying out the audit, recording and reporting the results through our Audit Tool.

21. Review of the policy

This policy will be reviewed annually or sooner if the need arises.

The review team comprises: Operational leads, clinical and medical leads within the Mental Health Liaison services, Senior service manager and Divisional Directors.

22. References and Associated documents

- Quality Standards for Liaison Psychiatry Services, Royal School of Psychiatrists (Fourth Edition 2014)
- No Health Without Mental Health, HM Government (2011)
- Essence of Care, Department of Health (2010)
- Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance (NICE, NHS England, 2016)
- National Health Service Litigation Authority (NHSLA) Risk Management Standards 2013-14 for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care (NHS Litigation Authority)

- CPA (Care Programme Approach) and Care Process Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy and Guidance
- Multi Agency Safeguarding Adults Policy
- Bed Management Policy
- Security Management – Lone Working Policy
- Data protection policy
- Access to Health Records Policy and Procedure
- Complaints Policy
23. **Appendices:**

**Appendix i: Advice and Complaints policy**

**C&I Advice and Complaints Policy**

**Appendix ii: Service User/Carer Information Leaflets**

There are leaflets which must be given to all service users/carers who are referred to the service – printable copies can be downloaded from these icons:

- Support in the Emergency Department
- MHLT leaflet v3.pdf

**Stand-alone documents**
Appendix iii:

MENTAL HEALTH LIAISON TEAM
PARALLEL REFERRALS

What is a parallel assessment?
- An assessment of a patient’s mental health that takes place whilst a patient is still being medically assessed, i.e., before they are ‘medically fit’

Who can be referred for a parallel assessment?
- Patients in the Emergency Department whose treatment will finish within the 4-hour target time.
- Patients who have taken an overdose but whose bloods are anticipated to be ‘normal’.
- Patients with a medical problem where it is believed they may also have a psychiatric problem.
- Patients who request to see the mental health team at the initial triage stage.
- In all cases the patient must be assessable.

Who can make a referral for a parallel assessment?
- Doctors in the emergency department.
- Doctors on wards.

When can a patient be referred for a parallel assessment?
- 7 days a week, 24 hrs a day.
- Between the hours of 9pm-9am parallel assessments may not automatically be possible if the duty CT is busy, and should only be requested on the premise that the patient is definitely assessable and envisaged to be medically cleared within the 4 hour breach time

Please Note:
Any patient referred for a parallel assessment remains under the care of the Emergency Department or ward clinic team.
Appendix iv : Information Sharing and consent Form


Stand-alone document
Appendix v: Referral Log Template

Liaison Team Referral Log

Date:

Referrer details
Name
Position
Location
Bleep number
Referral taken by

Patient information
Name
Date of Birth
NHS number
Gender
Address

GP details

Interpreter needed?
Is the patient aware of the referral?

Reason for referral to MHLT (nature of concern, current mental state, medication given)

…………………………………………………………………………………………………
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Is the patient medically cleared? (Please circle) YES NO
Has any medication been prescribed?
If parallel assessment requested, which investigations/results are outstanding?

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

Previous psychiatric history (are they currently open to a MH team?)
Appendix vi: Joint policy on use of Section 136

Access from C&I Trust Intranet

Appendix vii: Mental Health Act procedures

Referral Protocol and responsibilities for organising Mental Health Act Assessments

Office Hours (9-5pm)

All 3 Liaison Teams (UCLH, Royal Free Hospital, Whittington Hospital)

- Will provide Section 12 Doctor cover 9-5 Mon-Fri.
  If Assessment is required under the MHA the Section 12 Doctor will conduct the initial assessment. Once Medical Recommendation is complete
- Will be responsible for contacting the AMHP duty service
  Camden 0203 317 2921
  Islington 0207 561 4433
  Haringey 0208 442 6421
  Westminster 0207 854 4399

- Will be responsible for sourcing a bed in the patients local catchment area by speaking to the relevant bed management team
  Camden & Islington 0207 561 4182
  Barnet Enfield and Haringey 020 8702 5550
  Westminster 07860927381

- The liaison team will contact the Crisis/Resolution and home treatment team to see if they will be able to attend the assessment or for the purposes of gatekeeping.
- The assessing AMHP is responsible for identifying for the second opinion (Sec 12) Doctor and of coordinating the assessment.
- If the patient is detained it is the responsibility of the AMHP to inform the patient of the decision and their rights, and the rights of the Nearest Relative.
- It is the responsibility of the AMHP to scrutinise the section papers
- The liaison team in conjunction with MHA assessing team will arrange for conveyance to designated hospital
- The liaison team will inform and update all relevant family and professionals involved in the patients care (Next of Kin, Care co-ordinator, GP)

Out of Hours

- All 3 liaison teams will conduct the initial assessment of every patient who may require a MHAA
If a MHAA is required the liaison team will source a bed from the patients catchment area.

The liaison team will contact the relevant Crisis Team to discuss attendance and gatekeeping.

The liaison team will contact the Duty Specialist Trainee (ST) to request an initial assessment. If the ST makes a recommendation then it is the responsibility of the liaison team to contact the appropriate duty team.

It is good practice for a MHAA to be completed with all professionals present. This reduces the number of separate assessments a service user has to undergo. However, due to competing demands and time constraints this is not always possible. If viable:

- The ST will liaise with the Duty AMHP via the Emergency Duty Team

Camden 0207 974 4444
Islington 0207 226 0992

It is the responsibility of the AMHP to co-ordinate the MHAA and to arrange the appropriate S12 approved doctors.

Upon completion of the assessment – depending on outcome - it is the liaison team in conjunction with the assessing team to arrange appropriate conveyance.

If the patient is detained it is the responsibility of the AMHP to inform the patient of the decision and their rights, and the rights of the Nearest Relative.

Appendix viii: Informed consent for voluntary admission forms

Informed Consent for voluntary admission

Voluntary In-Patients Form Aug 2015 [dm]

Stand-alone documents
Appendix ix: Escalation Protocol

Escalation Protocol for Acute/Mental Health Trust Interface

Guidance Notes
Reasons for escalation may include: long waits for patients needing psychiatric admission, serious incidents, capacity of wards/ED, staffing issues. Long waits in EDs are the most common cause for escalation.
Parallel escalation to senior managers via both the acute hospital and mental health trust lines will be expected at the following points following Psychiatric Liaison Team Assessment in EDs:
- 4 hours = GREEN Band 7 Team Manager/Nurse in Charge
- 6 hours = AMBER Band 8a/8b Liaison Operational Manager/General Manager
- 7 hours = AMBER 8b Senior Service Manager/ED Matron
- 8 – 10 hours = RED Band 8c/8d - DCD/AD/Senior Matron
- 11 hours = RED Chief Operating Officer/Medical Director
- 12 hours from DTA (decision to admit) is logged as a serious incident

Delays to accessing a psychiatric inpatient admission from a medical ward will be escalated at 24 hours within C&I’s daily bed management meeting.
- C&I work with the necessity to avoid reportable “12 hour trolley breaches” which is defined as a wait of 12 hours plus from the point of decision to the point of admission.
4 Hours from Psychiatric Liaison Assessment

6 hours

8-10 hours

Band 7: NIC = MHLT Manager

Band 8a/8b Operational/Senior Service Manager = General Manager/Matron Acute Trust

Band 8c/8d DCD/AD/senior Matron/Director
C&I - Adele McKay Acting Associate Director 07825 843 236
UCLH - Donna Adcock Senior Divisional Matron Emergency Services 07930 261051
RFH - Camilla Wiley Hospital Director 07930 609 698
Whittington Health - Carol Gillen Chief Operating Officer 07909 572794 (Danielle Morrell)

C&I
Michael Dunning
Operational Service Mgr. 07768 507587
Senior Services Manager - Vacant Post

UCLH
Holly Taylor
General Manager Emergency Dept
07572 614696

RFH
Eleanor Woodward
Senior Ops Mgr ED 07751 861 045
Ogechi Anodu
Service Mgr 0203754 2000 x 38001

Whittington
Eleanor Woodward
Senior Ops Mgr ED
07751 861 045

Royal Free Hospital
Hayner Harries
Clinical Team Manager
07771 379 269

Whittington
Vacant Post
Clinical Team Manager

UCLH
Jo Malone
Clinical Team Manager
07507 969 981

C&I Silver Manager on-call Pager: 07659 153 379

C&I Gold Director on-call Pager: 07659 175 451

Out of hours

C&I Bronze: Duty Nurse 020 3317 3500
Mental Health Patients in the Emergency Department

- The ED Charge Nurse will contact Psychiatric Liaison if they have not arrived to assess any patient within 1 hour of referral.
- Psychiatric Liaison will update the ED Charge Nurse with reason for delay if over 1 hour.
- Any wait over 1 hour to be seen by Psychiatric Liaison will be escalated to the Team Manager by the Liaison Nurse.
- Psychiatric Liaison will contact the on-call core trainee doctor to assist out of ours when needed.
- Psychiatric Liaison will communicate the C&I bed state with the ED Charge Nurse regularly when a patient is being admitted.
- Psychiatric Liaison will give 2 hourly bed updates to the ED charge Nurse, ED Nurse Coordinator and Matrons.
- The ED Matrons will keep the General Manager and ED Consultant in charge of the Mental Health bed state.
- Psychiatric Liaison will communicate any immediate safety issues to security.

- Psychiatric Liaison will contact the Consultant/ SPR and SPR (24/7) and request assistance in ED if the wait to be seen is between 2-3 Hours.
- The Psychiatric Liaison Nurse will contact the Liaison Team Manager to escalate any safety concerns.
- The Liaison Team Manager will communicate bed delays or safety concerns to the ED nurse in charge, ED Consultant in Charge, Matrons and General Manager.
- The Liaison Team Manager will ensure that every patient is formally reviewed at least every 4 hours.
- The Liaison Service Manager will liaise with the C&I Bed Managers if there are delays over 4 hours from time of medical discharge.
- The Liaison Service Manager will keep the C&I Senior Service Manager informed of any delay issues beyond 6 hours.
- The Liaison Service Manager will feed into the C&I daily bed management meeting and liaise directly with the Matron responsible for Bed Management.

- Any delays in beds over 8 hours will be communicated between the ED General Manager and the C&I Senior Services Manager.
- The ED General Manager will keep the ED Nurse in Charge, Nurse Coordinator, Matrons and ED Consultant in charge of any significant issues related to bed delay.
- The Liaison Team Manager will attend ED to support when required.
- C&I Senior Service Manager will escalate to the Divisional Director to establish agreement to seek a private placement if a C&I bed has not been identified.
- C&I Divisional Director will advise the COO/Medical Director if a private placement is required.
### Guidance for Mental Health Liaison Teams
Capturing Referral Source and Types of Activity on Carenotes

<table>
<thead>
<tr>
<th>Checklist for OPENING A REFERRAL to A&amp;E Liaison Team</th>
<th>Guidance notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Referral via “Community Episode”</td>
<td>For “Referral Source” Clinicians must choose from only two options:</td>
</tr>
<tr>
<td>Fill out the “Referral Source” field accurately</td>
<td>Referral from A&amp;E - choose ‘Accident &amp; Emergency Department’</td>
</tr>
<tr>
<td></td>
<td>Referral from any Inpatient Acute Ward - ‘Other Secondary Care Speciality’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Checklist for Capturing the Activity in your Carenotes Diary</th>
<th>Guidance notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter EVERY activity in your Carenotes Diary</td>
<td>There is a limit to the choices of code:</td>
</tr>
<tr>
<td></td>
<td>For the INITIAL fact-to-face contact clinicians will only choose ‘New Patient Assessment’</td>
</tr>
<tr>
<td></td>
<td>For every contact subsequent contact clinicians will only choose “Follow Up Appointment”</td>
</tr>
</tbody>
</table>