OPERATIONAL POLICY
BEDFORDSHIRE
CRISIS RESOLUTION & HOME TREATMENT TEAM

OPERATIONAL POLICY NUMBER:	1.0
VERSION NUMBER:	Version A
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CONSULTATION GROUPS:	DMT
IMPLEMENTATION DATE:	02/04/2019
AMENDMENT DATE(S):	24/01/2020
LAST REVIEW DATE:	24/01/2020
NEXT REVIEW DATE:	
APPROVAL BY SERVICE MANAGEMENT BOARD:	

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INTRODUCTION & PURPOSE

The Crisis Resolution and Home Treatment Team (the Service) provides a system for the 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.

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

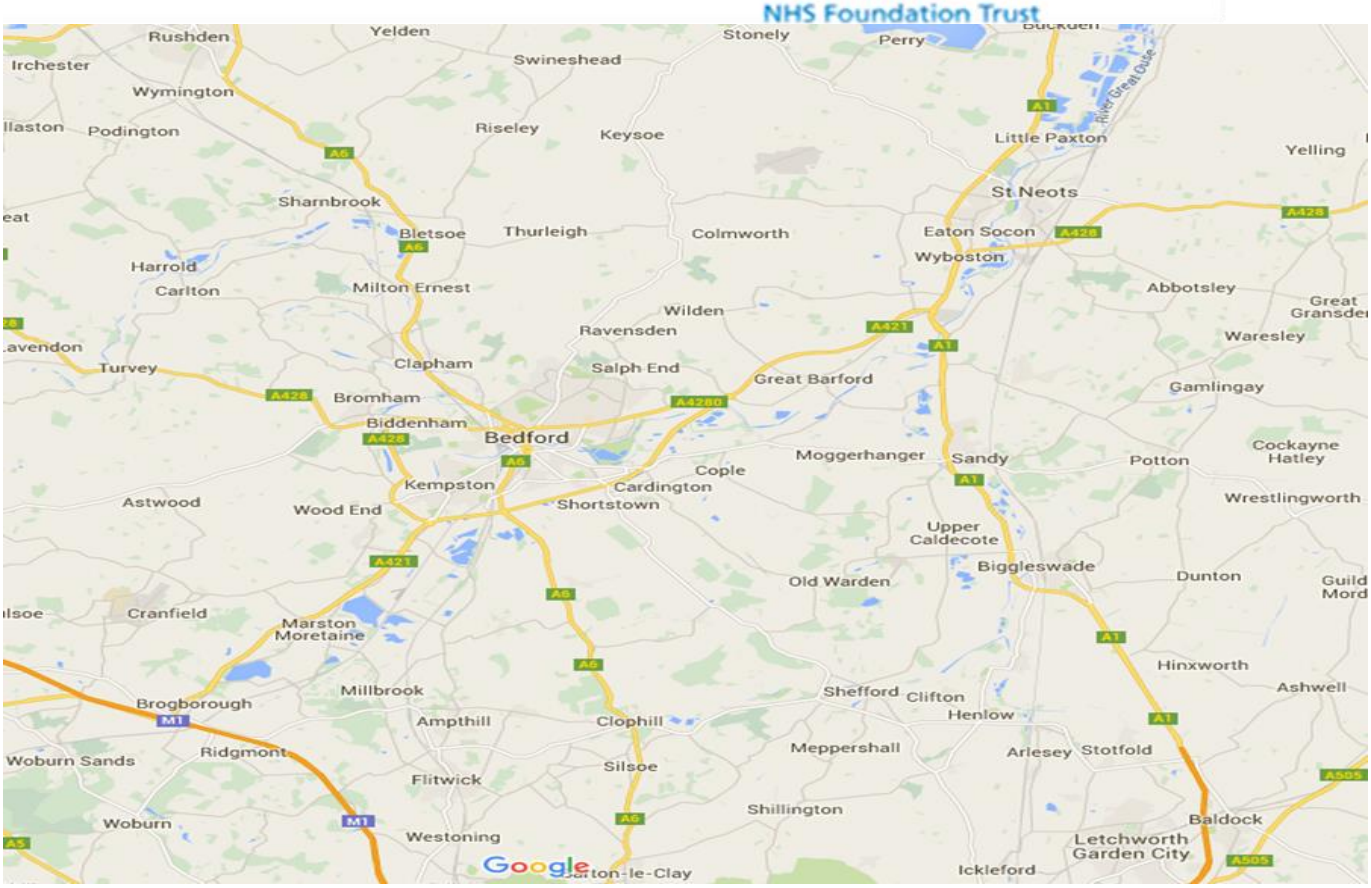
The aim of the Service is to treat Service Users in the least restrictive environment, with minimum disruption to their lives in a range of settings which offers an alternative to inpatient care. Bedfordshire and Luton CRHT, in partnership with the CORE 24 services, strives to provide urgent care and 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

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



SERVICE DESCRIPTION

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

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 times a day according to need and operational capacity of the team.

Patients open to the team that develop a crisis outside our working times can ring the crisis line 24hrs a day. 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.

CLIENT GROUP AND ACCESS CRITERIA

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

PATIENT ZONING CHART

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 there home setting with daily visits by Crisis practitioner. Patients has insight into their illness and recognises 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 deduced contact with services

Green

A patient who requires contact less than 2 times a week or is ready for discharge
A patients who is now at the last stage of their crisis and risk is classified as low

.

Co-Morbidity

The CRHTT is accessible to people with learning disabilities in line with the standards of the Greenlight Toolkit and joint working with IST.

The service 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.
Luton and Bedfordshire Care Pathway:

Inclusion Criteria:

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

L&B 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.

EXCLUSION CRITERIA

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 who are under the age of 16. (please refer to CAMHs crisis service)
Residents L&B whose mental illness is of a severity where risks to selves or others cannot be contained in the community within the capacity of L&B 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.

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.

REFERRAL PROCESS

All referrals from primary care for service users open to CMHT must be seen by their Care coordinator or Duty worker before CRHT accepts the referral.
The L&B CRHT will expect the referrer to have assessed the service user in the previous twenty four hours prior to making the referral. 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.

The referrer should be available to discuss the service user and give a verbal handover to a member of CRHT. All referral must be written on the approved CRHT referral form.
L&B CRHT staff would strive to assess every valid referral within 24hrs for non-urgent referral and urgent referrals will be assessed in a timely manner usually within 4 hours. Correspondence of this decision will be sent to referrer on the same day.
Referrers should note that home treatment is an alternative to inpatient treatment and should Only refer those service users showing relapse indictor and without the input of intensive home treatment and crisis intervention may require admission.

All new referrals will require an assessment by a qualified health practitioner prior to acceptance by the CRHT. This should have taken place face-to-face during the previous 24 hours and ensures the person is medically fit and agreeing to be seen. Some referrals will be received from non-medical staff including first contact nurses. It is imperative that the referrer has actually seen the service user and thereby retains the ability to provide the above information accurately.
Referrals must be assessed initially at primary care level on direct contact with the service user or CMHT and specialist service if open on their caseload. It is inappropriate to refer service users solely on the basis of third party information (eg.such as a telephone call from a neighbour or relative).
A care coordinator or duty worker at a CMHT who is considering making a referral, they should discuss this with the CRHT duty worker before sending 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.
If EDT or AMHP is assessing a service user deemed to be suitable for CRHT the clinician should discuss this decision with CRHT base on trusted assessment and lease restrictive practice.
Out of hours referrals should be discussed with the Duty Senior Nurse who will act as gatekeepers out of hours. (this will change in December 2019 when CRHT implements a24/7 service)
CRHT would not be able to accept referrals for service users who are not traceable in the community or has not been seen.
The CRHT act as 'gate-keepers' for all potential L&B admissions to the inpatient services in Bedfordshire. The CRHT needs to be informed of all admissions including those under the MHA, in accordance with the local admissions policy.

Physical health of service users living in the community will be jointly managed with the primary care teams. See attached protocol.

Psychiatric liaison Referrals.

Referrals from PLS will be treated a trusted assessment and triaged in daily handovers. All referrals that meet the criteria will be accepted and those that don't meet the criteria will have a review assessment. (see inclusion and exclusion criteria)

INTEGRATED CARE AND EARLY DISCHARGE

- 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.

- Crisis Resolution /Home Treatment teams 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 CRHT is facilitating discharge from hospital, the ward must provide the care plan, including risk assessment, needs assessment and a discharge summary.
- Early discharge assessment are allocated based on sites. Luton CRHT will assess all patients in there locality and Bedford CRHT for the Bedford locality.
- 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

GATE KEEPING

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 BEDFORSHIRE 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.

Assessments

The assessment pathway will follow that of the Trust's policy and procedure for CPA. 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.

The assessment should be conducted in a way that maximises the co-operation and involvement of the user, carer, family and significant others, and meets the needs of the situation. The consent of the client (and guardian where appropriate) should be sought regarding their involvement and the disclosure of information, so that questions of breach of confidentiality do not arise.

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.

The CRHTT worker must be thorough in the assessment of people with apparent psychiatric disturbances, recognising that signs and symptoms of mental health disturbance may be presenting features of a psychiatric, neurological or medical problem.

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 user being present.

See RIO for assessment documents.

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.

East London NHS
NHS Foundation Trust

CARE PATHWAY FOR ACUTE AND CRISIS SERVICES

Presentation Stage

Person present in mental health crisis at A&E/Community settings,/ Police/ IAPT/ GP and other services

Safeguarding
If a professional is concerned that they maybe a child protection or SOVA Issue the local procedure should be followed

Mental Health Assessment Stage

All urgent assessment completed with 4hrs by the CRHT. An MHA is completed by Duty AMHP/CRHT (either in the community or as a Sec136) services users detained under the MHA will be admitted directly to the treatment unit

Crisis management and Treatment stage

Transfer to acute treatment Unit required / PICU based on presenting needs and risk. Early discharges to home treatment may be appropriate following treatment or discharge to other community services with Ongoing community treatment and support package.

Crisis managed through CRHT package for up to 6 –8 weeks.

Ongoing Support and Discharge Stage

Discharge from acute and crisis service into CMHT, Drug and alcohol services and other community care services

No further health or social care service required
Discharge to primary care

Other health/ social care intervention ongoing

Acute and Crisis Services

Communiity Mental Health Service

Other health and social Care services

No further health and social care services required

.
Medical review will be completed as soon as reasonably possible by one of the CRHT doctor's base on need.

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.

WORKER SAFETY

The following principles form the basis for safe practice:

All workers will follow the Lone Working Policy.

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.

DISCHARGE PLANNING FROM CRHTTT

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 subject to 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.

Integrated mental health and physical health

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 along side 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.

ROLES AND RESPONSIBILITIES

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 medical staff.
- 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.
- 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.

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

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.

For All detailed process please refer to CRHTT manual