Mental Health
Integrated Access Partnership
Intelligent Mental Health System Response

Mental Health Clinical Assessment Service (MH CAS) Standard Operating Procedure (SOP)

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Introduction

The Integrated Access partnership (IAP) is a collaborative, award winning, innovative endeavour which is transforming urgent and emergency care services (999 and 111) for people in mental health crisis.

In collaboration, BrisDoc Healthcare Service, Avon and Wiltshire Mental Health Partnership Foundation Trust and South Western Ambulance Service NHS Foundation Trust - as well as Avon and Somerset Police, Avon Fire and voluntary sector organisations - have implemented an integrated urgent and emergency care front door service across both 999 and 111 for people in mental health crisis. The service provides three layers of intervention and trusted onward referrals to support any person presenting with mental health needs to 999 or 111; providing remote advice through a multidisciplinary mental health team; or a rapid face-to-face response through a network of 'mobile pods' across the area.

The Partnership services are outlined in the table below. Each part of the service is covered by a Standard Operating Procedure.

Integrated Access Partnership (IAP) Services									
Mental Health Specialist Desk (MH SD) Emergency Operations Centre (EOC) 999		**Mental Health Response Vehicle (MH RV) 999/111**		**Mental Health Clinical Assessment Service (MH CAS) 111**		**Urgent Assessment Centre Gloucester House (UAC) 999/111**		**Professional Line (PL) 999**	
Current Provision		**Current Provision**		**Current Provision**		**Current Provision**		**Current Provision**	
BNSSG Glos BSW Somerset Devon Dorset Cornwall	24/7 08:00-00:00 7/7 08:00-00:00 7/7 08:00-00:00 7/7 08:00-00:00 /7 08:00-00:00 7/7 08:00-00:00 7/7	BNSSG RRV Glos RRV	24/7 Mon-Thurs 12:00-00:00	BNSSG	08:00-20:00 7/7	BNSSG	17:30-00:00 7/7	SWASFT BNSSG Avon and Somerset Police Avon Fire and Rescue	24/7 24/7 24/7

IAP Contact Details

Integrated Access Partnership (IAP) Services				
Mental Health Specialist Desk (MH SD) Emergency Operations Centre (EOC) 999	**Mental Health Response Vehicle (MH RV) 999/111**	**Mental Health Clinical Assessment Service (MH CAS) 111**	**Urgent Assessment Centre Gloucester House (UAC) 999/111**	**Professional Line (PL) 999**
Address	**Address**	**Address**	**Address**	**Address**
SWAST EOC St James A St James Court Bradley Stoke Bristol BS32 4QJ	Bristol Ambulance Station Croydon Street Easton Bristol BS5 0DA	BrisDoc Healthcare Services, Unit 21, Osprey Court, Hawkfield Business Park, Whitchurch, Bristol, BS14 0BB	Gloucester House Southmead Hospital Dorian Way Bristol BS10 5NB	8 X 8 Telephone System
Direct Dial	**Direct Dial**	**Direct Dial**	**Direct Dial**	**Direct Dial**
MH RV Dedicated Line 0300 373 0813		0117 244 9283		0300 373 0813

Mental Health Clinical Assessment Service (MH CAS)
Standard Operating Procedure (SOP)

Objective

The Standard Operating Procedure is to provide guidance to IAP staff on the day-to-day operation of the Mental Health CAS Service.

Overarching SOP

Please refer to the Overarching SOP for matters relating to:

- Key Roles & Responsibilities
- Clinical Intervention
- Clinical Records
- People with Unmet Needs – High Intensity Users (HIU)
- Safeguarding
- Data Protection and Confidentiality
- Business Continuity
- Quality and Governance
    - Learning Events/Incidents
    - Clinical Audit

Mental Health Clinical Assessment Service (MH CAS) Overview

MH CAS Review, Triage and Assessment is available as detailed by the service outline table below.

Mental Health Clinical Assessment Service (MH CAS) 111	
Current Provision	
BNSSG	08:00-20:00 7/7

This part of the IAP is the entry point for mental health support via 111. It is currently subject to the most development in preparation for the NHSE mandate for all crisis access to route via 111 by April 2024. Work is underway to develop and expand the service at pace in preparation for this requirement.

MH CAS staff receive training on the use of SevernSide systems. Adastra has a series of 'queues' which can be assigned to different specialisms. The MH CAS will have a dedicated 'Mental Health' advice queue. Staff in the MH CAS will only contact patients once they are held on the Mental Health Adastra call queue. Calls can arrive in this queue via several routes:

- Direct referral from 111 Health Advisor or 111 Online via the Directory of Services (DoS)
- From the IUC Advice Queue – pushed or pulled into the Mental Health Queue
- From the System CAS Advice Queue – pushed or pulled into the Mental Health Queue
- From the ACE Advice Queue – pushed or pulled into the Mental Health Queue.

The MH CAS will call back patients allocated to the Mental Health queue in order of prioritisation. 111 mental health calls within the MH call queue will be prioritised for call back using the priorities pre-defined by Adastra and will be informed by the NHS Pathways assessment. Calls meeting category A+B of the UK MHTS would be best managed by registered staff.

'Fishing' for appropriate calls in other queues will be essential in refining the pathway and increasing call volume in the early stages. MH CAS workers will 'fish' for calls by searching through the System CAS and IUC Advice queue for calls that relate to mental health.

Resourcing

As a minimum, the MH CAS must be staffed by 1x Band 7 or 1x Band 6 registered MH professional.

Any changes to MH CAS resourcing must be made in line with the process in Appendix 5.

Process & Functionality

While operating in the MH CAS, IAP staff must comply with BrisDoc Policies and SOPs which are available here: Policies & SOPs – Radar (radar-brisdoc.co.uk). The SevernSide shift manager will be available at all times should any advice or support on process or functionality be needed to IAP staff operating in the MH CAS.

The digital functionality available to IAP staff operating in the MH CAS includes:

- Adastra and associated functionality
  - Templates (Clinical Record)
  - GP Connect (Own GP Appointment Booking)
  - Practice Liaison Service (Own GP Emergency Follow Up, the following day)
  - Electronic Prescribing (via Physical Health Team)
  - Agency Referral (to MIU/UTC/ED)
- Access to EMIS (Pt's own GP record)
- Access to Connecting Care (via EMIS)
- Access to RiO (Citrix Gateway (awp.nhs.uk))
- AccuRx (Photo and Video Consulting and Patient texting) (Accurx)
- Access to BrisDoc Weblinks Functionality (Weblinks – BrisDoc Healthcare Services)
  - BrisDoc Clinical Toolkit (BrisDoc Clinical ToolKit)
  - MiDoS (MiDoS – BrisDoc Healthcare Services)
  - ToxBase (Tox Base – BrisDoc Clinical ToolKit)

Training and User guides are available here: Training / User Guides – BrisDoc Clinical ToolKit

Case Finding

There are multiple queues within Adastra, such as 'IUC Advice' and 'System CAS'. The MH CAS team will have access to all queues and, when able, will 'fish' in these queues to find patients that may benefit from mental health specialist input.

To support a case, it must be transferred to the mental health queue. A case tag must be added to make others aware the case is being managed by the MH CAS team. When the MH CAS intervention is complete, the case should be closed. If the case subsequently requires a physical health intervention, the case tag should be removed and the case forwarded to the relevant Adastra queue.

Clinical Navigators and physical health clinicians can also add the mental health case tag to draw the case to the MH CAS team's attention for advice, support or intervention. If a MH clinician reviews a case and determines the case does not require input from the MH CAS team, the case tag must be removed.

Call Back Prioritisation

The most senior registered MH clinician working in MH CAS will take the lead role in triage and prioritisation of calls in the queue. They will adhere to the principles of the UK Mental Health Triage scale to review calls in the queue and prioritise where appropriate. Calls being reviewed as Category A will be suitable for diversion to 999, but this must be considered on a case-by-case basis.

The senior MH clinician will not be able to downgrade or change the NHS Pathways assessment priority on Adastra, but they will be able to mark a case as a priority for the next call back, using the priority case tags on Adastra.

Adastra will automatically highlight calls that are approaching their priority waiting time, using a RAG rating:

- Green – plenty of time left until the target time
- Amber – been waiting a little while
- Red – approaching target time
- Black – the case has waited past its target time

The BrisDoc operational team will support the MH CAS by contacting patients who have breached the target waiting time on the queue. The operational staff will contact the patient to advise on delays, record and feed back any worsening conditions to the MH clinician in accordance with safety calling procedures.

GP Follow Up & Prescribing

BNSSG Registered Patients ONLY

Only the MH CAS has the functionality to contribute to the patient's own GP's clinical record system (EMIS), with the Adastra case report being shared automatically on completion of each case via a post event message (PEM).

Any member of staff operating within the IAP can make professional referrals to the patient's own GP, using the BrisDoc Professionals Line. When calling, please identify as calling from the IAP and that you want to share information with the patient's own GP. The detail relating to the patient contact, requested action for the GP and subsequent referral MUST be recorded within the RiO clinical record.

	Telephone	Process
In Hours	0117 244 9283	You will be connected to the patient's own GP Practice
Out of Hours*	0117 244 9283	Patient information will be added to Adastra to be managed by the MH CAS team the next working day (this may not then be actioned until the following working day)

*The out of hours pathway is only appropriate for requesting follow up from the patient's GP practice on the next working day (longer delays for bank holidays). Mental health clinicians who need more urgent clinical advice or a prescription out of hours, must contact the professionals' line and request a call back from one of the BrisDoc clinicians.

MH CAS Action

The senior MH clinician working in the MH CAS will review the calls relating to an 'out of hours' contact, search the RIO notes and copy and paste the clinical information into Adastra. All out of hours referrals must be processed by the MH CAS mental health team as soon as practicable. Practices may only reconcile referrals once a day; therefore, they may not get looked at after this has occurred in the morning of the following working day.

Information copied to Adastra must reflect the assessment conducted out of hours and include a clear request for the GP to action. The assessment plan recorded in RiO may, for example, read: '…Assessment completed, no role for mental health services. Request for GP to offer routine consultation and review anti-depressant medication'.

Deploying the MHRV

To deploy the Mental Health Response Vehicle (MHRV) for a patient who has been assessed in the MH CAS, the IAP staff member must contact the MHCC in the MHSD requesting its availability. This can be done via the phone or MS Teams. If the MHRV is available and the MHCC agrees for its deployment, case notes must be added to reflect the onward pathway for the patient and the accepted referral to 999. The Adastra case must then be closed, marked as referred to 999.

A new case must be opened by the MHSD on CAD (SWASFT system) and the management of the patient continues in line with the operation of the MHRV (see separate SOP). If further intervention is required by SevernSide/MH CAS, a new case must be opened via the SevernSide professional line (0117 244 9283) to allow record keeping and intervention as required.

Liaising with Physical Health

Should a patient require support from a physical health clinician, the MH CAS team member can take one of the following approaches:

- Primary need is mental health with secondary physical health need
- Provide the intervention required and make suitable notes within the clinical record, take brief details of the physical health needs and discuss them with the SevernSide Clinical Co-Ordinator (SevernSide CC).
- Primary need is physical health with secondary mental health need
- Provide notes to the record to assist the assessment from the physical health clinician and support their decision making in regards to mental health intervention – this should include noting the advice given and any referrals made on behalf of the patient by the MH CAS.
- Where the primary need is unclear
- Seek further information from the patient, conduct a suitable assessment and liaise with the SevernSide CC to determine and agree the best course of action.

Prescribing

If a patient requires a prescription, wherever possible, the assessment and recommendations should be recorded by the MH CAS team member within the Adastra case record. This should then be discussed with the SevernSide CC and transferred to the relevant queue for the electronic prescription to be sent by the relevant clinician.

A list of open pharmacies is available here: Find a pharmacy - NHS (www.nhs.uk)

(N.B Please ask the Shift Manager about Bank Holidays)

Accessing interpreting services for patients using British Sign Language

BrisDoc has an account with Sign Solutions to access interpreters for British Sign Language (BSL), which can be used to contact patients using BSL.

To book an interpreter, telephone Sign Solutions on 0121 447 9620. You will then need to choose either option 1 for face-to-face support, or option 2 for video support (which is likely to be most appropriate for any remote triage). You will need to quote 'BrisDoc Healthcare Services' so that the account can be located and relevant assistance provided. For patients who have entered the MH CAS from NHS 111, the interpreter will ideally have been booked in advance; however, it is best to check this and make our own arrangements if necessary.

For patients using BSL requiring contact from the 999 MH Desk, the MH CC will transfer the care of the patient to the MH CAS, as there is not currently an option to make outbound BSL contact from SWAST EOC. The MH CAS clinician will need to contact Sign Solutions to book the interpreting services. An interpreter may not be immediately available. When an interpreter is booked, the patient should be notified of the expected contact time via SMS (through AccuRx) so that they are aware when they should expect to be contacted and to try to minimise failed contacts.

Conducting a video consultation

Advise the interpreter that you will be using the AccuRx platform. Once they have located someone, they will provide you with their email address for you to invite them.
To start your consultation, you should send the SMS text with the video invitation, as usual, to the patient. You then have two options:

- On your confirmation email, you can copy the invitation link and send this on to your interpreter
- If the confirmation email is not received, you can open the video consultation and then copy the URL from the top of the webpage and send this to the interpreter.

When Sign Solutions has been used for a consultation, please ensure the BrisDoc Shift Manager is made aware so that it can be documented that the service has been used.

Case Closure

When the case has been completed, it should be closed and the relevant information added including coding, onward referral, and case questions answered. Where an unregistered team member has completed the case, it MUST be flagged using the MHCC Review Tag. The senior registered MH clinician must then review the case before closing it, ensuring the intervention and outcomes were appropriate based on the assessment of the patient.

Unregistered team members must not close cases.

Monitoring & Change Register

The IAP SOP will be reviewed at least annually and more regularly to account for service changes and expansion.

Date	Version	Author	Change
18/02/2022	1.0	Matthew Truscott	Version 1.0 published
27/09/2022	1.1	Matthew Truscott and Rhys Hancock	Updated subject to review
17/08/2023	2.0	Matthew Truscott, Rhys Hancock and Kerry Geoghegan	Updated as part of Integrated Access Partnership and relationship with other IAP services. Added details of accessing BSL interpreters. Added Appendix 5.

Appendices

Appendix 1: SBAR Format for Assessment

IAP staff will use the SBAR format for recording their assessment. This assessment will capture key factors of assessment in line with AWP guidance found in the clinical toolkit. The SBAR will be supplemented with the Risk Assessment and Formulation Guidance available in the AWP Clinical Toolkit. Below is an example of the SBAR format being used clinically.

Situation
• The referral screened as per current policy. • For routine 4wk referrals which include any of the 4 identified points noted below
Background
• Assessed by the recovery or crisis team within the last year? • Have they been assessed by street triage and/or Psych liaison within the last 3 months? • If someone has a significant history and contact with the mental health team • If the referrer is asking for a specific request i.e., medication review, medication advice, signpost to psychology
Assessment
• What has changed since their last assessment? Explore have they followed recommendations made in the last assessment? • Focus on current risks, any safeguarding and current concerns. Ensure the UK Triage Mental Health rating scale is referenced. • If there is no need for secondary services or the referred person does not meet the criteria, then the Triage clinician will sign post to the relevant services that can help. • If the clinician feels a further assessment is indicated, then refer to the relevant sector for assessment. • SBAR to be documented in the service user's progress notes and in Triage and Assessment Form. Ensuring a Full Triage was not completed is documented, outlining which 4 points above signified a SBAR was appropriate
Recommendation
• Once the assessment has been completed, using the SBAR, a care pathway will be identified - either signposting or secondary assessment.

Appendix 2: UK Mental Health Triage Scale

UK Mental Health Triage Scale				
Triage Code /description	**Response type/ time to face-to-face contact**	**Typical presentations**	**Mental health service action/response**	**Additional actions to be considered**
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

Appendix 3: Clinical Audit Tools

	Remote Contact (Telephone/Video)	Clinical Records
Key Principles of Audit:	• Makes effort to speak directly to patient / Confirms ABC's • Confirms Demographics. • Introduces Self, purpose of call. • Professional, Caring & Compassionate approach. • Accurately determines the presenting complaint, including use of Video Consultation (as appropriate) • Seeking collateral input from carers , friends and relatives wherever practicable • Determines relevant Past Medical History including Medications and Allergies where appropriate. • Reaches a safe and appropriate outcome and communicates this effectively. • Safeguarding where relevant • Relevant, Accurate Clinical Advice Provided • Targeted & General Worsening Advice Provided • Uses appropriate questioning techniques and avoids Jargon • Manages risk accurately to arrive at a timely outcome	• The level of clinical recording is proportionate in relation to review, triage and assessment (as defined in SOP above). • Evidence of format for assessment that aligns with SBAR framework. • Risks are clearly formulated using Structured Professional Judgement with reference to UKMHTS • The key components of Mental State Examination is recorded in all 'triage' and 'assessment' calls • Any reference to capacity is decision specific • Non-registered staff referencing clinical supervisor in relation to all clinical decision making • Records show a final impression and formulation that captures risk and clinical impression • Plans are clear and proportionate to the presenting situation

Appendix 4: Clinical Tool Kit – Structured Professional Judgement (Risk)

Please note – IAP staff should not consider this exhaustive guidance on risk and should access the AWP clinical tool kit.

The four categories of risk factors

As you consider risk factors, it is useful to have a shared understanding of what you mean by the classification of different types of risk. The framework below is a modified version of Structured Professional Judgement.

1. Static risk factors:	2. Dynamic - stable risk factors
These are factors that do not change or alter in any way; they are statements of fact – events or factors that the person or professional cannot alter – that have been shown to have a marked correlation with future untoward outcomes as a result of studying groups of people with the same characteristics. For example, static factors known to be indicative of increased risk of suicide are: • History of self-harm • History of violence towards others • Seriousness of previous suicide attempts • Previous admission to psychiatric hospital • History of mental illness • Family history of self-harm and suicide • Aged over 65 years • Male gender • History of psychologically traumatic event/s It is important that our risk summary includes the recording of our sustained attempts to gather historical as well as current risk factors from the service user directly, any involved carer/s, previous health	These are long-term in nature. It is possible to intervene with these factors in order to reduce their influence on the level of risk. Stable factors known to be indicative of increased risk of suicide are: • The absence of a stable relationship – e.g.: divorce, separation, bereavement • Psychiatric diagnosis – all mental illness is associated with an increased risk of suicide, in particular depression; some mental illnesses are associated with symptoms such as command hallucinations which focus on harm to others • Suicidal or self-harming thoughts or ideas – usually referred to as 'suicidal ideation' and this needs to be present in order for a person to develop suicidal intent • On-going impact of childhood trauma and adversity • Substance misuse • Negative attitude of the person from their carers • Social deprivation • Middle-aged years

records – e.g.: from CAMHS, and other agencies such as the person's GP, probation service, police, housing, etc.	
3. Dynamic – acute risk factors or risk triggers These are present for a short length of time and may fluctuate markedly in both duration and intensity. Attending to these factors is arguably one of the most important components of the whole risk assessment process. • Acute suicidal ideation, communication and intent • Acute feelings of hopelessness or helplessness • Active psychological symptoms, such as low self-esteem/self-worth, negative thoughts, belief that others will be "better off without me" • Negative impact from use of drugs or alcohol • Psychiatric hospital admission and discharge – while psychiatric admission can be useful as a way of maintaining/contributing to the person's safety, the process of admission and discharge are in themselves associated with a high degree of risk • Transitions in care – this includes major changes and alterations to the person's care or care pathway, such as the handover from one care team/service to another, change of care coordinator, any other major alteration in the way the person's care is delivered, or by whom it is delivered • Transitions in the phase and nature of a person's mental health difficulties – e.g.: • At risk of prodrome to psychosis and the early phase of recovery are known to be times of greater risk for some individuals who experience psychotic episodes.	**4. Future risk factors:** Some future risk factors can be anticipated and will result from the changing circumstances of the individual: • Access to preferred method of suicide; this needs careful consideration and will vary from setting to setting. For example, in an inpatient unit, environmental factors such as easy access to fixed ligature points, need to be considered. In a community setting, this may include access to medication with a high lethality, access to firearms, etc. • Nature and extent of service and professional contact. This is linked to transitions in care but is of prime importance in its own right; examples may include situations whereby a person does not have easy or direct access to services (e.g.: out-of-hours), poor inter-team/service communication, and arrangements for staff/service contact when the person's care coordinator is not available. • Future response to physical treatments (including, for example, impact of side effects of medication) • Future response to psychosocial interventions • Future intra and inter-personal stress

• The period when the person's mood starts to improve after an episode of depression – i.e.: when the level of activity and motivation returns, enabling them to act on their earlier suicidal thoughts. • Nature and degree of interpersonal stress/conflict – this will include any significant life event, as defined and understood by the service user. It could be something very obvious such as a relationship breakdown, loss of employment, or may include on-going communication difficulties and issues within existing relationships, such as those with the person's significant other, children, parents, etc. • Reduced ability to problem-solve – this is a key deficit and is linked to the other psychological symptoms identified above. If the person is unable to consider alternative ways of dealing with their stress that are future-orientated, then risk will be increased exponentially.	

Appendix 5: Changes to MH CAS Resourcing Process Chart

Rota change within 7 days	Rota change within 24 hours
Any changes made by CC to rostering for MH CAS within 7 days, should be emailed to the BrisDoc Rota team on brisdoc.rotateam@nhs.net **and** awp.iaproster@nhs.net	In addition to the actions detailed for rota changes within 7 days, any rota change within 24 hours must be notified to the BrisDoc shift manager on 0117 244 9283 with as much notice as possible.

Where the MH CAS service cannot be operated for the entirety of its operating time, priority should be given to maximising the hours it can be operated, in line with the *Service Priority and Minimum Staffing Levels Decision Making Flowchart* within the Overarching SoP.

For example, if it can only be staffed from 10:00 – 16:00, then it should be.

To facilitate this, if changes to shift locations are required:

1. CC to identify member of staff to work in MH CAS.
2. CC to contact staff member, where possible, to advise them of the shift location change and ask them to begin their shift at BrisDoc.
3. Where contact is not possible, the staff member should start their shift at their previously rostered location; CC to make contact at start of shift to advise them of the requirement to work in MH CAS.