# Kent and Medway
## Ambulance Mental Health Referral Pathway

<table>
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<tr>
<th>KMPT Document Reference No.</th>
<th>To be allocated by the KMPT Policy Manager</th>
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<tr>
<td>Replacing document</td>
<td>New protocol</td>
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<tr>
<td>Target audience</td>
<td>Trust wide clinical staff and SECAmb staff</td>
</tr>
<tr>
<td>Author</td>
<td>Eastern Coastal Liaison Psychiatry Service Manager KMPT</td>
</tr>
<tr>
<td>Group responsible for developing document</td>
<td>Operational Quality Improvement Group CQUIN 3.3 working group</td>
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<tr>
<td>Status</td>
<td>Draft approved by KMPT on 29.9.10 subject to integrating doc with SECAmb and amendment to age criteria</td>
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<tr>
<td>Authorised/Ratified By</td>
<td>KMP Trust wide Clinical governance group</td>
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<td>To be confirmed in new format</td>
</tr>
<tr>
<td>Date of Implementation</td>
<td>29.9.10 and resubmitted in new format on 26.10.10</td>
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<tr>
<td>Review Date</td>
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</tr>
<tr>
<td>Review</td>
<td>This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.</td>
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<td>Contact Point for Queries</td>
<td><a href="mailto:policies@kmpt.nhs.uk">policies@kmpt.nhs.uk</a></td>
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<tr>
<td>Copyright</td>
<td>South East Coast Ambulance Service and Kent and Medway NHS and Social Care Partnership Trust 2010</td>
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<tr>
<td>South East Coast Ambulance Service Clinical Pathways Group</td>
</tr>
<tr>
<td>KMPT Clinical Governance acute service line and trust wide Groups</td>
</tr>
<tr>
<td>Final approval by SECAmb’s Medical Director and Chair of Clinical Pathways Group</td>
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DOCUMENT TRACKING SHEET

Kent and Medway Ambulance Mental Health Referral Pathway Protocol

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REFERENCES

- Equity and Excellence – Liberating the NHS DH 2010
- NICE Mental Health Triage Scale DH 2010
- NICE Guideline on Treatment and Management of Depression in Adults DH 2010
- Mental Health and Well Being DH 2010
- Taking Healthcare to the Patient – Transforming Ambulance Services NHS DH 2005

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

SECAmb links

- ..\NICE and other guidelines\mental health\NICE Mental health triage scale Self Harm.pdf..
- consent\Capacity and Consent Procedure.docx
- ..\consent\Appendix A Staff Pocket Guide.docx page 8
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1 INTRODUCTION

1.1 This protocol has been developed jointly by Kent and Medway NHS and Social Care Partnership Trust (KMPT) and South East Coast Ambulance NHS Trust (SECAmb) and describes the process for ambulance crews to refer people to mental health services across Kent and Medway.

1.2 In addition it sets out the responsibilities of both Trusts’ staff and includes an algorithm with contact numbers.

1.3 It identifies who to contact when there is an issue that cannot be resolved and who within each Trust is responsible for its review.

1.4 It also includes an education support programme for ambulance staff.

2 CONTEXT

2.1 The Urgent Care Model supports care being delivered closer to home with less complex pathways and simple access to urgent care services.

2.2 According to the National Ambulance Service Network, ambulance crews attend to people with a wide range of mental health problems. Many of these people will need to go to an Emergency Department (ED) for a physical/medical assessment/treatment, however for some there is currently no alternative way of accessing care.

2.3 This protocol has been developed to enable people to access mental health services and improve patient experience, rather than being taken to the ED and is available 24 hours, seven days a week.

3. REFERRAL PATHWAY

3.1 SECAmb staff must complete a non-conveyance form and include the working condition codes on the patient clinical record. SECAmb staff must apply the algorithm and risk matrix as described in appendices C and D.

4. ELIGIBILITY CRITERIA

4.1 Anyone who presents with a mental health illness (whether previously known to mental health providers or not) AND does not require a medical or physical intervention by the ED. In the first phase, an ambulance paramedic practitioner or paramedic attending an incident in Kent and Medway can contact the local mental health service for advice or to directly refer a person aged 18 and over at risk as a consequence of:

4.2 Anxiety/panic attacks (exclude physical cause)

4.3 Depression

4.4 Psychosis or mania (new onset or exacerbation)
4.5 Reaction to severe distress (maybe related to unemployment, bereavement, isolation, loneliness, physical disability, significant illness)

4.6 Eating disorder

4.7 Dual diagnosis

4.8 Self harming behaviour or expression of wish to self harm or end their life

4.9 **AND IN ALL CASES** does not require a medical or physical intervention by the ED. Consent must be obtained from the patient prior to referral, if there is a doubt about the patient’s capacity to consent seek advice (as per SECAmb Trust’s Consent and Capacity Policy and Procedure).

4.10 **Exclusion criteria:**

4.11 Those with any actual serious injury

4.12 Those with high risk of suicide or serious self harm

4.13 Self-neglect

4.14 Frail

4.15 aged 17 and under

4.16 Those with a physical illness

4.17 Those who are intoxicated to the level where they may need a physical intervention (e.g. i.v. fluids, monitoring of gag reflex)

4.18 **Referral to Paramedic Practitioner**

4.19 Those with a physical wound (may then refer to mental health trust pathway after initial wound management)

4.20 Those with a complex or chronic condition such as dementia (may then refer to primary, community or social care).

5. **NOT FIT FOR ASSESSMENT**

5.1 If the person is intoxicated or declining a referral to mental health, the ambulance crew may request advice and support on risk assessment and management from mental health services. Mental health clinicians are required to contribute to the assessment of risk and enable the formulation of a plan to manage and reduce those risks.

5.2 Alcohol increases the risk of either acting on thoughts of self harm or harm to others. Whilst it is not necessarily possible to accurately risk assess an intoxicated person intoxication is not, in itself, a reason for the mental health service to refuse a referral or to not attend and contribute towards the risk assessment and formulation...
of a plan. It is important to note that not all intoxicated individuals will require referral.

5.3 Patients who are otherwise eligible but have taken alcohol may still be included in the pathway.

6. MENTAL HEALTH SERVICE CONTACT DETAILS

6.1 The contact details for the mental health teams across Kent and Medway are shown on the algorithm (appendix D) and available to the ambulance crews. In hours the ambulance staff will contact the relevant Duty Team and out of hours the Crisis Resolution Home Treatment Team (CRHTT).

7. INFORMATION SHARING AND COMMUNICATION OF RISKS

7.1 There is an agreement between both Trusts to work collaboratively and to share information as a means to support decision making and promote the safety of the patient, public and staff.

7.2 All sharing of information between Trusts must be done in accordance with legislation, best practice and individual Trust policy. In particular, the Caldicott Principles should be applied to ensure that the information shared is done so on a need to know basis with the minimum amount necessary shared to minimise any clinical risk or ensure an appropriate level of continued care. All information sharing must be justifiable and proportionate for each case and if there is any doubt or concern, advice should be sought.

7.3 If, during any interaction or assessment, a risk to others is identified or disclosed, the assessing clinician must seek advice and contact the relevant services i.e. police, the individual or carer and disclose.

7.4 It is the responsibility of both Trusts’ staff to alert appropriate services if there are concerns of risks/needs of a child or of a vulnerable adult.

8. CORPORATE RESPONSIBILITIES

8.1 KMPT with SECAmb will have shared clinical and governance accountability from the point of the decision to transfer to mental health services and through the duration of the period that the ambulance crew remain on scene with the patient.

8.2 KMPT will have clinical and governance accountability from the point of acceptance for assessment by the KMPT clinician.

8.3 Where KMPT advised SECAmb staff for a patient refusing referral to KMPT, the clinical and governance accountability will remain with SECAmb.

8.4 This pathway has been approved by both Trusts’ leads for risk and business development via appropriate committee and group meetings in September and October 2010. Both Trusts have developed this pathway with support from clinical governance leads and groups.
9. COMPLAINTS

9.1 In the event that there is a complaint from SECAmb personnel against KMPT then this should follow the KMPT formal complaints procedure and vice versa with relation to KMPT making a complaint against SECAmb.

9.2 Complaints from Patients will involve both Trusts investigating jointly with the Trust either receiving the complaint or with the majority of accountability for the complaint, taking the lead.

10. GRIEVANCES

10.1 Grievances will be dealt with by reference to the Director of Acute Mental Health Service and the Medical Director of SECAmb and follow both Trusts’ existing grievance procedures.

11. CONFIDENTIALITY

11.1 Both parties agree that in the course of their duties they are dealing with confidential matters and that all information should be treated as confidential in accordance with the Data Protection Act 1983.

12. TIMESCALES FOR ASSESSMENT

12.1 Mental health services will agree the timescale to assess the person in collaboration with the ambulance staff, the individual and carer (if appropriate) and the time lapse will depend on the presenting risks. If an emergency assessment is required this will take place within 4 hours.

13. SECAMB RESPONSIBILITIES

Ambulance staff will:

13.1 Obtain two clinical observations and record

13.2 Follow the protocol and risk assessment prior to assessing eligibility of the patient for inclusion in the pathway

13.3 On contacting the mental health service will identify that they are an “ambulance on scene and require an urgent response”

13.4 Clarify if advice or a referral is required

13.5 Provide the mental health team with the ambulance incident number, vehicle telephone number and the person’s land line in case phone contact is lost

13.6 Provide the person’s details, observations and confirm if consent given

13.7 Agree the response and timescale from mental health service

13.8 Follow SECAmb’s non conveyance policy
13.9 Remain clinically responsible whilst on scene and until transfer agreed with mental health team

13.10 Complete the non-conveyance form (where appropriate) and include the crew condition codes on the Patient Clinical Record.

13.11 Refer to Paramedic Practitioner where appropriate for further assessment, follow up or other treatment required

13.12 If the timescale cannot be achieved then the individual will be taken to the nearest ED.

14. **KMPT MENTAL HEALTH RESPONSIBILITIES**

Mental health staff will:

14.1 Prioritise ambulance referrals and coordinate the response (not direct the crew to another part of the mental health service)

14.2 Exchange telephone numbers with ambulance crew and request incident number

14.3 Determine urgency on gathering information; within ten minutes of referral will agree a response and timescale with the crew, individual and carer which includes a time and place for assessment

14.4 Provide the person and carer with the mental health service telephone number

14.5 Clinical responsibility remains with SECAmb staff whilst on scene and until an agreement with the mental health team for transfer to KMPT has been reached. Once the patient has been accepted for assessment by the Mental Health Service and a plan agreed there will be a formal transfer of care from SECAmb to KMPT and this will be clearly recorded. SECAmb personnel will make a decision as to when they leave the scene.

14.6 If the referral is out of hours and screened as not urgent, the CRHTT will advise the person that they will be contacted the next working day by the duty team and will give the duty team telephone number. On receipt of referral the duty team will make immediate telephone contact to arrange an assessment.

15. **MENTAL HEALTH AWARENESS/ACCREDITATION/TRAINING**

15.1 SECAmb is, in conjunction with commissioners and other partners developing a new role for paramedic practitioners that will enhance and support improved outcomes for people at home or in a primary care setting. A service level agreement with KMPT already provides a placement for paramedic practitioners within a mental health setting to acquire a broader range of experience than would be possible in their normal operational setting. Opportunities will also be available for up to 100 paramedics and technicians for one or two day placements which will be arranged with the duty and Crisis Teams direct.
15.2 As Paramedics and Paramedic Practitioners refer patients using the protocol and risk assessment tool, the acceptance by mental health clinicians of the referral and monitoring of outcomes for each patient, will act as accreditation.

15.3 Paramedic Practitioners attend a module on mental health in their education programme, and as the pilot gets underway, those with an interest can act as local trainers for Paramedics (and Technicians phase 2) who require education and cannot attend the two days placements at the mental health Trust.

16. ESCALATION

16.1 Whilst this pathway and protocol has been developed jointly between KMPT and SECAmb there may be occasion when an issue cannot be resolved.

16.2 For KMPT Monday to Friday 9am - 5pm contact the Director of Acute Service Tel no 01227 459371

16.3 And out of hours contact: The on call psychiatric manager Eastern and Coastal 01227 76687 and for Medway and West Kent 01322 622222

16.4 For SECAmb contact the Emergency Dispatch Centre Duty Manager 01622740382

17. EVALUATION AND REVIEW

17.1 The Director of Acute Service KMPT and the SECAmb’s Medical Director will be responsible for the protocol, its update, monitoring and evaluation on a quarterly basis.

17.2 This pathway will be implemented in January 2011 and reviewed in September 2011.

17.3 A six monthly update on the pilot’s progress will be made to SECAmb’s Clinical Pathways Sub Group, an exception report against the agreed Evaluation Framework via SECAmb Clinical Governance and Innovation Working Group will be made to the SECAmb Risk Management and Clinical Governance Committee.

17.4 The mental health Trust will carry out and facilitate the evaluation with support from SECAmb. The input from SECAmb will be dependent on capacity and mainly consist of relevant data sharing. The proposed areas of evaluation are:

17.5 Patient experience reports
17.6 Significant events
17.7 Serious incidents
17.8 Number of patients included
17.9 Preventative outcomes i.e. patient did not self-harm, did not attempt suicide, had preferred place of care i.e. Mental Health Trust not ED.
17.10 Patient outcomes
17.11 Reduction of transfers to ED
17.12 Length of time for patient to see mental health practitioner (within agreed risk categories)
17.13 Feedback from staff involved
17.14 Feedback from trainers
17.15 Number of vulnerable adult referrals
17.16 Number of SECAmb staff taking up two day placement with the mental health teams
17.17 Number of local training sessions for Paramedics (and Technicians Phase Two)
17.18 Characteristics of patients accepting direct referral (age, gender, ethnicity, sexual orientation, disability, long term condition, social factors etc.)
17.19 Number of repeat calls to SECAmb for individual patient call (i.e. patient calls 999 again whilst waiting to be seen by KMPT).
17.20 The initial phase will include age range up to 65 years (based on current model of provision and different clinical need for older patients), but as the service is developed this will seek to include all age ranges.

18. ROLL OUT

18.1 A phased approach will be taken initially introduced by Paramedics with support from Paramedic Practitioners and initially for people aged 18 -64. As the protocol and pathway evaluates and any concerns or risks are identified and managed, the intention is to roll out local training packages, so that Technicians can also apply the protocols and pathways. A decision as to roll out will be made six months after the initial phase for people aged 65 and over.

19. EQUALITY IMPACT ASSESSMENT

19.1 All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." In effect to undertake equality impact assessments on all policies/guidelines and practices. This obligation has been increased to include equality and human rights with regard to disability age and gender. See Equality Assessment at Appendix A.

20. HUMAN RIGHTS

20.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that requirements of the Human Rights Act are properly upheld.
APPENDIX A  FULL EQUALITY IMPACT ASSESSMENT (EIA) TOOL

If you prefer not to use this tool – you can create a separate document that answers the following questions:

- What is being assessed and what are the intended aims and outcomes?
- Are there any partners/contractors (internal and external) that will be involved in implementation?
- Which groups are currently affected and could be affected in the future (stakeholders)
- Have you got data on staff, service users, clients, carers and families by equality strand in relation to the policy?
- Which groups (internal and external) have been consulted?
- Could the policy directly/indirectly discriminate? (refer to definitions in EIA guidance document)
- Is there an opportunity to promote equality and diversity?
- What actions will you take to remove any potential discrimination?
- How will the EIA be monitored?

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<td><strong>1.</strong> Name/s of policy, procedure, or practice:</td>
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<td><strong>3.</strong> Policy Owner:</td>
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<td><strong>4.</strong> EIA Lead:</td>
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<td><strong>5.</strong> Lead Manager/Director:</td>
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<td><strong>6.</strong> Date of screening:</td>
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<td><strong>7.</strong> Is this a proposed or existing policy, procedure or practice:</td>
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<td><strong>8.</strong> What are the overall aim/s or purpose of the policy, procedure or practice?</td>
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<td><strong>9.</strong> Which groups of people will be affected by the policy, procedure or practice? E.g. particular service users, staff groups</td>
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<td><strong>10.</strong> Are any other Directorates/teams involved in the delivery of the policy, procedure or practice?</td>
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<td><strong>11.</strong> Are any partner agencies involved in the delivery of the policy, procedure or practice?</td>
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### Data and Consultation

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<td><strong>12.</strong> Do you monitor the policy, procedure or practice in relation to any of the following?</td>
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<td><strong>13.</strong> If you answered yes to any of the above, do you collect this data broken down by any of the following?</td>
<td>Age, Gender, Race</td>
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<td><strong>14.</strong> What consultation with <strong>service users</strong> taken place on the policy, procedure or practice within the last two years?</td>
<td><strong>Who was consulted?</strong></td>
<td><strong>Summarise the findings</strong></td>
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<td>Disability, Age, Sexual orientation, Religion and Belief, Transgender</td>
<td>Patient surveys identify need for alternative access to mental health service other than Emergency Depts</td>
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<td>Carers</td>
<td>Carers Briefings, Locality Planning and Monitoring Groups</td>
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<td><strong>15.</strong> What consultation with <strong>staff groups</strong> has taken place on the policy, procedure or practice?</td>
<td><strong>Which groups?</strong></td>
<td><strong>Summarise the findings:</strong> Initial anxieties relating from KMPT staff however well accepted by SECAmb staff</td>
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<td>Is there any other evidence to support this EIA that suggests any group may be affected differentially by this policy, procedure or practice?</td>
<td><strong>Summarise and reference the evidence:</strong> Ambulance Network and NHS Confederation briefings, Count Me In CQC 2009, Forensic Mental Health Services Sainsbury 2007, New Ways of Working for Everyone DH 2007, National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2009</td>
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<td>Advice from SECAmb Equality &amp; Diversity Lead</td>
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<td>EIs completed by national bodies and partners</td>
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### Conclusions

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<th>17.</th>
<th>Will the policy, procedure or practice affect any group differently?</th>
<th>If yes – can this be legally justified? (explain)</th>
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<td>Sexual Orientation</td>
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<td></td>
<td>Religion and Belief</td>
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<td>Age</td>
<td><strong>YES</strong> it was agreed to initiate the current pathway for people aged 18-64 as the needs of people aged 65 and over are more complex, with differential diagnosis or presentation relating to physical illness and to roll out for people aged 65 and over in phase 2 (approx 6 months later)</td>
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<td>Transgender</td>
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| 18. | Does the policy, procedure or practice miss any opportunities to promote equality? | **No** as it promotes positive awareness of mental health and reduces negative experiences in Emergency Depts for people with mental health problems |

| 19. | Does the policy, procedure or practice encourage disabled people to participate in public life? | **Not applicable** |

| 20. | Does the policy, procedure or practice promote positive attitudes towards disabled people? | **Yes as above** |
21. Is there a need to gather more information than is currently available to assess the impact of the policy, procedure or practice

| Yes | Monitoring referral rates from Emergency depts and ambulance staff |

22. Is it possible to easily modify this policy, procedure or practice to address any issues highlighted above? Please give details of how and when this could be implemented

| Not applicable |

23. The EIA has identified: (please tick)

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<th>Disability</th>
<th>Sexual Orientation</th>
<th>Religion and Belief</th>
<th>Age</th>
<th>Transgender</th>
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<th>Adverse impact that can be mitigated (detail in improvement/equality action plan)</th>
<th>More research/consultation needed (detail in improvement/equality action plan)</th>
<th>Adverse impact that cannot be mitigated or legally justified (policy must be cancelled)</th>
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### 24. Additional comments


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<th>Issue</th>
<th>Action Required</th>
<th>How will the impact/outcomes be measured in practice</th>
<th>Completion Date</th>
<th>Responsible Officer</th>
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<td>1</td>
<td>Data collation and monitoring</td>
<td>Analysis of referral activity according to race, age, gender and potentially disability</td>
<td></td>
<td>Director of Acute Service Line</td>
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</tbody>
</table>

SIGNED: Kim Solly  
EIA Lead: Kim Solly  
Head of Department/Directorate: David Tamsitt  
Equality & Diversity Team member: Aishnine Benjamin  
Completion Date: 30th September 2010

Send the Full EIA to the Equality and Diversity Team equalities@kmpt.nhs.uk
APPENDIX B ABBREVIATIONS AND DEFINITIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
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<tr>
<td>CRHTT</td>
<td>Crisis Resolution Home Treatment Team</td>
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<tr>
<td>SECAmb</td>
<td>South East Coast Ambulance Trust</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
</tbody>
</table>
APPENDIX C

The following guidelines apply to SECAmb staff when dealing with persons suspected to be at risk of suicide. They are not intended to be either rigidly applied or exhaustive, as each circumstance must be considered in its own context and on its own merits, and clinicians will still be required to make dynamic risk assessments and relevant clinical judgements.

Risk assessment question (responses are required to all questions)

High-risk indicators are in red print

1. Do you have thoughts about harming yourself?
2. Are you thinking about suicide?
3. Do you have a specific plan to kill yourself?
4. What methods have you considered?
5. Do you have access to any of these methods?
6. Do you have a date or place in mind?
7. Have you ever self-harmed or attempted suicide in the past?
8. Has anyone in your family died by suicide or attempted suicide?
9. Are you suffering from mental health problems?
10. Have you suffered from mental health problems in the past?
11. Have you had ever been in contact with mental health services or seen your GP in relation to psychological or psychiatric problems before?
12. Are you taking any medication for mental health problems?
13. Do you have a problem with drugs or alcohol?
14. Have you been drinking or taking recreational drugs in the past few hours?
15. Are you experiencing particular difficulties in your life or struggling to deal with difficult past events (e.g. bereavement, divorce, running away from home)?
16. Do you have friends or family you can turn to for help?
17. Do you feel that the future is hopeless and that things cannot improve?
<table>
<thead>
<tr>
<th>Level of risk</th>
<th>Key assessment information</th>
<th>Action required</th>
</tr>
</thead>
</table>
| **Standard** | ● No plans or thoughts relating to self-harm or suicide. Protective factors evident  
● The person may have already self-harmed, but regrets doing so and has no plans or thoughts relating to further self-harm  
| Ideally, leave the individual in the care of a supportive friend or relative  
● Advise them to seek further help through their GP (or mental health team if they have one) as soon as possible  
| Give Mental Health Matters Helpline 0800 107 0160 (available out of hours)  |
| **Moderate** | ● Suicidal thoughts present, with no immediate plans to self-harm or attempt suicide  
● Can maintain safety until assessment by mental health team (e.g. with friend or family)  
| Monday to Friday 0800hrs-2000hrs contact Mental Health Duty Team  
● Any other time contact Crisis Team  
● Agree time and location of mental health assessment  |
| **High** | ● Has imminent plans relating to suicide, and/or  
● Is seeking access to lethal means of suicide  
| CAN MAINTAIN OWN SAFETY until mental health assessment: Treat as if Moderate Risk (above)  
● CANNOT MAINTAIN OWN SAFETY until mental health assessment: Take patient to Emergency Department  |

Adapted from Kent Police Risk Management Matrix 13th September 2010 (v4), developed with Kent & Medway Suicide Prevention Group
# Kent and Medway Contact Numbers for mental health advice/referral

<table>
<thead>
<tr>
<th>Duty team</th>
<th>Contact</th>
<th>Mon- Friday</th>
<th>Crisis Team</th>
<th>Out of hours including weekends &amp; bank holidays</th>
</tr>
</thead>
</table>
| Eastern Coastal    |                 |              | South East Kent   | 07699 739303  
| Ashford            | 01233 204150    | 09:00 – 17:00|                   | Page "ambulance on scene please phone tel no………"
| Dover/Deal         | 01304 216666    | 09:00 – 17:00|                   |                                                 |
| Shepway            | 01303 852706    | 08:30 – 17:00|                   |                                                 |
| Canterbury         | 01227 597111    | 09:00 – 17:00|                   |                                                 |
| Thanet             | 01843 855424    | 09:00 – 17:00|                   |                                                 |
| SWK                |                 |              | North East Kent   | 07699 746208  
| Tonbridge          | 01732 360032    | 09:00 – 17:00|                   | Page "ambulance on scene please phone tel no………"
| Tunbridge Wells    | 01892 709211    | 09:00 - 17:00|                   |                                                 |
| Sevenoaks          | 01732 470840    | 09:00 - 17:00|                   |                                                 |
| Maidstone          | 01622 725000    | 09:00 – 17:00| Maidstone         | 01622 725000 |
| DGS                | 01322 622010    | 09:00 - 17:00| DGS               | 07795 642344 |
| Medway             | 01634 825381    | 08:00 - 20:00| Medway + Swale    | 07876563668 |
| Swale              |                 |              |                   |                                                 |
| Sheppey            | 01795 580528    | 09:00 – 17:00|                   |                                                 |
| Sittingbourne      | 01795 418355    | 09:00 – 17:00|                   |                                                 |
**APPENDIX D**

**ALGORITHMS**

**Kent & Medway Mental Health / Ambulance referral Pathway (age18-64)**

**SECAmb Ambulance Paramedic Practitioner/paramedic/technician on scene**

Mental Health (MH) problem identified does not require attendance for medical/physical intervention at the emergency department (ED) Obtain 2 clinical observations & record
Consider contacting MH team for advice / referral (see protocol) if unsure discuss with paramedic practitioner

**Contact relevant MH Team (Duty or Crisis Team) via EDC and request call is taped**

For advice or to make a referral
When referring the term 'Ambulance on scene' will identify that an urgent response is required from the mental health service

**MH team respond**

- Duty worker will co-ordinate response and ensure Ambulance crew are informed of outcome within 10 minutes of end of initial contact
- Exchange phone numbers with Ambulance crew
- Ask for ambulance incident number; patient details; presenting problem/concerns; observations; contact information; and patient consent
- Speak with patient and carer
- MH team will:
  - Assist to determine and agree Urgency
  - Identify most appropriate MH service to assess
  - Agree a timescale for contact from MH services with patient/carer and ambulance crew
  - Agree time and place for assessment.
  - Agree transfer of care with ambulance crew
  - Give the patient/carer the relevant mental health team contact number

Ambulance crew can leave unless otherwise indicated* and follow SECAmb's Non-conveyance Policy

* If timescale cannot be achieved then patient will be taken to the nearest ED

**Community mental health services**
Respond / assess within agreed timescale with AMHP if MHA ax required

**Crisis Team**
Respond / assess as per agreed timescale
With AMHP if MHA ax required

**Acute Care**
as per Acute care pathway

**Community Mental Health Team**
**Protocol for Inclusion in Kent & Medway Mental Health Direct to KMPT Pilot**

- **Patient calls 999 and presents with mental illness symptoms**
  - Exclude physical causes – be mindful of delirium, confusion caused by sepsis, transient loss of consciousness, epilepsy, hypoxia, hypoglycaemia, head injury, dementia and other possible causes. Take baseline observations and record
  - Take baseline observations and record
  - Transfer to A/E or arrange Paramedic Practitioner to assess or refer to G.P/OoHs according to need
  - Complete vulnerable adult referral where appropriate

- **Assess eligibility for inclusion in pilot (18 – 64) with manageable risk) and gain consent. N.B. follow consent and capacity procedure where applicable.**
  - Not eligible (see list)
  - Eligible (see list) Contact KMPT via EDC and ask for call to be taped

- **KMPT clinician accepts patient – agree risk level and time frame for patient to be seen. Ensure patient has contact numbers for support and understands how to access KMPT.**
  - Complete non conveyance form where appropriate. Complete pcr with working condition codes, details of joint risk assessment and KMPT clinician accepting patient.

- **Complete vulnerable adult referral where appropriate.**

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Some young people over the age of 18 may still be under the care of children’s services if they have severe learning disabilities

See over for lists
ELIGIBILITY CRITERIA

- Anyone who presents with a mental health illness (whether previously known to mental health providers or not) AND does not require a medical or physical intervention by the local Emergency Department. An ambulance paramedic practitioner or paramedic attending an incident in Kent and Medway can contact the local mental health service for advice or to directly refer a person aged 18 to 64 at risk as a consequence of:
  - Anxiety/panic attacks (exclude physical cause)
  - Depression
  - Psychosis or mania (new onset or exacerbation)
  - Reaction to severe distress (maybe related to unemployment, bereavement, isolation, loneliness, physical disability, significant illness)
  - Eating disorder
  - Dual diagnosis
  - Self harming behaviour or expression of wish to self harm or end their life

AND IN ALL CASES does not require a medical or physical intervention by the ED

ALWAYS EXCLUDE PATIENTS WHO ARE:

- Frail
- Aged 65 or over; aged 17 and under
- Those with a physical illness or injury
- Those who are intoxicated to the level where they may need a physical intervention or support (e.g. i.v. fluids, monitoring of gag reflex)

REFERRAL TO PARAMEDIC PRACTITIONER:

- Those with a physical wound (may then refer to mental health trust pathway after initial wound management)
- Those with complex or chronic condition such as dementia – PP may then refer to primary, community or social care as appropriate.

PATIENTS NOT FIT FOR ASSESSMENT

- If the person is intoxicated or declining a referral to mental health, the ambulance crew may request advice and support on risk assessment and management from mental health services. Mental health clinicians are required to contribute to the assessment of risk and enable the formulation of a plan to manage and reduce those risks.
- Alcohol increases the risk of either acting on thoughts of self harm or harm to others. Whilst it is not necessarily possible to accurately risk assess an intoxicated person, intoxication is not, in itself, a reason for the mental health service to refuse a referral or to not attend and contribute towards the risk assessment and formulation of a plan. It is important to note that not all intoxicated individuals will require referral.