journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Crisis Resolution and Home Treatment Team (CRHT) Operational Policy (AMH)

(including AMH addendums, MHSOP CRHT)

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Contents

1 Introduction

This operational policy describes and explains the role and function of the Crisis Resolution and Home Treatment Team's (CRHT). Whilst no policy can capture every process of the service, it is intended to provide a clear ethos of care.

The document is split into 2 main sections:

1. The initial overarching policy defines the service and explains its purpose and function.
2. The second section consists of a series of addendums pertaining to each Clinical Care Group and team information.
3. There is a separate 111 Select Mental Health Process as a subsidiary of this policy.

Within Tees Esk and Wear Valleys NHS Foundation Trust (TEWV) there are several CRHT's covering specific geographical areas. This policy relates to the adult CRHT teams in Durham and Darlington, Hartlepool, Middlesborough, Redcar & Cleveland, Stockton (Durham Tees Valley and Forensic, Clinical Care Group) and Hambleton and Richmond, Harrogate and Ripon Rural areas, York and Selby and Scarborough Whitby Ryedale (North Yorkshire, York, and Selby Clinical Care Group).

1.1 Context

Tees Esk and Wear Valleys NHS Mental Health Trust (TEWV) serve patients across a large geographical area. Our main towns and cities are Durham, Darlington, Middlesborough, Scarborough, Whitby, Harrogate, Ripon, York, and there are numerous smaller seaside and market towns scattered throughout our geography. We are also in the catchment area for the largest concentration of armed forces personnel in the United Kingdom (UK) (Catterick Garrison). With over 7,500 staff, we deliver our services by working in partnership with patients and their carers/families, Primary Care, Ambulance Trusts, Acute Trusts, Local Authorities, Police, and Integrated Care Boards (ICBs), a wide range of other providers including voluntary organisations and the private sector.

In June 2020, NHS England requested that all Mental health Trusts establish a single point of access/line for crisis services in response to the Covid-19 pandemic and in line with the Long-Term NHS Plan (2019). Crisis services need to be openly accessible, and numbers are available to all on the NHS pathfinder website. This has helped to improve access to crisis services and diverted individuals from Emergency Departments (ED) whilst protecting the public from Covid-19 transmission.

Following on from the above, the Long-Term Plan (2019) ambition for 2023/24 comprehensive crisis care pathways will be enhanced and developed to ensure 100% coverage of 24/7 age-appropriate crisis care via the freephone, 111 select mental health option across the country.

In April 2024, 111 select mental health which is now the single point of access for mental health crisis was introduced in the Trust/region/s. The line provides access to all age response within the respective care groups. (Please refer to the 111 select Mental Health Process).

CRHTs and their functions have **not changed**, they still provide triage, face to face assessment, and Intensive Home Treatment (IHT) although some CRHTs have distinct teams now to deliver these aspects, along with central hubs where referrals come into.

The age range that TEWV CRHTs work with are those aged 18 years and over, however most teams deliver crisis intervention to those over 65 years (functional mental health conditions). There are also commissioned Child and Adolescent Mental Health Crisis Teams and Older Persons crisis teams in some areas, these would see and treat those with both functional and organic presentations. During out of office hours, individuals with diagnosed or suspected learning disability who need crisis support will be supported by the adult mental health crisis team.

Provision of universal crisis service is aspired to, and teams collaborate with colleagues in other specialities.

There are three main locality Adult Mental Health (AMH) CRHT's teams which cover the geographical area and nine local authorities, who are all working together to fulfil the aims set out in the NHS Long Term Plan (2019) and standards for CRHTTs (Quality Network Crisis Resolution Home Treatment Teams- (QNCRHTT), Royal College of Psychiatry).

CRHT teams are generally made up of mental health professionals such as Mental Health Nurses and Consultant Psychiatrists, Psychologists, Psychology associates and Support Workers; however some may also have staff from other professional backgrounds for example: Occupational Therapists, Social workers; with links to other professionals as required including psychological therapists, peer support workers (in some teams) and pharmacy support along with students from all professional backgrounds. The teams may also have Nurse Consultants, community Crisis Matrons and/or Service Managers alongside the leadership team. There are two General Managers for Urgent Care – one in NYYS and one in DTV. The Trust has an Urgent Care Pathways Lead. It is our aim to have peer support workers within all the CRHTs in the future. The teams also have 'champion roles' covering carers support, veterans, dual diagnosis as examples, and may work in partnership with many voluntary care sector organisations to deliver crisis services and alternatives.

A free phone, Listening and Mental Health Support line are in situ covering Teesside, Durham and Darlington which formed part of the NHS England transformation funds to support alternative crisis options locally.

The CRHTs have dedicated professional lines and separate lines for patients receiving IHT are also available for direct access.

The CRHTs all use the BT- CCNG telephony platform where the calls are recorded and CITO – Trust's Electronic Patient Record.

It is vital that the functioning of Crisis Services takes place within the context of effective partnerships with service users and their carers, all other community care providers, as detailed in the Five Year Forward View, (NHS England October 2014), The NHS Long Term Plan (January 2019) such as Emergency Departments (Accident and Emergency), General Practitioners, Community Mental Health Services, Talking Therapies, Psychiatric Liaison Services, Early Intervention Services, Inpatient Services, Police, statutory and non-statutory services to ensure smooth care pathways.

TEWV crisis services continuously aim to improve their pathways within inpatient, urgent and community models as part of the Trust's business plan and Journey to Change- collaborating with patients, carers, and stakeholders/partners. We also work closely with NHS England and Integrated Care Boards (ICBs).

1.2 Background

What is a Mental Health Crisis?

Crisis is best defined by the person experiencing it.

A mental health crisis is self-defined as a severity where an urgent response from mental health services is required. (Royal College of Psychiatry, 2022).

Crises may vary in form- they may be developmental, situational, or because of severe trauma. Crisis services have been historically concerned with those crises associated with severe mental illness (Rosen, 1997-cited in Mental Health Topics, Crisis Resolution, Sainsbury Centre for Mental Health).

Crisis is often a normal response to abnormal situations and events; distress is often the outcome of a crisis regardless of its source.

The primary objective for CRHTs is to minimise distress and harms, including harm to self, harm to others, harm from others and potential unintended harm from our intervention in line with the Safety and Risk Management Policy. They work with patients to prevent relapse and deterioration, and to help support the individual using a bio psychosocial model.

Patients who are admitted to an acute mental health inpatient ward following assessment, where appropriate, can access intensive home-based treatment during leave and following discharge from hospital, with an aim to work towards recovery within their home environment. (Crisp, 2015).

Most patients and carers prefer community-based treatment and research has shown that clinical and social outcomes achieved by community based' treatment are at least as good as those achieved in hospital (Soldini et al, 2022). IHT can be provided in a range of settings and is not restricted to the individual's home. For some, hospital may not be helpful, whereas for others it may be the most appropriate option.

Sometimes people may not be well enough to make decisions about their treatment. If their health or safety is at risk, or if other people might be harmed if they are not given treatment, they may be detained under the Mental Health Act and taken to a hospital. This is also called being 'sectioned.' The crisis team should be part of this assessment to ensure that the least restrictive options are explored.

Crisis services consider all available options and work collaboratively to ensure the best fit with patients and carers to help aid the individual at a point in time to support their recovery and reduce potential harms. We recognise that complex dynamics occur within relationships and different parties can have different views on needs and care/intervention required. However, it is important to give space to patients and carers to gain a clear understanding of the needs of both.

Care must be individualised, collaborative and based on each patient's needs.

1.3 How this policy links to Our Journey to Change

Having this policy in place gives assurance to patients, carers, and their families that our staff are adhering to the crisis care quality standards pathway, national policy and guidance whilst providing compassionate, evidence-based care with the patient at the centre. It will help us deliver our Goals as follows:

Goal 1: To co create a great experience for our patients, carers, and families:

- We will support people to lead their best lives, access support at the right time, in the right place and from the right service.
- We will provide crisis services which are based on a shared care model considering the needs and preferences of patients and their carers/families.
- Prioritise a 'least restrictive approach' to care and treatment of acute mental ill health by providing care at the patient's home/residence. Where we cannot and in the event hospital admission is needed, the CRHT will endeavour to facilitate recovery focused early discharge planning with the inpatient service.
- We will promote hope and recovery focusing on, Compassion, Respect and Responsibility, collaboration and shared decision making along with the recognition that care cannot proceed or progress without the involvement of patients and their carers/families and should be co- created.
- Try and minimise the need to repeat information with different staff and services which may be upsetting.
- We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving you and your carers/family as equal partners.
- We will listen, learn, improve, and innovate together with our communities, valuing the opinions and experiences of the patient and their wider support network.
- Take on board feedback, compliments, concerns, and/or complaints to learn and improve crisis services.

Goal 2: 'To co create a great experience for our colleagues'.

This policy supports delivery of this by:

- Ensuring colleagues have the necessary skills, experience, and training to conduct their roles effectively and competently.
- Ensuring staff have access to the tools they need to deliver safe, compassionate, and evidence-based care.
- Ensuring crisis services work to the standards set out by QN-CRHTTs and supported by national policy.
- Following the crisis care pathway (quality standards).
- Have effective leadership structures and governance in situ to support staff.
- Have established partnerships and Trust-wide Urgent Care Network to learn, support and develop our services together.

Goal 3 'To be a great partner.'

This policy supports delivery of this by setting out how we will work collaboratively, flexibly, and innovatively together to deliver crisis services and explore alternatives to crisis services as set out by the Long-Term Plan (2019), ensuring that our services are designed for those that require them. It reflects the partnership working within our crisis teams and wider services to deliver evidence-based care, with recognition that we achieve more together, and that people need different support.

Our values of Respect, Compassion, and responsibility

Living our values is particularly important during a time of crisis. This policy helps ensure we do this by showing respect to patients and their families/carers, by actively listening to their concerns and acting upon them. We acknowledge that supporting a person and their loved ones in crisis can be distressing, but following the policy will help staff ensure we are always compassionate, kind, caring and supportive. Furthermore, the policy ensures we will be open and honest in our conversations, where at times there may be occasions where we may disagree on options and/or approaches, but we will always explain the rational for such. We will explain if we cannot fulfil an aspect of care or visit when we agreed, why and will agree a plan to support you and your family in the interim.
We will be receptive (listening) to how much information a person may want, when, and in what kind of format, and a partner in care and treatment.

2 Why we need this policy.

2.1 Purpose

The purpose of this policy is to describe how CRHT services and TEWV staff working in partnership with other agencies, patients and families/carers conduct their core functions and outlines the crisis pathway.

In summary to:

- To support an individual through a mental health crisis to aid their personal recovery. CRHT's will provide patients with safe, effective, compassionate, high-quality care throughout the duration of their input.
- To provide timely, responsive triage at point of contact, assessment of needs, IHT, and alternatives to admission, to patients and their carers/families. Our aim is one of minimising distress, harm to self, from others, harm to others and potential unintentional harms, for example unnecessary admissions, preventing relapse, building on strengths, focusing on recovery, and based on collaboration and equal partnership.

2.2 Objectives

TEWV staff by adhering to the service model principles of:

- For any individual and/or their family, carer, or friend to be able to access and receive advice, support, and intervention (where required) for a mental health need 24/7, regardless of age or where they live.
- Ensuring patients and carers can contact the service in a timely manner.
- Getting the right help and care safely and easily at the right time, in the right place.
- Having a caring, skilled, and flexible workforce that reflects our values of compassion, respect, and responsibility.
- Helping patients to achieve recovery (as defined by them).
- Supporting families and carers in their role.
- Being able to reach us again simply and quickly if the need arises.

3 Scope

3.1 Who this policy applies to:

This policy applies to all staff working within AMH CRHT services and wider supporting teams as documented within the policy in partnership.

The policy has had considerable input from CRHT staff across the specialties, managers and clinicians within the services, the Urgent Care Network, Specialty Development Groups and via patient groups.

The CRHT's will fully comply with Trust-wide policies and procedures applicable to both urgent and planned care services with the expectation that CRHT's function (and receive accreditation via peer review) in line with the national QNCRHT standards (formally known as 'Home Treatment Accreditation Standards' (HTAS) for CRHT's) and core fidelity principles.

3.2 Roles and Responsibilities –

Role	Responsibility
Executives	• To thoroughly review this policy with other Executives. • To give final approval to the publishing of, and amendments to this policy. • To always have a named executive with overall responsibility for this policy.
Care Group Directors	• To lead the implementation of this policy. • To ensure there are systems in place that promote the adherence to this policy. • Champion the urgent care pathway and promotion within care groups, ensuring alignment with the policy and national/regional policy/directives.
General Managers	• Implement and review this policy in their specialist areas. • Ensure that systems and processes are in place that promote the standards detailed in this policy. • Provide opportunities for training, development, and supervision to support the policy standards.
Service Manager/Crisis Matron/Team Managers	• Ensure implementation of the systems and processes in their ward or team. • Ensure all employees attend relevant training relating to this policy.

	• Provide leadership oversight and assurance.
CRHT staff/workforce	• Adhere to and work within the framework of the operational policy, other supporting policies and procedures, Trust values and the crisis pathway, to work collaboratively with patients, carers, and their families. • To have a meaningful, compassionate, therapeutic relationship to those they work with, in triage, assessment and provision of IHT. • Will adhere to the principles in the content of this policy. • Implement the policy standards and procedures. • Engage in training and development to maintain individual competence relating to this policy. • Work in line with the Royal College of Psychiatry QNCRHTT standards for CRHTTs and where not accredited, work towards gaining this accreditation. • Read all Trust communications regularly to ensure you stay up to date with any changes to this policy and/or other policies that may impact this one.
Urgent Care Pathways Lead	• Policy lead responsible for updating the policy, leading consultation. • Provide advice and guidance on crisis care standards, models, aspects of policy and crisis pathway. • Be a conduit between national and regional NHS E team within their regional NHS E role of Acute Pathways Lead (NE and Y). • Work with the QNCRTT to ensure the Trust/Teams embed standards as set out for crisis care. • Work collectively with partners, stakeholders, and patients/carers across the system to share practice and learning, advocate the crisis pathway and promote and develop alternatives to crisis.
Specialty Development Groups	• Oversight of the policy and guidance, support of crisis pathway and processes.
Patients/Carers/Families	• To engage in and provide feedback on the care and treatment that they receive, being an active partner. • Challenge any care and/or treatment that may not meet the standard of care we expect or is set out in the policy. • Where willing, contribute to service improvements, recruitment, and training.
Partners/stakeholders	• To work together as a partner with the Trust and CRHTs to provide an effective and safe crisis pathway to patients and their families/carers.

4 Aims of the service

The CRHT will:

- Appropriately triage at the point of referral/contact and provide a clinical response/ assessment within the required clinical priority standards to individuals across all specialties (if there are no other locally commissioned services to do so) who are experiencing a mental health crisis.
- Assertively engage individuals and families/carers in the assessment process and with referral to the CRHT.
- If an assessment is undertaken and IHT is deemed appropriate, provide care and support in line with the Trust's quality standards work and other Trust wide Policies and Procedures.
- Function as a gateway to mental health services once alternative to admission is excluded, rapidly assessing individuals in crisis, and referring as necessary to the most appropriate agency which may include in-patient areas – detailing decision making related to the outcome/actions agreed.
- Provide multi-disciplinary community-based treatment 24 hours a day, 7 days a week.
- Remain involved with the patient until the crisis is resolved (to an acceptable level) and there is no longer a role for the CRHT. The CRHT will facilitate contact/referral with services and agencies that promote recovery.
- To provide a carer contact for all individuals who are receiving IHT.
- Where an in-patient admission is necessary liaise with the respective Bed Management Team (out of operational hours of the Bed Management Team this remains the role of the CRHT) regarding appropriate bed, provide a clear rational for admission, and be actively involved in the Purposeful Inpatient Admission Process (PIPA) at the earliest possible stage to agree any requirements from the CRHT and/or aim to provide IHT at the earliest opportunity.
- To provide a comprehensive handover to the inpatient ward when admitting patients to a bed.
- Offer short-term, relational support that buffers individuals in distress who may not otherwise have access to such support. These may include skills training and self-management techniques.
- Work collaboratively with all Community Intervention Teams (CITs) and referrer (professional) regarding all support available and communicate the outcome of any triages/onward referrals agreed.
- Undertake facilitation and attendance to Section 136 detentions/mental health act assessments and liaison with Street triage teams (or equivalent named – police response teams) and psychiatric liaison teams to consider offer of IHT as an alternative to inpatient admission (where appropriate).
- When a situation arises involving Community Treatment Order (CTO) recall within working hours the CRHT should be made aware of the potential recall and there should be liaison between the CIT and the CRHT regarding whether a joint assessment should occur. When a potential CTO recall occurs **outside** of working hours there is an expectation that the CRHT will conduct a joint assessment with the nominated Approved Clinician (usually the On-call Consultant) responsible for the recall and will be involved in facilitating admission where appropriate.

No admission can be made to an adult in-patient bed without an assessment by CRHT staff to consider the best option to minimise both short- and long-term harm to the individual within their recovery and consider alternatives.

This will include those assessed and consequently detained under the Mental Health Act 1983. The only exemption from this is recall under a Community Treatment Order (CTO).

Below are situations where CRHT's do not have to consider an alternative treatment option, as agreed under national protocols.

- Patients recalled on Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment. – needs to be transferred from an NHS Mental Health Trust – this must be an in-patient transfer e.g., direct from another NHS Trust hospital ward to TEWV hospital ward.
- Internal transfers of service users between wards in the trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admissions for psychiatric care from specialist units such as eating disorder units are excluded.

4.1 Patients admitted to Inpatient Beds – Section 136/Mental Health Act Assessments.

Consultant Psychiatrists on call (out of hours) that assess patients under section 136/Undertake Mental Health Act assessments **are** part of the CRHT at this point. Therefore, assessment should consider IHT, and any activity recorded would be part of CRHT gatekeeping. If the CRHT cannot physically attend (this should be an exception) an assessment the Consultant on call and/or Approved Mental Health Professional (AMHP) undertaking the assessment clearly discusses and communicates the outcome of the assessment with the CRHT. If an inpatient bed is required following assessment, the Consultant on call should verbally communicate with the on-call Doctor (Dr) and receiving ward (nurse in charge) regarding assessment, needs, risks, management, any safeguarding issues whilst also considering the appropriate bed required (i.e., picu, seclusion). Conveyance options and estimated time of arrival to the ward should be discussed with a comprehensive handover to the transporting team/staff. Documentation should be timely and detailed with any section papers being sent to the ward. Where appropriate patients, family/carers should be provided with information relating to the decision along with contact details for the receiving ward/Hospital.

4.2 Partial exemption

- Admissions from out of the Trust area where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in their parent location. This should be clearly documented within CITO as the case by the Crisis Team attached to the in-patient unit when admission takes place. – this also

applies to patients with a TEWV CCG who are staying out of the area. Time, date and who conducted the assessment to be clearly recorded and if within the 24-hour time of admission then can be counted – otherwise this will be classed as a breach. Where there is an out of area bed, the bed management team, and ward will endeavor to ensure that the patient is repatriated back to their local area at the earliest convenience when a bed is available (unless this would be detrimental to the patients care and treatment). This is paramount to ensure that the patient receives care closer to home and for families/carers to visit, and other longer term care options to be arranged and delivered.

- In terms of Green Light admission for those with learning disabilities to AMH beds the enhanced learning disability community teams (where available) will undertake such role and function.

5 Referrals

Access to the Crisis services in TEWV is available 24 hours per day by calling the 111 select Mental Health option. Calls will be screened by appropriately trained staff and anyone requiring crisis support will be transferred to the respective CRHT. They will be triaged in line with the UK Mental Health Triage Tool regardless of where they reside, in line with agreed Trust-wide processes. This will determine a timeframe to be seen and direct individuals to the most appropriate service identified to meet their needs.

Internally, professionals may also refer directly to the CRHT for triage/ IHT and there is direct access via professional lines for partners. In Teesside patients can self-present to the Crisis Assessment Suite (CAS). CRHTs also provide support and cover to the Health Based Place of Safety Suites (HBPOS) in which those detained under section 136 (via police) are taken to for assessment.

5.1 Consent

It is important that a patient is made aware of the intention to refer to a CRHT and that referrers are clear as to why they are doing so, for the CRHT to work collaboratively with a patient. It is also expected that the CRHT clearly discusses communication methods, including interpreter services, consent and assesses capacity to engage.

Sometimes an individual may not be able to consent to assessment and/or choose not to engage with the CRHT for various reasons, but we will do everything possible to promote engagement so that patients obtain the right help and support. The clinician should ascertain as much information as possible from the patient, referrer, and relevant others to aid their decision making and discuss with senior staff on duty (if they are unclear) to agree any next steps.

Staff must adhere to the **Commonsense Confidentiality Principles** whereby confidentiality can be overruled if there is a risk to the individual and or others – contacting the necessary agencies immediately.

Where a referral for triage has been made to the CRHT and an individual may for a matter of reasons not wait on the line for triage – where we have personal

details and contact numbers available, we will attempt to contact the patient to undertake a triage.

Carers, family, and friends may often contact regarding a friend and or family member, CRHT should encourage the patient to engage, however we recognise that this is often not always possible for many reasons despite the need for support. The CRHT should triage the patient with the family/carer/friend and agree to any next steps, this may be calling the patient, arranging to visit and or referral to other agencies. We **do not** need the patient's consent if there are presenting risks which may lead to and cause harm.

Professionals can contact the respective CRHT via the dedicated professional line numbers for advice, guidance, and support.

5.2 Staff

Staff will:

- Clinically triage the patient and level of need/time frame to be seen if needed (as supported by the UK Mental Health Triage tool).
- Provide telephone advice to the patient/carer/referrer to inform care and treatment and then may:
- Provide a timely response, face to face assessment as per clinical priority of need.
- Determine any preferred communication methods and needs with the individual/referrer.
- Refer to alternative services/agencies.
- Alternative options if an individual does not wish to engage and may lack capacity (mental health act assessment).
- There is also an urgent care Did Not Attend/Was Not Brought process and flow (to be used in conjunction with the Trust Policy) for those individuals who may not engage or disengage during their time with the CHRT. We will actively try to engage where this occurs.

5.3 Accessing CRHT

The CRHT can be accessed by the following:

- Self-Referral.

Individuals and their families/ carers can contact 111 select mental health if they have concerns. They will then be screened and referred to the respective CRHT for triage (if required).

- Any Mental Health Services including all CITs currently operational within TEWV NHS Foundation Trust and external. For these individuals, it is expected that the respective CIT will have increased their own input in collaboration with the patient prior to referral and will be triaged in the same way as other referrals to agree what would be the appropriate options.

  Any referrals from secondary mental health services outside out of TEWVs geographical area e.g., referral of temporary residents staying with relatives, will be supported.

- Substance Misuse Services.

  In the event of a service user being referred to a CRHT in a crisis situation where the referrer indicates that the individual is or may be under the influence of drugs or alcohol, the service will see the individual to assess both needs and any risk, ascertain whether a mental health assessment can take place and devise an appropriate safety plan in accordance with Trust Policies regarding risk management (TEWV Dual Diagnosis Policy). If it is apparent that an individual is unable to participate within an assessment, is unconscious, or grossly intoxicated, other medical intervention may be required at this time, or we may advise that a carer/family/friend remains with the person, however, we will remain in contact with the referrer/patient/family/carer to assist at a more appropriate time.

- Primary Care Health Professionals including GP's. The stepped care model on many occasions will be appropriate, however this should not preclude a referral to the CRHT.
- Emergency Departments/Acute Hospitals/111/ambulance
- Social Services/Emergency Duty Team
- Police/Forensic Medical Examiner working in custody suites/Street triage teams.
- Talking Therapies
- Non-Statutory Agencies
- Any specialist services whereby intervention required is essential, for example: Early Intervention Teams work with a client group who have an elevated risk of admission and or complex needs and risk. All new patients presenting with psychosis who are assessed initially by CRHT will be referred to Early Intervention in Psychosis Team (EIP) as part of the IHT intervention. Those pre- and post-natal and those with eating disorders should also be considered due to thresholds for relapse and need for earlier intervention.
- During out of office hours, individuals with diagnosed or suspected learning disability who need crisis support will be supported by the adult mental health crisis teams. Advice can be sought from the on-call learning disability staff (if available in locality) or from the learning disability medical staff, as and when needed.

5.4 Perinatal

- CRHT's to discuss all patients who are pregnant or <1yr postnatal with perinatal duty worker (either at the time of referral, or next perinatal working day).
- Perinatal team undertake routine assessments within 28days. For patient open to CRHT team, CRHT team may request joint assessment with perinatal team, and this should be within 3 working days. (CRHT will have already completed their assessment, this is for further perinatal assessment and guidance).
- For patients with possible puerperal psychosis, CRHT can request that perinatal team/worker accompany them at urgent assessment – the perinatal duty worker will endeavour to attend.

6 Assessment

6.1 Clinical priority standard

The assessment will start as per the clinical priority standard assigned, this is in line with the UK Mental Health Triage Tool and may be classed as Emergency (emergency response for example, ambulance, police etc.), Very Urgent (within 4 hours), Urgent (within 24hrs) and/or Routine (over 24hrs). Routine assessments tend to be referred to the respective CIT/CMHT.

If the assessment cannot occur within the time frame, a safety plan will be agreed with the referrer/ patient/carer. This should be an exception.

6.2 Before the assessment

Before arranging the assessment, as much collaborative information will be sought from the screening documentation/referrer at the point of contact with the individual to; arrange the most appropriate assessment venue, time and ensure that as much information is gathered to aid the bio psychosocial assessment of the individual.

Evidence of needs, harm, risk, and safety will be discussed to promote a harm minimisation approach (as supported by the Safety and Risk Management policy) involving individuals and carers in any decisions when considering treatment options.

6.3 Communication

An interpreter will be needed for some individuals, whose first language is not English, and staff should always consider the most appropriate methods of engagement and communication with those who have protected characteristics and make reasonable adjustments. Patients and their family/carers have the right to ask for a second opinion, access advocacy services, view their health records - accessible information should be provided by staff.

6.4 Conducting the Assessment

Initial assessments in the community will *normally* be conducted by two CRHT staff members of which disciplines will be decided at the point of arranging assessment. It is not necessary to assume this will be two band 6 clinicians, and there will be times when staff work individually.

Decisions relating to assessment should be based on clinical need, risk, safety, resource, and teamwork and be agreed as an MDT. In most circumstances joint assessment in collaboration with other professional colleagues from other teams/agencies will be appropriate.

6.5 Involvement of families and carers

The active involvement of families and carers is integral and encouraged, information from families and carers will be considered unless the patient wishes or confidentiality overrides such. Information may be offered from families and carers to the team confidentially and/or may be provided to the patient at the time of triage/assessment with their consent. These views should be documented.

The Assessment will be arranged and conducted using the standard assessment tool with particular emphasis on the recovery Connectedness, Hope, Identity, Meaning, Empowerment (CHIME) principles.

6.6 Following assessment

Following the assessment, a discussion will be held with the patient, family/carers, and any relevant others regarding options. They may include:

- IHT – with formulation of need
- Direction/referral onwards to other services and/or agencies.

6.7 Admission

Admission to an inpatient facility or supportive accommodation including community support/crisis beds – where this is required completion of the MCA1 Capacity assessment should be documented. To give valid consent to admission to, or remaining in, a mental health unit the person must have the capacity to consent to the actual care and treatment regime that will be in place for them. Capacity is determined in accordance with the Mental Capacity Act 2005 (MCA).

Valid consent requires that the person be given sufficient information relevant to the decision and the information they are consenting in this instance will include:

- That they are/will be in hospital to receive care and treatment for a mental disorder; and
- The core elements of that care, treatment, and measures which may be put in place to supervise the patient. Therefore, capacity should be assessed and recorded at the time the decision is made (MCA1)

Staff will complete the required documentation on the electronic system including the safety summary, safety plan and incident log, providing a handover to ward staff and further information to the patient and carer/family relating to the ward environment.

A written plan will be agreed and left with the patient/carer/family at the end of the assessment – on the Patient Information Leaflet.

6.8 Communication following assessment

Following assessment, the team sends correspondence detailing the outcome of assessment and of any recommendations to the referrer, GP, and other relevant services within **72hours. The patient should receive a copy.** Where no further involvement is required by the CRHT at this time, the individual will be provided with advice and information relating to any other supportive services and how to re access support if needed.

7 Meeting Carers' Needs

Carer Champions are identified in each CRHT, and the team offers separate supportive appointments to relatives and carers of those receiving IHT.

Local carer support can be assessed linking family with local organisations.

- Carers (with patient consent) engage in discussions and decisions about the patient's care, treatment, and discharge planning. This includes attendance at review meetings where the patient consents.
  Guidance: This includes the opportunity to discuss risk management, where appropriate.
- Carers are supported to access a statutory carers' assessment, provided by an appropriate agency.
  Guidance: This advice is offered at the time of the patient's initial assessment, or at the first opportunity.
- Carers are offered individual time with staff members to discuss concerns, family history and their own needs.
- The team provides each carer with accessible carer's information.
  Guidance: Information is provided verbally and in writing (e.g. carer's pack). This includes the names and contact details of key staff members in the team and who to contact in an emergency. It also includes other local sources of advice and support such as local care. Interpreting and translation services may be required to ensure effective communication and understanding.

Regular audits highlight the involvement of carers in referral, assessment and IHT providing a clearer picture of carer involvement in care and treatment. The teams should adhere to the Trust's Carer's Charter.

8 Intensive Home Treatment /Intervention (IHT)

Intensive home treatment will provide a range of co-produced and specific interventions, in the community, with the goal of improving well-being and promoting recovery. All interventions will be worked through in a collaborative manner placing importance on basic human connectedness and trust.

8.1 Basis of IHT

IHT will be determined and based on **any** of the following:

- Distress level
- Impact on functioning
- Potential for harm
- Carer/family support

8.2 Aims

The aims of involvement are to:

- Reduce acute distress.
- Minimise potential for immediate harm.
- Provide alternative to hospital admission.
- Facilitate hospital discharge and leave through step down support.
- Problem solve acute social or interpersonal crisis.
- Help explore and develop a formulation to understand what the individual's needs, strengths, aspirations, and goals and longer-term needs.
- Explore and develop a co-created safety plan to aid recovery and help support the individual longer term, reducing any risks, potential for relapse and remaining well.

For individuals known/active to the CIT, this will build upon previously agreed care plans/ advance statements and pre-existing safety plans but will include interventions to manage the crisis episode. The Key Worker/Coordinator of Care from the CIT/CMHT should continue to see the individual regardless of CRHT/IHT input at least weekly.

The overall treatment plan includes providing interventions at the individual's home or alternative environment as agreed. Patients and their family/Carers will be provided with a contact number whilst receiving IHT.

8.3 Initial 72 hours of IHT

During the initial 72 hours of IHT there will be at least a minimum daily face to face to contact (via a registered professional or professionals as needed) to assess mental health need further, if needed and to formulate care and treatment, working with the patient, carer/families. After this, the patient will

be visited regularly, and the number of visits and level of input will be discussed with them based on their needs.

It is acknowledged that not all patients may require the above daily visits by a registered staff member, if clinically assessed and indicated. In these circumstances this must be discussed as a Multi-disciplinary Team (MDT), documented within the safety summary and safety plan as to the reason these are not required.

With any IHT episode things may change quickly, contacts may increase, and/or decrease in frequency depending on patient/family/carer needs and should be reviewed regularly at each contact.

8.4 Therapeutic treatment options

There is an agreed range of therapeutic treatment options that are available which will be fully discussed with the patient and their family/carer when a need has been identified.

8.5 Team working system

The CRHTs operate a team working system, which in effect means that members of the team are aware of the issues concerning each patient and their care plan. This ensures that they do not need to repeat their story at each contact. Where possible the team will endeavour to identify key staff to provide clinical consistency and to promote high level engagement. This is in line with feedback from patient experience.

8.6 Home visits and therapeutic telephone contact

When the need for home visits on a regular basis is no longer agreed as necessary, then therapeutic telephone contact can be used for supportive purposes and can be used as part of a planned withdrawal/discharge/step down. Telephone contact and other forms of agreed communication with the individual may also complement any face-to-face visits (video conferencing).

Telephone contact will initially be used to arrange time and venue of visit and NOT AS A REPLACEMENT to Face to Face contact (where this is required).

People utilising IHT, their family and carers can contact the team 24 hours a day if needed.

8.7 Formulation

During the initial 72hrs of IHT, a 5P formulation will be developed and this will inform the IHT care plan. The 5p formulation covers the following domains:

Presenting problems – this includes the reason for referral to IHT, any relevant background history and the person's presenting difficulties that brought them into contact with IHT.

Predisposing – this includes factors that may have increased the person's vulnerability to experience their current difficulties or may increase their vulnerability of experiencing a decline in their mental health.

Precipitating – this includes factors that may have triggered the presenting problems that led to the contact with Crisis Services.

Perpetuating – these are factors that may maintain a person's current difficulties or pose challenges to recovery.

Protective – this will include factors that are important and positive in the person's life such as personal strengths and available support.

The development of a collaborative 5p formulation during the initial 72hrs of contact with IHT can be a helpful way to support patients in making sense of their current difficulties and to understand any offers of intervention, where this need is identified. Where possible, the 5p formulation will be developed collaboratively. However, should it not be possible to complete the 5p formulation collaboratively, it will be developed based on the available information held in the care record.

9 Care and Safety Planning

9.1 Categories A-C of UK Mental Health Triage Tool - safety summary and safety plan

All patients referred to a CRHT following triage (Categories A-C as identified alongside the UK Mental Health Triage tool) and any subsequent face to face assessment will have a safety summary completed immediately at the time of contact (or prior to end of shift) to mitigate any identified risks and proactively plan for potential risks or deterioration, identifying strengths, who can help and how. This also applies to those patients open to CRHT/IHT and it is expected that as further information becomes available the safety plan will be enhanced and refined as staff get to know the patient better.

Patients can expect to have a Safety Summary and Safety Plan co created in line with the Trust Safety Summary/ Safety Plan work and Safety and Risk Management policy/CPA Policy and staff within CRHT's should follow the guidance as set out in these policies/protocols.

Care and Safety planning (and any other resultant plans) should be based on a collaborative co-created process between the individual, carer and or family and multi-disciplinary team wherever possible. They will also take into consideration the fact that individuals accessing crisis services are likely to be doing so because of acuity of mental distress/ experiences and encompass a trauma informed care approach.

9.2 Categories D-G of UK Mental Health Triage Tool - Safety Summary and Safety Plan

For those triaged in of the UK Mental Health Triage Tool the Safety Summary and Safety Plan is not expected to be completed – unless pertinent information is provided.

9.3 Recovery orientated approach

It is recognised that longer-term recovery and wellbeing is likely to take place once the crisis has been supported and the intensity of difficulties reduced sufficiently. A key aspect of care and safety planning and support therefore needs to be informed by a recovery orientated approach. Care/safety planning will recognise that when people are in intense distress, they have difficulty problem solving and goal setting, for some, attempts to goal set and problem solve prior to supporting a reduction in distress can heighten rather than reduce distress. They will also recognise that longer term goal setting and planning for recovery may be in place within community care plans or will take place once the crisis has resolved.

For those patients that are known/open to TEWV services/CITs, they will already have a care plan on CITO. The CRHT will add to this care plan following formulation.

9.4 Care/Safety Plan

The Care/Safety Plan will detail:

- The person's perspective and understanding of what is happening and their needs, and preferences. Reflecting the formulation/reviews undertaken.
- Any differences in opinions between the patient, their carer/family and the multi-disciplinary team will be made clear either in the plan or care record.
- It will recognise the need for a supportive relational environment which creates safe and validating spaces as a core factor supporting individuals when they are in acute distress.
- Identify natural supports and networks and how they can support the individual through the crisis.
- How links with other relevant Trust teams and external providers will be facilitated and maintained.
- Frequency of visits, which needs to be flexible enough to respond to any changes.
- Contact telephone numbers and advice for the patient, their family, and carers, informing them how to access the team along with any specific reasonable adjustments a team may need to make to engage with service users and their families/carers.
- Will detail any specific interventions individuals are receiving.
- Patient and their families/carers are offered a copy of their care plan.

If appropriate, include recovery-oriented goal setting at an appropriate e.g., transitioning from wards into the community and home treatment. To be linked with CITs and coordinators of care/key workers.

Include a safety plan, exploring contingencies, relapse indicators, strengths, what/who has helped, any triggers and supports and encompassing any formulation.

Following formulation, patients open to IHT should actively be involved to produce a care plan, also considering the views of their carer/family. They should be offered a copy of their care and safety plan. Evidence should be documented in the electronic care record that this has been offered, and or declined.

9.5 Patients in CRHT that require a Bed (non-available)

Both nationally and locally, there are pressures on beds within mental health and learning disability services. There may be occasions where an inpatient bed is required, however may not be available, despite efforts to locate a bed internally and externally.

If no bed can be located for the patient (including the provision of independent sector beds) a clinical discussion will take place to consider whether the patient can be safely supported to remain in the community until a bed can be located. A safety plan will be discussed and co-created with the patient and carer if it is considered safe to remain at home whilst awaiting a bed.

Please refer to Appendix- 3. Process for patients to provide safe care in the community whilst awaiting admission to hospital for further guidance.

10 Physical Health

A physical health review takes place as part of the initial assessment, or as soon as possible. Guidance: The review includes but is not limited to: Details of past medical history; Current physical health medication, including side effects and compliance with medication regime; Lifestyle factors e.g., sleeping patterns, diet, smoking, exercise, sexual activity, drug, and alcohol use. Staff members arrange for patients to access screening, monitoring, and treatment for physical health problems through primary/secondary care services. This is documented in the patient's care plan.

All individuals accepted onto IHT caseload will have base line observations taken, blood pressure, pulse, height, weight, information on smoking and alcohol/ drug use identified.

Service users taking antipsychotic medication will be supported to have their bloods taken if no evidence can be found within the last 6 months. Ongoing physical observation will be taken as required. The GP will manage general physical health; IHT will support the service user to access primary care services as required and identify any needs, consulting with GP's/others, as necessary.

Deterioration in physical health will be flagged to the GP and Consultant Psychiatrist/medic. Emergency treatment re physical health will be managed through the normal 999 service.

11 Prescribing, Management of Medicines/ Medication Management

The prescribing of medication is a key part of the role of the CRHT's.

On admission to the IHT, a team member will obtain a medication history from the patient, as well as contact the patient's GP and carer and access the Summary Care Record to view a copy of their medicines records as per Trusts Medicines Reconciliation policy. Guidance: This

includes current medicines for mental and physical health, medicine's history, recent laboratory results and any other issues which may impact on medicines. This information should always be accessed at source to ensure safety and accuracy.

Medical staff and Non–Medical Prescribers (NMPs) can prescribe medication. The team has a nominated medicines management lead and has rapid access to medication, 24 hours a day. CRHTs have 24-hour access to prescribing advice from a Consultant Psychiatrist or NMP.

Nursing members of CRHTs with a Registered Mental Nursing qualification can administer prescribed medication and offer advice on taking it in line with how it is prescribed. Other members of the Crisis Teams (Social Workers, Support Workers, etc.) can be called upon to convey medication and supervise patients administering their own medication in line with the prescription but are not able to administer it or offer any advice (unless specifically trained).

- Where possible IHT will support service users to manage their own medication.
- The team will provide education, information and advice on medications and physical health promotion and/or signposting as necessary to the appropriate resources/professionals where required.
- The team should monitor any prescribed side effects, adverse effects and provide information on any increased risks that may occur and what to look out for/when to seek help.
- Where it is necessary for CRHT to manage medication for service users by collecting or retaining prescriptions:
- All medication will be stored in a secure cabinet in accordance with Trust policy.
- All medication will be covered and checked against a current prescription signed by a Prescriber.
- The IHT care plan will cover all aspects of the management of medication.
- The prescription KARDEX will be used in respect of any administration of Medication.
- If the CRHT is overseeing medication administration/concordance as part of IHT, patients should have a medicines Kardex, completed by a Doctor, Pharmacist and or Non-Medical Prescriber and all medicines that are administered or supervised by the team are recorded on the chart and signed.
- Patients who are prescribed mood stabilisers or antipsychotics are offered and encouraged to have the appropriate physical health assessments at the start of treatment and continued as per NICE guidance. Guidance: This will need to be communicated to the CIT or the GP to continue the physical monitoring on discharge.
- The team will adhere to any prescribing guidance in situ, for example antipsychotic monitoring guidance.

11.1 Patient Group Directions (PGDs) utilised by CRHTs.

PGDs are documents permitting the supply of Prescription-only Medicines (PoMs) to groups of patients, without individual prescriptions. Healthcare workers using PGDs should be sufficiently trained to be able to supply and administer PoMs.

12 Key Worker/Coordinator of Care.

Whilst a patient is receiving IHT the CRHT will act as key worker/coordinator of care and allocate a named person who will act in this role unless the person is already active to a Community Intervention Team (CIT or CMHT) and has an identified key worker/ Coordinator of Care.

13 Review of Care and Treatment

The care provided to patients is reviewed on a regular basis by the visiting staff member, MDT, and discussed fully in team huddles and formulation meetings which are documented and entered into the electronic care record CITO. Reviews will be dependent on the patient and their needs and may be required more frequently. As a minimum standard care is reviewed once weekly via the MDT in the team huddle.

The Safety Summary, Safety Plan, Care Plan and Formulation are regularly reviewed by the CRHT and documented within the appropriate section within the electronic care records.

CRHT staff will attend professional meetings (Safeguarding, MARAC or MAPPA or complex case reviews alongside other services when involved in IHT and as appropriate).

Clinical outcome measures are collected at two points in time (minimum of assessment and discharge).

13.1 Planning for Discharge/Transition

The CRHT begin discharge planning at the point of assessment with the patient and their family/carer, where appropriate, and this is communicated to relevant parties.

When the crisis has resolved or becomes manageable, and the patient no longer requires the involvement of the CRHT.

This may include transfer to other services within the mental health pathway or to external agencies.

Discharge will take place when:

- Aims of IHT have been met.
- Distress and risks have reduced to a level that no longer requires IHT.
- Referrals to other agencies are completed and the patient and their family/carers are fully aware of on-going care arrangements including the GP.

Trigger factors have been identified, explored and Safety Plans have been developed and agreed with the individual and their carer/family.

- Coping strategies have been explored with the individual, their family, and carers.
- Any clinical outcome measures are completed.
- The individual, their family and carers should have the opportunity to comment on the service they have received and therefore contribute to service improvement.

When transferring a patient's care to another service or discharging from the CRHT, a discharge summary will be devised, detailing ongoing care arrangements, crisis and contingency arrangements, medication, including monitoring arrangements and when, where and who will follow up with the patient as appropriate. A copy sent to relevant professionals and the patient and/or carer within 48hours.

- Transfers to other services should be undertaken swiftly, safely, and collaboratively with the relevant workers/teams in line with the Personalised Care Planning Policy/ CPA Policy/Transfers Policy ensuring transition is supported and seamless.
- For referrals to a CIT/CMHT the patient should be allocated to a Keyworker/ Co-ordinator of care within 72 hours and seen jointly within one week. Prior to discharge a joint visit should be undertaken together. If a worker cannot be allocated timely, the duty worker should undertake any liaison/joint visits. Any delays in allocation should be escalated via the leadership team/s and an Inphase form completed.

13.2 Discharge from Inpatient Ward/3Day Follow Up

An integral role of the CRHT is to facilitate and support discharge from acute inpatient wards for patients who continue to require support, but no longer require continued hospitalisation. These individuals would benefit from IHT/ community support and whereby risks are collaboratively assessed, considered, and reduced via a therapeutic plan. This may involve joint working with CITs and other relevant teams along with the provision of a follow up within 72 hrs in line with national guidance. CRHT's have a responsibility to attend ward report out meetings and attend formulations/discharge meetings where appropriate. CRHT's should have daily links with respective bed management teams and wards to identify patients that no longer require continued hospitalisation but may benefit from IHT.

Where IHT can be facilitated, the CRHT will arrange to see the patient within 24hours of discharge from the ward and/or commencement of IHT.

National guidance states that if an individual is discharged from an in-patient unit, they should be followed up by the service as soon as possible, within 72 hrs (3 days) of going home or sooner if need arises. The individual should have an arranged appointment, date and time prior to discharge and have a care plan in place at the time of discharge shared with relevant others. Follow-up may be provided by a CRHT, Key worker/Coordinator of Care or another relevant professional whom the patient is known too. (NCISH, October 2017)

14 Shift Coordinator Role and Function

The Shift coordinator role is central to the day-to-day operations of the team. The main function of this role is to offer a single point of contact resulting in a coordinated, structured approach to allocating and organising the changing workload, ensuring that all new referrals are responded to within the priority identified via the UK Mental Health Triage Tool and the needs of those individuals receiving IHT continue to be met.

Each shift will have a designated shift leader/coordinator who will coordinate and delegate, as necessary.

Each staff shift will work as a team. All significant issues will be discussed with the shift coordinator and/or leadership team. Any deviation from the care plan or change in risk/safety or presentation should be immediately escalated to the shift leader.

The shift coordinator should remain office based where possible within the teams/or hub.

The team will keep in regular contact by telephone/video conferencing or person to organise and prioritise work.

There will be a handover period at the beginning and end of each shift during which the completed and outstanding work will be reviewed to plan the next shift.

The shift coordinator will allocate roles having regard to lone worker policy, skill mix, risk/safety, individual needs and choice, continuity of care with the effective use of staff resources and clinical need in mind.

Shift coordinator /designated other will contact the Bed management Team within their Care Group daily to explore options for any potential discharges and IHT support liaising with the respective inpatient wards.

All staff should ensure that they clearly document their whereabouts on the board, identifying time and client initials. The shift coordinator will be mindful of any delay in the staff member returning to the team office/maintaining contact and implementing any lone working protocols.

15 Team and Huddle Meetings

All CRHTs meet to hold a daily 'huddle' to discuss, plan, formulate and manage the care and treatment they provide to patients and their carers/families. This is recorded using a standard template. The huddle meetings are multidisciplinary in nature, occur 7 days per week with professionals from a variety of backgrounds in attendance, utilising and updating the electronic records and visual control boards (vcb's)

The standard visual control boards are a visual aid to support care and treatment whilst underpinning evidence-based practice, ensuring quality and safety. Tasks and home visits are assigned, being led by a shift coordinator and the VCB updated.

The CRHT staff work integrally across the whole urgent, inpatient and community care pathways, whereby they join other daily huddles as appropriate, for example acute inpatient huddles and community huddles to ensure continuity of care, collaboration, and communication.

Any significant clinical team discussions should be documented in CITO, identifying all staff involved in the discussion and outcome/ concerns raised (for example the 72-hour review/formulation).

There will be a weekly clinical review meeting led by the Team Manager or delegated staff member. Patients that have been on caseload for 7 days will be reviewed within this meeting. Those on caseload for 30 days plus will have a further MDT review.

15.1 Team Meetings/Supervision

Monthly team meetings take place within each CRHT, chaired by the Team Manager/s/nominated staff member on a regular basis as part of the Trust's Governance arrangements. Service developments and improvements are discussed along with any performance metrics and quality measures.

Monthly group supervision and any reflective practice sessions are open to all clinical and non-clinical staff and are promoted within the teams.

Staff have an annual appraisal and participate in personal development planning, talent management conversation.

Clinical staff members receive individual clinical supervision at least monthly, or as otherwise specified by their relevant professional body, also in line with the Trust Supervision policy.

CRHTs participate in team building session on an annual basis.

Any new staff within CRHTs receive a formal induction, by which they understand the functions of the team, service, and principles of IHT. This may include shadowing, networking, observations, and supervision to ensure core competencies have been assessed.

There is a Trust wide Urgent Care Network (all specialities) held bi-monthly, chaired by the Trusts Urgent Care Pathways Lead.

16 Safeguarding - refer to Trust Policy

All staff within health services have a responsibility for the safety and wellbeing of individuals and colleagues. Safeguarding adults/children is a part of patient safety and wellbeing and the expected outcomes of the NHS, providing additional measures for those least able to protect themselves from harm or abuse.

All Trust staff have a professional and moral obligation to report to their line manager any incidents of actual or suspected abuse and concerns that there are environmental factors to support the potential for abuse. If there is a concern relating to a child and/ or adult who is experiencing, or at risk of, abuse or neglect; and because of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect they have a duty to act upon this and report this.

The Trust also recognises that certain groups of people may be more likely to experience harm, and the Trust expects employees to act upon this immediately in line with our Safeguarding policies and procedures.

17 Lone Working

There are measures in place to ensure staff are as safe as possible when conducting their roles.

All CRHT staff must adhere to their local lone working arrangements to support the health, safety and wellbeing of staff and patients. This is supported in conjunction with the TEWV Lone Working policy.

There are times when risks to staff (and others) are identified. In these circumstances, arrangements and plans can be made to ensure that other local venues and arrangements are used instead of home residences to ensure safe working practice and reduce harm. This aims to identify any control measures to prevent or reduce any risks identified.

18 Record Keeping

All patient information is kept in accordance with current legislation.

The Records Management policy details how all records, including paper and digital records, and the equipment and environment in which they are held should be written and secured. This covers the full lifecycle of the record from its creation, during its use and the period of retention and if appropriate information on the destruction. All staff should be familiar with the content of this policy.

All Crisis Staff have access to the Trust's electronic Health Care Records CITO, some via mobile technology and direct data inputting.

Staff undertake training in Information Governance and are to adhere to their Professional Codes of Conduct, Standards of Practice and Behaviour and TEWV Policy at all times.

19 Confidentiality

Confidentiality and its limits are explained to the patient and their family/care at the time of assessment, both verbally and in writing. Patient preferences for sharing information are respected and reviewed regularly.

Sometimes information sharing with other agencies and professionals is needed to manage risks appropriately, in accordance with professional body standards and Common-Sense Confidentiality Principles.

Staff will respect patient confidentiality and will provide time to carers/relatives to listen to concerns within the framework of Common-Sense Confidentiality.

Individuals and their carer/families should be informed as to what happens to their information, to create safety, care plans, and receive copies of letters (should they wish) from the team.

20 Reporting Incidents

All staff are responsible for recording and reporting incidents.

Timely recording and review of all incidents is essential to improving patient safety. This process begins with recording any incidents that impact on patients, visitors, staff, or Trust service provision, clinical or non-clinical and covering all levels of harm.

Adherence to TEWV Health and Safety Policies will be observed. Any incidents or near misses will be reported and recorded in line with TEWV incident reporting procedures. Everyturn will use their own systems.

All staff are responsible for recording any incident on the Trust's incident recording system (InPhase) within 24 hours of occurrence or being identified, if this is not possible then this should be escalated to the relevant line manager.

The primary aim of a good quality patient safety incident investigation is to accurately, and thoroughly, identify what happened (problems arising) and why; and establish strong/effective systems-based improvements to prevent or significantly reduce the risk of a repeat incident.

Accurate incident recording, providing correct and full details of the incident and everyone involved is an important first step.
As part of the new Learning from Patient Safety Events, all patient safety incidents are submitted to the NHSE national system.

20.1 Monthly reports

Monthly reports will be generated, and information analysed for any trends. Any learning from incidents will be shared at the Team Governance Meetings and fed into the Service Line and Care Group reporting meetings.

20.2 Ensuring all incidents are reported

Whenever there is an incident on Trust premises or arising from a Trust activity outside Trust premises, it is the responsibility of the person who has been directly affected by the incident to report it. Where the affected person is not a member of staff or is a member of staff but incapable of reporting, the person who observed the incident or was first notified is responsible for reporting. When a member of the CRHT has observed or been involved in an incident it is the responsibility of the individual and the teams shift Clinical Lead to ensure that the incident is reported by the end of the shift. This includes updating the incidents and events information on the safety tab on CITO.

20.3 Serious Incidents (SI's)

Serious Incidents (SI's) must be reported immediately to the Line Manager and Shift Clinical Lead and an incident form completed as soon as it is practical. There is an expectation that this should be before the end of the shift in which the incident occurred or that staff became aware that a Serious Incident has occurred. If it is thought that an incident is, or might be an SI, the most senior member of staff on duty should contact the appropriate Service or General Manager (in hours) and On-Call Manager (out of hours). The Service Manager or On-call Manager will verbally alert the appropriate Director on Call.

All SI's will be investigated by the Patient Safety Team, in line with the Trust Policy and Everyturn policy. Any learning will be shared locally and Trust wide/with partners/agencies.

20.4 Raising concerns

All staff members can challenge decisions and raise any concerns they may have about the standards or care. The Trust has a Whistleblowing policy in situ and staff are encouraged to raise any concerns.

20.5 Duty of Candour

When mistakes are made in care, these are discussed with the patient and their family/carers in line with the Duty of Candour policy.

21 Infection Control

Staff will follow reporting and management procedures as detailed within TEWV's Infection Control Policy and/or their own organisations policy.

22 Service Development

The Trust has an Urgent Care Programme Board which meets monthly and Care Group Urgent Care Governance meetings. There are Specialty Development Group Meetings Trust wide.

The Trust has a bi-monthly Urgent Care Network to share good practice, develop core standards and network with colleagues within and across Urgent Care chaired by the Trust wide Urgent Care Pathways Lead.

There is a regional NE and Y (NHS E) Communities of Practice Network which meets quarterly which is led by the Acute Pathways Clinical Lead for NE and Y and Out of Area Placement Clinical Leads and there are regular external Urgent Care programme meetings, interface meetings webinars, ICB meetings.

Some of the Trust CRHTs have attained accreditation with the QNCRHTT (formally HTAS) now which focus upon national standards of best practice for CRHTS. Those that are not accredited are working towards this status and should work within these standards regardless.

The CRHTs participate in Quality Improvement activities and actively encourage patients and carers to be involved alongside the Trust wide Urgent Care Transformation work which is underway. Training, education, recruitment, and service improvements should involve individuals and carers with lived experience.

The services review their clinical data at least annually exploring referrals, outcomes, quality of calls and other experience measures. Benchmarking data is submitted to NHS E regularly which is compared nationally, and action is taken to address any improvements and or inequalities of access that are identified.

23 Compliments, Concerns and Complaints.

The Service will proactively learn from all feedback received about the quality of our services and the experiences of those who access them. The service will manage your complaint in the best possible way to ensure that you receive a timely and compassionate response that clearly identifies what actions we will take which will demonstrate how we have learnt from your experience which will be used to improve our services.

In the first instance we ask that you talk to the staff involved with your care or treatment, or their manager. This is often the quickest way for us to put things right and stops them from becoming a formal complaint. If you do not feel comfortable about approaching this person, ask directly to speak to the Team Manager, the Modern Matron, the Service Manager, or the General Manager. Please do not be afraid to say what you think. If you bring your feedback to our attention, it will not affect your future treatment or care. The Trust (and Everyturn) has a policy of dealing with concerns openly. We welcome all feedback, and we will do everything possible to put things right.

How do we aim to resolve the concerns raised? We will:

- Agree the concerns that you wish for us to have a closer look or be investigated.
- Be thorough and fair.
- Let you know when we will respond to your complaint or if there is a delay.
- If there is a delay, we will keep you up to date with what is happening.
- Learn lessons from your experience of our services and make identified improvements.

Feedback received will be reviewed monthly by the team as part of learning, improvement, and performance monitoring. Both positive comments and those regarding what should be improved will be discussed as a team with resulting lessons learnt and action planning recorded in team meetings.

Below is the link where you can provide feedback.

Patient and carer feedback - Tees Esk and Wear Valley NHS Foundation Trust (tewv.nhs.uk)

24 Definitions

Term	Definition
Crisis Resolution and Home Treatment Teams (CRHT)	Crisis teams can support you if you have a mental health crisis outside hospital. You may also hear them referred to as crisis resolution and home treatment teams (shortened to CRHT or CRHTT). They are available 7 days a week, 24/7 providing triage, assessment, and intensive support along with gatekeeping roles.
Community Treatment Order (CTO)	If you have been sectioned and treated in hospital under certain sections, your responsible clinician can put you on a CTO. This means that you can be discharged from the section and leave hospital, but you might have to meet certain conditions such as living in a certain place or going somewhere for medical treatment. Sometimes, if you do not follow the conditions or become unwell, you can be returned to hospital.
Care Plan	A care plan is a written plan that describes the care and support staff will give a patient. Patients should be fully involved in creating the plan (and with their carers), agreeing, signing, and keeping a copy.
Safety Plan (or known as a crisis plan)	Is a plan developed with the patient and their family/carers to plan for future crisis situations and think about what would be helpful, what support you want (and not want), practical help, who you would want to be contacted who could help support you, what treatments you may want, and how others could spot the signs of a crisis. You should keep a copy and give a copy to relevant others.
Mental Capacity Act (2005)	The Mental Capacity Act 2005 is the law that tells you what you can do to plan ahead in case you cannot make decisions for yourself, how you can ask someone else to make decisions for you and who can make decisions for you if you have no plans in place.

Responsible Clinician (RC)	This is the mental health professional in charge of your care and treatment while you are sectioned under the Mental Health Act. Certain decisions, such as applying for someone who is sectioned to go onto a community treatment order (CTO), can only be taken by the responsible clinician. All responsible clinicians must be approved clinicians. They do not have to be a doctor, but in practice many of them are.
Safeguarding	In social care, safeguarding means protecting your right to live in safety, free from abuse and neglect. Local authorities have duties under the law towards people who are experiencing or are at risk of abuse and neglect.
Intensive Home Treatment (or intensive home-based Treatment) - IHT	Interventions, support, and treatment delivered by the crisis team in a suitable environment. These tend to be intensive in nature daily for a brief period.
Multi-disciplinary Team – (MDT)	Is a diverse group of professionals who work together. Their aim is to deliver person centred and coordinated care to support and individual with their care needs.
Community Intervention Team or Community Mental Health Team (CIT) (CMHT)	CMHTs support people with mental health problems living in the community, and their carers.
Care Programme Approach - CPA	The Care Programme Approach is a way that secondary mental health services are assessed, planned, coordinated, and reviewed for someone that lives in England. Secondary mental health services include the Community Mental Health Team (CMHT), Assertive Outreach Team and Early Intervention Team. You should get: • a full assessment of your health and social care needs • a care plan • regular reviews • a care coordinator who will be responsible for overseeing your care and support.
Care Coordinator (CC) *May now be referred to as Cooordinator of Care/Key Worker.*	A care coordinator is the main point of contact and support if you need ongoing mental health care. They keep in close contact with you while you receive mental health care and monitor how that care is delivered – particularly when you are outside of hospital. They are also responsible for carrying out an assessment to work out your health and

	social care needs under the care programme approach (CPA) A care coordinator could be any mental health professional, for example: • a nurse • a social worker • another mental health worker. This is decided according to what is most appropriate for your situation. A care coordinator usually works as part of the community mental health team.
Improving Access to Psychological Therapies (IAPT)	Is an NHS programme in England that offers interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression or anxiety.
Approved Mental Health Professional (AMHP)	AMHPs are mental health professionals who have been approved by a local social services authority to carry out duties under the Mental Health Act. They are responsible for coordinating your assessment and admission to hospital if you are sectioned. They may be: • social workers • nurses • occupational therapists • psychologists.
Emergency Duty Team (EDT)	The EDT provides an out of hours country wide, emergency service and response which aims to provide support and safeguarding services at a time of crisis, ensuring agencies, carers, service users and the public have a key point of contact when day teams are not available.
Quality Network for Crisis Resolution and Home Treatment Teams (QNCRHTT)	The group which is part of the Royal College of Psychiatrists purpose is to improve the quality of home treatment teams by supporting standards-based peer-review and accreditation.
NHS England	NHS England and NHS Improvement leads the national health service in England collaborating with regional teams to support the commissioning of health care services.
CITO	TEWV's electronic patient care record.

Visual Control Board (VCB)	Standard boards used within all teams and services to ensure quality, safety, and compliance of the pathways, supporting actions and daily team workload.
Place of Safety	A locally agreed place where the police may take you to be assessed. It is usually a hospital but can be your home. A police station should only be used in an emergency.
Integrated Care System (ICS)	Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities, and others to take collective responsibility for planning services, improving health, and reducing inequalities across geographical areas.
Integrated Care Board (ICB)	Responsible for NHS services, funding, commissioning, and workforce planning across the ICS area
Health Based Place of Safety (HBPOS)	Health-based places of safety (HBPoS) are the spaces NHS mental health service providers provide and manage for police officers to take people who have been detained under Section 136 of the Mental Health Act; people are taken to HBPoS for assessment by mental health care professionals.

25 Related Documents

Personalised Care Planning Policy

111 Select Mental Health Process

Lone Working Procedure

Safeguarding Adults

Safeguarding Children

Did Not Attend/Was Not Brought (urgent care supporting protocol)

Deprivation of Liberty Policy

Safety and Risk Management Policy

Supporting Behaviours that Challenge Policy

Privacy and Dignity Policy

Protocol for Hospital Transfers between TEWV NHS FT and Acute Hospitals

Interpreter and Translation Policy

Admission Transfer and Discharge framework

Missing Person Procedure

Trauma clip

Autism Strategy

Green Light Project

Trust wide Bed Management Policy

Mental Health Act related policies and procedures

TEWV, and other organisations, Interpreting and Translation Policies

The Carer's Charter

Quality Network for Crisis Resolution and Home Treatment Team (QNCRHTT) Standards

Purposeful Inpatient Admission Process (Pipa)

Rapid Process Improvement Workshop – AMH Triage, Assessment and Home-Based Treatment Standards (Quality Standards- form pathway for Crisis care).

Please contact H Embleton for further information.

26 How this policy will be implemented

- The policy will be published on the Trust's intranet and website, and in the staff bulletin.
- Service Managers and Line managers will disseminate this policy to all Trust employees through a line management briefing and discussion at their team meetings of content.
- All staff working with CRHT services to read the policy and work within the guidance and standards (in conjunction with other Trust Policies and Procedures).
- The Urgent Care Pathways Lead will circulate the link to the operational policy when published and discuss at the Trust-wide Urgent Care Network.

26.1 Training need analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
New staff to CRHTs to undertake Trust and local induction into team/s.	Formal and informal induction, supervision, mentoring, networking	As agreed with manager	Upon joining the Trust/Team and via ongoing identified appraisal processes
All staff to work to Crisis Pathway/quality standards work as agreed	Via observing team members, huddles, mentoring and through reading crisis operational policy and standard work.	As agreed with manager	Upon joining the team and during role.
All staff to undertake safety summary/safety plan workshop/training.	Online webinar	2 hours	Planned session.
A representative from the teams/care groups to attend the Trust-wide Urgent Care Network.	Network, discussion, shared learning, feedback, presentations, training	1.5. hrs.	Bimonthly meetings

Staff from CRHTs, Trusts, ICBS and partners to attend the Regional NE and Y Communities of Practice Network (NHS E)	Regional network, National guidance, learning, EBP	2hrs	Quarterly Meeting.

26.2 How the implementation of this policy will be monitored

	Auditable Standard/Key Performance Indicators	**Frequency/Method/Person Responsible**	**Where results and any Associate Action Plan will be reported to, implemented, and monitored; (this will usually be via the relevant Governance Group).**
1	Crisis Quality Standards: triage, assessment, safety summary and safety plan, use of VCB's.	Standard work for all amh CRHT's, monitored via VCB, huddles and electronic records by team managers/modern matrons, service managers and general managers.	In electronic patient records. Associated case notes audits within teams/localities. Any Trust wide audits with Urgent Care Pathways Lead involvement. (see below)
2	Performance measures relating to clinical priorities, quality, and safety/standards – documentation and crisis pathway.	Monitor on a daily/weekly and monthly basis by the team/staff on shift, Performance Team, Team Managers, Service Managers, General Managers and Directors of Operations, Urgent Care Pathways Lead and within Clinical Care Group Urgent care meetings monthly.	Reported on IIC and reviewed. Daily monitor of breeches. Review and monitoring of IIC crisis line call data, missed calls and unanswered calls, heatmaps, trends and complaints. Peer review visits and audit. Director led visits and feedback. Audit of Documentation standards and pathway including triage tool/clinical priority and documentation quality. Discussion of patient and carer feedback at the Urgent Care Network and clinical care group meetings linking in with lived experience directors and head of co creation.

3	Did Not Attend/Was Not Brought protocol	Staff and Team Managers via recording in records when using protocol as and when required.	In electronic patient records.
4	Quality Network for Crisis Resolution and Home Treatment Teams (formally HTAS standards).	Teams and staff work to standards and aim for peer review and accreditation by the QNCRHTT.	QNCHTT formal accreditation awarded and assessed accordingly via peer reviews and accreditation.

27 References/Further Documents

Carers Trust (2013) The Triangle of Care Carers Included: A Guide to Best Practice in Mental Health Care in England. Second Edition.

Crisp, N. Improving Acute Psychiatric inpatient care for adults in England – interim report. July 2015 (Commission on adult acute psychiatric care).

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis. Department of Health and Signatories. February 2014.

NHS England, Public Health England, Health Education England, Monitor, Care Quality Commission, NHS Trust Development Authority Five- Year Forward View (2014)

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness by People with Mental Illness (2024). Annual Report: England, Northern Ireland, Scotland, and Wales NCISH | Annual report 2024: UK patient and general population data 2011-2021

Nursing and Midwifery Council. Professional Standards of Practice and Behaviour (The Code) (2015)

NHS Long term plan (2019) NHS England.

Royal College of Psychiatrists (2022). Practice Guidelines for Crisis Line Response and Crisis Resolution Home Treatment Teams. QNCRHTT.

Soldini E, et al (2022). Effectiveness of crisis resolution home treatment for the management of acute psychiatric crises in Southern Switzerland: a natural experiment based on geography. BMC Psychiatry. 2022 Jun 17;22(1):405. Doi: 10.1186/s12888-022-04020-z. PMID: 35715789; PMCID: PMC9204869.

Sands, N., Elsom, S. & Colgate, R. UK Mental Health Triage Scale Guidelines, UK Mental Health Triage Scale Project, Wales, 2015

Standards for Inpatient Mental Health Services, 3rd Ed (2019) CCQI. The Royal College of Psychiatrists.

UK Mental Health Triage Tool

Link to QNCRHTT guidance – link (accessed on 06 Jan 2025)
Practice guidelines for Crisis Lines and CRHTTs (rcpsych.ac.uk)

28 Addendums for Localities

28.1 Durham and Darlington CRHT

Service Outline & Structure

Durham and Darlington Crisis services are based across two bases.
West Park Hospital
Lanchester Road Hospital

Serving an approximate population of 650,000

The service works in partnership with the ICS and ICB and 2 Local Authorities

Partner Services: -

- Lanchester Road Hospital
- West Park Hospital
- Community Intervention Teams
- ACCESS
- Street Triage Team
- Liaison & Diversion teams
- GP Aligned Practitioners
- Liaison Psychiatry team's (based at University Hospital North Durham and Darlington Memorial Hospital)
- Durham Constabulary
- In this Locality there are also Child Adolescent Mental Health and Learning Disability crisis teams both based at Lanchester Road Hospital

Population/Demographic Serving

Source; Office of National Statistics website

Key: Red = Local statistic reflects worse picture in comparison with national statistic
Green = Local statistic reflects better picture in comparison with national statistic

External Partner Agencies

Durham	Darlington
- Combat Stress (Veteran's Mental Health Charity) - Everyday Language Solutions - Moses Project - Relate	- Carers Together - Change Grow Live - DISC - Early Help - The Junction - My Sister's Place

- Alice House Hospice - The Atrium - Community Campus 87 - Hartlepool Action Recovery Team - Hartlepool Carers - Hartlepool Voluntary Development Agency - The Haven - Lifeline - Mesmac - Parents in Need of Support (PINS) - Police Liaison Officer - SAFA - 13 Housing - The Tramsheds - West View Resource Centre	- Bereavement Care - New Horizons - Stockton Carers Service - Stockton Navigation Project	- Bankruptcy - Barnados - Cargomm - Church Housing - Connections - Eclipse - Erimus housing - Fairbridge Project (Princes Trust) - Hope Northeast - Hospice - Mesmac - New Horizons - Positive Action Teesside - Relate - Red Cross - Riverside (Veterans) - Sahara - SAFA - Shaw Trust - Stages - Sure Start - Victim Support	- EVA - Fairbridge (Princes Trust) - Hospice - ManShed - Red Cross - Veterans Service - Salvation Army - Transformation Challenge Team - Women's Support Network Carers support group, Stonham, Disc, MIND, Insight, Drug and Alcohol

Processes to promote joint working with our partners include:

- Monthly Urgent Care Interface meeting.
- Repeat presentations to services meeting.
- Direct links between agencies and crisis leadership team.
- Urgent Care Network- Tewv
- Regional NE and Y Liaison and Crisis Community of Practice (led by urgent care lead in clinical lead role for NHS E NE and Y).

Service Training & Development Programme

Beyond Trust required mandatory and statutory and role-based training, staff are also offered:

- Where possible, support to attend training events of personal professional interest with the expectation that they will both implement and share their learning with the team for the improvement of the service overall as well as their own professional development.
- Following a recent review of crisis services there is ongoing quality improvement work to support and enhance improvements for patient care, staff wellbeing and other agencies.

28.2 Teesside

Crisis Service Operational Policy – Teesside Service Addendum
Service Outline & Structure

Teesside Crisis Service is made up of 2 community crisis intensive home treatment teams (CIHTs) and the Tees Crisis Triage & Assessment Service:

The Triage and Assessment service offers mental health assessments to service users who are referred by others, self-refer or self-present requesting assessment. They also offer advice based on the assessment and referring on to/consulting with appropriate services as required. The team will conduct a single assessment appointment with a service user and carer and then create a plan to address the individual's needs. The service can access hospital admission if required, Crisis Intensive Home Treatment via the CIHTs, longer term support via community mental health teams or can recommend non-TEWV services in the community that may help.

The Triage and Assessment team offers a 24-hour, 7-day service staffed by a team manager, Clinical Nurse Specialists, crisis clinicians and healthcare assistants as well as admin staff and access to medical and psychological input as required.

The 2 community CIHTs offer a different role and accept referrals from the triage & Assessment service, community mental health teams or other internal TEWV teams. They cover Teesside from Hartlepool to East Cleveland and are split into the North and South teams. They offer a 7-day service staffed by team managers, Clinical Nurse Specialists, crisis clinicians, occupational therapists, peer workers, assistant psychologists, psychological well-being practitioners and healthcare assistants as well as admin staff and access to medical and psychological input as required.

Intensive home treatment includes a variety of interventions including direct interventions and consulting with other services as appropriate.
The assessment team may, on occasion, conduct a single assessment appointment with a service user but, most often, work with service users for a minimum of 3 days. There is no specific time limit to how long the CRHTs will work with someone, but their focus is to provide intervention over a shorter time. Their aim is to support the service user to recover to the point they no longer feel in crisis and, if appropriate, move on to another service for longer term work.

Both the Triage & Assessment team and CIHTs also gate-keep hospital admissions.

Staff are allocated to their specific teams and shifts allocated at team level in the first instance. However, staffing is looked at service wide with staff moving between teams as needed to ensure the service is staffed safely and most efficiently and productively.

Beyond their day-to-day clinical roles, most team members also fulfil an additional role of team lead/champion in a specific area. E.g., Carer Lead, Safeguarding Link Professional, Revalidation Lead, Smoking Cessation Lead, Veteran Lead and Student Lead.

Population/Demographic Serving

Source; Office of National Statistics website **Population (2021)**

Area	**Total**	**Age 16-64**	**Age 65+**
Tees Valley	569,300	445,800	111,600
Hartlepool	92,300	57,700	18,300
Middlesbrough	143,900	91,500	24,200
Redcar & Cleveland	136,500	82,200	31,800
Stockton	196,600	123,200	37,300

Service Outline & Structure

There are 4 Crisis Resolution & Home-Based Treatment Teams operating within the North Yorkshire locality:

Scarborough, Whitby, and Ryedale
Cross Lane Hospital
Cross Lane
Scarborough
Y012 6DN

York & Selby
Foss Park Hospital,
Haxby Road,
York YO31 8TA

Hambleton & Richmond
North Moor House
North Moor Road
Northallerton
DL6 2FG

Harrogate
The Orchards
Princess Close
Ripon HG4 1HZ

- CRHTT's operate an all-age crisis phone line which is open to anyone within the area covered by TEWV who wishes to contact the service regardless of age. The all-age crisis line operates 24/7 and is accessed via 111 select mental health which is the single point of access for mental health crisis services.

- All CRHTT's accept referrals from current service users, carers, self-referrals from those not known to services following a screening conversation being completed via the 111 select mental health service.
  Professionals from TEWV, external agencies and partners can contact the relevant local Crisis Team directly to make a referral.

- Crisis Teams provide an urgent response (within 4 hours or 24 hours, dependent on the outcome of our triage assessment), and will complete a mental health assessment. Following this assessment, we can provide intensive home treatment as an alternative to acute hospital admission if this is required.
  We can also signpost to other agencies, depending on individual need.

- The CRHTT's offer a 24-hour, 7 day a week service with the teams being staffed by Team Managers, Clinical Psychologists, Advanced Nurse Practitioners, Consultant Psychiatrists, Support Workers, band 6 Crisis Clinicians, band 5 Home Intensive Treatment Workers, Medical Secretaries, and a Team Secretaries.

- The CRHTT's offers assessments and, for those accepted into service a period of home treatment which is an alternative to hospital admission. Home treatment includes a variety of interventions including direct interventions and liaising with other services as appropriate.

- The CRHTT's may on occasion conduct a single assessment appointment with a service user but, most often, work with service users for a minimum of 3 days. The current time limit the CRHT will work with someone for is 12 weeks, but their focus is to provide assessment and intervention over a shorter time period to support the service user to recover to the point they no longer feel in crisis and, if appropriate, to move on to another service for longer term work.

- The CRHTT's offer a face-to-face assessment for all requested admissions to hospital due to gatekeeping responsibilities. This ensures that all alternatives have been explored in accordance with the least restrictive approach. In the event hospital admission is required, the CRHTT maintains contact with the service user. As part of the gate keep process CRHTT will attend all mental health act assessments to explore appropriateness of alternative options to hospital admission.

- Each team offers in-reach/recovery at home into the inpatient wards for those patients within each individual team's catchment area for the purpose of early discharge support. This additional function seeks to provide planned early discharge from the inpatient environment and includes supported leave from the ward. The CRHTT attend formulation and discharge planning meetings. We contact the wards regularly and attend the wards face to face when required.

- S136 HBPoS are located at Cross lane Hospital and Foss Park Hospital and facilitated by CRHT staff 24/7, providing a place of safety for all ages.

- The staff members are split into two functions with the Band 5 clinicians providing Intensive Home Treatment and the Band 6 clinicians providing assessment and gatekeeping roles. The Band 6's will also prove Intensive Home Treatment if required. Band 3 support workers

have a hybrid role in supporting with Intensive Home Treatment and in HBPoS (where located)

- Beyond their day-to-day clinical roles, most team members also fulfil an additional role of team lead/champion in a specific area. E.g., Carer Lead, Smoking Cessation Lead, Safeguarding Lead, Health and Safety Lead, Perinatal Lead, Structured Clinical Management Lead, Physical Health Lead, Dual Diagnosis Lead, Veterans Lead, PGD Lead and Student Lead.

Population/Demographic Serving

Sources: Office of National Statistics website
www.DataNorthYorkshire.org

Population (mid-2016)	
Area	**Total**
Scarborough, Whitby & Ryedale	161,300
York & Selby	239,683
Hambleton & Richmond	142,500
Harrogate	156,300

Partner Services Within TEWV

- Primary Mental health Services
  Primary Care Metal Health Practitioners based in GP surgeries across the locality.
  Access to Mental Wellbeing Team (York & Selby only)

- Secondary Mental Health Services
  Integrated community Teams (ICT)
  Community Mental Health Teams (CMHT)
  Assertive Outreach Team
  Perinatal services
  Early Intervention in Psychosis (EIP)

- Liaison Psychiatry Teams based in A&E departments within the locality.
- Improving Access to Psychological Therapy (IAPT)

- Child and Adolescent Mental Health Service (CAMHS)
- CAMHS Crisis Team
- AMH Inpatient wards based at Cross Lane & Foss Park Hospital

External Partner Agencies

Across Scarborough, Whitby, Ryedale
- Scarborough Survivors and Crisis Café - Andy's Man Club Scarborough - Woman's wellbeing club - Scarborough Disability Action Group (DAG) - Carers plus Yorkshire - First light Trust - North Yorkshire Horizons - Broadacres - Citizens Advice Bureau - Local Authority/Social Care, STR Workers, Living Well Team - Northern Lights Therapy Service Scarborough - Age UK Scarborough - Advocacy Alliance - Mental Health Matters - Mind - Recovery College - Samaritans - Rainbow Centre - Foundation Housing, Horton Housing - IDAS - Safer Neighbourhoods and Community Impact Team

External Partner Agencies

Across York & Selby

- Carers Resource, Young Carers and Carers Support
- Citizens Advice Bureau
- Local Authority/Social Care, STR Workers, Living Well Team
- Mental Health Matters
- Mind
- The Haven
- Recovery College
- Samaritans
- Survivors
- Rainbow Centre
- Foundation Housing, Horton Housing
- IDAS
- Safer Neighbourhoods and Community Impact Team
- Communi-tea

Across Hambleton and Richmondshire
- Carers Resource centre including young carers. - Citizens Advice Bureau - Local Authority/Social Care (North Yorkshire County Council) including STr workers, Living Well team. - North Yorkshire mental health helpline - North Yorkshire Horizons (Substance Misuse) - The Living Rooms including the Man Shed - Phoenix House, Catterick (Help for Heroes) - RELATE - Combat Stress - Independent Domestic Abuse Service (IDAS) - Samaritans - MIND/Centrepoint - Mental Health Police Liaison officer - The Clock, Thirsk - Broadacres - Hambleton District Council - Herriot Hospice Homecare

Across Harrogate
- Carers Resource centre, East Parade - Citizens Advice Bureau - Local Authority/Social Care, STR Workers, - The Orb - Mind - Claro enterprises - Samaritans - Springboard / Homeless project - No second night out - North Yorkshire mental health helpline

Processes to promote joint working with our partners include:

- Bi- monthly Urgent Care Interface meeting
- Repeat Attender meetings.
- Direct links between agencies and crisis leadership team.
- Tasking meeting attended by Safer Neighbourhoods, 3rd sector, police, housing, YAS.
- Interagency Operational Group meeting – bi-monthly.

Service Training & Development Programme

Beyond Trust required mandatory and statutory and role-based training, staff are also offered:

- Team away days specifically focused on service cohesiveness, development over the past year and service direction and asking for feedback from staff re same.

- Monthly team meetings where 3rd Sector Services are invited to update the team on what they can provide service users and consultants and specialist practitioners also provide the team with training in their areas, such as Trauma Informed Care, Attachment Disorders, Personality Disorders and Dual Diagnosis.

- Access to supervision from the trusts Safeguarding Lead and Personality Disorder Psychology Lead.

- Where possible, support to attend training events of personal professional interest with the expectation that they will both implement and share their learning with the team for the

improvement of the service overall as well as their own professional development, including Leadership courses, Dual Diagnosis training and Structured Clinical Management.

28.3.1 MHSOP

There is no dedicated MHSOP crisis service provision for older adults in SWR, York and Selby. CITs are currently commissioned to operate 5 days per week. This can lead to service gaps for CIT's providing increased support in teams. CIT's often request crisis teams to support patients in crisis with identified care plans for daily visits over weekend and/or bank holidays.

Care Home and Dementia Team (CHAD) based in York, operate 7 days per week and can support with crisis input for organic patients at home or in care placements.

28.3.2 Harrogate MHSOP Service Addendum

MHSOP Crisis and Home Treatment Team (CRHT).

Service Outline & Structure

- Persons over 65 years of age (or persons younger than 65 experiencing cognitive illness and comorbid illnesses that are more appropriately met by a specialist MHSOP service) living within the Harrogate, Ripon and Wetherby area can access rapid assessment, treatment, and support from the MHSOP CRHT.
- The MHSOP CRHT offers a 12-hour daily service from 8.00am – 20.00hrs, 7 days a week, 365 days a year. The team are based at Alexander house, Ashtree road, Knaresborough, HG5 0UB.
- The MHSOP CRHT accepts referrals from all sources - including self-referrals; for those who need an urgent or rapid response to their mental health needs. The team aims to assess and engage all referrals within 4 – 48 hours – dependent upon the information provided and agreed outcomes reached from effective triage with the person, carer and/ or referrer.
- The MHSOP CRHT offers triage, assessment, signposting, and treatment for those referred to service for crisis or home treatment support.
- MHSOP CRHT gate keep admission to inpatient psychiatry hospital wards – having links to Foss Park Hospital (York) and Rowan lea Hospital (Scarborough) on both formal (MHA) and informal basis.
- The MHSOP CRHT offers crisis assessment and treatment in persons own homes as an alternative to inpatient psychiatry admission. Support is provided to a person's designated place of residence – their own home or another place of residence such as supported accommodation and care home environments.
- MHSOP CRHT includes a variety of interventions including direct face to face contact: either at home, at the team base or in alternative arenas whereby there is a community wide support plan and/ or and liaison with other community services as required.
- The team work alongside alternative agencies such as the police, ambulance service, liaison and diversion team, accident and emergency and psychiatry liaison teams, social care teams, Third sector services; social and Private care home facilities and community package teams.
- MHSOP CRHT can facilitate early discharge for those persons who no longer require treatment to be restricted to the inpatient psychiatry setting and where treatment and interventions can be provided at home to aid further recovery.
- MHSOP CHTT offer intensive support and treatment in the home environment for persons presenting with deteriorating mental health, mental health relapse, mental health distress or increasing risks associated with mental health and / or co morbid mental and physical illness. The team adopt a recovery-based approach working with persons and their families and carers to develop effective treatment plans and person centred Crisis care plans that acknowledge and utilise a person's strengths, develop resilience and follow the recovery principles of CHIME to strive for long term recovery goals and independence in the management of chronic or co morbid illness and mental health conditions.
- MHSOP CRHT ensures health and social care needs and risks are assessed with the person in receipt of the service. Carers can also be offered a carers assessment which may enable them to receive additional support in their role and further signposting to access health and care services that may support their own health needs – taking into consideration systemic family and support circle needs for sustained recovery and positive health outcomes.

- The MHSOP CRHT may on occasion conduct a single assessment appointment with a service user and refer on to other agencies or signpost to third sector providers that may be most appropriate to meet the patient's needs.
- The current average time limit the CRHT will work with someone for is approximately 4 - 6 weeks but their focus is to provide assessment and intervention over a shorter time period to support the service user to recover to the point they no longer feel in crisis and, if appropriate or needed, facilitate any ongoing support with other services for any longer-term work.

Population/Demographic Serving

Office of National Statistics website

Greater detail on topics can be found in our Joint Strategic Needs Assessment (JSNA) resource at www.datanorthyorkshire.org

'' The population of Harrogate Borough is **estimated to be 160,533 and is set to increase to 161,700 in 2025.** The birth rate in the district is 56 per 1,000 women (England= 69 per 1,000 women). Projections indicate that the **population in the over-85 age group is expected to increase in Harrogate by approximately 26% by 2025. For the same age group, an increase of 23% is expected in North Yorkshire and an increase of 22% in England.** A **15% increase is also anticipated for those in the retirement category (age 65-84) in the district.** Meanwhile, the under 45 population in Harrogate is projected to decrease by 9% across the two relevant age groupings.''

'' Harrogate Borough has an older population than England, with **more residents between the ages of 45-89, and fewer aged under 45.** …….. typical of a population with long life expectancy and low birth rate. **There are about 15,600 people aged 65+ with a limiting long-term illness**. Of these people, 42% (6,600) report that their daily activities are limited because of their illness (POPPI, 2019). Approximately 4% of the population is from Black, Asian and minority ethnic groups, compared with 2.8% in North Yorkshire and 15% in England.''

'' The population in Harrogate Borough is ageing. **By 2025, there will be 5,800 additional people aged 65+**, a 16% increase from 2018, but a 3% decrease in the working-age population. This will lead to increased health and social care needs with fewer people available to work in health and care roles.''

Partner Services Within TEWV

- Moor Croft Ward (Functional inpatient) and Wold view (Organic Inpatient ward) Springwood (Long term care and behaviour specialist ward)
- Secondary Mental Health Services (Community mental health team – Harrogate, Knaresborough, Wetherby, and Ripon)
- Liaison Psychiatry Team (Harrogate District Hospital)
- Primary Care Mental Health team
- Memory Clinic
- IAPT
- HARA (Harrogate and Rural Alliance) mental health nurses

External Partner Agencies

Across Harrogate
- Carers Resource centre - Citizens Advice Bureau - Local Authority/Social Care, STR Workers, - Mind - Claro enterprises - Samaritans - Dementia Forward - Alzheimer Society - North Yorkshire Horizons - ARCH (Acute response and rehabilitation- community and hospital) Team - SDS (Supported discharge service) Team – Harrogate District Foundation Trust - Harrogate Social care and Harrogate Borough Council

Professional Educational Placements

The MHSOP CRHT is part of the TEWV NHS Trust commitment to providing excellent professional training placements and hosts trainees from various health occupations including Doctors (Psychiatric, GP trainees, Foundation) Mental health Nurses and social workers, Associate physicians, Trainee nurse associate, Pharmacy and Acute medicine trainees and professionals.

Service Training & Development Programme

Beyond Trust required mandatory and statutory and role-based training, staff are also offered:

- Access to fortnightly CPD sessions: education and learning through internal and external presenters – on relevant mental and physical health topics or national and regional events and project reviews.
- 3 monthly management supervision and 3 monthly Clinical supervision for direct discussion on both personal and service developments including goal setting for establishing a personal pathway for staff members to link the two objectives in an educational and developmental way.
- Once monthly team meetings; are provided for a shared team, service, and locality agenda. Once monthly team development meetings are provided for focus on specific project developments, feedback, and review from quality improvements: old and new.
- Yearly appraisal and talent management session provided for personal development and planning.
- When available to access; the team are considered to take part in local and national research and new Randomised Control Trials/Pilots regarding mental health care and its evidence base.
- When teaching and workshops become available and where relevant to a staff members personal or professional interest or the interest of the team - staff are encouraged to take up opportunities to learn (and their time protected in practice to attend learning) with the expectation that they will implement and share their learning with the team for the improvement of the service, as well as their own professional development.
- All band 6 members are offered the opportunity to become non-medical prescribers.

- All staff members are offered clinical skills training for ECG and phlebotomy.
- All staff members are offered clinical tools training for functional and organic assessment.
- All staff members are offered leadership roles within the team for service effectiveness and growth, including but not limited to: - Prescribing, Physical health care and monitoring, Dementia pathway and strategies, Delirium pathway and strategies, Carer and service user experience, Trauma informed care, non-pharmacological approaches in treatment - governed and non-governed approaches and therapies.

29 Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	21 January 2025
Next review date	21 January 2028
This document replaces	COP-0017-v4.1 Crisis Operational Policy
This document was approved by	Trustwide Urgent Care Network (virtual)
This document was approved	06 January 2025
This document was ratified by	Management Group
This document was ratified	21 January 2025
An equality analysis was completed on this policy on	06 January 2025
Document type	Public
FOI Clause (Private documents only)	n/a

Change record.

Version	Date	Amendment details	Status
1	14 Mar 2018	New policy	Withdrawn
2	12 Jun 2019	Updated to reflect a more recovery-focused approach, considering harm minimisation and modern approaches to crisis services in line with other Trust policies creating common language and based upon the CHIME principles.	Withdrawn
3.	30th June 2020	Removal of hyperlinks – existing policies Team addendums updated. CTO line added	Withdrawn

4.	05 Oct 2021	Updated to reflect safety summary and safety plan changes, language, New OJTC Trust values, goals, Consultant assessment/AMHP out of hours communication, Carer's Charter, general section updates; shift coordinator, physical heath, medication, care planning, mental capacity act 1 and central crisis line, team addendums. Transferred to new template. Note – the ratification on the 05 Oct 2021 O&A Group was subject to amendment of OJTC text, the amended OJTC was approved by the Assistant Chief Executive on the 27 Jan 2022.	Withdrawn
4.1	14 Dec 2022	Reviewed by Management Group on 21 Sept 2022: - Minor amendment to reflect current practice within Trust wide Crisis Teams use of new national clinical priority standards and UK mental health triage tool. Updated references to job titles and assurance groups. (Plus, changes requested by Management Group on 21 Sept 2022) Updated LD paragraph (During office hours…) section 5. Addendums updated.	Withdrawn
v5	21 Jan 2024	Full 3 yearly Policy Review including clarifications and amendments throughout, main changes are: Language updated to reflect new roles and governance structures. Policy to be used in conjunction with the 111 select mental health process. Addendums about local crisis teams specific to Care Groups updated. Equality Impact Assessment reviewed and updated. Updated to reflect other policy changes – Harm minimisation (now Safety and Risk Management Policy), Personalised Care Planning, Perinatal, bed management, introduction of CITO. Consideration of 6th edition standards review by the Quality Network for Crisis Resolution and Home Treatment (CRHTT) to be published (in draft) Crisis flowchart Summary added as an appendix. Management of patients in CRHT/IHT when a bed is not available – process added as an appendix.	Ratified

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Crisis Teams – Trust Wide
Title	Crisis Operational Policy
Type	Policy
Geographical area covered	Trust-wide
Aims and objectives	The Purpose of this policy is to describe how CRHT services will carry out their core functions of which are to provide timely, responsive triage, assessment, home based treatment and alternatives to admission, to service users and their carers, in keeping with national drivers and directives and contemporaneous evidence-based practice, whilst collaborating with a range of partner agencies.
Start date of Equality Analysis Screening	09 September 2024
End date of Equality Analysis Screening	06 January 2025

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project, or Business plan benefit?	Any service user, Carer, family member/friend of a service user along with TEWV staff and partner agencies including GPs, CCGS, Local Authorities accessing CRHT's.
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project, or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveler) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism, and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on parental leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans, and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	none
Describe any positive impacts / Human Rights Implications	Interpreting services to be accessed and arranged as required via protocols for each Care Group considering patient and carer needs, staff should not use family members as interpreters. All CRHT staff need to be familiar with how to access the interpreting service. There is a dedicated direct number to the CRHT hub/s (York and Teesside) for those who are deaf/hearing impairment- for those contacting 111 select Mental Health option/via RELAY. The interpreter will call the CRHT direct for triage (this is a national directive) as opposed to calling 111 select MH option. There are national text support services including SHOUT which can be accessed.

	Staff can contact the Equality and Diversity team for advice, guidance, and information. Staff to be sensitive regarding (requests relating to the gender of staff and consider where possible patient preference. Refer to Minimum Standards for Clinical Record Keeping and Privacy and Dignity policies for further information about how to record gender for trans patients within the electronic records. It is also important to ensure that the patients preferred pronouns, gender and name are always used. Staff to consider an individual's religion, faith, and practices along with the impact on their mental health. Also consider specific religious practices including Ramadan and if those individuals can continue to take medication at this time. Staff can access support and advice via the chaplaincy team and specialist chaplains. Physical ability – to assess needs and consider any impact planning care accordingly and jointly where necessary making reasonable adjustments where needed i.e., patient own aids, Trust environments, access etc. Those with a learning disability - refer to local procedures and policies for interdisciplinary working. Staff should also assess and put in place reasonable adjustments for those with a learning disability/autism. For visual impairment - utilise audio information and braille according to the patient's choice. Staff to Consider higher rates of suicide and self-harming behavior that is reported in service users from the LGBTQ+ community – consider impact of such at times of assessment along with other risk factors for those with protected characteristics. AGE- Refer to each locality service models. Unless there are operational services to assess, i.e., CAMHS, MHSOP the CRHT would see.

Section 3	Research and involvement
What sources of information have you considered? (e.g., legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	See references
Have you engaged or consulted with service users, carers, staff, and other stakeholders including people from the protected groups?	yes
If you answered Yes above, describe the engagement and involvement that has taken place	Trust wide engagement has been undertaken relating to the crisis operational policy including staff from all specialties and a consultation period. This includes feedback and comments from the Specialty Development Managers for the specialties across the Trust, previous Recovery leads, Trauma leads, Autism Strategy Manager, Urgent Care Network, Equality and Diversity team along with local authority partners and Experts by Experience. Wider national, regional and feedback from the Royal College (QNCRHTT) standards and consultation.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Web ex/use of attend anywhere – exploration of technology Trust wide to support the above protected characteristics. Staff have received training on the new Electronic Patient record – CITO. Staff have received training on the new BT CCNG telephony platform which has been introduced through Crisis Services. Alternatives to crisis have been promoted and Directory of Services (service finder) has been updated. The deaf and hearing lead E Chan has also linked in with the Urgent Care Network and teams and has met with the Urgent Care Lead for updates. Urgent Care Pathways Lead links in with regional NHS E and national colleagues relating to the 111

	select MH models and developments. They are the NE and Y Acute Pathways Clinical Lead (NHS E) also working one day per week on urgent care aspects. Autism awareness training has been encouraged for all urgent care staff and there is a mandatory session which all staff must undertake. Wider transformation work is underway in terms of clinical models and via the Urgent Care Programme Board.
Describe any training needs for patients	n/a
Describe any training needs for contractors or other outside agencies	n/a

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – A co-created safety plan with a patient and carer is required when an inpatient bed is unavailable and when it is considered safe to remain at home whilst awaiting a bed.

To update clinical staff, bed managers and Tactical on Call leaders of the process for patients who require a co-created safety plan to provide safe care in the community whilst awaiting admission to hospital.

Key message:

All patients should have a comprehensive safety plan to support the patient whilst awaiting hospital admission. Areas to be considered include:

- Crisis team to conduct a gatekeeping assessment and MDT discussion about the patient's presentation/ risks/ mitigation whilst awaiting a bed. If clinically indicated and patient presentation requires, discuss the plan with Crisis Team or Community Consultant. Out of hours, discuss plan with on call Higher trainee/ Consultant.
- Discuss and record who the patient will be staying with whilst awaiting a bed, including the carer/family members name, contact details and address- ensure this is recorded on Paris.
- To discuss and record the management of risk whilst awaiting a bed and ensure the carer/family are aware and agree with the plans made to support the patient.
- The carer/family member should be aware of what actions to take if there is an increase in risk or deterioration of mental state, including the numbers they should call.
- The patient to be supported under IHT whilst awaiting a bed with a minimum of once daily, face to face reviews.
- The patient should be seen by a Crisis clinician for review within 24hrs of the initial request for inpatient admission and where needed, a discussion with a Crisis team Specialty doctor/ Senior Psychiatrist could take place for advice on further clinical management. This would be ordinarily CHRT medics in normal working hours. Please note **there is no expectation** that this medical contact is Face to Face (unless the clinical presentation and rationale indicates this) and **there is no expectation** that a clinical decision of admission will be reversed as part of this MDT discussion. Its main purpose is to support the patient/team whilst awaiting a bed.
- In addition, as part of the ongoing daily review of the patient in the community, the Crisis clinician can also seek advice from the Out of hours senior registrars under consultant supervision.
- Frequency of contact with carer/family should be agreed and documented to review the patient's presentation and plan for support.
- Liaise a minimum of twice daily with bed management regarding bed availability.
- Identify any actions for other involved services to ensure the patient has a comprehensive plan of support whilst awaiting admission.

Process for patients to provide safe care in the community whilst awaiting admission to hospital.

Role and responsibilities	Lead
Patient assessed as requiring a hospital admission and gate keeping completed by crisis team. All required care documents and care records updated to reflect the patient's current mental state, presentation, and reason for hospital admission.	Community, liaison or Crisis team
Liaison with Bed managers to provide patient details and to advise that hospital admission is required. Bed escalation process to be followed by bed management team if no bed can be located. If a bed cannot immediately be available (for example whilst awaiting the outcome of a leave bed or ward discharge meetings) an immediate safety plan will be discussed and commenced with the patient, family, and carers.	Crisis team/Bed management
If no bed can be located for the patient (including the provision of independent sector beds) a clinical discussion will take place to consider whether the patient can be safely safety planned to remain in the community until a bed can be located.	Community team/AMHP/ Liaison Psychiatry/ Crisis team
In-Phase form to be completed	Community, liaison or crisis team
Patient and carers to be updated to advise that there is no current bed availability and to establish if there is a short-term plan that could be supported within the community to safely support the patient at home.	Community, liaison or crisis team
Patient will then be transferred to receive Home Based treatment and patient added to crisis team Visual Control Board (VCB)	Crisis Team
The safety plan document within the care record will be updated to reflect the plan that has been discussed with the clinician, patient, and family/carer (see appendix 2, guidance for considerations to be made when completing a safety plan) Please note – if the patient is in an acute trust hospital and is awaiting a mental health bed, a safety plan should be completed in discussion with the patient, family and the acute trust by the Liaison Psychiatry team and daily visits/reviews of the patient should be conducted.	Community, liaison or crisis team

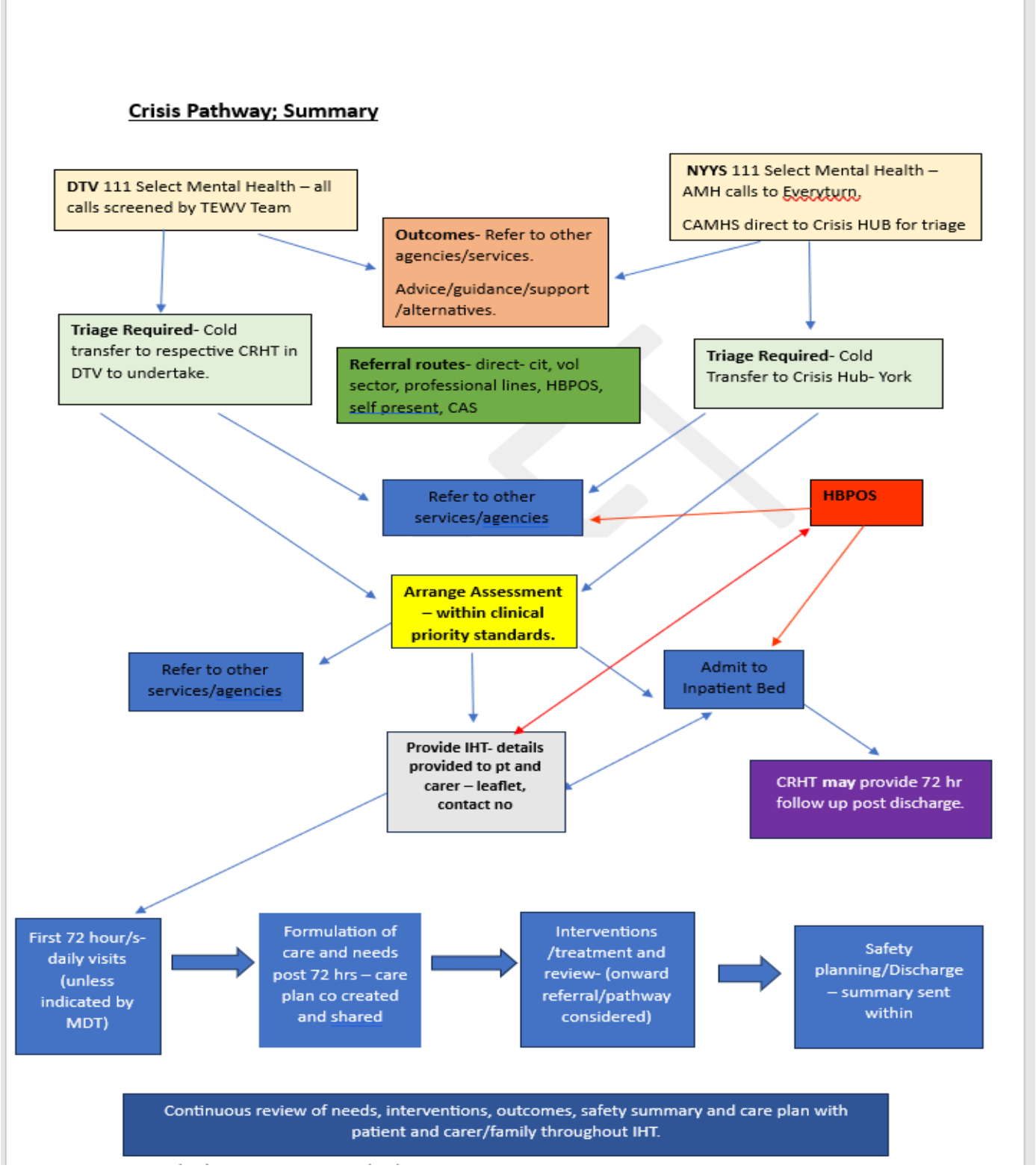
The safety summary care document should be updated to reflect that patient requires admission and that a safety plan is in place to support the patient within the community whist a bed is located.	Community, liaison or crisis team
All standard processes for patients under the care of crisis teams/Home based treatment will be followed including: • Care document completion. • Formulation within 72hrs (for patients not open to TEWV services) • Physical health monitoring • Daily review by qualified clinician	Community, liaison or crisis team
Minimum twice daily contact with the bed management team to review bed availability and patient/family to be updated daily whilst being supported in the community.	Bed management/crisis team

CONSIDERATION FOR COMPLETING A SAFETY PLAN WHEN A PATIENT IS WAITING FOR AN INPATIENT BED

This is an example of the minimum requirements of what should be considered and documented in the patient's safety plan, within the "Important things to know and what things are we doing right now in relation to these risks" section. This guide is not exhaustive and should be individualised for each patient.

Safety Plan
Important things to know
• Write that they are waiting for an inpatient bed in bold – "**PATIENT CURRENTLY AT HOME AWAITING INPATIENT BED"** or 'PATIENT **CURRENTLY MANAGED IN HEALTH PLACE BASED OF SAFETY (HBPOS) AWAITING INPATIENT BED'** • Overview of current presentation • Any existing information that remains relevant should not be deleted
What things are we doing right now in relation to these risks (immediate mitigations)
• Consider and document whether the patient needs to be cared for in a place of safety – If they do and there are no concerns about physical health, arrangements should be made for them to be brought to the nearest Health Base Place of Safety (HBPOS). • If the person is safe to be cared for at home while a bed is identified, consider, and document the following: o When in hours discuss with Team or Community Consultant. Out of hours, discuss plan with on call Consultant. o Document who, i.e., carer/family member, is going to be staying with the patient while they are waiting for the bed including their name, telephone number and address. o Discuss and document the management of risks whilst the patient is being cared for at home and ensure the carer/family member is aware and in agreement with the planned support. o Discuss and document the plan around what the carer should do if there is an increase in risk or further deterioration in mental state. Explain and document what this could or might look like and the steps to take and include the contact numbers they can call. o Referral to be made to Intensive Home Treatment. o Agree and document a plan for review points – this should include: ▪ Appropriate clinician/ Crisis clinician (within/ out of hours) review within 24 hours ▪ Frequency of reviews by CRHT – this needs to be a minimum of once daily, face to face review. If clinically indicated frequency should be increased. ▪ Frequency of telephone calls to review contingency plan and patients' presentation with carer/family member and confirm that they continue to agree with the contingency management plan in place (We need to consider if this is required Out of Hours). Explore carer/family wellbeing during these calls. ▪ Minimum of twice daily updates regarding bed availability with bed management as per protocol needs to be added to the plan. ▪ Identify actions from other involved services and agencies, for example, contact with care team/probation/substance misuse service/Emergency Duty Team and record into the plan. Crisis clinicians should clarify with AMPHs or EDT what their next steps are and document this.

Appendix 3 – Crisis Flow Chart- Summary.



Appendix 4 - Approval checklist

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	yes	policy
2.	**Rationale**		
	Are reasons for development of the document stated?	yes	
3.	**Development Process**		
	Are people involved in the development identified?	yes	Task and Finish Group with key Urgent Care Staff – 10/09/24 and 08/10/2024. Wide consultation and feedback over Teams Channel, through Trust policy consultation process.
	Has relevant expertise has been sought/used?	yes	Via leads within Trust, and in regional/national NHS E teams and via the QNCRHTT/standards.
	Is there evidence of consultation with stakeholders and users?	yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	yes	Quality standards for crisis care pathway reviewed and in situ. QNCRHTT 6th edition standards under review.
4.	**Content**		
	Is the objective of the document clear?	yes	
	Is the target population clear and unambiguous?	yes	
	Are the intended outcomes described?	yes	
	Are the statements clear and unambiguous?	yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	yes	
	Are key references cited?	yes	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Are supporting documents referenced?	yes	Added appendices
6.	**Training**		
	Have training needs been considered?	yes	
	Are training needs included in the document?	yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	yes	Plan in place
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	yes	E and D officer aware of work to date and future plans.
	Have Equality and Diversity reviewed and approved the equality analysis?	yes	Updated by Urgent Care Pathways Lead jointly.
9.	**Approval**		
	Does the document identify which committee/group will approve it?	yes	Management Group
10.	**Publication**		
	Has the policy been reviewed for harm?	yes	
	Does the document identify whether it is private or public?	public	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	