Birmingham and Solihull Mental Health NHS Foundation Trust

Doctors On-Call Guide: BSMHFT

January 2023

compassionate inclusive committed

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Section 1 - General On-Call Guidance

Welcome

Welcome to Birmingham and Solihull Mental Health NHS Foundation Trust.

We hope that this handbook can help with you in your on-call work, whether you are a new doctor starting work in the trust, a returning doctor or simply just looking to update your knowledge about working in BSMHFT.

The on call system in BSMHFT is based upon a three tier system; The Junior Tier is split into six rotas and provides cover to inpatient units (including forensics) and acute hospital Urgent Care teams, the Middle Tier and Consultant Tier are organised around three geographical 'Hubs' – North, South and East/Solihull and the Middle Tier provides cover for Mental Health Act and Community Out-Of-Hours Assessments (excluding forensics) within their Hub, with the Consultant Tier providing advice and support at busy periods. Detailed information relating to each of the rotas within each particular tier can be found later in this guide – including the split between secure and non-secure services (forensics). The way in which rotas are split is subject to regular review and feedback from junior doctors.

If, for any reason, the on-call consultant covering your Hub or rota cannot be contacted, then advice should be sought from the on-call consultant from one of the other Hubs.

Rarely, a doctor may be asked to participate in out of hours work which is not covered by the scope of this handbook (e.g., in a location not listed). In such circumstances, you should seek clarification from a senior on-call rather than refuse to do the assessment as the handbook cannot cover all possible situations. And please let us know after your on-call has finished if the handbook needs to be amended.

Any issues and problems regarding the out of hours system should be reported to:

XXXX XXXX, email: XXXX

Introduction and Overview of BSMHFT Services

Birmingham and Solihull Mental Health NHS Foundation Trust provides mental health services to a culturally and socially diverse population of over one million, covering the geographical areas of Birmingham and Solihull. We manage various services ranging from primary care psychology (i.e., Birmingham Healthy Minds) to inpatient forensic services, and cover all ages from patients who are children and adolescents (in Solihull only) all the way to older adults, and some services which are age-inclusive (i.e., Urgent Care).

Within Birmingham, BSMHFT shares the delivery of mental health services with Forward Thinking Birmingham (FTB) where FTB provide inpatient and community mental health services for Birmingham resident patients aged 0 – 25, and those under the care of the Early Intervention in psychosis Service (EIS). However, BSMHFT is still commissioned to provide services to FTB patients who present within the Urgent Care Pathway (e.g., Urgent Care Teams and Place of Safety) and FTB patients can still access the Psychiatric Decisions Unit (PDU).

BSMHFT also provide a number of specialist services such as Inpatient Perinatal, Inpatient Eating Disorders, Inpatient Regional Deaf Service, Dual Diagnosis services
(COMPASS), Secure Services (Ardenleigh, Tamarind, Hillis Lodge and Reaside) and Specialist Psychotherapies Services (SPS). Owing to the large geographical area served by BSMHFT, all referrals into the service from primary care come through one Single Point of Access (SPOA) who allocate this work based upon the location of the patient's GP Practice to either Community (CMHT) or Home Treatment Teams (HTT). There are some circumstances where a patient is not registered with a GP – see section on Additional Useful Information.

Types of rota in use in BSMHFT (Including a 15 minute hand-over period)

Full Shift (Junior Tier Rotas 1-6)

This type of rota is split into a Day Shift (5pm – 9:30pm weekdays and 9am – 9:30pm weekends) and a Night Shift (9:15pm – 9.15am). During the weekdays, there is a different doctor on duty in the evening following a normal day's work. At the weekends, it is the same doctor covering both Saturday and Sunday Day Shift. The night shift is 9.15pm- 9.15am with the same doctor covering Friday – Sunday (weekend nights) and Monday – Thursday (weekday nights).

Duty Details

Duty	Name	Type	Start	Finish	Days	Duration
A	NWD	Shift	9:00	17:00	1	8:00
B	Long Day	Shift	9:00	21:30	1	12:30
C	Nights	Shift	21:15	9:15	2	12:00
D	Half Day	Shift	13:00	17:00	1	4:00

On-Call (Middle Tier Rotas North, South and East/Sol)

A doctor is defined as being 'on-call' when (s)he is required by the employer to be available to return to work or give advice by telephone but is not normally expected to be working on site for the whole period. This type of rota applies to continuous duty from 5pm until 9am the following morning after normal day's work. At the weekend, it is continuous duty from 9am on Saturday or Sunday through to 9am the following morning. The following day is a non-scheduled workday where the expectation is that routine clinical work would not be arranged so that if full rest requirements for the oncall period are not met, this can be done the next day.

North & South Split Weekend - Duty details

Duty	Name	Type	Start	Finish	Days	Duration	NR Start	NR Finish	NR Days	Estimated call-out
A	NWD	Shift	9:00	17:15	1	8:15				
B	Weekday OC	On-call	9:15	9:15	2	24:00	17:00	9:15	2	9:00
D	Weekend OC	On-call	9:00	9:00	2	24:00	9:00	9:00	2	9:00
F	F	Shift	9:00	21:30	1	12:30				
G	G	On-call	21:00	9:30	2	12:30	21:00	9:15	2	8:00

Solihull & East - Duty details

Duty	Name	Type	Start	Finish	Days	Duration	NR Start	NR Finish	NR Days	Estimated call-out
A	NWD	Shift	9:00	17:00	1	8:00				

D	Weekend	On-call	9:00	9:00	2	24:00	9:00	9:00	2	5:00
F	F	On-call	9:15	9:15	2	24:00	17:00	9:00	2	5:00
I	I friday	On-call	9:30	9:30	2	24:00	17:00	9:30	2	5:00

Reaside & Tamarind - Duty details

Duty	Name	Type	Start	Finish	Days	Duration	NR Start	NR Finish	NR Days	Estimated call-out
A	NWD	Shift	9:00	17:00	1	8:00				
D	Weekend	On-call	9:00	9:00	2	24:00	9:00	9:00	2	5:00
F	F	On-call	9:15	9:15	2	24:00	17:00	9:00	2	5:00
H	H Saturday	On-call	9:00	9:00	2	24:00	9:00	9:00	2	5:00
I	I friday	On-call	9:30	9:30	2	24:00	17:00	9:30	2	5:00

Switchboard

1. *North Switchboard (Northcroft 0121 301 5500)*

Main switchboard (at Northcroft) will contact each of the doctors on the Junior and Middle Tier rotas on the morning of the day's duty to ensure that the doctor knows that they are on shift and that Switchboard holds the correct contact information. For weekend duty, they will contact doctors on the Friday morning.

If for any reason you believe you are on shift but have not been contacted by Switchboard by midday on the day of your duty (or Friday if the weekend) then it is your responsibility to contact switchboard directly to clarify if there is an error and you should be working.

2. *South Switchboard (Barberry/Oleaster 0121 301 2000)*

South Switchboard will contact each of the Doctors on the Juniors, South Middle Tier and South Consultant Rotas on the morning of their day's duty to ensure that the doctor knows that they are on shift and that Switchboard holds the correct contact information. For weekend duty, they will contact the doctors on the Friday morning.

If for any reason you believe you are on shift but have not been contacted by Switchboard by Midday on the day of your duty (or Friday if the weekend) this it is your responsibility to contact switchboard directly to clarify if there is an error and you should be working.

3. *Reaside Switchboard (Forensic Middle Tier and Consultants 0121 301 3000)*

Reaside Switchboard will contact each of the Doctors on Forensic Middle Tier and Forensic Consultant Rotas on the morning of their day's duty to ensure that the doctor knows that they are on shift and that Switchboard holds the correct contact information. For weekend duty, they will contact the doctors on the Friday morning.

If for any reason you believe you are on shift but have not been contacted by Switchboard by Midday on the day of your duty (or Friday if the weekend) this it is your responsibility to contact switchboard directly to clarify if there is an error and you should be working.

Changes to the out of hours online rota

It is the responsibility of individual doctors to arrange appropriate cover if they know in advance they are going to be unable to do their duty. Doctors are not permitted to take their annual or study leave if appropriate medical cover has not been arranged, communicated and confirmed by all parties. All rota changes must be made via the Medical Workforce Department via email to ***bsmhft.change.my.rota@nhs.net*** (for Rota 1, Rota 2, Rota 6, ST4-6 for Solihull & East, ST4-6 for North, Solihull & East Consultants and North Consultants) or ***bsmhft.change.my.rota.South@nhs.net*** (for Rota 3, Rota 4, Rota 5, ST4-6 for South, ST4-6 for Reaside & Tamarind, South Consultant and Reaside & Tamarind Consultants) as soon as possible in order that the rotas can be updated and switchboard be notified.

For any late changes to the rota (e.g., occurring after contact from switchboard on the morning of the day's duty) it is the responsibility of individual doctors to contact the On-Call Consultant for their shift and notify them of the change as well as to directly notify switchboard of the change with relevant covering doctor's contact information.

The sofa bed in the Doctors room at Newbridge House will be set up on request by the cleaning services. It is the junior doctor's responsibility to request this via Newbridge House reception 24hrs prior. The bed will automatically be folded away the following morning unless requested otherwise. For any issues the cleaning supervisor is Kathy Knowles is contactable on 07990 527387.

In cases of unexpected leave, due to sickness for example, the doctor should contact the Medical Workforce Department to advise of this absence as soon as possible in order that cover can be arranged. In the case of unexpected leave occurring outside of normal workday hours, the doctor should contact the On-Call Consultant as soon as they become aware they will not be able to fulfil their shift.

Handover Arrangements

It is the responsibility of all doctors working on shift to ensure that if there is any work to handover that this is done appropriately and timely in accordance with local policies regarding information governance. In most circumstances this would be a telephone call to the next doctor coming on shift to handover, or in the cases of post on-call night shifts to the day team who are starting the following day. In the case of junior doctors who cover a forensic inpatient unit on their rota there is a formal handover process in place (see Junior Tier Rotas 1-6 Secure Services (Forensics). All doctors are required to update Rio timely and accurately during their on-call activities.

Emergency Cover

If a doctor fails to turn up for their duty out of hours, then the covering doctor must stay on-call and contact the Consultant and On-Call Manager, who will then arrange emergency cover. Switchboard hold an up-to-date list of doctors who are willing to provide emergency cover on a locum basis at short notice, please contact Medical Workforce if you wish for your details to be added to the list. The trust locum policy, including pay and working hours, will be applied.

For doctors who are working 'Full Shift' as part of their normal work schedules then time off after a night shift has been completed is built into the rota design. If doctors are choosing to undertake locum work for 'Full Shift' nights then they would need to make alternative arrangements (e.g., annual leave, time-shifting) in order to not be in work the following day, otherwise it is the expectation that doctors undertaking locum work to cover a 'Full Shift' night shift would be unable to meet the satisfactory rest requirements. Doctors who opt to do a locum "on call night" must comply with the compensatory rest as per new contract.

Out of Hours Support for Staff

The first point of contact for any issues experienced by Junior or Middle Tier staff on shift should be the On-Call Consultant. At the start of a shift, doctors should ensure they are aware of the details for the On-Call Consultant and how to contact them (via switchboard). In the unlikely event of not being able to contact the Consultant responsible for your rota then it is advised to contact one of the other On-Call Consultants covering either of the other two Hubs (North, South and East/Sol).

General management Out of Hours is, in the first instance, the responsibility of the night Bed Manager (based at Place of Safety, Oleaster, 0121 301 2345). For the Middle Tier, who work with Home Treatment Team staff Out of Hours on Community Assessments then if one Hub experiences significant capacity issues the night Bed Manager may be able to help arrange support from other Hubs if possible. In addition, at all times, a Director and Executive Director are On-Call to handle any serious issues which arise out of hours.

Exception Reporting and Guardian of Safe Working (see also Appendix A)

Exception Reporting applies to doctors in approved postgraduate training programmes employed on Terms and Conditions of Service for NHS Doctors and Dentists in Training 2016. BSMHFT use an exception reporting tool from Allocate Software which is designed to follow the contractual process as closely as possible. Every doctor should be provided with log in details. If these have not been provided to you, please contact XXXX XXX

The purpose of Exception Reporting is to ensure that there is a mechanism for junior doctors to inform their Educational Supervisor and/or the Guardian of Safe Working Hours if their day-to-day work varies from the agreed work schedule, either:

- In the hours of work (including rest breaks), or
- In the agreed working pattern (including the educational opportunities made available)

BSMFHT strongly encourages doctors to report exception reports. For full details on how to complete an exception report and what to expect of the process, including the roles and responsibilities of junior doctors and clinical supervisors, please see Appendix A of this document.

The Associate Medical Director (Medical Education) is XXXX; email: XXXX and The Guardian of Safe Working Hours is XXXX email:XXXX

Section 2 - Guide for Junior Tier Doctors (Rotas 1 – 6)

See Appendix 1-5 of the on-call Standard Operating Procedure (SOP) or access on Connect: 3. On call Rotas (sharepoint.com) 'On Call SOP (005).docx' See also Appendix H and I of this document

Inpatient Wards

Doctors on the Junior Tier rotas are responsible for providing medical input and general psychiatric cover to all inpatient wards and rehabilitation units across BSMHFT sites, including the medium secure and low secure Forensic units (see later section on Secure Services).

Please familiarise yourself with the inpatient wards and psychiatric units which are covered on your rota, the geographical location and contact details. As rotas 1 – 6 operate a 'Full Shift' pattern, overnight accommodation

for each of the rotas is provided at one of the inpatient units covered by each of the rotas (as well as their being some additional facilities available on other sites see Appendix G). Some units require doctors to make contact in advance of their shift and request that overnight accommodation is made ready by housekeeping.

Medical emergencies within the psychiatric inpatient setting must always take priority before urgent assessments in A&E or general clinical duties. If there are several issues to deal with, the most urgent should be prioritised to minimise the response time. For urgent issues, especially those which relate to physical health concerns, junior doctors should aim to attend within 45 minutes of the call. Where achieving this response time is impracticable due to competing commitments, there is the option to seek help from the other junior doctor rotas and the on-call consultant can also be contacted to provide advice.

Prior to seeing a patient in any inpatient setting you should request an alarm from the nurse in charge of the unit.

Inpatient psychiatric care provided by the Junior Tier includes;

A) Admission clerking for new admissions – where possible planned admissions should take place before 5pm. Where this is not possible it is the responsibility of the team expecting an admission to plan for handover to the Junior Tier doctor. For patients who are admitted via the Middle Tier doctor assessments in A&E, Place of Safety, or community, details of earlier assessments by Urgent Care or Home Treatment Teams should be available on RiO.

   Physical health concerns – are the responsibility of the Junior Tier doctor with support from on call consultant or our medical colleagues working on Acute Medical or Surgical Admissions Units / A&E as appropriate. Inpatient Units covered by the Junior Tier include Old-Age Inpatients, Eating Disorder Inpatients and PICU / Seclusion.

   Mental health needs – including level of nursing observations and acute psychiatric emergencies with support from the Consultant on call or Middle Tier as appropriate (the Middle Tier doctor is responsible for carrying out Mental Health Act Assessments on Inpatient Units if required).

   Prescribing needs – including use of rapid tranquilisation (see Trust Policy) and admission / medicines reconciliation and EPMA.

   Requests for leave or discharge (including decisions to utilise Section 5(2) where appropriate). In the case of an inpatient making a request for unplanned leave or discharge, or if use of Section 5(2) is being considered or has been utilised this should be discussed with the on-call Consultant to ensure an appropriate management plan is put in place (see Appendix B).

B) Seclusion reviews – Junior Tier doctors may be called to carry out a review at a seclusion suite. This is an area in which patients may be contained on their own for extended periods of time. Patients are usually placed in seclusion because they pose a significant and immediate risk of harm to themselves or others and the safety and physical wellbeing of patients in seclusion is taken very seriously. A regular programme of review is instituted and out of hours the Junior Tier doctor would be expected to undertake initial review within 1 hour, and 4 hourly review thereafter until an MDT review has taken place. Should there be reasons why this might not be possible it would be important to seek advice from the Consultant on call. The review itself may be relatively brief, but the junior doctor should aim to speak to the patient and the nursing staff about their progress. The junior doctor will need to consider whether the patient should remain in seclusion and take advice from the senior nurses on site regarding this issue. The physical health of the patient is a very important aspect of a seclusion review, and if there are any concerns regarding the physical health of patients in seclusion this should be discussed in detail with the nursing staff and On Call Consultant.

For further guidance on providing inpatient psychiatric care as a junior doctor as well as prescribing, use of Section 5(2) and seclusion reviews it is advised that you read The Junior Doctor Handbook, which also contains

useful information on how to undertake a full psychiatric assessment and the requirements for admission clerking, as well as providing a guide to the use of the RiO system. Urgent Care and Acute Hospitals:

Doctors on the Junior Tier rotas are also responsible for providing psychiatric cover to the acute hospitals in the region. In the majority of cases, all acute hospitals within Birmingham have a 24-hour, 7 day a week staffed Urgent Care Liaison Team.
Exceptions to this are Moseley Hall Hospital (which has no A&E/Acute) and Solihull Hospital which has an Urgent Care Team that is commissioned to operate from 7am – 8pm only, 7 days a week. URGENT CARE standards for time response at Solihull Hospital applies only for the same hours of URGENT CARE commissioned hours, outside those hours the general rules for work priority apply.

Useful Contact Numbers

Good Hope Hospital – Urgent Care Team Duty Mobile – 07985 883048
City Hospital – Urgent Care Team Duty Mobile – 07985 882816
UHB Hospital – Urgent Care Team Duty Mobile – 07985 883550 or 07876 398578
Heartlands Hospital - Urgent Care Team Duty Mobile – 07985 882241
Solihull Hospital – Urgent Care Team Duty Mobile – 07985 882035 (7am-8pm)

Remote Working
All acute hospital trusts can access the BSMHFT remote working platform via a Citrix login. The web address to access this is XXXXX

All Hospitals in HEFT (Heartlands, Good Hope and Solihull) have a generic login (see individual site / rota details later in this guide) to first access the HEFT IT system and a link to Citrix is available from the desktop. City Hospital does not have a facility for generic login and therefore doctors requiring access to Citrix would need an URGENT CARE Team staff member to first login to the SWBH IT system. UHB Hospital has two computers which are permanently accessible via generic login in the main office and A&E office.

Facilities in acute hospitals
With respect to car parking on the site of acute hospital trusts out of hours it is not possible to provide passes for car parking. It is important you are mindful of the parking regulations of the hospital you are attending. If you are concerned about safety or coming into the hospital out of hours / returning to your parked car then please notify security on site of the acute trust and request support or assistance with this.

HEFT Switchboard 0121 424 2000
City Hospital Switchboard 0121 553 1831
UHB Switchboard 0121 627 2000

All acute trusts have public facilities available as well as on site shops/cafes (in hours) and vending machines (out of hours). If you are unsure about where you can access food and drink, or toilet facilities then please speak to a member of the URGENT CARE Team or A&E/Ward staff as appropriate.

On Call Psychiatric Assessments in A&E or Acute Hospital Wards
On call assessments should be approached in the same way as routine assessments undertaken during normal working hours, with specific consideration given to updating risk information and progress note entries to communicate the assessment, treatment and management plan to onward teams. The main difference is that, in the majority of cases, a comprehensive assessment will have already been carried out by a member of the URGENT CARE Team.

The current guidance is that further assessment by the Junior Tier doctor out of hours be jointly undertaken with a member of the URGENT CARE Team where possible. For less experienced trainees, e.g., FY2, GPST1/2 and CT1 this is advised. For more experienced trainees at CT2/3 level, they may elect to see patients on their own if

confident to do so. In some circumstances, it may be that the URGENT CARE Team staff member is busy with other assessments or attending to an urgent situation and not free to attend with the Junior Tier doctor for some time. It is not necessary to wait for the URGENT CARE Team staff member to be available, if appropriate, the Junior Tier doctor should consider whether to go ahead and see the patient to avoid delay. If there are concerns regarding risk or additional support is required then A&E staff or ward staff can be approached to accompany during the assessment. Under no circumstances should you see a patient on your own if you do not feel it is safe to do so.

Very occasionally, a referral may bypass the normal referrals process for the URGENT CARE Teams and come directly through to the on-call psychiatry Junior covering a particular hospital. In this case the Junior Tier doctor would need to liaise with the URGENT CARE Team staff member after seeing the patient or giving telephone advice in order to ensure that appropriate follow up or discharge planning was put in place.

After 8pm calls to request an urgent psychiatric assessment at Solihull Hospital will come directly through to the Night Bed Manager who will then co-ordinate with Home Treatment Team cover and the Junior Tier doctor to undertake a joint assessment of the patient at Solihull Hospital.

Admissions, Discharges and Mental Health Act Assessments

When an assessment under the Mental Health Act is indicated, this would be passed to the Middle Tier doctor covering that particular acute hospital and coordinated via the Emergency Duty AMHP Team (0121 464 9001). The On Call Consultant for each area is available to Junior Tier doctors assessing patients with URGENT CARE Teams out of hours to give advice, and to discuss admission and discharges where necessary. Less experienced trainees, e.g., FY2, GPST1/2 and CT1 should discuss any decision to admit a patient or discharge them home with the On Call Consultant.

Experienced trainees (at CT2 or CT3 level) may elect to discharge a patient home after completing a joint assessment with URGENT CARE or HTT without discussing it with the On Call Consultant, although the consultant will always be available to discuss any problems. In cases where admission is required, regardless of the experience of the Junior Tier doctor this should be discussed with the On Call Consultant first in order to ensure robust gatekeeping to our inpatient services.

The Bed Management Team based at the Oleaster (0121 301 2345) will coordinate all patients who require admission from A&E or acute hospital trust wards if aged >25 years or a resident of Solihull and aged >16 years. If there is likely to be a delay in admitting a patient from an acute trust A&E or ward then an appropriate management plan should be implemented to account for any necessary treatment or care required until admission can be arranged.

For patients who are appropriate for discharge following assessment, then the URGENT CARE Team staff will be available to support any onwards referrals process to Home Treatment Teams, PDU, Respite, CMHT or Birmingham Healthy Minds. It is also a standard part of the discharge process that copy letters of all assessments are sent to the patient's GP.

Admission for patients <25 years and Crisis / Home Treatment Team follow up for patients who are resident in Birmingham should be directed to the Bed Managers or Crisis Team/HTT at Forward Thinking Birmingham via the Access Centre number on 0300 300 0099.

Admission for all patients aged 16 & 17 to General Adolescent Units (CAMHS) follows a Specialist Commissioned Pathway vis NHS England. In hours this process is coordinated via the Inpatient Team at Parkview Hospital, but out of hours referrals need to be sent to Huntercombe Hospital, Stafford, upon completion of Form 1 (see Appendix F).

Information for Junior Tier Doctors Covering Secure Units

There are 4 secure hospitals that you may cover when working on a Junior Tier rota. Secure hospitals deliver treatment to mentally disordered offenders and have robust physical, relational, and procedural security measures in place. Patients treated within these hospitals are detained under various Sections of the Mental Health Act 1983. These can be both civil and 'Forensic sections'. These sections must be considered when caring for patients detained within secure units, as these may have an impact on the actions that you undertake. A Forensic Consultant Psychiatrist provides out of hours cover to these units and should be contacted about any concerns.

During out of hours shift work the doctors covering the Junior Tier rotas are responsible for the physical health and psychiatric care of patients detained within the secure units. The Junior Tier rota doctors should not receive any calls about Forensic issues from the community or A&E. These would go to the Forensic ST4-6 rota and On Call Forensic Consultant Psychiatrist. The Forensic ST4-6 and On Call Forensic Consultant Psychiatrist are also available for advice to the Junior Tier doctor when covering Forensic inpatients, as needed. The clinical problems that you will encounter within these units are the same as those you will see in general inpatient psychiatric wards, though there are some important specific issues to be aware of:

Secure Units in Birmingham and Solihull

Ardenleigh - Medium Secure Forensic CAMHS/Mixed-Sex, Medium-secure Women's and Low Secure Adolescent Female (Rota 4)

Tamarind Centre – Medium Secure Male (Rota 4)

Reaside Clinic – Medium Secure Male (Rota 5)
Hillis Lodge – Low Secure Male (Rota 5)

These units are different to general acute hospitals. There are 24-hour staffed receptions and security desks. Photo ID will need to be shown and it is important to be aware that there are various 'contraband' items which are not allowed within clinical areas. This includes your mobile phone which should be handed in to staff, who can take any calls for you if required. You can contact switchboard yourself and advise that you are entering a secure unit, or request for the reception/security staff to do so on your behalf. Then it would be advisable to leave your duty phone with the reception/security staff so that you are still contactable by other sites whilst on the secure unit in the event of an emergency. Alternatively, you can ask for a bleep which is available at all receptions to allow you to be contactable while moving between wards inside secure units.

You will be given an alarm +/- keys and a member of staff will collect you to take you to the clinical area required if you have not already had a security induction and do not have keys.

Seclusion

Seclusion is covered in your general induction and earlier in this section under guidance for inpatient wards. There are seclusion suites in various sites and these are used more frequently in forensic services. Worth noting is the need for a medical review within 1 hour of initiating seclusion, then 4 hourly until first MDT review (typically undertaken by Forensic ST4-6 or Consultant), and the requirement of a medical review once every 24 hours. This is a requirement even out of hours/at weekends, though SHOULD have been carried out by the team doctor during weekdays.

On rare occasions a patient from one part of the trust covered by one on-call rota will be placed in a seclusion suite that falls under another on-call rota. In this situation, the medical reviews should be completed by the doctor who covers that location of the seclusion suite. For example, a general adult patient from Northcroft (rota 1) is moved to seclusion on Larimar (rota 2) - the junior doctor from rota 2 will complete the medical reviews.

The only exception is any forensic female or CAMHS patients being cared for in the Larimar seclusion suite who should continue to be reviewed by the doctor that covers Ardenleigh (rota 4).

Need for Transfer to a General Hospital for Medical Treatment

The patient's physical health should be seen as a priority and they should not be disadvantaged due to being treated within a forensic unit. However, it is important to recognise that there are inherent risks associated with potential transfer to a general hospital. In a life-threatening emergency, this is unavoidable and should be undertaken. Nursing staff can liaise with the Consultant Forensic Psychiatrist on call to discuss risks and escort level required, but it is also helpful to speak with the Consultant yourself to explain the need for transfer.

If the patient's physical health can be managed within the forensic hospital, then this should be the aim. GP's visit the units weekly and can provide more expert medical input. You should visit the unit to assess the patient when you are called and when it is not a life-threatening emergency. If transfer to hospital is necessary then there are further points to consider/potential actions to undertake

- Undertake risk assessment – risk of violence to others, absconsion risk, other relevant risks highlighted on 'Level 2 – Risk Formulation' on Rio
- Use this information to inform a discussion with nursing staff about escort level, transport arrangements and need for handcuffs
- It is essential that any leave to hospital is discussed with the Consultant Forensic Psychiatrist on call
- Recognise that the Ministry of Justice should be informed of the movement of Restricted Patients (those with a /41 or /49 as part of their section). This should ideally be done before the patient is moved, though can be afterwards if this is an emergency

Write an accompanying letter and take actions to make contact with staff at the receiving hospital to inform them of planned attendance, risks and potential benefits of quick review and reduction of waiting time (including notifying relevant URGENT CARE Teams where applicable)

Consent to Treatment

All patients detained under the Mental Health Act 1983 require assessment of 'Consent to Treatment' after 3 months (see also Appendix D). Longer stays are more common in forensic services and so before prescribing any psychotropic medications, or those required to manage the side effects of these medications, when you are working on call it is crucial to review the T2 or T3 documentation to see what has been specified. Both T2 and T3 can be found on RiO – T2 : Consent/Treatment -> T2 Consent to Treatment ; T3 : Uploaded to 'Clinical Documents'. If in doubt, contact the on call Forensic ST4-6/Consultant for advice.

If the medication required has not been documented on one of these forms and if the patient has been detained under the Mental Health Act 1983 for over 3 months, then a Section 62 may be required. This is ONLY for medication, which is immediately necessary to save the patient's life, prevent a serious deterioration of the patient's condition, alleviate serious suffering by the patient and/or represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to him/herself or others. Section 62 form can be found on RiO – Consent/Treatment -> Section 62 – Treatment

Specific Points re: Forensic CAMHS at Ardenleigh

It is important to be aware that there is specific guidance available with regards to rapid tranquilisation in younger patients within this unit. Discussion with Consultant Forensic Psychiatrist on call MUST take place prior to prescription.

Handover Arrangements

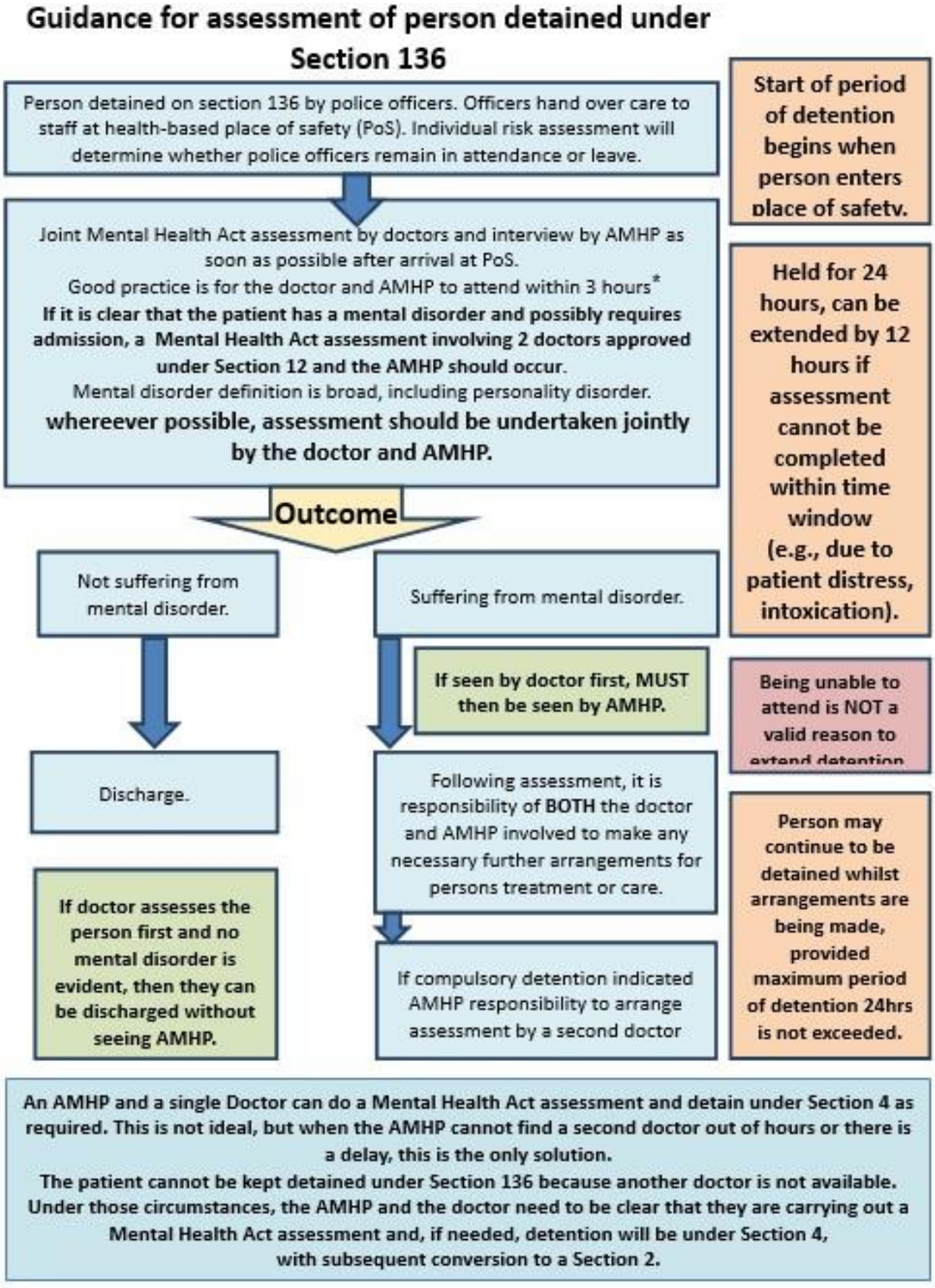
If there is something urgent to handover, then a phone call must be made to the doctor taking over from you or the team doctor who is starting work. Please email the consultant responsible for the patient's care if there are significant concerns. The Consultant Forensic Psychiatrist or ST4-6 on call should be contacted for discussion if you are concerned about anything or if significant actions are being undertaken on shift.

Section 3 - Guide for Middle Tier Rotas

Guide for Middle Tier Rotas.

There are three Middle Tier rotas organised around the three geographical Hubs: North, South, East & Solihull and one separate Middle Tier rota for Forensic secure services.

The Middle Tier doctor is responsible for undertaking out of hour's assessments in the community, at night and weekends with the relevant Home Treatment Teams. They are also responsible for providing telephone advice to Home Treatment Team staff out of hours and undertaking Mental Health Act assessments in the community, at the Place of Safety or at Police Stations and the Police Custody Suite. At the Place of Safety the Middle Tier doctor may be joined by the Bed Manager in place of a Home Treatment Team nurse for assessments.



Single Point of Access

BSMHFT Single Point of Access (SPOA) operates from 8am – 7pm Monday to Friday and takes referrals from GP's or Badger Service etc. Outside of these hours, and for any general calls from outside agencies these calls will go

through to Northcroft Switchboard who, in order to ease swift access to the most appropriate professional, will route out of hours calls through the Middle Tier Doctor.

Out of Hours call to Northcroft switchboard
(0121 301 5500)

Northcroft switchboard will attempt to connect call
to relevant medic (Middle Tier by HUB), and give that medic's direct number to the caller

Middle Tier
Caller contacts the on call Middle Tier Doctor
Doctor liaises directly, if not automatically connected with other
Message left if unavailable. professionals as appropriate
If no response after 30 minutes, switchboard contacts the On Call Consultant for relevant

Responsibility for Mental Health Act assessments and community assessments are allocated based on the patient's GP and relevant Home Treatment Team to whom the patient would be allocated. It is in no one's interest to get into dispute over which area should be called to assess the patient and if unclear, it is always best to undertake an assessment and then review later whether the correct team has been identified. In cases where this cannot be clarified then advice from Bed Managers or Senior OnCall managers should be sought to avoid causing any delay in patient care.

The Middle Tier doctor is also responsible for providing clinical advice to the Junior Tier doctor if the Consultant On-Call is not immediately available and for undertaking senior psychiatric review or Mental Health Act assessments for patients who are admitted to inpatient wards or present to A&E/acute wards of the General Hospitals within their Hub.

The Trust uses electronic prescribing via EPMA and therefore if you feel it is appropriate after consideration that medication should be changed, please ensure that you note your rationale in the patient's clinical RiO record to advise the day team of your decision. Please ensure that prescribing is in line with Trust guidelines (see Intranet).

There is only one site designated as a 'Place of Safety' for the purposes of section 135 or 136 of the Mental Health Act and this is in the South Hub, at the Oleaster. Therefore, once the appropriate Middle Tier doctor providing cover to the HTT for the area where the patient is, is identified, they should travel to the Place of Safety to conduct an assessment when requested.

To organise an admission for a patient, it is the responsibility of the Home Treatment Team and Middle Tier doctor conducting the assessment to contact the Bed Manager (0121 301 2345) and arrange admission. Where there is likely to be a delay in identifying a bed for admission it is the responsibility of the Middle Tier doctor and / or the Home Treatment Team or URGENT CARE Team completing the assessment to ensure that an appropriate management plan is in place for that patient to remain where they are, pending admission (e.g. if a patient is to remain in A&E or on an acute medical ward).

Specific Advice for Forensic ST4-6/Middle Tier rota

Assessments taking place out of hours should always be discussed with Consultant Forensic Psychiatrist on call.

When patients are admitted out of hours from the community or from police custody, the following forms must be completed on RiO to ensure that appropriate care is arranged for the patient.

- Level 2 - Risk Formulation
- HoNOS and Cluster (Secure)
- CPA Care Plan

In addition, management and care plans should be discussed with ward staff.

Section 4 - Specific Rota Information

Junior Tier Rota 1: (North Hub Consultant)

Resident (Full Shift) rota with overnight accommodation available at Northcroft Hospital. Please note that this includes Forward Thinking Birmingham Medics (FTB) partaking within BSMHFT Out of Hours Rota.

Northcroft Site – 190 Reservoir Road, Erdington, B23 6DW, Tel: 0121 301 5500, Eden Unit, George Ward and Endeavour House (Male Acute) and Eden PICU (Female PICU).

Endeavour Court and Forward House – 71 Fentham Road, Erdington, B23 6AL,
Inpatient Rehabilitation

Reservoir Court - 220 Reservoir Road, Erdington, B23 6DJ, Tel: 0121 301 7333, Older-Adult Inpatient Unit.

Good Hope Hospital - Rectory Road, Sutton Coldfield, Birmingham, B75 7RR,
Switchboard – 0121 424 2000, URGENT CARE Team Office – 0121 424 7655, URGENT CARE Team Duty Mobile – 07985 88 3048

The URGENT CARE Team office at Good Hope Hospital is located on the 3rd Floor of the Fothergill Block. This is towards the back of the hospital, at the opposite end to A&E and AMU. This URGENT CARE Team is staffed 24 hours a day and it is likely that after 8pm there would only be one member of trained staff on duty. It is advisable to arrange where to meet staff when called out. If you require access to the office to write up an assessment or look up information prior to carrying out an assessment then the URGENT CARE Team staff member will need to let you in.

Junior Tier Rota 2: (North Hub Consultant for all except Larimar and Rookery Gardens which is East/Sol Hub Consultant)

Resident (Full Shift) with overnight accommodation available at Ardenleigh.

Mary Seacole Hospital - Lodge Road, Winson Green, Birmingham, B18 5SD, Tel: 0121 301 6100, Ward 1 (Male Acute), Ward 2 (Female Acute) and Meadowcroft (Male PICU).

Ashcroft Unit - The Moorings, Hockley, Birmingham, B18 5SD, Tel: 0121 301 6140, Older-Adult Inpatient Unit.

Larimar Ward and Rookery Gardens – Ardenleigh, 385 Kingsbury Road, Erdington, Birmingham, B24 9SA, Tel: 0121 301 4411 Non-Forensic Wards based at Ardenleigh, Larimar (Female Acute) and Rookery Gardens (Inpatient Rehabilitation).

City Hospital – Dudley Road, Birmingham, West Midlands, B18 7QH, Switchboard –
0121 553 1831, URGENT CARE Team Office – 0121 507 6063, URGENT CARE
Team Duty Mobile – 07985 88 2816

There are several URGENT CARE Team offices at City Hospital. The main base out of hours is the same office which the team uses during the day. If you enter through the main entrance and take a 1st right down that

corridor then there is a sign visible for the Psychiatric Liaison Team and you would see Psychiatric Liaison Team on the door.

This URGENT CARE Team is staffed 24 hours a day and it is likely that after 8pm there would be one or two members of trained staff on duty overnight. There is no generic login to access the IT systems at City Hospital so URGENT CARE Team staff would need to assist with this.

If you are required to assess a patient on either D43 or D42 at City Hospital then there is a swipe card access which needs to be obtained from the URGENT CARE Team main office to gain entry. URGENT CARE Team staff also have access to a smaller office close to A&E. You can access either office to write up an assessment or look up information prior to carrying out an assessment.

Junior Tier Rota 3: (South Hub Consultant)

Resident (Full Shift) with overnight accommodation available at Juniper Centre.

The Juniper Centre – Moseley Hall Hospital Site, Alcester Road, Moseley, B13 8JL, Tel: 0121 301 5700, Older-Adult Inpatient Wards; Sage (male), Rosemary (female) and Bergamot (mixed).

Moseley Hall Hospital – Alcester Road, Moseley, B13 8JL, Tel: 0121 466 6000
Grove Avenue – 32 Grove Avenue, Moseley, B13 9RY, Inpatient Rehabilitation.

Psychiatric Decisions Unit – Oleaster, 6 Mindelsohn Crescent, Edgbaston, Birmingham, B15 2SY, for urgent/emergency psychiatric assessment out of hours only

University Hospital Birmingham - Mindelsohn Way, Birmingham, B15 2TH, Switchboard – 0121 627 2000, URGENT CARE Team Office – 0121 371 2619, URGENT CARE Team Duty Mobile – 07985 88 3550

There is a main URGENT CARE Team office at UHB located in the Heritage building which is used by the team during normal working hours. Out of hours there is an office based in the A&E department close to the A&E sub-wait. If you attend the main A&E department entrance and ask for the Seminar Room which the URGENT CARE Team use – you will be directed to its location. A&E at UHB is accessed via a separate entrance to the rest of the hospital and if you arrive at the main hospital entrance you will have difficulty getting into the A&E department without swipe card access.

This URGENT CARE Team is staffed 24 hours a day and it is typical that after 8pm there would be two members of trained staff on duty, one on the night and one on a twilight shift. It is advisable to make your way to the Seminar Room which the URGENT CARE Team use within the A&E department and if there is no staff present then contact via the duty mobile. There is a computer with generic login access available in this office to write up an assessment or look up information.

Junior Tier Rota 4: (East/Solihull Hub Consultant or Forensic Consultant if secure services)

Resident (Full Shift) with overnight accommodation available at Newbridge House.

Newbridge House – 130 Hobmoor Road, Birmingham, B10 9JH, Tel: 0121 301 6598, Female Inpatient.

Tamarind Centre – 165 Yardley Green Road, Bordesley Green, B9 5PU, Tel: 0121 301 0500, Medium-Secure Male

Ardenleigh (excluding Larimar and Rookery Gardens) – 385 Kingsbury Road,
Erdington, B24 9SA, Tel: 0121 301 4411, Medium-Secure Forensic CAMHS/MixedSex, Medium-secure Women's and Low-Secure Adolescent Female

Heartlands Hospital – Bordesley Green East, Birmingham, B9 5SS, Switchboard – 0121 424 2000, URGENT CARE Team Office – 0121 424 0860, URGENT CARE Team Duty Mobile – 07985 88 2241

The URGENT CARE Team office at Heartlands Hospital is located on the ground floor just off the main corridor heading towards the tower block (wards 1-12 / ITU). It is the first room along the Medical Engineering Corridor (swipe access only) and the entrance to this is opposite the Faith Centre. This URGENT CARE Team is staffed 24 hours a day and it is likely that after 8pm there would be two members of trained staff on duty, one on the night shift and one on a twilight shift. If you require access to the office to write up an assessment or look up information prior to carrying out an assessment then the URGENT CARE Team staff member will need to let you in.

The sofa bed in the Doctors room at Newbridge House will be set up on request by the cleaning services. It is the junior doctor's responsibility to request this via Newbridge House reception 24hrs prior. The bed will automatically be folded away the following morning unless requested otherwise. For any issues the cleaning supervisor is Kathy Knowles is contactable on 07990 527387.

Junior Tier Rota 5 (South Hub Consultant or Forensic Consultant if secure services)

Resident (Full Shift) with overnight accommodation available at the Oleaster.

The Barberry – 25 Vincent Drive, Edgbaston, Birmingham, B15 2FG, Chamomile (Inpatient Mother and Baby), Cilantro (Inpatient Eating Disorders), Jasmine (Inpatient Regional Deaf Service) and Vetiver Suite (Inpatient EEG Suite).

The Oleaster – 6 Mindelsohn Crescent, Edgbaston, Birmingham, B15 2SY, Tazetta and Magnolia Wards (Male Acute), Melissa and Japonica Wards (Female Acute) and Caffra (Male PICU).

Place of Safety and PDU (Psychiatric Decisions Unit) – The Oleaster, for urgent physical health assessments and prescribing.

Reaside – Reaside Drive, Birmingham Great Park, Rubery, B45 9BE. Tel: 0121 678 3000, Medium-Secure Male.

Hillis Lodge – Hollymoor Way, Birmingham, B31 5HE. Tel 0121 301 4100, Low-Secure Male Forensic Unit.

Junior Tier Rota 6 (East/Solihull Hub Consultant)

Resident (Full Shift) with overnight accommodation available at the Zinnia Centre.

Zinnia Centre – 100 Showell Green Lane, Sparkhill, B11 4HL, Tel: 0121 301 5300, Lavender (Female Acute) and Saffron (Male Acute).

David Bromley House - 2-4 Woodside Crescent Downing Close, Knowle, B93 0QA, Tel: 0121 301 4935, Inpatient Rehabilitation.

Dan Mooney House – 1 Woodside Crescent, Downing Close, Knowle, B93 0QA, Tel:

0121 301 4930, Inpatient Rehabilitation.

Hartford House – 29 Old Warwick Road, Olton, Solihull, B92 7JQ, Tel: 0121 301 4860, Inpatient Rehabilitation.

Solihull Hospital – Lode Lane, Solihull, B91 2JL, Switchboard – 0121 424 2000, URGENT CARE Team Office – 0121 424 4495, URGENT CARE Team Duty Mobile – 07985 88 2035

The URGENT CARE Team office at Solihull Hospital is located on the ground floor in between the minor injuries' unit and AMU. There is an access code to gain entry and the code is available from the Bed Management Office (0121 301 2345). This URGENT CARE Team is staffed from 7am to 8pm, seven days a week. After 8pm all referrals for an urgent psychiatric assessment at Solihull Hospital go through to BSMHFT Bed Management at the Oleaster and are coordinated for the Junior Tier doctor from rota 6 to undertake with a member of the Home Treatment Team for
Solihull.

North Middle Tier Hub Rota: (North Hub Consultant)

Non-Resident On Call ST4-6 or SAS doctor provides advice to Junior Tier doctors on Rotas 1 and 2 (North Hub) as well as carrying out Mental Health Act assessments in the same units covered by the North Hub Consultant, with the exception of Ardenleigh secure services which are covered by the Forensic ST4-6.

Police Station Assessments

All patients are taken to the Perry Barr Police Custody suite which is covered by the North Middle Tier rota.

Middle Tier doctors for North Hub work with the following Home Treatment Teams at the weekend and before 9pm: North HTT and Handsworth and Ladywood HTT. After 9pm there is a pan-Birmingham HTT service staffed by nurses drawn from all the HTT's and work is allocated based on need by the night Bed Manager.

South Middle Tier Hub Rota: (South Hub Consultant)

Non-Resident On Call ST4-6 or SAS doctor carry out Mental Health Act assessments in the same units covered by the South Hub Consultant, with the exception of Reaside Clinic and Hillis Lodge secure services which are covered by the Forensic ST4-6.

The South Middle Tier rota also covers referrals from The Royal Orthopedic Hospital.

Middle Tier doctors for South Hub work with the following Home Treatment Teams at the weekend and before 9pm: South East HTT, South West HTT and Sparkhill and Sparkbrook (Zinnia) HTT. After 9pm there is a pan-Birmingham HTT service staffed by nurses drawn from all the HTT's and work is allocated based on need by the night Bed Manager.

East & Solihull Middle Tier Hub Rota: (East/Solihull Hub Consultant)

Non-Resident On Call ST4-6 or SAS doctor provides advice to Junior Tier doctors on Rotas 4 and 6 (East/Solihull Hub) as well as carrying out Mental Health Act assessments in the same units covered by the East and Solihull Hub Consultant, except for Tamarind and Ardenleigh secure services which are covered by the Forensic ST4-6.

Middle Tier doctors for East and Solihull Hub work with the following Home Treatment Teams at the weekend and before 9pm: Solihull HTT and Central (Zinnia) HTT. After 9pm there is a pan-Birmingham HTT service staffed by nurses drawn from all the HTT's and work is allocated based on need by the night Bed Manager.

Forensic Middle Tier / ST4-6 Rota: (Forensic Consultant On Call)

Non-Resident On Call ST4-6 or SAS doctor provides advice to Junior Tier doctors covering Inpatient Forensic Units; Ardenleigh, Tamarind, Reaside Clinic and Hillis Lodge, supports Seclusion Review process at Inpatient Forensic Units and undertakes out of hours Forensic assessments in the Community and Police Stations.

Section 5 - Specific On-Call Issues

On-Call Consultant

The On-Call Consultant provides advice to the other doctors on Junior and Middle tier as detailed in the previous section. Junior and Middle Tier doctors should feel able to contact the On-Call Consultant when necessary. If you have any clinical issues whilst working on call then it is advised that you discuss this with the On-Call Consultant if it is a matter which requires urgent attention. In exceptional circumstances, for example if the number of referrals is so large that the Middle Tier doctor is unable to deal with them in a timely manner, then consultant should be contacted if assistance is needed to triage and prioritise patients. The consultant may need to also assess patients. If the On-Call Consultant cannot be contacted, the Junior Tier doctor should seek advice from either the Middle Tier doctor or one of the other On-Call Consultants.

All events when on-call consultants or senior doctors could not be contacted should be reported as soon as possible to XXXX (Deputy Medical Director for professional practice and workforce) on XXXX and copy XXXX An eclipse form should also be completed.

If you have any clinical issues whilst working on call that are not urgent and do not require immediate discussion with the On-Call Consultant then it is advisable to discuss any clinical concerns relating to on call issues with your Clinical Supervisor during Supervision, or at the next available opportunity. Part of the role of Clinical Supervision by the trainees own Consultant will involve post-hoc discussion of the trainees on call experience.

Self-Presentation

Very rarely patients will self-present to one of the Inpatient Units. The most appropriate course of action is to take down the full details of the patient (Name, DOB, Address and GP) with one of the Senior Nurses on Duty and then discuss with the Middle Tier doctor and Home Treatment Team for further assessment.

Out of Hours Calls from Relatives/Carers

Relatives contacting the Trust are often very distressed. If the patient is not known to you, advise switchboard to ask them to phone the following day and speak to the team doctor, or put the call through to the ward. Remember that there may be issues of confidentiality when speaking to relatives. However, confidentiality is not a reason to not listen to relatives and carers and record their concerns, or any information they can give about the patient on RiO.

Joint Assessments with AMHPs

It is desirable for these assessments to be completed jointly with the AMHP however this is not always possible. In cases where the Middle Tier doctor completes an assessment before the AMHP arrives, it is not necessary for them to wait providing the doctor is available to liaise with the AMHP via telephone and leaves the appropriate paperwork in a secure place. In no circumstances should a doctor refuse to see a patient "unless it is a Mental Health Act Assessment".

A medical recommendation is a legal document and as such the correct recommendation (Section 2 / Section 3) should be completed. A medical recommendation is a report which represents the medical evidence necessary to detain the patient. As such it should represent the doctor's opinion as to the appropriate order, albeit once appropriate discussions have taken place with the AMHP. Should you make a medical recommendation and the patient is not admitted, for whatever reason, you still have a responsibility to formulate the best care plan possible to meet the patient's and carers' needs.

No Fixed Abode (NFA)

When patients present without an address in Birmingham, or are of no fixed abode, the Home Treatment Team and Middle Tier doctor responsible for the geographical area where the patient is identified should be contacted to carry out a joint assessment. In the case of NFA patients who present to A&E/Acute Hospitals, the appropriate URGENT CARE Team and Junior Tier doctor would be contacted to assess the patient. In the case of patients who are of no fixed abode requiring admission, this should be discussed with the On-Call Consultant in the same way as all other patients.

Alcohol & Substance Abuse

Admission for inpatient detoxification only is not standard practice for Inpatient Psychiatric wards. The presence of acute intoxication or withdrawals is indication for medical assessment and possible admission to a medical ward in the case of acute withdrawal due to risk of delirium tremens. It is advisable to discuss with the Middle Tier doctor or On-Call Consultant if there are problems.

Section 136, Place of safety and Police Custody

There is only one site designated as a 'Place of Safety' for > 18 years for the purposes of Section 135 or 136 of the Mental Health Act and this is located at the Oleaster, 6 Mindelsohn Crescent, Edgbaston, Birmingham, B15 2SY. Assessments are undertaken by the Middle Tier doctor based on the geographical location of the patient's GP (North, South or East/Sol Hub).

Assessments of patients in the Perry Barr Police Custody Suite are assigned in the same way as Place of Safety assessments to the Middle Tier doctor and HTT by geographical location

When a patient is taken to an acute hospital A&E department on Section 136 with a complicating physical health condition (often injury or drug intoxication) then the review of the Section 136 detention should be carried out by the Middle Tier doctor covering that particular hospital along with an AMHP. This is of particular relevance following the recent changes to the length of time a patient can be detained on Section 136 from 72 hours to 24 hours (with the option to extend for a further 12 hours if applicable).

Out of Area Patients

Assessment follows the same process as patients who are of no fixed abode but if the patient requires admission, or urgent follow up by Crisis/Home Treatment Teams

then this is done by contacting the relevant Bed Managers or Crisis/Home Treatment Team.

Forward Thinking Birmingham (FTB)

In Birmingham, patients aged 0-25 years and those requiring EIS (Early Intervention in psychosis Service) receive inpatient and community services from FTB. BSMHFT is commissioned to provide services in Place of Safety at the Oleaster and via URGENT CARE. FTB On-Call services will take over care and arrange beds for admission or Crisis / Home Treatment Team follow up on a "Trusted Assessment" basis. FTB is best contacted via the Access Centre number on 0300 300 0099 or 0121 333 9196. In hours, the FTB Bed Manager can be contacted via 0121 333 8009.

Patients over 65 years

It is the case that patients aged over 65 years may require an assessment in their own home. These patients should be assessed in the same way as all other patients by the relevant Middle Tier doctor and the HTT responsible for the area in which they live. HTT input may or may not be appropriate for these patients in which case it may be necessary to refer on to the appropriate Mental Health Service for Older People for follow up. BSMHFT operates "No Age Discrimination" policy.

Section 6 - Consultants On-Call

Availability

All on-call consultants must ensure that there are available and contactable throughout their duties. It is advisable to make sure that the relevant switchboard has more than one number for the on-call including a landline especially if they are in a poor reception area.

If, for any reason, the on-call consultant covering one Hub or rota cannot be contacted, then the other 2 on-call consultants covering the other hubs could be contacted by the junior doctors for advice.

Lack of availability

If a junior doctor is not available for their on-call duties

In exceptional circumstances the use of locums to provide essential cover will be unavoidable and therefore where locum doctors need to be used, the risks should be appropriately assessed and managed.

Where doctors designated to be on call are unable to attend work due to sickness absence they should in the first instance notify their supervising doctor, unless this arises 'out of hours' in which case they should contact the relevant switchboard who will inform the relevant on call Consultant and on call Manager (Note - where a

doctor is unable to fulfil their on call shift, the doctor covering the preceding shift should in if possible, remain until alternative cover is arranged).

The on-call Consultant will liaise with the relevant switchboard at Barberry, Reaside or Northcroft to ascertain if cover can be provided by a doctor from the agreed locum doctor list.

It is the responsibility of the Clinical Director/supervising Consultant (or in out of hours situations the relevant On-call Consultant, in conjunction with the designated on call Manager) to ascertain whether the reorganisation of existing cover may provide the necessary solution, to avoid the use of locum cover.

Acting Down

"Acting Down" is the term used to refer to situations where Consultants and SAS Doctors, will as a result of an emergency or unforeseen event, the alternative to which would put the well-being and safety of patients at significant risk, undertake duties usually performed by a more Junior member of medical staff. "Acting Down" should be the exception rather than the rule and all attempts to avoid the necessity for it should be made.

Consultants/SAS Doctors are usually requested to act down owing to an unforeseen shortage or absence of Junior medical staff. The majority of such absences or shortages are known in advance. Leave for all medical staff should be requested at the earliest opportunity and no lesser than 6 weeks in advance. All medical rotas must make provision for cover of all planned leave and arrangements for leave should be clearly explained to Junior Doctors at Induction.

Sickness absence should be notified to Medical Resourcing at the earliest opportunity so that cover can be arranged wherever possible.

PROCEDURE FOR REQUESTING MEDICAL STAFF TO ACT DOWN

General Principles of Acting Down

Acting down places an increased pressure on senior medical staff and should be the exception rather than the rule. All efforts where possible will be made to avoid it.

Acting down arrangements will only be implemented when it is clinically safe to do so.

Procedure for Consultants Acting Down to SAS Level

When a slot becomes vacant for an SAS Doctor, Medical Workforce Team will make every effort to find cover. Where a vacancy slot becomes available out of hours the consultant responsible for the on-call rota should attempt to find cover (SAS Doctor).

Where attempts to cover a vacant SAS Doctor slot on the rota have been unsuccessful, the Consultant on-call will be required to act down

If the on-call consultant is suddenly not available to carry their duties

In the event if the on-call consultant finds himself/herself suddenly unable to carry out their duties (e.g., sudden sickness), he/she should do the following:

- Contact the on-call manager
- Arrange with the two other on-call consultants to take over their duties
- Inform relevant switchboard of the agreed arrangement
- Inform XXXX (Deputy Medical Director for professional practice and workface)onXXXXand copy XXXX XXXX

Appendix A

Understanding your work schedule and the exception reporting process

1. Work Schedules

A work schedule is a document that sets out the intended learning outcomes (mapped to the educational curriculum), the scheduled duties of the doctor, time for quality improvement, research and patient safety activities, periods of formal study (other than study leave), and the number and distribution of hours for which the doctor is contracted.

A generic work schedule should be provided to junior doctors from Trust before they join the service. The generic work schedule will form the basis for a then personalised work schedule.

Junior doctors and their consultant Clinical Supervisor are jointly responsible for personalising the work schedule, according to the doctor's learning needs and the opportunities within the post. Where possible within the constraints of service delivery, adequate account will be taken of reasonable requests when agreeing the personalised work schedule.

A work schedule review is a formal process by which changes to the work schedule may be suggested and/or agreed. Such a review can be triggered by one or more exception reports, or by a request from either the doctor or the employer. A work schedule review should consider safe working, working hours, educational concerns and/or issues relating to service delivery.

2. Exception reporting

The purpose of Exception Reporting is to ensure that there is a mechanism for junior doctors to inform their Educational Supervisor and/or the Guardian of Safe Working Hours if their day-to-day work varies from the agreed work schedule, either:

a) In the hours of work (including rest breaks), or

b) In the agreed working pattern (including the educational opportunities made available)

Exception reporting applies to doctors in approved postgraduate training programmes employed on Terms and Conditions of Service for NHS Doctors and Dentists in Training 2016.

The TCS for NHS Doctors and Dentists in Training 2016 makes clear the roles and responsibilities of junior doctors and supervisors as part of the Exception Reporting process.

Roles and responsibilities of the Doctor:

a) Records new exceptions

b) Accepts or rejects the outcome made at each review level

c) Has access to current and historic exception reports

Roles and responsibilities of the Supervisor:

a) Assigned to an individual exception report by the doctor

b) Every doctor should be provided with the name of the supervisor dealing with their exception reports (it is important that the doctor selects the correct name when filling in an exception report - the name of the correct supervisor can be confirmed with XXXX XXXXX.

c) The supervisor makes work schedule review decisions

d) The supervisor will contact the doctor to arrange a discussion and review. Where appropriate this discussion will take place over phone

What can be raised through the exception reporting process?

Primarily the variations will be differences in,

a) Total hours of work (including opportunities for rest breaks)

b) Pattern of hours worked.

c) Educational opportunities and support available to the doctor, and/or

d) Support available to the doctor during service commitments

3. Reporting Process

The Trust has acquired an exception reporting tool from Allocate Software which is designed to follow the contractual process as closely as possible. The tool has been designed to be fully responsive to any screen size, meaning that it works on both desktop and mobile environments that have internet connectivity.

Every doctor should be provided with log in details. If these have not been provided, please contact XXXX XXXXX.

The exception report contains the following fields:

a) Rota name

Enables the selection of the junior doctor's current rota. This is a smart search of all live rotas in the organization.

b) Supervisor

Enables the selection of the doctor's supervisor for the purpose of exception reporting. This is a smart search of all active users in the organization who have been assigned the supervisor role.

c) Exception type

Enables the doctor to define the reason for submitting the exception, derived from the requirement of the 2016 contract. The four exception types are: (1) Difference in the hours of work, (2) Difference in the pattern of hours worked, (3) Difference in educational opportunities or available support, and (4) Difference in the support available during service commitments.

d) Exception episode

Multiple individual exception episodes can be added to a single exception report as long as all episodes are of the same type. Each episode must have a date, but the

occurrence is non-mandatory. Where necessary, the occurrence time should be used to indicate the starting point of the issue.

For each episode, doctors can indicate whether or not this was an immediate safety concern by checking the tick box. Immediate safety concerns progress through the workflow like all other exception reports; however they are red flagged as important issues on supervisor, guardian, Director of Medical Education and administrator dashboards.

e) Variance from Work Schedules

Enables the doctor the opportunity to indicate why the episode is different from their contract rota and responsibilities

f) Steps taken to resolve matters prior to escalation

Enables the doctor the opportunity to indicate any previous actions or discussions that have taken place prior to escalation

It is important that all fields of the report are completed as accurately and comprehensively as possible to assist the recipient in understanding the issue.

4. Recommended time limits

Safe working practices:

If the trainee woks outside of the work schedule, they must raise an exception report within 7 days if payment is being requested or 14 days if it is not requested.

The exception report must be sent to the supervisor and, if it is related to safe working, a copy must be sent to the guardian, who will include it in the quarterly report.

Initial Review:

Within 7 days of receipt, the supervisor will meet with the trainee to review and discuss the reasons for working outside of schedule.

If the exception was due to workplace requirement for additional work, the supervisor and trainee should agree on payment or Time Off In Lieu, as appropriate.

Work Schedule Review:

If there is a pattern of working outside of scheduled hours the supervisor will, within 7 days of the initial review meeting with the trainee, undertake a level 1 review of the work schedule.

If the work schedule is agreed, the exception report will be closed and notification sent to the guardian. If it is not agreed, the trainee has 14 days to request a level 2 review of schedule.

The supervisor must carry out the level 2 review within 21 days of the trainee's request. If the schedule is agreed, the exception report will be closed and notification sent to the guardian; if it is not agreed, the trainee has 14 days to request a level 3 review.

The Level 3 review should be held within 10 days of the trainee requesting a review.

Immediate Safety Concerns:

Where the doctor's concern is that there is an immediate and substantive risk to the safety of patients, or to the safety of the doctor, this should be raised immediately (verbally) by the doctor to the consultant responsible for the service in which the risk has been raised. (Typically, this would be the Head of Service or the on-call consultant.)

The doctor must additionally then submit an Exception Report Form electronically within 24 hours.

The Head of Service or on-call consultant receiving the verbal exception report will respond as follows:

If he/she considers that there are serious concerns, and agrees that there is an immediate risk to patient and/or doctor safety, he/she will:

a) (Where appropriate) grant the doctor immediate time off from their agreed work schedule and/or

b) (Depending on the nature of the reported variation) ensure the immediate provision of appropriate support to the doctor.

c) (In addition to the doctor's Exception Report Form submission) notify the Supervisor and the Guardian of Safe Working within 24 hours.

The Supervisor will undertake an immediate work schedule review (see work schedule review procedure for timescales), and will ensure appropriate (and where necessary, on-going) remedial action is taken.

Frequently raised issues:

Under changed terms for the definition of on call working, junior doctors working 'on call' should expect to get eight hours rest per 24-hour period, of which at least five should be continuous rest between 22:00 and 07:00.

Where this rest requirement is not expected to be met, rostered work on the day following the on-call period must not exceed five hours. If the doctor is not able to get 5 hours continuous rest between 10 pm and 7 am, they should get compensatory rest equal to time lost the following day (must be used within 24 hours).

If the rest is significantly disrupted, the doctor may be unsafe and the doctor would be within their rights to inform the service that they will not be attending the work as rostered other than for handover. A breach will occur if the above are not facilitated.

A shift is any period of working where a doctor is expected to be at their place of work at all times and will count as actual work. There must be 8-hour gap between two consecutive shifts.

Actual work during an on-call period is the time spent at work plus the travel time.

For phone conversations, it is the duration of the phone call.

For on call rotas doctors will be provided with estimated average number of work hours on call in their generic work schedule. Doctors need to complete an exception report if the average of actual hours worked over a rota cycle is above the average on the work schedule.

Useful contacts:

Human Resources / Medical Workforce Team Contact: XXXX Email: XXXX
Associate Medical Director (Medical Education): Contact: XXXX Email: XXXX

Guardian safe working Hours: Contact: XXXX Email: XXXX

Appendix B

Procedural Guidance on the Use of Section 5(2):
Doctors' and Approved Clinicians' Holding Power

This is the Section of the Mental Health Act that you will come across most whilst on call. The Oxford Textbook of Psychiatry defines its role as: "an order for the emergency detention of a patient who is already in hospital but wishes to leave, and for whom the doctor believes an application should be made for compulsory admission under the Act"

The resident Junior Tier doctor has the power to use this Section of the Mental Health Act. It should be used if you consider someone who is already admitted to hospital to be: "suffering from a mental disorder" and believe that it is appropriate for them to be detained in hospital: "in the interests of the patient's own health or safety or for the protection of others". This should, where possible, be discussed with the On Call Consultant beforehand.

To implement a Section 5(2), complete the relevant paperwork on the ward with your full name, the full name of the patient and your reasons for detaining them. The Section 5(2) is not applicable unless this paperwork is given to the Duty Nurse, who then receives it on behalf of the Hospital Managers.

A Section 5(2) can be used on Acute Hospital medical wards but not in A&E and cannot be used to detain a person brought to the hospital for further assessment who then refuses admission (e.g., on the PDU). If faced with either of these situations you should contact the Middle Tier doctor or On Call Consultant for advice and consider whether use of the Mental Capacity Act may be appropriate to prevent a patient from leaving if you consider there to be significant risks. You can use a Section 5(2) immediately after someone has been admitted as an informal patient, but this is considered bad practice.

A Section 5(2) lasts for up to 72 hours, and in this time should be reviewed by either the patient's own Consultant the following day, or the Middle Tier doctor if occurring over a weekend. It requires assessment for consideration of further detention under the Act and gives the authority to detain the person against their will, but not to give them treatment against their will.

"The power can be used where the doctor or approved clinician in charge of the treatment of a hospital in-patient (or their nominated deputy) concludes that an application for detention under the Act should be made. It authorises the detention of the patient in the hospital for a maximum of 72 hours so that the patient can be assessed with a view to such an application being made." (Code of Practice to the Mental Health Act 1983)

Definition of an Informal Inpatient:

"…a hospital in-patient means any person who is receiving in-patient treatment in a hospital, except a patient who is already liable to be detained under Section 2, 3 or 4 of the Act, or who is a supervised community treatment patient. It includes patients who are in hospital by virtue of a deprivation of liberty authorisation under

the Mental Capacity Act 2005.1 It does not matter whether or not the patient was originally admitted for treatment primarily for a mental disorder." (MHA Code of Practice 1983, para. 12.6)

1. Responsibilities of the Doctor or Approved Clinician using Section 5(2)

- For the purpose of these procedures, the term 'doctor' will be used in place or 'doctor or approved clinician' as currently all ACs within the Trust are doctors.

- The power to hold under Section 5(2) should not be used as an independent power of detention under the Act. Section 5(2) must properly be used to
  'trigger' assessment for detention under Section 2 or 3.

- Section 5(2) should only be used if, at the time, it is not practicable or safe to take the steps necessary to make an application for detention without detaining the patient in the interim. Section 5(2) is not an admission section under the Act.

- The patient's doctor or nominated deputy should only use the power immediately after having personally examined the patient.

- The doctor should not complete a Section 5(2) Form H1 and leave it on the ward with instruction to submit it to the Mental Health Act Administrator (MHAA) if the patient is about to leave.

- The doctor invoking the Section 5(2) must ensure that his or her report (Form H1) is immediately delivered to the MHAA.

- It is the personal responsibility of the doctor invoking the Section 5(2) to ensure that his or her report is delivered to the MHAA

- Section 5(2) should not be used as an alternative to making an application for detention under Section 2 or Section 3, even if it is thought that the patient will only need to be detained for 72 hours or less.

- Doctors may leave instructions with ward staff to contact them (or their nominated deputy) if a patient wants or tries to leave the ward but they may not leave instructions for their nominated deputy to use

- Section 5(2), nor may they complete a Section 5(2) report in advance, to be used in their absence.

2. The Nominated Deputy and his/her Responsibilities

- The doctor in charge of an in-patient's treatment may nominate a deputy to exercise Section 5(2) powers during his or her absence from the hospital. That deputy will then act on his or her own responsibility and should be suitably experienced.

- Only one deputy may be authorised at any time for any patient and it is unlawful for a nominated deputy to nominate another

- It is permissible for deputies to be nominated by title rather than by name (e.g. junior doctor on call)

- Doctors should not be nominated as a deputy unless they are competent to perform the role. If nominated deputies are not ACs or Section 12 approved, they should, wherever possible, seek advice from the person for whom they are deputising, or from another AC or section 12 approved doctor.

- Only a doctor or AC on the staff of the same hospital may be a nominated deputy (although the deputy does not have to be a member of the same profession as the person nominating them).

- It is usual that, outside normal working hours, the nominated deputy is the on call junior doctor and during working hours it is the team junior doctor.

3. Patients on Medical Wards

- For the purposes of Section 5(2), informal inpatients include those being treated for physical disorders that need treatment for a mental disorder.

- Where a Section 5(2) is used on a patient who is not, at the time, under the care of a psychiatrist or an approved clinician, the doctor invoking the power should make immediate contact with a psychiatrist or an approved clinician, in order to obtain confirmation of their opinion that the patient needs to be detained.

- Where a patient is receiving treatment for a physical disorder and a mental disorder, for the purposes of Section 5(2) the consultant psychiatrist is the doctor in charge of treatment.

4. Assessment by ST4-5 / Consultant / Associate Specialist

Arrangements must be made, as soon as possible, for an assessment of the patient by a senior member of the medical staff (i.e. ST4-6, associate specialist or consultant) to determine whether detention of the patient under Section 2 or 3 is required.

Detention under Section 5(2) will end immediately if the doctor decides that no assessment under Section 2 or 3 needs to be carried out.

5. Further Detention under Section 2 or 3

- If the patient's Responsible Clinician (RC) or Approved Clinician (AC) decides that detention under Section 2 or 3 may be required then they should a) complete the first medical recommendation and b) contact the Approved Mental Health Professional (AMHP) or Duty AMHP to arrange an assessment (this needs to be done as soon as possible, preferably within the first 24hrs)

- The AMHP will then co-ordinate an assessment, including making contact with the patient's GP, or, if the GP is not available, a Section 12 Approved Doctor.

- Section 5(2) cannot be renewed

6. Information about Patients' Rights

- As soon as possible after being detained under Section 5(2) the patient should be told that he or she is being detained and given their legal rights. They should be given the appropriate Patients' Rights Leaflet.

- Section 5(2) provides no right to appeal to the Tribunal or the Hospital Managers and no right to an IMHA

7. End of Detention under Section 5(2)

Detention under Section 5(2) will end immediately where:

- The doctor decides that no assessment for detention under Section 2 or 3 needs to be carried out; or

- An assessment for admission under section 2 or 3 is made and a decision is taken by an AMHP not to make an application for detention under Section 2 or 3.

- The patient should be told immediately that he or she is no longer being detained under Section 5(2).

- The time at which a patient ceases to be detained under Section 5(2) must be recorded on the Trust Section 5(2) Monitoring Form established for this purpose. This will include a record of the reason why the patient is no longer detained and the outcome e.g. remained in hospital as an informal patient, was discharged or was subsequently detained under another power.

8. Treatment

- The Consent to Treatment provisions of Part 4 of the MHA do not apply to patients subject to Section 5(2). This means that they are in exactly the same position as patient who are not detained under MHA and cannot be given medication or ECT without their consent (Code of Practice, 12.39.)

- However, treatment for mental and physical disorder can be given to a patient provided the patient has the capacity to make their own decision about a proposed treatment and consents to it.

- A patient can also be treated under the Mental Capacity Act 2005 if it can be shown that the patient lacks capacity to consent to treatment and treatment is necessary and in their best interests provided there is no advance decision or lasting power of attorney/Deputy of the Court of Protection saying that treatment cannot be given.

- Therefore, in the absence of consent, capable patients have the right to refuse treatment unless in an emergency for the protection of the patient or other persons, treatment can be justified under common law

9. Transfers

- Patients detained under Section 5(2) are not detained by virtue of an application under the Act and therefore the transfer provisions of Section 19 of the Act do not apply.

- Section 5(2) does not provide lawful authority to transfer a patient detained under its provisions.

Transfers to Psychiatric Units of Other Hospitals:

- If the patient is an out-of-area resident he or she should be assessed fully and speedily for possible admission under Section 2 or 3.

- If an out-of-area patient is subsequently detained under Section 2 or 3, he or she can then be transferred under Section 19 of the Act.

Transfers to Medical Wards of Other Hospitals:

- Transfers for urgent medical treatment can be affected with the patient's valid consent.

- In the absence of consent, the patient can be transferred for treatment which is immediately necessary, subject to the provisions of the Mental Capacity Act 2005 & Code of Practice. Transfer for treatment in an emergency must not result in a deprivation of liberty, unless an urgent authorisation has been sought under the Deprivation of Liberty Safeguards.

Transfers to Other Sites of the Same Hospital:

- Where circumstances indicate that an immediate transfer is necessary for the proper care and safety of a patient detained under Section 5(2), the patient should be fully assessed without delay to determine whether detention under Section 2 or 3 is appropriate.

- If the patient is subsequently detained under Section 2 or 3 s/he may be transferred to other sites of the same hospital.

10. Use of Restraint

- It may sometimes be necessary for nursing staff to use restraint to prevent a patient from leaving the ward either immediately before a Section 5(2) has been completed or after a Section 5(2) has been accepted.

- On each occasion that restraint is used, the nurse in charge must ensure that the restraint was carried out in accordance with the Trust's Policy on the Use of Restraint.

Appendix C

Medical Protocol for Falls Management in Older-Adult Inpatient Units including Suspected or Unobserved Falls

It is recognised that elderly or frail patients with dementia may be unable to articulate or localise pain or injury sites after a fall / suspected fall, but that fractures might occur even after relatively minor injury.

It is essential that doctors called to examine such patients after an incident which may have involved a fall, consider the possibility of a fracture in such patients and evidence their consideration of this, and their proposed management, in the clinical documentation on RiO.

The following criteria must be followed by the doctor called to examine a patient with dementia or cognitive impairment after a fall on an Older-Adult Inpatient Unit.

Rationale for this Protocol:

To ensure that patients who suffer from dementia or cognitive impairment, and who suffer a fall or suspected fall or injury on an Older Adult Inpatient Unit, are clearly assessed for fractures, in particular fractures of the neck of femur, and that this is clearly documented in RiO notes and that the patient's inpatient Consultant Old-Age Psychiatrist is also alerted to the incident.

Criteria:

1. The Junior Tier doctor will attend the ward as soon as possible after being requested to do so, in the case of a patient with dementia or cognitive impairment having fallen or thought to have fallen on an inpatient unit. If there is to be any undue delay, this must be communicated to the nurse in charge of the inpatient unit and consideration given to calling an emergency ambulance instead.

2. The Junior Tier doctor will examine the patient physically, having ascertained the circumstances of the fall or apparent fall, including the examination of upper and lower limbs, in a suitable, private environment.

3. The physical examination must be clearly documented on RiO, including the examination of the upper and lower limbs, with note being made of the examination of the hips and legs in particular, noting the presence or absence of shortening of the leg and/or external rotation in keeping with suspected hip fracture.

4. The Junior Tier doctor will then provide a treatment / management plan, including the consideration of X-Ray referral in the case of a fall. If X-Ray is not considered necessary, the reasons for this should be clearly documented.

5. If the Junior Tier doctor is unsure of how to proceed, or in any doubt about their findings, a more senior colleague should be consulted immediately for further advice.

6. Following the assessment of the patient, the attending doctor must establish who the patient's Inpatient Consultant is, or request the nurse in charge to do so, and alert them by email to the incident. This must also be documented on RiO.

Appendix D

Procedure for use of Emergency Treatment under Section 62

Use of Section 62 allows treatment to be given, when the procedure laid down under Sections 57 & 58 (Consent to Treatment) cannot be complied with due to an emergency e.g. an urgent need to administer ECT/medication to a non-consenting patient whose condition would seriously deteriorate before a Second Opinion Approved Doctor (SOAD) was available to complete a form T3/T5

For Section 62 to be used, the following criteria must be met and a review date must be clearly recorded on the form:

1. This section is not to be used for informal/voluntary patients.
2. Section 62 should be completed by the RC.
3. However, if the RC is not available a junior doctor can complete the certificate as long as there is evidence of consultation with the RC clearly documented.
4. On completion of the form ensure the original form is sent to the Mental Health Act who will scan onto RiO and attach a copy of the form to the patient's treatment card.

Appendix E

Management of exposure to a wide range of pharmaceuticals, chemicals (agricultural, household and industrial), plants and animals.

TOXBASE is the primary clinical toxicology database of the National Poisons Information Service (NPIS). It is the backbone of the service and the first-line resource for UK healthcare professionals. The National Poisons Information Service (NPIS) in the UK is a Department of Health approved, and Public Health England commissioned, national service that provides expert advice on all aspects of acute and chronic poisoning.

The TOXBASE database provides information about routine diagnosis, treatment and management of patients suffering from exposure to a wide range of pharmaceuticals, chemicals (agricultural, household and industrial), plants and animals. Hospitals, General Practitioners and other health care workers in the UK can have direct access to TOXBASE, the clinical toxicology database which is specifically designed for healthcare professionals. TOXBASE is coordinated by the NPIS (Edinburgh Unit), with input from all four other NPIS Units. Doctors should consult TOXBASE before telephoning for more expert and specific advice.

All inpatient wards are registered with TOXBASE and registration is free for medical staff, by following the link https://www.toxbase.org/Application_for_TOXBASE_registration/

In addition to this, Pharmacy has access should there be queries where medical or nursing staff do not have access.

Appendix F

A Guide to the Out of Hours CAMHS Admission Policy for 16-17 Year Olds via NHS England.

Out of Hours referrals should be directed to Huntercombe Hospital Stafford (Hartley unit) and ask to speak with the Senior Nurse on site. Referrers will be expected to complete Form 1 and Form 2 is then completed by the Access Assessor (team managing the Gateway Assessment).

These forms are lengthy and require comprehensive information about the young person, their current mental state, psychiatric history, forensic history, drug and alcohol history and social circumstance as well as any Local Authority involvement or care arrangement.

It is worth having a copy of the Form 1 to hand before patient's and / or carers leave as they may be necessary to you in completing some of this information. Where Form 1 is being completed when a young person presents to A&E or Acute Hospital Ward, URGENT CARE Teams will be able to assist with completion.

It is then the responsibility of Huntercombe Hospital Stafford to liaise with and confirm the availability of a bed and its location with the referrer. It is also the responsibility of Huntercombe Hospital to ensure that all completed paperwork (whether admission has been facilitated or not) is sent to NHS England Case Worker as soon as normal working hours resume.

It is important to highlight that during the process of seeking a General Adolescent Unit Inpatient bed the clinical responsibility of the patient remains with the referring organisation, for patients aged 16-17 and resident in Birmingham this would be FTB, for Solihull residents, BSMHFT.

Any transport costs incurred are not funded by NHS England or the admitting provider.

If the child or young person is liable to be detained under the Mental Health Act, it is important that the section papers are both faxed, or scanned and emailed across to the receiving provider, are legible and fully completed and that the original documents travel with the patient.

All doctors are reminded to always consider their safety while working out of hours in line with our policies. Trainees have been encouraged to discuss safety issues with the on call consultant if they have any concerns following appropriate risk assessment. Following advice from the Trust Security Officer, personal alarms are available to all doctors at PGME.

All doctors who feel too tired or unsafe to drive in line with DVLA regulation must consider utilizing the Trust Taxi policy.

Appendix G

Trust Taxi Policy

Process to follow:

1 Check the eligibility criteria for your booking.

2 Telephone 0121 301 2244 or call internally on 2244

3 You will be presented with 4 options:

- Option 1 - Non-emergency patient transport (NEPT)
- Option 2 - Taxi (ensure booking criteria has been followed)
  Working hours 07:00 – 18:00 discussion will be with SSL
  Out of hours 18:00 – 07:00 calls will be directed to the provider
- Option 3 - Secure patient transport
  Please ensure you adhere to the secure patient process and staffing algorithm for this service
- Option 4 - Any other transport, not covered above

4. When making a taxi booking you will asked to provide the following information:

a) What the journey is in relation to – Staff, Patient or Courier:

STAFF – Staff should only book taxis in exceptional circumstances and with written authorization from their budget holder. Please note staff are required to make their own way into and out of work, to attend meetings and training, the use of taxi's for these activities are not an option.

PATIENT- For trips for service user alone or service user and staff travelling together

COURIER - used for trips transporting objects rather than passengers (bloods, medication etc), this should be in emergency circumstances only.

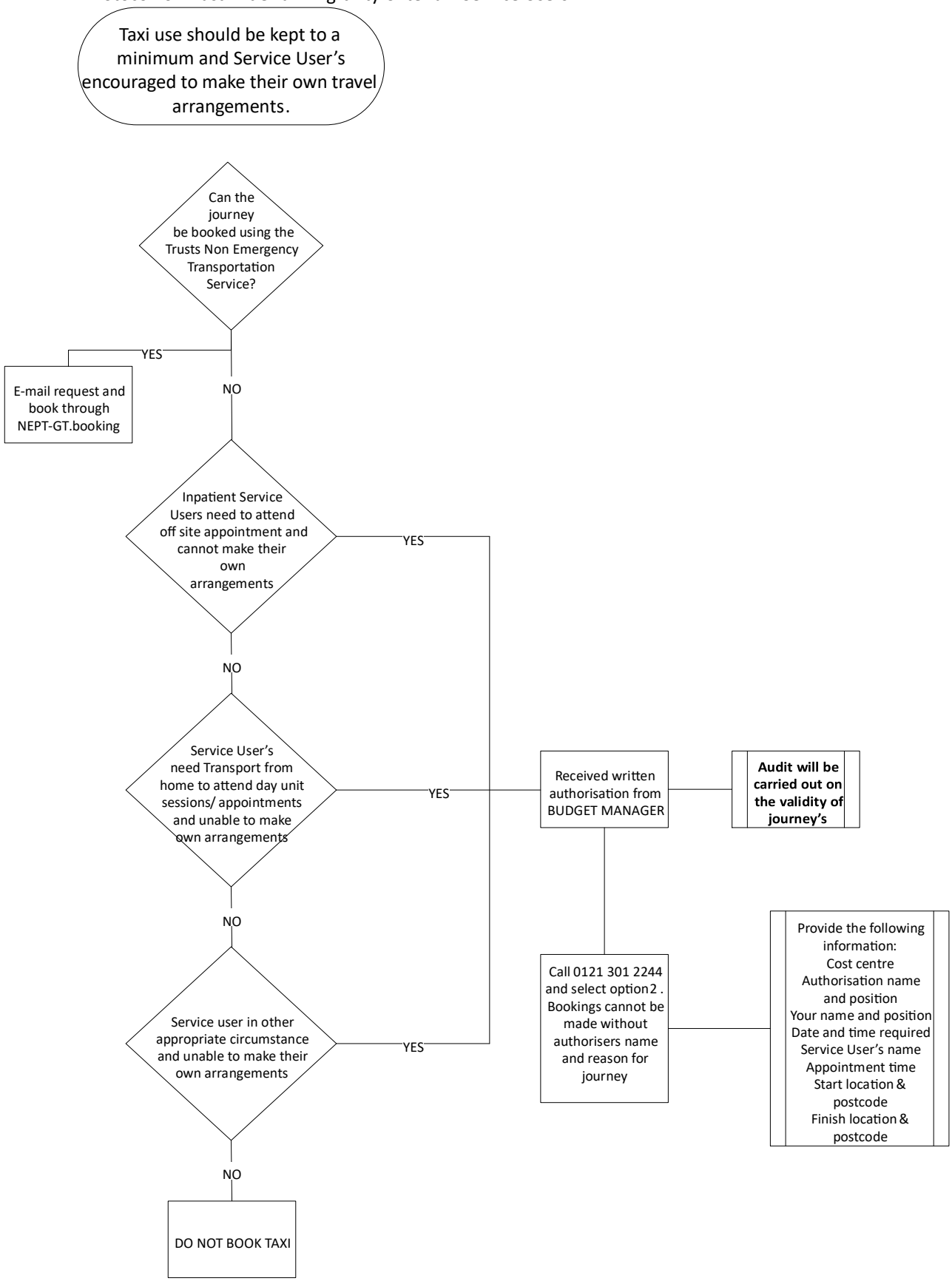
b) **What is the Cost Centre Code for this journey (all Cost Centre Codes start with two letters followed by four numbers)**

c) **Full name and contact number of the person booking the taxi**

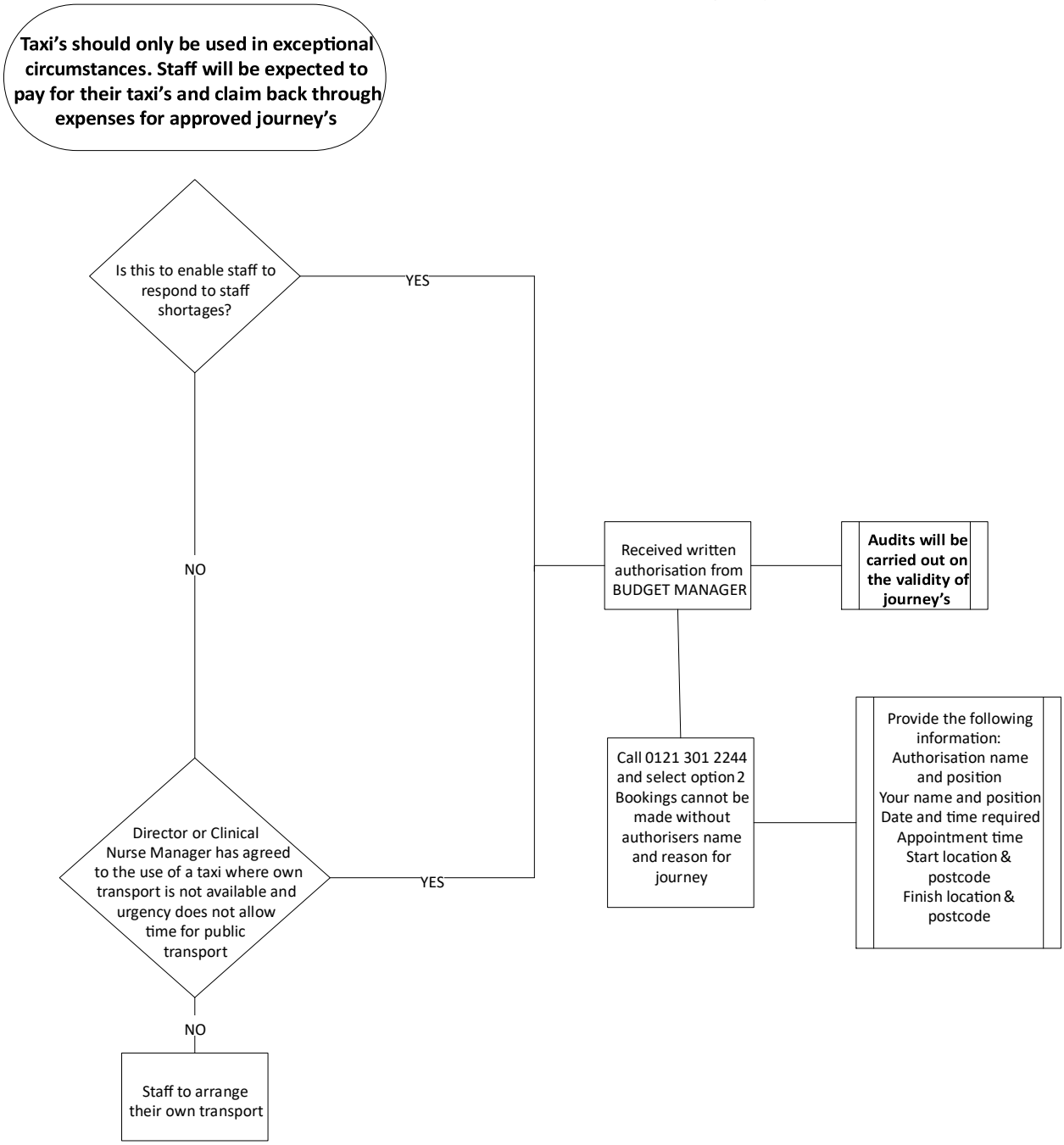
d) **Full Name and contact number of authorising manager**

Should any of the above information be missing, unfortunately we will not be able to process your booking and you will be asked to call back when in receipt of all information required

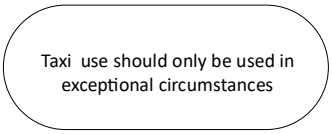
Protocol for Trust-wide Taxi Eligibility Criteria – Service Users

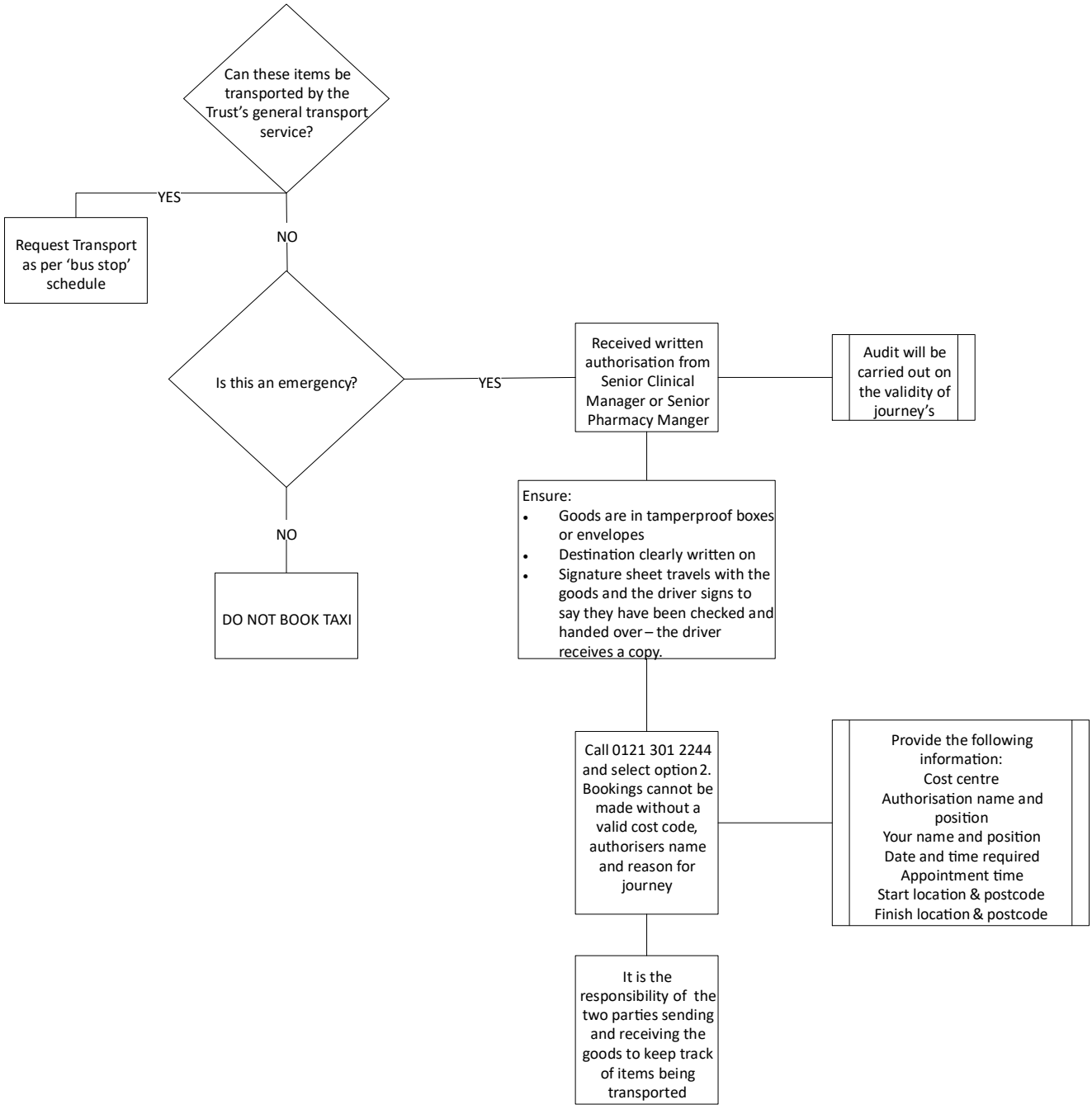


Protocol for Trust-wide Taxi Eligibility Criteria – Staff



Protocol for Trust-wide Taxi Eligibility Criteria – Pharmacy Items, Specimens & Clinical Notes




Can these items be transported by the Trust's general transport service?
YES
Request Transport as per 'bus stop' schedule
NO
Is this an emergency?
YES
Received written authorisation from Senior Clinical Manager or Senior Pharmacy Manger
Audit will be carried out on the validity of journey's
NO
DO NOT BOOK TAXI
Ensure:
Goods are in tamperproof boxes or envelopes
Destination clearly written on
Signature sheet travels with the goods and the driver signs to say they have been checked and handed over – the driver receives a copy.
Call 0121 301 2244 and select option 2. Bookings cannot be made without a valid cost code, authorisers name and reason for journey
Provide the following information:
Cost centre
Authorisation name and position
Your name and position
Date and time required
Appointment time
Start location & postcode
Finish location & postcode
It is the responsibility of the two parties sending and receiving the goods to keep track of items being transported

Appendix H

On Call Facilities Information

					Reception No	Computer Access	Fridge	Kettle	Microwave	Toaster	Bed	Sofa	Phone Signal		
Rota 1 Northcroft, Good Hope	Shift	Rota 1 Main on call site	Ardenleigh	Flat - key from reception.	0121 301 4411	Yes	Yes	Yes	Yes	No	No	Chairs space for recliner	Yes		
Rota 2. City, Mary Seacole, Ashcroft, Larimar, Rookery Gardens	Shift	Rota 2 Main on call site	Ardenleigh	Flat - key from reception.	0121 301 4411	Yes	Yes	Yes	Yes	No	No	Chairs space for recliner	Yes		
Rota 3 QE Hospital, Juniper, Grove Avenue	Shift	Rota 3 Main on call site	Moseley	Doctors Mess	0121 301 5885			Yes							09.00-15.00
Rota 4 Heartlands , Newbridge, Tamarind, Ardenleigh	Shift	Rota 4 Main on call site	NBH	external building access via buzzer/ward nursing staff only	0121 301 6598	Yes			Unknown	Unknown	No	Yes	Yes		NBH N/A
Rota 5 Oleaster(PDU/POS (only physical health Required) Barberry, Reaside	Shift	Rota 5 main on call Site	Oleaster	Key, lockable internally/externally	0121 301 2200	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not from office		08.0014.00 M-F only

Rota 6 Solihull/Zinnia	Shift	Rota 6 Main on call site	Zinnia	External access via swipe. Room often used by on call service manager, needs to be prebooked.	0121 301 5300	Yes		Yes						Needs to be pre-booked	09.0015.00 Juniper

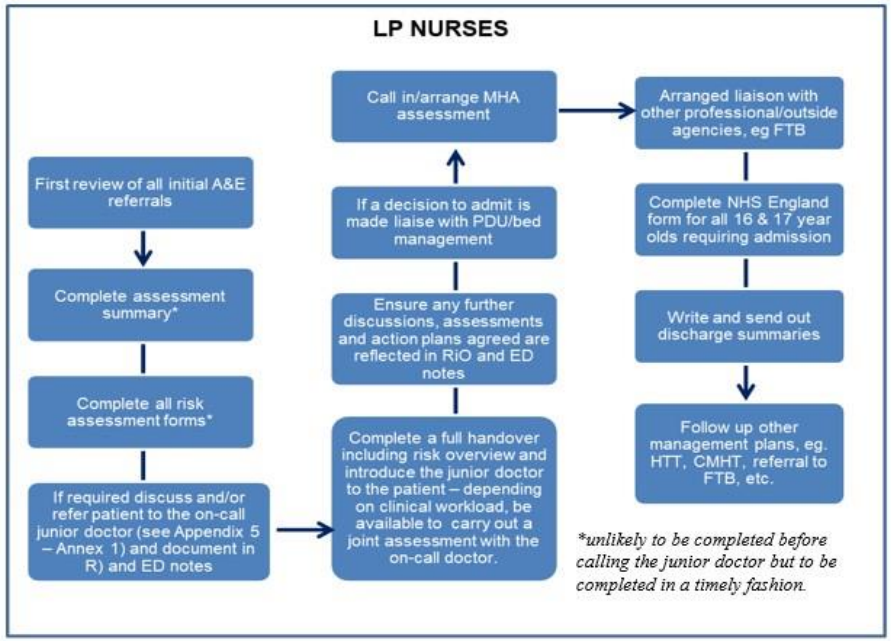
ALTERNATIVE ON CALL FACILITIES

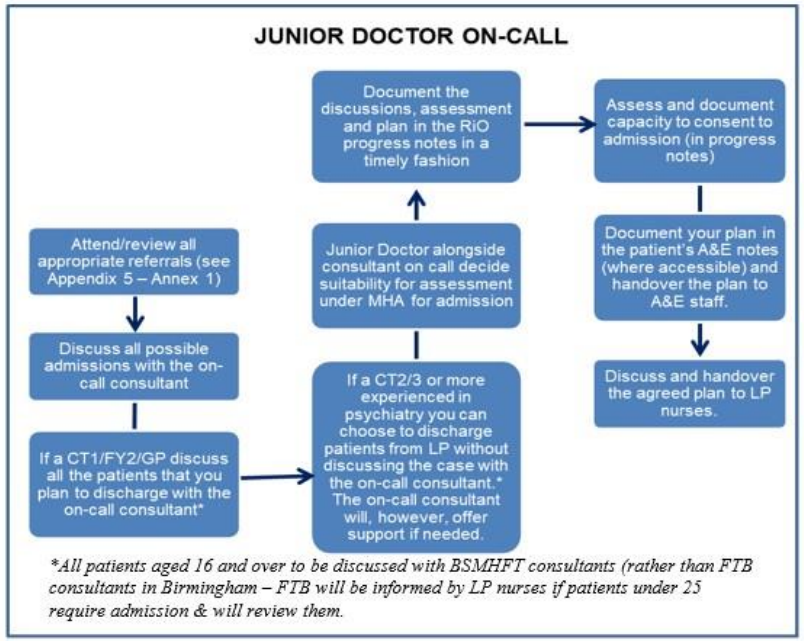
				Reception No	Computer Access	Fridge	Kettle	Microwave	Toaster	Bed	Sofa	Phone Signal		
Rota 1 Northcroft, Good Hope	Shift	Ardenleigh	Flat - key from reception	0121 301 4411	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Currently being refurbished, unclear when this will re-open	12.00 - 13.30pm
Rota 2 City, Mary Seacole, Ashcroft, Larimar, Rookery Gardens	Shift													
Rota 3 QE Hospital, Juniper, Grove Avenue	Shift	QEH	URGENT CARE Office is only option - Suggest use Oleaster Room	0121 371 2619										
Rota 3 QE Hospital, Juniper, Grove Avenue	Shift	Grove Ave	Staff Room available to Juniors	0121 678 4004			Yes							N/A
Rota 3 QE Hospital, Juniper, Grove Avenue	Shift	Juniper	Offices per ward, accessed via nursing staff. Not lockable.	0121 301 5700	Yes	No	No	No	No	No	No	Not from office		09.0015.00 Juniper

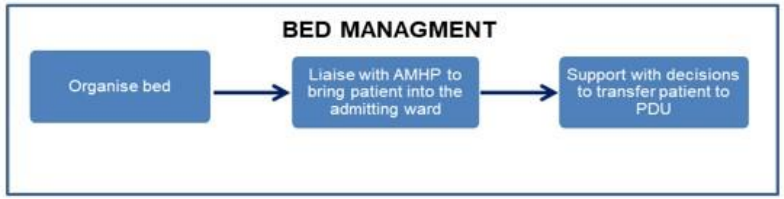
Rota 4 Heartlands , Newbridge, Tamarind, Ardenleigh	Shift	Tamarind	Doctors Mess	0121 301 0500	Yes	Yes	Yes	Yes	Yes	Yes		yes		13.00-14.00 daily
Rota 5 Oleaster(PDU/POS (only physical health Required) Barberry, Reaside	Shift	Reaside	Doctors Mess	0121 301 3000	Yes	Yes	Yes	Yes	Yes			yes		Hot Available
Rota 6 Solihull/Zinnia	Shift	Solihull	Staff Room for All	0121 424 5244			Yes							Available in Hospital

Appendix I

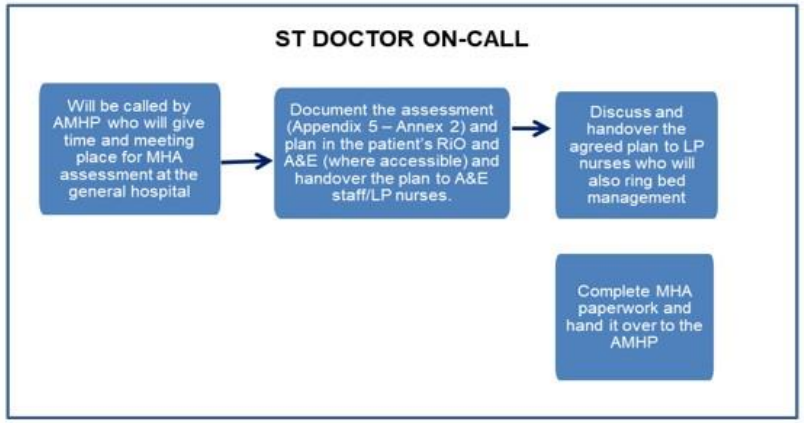
JUNIOR DOCTOR DECISION TREE : GENERAL HOSPITAL ASSESSMENT (Referred to as Appendix 1 in this document)

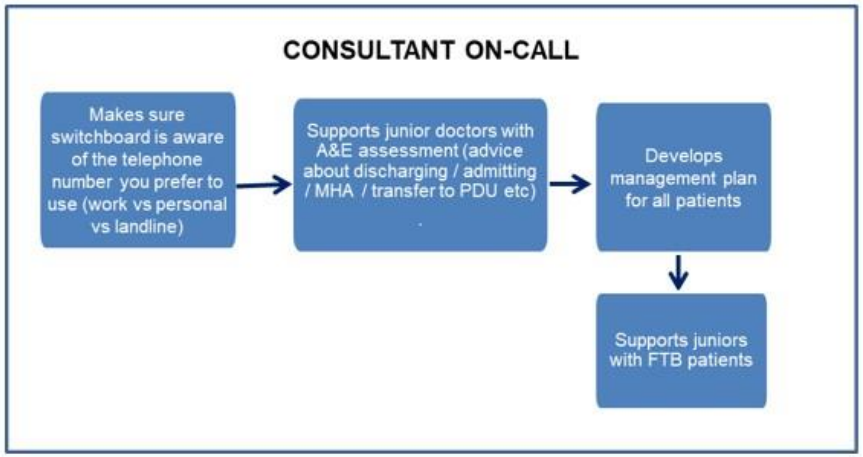

LP NURSES
First review of all initial A&E referrals
Complete assessment summary*
Complete all risk assessment forms*
If required discuss and/or refer patient to the on-call junior doctor (see Appendix 5 – Annex 1) and document in R) and ED notes
Complete a full handover including risk overview and introduce the junior doctor to the patient – depending on clinical workload, be available to carry out a joint assessment with the on-call doctor.
Ensure any further discussions, assessments and action plans agreed are reflected in RiO and ED notes
If a decision to admit is made liaise with PDU/bed management
Call in/arrange MHA assessment
Arranged liaison with other professional/outside agencies, eg FTB
Complete NHS England form for all 16 & 17 year olds requiring admission
Write and send out discharge summaries
Follow up other management plans, eg. HTT, CMHT, referral to FTB, etc.
*unlikely to be completed before calling the junior doctor but to be completed in a timely fashion.

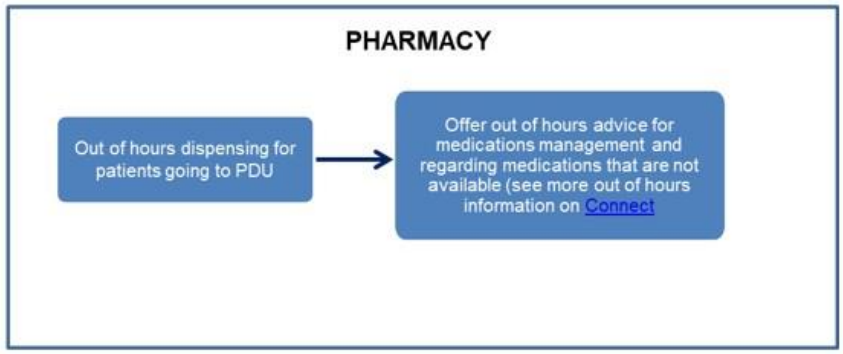

JUNIOR DOCTOR ON-CALL
Attend/review all appropriate referrals (see Appendix 5 – Annex 1)
Discuss all possible admissions with the on-call consultant
If a CT1/FY2/GP discuss all the patients that you plan to discharge with the on-call consultant*
If a CT2/3 or more experienced in psychiatry you can choose to discharge patients from LP without discussing the case with the on-call consultant.* The on-call consultant will, however, offer support if needed.
Junior Doctor alongside consultant on call decide suitability for assessment under MHA for admission
Document the discussions, assessment and plan in the RiO progress notes in a timely fashion
Assess and document capacity to consent to admission (in progress notes)
Document your plan in the patient's A&E notes (where accessible) and handover the plan to A&E staff.
Discuss and handover the agreed plan to LP nurses.
*All patients aged 16 and over to be discussed with BSMHFT consultants (rather than FTB consultants in Birmingham – FTB will be informed by LP nurses if patients under 25 require admission & will review them.


BED MANAGMENT
Organise bed
Liaise with AMHP to bring patient into the admitting ward
Support with decisions to transfer patient to PDU

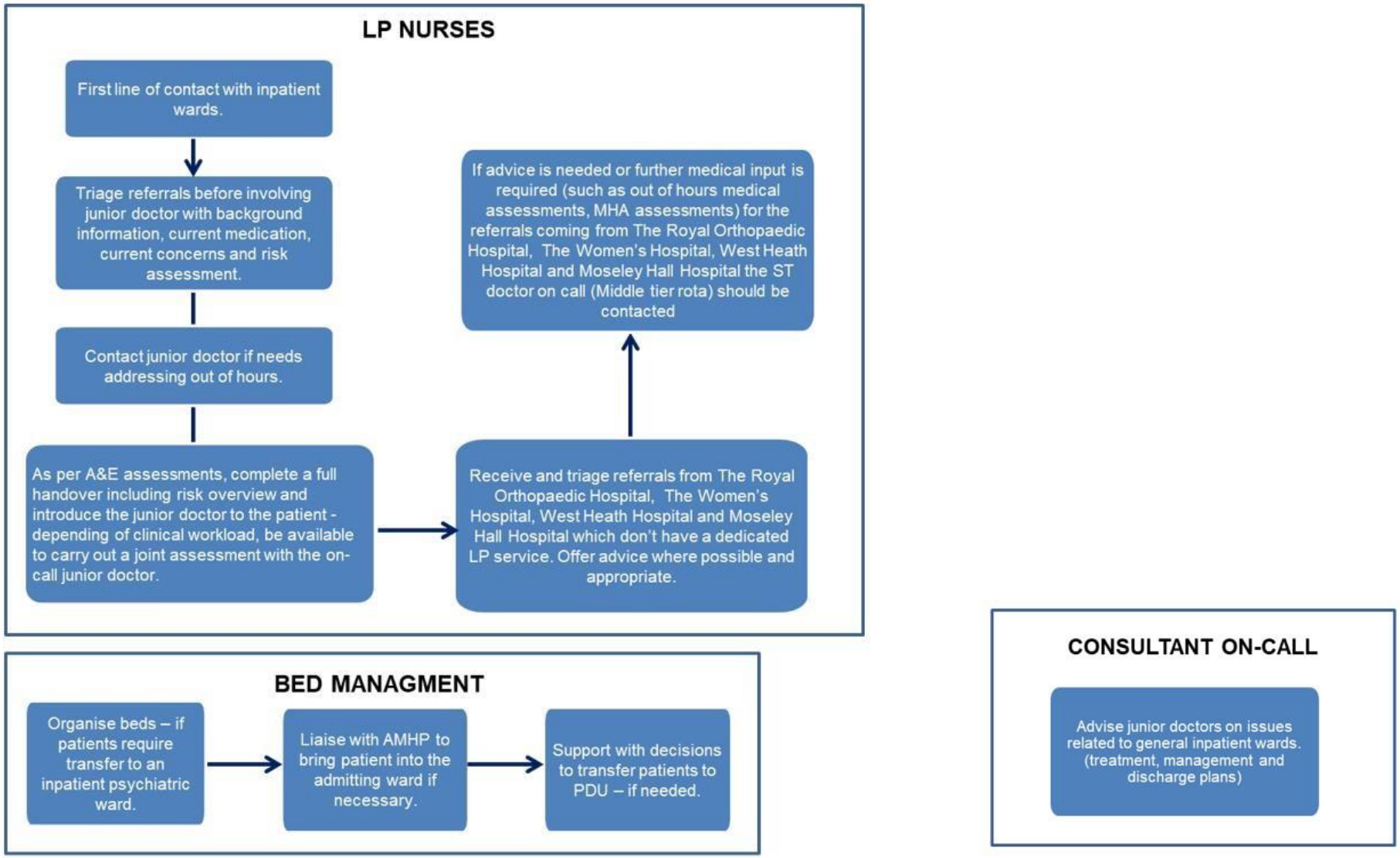

AMHP
Contact the ST doctor to organise MHA assessment
Liaise with bed management to bring patient into the admitting ward
Handover any pending action plan to the LP team


ST DOCTOR ON-CALL
Will be called by AMHP who will give time and meeting place for MHA assessment at the general hospital
Document the assessment (Appendix 5 – Annex 2) and plan in the patient's RiO and A&E (where accessible) and handover the plan to A&E staff/LP nurses.
Discuss and handover the agreed plan to LP nurses who will also ring bed management
Complete MHA paperwork and hand it over to the AMHP

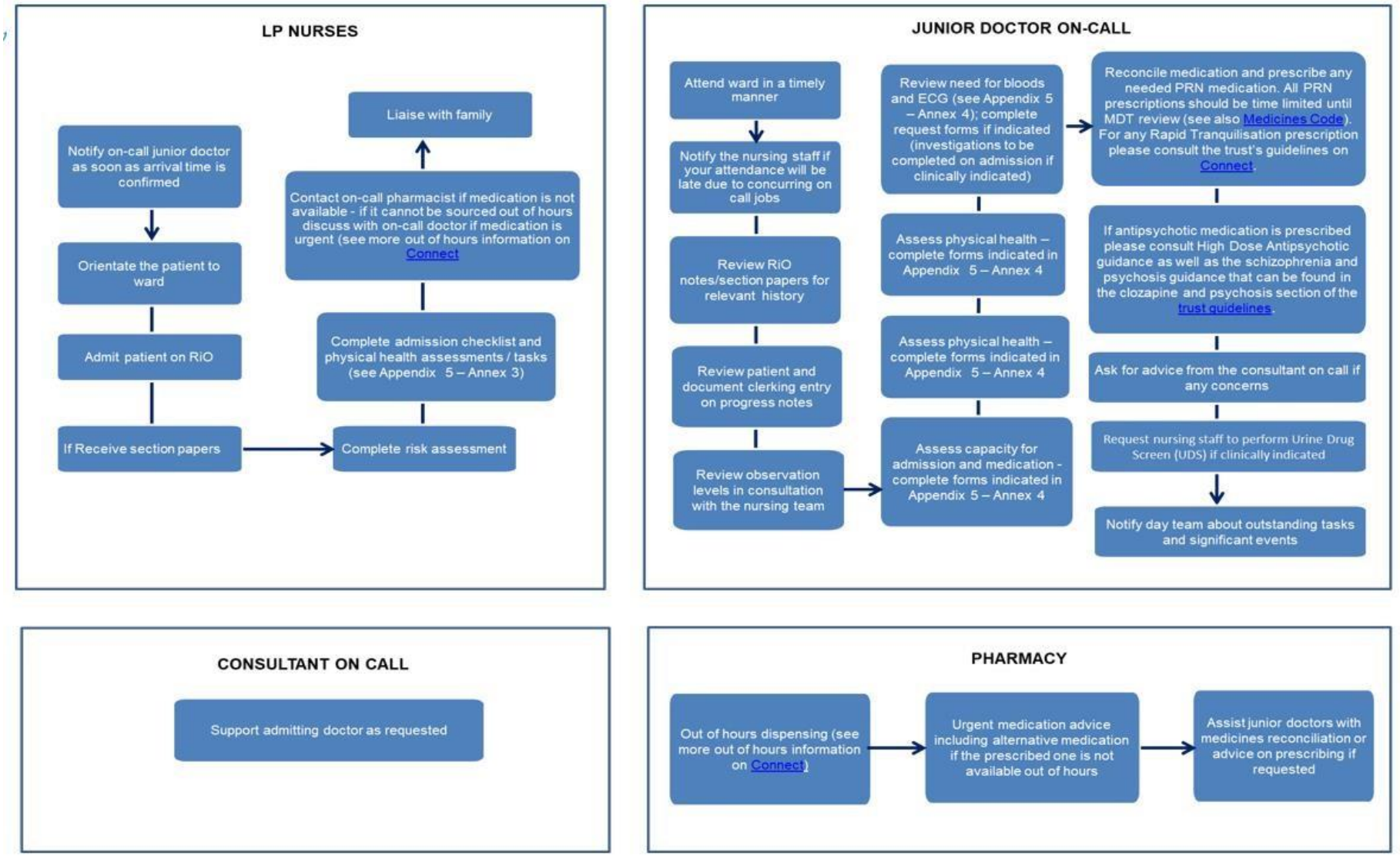




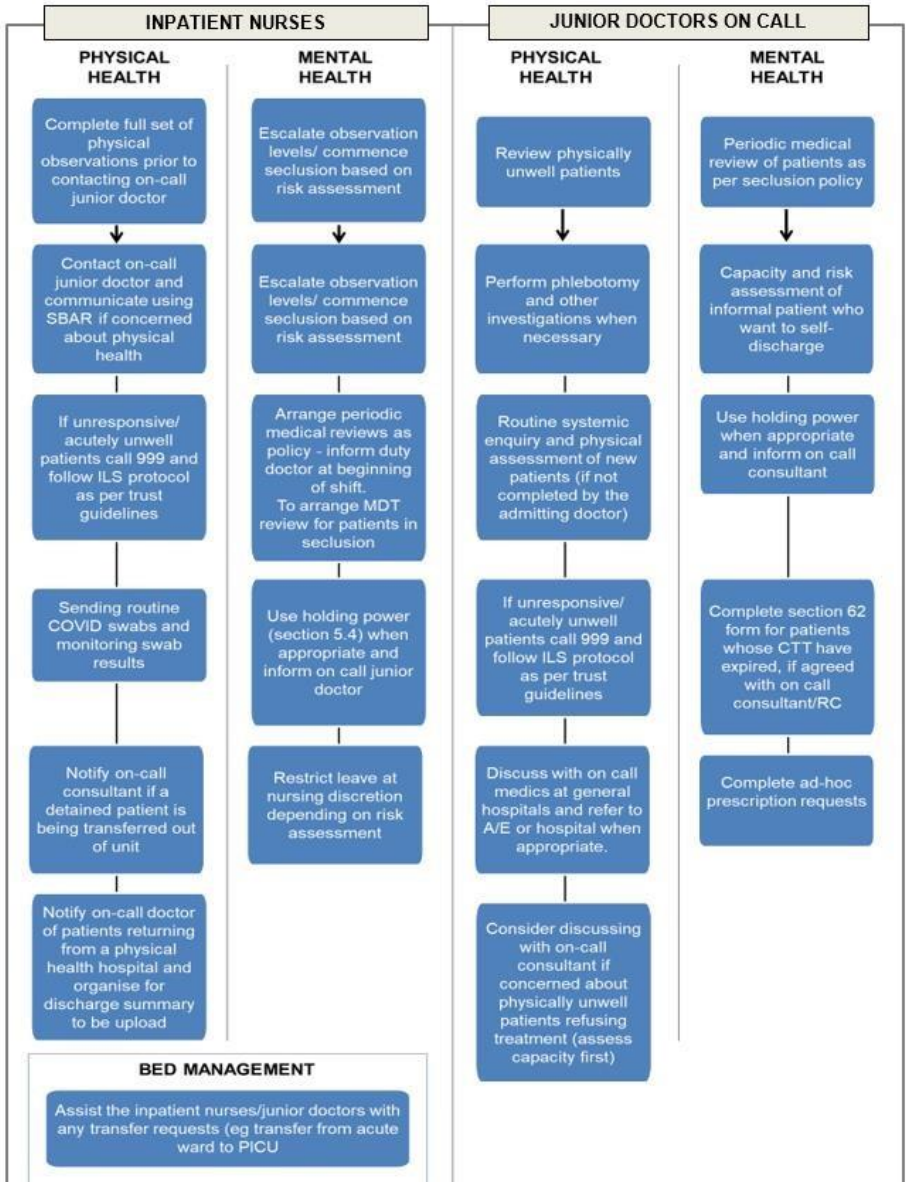
GENERAL HOSPITAL CURRENT INPATIENT ASSESSMENT (Referred to as Appendix 2 in this document)



MH HOSPITAL – NEW ADMISSION (Referred to as Appendix 3 in this document)



MH HOSPITAL – CURRENT INPATEINT REVIEW REQUEST (Physical or mental health) (Referred to as Appendix 4 in this document)


INPATIENT NURSES
JUNIOR DOCTORS ON CALL
PHYSICAL HEALTH
MENTAL HEALTH
PHYSICAL HEALTH
MENTAL HEALTH
Complete full set of physical observations prior to contacting on-call junior doctor
Contact on-call junior doctor and communicate using SBAR if concerned about physical health
If unresponsive/ acutely unwell patients call 999 and follow ILS protocol as per trust guidelines
Sending routine COVID swabs and monitoring swab results
Notify on-call consultant if a detained patient is being transferred out of unit
Notify on-call doctor of patients returning from a physical health hospital and organise for discharge summary to be upload
Escalate observation levels/ commence seclusion based on risk assessment
Escalate observation levels/ commence seclusion based on risk assessment
Arrange periodic medical reviews as policy - inform duty doctor at beginning of shift.
To arrange MDT review for patients in seclusion
Use holding power (section 5.4) when appropriate and inform on call junior doctor
Restrict leave at nursing discretion depending on risk assessment
Review physically unwell patients
Perform phlebotomy and other investigations when necessary
Routine systemic enquiry and physical assessment of new patients (if not completed by the admitting doctor)
If unresponsive/ acutely unwell patients call 999 and follow ILS protocol as per trust guidelines
Discuss with on call medics at general hospitals and refer to A/E or hospital when appropriate.
Consider discussing with on-call consultant if concerned about physically unwell patients refusing treatment (assess capacity first)
Periodic medical review of patients as per seclusion policy
Capacity and risk assessment of informal patient who want to self-discharge
Use holding power when appropriate and inform on call consultant
Complete section 62 form for patients whose CTT have expired, if agreed with on call consultant/RC
Complete ad-hoc prescription requests
BED MANAGEMENT
Assist the inpatient nurses/junior doctors with any transfer requests (eg transfer from acute ward to PICU

ANNEX 1: Criteria for appropriate referrals

Age above 16

Not under the influence of alcohol or illicit drugs

Fit to be assessed. *(Mostly this means medically fit for discharge but in some cases, this may not be the case. As long as they are medically fit to be assessed properly, an assessment can take place, but this is preferably done when the patient is medically fit to be discharged.)*

Initial nurse led assessment identifies additional input for next step. Could be discharge planning or PDU referral or admission to Psychiatry.

ANNEX 2: Plan Documentation for Patients to be admitted

It is the responsibility of the doctor requesting/ recommending admission to outline:

1. Admission: formal/ informal including aim of admission and the type of ward.
2. Level of observations suggested on the ward, including need of seclusion
3. Description of specific immediate risk identified.
4. Immediate medication suggestion, including PRN. All PRN prescriptions should be time limited until MDT review (see also Medicines Code). For any Rapid Tranquilisation prescription please consult the trust's guidelines on Connect.
5. Instruction/suggestion of ongoing treatment plan. High Dose Antipsychotic guidance as well as the schizophrenia and psychosis guidance that can be found in the clozapine and psychosis section of the trust guidelines.
6. Instruction for investigations if appropriate as per Physical Health Policy
7. Contingency plan such as consideration of MHA, specialing, rapid tranquilisation, senior discussion.

ANNEX 3: Assessments and forms to be completed by nursing staff

On admission, the following assessments are required to be done by **the nursing staff** in the ward environment in a timely manner (as per the Physical Health Assessment Policy C38):

- Basic physical observation, NEWS and a digital ward prescription entry-
- MRSA swab (admission from acute hospitals) and COVID swabs (all patients)
- Allergies reviewed
- Pressure ulcer tool - Purpose T (and body map) - digital ward prescription entry
- aSSKINg assessment and digital ward record (if necessary)
- Falls prevention risk assessment
- Malnutrition tool – MUST
- Weight/BMI
- Digital ward entry for food and hydration (if necessary)
- Pregnancy status- if applicable
- Dysphagia screening tool

ANNEX 4: Assessments and forms to be completed by junior doctors

- Mental Capacity form 1
- Mental Capacity form 2
- Systemic Enquiry and Physical Examination form on RiO electronic records system (including a full physical examination)
- Physical Health Assessment form on RiO electronic records system
- Blood request form (if clinically indicated) *
- ECG request form (if clinically indicated) *
- Urine drug screen request form (if clinically indicated)

* As per the Physical Health Assessment Policy C38, review latest pathology results (order or complete investigations if clinically indicated) and review latest ECG trace (order/complete if needed, ideally within 24 hours of admission and prior to any haloperidol being given as Rapid Tranquilisation). Investigations carried out within the last three months may be adequate for routine physical health checks, but additional tests should be arranged if clinically indicated (such as new/change to medication, change in physical health etc). Any review of results must be recorded in the progress notes, or on the physical health forms.

Appendix J

Admission Notes

Dear Doctor,

Following discussion in the MAC around admissions to psychiatric wards, the time of admission was recognised as an extremely vulnerable time for patients & staff and, that a robust plan to support the admission is essential. It was agreed that at the point of advising/recommending admission of a patient to a Psychiatric inpatient unit, having an action plan outlined by the attending doctor was vital for patient care. A clear plan helps the ward nurses and doctors to look after the patient until a senior review. This will improve safety and the experience of admission for patients and staff. Unfortunately, such a plan had not always been drawn up. Therefore, clear guidance was drawn up in May 2021 for the attending doctor to outline an immediate action plan that can be put into action when the patient reaches the ward. This has now been updated keeping in mind the principles of least restriction of patients, the potential delay between assessment & admission, and the need to ensure that opportunities for training, & autonomy of the accepting units are preserved. The plan is to be noted on RiO at the time of request for a bed. This provisional plan can be reviewed by the accepting doctor and team – it gives a sound starting point for on-going assessment and treatment. The bed manager may remind the doctors to make this documentation, but it is ultimately the responsibility of the doctor recommending admission to ensure it is in place. Thank you for your understanding and cooperation. NOTE: It is the responsibility of the doctor requesting/ recommending admission to outline:

1. Reasons for admission: Mode: formal/informal
   Ward: Acute/ PICU

2. Any identified specific immediate risks to help with drawing the management plan.

3. Recommended level of observations on the ward, where appropriate.
   (in all other cases, this will be decided locally jointly by the clerking doctor and the nursing team, taking advice from the consultant on-call where necessary)

4. Treatment plan including suggested PRN, to cover up to 72 hours. The clerking doctor may discuss with on-call consultant and tailor this.

5. Instruction for any specific investigations, where appropriate

If you have any query or feedback, please do not hesitate to contact Contact: XXXX Email: XXXX Contact: XXXX Email: XXXX Agreed with:

XXXX XXXXX (Clinical Director, Urgent Care)
XXXX XXXXX Clinical Director, Acute Care)
XXXX XXXXX (Deputy Medical Director)
XXXX XXXXX (Deputy Medical Director for Quality and Safety

Appendix K

Quick Guide to Out of Hours Medics Cover

Solihull and East Consultant	North Consultant	South Consultant	Forensic Consultant
Larimar, Rookery Gardens, Zinnia, Newbridge House, Heartlands Hospital, David Bromley, Dan Mooney, Hertford House Solihull Hospital Hospital AWA seclusion reviews at Eden, Larimar and Tamarind	Mary Seacole, Ashcroft, City Hospital, Northcroft Site (Eden, George, Endeavour House), Endeavour Court, Forward House, Reservoir Court, Good Hope Hospital Hope Hospital AWA Seclusion Reviews at Meadowcroft	Oleaster, Barberry, Juniper Centre, Moseley Hall Hospital, Grove Avenue, Psychiatric Decisions Unit, University Hospital Birmingham AWA Seclusion Reviews for Caffra and Reaside (Linked with Rota 5 Juniors).	Tamarind, Ardenleigh, Reaside, Hillis Lodge

Solihull and East SPR/SAS	North SPR/SAS	South SPR/SAS	Forensic SPR/SAS

South Solihull, North Solihull, Bromford Lane, Stechford, and Steelhouse Lane Police stations **Please Note:** Please provide advice to Junior Tier Doctors on Rotas 4 and 6.	Thornhill Road, Queens Road, Ladywood, New Street Railway, Sutton Coldfield, Kingstanding, and Erdington Police stations **Please Note:** Please provide advice to Junior Tier Doctors on Rotas 1 and 2	Bournville, Kings Heath, South Solihull, North Rose Road, and Belgrave Road Police station **Please Note:** Please provide advice to Junior Tier Doctors on Rotas 3 and 5.	Ardenleigh, Tamarind, Reaside, and Hillis Lodge **Please Note:** Please provide advice to Junior Tier Doctors covering Ardenleigh, Reaside, Tamarind and Hillis Lodge
Carry out MHA assessments in East and Solihull Hub units, except Ardenleigh and Tamarind	Carry out MHA assessments in North Hub units except Ardenleigh	Carry out MHA assessments in South Hub units except for Hillis Lodge and Reaside	Support seclusion reviews and undertake out of hours forensic assessments

Junior Trainees Rota 1 Northcroft, Good Hope *North Consultant*	**Junior Trainee Rota 2** City Hospital, Mary Seacole, Ashcroft *North Consultant* Rookery Gardens, Larimar *Solihull and East Consultant*	**Junior Trainee Road 3** Queen Elizabeth Hospital (UHB), Juniper Centre, Grove Avenue *South Consultant*

Junior Trainee Rota 4 Heartlands Hospital, Newbridge House *Solihull and East Consultant* Tamarind, Ardenleigh Hillis Lodge *Forensic Consultant*	**Junior Trainee Rota 5** Oleaster, Barberry *South Consultant* Reaside *Forensic Consultant*	**Junior Trainee Rota 6** Solihull and Zinnia *Solihull and East Consultant*