JISC update Dec 2018 - Jan 2019

What is a good risk assessment tool for use in A and E by A and E staff?

NB all attachments in this response are accessible by clicking on the paperclip on the left side of the document.

1. This (**attachment RAM.pdf**) is used across all the Liaison teams in the AWP Trust (south-west) and St Georges in London.

2. Another ED has modified the one (**attachment 'RVI.pdf'**) used in Cambridge – it's in the RCEM MH ED toolkit; but it uses the term 'specialling' and is quite long.

Previously we used a much shorter matrix based on a London model which is attached (**attachment 'MHTriage.pdf'**). It is more user friendly, doesn't claim to predict anything, but may help people articulate what their gut feeling around risk is.

3. See **attachment 'TriageLiaison.pdf'**

4. This clinician warns that it is a good thing to explore risk but be careful what you call things. 'There is no evidence base for anything working as a "risk assessment tool" for suicide'. He advises us to be wary of any electronic or paper form having this wording on it. 'It's not just about being pedantic. Using the phrase can give a false sense of security. It can also be used unhelpfully in critical incident reviews, inquests and fatal accident inquiries'.

5. See **attachment 'BJPsych.pdf'**

6. This clinician encloses a copy of his self-harm assessment (**attachment 'SelfHarmAssessment.pdf'**) and discharge summary letter (**attachment 'SummaryLetter.pdf'**) They photocopy the 8 page document and place it in the ED notes. Some of their staff also uses this as a template for a generic psychiatric assessment.

A&E consultant responsibility

This was a conversation (driven by MHAA-related ED breaches) about whether the mental health trust could or should take over responsibility for patients whilst they're still in the ED (as they are an 'external' provider). Ed could then 'stop the clock' even if there is a protracted MHAA, thereby reducing the number of breaches. Is there experience of other liaison teams 'taking over clinical responsibility for ED patients in this way? If so, what have been the advantages and pitfalls? Has it worked?'

Response one: this clinician has been asked this by ED clinicians in the past, however the Acute Trust must have a named clinical lead from within their organisation. In addition he argues that he does not have admitting rights to the hospital so ED cannot discharge a patient to Psychiatry; and this is explicit in his honorary contract. Otherwise the patient would arrive in a 'governance black

hole'. If rapid assessment but off the ED clock is required then he would suggest that another way of facilitating this is found (CDU or similar).

Response two: Does not advocate this idea. 'Our A&E simply accepts that breaches are likely to happen, often with psychiatric patients'.

Acute MH strategy

Experience and advice is sought from Liaison colleagues within Acute Trusts which have a **'Mental Health Strategy'** and/or **Mental Health lead** (who may or may not have MH background). If so, what that might look like in relation to liaison teams?

Response one: This service has someone with an OT by background (no mental health background) with a *role to liaise with mental health services* when needed and *to organise (limited) training to general hospital staff* on mental health issues; and *to oversee mental health and capacity act issues*.
This has settled into a comfortable relationship between her and the team. she has stepped back somewhat from the day to day aspects of mental healthcare in the hospital but does continue to be involved in projects, providing MCA training; and sits on our local steering group, MUS group, frequent attenders group, etc

Response two: We have a formal *mental health committee* which oversees mental health care in the acute trust including mental health strategy, chaired by the chief nurse. Psychological medicine is represented at the committee along with all the divisions and relevant others.

Response three: There are acute trust employed 'director of nursing for mental health'/'head of nursing for mental health' posts at 3 of the 4 trusts SLaM works with for liaison- they are all slightly differently formed jobs in terms of seniority and banding, slightly varying because of the size of the trusts, and in what the job role includes. St Thomas' have a very senior Band 8d role, Croydon University Hospital have a Band 8b role.

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