WORKING DRAFT

OPERATIONAL POLICY
BEDFORDSHIRE
CRISIS RESOLUTION & HOME TREATMENT TEAM

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INTRODUCTION & PURPOSE

The Crisis Resolution and Home Treatment Team (the Service) provides a system for the gatekeeping rapid response and assessment of mental health crisis in the community with the possibility of offering comprehensive acute psychiatric care at home until the crisis is resolved, usually without hospital admission. Acute care is delivered by a specialist team to provide an alternative to hospital admission for individuals with serious mental illness who are experiencing acute difficulties. It provides a credible alternative to

treatment for mental health crisis in the community, to minimise stigma, increase patient choice and facilitate recovery.

The CRHT promotes decision making by the service user, in order to empower service users and work in line with the personalisation agenda where applicable.
It works on the principle of social systems, and involves carers and social networks in enabling recovery, while balancing this with respect for patient confidentiality. CRHT would offer needs assessments where applicable. Interpreting service will be used for Service user where needed.

The Service gate- keeps all admissions to the Assessment and Treatment Units.

The aim of the Service is to treat Service Users in the least restrictive environment, with minimum disruption to their lives in a range of settings which offers an alternative to inpatient care. Bedfordshire and Luton CRHT, in partnership with the CORE 24 services, strives to provide urgent care and assessment 24 hours a days, 365 days a year. The service also aims to facilitate early discharge from hospital for those still requiring the intensity of care involved during an admission but who can safely be managed in a less restrictive environment.

HOURS OF OPERATION

Both Luton and Bedford CRHT operates a 24/7 service and is located at the following address:

Luton and south Bedfordshire CRHT.
Calnwood Court.
Calnwood Road.
Luton.
Bedfordshire.
LU4 0LX
Telephone number: 01582 556971
Operational Times: 24/7

Luton CRHT cover Luton, Streatley, Leighton Buzzard, Dunstable, Woburn, Woburn Sands, Toddington and surrounding villages

Bedford and Mid Bedfordshire Crisis Resolution and Home Treatment Team.
Florence Ball House.
Bedford Health Village.
Kimbolton Road.
Bedford
MK40 2NT
Tel: 01234 315691
Operational Times: 24/7

Bedford CRHT cover Bedford, Biggleswade, Shefford, Flitwick, Harlington, Barton –le- clay, Westoning and surrounding villages.

As a guide the CRHT are divided by the M1 motorway with Luton CRHT covering the west side and Bedford CRHT covering the East side.

SERVICE DESCRIPTION

The CRHTT provides acute home treatment for adults aged 18 and upwards with no upper age limit whose mental health crisis is so severe that they would otherwise be admitted to an acute inpatient ward.
There is an interim care pathway for OPMH joint working process with functional mental health illness in Crisis (please see appendix 2)

Team structure:

The Luton and Bedfordshire CRHT is a multi-disciplinary team with a work-force that provides a skill mix aiming to provide high quality and holistic care:

- Operational Manager and Clinical Leads
- Mental Health Nurses
- Social Workers including AMHPs
- Clinical Psychologists
- Assistant Psychologists
- Support Workers
- Administrative staff
- Associate Specialist and Trainee Doctors
- Peer support workers
- Consultant Psychiatrist providing Clinical Leadership
- Occupational therapist

The Luton and Bedfordshire CRHT provides urgent care for mental health related crises. The CRHTT delivers care seven days a week and has the capacity to visit service users up to twice a day according to need.

Services Provided

- Crisis Triage Assessments
- Home Treatment
- Psychology (for those open to CRHT, not those that are accessing secondary care)
- Medical Reviews
- Early Discharge
- Gate Keeping

Duty Coordinator (previously called Nurse in Charge)

There is a Duty Coordinator assigned to each shift that functions as a focal point of contact for the team to triage calls, prioritise assessments and home treatment activities. The Duty Coordinator will be a senior member of the CRHTT on duty.

The duties allocated to staff working on each shift correspond to the following roles and enable the CRHTT to deliver its core functions. These are:

Duty Coordinator:

- Coordinating and leading handover meetings.
- Deputising for the Clinical Team Lead in their absence.
- Escalating all matters of concern regarding assessments and home treatment to the CRHTT Clinical Team Lead and medical staff as required.
- Providing a comprehensive handover of all matters relating to the care and treatment of service users on the CRHTT caseload, to the CRHTT Clinical Team Lead and medical staff as required.
- Discussing all referrals with the wider MDT as appropriate.
- Delegating responsibilities to staff, including the update of care plans, risk assessments and other clinical records.
- Triaging referrals and dealing with clinical information pertinent to the function of the CRHTT.
- Ensuring staffing levels are appropriately maintained for the shift and that any rota requirements for the following shifts are dealt with.
- Ensuring that there is an effective handover of pending duties with the oncoming shift coordinator including planned assessments.
- Ensuring that all documentation is completed by team members before the end of each shift.(RIO)
- Liaising with staff completing all very urgent and A&E assessments, to ensure that decisions regarding referrals are appropriately discussed with the wider CRHTT MDT.
- Triaging and allocating assessments.

CLINICAL AND MEDICAL RESPONSIBILITY

The Consultant Psychiatrist and Team Manager are responsible for overseeing, supervising and managing the clinical work of the team as a whole. Such supervision and responsibility can be delegated by the Consultant Psychiatrist to other medical staff within the team and by the Clinical Team Lead to other team members.

This process is conducted through the day-to-day shift handovers at which all team staff are present, alongside medical staff and either the Clinical Team Lead or senior members of the team.

REFERRAL PROCESS

CRHT now operate a no wrong door policy, referrals are accepted and triaged from all parties, inclusive of self-referrals and those from carers and relatives. In the cases where referrals are made from carers and

relatives CRHT must strive to gain consent from the service user to complete the assessment. If consent is unable to be established CRHT should continue to try and make contact with the service user to ensure that the triage takes place.

For those service users that are open to secondary care service the expectation is that the CMHT must be seen (video call expected as the minimum) by their Care coordinator/ Team CPN, Duty worker or Doctor within the past 24 hours before CRHT accepts the referral. For service users who are on CPA, the care co-ordinator must provide up-to-date care plan, risk assessment, needs assessment and previous discharge summaries. All written referrals must be emailed to

Bedford: elt-trBedfordCRHTTReferrals@nhs.net

Luton: lutoncrhtreferrals@nhs.net

Followed up by a telephone call to ensure the team pick up the referral.
Referrers should be made aware that home treatment is an alternative to inpatient treatment and should only refer those service users showing relapse indicator and without the input of intensive home treatment and crisis intervention may require admission.
The referrer should be available to discuss the service user and give a verbal handover to a member of CRHT. All referrals must be written on the approved CRHT referral form.

Triaging and Assessment are to be completed by a qualified member of staff and the expectation is that all assessments take place face to face.

BEDFORDSHIRE CRHT staff will triage all referrals within 4 hours;

Urgent to be assessed within 4 hours. This is defined as an acute risk to self or others that cannot be managed without CRHT intervention responding within the 4 hours.

Non Urgent to be assessed within 24 hours. The risk or needs presented in the referral are able to be managed with a short term plan prior to assessment taking place, for example family support, informing service user and relative of alternative out of ours support such as CRHT and the Hub.

If AMHP has completed a full MHA assessment and the recommendation is for home treatment with CRHT this service user will be accepted for home treatment without further triage.

CRHT would not be able to accept referrals for service users who are not traceable in the community or have not been seen.

Crisis Pathway Referrals

Referrals from Crisis Pathway Service such as PLS, Street Triage, EDT (out of hours) must have a safety plan/risk management plan in place as they have been seen face to face by a health care professional. These referrals will be triaged as non-urgent and assessed within 24 hours.

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RAG (Red, Amber Green) Status

CRHTT uses a traffic light systems to rate patients' risk which is reviewed daily

RED

A patient who requires up to 2 contacts a day. Eg patients who are unwell but manageable in their home setting with daily visits by Crisis practitioner. Patients have insight into their illness and recognise risk and agrees a saftey plan.

AMBER

A patient who requires contact on alternative days. Patients who are recovering. Risk factors have decreased and patients feel safe with reduced contact with services.

Green

A patient who has one of the following indicators:

- Requires contact less than 2 times a week.
- is ready for discharge
- is at the last stage of their crisis and risk is classified as low.

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Reasons for signposting to alternative services

Those Service Users who do not present with an acute mental health crisis but who would benefit from other specialist mental health intervention will be passed on to the relevant Community Mental Health Team, Early Intervention Team based on a triage or face to face assessment of their individual needs and risks.

Residents of Luton and Bedfordshire (BEDFORDSHIRE) who are under the age of 16. (Please refer to CAMHs crisis service)

Residents of BEDFORDSHIRE whose mental illness is of a severity where risks to selves or others cannot be contained in the community even with the support of CRHT.

Adults whose main needs are assessed to be chronic or physical health/ frailty/ cognitive impairment related where the crisis is not deemed to be related to mental health.

People whose mental health problems are the result of organic disease such as dementia.

Those with chronic high levels of self-harm, with no recent increase or exacerbation that require longer term care not short term intervention.

Adults whose main difficulties relate to substance or alcohol misuse who do not have a comorbid mental illness. Mental state assessments cannot be undertaken by the CRHT whilst the service user is significantly impaired by alcohol or other substances

Patients who are being sent on overnight leave returning in less than two nights.

Home Treatment

All staff complete visits to service users within the community. The expectation of these visits is to provide holistic care to aid their recovery. Staff will work together with service users to develop individual care plans which can then provide continuous care allowing different staff having to visit. Where possible the same staff will visit if working continuous day. Staff must also use their time during home visits to implement plans from the MDT and follow up outstanding actions e.g completing referrals.

All staff to inform and update Duty coordinator of changes to risk and community care

** safe staffing**
http://elftintranet/sites/common/Private/Contentobject_View.aspx?id=43036

http://elftintranet/download/57b77149-7899-4364-a474-1a3917a44aff/f/Guidance_notes_Safe_Care.docx

Medical review will be completed as soon as reasonably possible by one of the CRHT doctors based on consideration of the 72hr timescale, our best practice model would be within 24 hours. Exception: those that are accepted for early discharge and have established medical plans.

Every service user that is being supported with home treatment will be discussed in weekly Multi-Disciplinary Team Meetings and recorded in each service user's notes.

Red visits to be completed by qualified members of staff. All discharges to be completed by qualified members of staff. Visits must not be fleeting or superficial.

Review down of RAG status must always be assessed by qualified staff. All members of the team can uplift a service user's RAG status based on their risk assessment and presentation.

To involve family and carers in home treatment plans, provide them with both education and carer's assessment as required.

EARLY DISCHARGE and Leave Support

When hospitalisation is necessary, teams will be actively involved in the arrangements for admission and linking with acute inpatient units in offering joint ongoing care in which the best balance and staging of inpatient and community care is coordinated. Before discharge, teams can support leave from hospital, working with inpatient and community mental health team staff to respond to ongoing need.

Luton CRHTT are responsible for early discharge assessment on Crystal Ward, Onyx Ward and Coral Ward. Bedford CRHTT are responsible for early discharge assessments on Townsend Court, Ash Ward, Willow Ward, Poplars and Fountains Court. Both teams will assess all patients on their locality wards and refer service users to their locality CRHTT if required. In those cases where there are complex needs the CRHTT who will be providing the support in the community should be invited to complete that assessment. CRHTTs are to liaise between themselves to facilitate this.

CRHTT are commonly able to facilitate earlier discharge because intensive acute support can continue in the home setting once the pressing or immediate requirements for admission are no longer exerting such an influence. Good structured communication, active and early joint involvement in discharge planning is a routine task towards achieving this, and smoothing the transition between the different elements of the acute service. Throughout this collaboration the service user and their family should be fully consulted and involved in discussing options. When the CRHTT is facilitating discharge from hospital, the ward must provide the care plan, including risk assessment, needs assessment and a discharge summary.

In order for early discharge to take place there must be evidence to show that the presenting risks and symptoms of the service user that indicated their hospital admission have reduced to a point where home treatment is safe for the service user, their family/carers and the CRHTT. This home treatment should continue until the service user's mental health has improved to a state where they can either be transferred to secondary mental health services or referred back to their own GP.

The allocated member of the team staff will then discuss any new referrals for early discharge with other members of the team and wherever possible the team Consultant. If, after assessment the service user is not accepted for home treatment, the team must clearly identify the reasons why early discharge is not appropriate and identify what changes to the service user's presentation need to occur before a referral for early discharge by the CRHTT will be reconsidered. It is necessary that the inpatient medical team is aware and agreed to the referral. Referrals must be made before a service user is discharged from hospital. The CRHTT should, where possible, be involved with leave plans before they occur. Referral for longer-term service provision should be initiated by ward staff as soon as possible after admission (i.e. CMHT, Psychology, and Forensic Assessment etc). It is the responsibility of the inpatient medical team to formally medically review the patient prior to discharging the service user from hospital.

GATEKEEPING ADMISSIONS

The CRHT are responsible for gatekeeping all adult and older adult Beds. The CRHT will gate keep all informal admission 24/7 and liaise with the DSN.

- Inpatient admission wards must not accept direct referrals without first discussing them with the CRHT Duty Coordinator,
- Crisis Resolution/Home Treatment team must act as a gate-keeper to all admissions to the Trust's mental health psychiatric inpatient care as set out in 'Guidance Statement on Fidelity and Best Practice for Crisis Services'.
- This applies to all service users admitted to the adult wards.

The following cases can be excluded:

- internal transfers of service users between wards in a trust and transfers from other mental health trusts
- patients recalled on Community Treatment Orders; or
- patients returning from leave under Section 17 of the Mental Health Act 1983
- Patient detained under the MHA (gatekeeping record must be recorded)

Definition of gate-keeping:

- An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission or if they were involved in the decision-making process, which resulted in admission and consulted about such admission.
- CRHT will need to be notified of all pending Mental Health Act assessments and be assessing/reviewing all these cases before admission happens.

Practical steps to be taken

- Need for bed identified and **CRHT Shift Lead/ CRHT Clinical Leads contacted by referrer**. DSN must not accept bed request from referrers.
- CRHT staff to check patient details – if NOT REGISTERED IN BEDFORDSHIRE OR LUTON to advise the referrer to contact the patients local team and arrange admission to their area (only in exceptional circumstances should an OOA patient be admitted to a BEDFORDSHIRE OR LUTON bed i.e. if they are too unwell to transfer)
- CRHT screen for suitability for bed ensuring least restrictive options have been considered. Face-to-face assessment can be carried out if appropriate
- CRHT contact DSN and identify bed for admission(bed management remain with DSN)
- Bed identified and referrer informed by CRHT. Referrer and DSN linked and bed arrangement finalised
- Entry placed on RiO by CRHT Gate-keeper.
- CRHT Gate-keeper or admin to also enter contact in their RiO diary and complete the appropriate outcome.
- Referrer to then liaise with ward to plan admission. It is the referrer's responsibility to arrange appropriate transport ward, not CRHT.

CRHT practitioner Guidance for Gate Keeping

"Agreed intervention strategies for physical and mental health; Measurable goals and outcomes; Strategies for self-management; any advance directives or statements that the service user has made; Crisis and contingency plans; Review dates and discharge framework" – Home Treatment Accreditation Scheme (HTAS May 2017)

Gatekeeping from other services

- Assessment Purpose of admission e.g.: management of risk (suicidal etc.), medication review - initiation/ titration, acute symptom management.
- What community support has been considered e.g., CRHT support, increase support from CMHT, family and carer's.
- •Anticipated length of admission
- Interventions- What expected outcomes want to be achieved via the admission with service views; e.g. developed coping strategies, medication changes, attendance to personal hygiene.
- Care planning -What support will be needed for discharge e.g. CMHT, Penrose, Mind

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Informal admission via CRHT

- Assessment Purpose of admission e.g.: management of risk (suicidal etc.), medication initiation/ titration, acute symptom management.
- Interventions What expected outcomes want to be achieved via the admission with service views; e.g. developed coping strategies, medication changes, attendance to personal
- Care planning What support will be needed for discharge
- Discharge Planning, date for review, ward to complete comprehensive safety plan for discharge

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Gate keeping Guidance for colleagues to be clear on what is expected when calling CRHT

- To ensure that the admission is the most appropriate form of care at this time and there are no alternative options for support.
- To confirm the purpose of the admission and the interventions required.
- Plan for the first review date for the ward to consider discharge back to community services
- For each service user to have a robust and person centred safety plan. Focusing on "service users' strengths, self-awareness, sustainable resources, support systems and distress tolerance skills and should reference the management of transitions"

Assessment

The formal assessment begins at the point of direct contact between the CRHTT and the service user and extends through to the time when a comprehensive care plan is developed for the service user.

A comprehensive assessment procedure includes direct discussion with the service user and relevant carer/family members, contact with treating clinicians if appropriate and available, mental state examination, physical assessment, social and environmental circumstances. Service users must be given the opportunity to contribute information on their history and current situation. However, details must be verified and relevant and necessary information must be obtained from significant others.

Risk assessment should include significant people in the service user's environment, without the service user being present.

Documents that are to be completed at all assessments minimum are;

- Recovery Care pathway- Clinical Assessment
- History and Context
- My Safety Plan
- Risk assessment
- Letter to be sent to GP of outcome from assessment

Where it is established through the formal assessment process that the service user is not suitable for on-going CRHTT service because they do not meet the intake criteria, then the assessment will be concluded and the individual referred to another appropriate service or back to the referrer. However, the needs of the service user and family/carer will always be of primary consideration.

Assessments will be documented in line with CPA requirements and the approved Integrated Care Pathway for Acute Care and records maintained according to the Trust's Records Management Policy.

Co-Morbidity

The CRHTT is accessible to people with learning disabilities in line with the standards of the Greenlight Toolkit enabling service users to have reasonable adjustments made so that they can access mental health services and when CRHT support these service users the team should strive to practice joint working with IST to ensure they are given fair access to care and their needs are being met.

CRHTT will consider people who have dual diagnosis with drug and alcohol problems; however the primary presentation needs to be a mental health crisis at the time of referral to the CRHTT with joint work with Pathway to recovery. CRHTT works in collaboration with pathway to recovery and will accept direct referral by staff in that service.

Adults with mental health problems in an acute psychiatric crisis of such severity that, without the involvement of the BEDFORDSHIRE CRHTT, hospitalisation would be necessary.

BEDFORDSHIRE CRHT would work proactively to offer secondary prevention and reduce mental health morbidity and promote wellbeing and recovery

The team will be flexible and will not put barriers to access CRHT support.

Physical Health

With service users that have additional physical health concerns we must work closely with our colleagues in primary care teams. Please see Bedfordshire and Luton Physical GP Liaison Protocol.

All health and care professionals have responsibility in delivering closer integration between physical health and mental health. It is important that all professionals are willing and able to take a 'whole person' perspective, and be able to support integration of mental and physical health. This will involve working alongside the primary care sector. There is an increasing awareness of co-morbidity and the need for different health sectors to work in collaboration to achieve the best health outcomes for patients irrespective of which service they present at.

Discharge

Where it is established through the formal assessment process that the service user is not suitable for on-going CRHTT service because there needs do not require CRHT intervention. The assessment will be concluded and where appropriate will be signposted to additional services if required. However, the needs of the service users and family/carer will always be of primary consideration. The service user and their carers will be informed of the plan. Decision and plans to be shared with original referrer and GP.

All discharges are to be discussed with the team and where possible a senior member of the team, such as clinical lead, Doctor, Psychology.

The CRHTT prior to discharge should ensure that:

The decision to discharge from the team should be made through consultation between the CRHTT Multi-Disciplinary Team, the care coordinator (if assigned), the service user and carer.

Service users under CPA, discharge should be planned in conjunction with the service users care coordinator and whenever possible a joint visit should take place.

Upon discharge from home treatment, the Doctor will complete the discharge SUMMARY WITHIN 48 HOURS.

Where a decision is made to discharge a service user directly back to the care of a GP, it is good practice for a worker from within the team to notify the GP Practice before the service user's discharge and if possible discuss the on-going treatment plan with the relevant GP.

Referrals onward will be left open to the CRHT until the receiving team have opened the care, Nurses should not solely relay on email but also confirm with telephone communication to the respective team.

Clinical Governance

The service will ensure that it will have an embedded comprehensive system of clinical governance as evidence of a clinical review culture that will enable the following to be ensured:

Ensuring patient safety: Achieved through the process and practice of risk assessment, reflective practice including learning from untoward events, professional consultation, clinical supervision and record keeping.

Measurement of patient outcome: Achieved through the use of standardised and non-standardised measures suited to patient need, goals, clinical presentation and their experience of the services.

Service effectiveness: Achieved by following best practice including NICE guidelines, meeting Trust key performance indicators and the metrics detailed in the contract specification and management supervision.

Capacity management: Team Manager and Clinical leads will monitor peaks and troughs in caseload activity, and proactively prioritise aligned worker activities, and/or increases/decreases in resource levels, so as to ensure patients receive timely interventions and are discharged appropriately. The Clinical Leads will be accountable and Team Manager will be responsible for monitoring caseload activity on a daily basis, taking the appropriate coordinated actions with the Clinical Lead to resolve any clinical, medical or operational bottlenecks that are not enabling patients to receive appropriate acute care in the community and/or other services, and subsequently creating capacity to management pressures within the service.

WORKER SAFETY

All workers will follow the Lone Working Policy.

SAFEGUARDING OF ADULTS AND CHILDREN

All staff are trained in safeguarding and is expected to act in the best interest of the patients once a concern is identified. This will include raising SOVA, MASH LADO.
ELFT has a dedicated safeguarding team who work closely with the local authority to ensure Safeguarding concerns are raised and followed up.
Refer to trust policy.
Where the service user does not consent to disclosure, others should only be told information in general terms or in accordance with recognised CPA and medical practice.

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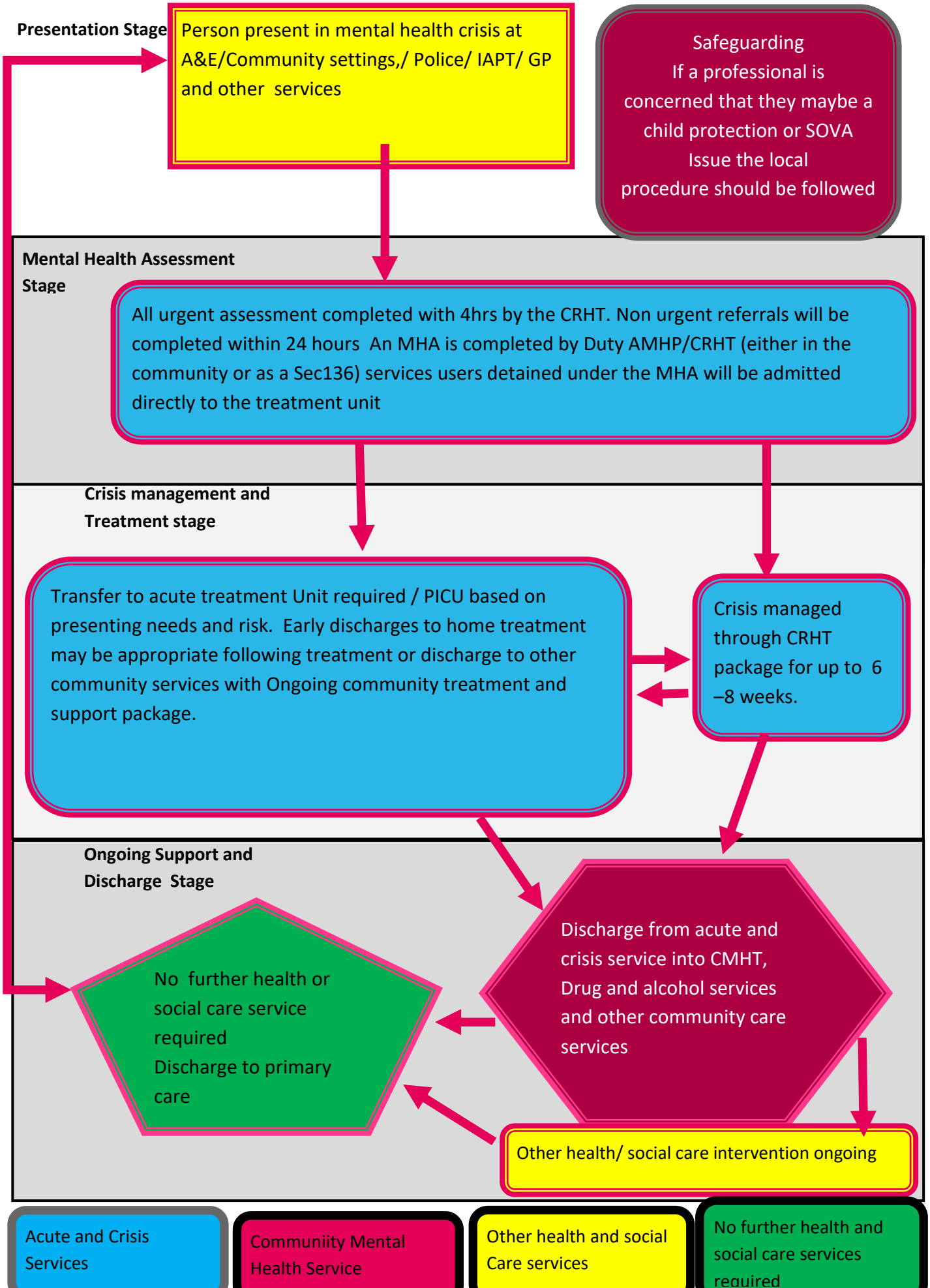
CARE PATHWAY FOR ACUTE AND CRISIS SERVICES



Older Persons Protocol

Bedfordshire CRHT are configured as a working age adult service and will need close support and access to the expertise of our colleagues in the Older Adult CMHTs and Older to manage these patients effectively and safely.

We have discussed and agreed some extra conditions that will need to be met in order to provide safe and effective care to older adults with functional mental illness and these are documented below:

1. All referrals of individuals over the age of 65 to CRHT will need to be triaged by the older adult services prior to the referral being accepted. The older adult CMHTs will need to assess the individual to confirm that they are experiencing an acute, severe functional mental illness requiring home treatment to prevent subsequent admission to psychiatric hospital. Organic illness needs to be excluded prior to referral to CRHT. Referral to CRHT is discussed among doctors for acceptance.

   If referral by GP is after 4:15pm, then GPs can be advised to refer directly to CRHT. However, GP would need to review patient themselves before making such referral and if concerns regarding acute confusional state then signposting to A&E should be considered.

2. Treatment under CRHT will be in partnership with the older adult CMHT with allocation of care coordinator and weekly joint visits with care coordinators. Similarly, when patients are discharged from CRHT then joint discharge meeting with care coordinator should be arranged.

3. If a patient over the age of 65 is seen and assessed by liaison psychiatry and it is felt that a referral to CRHT is appropriate, the liaison service will refer to CRHT. They should also inform older adults CMHT of such referral being made.

   Role of older adults CMHT in such cases-

   - Patients open to CMHT and on CPA - then care coordinator will make contact with CRHT within 24 hrs and plan a joint review within 72 hrs.

   - Patients open to CMHT and non CPA – CRHT doctor can seek advice from CMHT doctor regarding management

- Patients not open to CMHT- If more than 70 years old then CMHT doctor should plan initial review with CRHT to formulate the management plan within first week.

- Patients not open to CMHT – Over 65 to 70 years. Does not require older adults CMHT doctor review.

4. Patients, who are referred by out of area Crisis / HTT / PLS teams, would not be directly accepted by Bedford CRHT. This should follow the same pathway as advised in step 1.

These agreements may need to be reviewed in the future.