Mental Health
Integrated Access Partnership
Intelligent Mental Health System Response

Integrated Access Partnership (IAP) 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 Services (BrisDoc), Avon and Wiltshire Mental Health Partnership Foundation Trust (AWP) and South Western Ambulance Service NHS Foundation Trust (SWASFT) – as well as Avon and Somerset Police, Avon Fire and Rescue, 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 IAP services are outlined in the table below. Each part of the service is covered by a separate standard operating procedure.

Service Line	Service Provision	
Mental Health Specialist Desk (MHSD) SWASFT Emergency Operations Centre (EOC) St James A, St James Court, Bradley Stoke BS32 4QJ 0300 369 0151	BNSSG	24/7
	BSW	24/7
	Cornwall	08:00 – 00:00 (7/7)
	Devon	24/7
	Dorset	08:00 – 00:00 (7/7)
	Gloucestershire	24/7
	Somerset	24/7
Mental Health Response Vehicle (MHRV) Bristol Ambulance Station, Croydon Street, Easton, Bristol BS5 0DA (contact via MHSD)	BNSSG	24/7
	Cornwall & Isles of Scilly	14:00 – 02:00 (7/7)
	Devon	13:00 – 08:00 Mon – Fri 24 hrs, Sat-Sun
	Dorset	16:00 – 02:00 (7/7)
	Gloucestershire	14:00 – 00:00 Mon – Thurs only
	Somerset	10:00 – 22:00 (7/7)
Mental Health Link Officer (MHLO) (situated at MHSD)	Avon & Somerset Police footprint	24/7
Mental Health Clinical Assessment Service (MHCAS) BrisDoc Healthcare Services, Unit 21 Osprey Court, Hawkfield Business Park, Bristol BS14 0BB 0117 233 1402	BNSSG	24/7
Emergency Services Mental Health Professional Line (MHPL) incorporated within MHCAS 0117 233 1402	BNSSG	24/7

Integrated Access Partnership (IAP)
Standard Operating Procedure (SOP)

Objective

This standard operating procedure (SOP) provides guidance to IAP staff on the day-to-day operation of the IAP services, as listed in the introduction.

The IAP works to the following key principles:

- Provide specialist mental health triage and assessment for any individual on the 111 or 999 call pathways
- Promote the importance of working with strengths and aspirations of the person referred
- Lead a specialist response to any clinical situation relating to a 999 or 111 call where mental health is considered the primary need
- Give best practice advice and support in a broad range of conditions for people with both functional and organic mental health needs
- Provide succinct formulations and recommendations (inclusive of risk management advice) to support patient safety planning
- Advise and support on evaluating risk from a positive risk-taking perspective
- Ensure, where needed, that people experience a seamless transfer into provider/treatment services via trusted assessment processes
- Assess and advise on the impact of culture and diversity alongside colleagues from primary care
- Improve the efficiency of 111 and 999 response through an integrated access point to urgent and emergency mental health care
- Provide a dedicated emergency response to scene for mental health emergencies
- Strive to reduce on-scene time for non-specialist emergency responders wherever possible
- Deliver care and support in a caring, compassionate and timely way
- Work to the principles of the UK Mental Health Triage Scale (UKMHTS) (See Appendix 2)
- Promote the needs of family and carer/s, including various support networks and third sector agencies
- Support and advise within safeguarding and public protection procedures where the issues are complicated by mental health problems, alongside primary care colleagues
- Contribute evidence-based expertise to multi-disciplinary team processes
- Promote positive attitudes, mutual understanding and collaboration between non-mental health staff and mental health services, users, carers, voluntary agencies, primary care, and social services

Scope

The IAP will support 111 callers in the Bristol, North Somerset, and South Gloucestershire (BNSSG) area and 999 calls across the South West of England. The level of response provided will be dependent on local commissioning arrangements in each integrated care system (ICS). The IAP consists of a range of registered and non-registered mental health staff, providing mental health specialist advice and assessment to individuals calling 111 and 999.

The IAP provides specialist mental health support to:

- Callers to both 111 and 999 (depending on local commissioning arrangements)
- Patients of any age
- All mental health difficulties

- Calls with co-morbid mental and physical health needs.

The IAP will only lead on calls relating to a primary mental health need. The interpretation of primary need may require a multi-disciplinary discussion with physical health colleagues. However, the IAP may assist physical health colleagues who are managing calls with a primary physical need alongside mental health co-morbidities.

Response Levels

The IAP provides a clinical response to patients via:

1. Remote assessment of the patient
2. Specialist advice to other professionals
3. Face-to-face assessment

Remote Assessment

Remote assessment will form the primary response from the IAP model, providing specialist mental health telephone or video assessment of patients on the 999 and 111 pathways.

The services within the IAP that provide remote assessment are:

- Mental Health Specialist Desk (MHSD)
- Mental Health Clinical Assessment Service (MHCAS)

Third-party triage

The IAP will make contact with the patient, unless consent from the patient is unclear. In this circumstance, a dynamic risk assessment as to whether to phone the patient should be conducted and documented.

Specialist Advice to other Professionals

The IAP workforce is skilled in responding to urgent and emergency mental health calls. The IAP provides real time advice to non-mental health specialist professionals who require support and guidance, either at scene or to support remote assessment. This dedicated support to professionals is managed through the Emergency Service Mental Health Professional Line (MHPL), a call pathway known in the IAP as the ‘Professionals’ Line’.

The Professionals’ Line can be contacted on: 0117 233 1402.

Face to Face Assessment

Face to face assessment can be provided to mental health patients in the urgent and emergency care pathway. Face-to-face assessment will be coordinated by the IAP services who provide remote assessment. The dispatch of dedicated mental health response vehicles will be via the SWASFT Emergency Operations Centre (EOC).

Face-to-face assessment within the IAP is provided by the Mental Health Response Vehicle (MHRV).

Clinical Intervention

Staff working in the IAP will take a three-tiered approach to clinical contact with patients, this is to guide the amount of clinical intervention or time that is required in patient interactions to include remote and face to face assessment. This clinical response will be proportionate to the presentation of the patient to maintain the efficiency and availability of the service and will be in line with the IAP Clinical Contact Guidelines.

The three tiers of clinical contact are:

1. Review
2. Triage
3. Assessment

IAP contact with all patients will, wherever possible, include collection of the following information:

- Exclusion of a physical health emergency
- Patient identification using two or more identifiers
- Consent to access their clinical records
- Consent for onward referral.

Review

A clinical response which is considered a 'review' is likely to be best applied to calls which require limited resource allocation and time for managing the call. Most of the clinical time will be committed to a desktop review of collateral information to inform an efficient pathway for the call. Reviews often do not require specialist direct contact with the patient, as the information required to manage the call is evident from the clinical record or associated collateral information. Reviews will mostly be completed by the MH Clinical Navigator (MHCN) and allow for 'fast' prioritisation of the call.

Reviews will mostly be applied to the following:

- Diversion of a call to a specialist team for triage or remote assessment
- Re-prioritisation of the waiting call queue, such as clinical navigation
- Providing advice from an established management plan already added to the clinical record for use by another non-IAP clinician
- Booking for further assessment
- Low risk calls requiring emotional support and suitable for warm transfer to services such as Mind Line
- Implementation of a known high-intensity user's management plan

When a review is undertaken, it is essential to ensure that the assessment of information from the case and patient's records, and the justification for action taken, is clearly recorded in the case notes.

Triage

This will be the most common level of clinical engagement from the IAP. 'Triage' will involve direct contact with a patient, but the contact time will be focused on recent precipitating factors and changes supported by collateral information from the clinical record. The call will use 'here and now' information to update and assess for change from an established risk formulation and clinical impression. This approach is intended to make more efficient use of resources and reduce the need for patients to repeat themselves. This type of call is most suitable for:

- Frequent/high impact callers
- Known patients with a well-documented treatment plan
- Patients who are presenting with a similar presentation to a recent assessment
- Low to moderate complexity calls requiring signposting to an appropriate voluntary, community or social enterprise (VCSE) partner

Assessment

This will be the most comprehensive level of intervention provided by the IAP. 'Assessment' will acquire a wide picture of the patient, including a thorough history, including predisposing information relating to the patient background. The framework for Assessment uses the SBAR format (Appendix 1). This level of intervention will inform more complex discharges or referral onto treatment from secondary mental health services. This type of assessment will be most suitable in the following situations:

- Patients presenting with a mental illness who do not have a recent assessment or have not had contact with services
- Patients presenting with a level of acuity that a decision regarding treatment from secondary mental health services is indicated

Risk

The principles for comprehensive risk assessment are required to be well understood by all staff working in the IAP and are well described in the IAP Clinical Contact Guidelines. All staff should be working to manage risk using multi-disciplinary discussion and consideration of individualised risk formulation and safety planning.

Risk assessment for IAP interventions must be clearly documented on RiO, CAD and CLEO, as applicable. These should be escalated appropriately to ensure the safety of the patient, professionals and public. This may include liaising with the patient's locality team, GP, or Social Services to determine an appropriate care pathway.

Onward Pathways following clinical intervention

The primary outcomes from an intervention provided by the IAP are:

- Signposting back to NHS mental health assessment or treatment teams
- Signposting to voluntary/charitable services (eg. Vitaminds)
- Agreement for self-care – discharge without further action
- Use of police Section 136
- Referral to GP
- New referral to mental health assessment or treatment teams

- Referral to Drug and Alcohol services
- Conveyed to A&E

Key Roles & Responsibilities

The IAP team comprises both registered and non-registered staff, offering specialist mental health advice and assessment. The IAP works across a complex patient group and therefore the staffing model embraces staff with different backgrounds, skills and experience.

IAP Patient Facing Roles	
Registered Staff	**Non-Registered Staff**
Senior Practitioner (B7)	Senior Associate Practitioner (B5)
Development Senior Practitioner (B6)	Associate Practitioner (B4)
Specialist Practitioner (B6)	
Development Specialist Practitioner (B5)	

Non-Registered Staff

Non-registered staff form the core foundations of the model for the IAP. The IAP non-registered staff group will consist of associate practitioners at NHS AFC Band 4 and senior associate practitioners at NHS AFC Band 5.

Associate Practitioners (Band 4)

Associate practitioners play a crucial role within the IAP, providing focused, person-centred assessment and support to individuals experiencing an acute mental health crisis. They work autonomously within relevant practice boundaries, under the indirect clinical supervision of registered clinicians. Associate practitioners conduct comprehensive assessments of mental health needs and clinical risks, enabling appropriate support, signposting, and onward referral to services where required. For detailed guidance on the scope of practice and responsibilities of associate practitioners, please refer to Appendix 7.

Senior Associate Practitioners (Band 5)

Senior associate practitioners are the most experienced and skilled patient-facing unregistered professionals within the IAP. They play a crucial role in providing high-quality assessment and support to individuals experiencing an acute mental health crisis. In addition to the scope of practice of an associate practitioner, senior associate practitioners are entrusted with undertaking the most complex assessments within the scope of practice of non-registered members of staff, as deemed suitable by the MHCN.

Senior associate practitioners serve as mentors, coaches and supervisors for associate practitioners, sharing their knowledge and expertise to support the development of their colleagues. They are responsible for providing managerial supervision to associate practitioners, which includes regular one-to-one meetings, performance reviews, and supporting

professional development. This supervisory role is crucial in maintaining and improving the quality of care provided by the IAP.

In addition to their supervisory duties, senior associate practitioners take the lead on dual non-registered assessments conducted in the community, ensuring the highest standards of care and professionalism. They coordinate these assessments and serve as a resource for complex cases within the unregistered scope of practice, providing guidance to associate practitioners as needed.

Senior associate practitioners also contribute to service improvement initiatives and the development of best practices within the IAP. They may be delegated additional leadership roles and responsibilities, such as undertaking training roles and contributing to the smooth operation and continuous improvement of the IAP. Throughout their work, senior associate practitioners are expected to maintain a high level of clinical expertise, staying current with best practices and guidelines in mental healthcare, and using this knowledge to inform their practice and supervisory approach.

Semi-autonomous working

At times, unregistered practitioners may be working alongside only one registered practitioner. When the registered practitioner is unavailable, such as when taking their break or occupied with a consultation, unregistered practitioners can continue to work semi-autonomously, within the following parameters:

At MHCAS

Unregistered practitioners should continue to take calls, carry out assessments and accept warm transfers from call handlers. During this time, staff:

- should seek support from the MHCN at the MHSD if clinical advice is required
- must wait for the MHCN at MHCAS to return before ratifying any plans/decisions made, in conjunction with the MHCN
- undertaking a difficult call should continue as best they can, seeking support from colleagues around them if necessary.

At MHSD

It is advised that unregistered practitioners should continue to work on calls that have already been reviewed as appropriate by the MHCN or deputy. Staff requiring support or engaging in new calls during this period:

- should seek support from the MHCN at the MHCAS if clinical advice is required
- must wait for the MHCN at MHSD to return before ratifying any plans/decisions made, in conjunction with the MHCN
- undertaking a difficult call should continue as best they can, seeking support from colleagues around them if necessary.

In all circumstances when unregistered practitioners are unable to immediately escalate patients to a registered member of staff, they must have a low threshold for escalating patients for an emergency response, either within the EOC or via 999.

Registered Staff

Registered staff working in the IAP model consist of senior practitioners (NHS Band 7) and specialist practitioners (NHS Band 6).

Registered clinical staff provide direct clinical intervention to the most complex calls, as well as providing clinical consultancy to non-registered staff handling calls or having face to face contact.

Senior Practitioners

Senior practitioners are expert registered clinicians who play a crucial role in delivering high-quality patient care and maintaining clinical excellence within the IAP. Their primary focus is on direct patient care and clinical leadership, with additional responsibilities in supervision and informing service improvement and development initiatives.

Senior practitioners:

- Provide expert clinical interventions across all IAP service lines
- Assume the mental health clinical navigator role, overseeing clinical operations and ensuring effective resource allocation
- Lead by example in clinical practice, setting the standard for high-quality patient care and promoting best practices
- Offer clinical supervision and support to both registered and non-registered staff, fostering a culture of continuous learning and improvement
- Contribute to service development initiatives and quality improvement projects as delegated by team managers
- Participate in clinical audits and evaluations to maintain and enhance service standards
- Support team managers in addressing complex clinical situations and decision-making processes
- Engage in ongoing professional development to stay current with best practices in mental health crisis care

Development Senior Practitioners

Development senior practitioners are autonomous registered mental health practitioners who are on an individualised development pathway from specialist practitioner to senior practitioner. Development senior practitioners will work with other registered mental health colleagues who will provide support with their clinical decision making, and their clinical and leadership development.

Development senior practitioners:

- Work a 24/7 rota across all elements of the IAP model
- Are Band 6 clinicians who work in a direct clinical role, initially focusing all their time in providing direct patient care and incorporating other Band 7 senior practitioner roles and responsibilities as they progress along their development journey
- Can act autonomously to complete clinical interventions within the SP scope of practice, but require supervision when undertaking the senior practitioner scope of practice roles and responsibilities
- Can support unregistered staff in providing clinical interventions autonomously within their scope of practice
- Can deputise for the MHCN role, providing this is time-limited and for business continuity purposes
- Will provide clinical supervision to unregistered staff

Development pathways for development senior practitioners are individualised and, therefore, the scope of practice and autonomy will develop along the pathway.

Specialist Practitioners

Specialist practitioners are autonomous senior registered mental health staff who dedicate their time to patient facing contact under the leadership of senior practitioners.

Specialist practitioners:

- Are senior Band 6 clinicians who work primarily in a direct clinical role, focusing almost all their time in providing direct patient care
- Do not require supervision (can act autonomously) to complete clinical interventions such as changing the dispatch priority of an ambulance
- Will support unregistered staff in providing clinical intervention but will not routinely authorise ambulance stand down on their behalf
- Can deputise for the MHCN role, providing this is time limited and for business continuity purposes
- Will carry out most of the direct contact with service users, especially in relation to calls of higher complexity (Cat A-C on the UKMHTS)
- Can provide face to face assessment, including as a blue light response
- Will provide supervision to unregistered staff.

Development Specialist Practitioners

Development specialist practitioners are semi-autonomous registered mental health staff who are on an individualised development pathway from practitioner to specialist practitioner. Development specialist practitioners will work with other registered mental health colleagues who will provide support in their clinical decision making and development.

Development specialist practitioners:

- Are Band 5 clinicians who work in a direct clinical role, focusing all their time in providing direct patient care
- Require supervision when completing clinical interventions and ratification of clinical decision making
- Can support unregistered staff in providing clinical interventions but any decision making would need to be ratified with a specialist practitioner or senior practitioner
- **Cannot** deputise for the MHCN role

Development pathways for development specialist practitioners are individualised and, therefore, the scope of practice and autonomy will develop along the pathway.

Mental Health Clinical Navigator

A mental health clinical navigator (MHCN) will operate as the lead clinician in the MHCAS and MHSD. The most senior registered clinical staff member on duty will be rostered as the MHCN in each service line. The MHCN will be a senior practitioner, but this can be deputised to a development senior practitioner or specialist practitioner where necessary. The MHCN will be responsible for the allocation and oversight of all clinical interventions in their service line.

The MHCN will prioritise their navigation tasks and being available for consultation to colleagues. Where necessary, they will also be clinically active, engaging with the most complex calls directly. The MHCN should only engage with patients directly, when absolutely necessary, as this will prevent them from maintaining clinical oversight of the IAP workload and carrying out a support role to the wider team, which should remain their priority.

Core Responsibilities

The core responsibilities for the MHCN include:

- Remain available in a 'floorwalking' capacity to offer clinical advice/support/escalation and sign-off of mental health calls. This is more important than going active on incidents of care, unless taking over a complex call or answering the hard phone in MHSD. This should include physically moving around the room periodically.
- Review and validate incidents of care as they come in, adding the appropriate priority tag/comment on CAD/CLEO, as to appropriate skill level for the practitioner who will call back.
- Review emails to the IAP Clinical Inbox and ensure all follow-ups have been assigned/actioned.
- 'Fishing' for incidents of care or allocating somebody else to do this from the main CAD stack (MHSD)
- Review staffing over the next 24 hours. When reviewing staffing, the MHCN must: consider staffing levels (in line with Appendix 4); ensure there is a fair balance of staff across the MHSD and MHCAS, both in terms of staff numbers and skill mix
- Advertise any staffing gaps to the team (bank/overtime/shift swaps) and review the shadow calendar to check for any shadow staff that may need to be contacted to move to a different location.
- Make decisions to close services as early as possible. If alerted about any sickness during the shift, re-evaluate staffing. This includes taking the appropriate action to redeploy staff and close services when necessary, as per Appendix 8, ensuring team managers are kept up to date. Note: MHCAS cannot be closed.
- Monitor capacity to meet demand and mitigate ambulance dispatch in MHSD, request triage support from Clinical Support Desk as required
- Review activity levels and ensure that staff are released to have their breaks and attend supervision, team meetings and reflective practice as necessary.
- Check in with staff, making sure they are okay. The pastoral aspect is important and shouldn't be forgotten, no matter how busy it is. Please take into account whether staff are registered or not, and their experience within IAP. New or less confident staff may require more time for clinical support and reassurance.
- At MHSD, answer the hardline phone and allocate to others if needed/able. Anyone using the hard phone inappropriately (within BNSSG) should be directed to the professionals' line if applicable.
- Allocate planned breaks for staff and ensure these are taken (this should be allocated near the start of the shift; it is not acceptable for staff to work without a break or to leave work early due to not taking a break).
- MHSD CN to allocate MHRV and be aware of their availability status. All requests for availability should come through the MHSD CN, so they can triage the best use of the vehicle. If the request is coming from MHCAS, a telephone conversation should take place.
- Oversee jobs for the urgent assessment centre and monitor their availability for further assessments.
- Consider use and availability of the pool car as a response vehicle if staffing allows.
- Manage and oversee any extra people that are observing (students, new starters, bank staff etc).
- On the evening shift, consider workload and likelihood of being able to triage jobs in Cornwall and Dorset before midnight. Consider sending incidents back to SWASFT CSD for triage if unlikely to be actioned by the MHSD.
- When going on break, clearly communicate who is covering the MHCN role and provide a handover.

IAP Clinical Inbox

To streamline requests for information from the IAP team, as well as invitations to service user meetings and requests for follow-ups, a shared mailbox exists. It is the responsibility of the MHCN to manage this mailbox during their shift (awp.iapclinicalinbox@nhs.net).

Example uses of the Clinical Inbox:

- Clinical teams can highlight any relevant patient updates where there are concerns with deteriorating mental health alongside increasing risk. This is in addition to updates being recorded on the relevant patient record.
- Invitations to the IAP to attend service user professional meetings

The inbox should not to be used to arrange follow-up calls to GPs where a GP has been sent correspondence following a clinical contact on an earlier shift.

It is important for the inbox to be monitored and checked periodically throughout shifts. When emails are received, the MHCN should delegate emails to individuals, or disseminate pertinent information to the team as required, including during Daily Updates (handover) meetings. Once an email has been actioned, it should be filed in the 'Completed' folder to prevent duplication of any actions. Any emails remaining in the inbox (both read and unread) will be considered as still requiring action.

Police Mental Health Link Officer

Specialist police officers will work alongside MHSD colleagues, undertaking the role of Mental Health Link Officer (MHLO). The role of the MHLO is to review live incoming mental health related calls to the police, ensuring police attend incidents where there is a policing purpose present (including supporting ambulance staff where necessary), and referring calls where there is no policing purpose to more appropriate agencies.

This role is supported by a dedicated MHLO SOP.

Clinical Records

The table below details the primary and secondary record for clinical notes following a patient contact in each service.

Service Line	Primary Record	Secondary Record
Mental Health Specialist Desk (MHSD)	CAD (C3)	RiO*
Mental Health Response Vehicle (MHRV) (BNSSG)	ePCR	RiO*
Mental Health Link Officer (MHLO) (situated at MHSD)	RiO	N/A
Mental Health Clinical Assessment Service (MHCAS)	CLEO	RiO*
Emergency Services Mental Health Professional Line (MHPL)	CLEO	RiO*

***Where there is a clear mental health need, IAP staff must duplicate records onto the relevant instance of RiO (providing access is available) according to the location of the patient. Therefore, all face-to-face contact should result in a RiO referral being open. The**

record of the assessment must always be copied verbatim to capture all the relevant clinical details.

*IAP staff will only be expected to submit information into the contemporaneous record (progress notes) of the relevant RiO record. The IAP staff member will select available options within the progress note to add to the risk history if this is appropriate and available within the contemporaneous record. By exception, where patients have not previously had a risk history written, there will not be the option to add to the risk history. In these cases, where an assessment has been completed, IAP clinicians need to complete a risk history form within RiO.

Patient contact should always be recorded and formatted using the IAP Clinical Recording Template (Appendix 9), and in accordance to the IAP Clinical Contact Guidelines, which ensures adherence with the AWP assessment standards.

All outbound telephone calls must be made using a recorded line.

Data is collected from CAD, CLEO and ePCR for service improvement and performance purposes.

Completion of cases

Accurate and contemporaneous clinical records are an essential element of all patient interactions. Therefore, colleagues must complete their notes before starting the next incident. This is especially important for colleagues working on the MHRV. If in exceptional circumstances, crews need to relocate to write-up notes, they should advise Dispatch that they are changing location but are still unavailable to be dispatched to the next job until these have been completed.

Communicating with GPs and mental health teams

For all remote and face-to-face assessments where the person is not open to mental health services, the GP must be sent a summary of the assessment, including the outcome and any onward referrals. Where the person is open to a team, the allocated worker and/or team must be advised of the contact and details of the assessment.

This communication must also be recorded on the patient record in Rio and CAD/CLEO as applicable.

Record adjustments

In the event of a clinical recording error, it is necessary to correct the record. If a clinician realises a mistake prior the case being closed, the case record may be edited with the correct information being substituted for the incorrect. If the mistake is realised once the case has been closed, an incident/learning event must be completed and the respective organisation's process followed for record adjustments.

Children and Young People

A process has been agreed with CAMHS in BNSSG, to ensure that IAP documentation is uploaded to IAPTUS (Appendix 6). This has been agreed with senior managers from CAMHS and will remain in place until such a time as the IAP has edit access to IAPTUS to upload assessments independently.

Practitioners must make contact with CAMHS in all areas following contact with children and young people.

GP Follow Up & Prescribing

BNSSG Registered Patients ONLY

Only the MHCAS has the functionality to contribute to the patient's own GP's clinical record system (EMIS), with the CLEO 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 MHPL. 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 233 1402	You will be connected to the patient's own GP Practice
Out of Hours*		Patient information will be added to clinical system to be managed by the MHCAS team (this may not then be actioned by the GP practice 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 SevernSide professionals' line and request a call back from one of the BrisDoc clinicians.

Patients registered outside of BNSSG

To share information or request patient follow-up from GPs outside of BNSSG, clinicians should access NHS Service Finder or MiDOS to ascertain surgery email addresses, and email information or requests directly to the duty GP of that practice.

For more urgent clinical advice or prescriptions out of hours, contact should be made with the GP Out of Hours service for the respective areas:

Somerset: 01392 269455
Cornwall: 01872 303770
Devon: 01752 422730
Gloucestershire: 01452 687001
Dorset: 03000 334000
Wiltshire: 0300 1115818

Arranging Taxi Transport for Service Users

There may be occasions where it is necessary to arrange a funded taxi for service users as part of their interaction with the IAP. Taxis will be organised in line with each organisation's relevant process:

- Taxis originating from MHCAS or MHPL will be arranged through BrisDoc's process, in conjunction with the MHCAS Shift Manager
- Taxis originating from MHSD will be arranged through SWASFT's process, with further details contained within the MHSD SOP

Team Communication

A daily Microsoft Teams chat will be created to enable communication between staff working across all IAP service lines. The daily chat is purely for ongoing communication between IAP staff. Where necessary, it is permissible to share NHS numbers within the current shift's chat. Any referrals between services or conversations relating to patients will be made by telephone or other approved means.

People with Unmet Needs – High Intensity Users (HIU)

The appropriate identification and support for high intensity users will be essential in maintaining the efficiency of the service and mitigating system impact. The IAP will develop system leadership for mental health high intensity users to urgent and emergency care providers across BNSSG.

The IAP will, wherever possible, prevent high intensity users from having to tell their stories multiple times and so will manage the contact in accordance with the correct level of intervention. The IAP will have access to and use the relevant organisations' care and support plans and clinical information to allow an integrated care approach through a collaborative service delivery framework for high intensity users, which is efficient and addresses the unmet needs of high-intensity users. This may allow the call to be managed through 'review' wherever this offers therapeutic benefit to the caller. The IAP will be familiar with positive risk taking and personalised care, adhering to the therapeutic benefit of established care and support plans.

The IAP has a comprehensive suite of data which will be used to track and identify the activity of existing or emerging high intensity users.

Safeguarding

All staff working in the IAP will have undertaken adult and child safeguarding training (as per AWP Policy).

Where a potential Safeguarding issue arises, staff will discuss the case with the MH Clinical Navigator. The safeguarding policy for the organisation in which the patient is being cared for must then be followed.

Data Protection and Confidentiality

The IAP will adhere to the principles of the Data Protection Act (1998) and the respective organisation's Information Governance Policy, including the Data Protection and Confidentiality Policy and Procedure.

An Information Sharing Agreement (ISA) and Data Privacy and Impact Assessment (DPIA) have been signed by BrisDoc, SWASFT, AWP and A&S Police. This enables live sharing of information for patient care between all organisations and data transfer for the benefit of service improvement between SWASFT, AWP and BrisDoc.

When a caller is known to local mental health services, the IAP staff member will have access to their mental health records, including history and any crisis, contingency and care plans which already exist.

IAP will always endeavour to have direct contact with the individual in crisis. IAP staff will, where appropriate, inform callers that details of the call will be recorded, and documentation kept on clinical systems.

Where information from a call needs to be passed on to a third party or a referral to another service this will be discussed with the caller. Where there is an identified risk to the caller or others, the caller will be informed consent may be overridden in the interest of safeguarding or where capacity to consent is impaired and the staff members acts in the best interest of the caller.

IAP staff will only share information proportionately and in accordance with the situation presenting and the risks identified at the time of the disclosure. Callers will be asked what information, if any would they like to be shared with their family/carers should they be present during the call.

For referrals being declined, the IAP staff member will provide a rationale to the referrer. If the individual has a mental health record, the IAP member of staff may decide to record a contemporaneous note advising of the contact and that information to share has been declined.

Business Continuity

The IAP will refer to and apply business continuity plans (BCP) in accordance with their host organisation:

- SWASFT Business Continuity – Clinical Hubs (EOC)
- AWP Business Continuity – IAP
- BrisDoc Business Continuity – SevernSide

Mental Health Shift Manager

Out-of-hours, the MH Shift Manager will serve as a single point of contact for any business continuity incidents across the IAP, contactable via 0117 345 9239.

The MH Shift Manager will escalate any necessary incidents to the SevernSide on-call manager who, in turn, can escalate as necessary to the IAP senior leader on-call.

Out-of-Hours Crisis

Should there be a major issue within the Out-of-Hours Crisis team (such as significant staffing issues or telephony outage affecting delivery of service), the AWP On-Call Manager should contact the MH Shift Manager for escalation within the IAP and SevernSide.

Quality and Governance

Learning, auditing, and sharing of information for clinical quality will be essential in the IAP. The approach to these matters is detailed below.

Learning Events/Incidents

All staff operating within the IAP should have access to all three partner organisations' reporting systems. Where staff do not have access, IAP management will take responsibility for supporting the logging of incidents. Learning Events should be reported as detailed below:

Service Line	Reporting System
Mental Health Specialist Desk (MHSD)	SWASFT InPhase AWP Ulysses (BNSSG and BSW areas)*
Mental Health Response Vehicle (MHRV)	SWASFT InPhase AWP Ulysses (BNSSG and BSW areas)*
Mental Health Link Officer (MHLO) (situated at MHSD)	SWASFT InPhase
Mental Health Clinical Assessment Service (MHCAS)	BrisDoc Learning Event Portal
Emergency Services Mental Health Professional Line (MHPL)	BrisDoc Learning Event Portal

**InPhase will be the main point of recording for incidents outside of the AWP footprint (eg. patient in Dorset). Dual recording will take place on Ulysees when the patient is within the AWP area or the incident is significant and joint learning is required (staff must seek advice from management if this is unclear).*

The IAP management team are responsible for overseeing and referring to wider governance infrastructure regarding the reporting and sharing of learning events between AWP, BrisDoc and SWASFT. This includes escalation through organisations and consideration for joint investigation.

Traumatic Event

In the event of any traumatic event, including where IAP team members are assaulted or injured, the process in Appendix 5 must be followed.

Abusive/Inappropriate Callers

In the event of inappropriate or abusive callers, following appropriate termination of the call, staff should ensure a learning event/incident is submitted via the appropriate system.

Clinical Audit

Clinical audit will be completed within the IAP to review the quality and consistency of interactions with the service, the care/advice provided and the records of interactions. As well as assuring the quality and standards of the service, the results of audits and any identified learning will be used to contribute to staff supervision and development, and service improvements.

The Clinical Audit SOP provides full information surrounding clinical audit arrangements, with the following table providing a summary:

Service Line	Audit Method	Monthly Audit Sample	Audit Record
Mental Health Specialist Desk (MHSD)	• Review of CAD • Review of RiO notes	• 5% of cases, geographically representative	• IAP Audit MS Form

	• Review of call recordings	• Call recordings reviewed for 5% of audited cases	
Mental Health Response Vehicle (MHRV)	• Review of RiO notes • Review of call recordings	• 5% of cases (BNSSG only)	• IAP Audit MS Form
Mental Health Link Officer (MHLO) (situated at MHSD)	• Audit by Police		
Mental Health Clinical Assessment Service (MHCAS)	• Review of CLEO case notes • Review of RiO notes • Review of call recordings	• Minimum of 10 cases for each new clinician • Up to three call recordings for each new clinician • 5% of each clinician's cases following initial period	• Clinical Guardian • IAP Audit MS Form
Emergency Services Mental Health Professional Line (MHPL)	• Audited as part of MHCAS		

Staff Wellbeing

IAP staff are employed by their host organisation and hold honorary contracts with partner organisations within the IAP:

Employing Organisation	AWP	BrisDoc	SWASFT
Honorary Contracts Held With	BrisDoc SWASFT	AWP SWASFT	AWP BrisDoc

IAP staff have access to wellbeing services across all three organisations. Each organisation offers a range of physical, psychological, social and financial wellbeing support. An overview of the wellbeing offers available from each organisation is provided below.

For full details of the wellbeing offers available from each organisation, please refer to their respective intranet pages.

Staff are encouraged to utilise these resources to support their overall health and wellbeing. Please reach out to the wellbeing services at each organisation as needed.

Organisation	Wellbeing Offer	Wellbeing Intranet Page
AWP	Musculoskeletal Health Menopause support Physical activity programs Nutrition and hydration resources Sleep resources Smoking cessation support Stress and resilience training Trauma support services Employee assistance program Bereavement support Domestic violence resources Addictions treatment Occupational health services Financial Support Staff Benefits	http://ourspace/StaffServices/HR/Health-Wellbeing/Pages/Home.aspx
BrisDoc	Physical wellness resources and programs Emotional wellness coaching and support groups Financial wellbeing seminars and budgeting tools Social wellness events and advice Employee Assistance Programme	https://www.radar-brisdoc.co.uk/wellbeing-hub/
SWASFT	Self-Help Physical Health Employee Assistance Programme Username: swast@elewellbeing.co.uk Password: SWASTWellbeing	Staying Well Service

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
09/02/2022	0.1	Matthew Truscott, Rhys Hancock & Kerry Geoghegan	Initial Draft Completed
18/08/2023	1.0	Matthew Truscott, Rhys Hancock & Kerry Geoghegan	Publication of v1.0
14/11/2023	1.1	Ollie Crandon	Formatting amendments Correction to MHRV operating times Added third-party triage to 'Response Levels' section Added Development Specialist Practitioner role and responsibilities Added clarification in 'Review' section Added clarification regarding risk histories Added stipulation for all outbound calls to be made on recorded lines Added completion of cases to 'Clinical Records' section Added interim CAMHS IAPTUS process Added process for arranging taxi transport for service users Amended 'People with Unmet Needs – High Intensity Users (HIU)' section Added staff wellbeing section Amendment to appendix 5 Added appendix 7 (patient taxi transport services) Added appendix 8 (interim CAMHS documentation process)
19/01/2024	1.2	Ollie Crandon	Added 'Patients Registered Outside of BNSSG' Amended Core Responsibilities of Mental Health Clinical Coordinator Added management of IAP clinical inbox
01/02/2024	1.3	Ollie Crandon	Added Development Senior Practitioner role and responsibilities

06/03/2024	1.4	Ollie Crandon	Amendments in response to 1.3 draft Amended audit section
28/03/2024	1.5	Ollie Crandon	Added 'Remote Working' to MHPL section
03/04/2024	1.6	Ollie Crandon	Removed Appendix 3 (audit tools) in light of Clinical Audit SOP Amended Appendix 5 (Service Priority and Minimum Staffing Levels Decision Support Process Chart) Appendices re-numbered and references updated
09/04/2024	1.7	Ollie Crandon	Non-registered staff section amended Appendix 8 (Description of Duties) added
09/04/2024	1.8	Ollie Crandon	Appendix 9 (Service Closures) added
11/04/2024	1.9	Ollie Crandon	'Risk' section amended
27/06/2024	1.10	Ollie Crandon	'Communicating with GPs and mental health teams' added Amended 'IAP Clinical Inbox' section Amended Clinical Audit section Amended 'Interim CAMHS documentation process' 'Team Communication' added Amended 'Clinical Records' Amended 'Senior Associate Practitioners' following role review Added 'Police Mental Health Link Officer' section
22/10/2024	1.11	Ollie Crandon	Amended 'Clinical Records' to reference IAP Clinical Recording Template Added IAP Clinical Recording Template as Appendix 10 'Record adjustments' added to 'Clinical records' section Amendments to 'Associate Practitioner', 'Senior Associate Practitioner' and 'Senior Practitioner' sections Amended MHPL contact number Amended MH CC to MHCN throughout Amended MHPL service line for clinical recording and audit processes Amended GP Follow-Up and Prescribing Amended MHCAS Action Amended Appendix 6 Amended 'Clinical Audit' Amended Appendix 4 Amended 'MHCAS' Amended 'MHPL' Amended 'MHRV' Amended Appendix 9 Added Appendix 11

			Amended ‘Business Continuity’ Added ‘Abusive/Inappropriate Callers’
29/10/2024	2.0	Ollie Crandon	Publication of v2.0
07/03/2025	2.1	Ollie Crandon	Formatting amendments Revised MHSD operating hours Revised details of Cornwall MHRV Added details of Devon MHRV Clarification around MHRV dispatch Amendment to Appendix 4: *Service Priority and Minimum Staffing Levels* Amendment to Appendix 5: *Traumatic Incident Process* Amendment to Appendix 9: *Service Closures*
10/04/2025	2.2	Ollie Crandon	Added details of Dorset MHRV Removal of references to Urgent Assessment Centre Removal of reference to 8x8 telephony system Update to ‘Data Protection and Confidentiality’ Removal of Appendix 6 (taxi booking for UAC) Re-numbering of subsequent appendices
25/07/2025	2.3	Ollie Crandon	Transition from Adastra to CLEO Amendment to 'must' rather than 'strongly recommended' in 'Children and Young People' section Removal of MHCAS process within 'GP Follow-Up & Prescribing' as duplicate of MHCAS SOP Clarification of escalation to IAP senior leader on-call Removal of 'Services' section as duplication of individual service SOPs Minor amendments for clarity added to 'Clinical Intervention' Update to SWASFT Wellbeing Offer following change to Intranet and EAP provider

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 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 4: Service Priority and Minimum Staffing Levels Decision Support Process

There may be occasions when it is necessary to prioritise IAP service lines in the event of staff shortages or operational pressures, while trying to safely maintain the broadest coverage possible.

There should be a minimum of three staff members at MHCAS at all times; at least one of these must be a registered practitioner. Clinical navigators are supported in planning for closures of other service lines, if necessary, to maintain these minimum staffing levels.

In the event of a shortage of registered staff members, staff must be allocated to service lines in the following order.

Number of Registered Staff	Staff Deployment	Service Closures
1 registered staff member	MHCAS	All other service lines closed
2 registered staff members	1 to MHCAS 1 to MHSD	MHRV closed
3 registered staff members	2 to MHCAS 1 to MHSD	MHRV closed
4 registered staff members	2 to MHCAS 1 to MHSD 1 to MHRV	

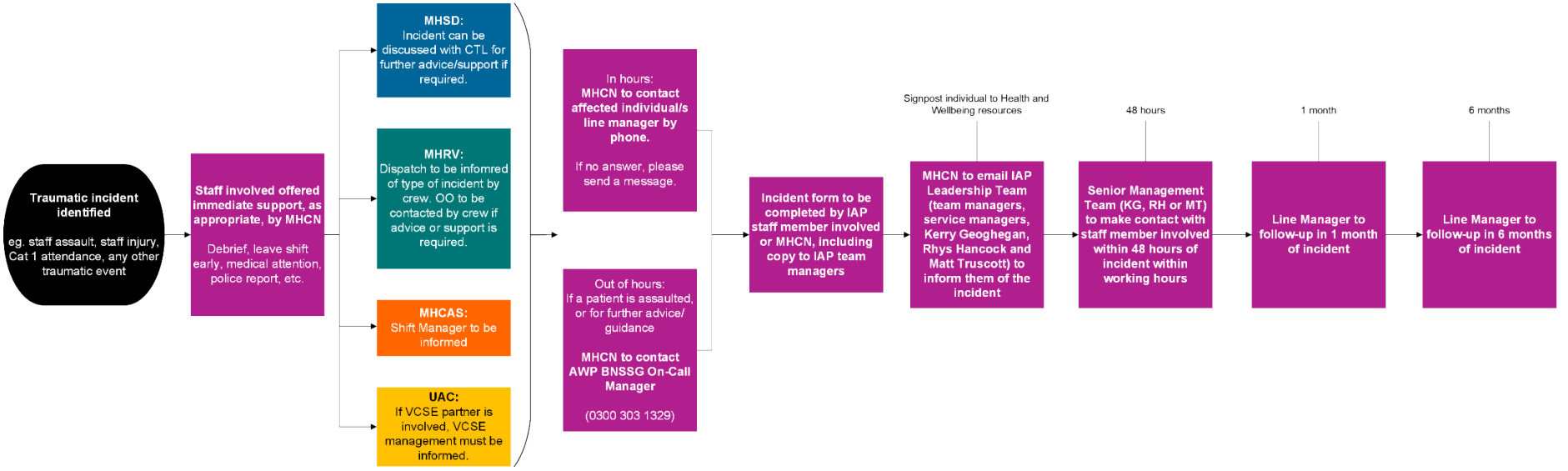
Unregistered staff members will be similarly allocated to service lines in the following order:

Number of Unregistered Staff	Staff Deployment
1 unregistered staff member	MHCAS
2 unregistered staff members	1 to MHCAS 1 to MHSD
3 unregistered staff members	2 to MHCAS 1 to MHSD
4 unregistered staff members	2 to MHCAS 2 to MHSD

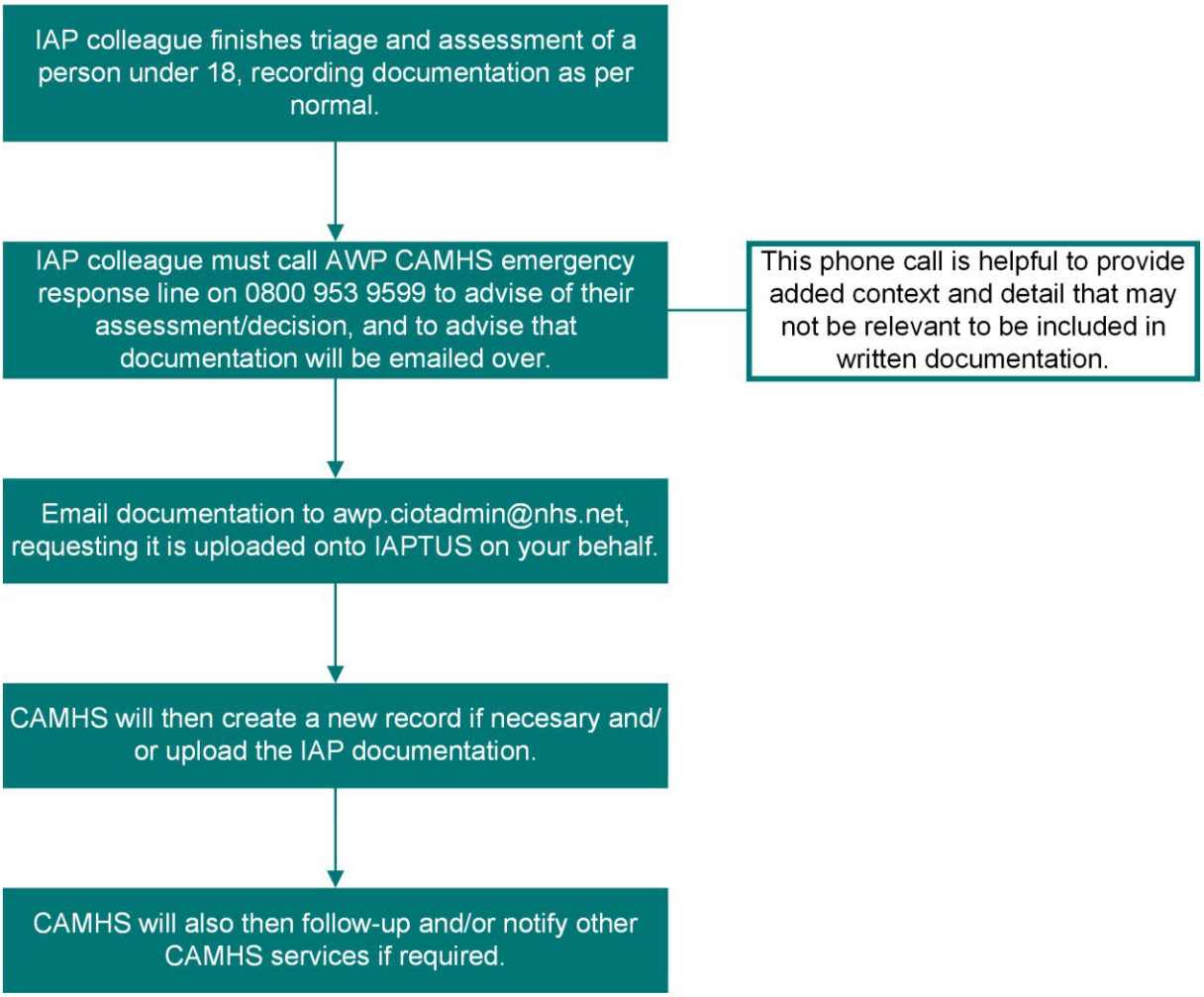
Any additional staff should be allocated to best meet the needs of the IAP, as decided through discussion between the MHCNs.

There may be occasions where additional staff are rostered within a service line to provide additional support for individuals; for example, there may be four registered staff on a shift, rostered between the MHCAS and MHSD, with the MHRV closed. It is not permissible, however, to understaff a service in order to operate additional services.

Appendix 5: Traumatic Event Process



Appendix 6: CAMHS Documentation Process for BNSSG



Appendix 7: Description of Duties for Associate Practitioners and Senior Associate Practitioners

Outlined below is the 'description of the duties' contained within the job description and person specification for associate practitioners, together with added IAP-specific context to enable associate practitioners and senior associate practitioners to best perform their role, with the support of specialist and senior practitioners.

- **Promote and champion the rights, values, responsibilities and diversity of people.**
- **Promote and maintain effective communication with people in order to build and sustain positive working relationships with individuals, families and carers, team members and other agencies. This may include accessing translation and interpreting services.**
- **Contribute to the planning, implementation and review of care packages, where applicable, including implementing specific parts of an individual care plan.**
    - Review all details contained in care plans, including crisis contingency plans, personal wellbeing plans, and other applicable management plans to gather and check the relevance of information that will inform the assessment and management of the individual.
    - Devise and record appropriate safety plans based on identified needs during assessment of individuals, for example: onward referrals or follow-up with GP or other relevant healthcare professional.
    - Where appropriate, implement elements contained within care packages and plans as part of your assessment and management of individuals.
- **Working autonomously within relevant practice boundaries, under indirect supervision of registered clinicians.**
    - Indirect supervision can include telephone discussion when working in different locations (eg. rapid engagement workers).
    - Associate practitioners should gather information and conduct a comprehensive assessment, which includes, risk, and should formulate a safety plan that must be discussed and agreed with a registered member of staff, before sharing and implementing the plan with the individual. This discussion and rationale for decision-making must be documented, including the registered clinician's name.
    - Where there may be a delay in speaking with a registered member of staff, where considered suitable, individuals can be offered a call back rather than needing to wait on hold.
    - The following are outside the practice boundaries for associate practitioners:
        - Requests for advice/support to emergency services professionals regarding the use of Section 136 of the Mental Health Act
        - Amending ambulance attendance to incidents (upgrading/downgrading/dispatching or standing down)
        - Individuals with certain forensic history
          (Any individual who is currently, or has previously been, under the care of the Ministry of Justice (under Section 37/41 of the Mental Health Act, as documented within Rio; any individual currently under the care of a

community forensic team; any individual under a Community Treatment Order (CTO).)

- Individuals who are actively suicidal
  (Any individual who is communicating that they have immediate plans or an immediate intent to end their life and/or are currently engaging in self-harming behaviours, which could cause imminent risk to life (see below for exceptions).)

  - At the discretion of the MHCN, depending on the specialism, experience and qualifications of individual staff members, the following higher-risk patient groups can be assessed by associate practitioners on a case-by-case basis:
    - Perinatal individuals
    - Individuals under 18 years of age
    - High-intensity users communicating immediate plans or intent to end their life or engage in self-harming behaviours, which could cause an imminent risk to life, where this is well-documented as the usual, presenting behaviour for an individual. If new or escalatory behaviour is disclosed, this should be immediately discussed with the MHCN for advice on how to proceed.

- **Conduct comprehensive assessment of mental health needs and clinical risks.**
  - Where required, a comprehensive assessment of mental health needs includes:
    - Accurately determining the presenting complaint
    - Seeking collateral input from carers, friends and relatives wherever practicable
    - Determining relevant past medical history, including medications and allergies where appropriate
    - Reaching a safe and appropriate outcome and communicating this effectively (following discussion with a registered member of staff)
    - Safeguarding (where relevant)
    - Using appropriate questioning techniques and avoiding jargon
    - Managing risk accurately to arrive at a timely outcome
    - Clearly formulate risks using structured professional judgement with reference to the UK Mental Health Triage Scale
  - A comprehensive assessment of clinical risk includes exploration of current and historical risk to self, risk to others and risk from others, as per Appendix 1, Appendix 2 and Appendix 3.
  - Where a full, comprehensive assessment is not required or possible, the rationale for this must be clearly documented.

- **Maintain accurate, confidential records of patient activity, contributing to a range of written documents as appropriate, including reports, referrals and letters.**
  - Documentation should be in-line with the Clinical Records section

- **Enable people to understand and manage their mental health needs in line with their care plan and relapse prevention strategies. This may include enabling people to**

manage their own domestic and personal resources, housing needs, and enabling people to access learning / training, or work opportunities.

- **Support individuals in developing and maintaining their identity and personal relationships, including potentially difficult relationships.**
- **Support people with mental health needs to engage with their own health care, in accordance with their care plan.**
- **Act to protect individuals from abuse and harm in line with local and national policies and procedures (eg. safeguarding, risk management, suicide prevention).**
- **Work proactively with carers and families, identifying carers' needs and signposting to appropriate services or agencies.**
- **Proactively develop your knowledge and practice, making use of both clinical and management supervision and available learning opportunities.**
- **Promote, monitor and maintain health, safety and security in the workplace.**

Appendix 8: Service Closures

The below processes outline the steps to take should an IAP service need to be closed.

For service closures of MHSD

- Complete an incident form within Ulysses, with:

  Cause group: Staffing and Workforce
  Cause: 088m – Staffing Under Numbers

- Email awp.iapservicemanagers@nhs.net **and** awp.iapteammanagers@nhs.net

The following process must be completed for each service affected:

MHRV

- Email operationsofficersbnssg@swast.nhs.uk
- Phone 0300 369 0181 to advise of the closure

MHSD

- Inform the CTL at the hub. (If no CTL on shift at Bristol EOC, advise Exeter CTL)
- Email forcecontrol@avonandsomerset.pnn.police.uk to advise that the MHSD will not be operational

MHCAS

- MHCAS cannot be closed and any potential for this must be escalated. During office hours, this must be escalated to IAP team managers. Out-of-hours, the MHCAS Shift Manager should escalate this to the on-call manager, who can liaise with the senior IAP manager on-call.

In the event of every IAP service needing to close, out-of-hours, the AWP on-call manager must be contacted.

Appendix 9: IAP Clinical Recording Template

Mental Health
Integrated Access Partnership
Intelligent Mental Health System Response

NHS

IAP Intervention Clinical Recording Template

NHS number:

Referral Source: Choose an item. **Reference Number:**

IAP Service involved: What IAP team does this relate to?

The contact started at:

Situation, Recent Triggers and Relevant Background

Assessment of contact

Safety Assessment (formulation of risk)

Safety Plan

Recommendation, Summary and Rationale for Decision

UK Mental Health Triage Scale: Choose an item.

Appendix 10: IAP and AWP Crisis/Intensive Teams Pathway

Background

It is recognised that there may be occasions when individuals calling 999, NHS 111 or AWP Crisis/Intensive teams will need an onward direction or pathway into other urgent or emergency services, or referral into Crisis/Intensive teams. This appendix provides the process and pathways for this escalation.

Aim

This aims to:

- Describe the process should an individual calling an AWP Crisis/Intensive team experience an escalation in their mental or physical health need
- Describe the process should an individual calling the IAP require an onward referral into AWP Crisis/Intensive teams.

Individuals calling AWP Crisis/Intensive teams with an escalation of need

Should an individual require emergency help, they should be advised to call 999 immediately. For individuals who require urgent physical health support, including out of hours, they should be advised to call NHS 111 and choose option 1 for physical health.

Individuals calling 999 or 111 who require an onward referral into the Crisis/Intensive teams

Following an assessment (using the UK Mental Health Triage Scale) provided by the IAP team, should an onward referral to a Crisis/Intensive team be required, the following process is agreed:

During the day (08:00 – 22:00)

The IAP practitioner must phone the relevant AWP team to refer:

- North Somerset Intensive Team: 01934 836497
- South Bristol Crisis: 01275 796209
- Inner City and East Bristol Crisis: 0117 354 7257
- North and West Bristol Crisis: 0117 354 6606
- South Gloucestershire Intensive Team: 0117 378 4250

Out-of-hours (22:00 – 08:00)

The IAP practitioner must phone the overnight service number to refer:

- BNSSG Night Crisis Team: 0117 919 5670