East London
NHS Foundation Trust

Newham
Serenity Integrated Mentoring Team Operational Guidance

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Team Model and Structure

1. Purpose of the policy

1.1 The SIM model introduces a specialist trained police officer into the mental health care pathways of specific services users so that a new model of care can be delivered, combining the best of nursing with the best of policing. This integrated model provides the service user with all possible supervision tools they may need; encouraging service users to better self-manage their behaviour, to consistently de-escalate and to find better coping mechanisms that pose less risk to themselves and others, that avoids the criminal justice system and that places less unnecessary demand on emergency and healthcare services

1.2 This Policy will provide operational guidance for the SIM Team and is to be read in conjunction with the Newham Adult Community Recovery Teams Operational Policy.

2. Philosophy and model of care

2.1 The SIM Team will implement a high intensity partnership project between police and mental health that is based largely on the design of the SIM programme. SIM was developed from July 2013 by Hampshire Constabulary and Isle of Wight NHS Trust in response to the problem of high intensity and frequent caller mental health patients, most notably the most intensive and risky cases that health staff alone are unable to manage.

3. Introduction to the team

3.1 The SIM Team is integrated within the Newham CRTs and uses the 'rotation' SIM model which entails the dedicated police officer supporting multiple health care professionals across the CRTs.

3.2 The Team mentors adults of working age who are under the care of the Newham CRTs and who are high intensity users of S136 Mental Health Act, 1983 and demonstrate high risk behaviours.

3.3 The funding and management stakeholders include ELFT Newham Mental Health Directorate, Newham CCG and Met Police.

3.4 The SIM Team covers the geographical area of the London Borough of Newham

3.5 Adults of working age (18 -65).

4. Team composition

4.1 The Team consists of 1x (whole time equivalent) Police Officer who will work across the CRT sub Teams to mentor identified high intensity service users and will work with multiple health care professionals (CPN/social workers) on the CRTs. This is described as the 'rotation' SIM model.

4.2 The Consultant Psychiatrist will remain the service user's existing clinician from the CRT during the period of mentoring.

4.3 Both the Police Mentor and health care professional mentors will undertake specific High Intensity Training prior to mentoring service users.

5. Hours of operation and service provision

5.1 The SIM Team will operate between 09.00 and 17.00, Monday to Friday with flexible hours for specific tasks or interventions.

5.2 The SIM Team will be embedded within the CRTs and based at the Passmore Edwards Building.

5.3 The SIM Team will provide mentoring of a caseload of 5-10 high intensity service users who are under the clinical care of the CRTs.

6. Team meetings

6.1 The Multiagency High Intensity User Group which consists of representatives from Newham Mental Health Directorate, Emergency Department Bart's Health, MET Police and London Ambulance Service will meet once a month.

6.2 The purpose of the meeting will be to review police, ambulance, Emergency Department and mental health data to identify service users by frequency of contact and risk of incidents. The group will make decisions regarding referrals for mentoring, the allocation of a mentoring team and the service user moving on/being discharged from the mentoring Team.
6.3 The health mentor and police mentor will discuss SIM service users at the weekly sub team clinical meeting in accordance with CRT Operational Policy.
6.4 The police officer mentor will attend CRT business meetings.

7. Supervision

7.1 The SIM team will ensure that the police officer mentor will be supported by monthly supervision by one of the CRT Operational Team Leads.
7.2 The police officer will also participate in the monthly South or North CRT reflective Team sessions and in specific cases will also be able to take advice from the Team‘s psychologist.
7.3 The police officer will also have regular police supervision.
7.4 The health mentors will be supervised in accordance with CRT policy.

Clinical Processes

8. Referral

8.1 Referrals are generated from the multiagency data (police, mental health (S136 detentions), emergency department and London Ambulance Service)
8.2 Referrals are discussed by the High Intensity User Group panel. The panel consists of representatives from police, mental health, ambulance and ED staff who have individually collated their own data and identified their own repeat patients. The group will process, record and collate all these names into one risk and demand document so that the service users can be ranked by intensity (frequency and risk together).
8.3 The panel meets on a monthly basis to discuss referrals and decide if a user meets the criteria for SIM.
8.4 Before mentoring can start, permission must first be obtained from the Consultant Psychiatrist for that service user. This is to ensure that the service user has sufficient mental capacity for a mentoring team, that they would benefit from such support and that mentoring would not complicate or disrupt any other treatments being undertaken by the service user at that time.
8.5 Inclusion criteria requires that the service user is of working age, has a mental disorder and meet the criteria for CRT intervention, resides in the London Borough of Newham, has been detained on multiple S136 in the past 12 months, demonstrates high risk behaviours, has sufficient mental capacity to engage with SIM mentoring and have the support and agreement from the treating Consultant Psychiatrist.
8.6 Exclusion criteria includes that the service user is not of working age, does not have mental health needs that require CRT intervention, resides outside of the London Borough of Newham, learning disability is the primary diagnosis, the service user lacks the sufficient capacity to engage with SIM mentoring and if the treating Consultant Psychiatrist does not view mentoring to be clinically appropriate.

9. Risk Assessment and management

9.1 The SIM mentors have a professional duty of care in high risk scenarios that may temporarily override the rights provided to the patient by the ECHR.
9.2 Any release of personal data to save life or protect a patient from harm must be deemed necessary to achieve the safeguarding objectives and the amount/nature of any data shared must be proportionate to the objectives at hand.
9.3 The sharing of personal data in these urgent circumstances overrides the patient’s rights under Article 8 (Right to respect for private and family life).
9.3 The police and health mentors have separate and specific risk roles that remain the responsibility of each organisation.
9.4 Clinical Risk – all risk relating to or resulting from behaviour that is being caused by a mental illness or a behavioural disorder must be primarily managed by the mental health trained clinicians.

This does not mean that untrained staff (such as a police officer) cannot contribute to the assessment of the risks, but the final risk decisions relating to illness or disorder must be the responsibility of a qualified clinician.
9.5 Criminal Risk – all risk relating to criminal behaviour must be led by the police officer in accordance with their office, legal powers and training. This does not mean to say that civilian staff (such as mental health nurses) cannot contribute to decision making in relation to offending behaviour but the final decisions relating to the prevention or detection of crime or disorder must be made by the police officer.
9.6 SIM service user's clinical risks will be recorded by the care coordinator mentor on the Rio risk assessment form in accordance with Trust policy.

10. Allocation and for Police and Health/care coordinator Mentor
10.1 Following agreement at the High Intensity User Group panel the service user will be allocated a police mentor and a CRT care coordinator/health care professional will fulfil the role of the health mentor.
10.2 A service user may be SIM mentored, but not care coordinated if CPA is not deemed to be clinically indicated. The service user will be allocated to the health mentor on Rio as a health care professional.

11. Service user's refusal to engage with mentors
11.1 Mentors should seek to proactively engage with high intensity service users. If there is a consistent refusal to engage there should be a multi-disciplinary discussion between the mentors, the Consultant Psychiatrist, other Team practitioners, family, friend, carer if appropriate/with permission and other relevant agencies involved in the service user's care to plan and agree their discharge from the SIM Team.

12. Discharge procedures
12.1 If a service user no longer requires SIM mentoring their case will be brought for discussion at the High Intensity User Group and agreement sought from the Police and health mentor and the treating Consultant Psychiatrist prior to the service user being discharged from mentoring.
12.2 It will be good practice to use a CPA review for the SIM discharge meeting of the service user if the service user is subject to CPA.
12.3 Discharge from SIM is a distinct and separate process from discharge from the clinical care of the CRT.

13. Service-user and carers involvement
13.1 Service users will co-produce and design their response plan which they will with their health and Police mentors and where appropriate with a friend/family member, carer.
13.2 The response plan will be signed by the service user, health mentor and police mentor
13.3 Service User permission is required for sharing explicit information with a carer, friend or family member. This should be sought at the earliest opportunity and re-affirmed at regular intervals.

14. Team documentation
14.1 Service users to be given a Your Records and You Leaflet.
14.2 Response Plans are plans written by the mentors (ideally with the full participation and consent of the service user). They outline how emergency, health and community responders should assist the service user if they are in crisis. It includes guidance on how to provide compassion and support to the service user but also what to do if their behaviours have breached pre-agreed boundaries. Response plans aim to support the patient as much as possible whilst also safeguarding the community and ensuring lawful behaviour and public order.
14.3 The Response Plans should adhere to the following principles:

- Response plans must be circulated to all relevant agencies and must be up to date.

- Response plans must never require a set response – plans can only provide strong advice in specific circumstances.
- Response plans must include the following information:
- The name and address of the patient
- Their current mental health diagnosis and a simple explanation of that diagnosis
- The current assessment of their mental capacity
- Their common crisis behaviours and locations
- The agreed behavioural boundaries and what to do if those boundaries are breached
- Chosen places of safety when in crisis
- Nominated people to whom they can be taken when in crisis
- Names of their mentors.

14.4 If the service user is on CPA, they will also have the eCPA and eRio risk assessment completed in accordance with Trust CPA policy.
14.5 Service users who would like the involvement of family, friends or carer will complete and sign the Involvement of Family, Friends or Carer form.

15. Use of criminal and behavioural sanctions

15.1 The presence of a police officer within the clinical team automatically brings a new presence and atmosphere into the model of care. This includes a healthy expectation of the service user to consistently adhere to standards of behaviour that remains lawful at all times. The primary role of the police officer in the team is to ensure the safety of the patient and the safety of any person who may be affected by the patient's behavioural choices. The officer also supports the patient in choosing behaviours that do not place them at risk of being arrested. Therefore, discussions within mentoring sessions that focus on behaviour and the likely legal consequences are an important element of the team's support so that new and healthy emotional rules and boundaries can be formed.

15.2 Well written response plans will clearly explain the behaviours that can and cannot be achieved by the patient when in crisis and the consequences that have been explained to the patient if these behaviours are repeated.

15.3 This transparency in reporting to other frontline professionals assists the patient to stop before they instinctively repeat the same negative, offensive behaviours. In the event of a criminal act being committed by the service user, any arrest/process for an offence is not considered a negative outcome by the mentors but rather an event where clearly set boundaries have been reinforced and where further support is required.

15.4 Arrest should never automatically lead to the service user being removed from the programme but rather an active opportunity to build further trust and offer more support.

16. SIM Training Material

16.1 All SIM staff will be able to access the High Intensity Network online resources that will support their ongoing professional development. The portal will provide training material relating to the following subject areas:

- Clinical Knowledge
- Mentoring
- Risk Management
- Data Collection and Administration
- Legal Knowledge

- Staff Safety and Welfare

The portal is accessed via www.highintensitynetwork.com

Quality and Governance

17. The Legal Basis for the processing of clinical data
17.1 The ICO considers it better to concentrate on making sure that you treat individuals fairly rather than on obtaining consent; this is now the transparency requirement and links to the emphasis on rights in the new DPA. The ICO adds: "if you need to process personal data to carry out your official functions or a task in the public interest – and you have a legal basis for the processing under UK law – you can. If you are a UK public authority, our view is that this is likely to give you a lawful basis for many if not all of your activities". Article 9(2)(h) specifically legitimises processing for health or social care purposes.
17.2 The ICO expands: "consent will not usually be appropriate if there is a clear imbalance of power between you and the individual. This is because those who depend on your services, or fear adverse consequences, might feel they have no choice but to agree – so consent is not considered freely given. This will be a particular issue for public authorities and employers." The legal reference is Article 6 of GDPR "processing is necessary for compliance with a legal obligation to which the controller is subject";

18. Sharing data to prevent or detect crime- specifics
18.1 Sharing of information between organisations is always lawful if the person releasing that information reasonably believes that it is necessary:

- To apprehend a service user who has committed an offence or
- To prevent a service user from committing an offence or
- To reduce the frequency or gravity of offending being actively committed at that time
- This includes behaviours that whilst not substantive offences in their own right, would be considered disorderly or anti-social for the purposes of any criminal or civil court order.

18.2 It should be emphasised that a service user should not be told about sharing information for this purpose unless advised to do so by the Police.

19. Dynamic incidents requiring quick decisions – 'sincerely held beliefs'

19.1 There may be circumstances where a rapid decision needs to be made in order to prevent offending, to preserve life and limb or to reduce significant risks to the community, a decision that is required so fast that it would be impracticable to refer to legislation or guidance notes for clear advice. In these types of dynamic incidents where decisions need to be made re the sharing of data then we will train all staff to rely on their 'sincerely held belief that sharing data is in the service users or the publics best interests'. We will encourage staff to trust their operational experience and make the best decision they can in the circumstances; that if they make a decision to share personal or clinical information believing that they are doing so in the best interests of any person then they must have the operational confidence to do so (regardless of the outcome or the likelihood of a legal challenge at a later date).
19.2 The SIM Team agrees with the release personal data in these circumstances.

20. Disclosure of personal and clinical information to family and friends
20.1 Personal Data (including sensitive personal or clinical information) may be released to family and friends if one of the following circumstances apply:

- It is in the service user's care plan.
- If it is believed that doing so will prevent or detect a criminal offence by the service user (consent is not lawfully required). This is a core public duty. If it is believed that doing so will

prevent an imminently anticipated incident that may lead to the death of or serious harm to any person (consent not lawfully required).

- If it is believed that doing so will lead to locating the service user and bringing them back into lawful custody from which they have absconded/failed to return (as provided by powers within the Mental Health Act 1983).

21. RiO

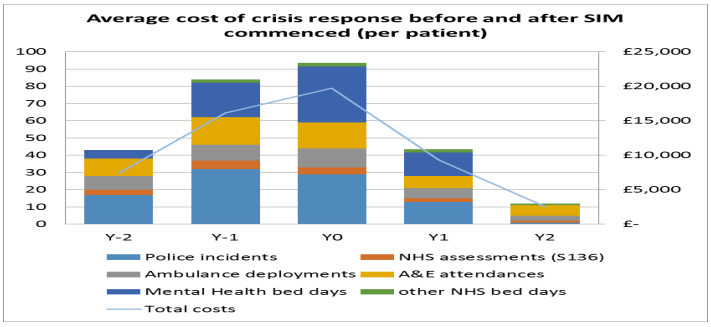
20.1 Opening and closure of SIM service users will be undertaken by the Band 4 administrator for the CRT Consultant Psychiatrist that the service user is open to.
20.2 Progress note recording will ordinarily be made by the health mentor in accordance with Trust policy.
20.3 The police mentor will be trained to use Rio and have access to read existing records and add new entries as required.
20.4 The primary author of the records will remain the clinician as they have all the clinical training required to risk assess and make key clinical decisions but the police mentor will add any record at any time that he/she feels appropriate to the case circumstances
20.4 Both the police and health mentors will maintain record keeping inline with Trust requirements.
20.5 The health mentor will record the Response Plan.
20.6 Joint record keeping by both mental health staff and police staff is essential and this will be primarily completed using the designated NHS system.

22. Governance: quality, safety and performance monitoring

22.1 No personal data will be used for this purpose.
22.2 The national network of High Intensity teams aims to build a national data set so the following 5 data sets are required for each nominated service user as a minimum agreed standard:

- Total Police incidents per month involving the service user (all types)
- Total Ambulance Deployments per month (any reason)
- Total ED attendances requiring treatment per month (any reason)
- Total MH bed days per month (any duration/reason)
- S136 detentions and Mental Health Act Assessments

22.3 Data is required for any service user who agrees to be mentored and is supported on three or more occasions by a mentoring team.
22.4 One off or informal contact by SIM trained staff does not require data.
22.5 The SIM Team will gather these 5 data sets for each service user on their programme.
22.6 Once all the 5 core data sets have been gathered (as described above), the following type of bar chart/graph will be created to show the cumulative effect of the demand placed each month by the service user on each of the four teams. This will be done as part of the Patient Data Spreadsheet submissions



22.7 The SIM Team will collate the 5 data sets into bar charts as show.
22.8 The Community Clinical Governance meeting oversees the project team and monitors key elements of the project, including:

- Staff Training and Welfare
- Performance and Data
- Partnership Development and Funding
- Networking

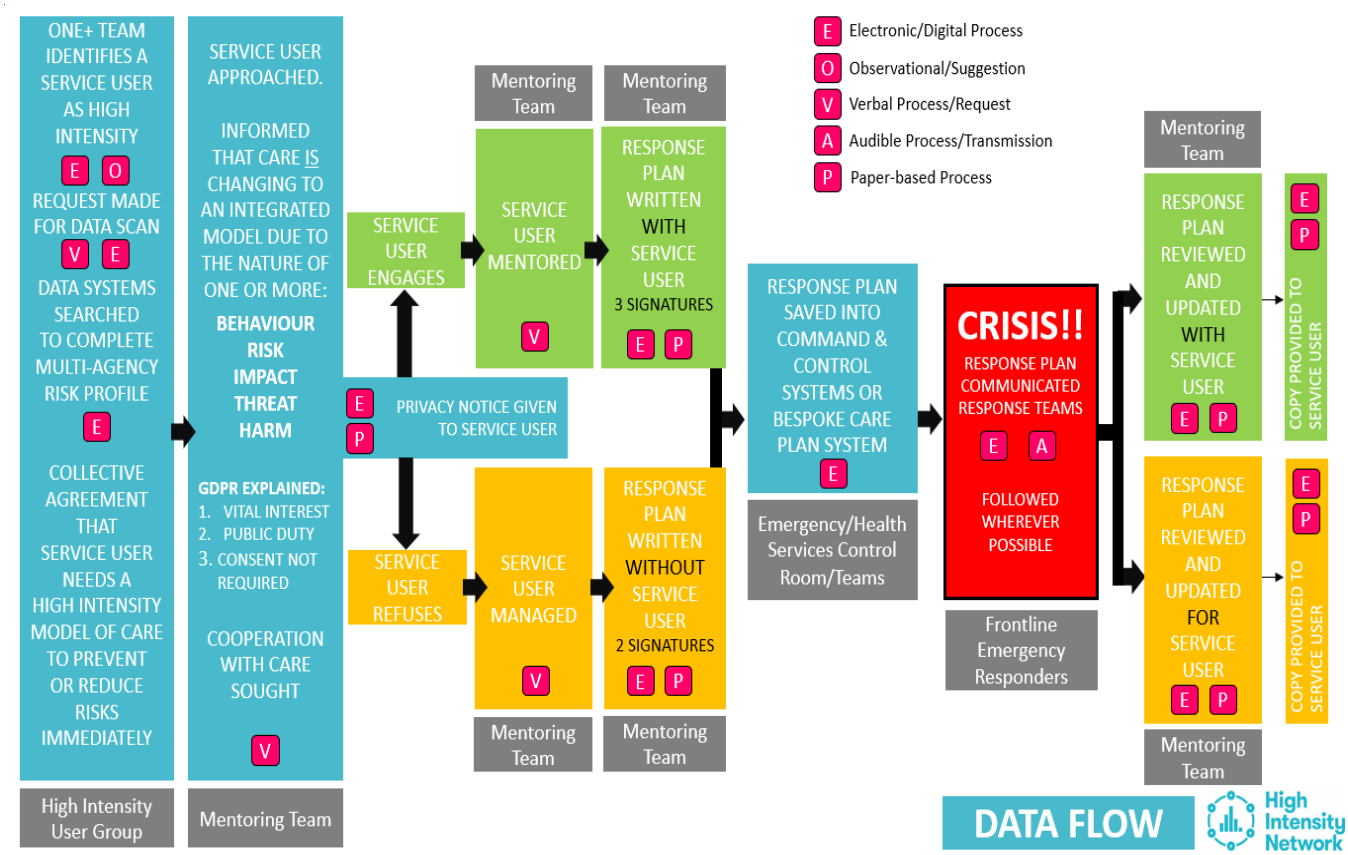
- Case Management and Risk

23. Complaints
23.1 Any complaints or allegations made towards any mentor will be dealt with according to Trust procedures.

24. References
PALS & Complaints Policy
Care Programme Approach (CPA) Policy
Clinical Risk Assessment and Management Policy
Newham Adult Community Recovery Teams Operational Policy
High Intensity Network Operational Delivery Guide, Version 10, July 2018
High Intensity Network Information Sharing Agreement

Appendix 1

Information Flow



Secure routes of transfer (for instance CJSM, NHS.net mail, Egress Switch) will be used to transfer information between signatories.

Appendix 2
Information Shared