Sussex Partnership NHS Foundation Trust

Crisis Resolution Home Treatment Team Policy

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POLICY AUTHOR	Interim Urgent Care Pathway Lead

EXECUTIVE SUMMARY:

SUMMARY OR KEY ISSUES, SERVICES/STAFF GROUP POLICIES APPLY TO:

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Please be advised that the Trust discourages the printing and retention of hard copies of policies and can guarantee that the policy on the Trust website is the most up-to-date version.

As a contingency a full set of up-to-date Trust policies are held by the Corporate Governance Team based at Trust HQ, Swandean

5. ATS Trusted CRHTT Case note Prompts and Format 6. Gate Keeping Case note Prompts and Format	

1.0 Introduction

- The Crisis Resolution Home Treatment Team (CRHTT) is a multi-disciplinary team of mental health professionals providing a 7 day per week service to people experiencing an acute psychiatric crisis. The team provides an alternative to acute hospital treatment by offering intensive community-based interventions and gate keeping all potential hospital admissions. Where a hospital admission does occur, CRHTT can assist in shortening the inpatient stay by facilitating supportive discharge back to the community.

- CRHTT's are an essential component of the developing trust wide Urgent Care Hubs. Other urgent care services within these hubs are Mental Health Liaison and Haven teams in addition to Liaison suites, Blue light triage and Crisis cafes.

- To enable flexible working which can be responsive to volatility in demand, these urgent care hubs are based around key geographic sites where staff can easily move between teams/functions at short notice. The make-up of hubs therefore varies across Sussex, reflecting the differing accommodation arrangements for teams. Please refer to local area's SOP appendices.

- These hubs create a framework for urgent care teams to work flexibly, supporting each other to deliver the best possible care for patients over the 24/7 period. Urgent Care Practitioners are able to work across pathways strengthening resilience of the urgent care pathway and supporting patients to experience seamless transition between the teams operating within hubs.

- Sussex Partnership NHS Foundation Trust (SPFT) is commissioned to provide Crisis Resolution Home Treatment services to the adult population of Sussex. There are six CRHTTs based in the following locations covering the following areas:
    - Millview Hospital – Brighton and Hove
    - Harold Kidd Unit – Chichester, Bognor Regis, Pulborough and rural West Sussex
    - Langley Green Hospital – Crawley, Horsham and Mid – Sussex
    - Department of Psychiatry – Eastbourne, High Weald, Lewes and Havens
    - Woodlands Centre for Acute Care – Hastings and Rother
    - Meadowfield Hospital – Adur, Arun and Worthing

2.0 Purpose of CRHTT

- To aid and support the personal recovery in the community of an adult aged 18 years and above who is experiencing a mental health crisis. CRHTT's will provide individuals with safe, effective, compassionate, high quality care in the community throughout.
- To provide timely intervention to service users including assessments and intensive home-based treatment as an alternative to an acute hospital admission.

The ultimate aim is one of minimising harm to self, from others and potential unintentional harms, for example unnecessary hospital admissions.

2.1 Values

- The Provision of CRHTT is based on a shared care model. This is centred around collaboration and shared decision making with the service user and their support network, being based towards recovery and building upon an individual's strengths.

- The CRHTT's will fully comply with Trust-wide Policies and procedures applicable to both urgent and acute care services.

2.2 Principles of this policy

- This policy provides the operational guidelines under which the Crisis Resolution Home Treatment Team will provide a safe and evidence-based service. The nature of the teams is such that it is not possible to cover all eventualities within this policy. CRHTT will need to consider the principles of this policy and other Trust policy and guidance when making decisions to best meet the needs of individual service users.

- This policy is applicable to all SPFT CRHTTs. Any local process variations and additionally funded services will be locally highlighted and compliment this policy.

3.0 Aims

Each CRHTT has been measured against the Crisis Resolution team Optimisation and Relapse prevention standards (CORE) fidelity model in order to optimise the functioning of service.

3.1 Our key standards are:

- Working within the context of effective partnerships with service users, their carers, family or friends, acute inpatient services (including out of area placements OOA) and community care providers. This includes statutory and non-statutory services as detailed in the Five Year Forward View, (NHS England October 2014) and the NHS Long Term Plan (January 2019). Please see the SPFT Community Team, Acute Adult Inpatient and Clinical Bed Management operational policies.

- Working particularly in partnership with the Assessment and Treatment Service (ATS) ensuring that CRHTT intervention and support is targeted and timely.

- Providing acute care which is holistic, person-centred and facilitates recovery focusing on the persons strengths and underpinned by humanity, dignity and respect.

- Ensuring that each service user has the following whilst under the care of CRHTT:

  - Consultant Psychiatrist/Doctor
  - Access to advice and support regarding medication.
  - Named lead CRHTT worker.
  - Comprehensive and collaborative assessment of their mental and physical health needs and risks that reflect their diverse and unique needs.
  - Collaborative personalised care plan identifying needs and risks and documenting any advanced statements that may have been made by the service user. This will be shared with the service user, carer family and/or friends when appropriate to do so.
  - Support in accessing resources to support recovery and maintain wellbeing.

- Ensuring that all risk assessments and care plans are reviewed regularly and any change in presentation or risk is reflected at all times and shared appropriately with the service user, and their support network.

- Developing or reviewing relapse prevention plans with service users. Ensuring that each plan contains structured self-management programmes to promote recovery or respond to future difficulties.

- Providing evidenced based assessment and interventions underpinned by the implementation of NICE guidance and in keeping with Crisis Resolution team Optimisation and Relapse prevention standards (CORE) and Clinical Academic Groups (CAGs) Menus of Care.

- Ensuring staff have the knowledge and skills required to deliver safe, effective and high-quality collaborative care.

- Ensuring the electronic clinical record (Carenotes) is used at all times to maintain clinical records.

- Ensuring information and resources are available for service users and carer(s) in a variety of formats and languages.

- Ensuring real - time feedback from service users using patient reported experience measures (PREMs) and patient reported outcome measures (PROMs) to inform service delivery.

- Ensuring service development and improvements will be co-produced with service users, family, friends and carers as well as other partners.

3.2 Our key performance standards are:

- Providing assessments for service users who are referred by their GP via the agreed 4-hour urgent referral pathway. In Brighton this task is undertaken by the Mental Health Rapid Response Service (MHRRS) and not CRHTT.

- Providing intensive home treatment and support for up to six weeks, however, when appropriate and to ensure continuity of support CRHTT may remain involved whilst arranging further support and treatment as applicable.

- Contacting the referred person within 4 hours of the accepted referral and where a need for a face to face assessment or review is identified this will take place within 24 hours of the original referral.

- Providing a range of evidence based psychosocial interventions (Section 9).

- Providing medical reviews, prescribing and monitoring of medication.

- Ensuring that within one day of CRHTT's assessment/trusted assessor review, written communication is sent to their GP to advise of CRHTT intervention, request the GP care summary or download this using the NHS Smart Card. This will be uploaded to Carenotes.

- Ensuring that on the day of discharge written communication is sent to the GP, service user and ATS community team (where applicable) is informed of the service users' medication, the nature of CRHTT input and any care plan following discharge.

- Joining Mental Health Act Assessments (MHAA) when possible in Hospital Places of Safety (HBPoS) or the community to support the consideration of the least restrictive principle, by providing an alternative to hospital admission when appropriate.

- Providing information to each service user on what support and help can be provided out of hours. (CRHTT will in due course and in accordance with the NHS Long Term Plan become a 24 hour service)

- Providing emergency assessments and overnight contact – this is currently delegated to Senior Nurse Practitioners (SNP), Hospital based Mental Health Liaison Teams (MHLTs) or the Havens.

- Providing a gatekeeping function for all adult acute inpatient requests to avoid unnecessary hospital admissions and ensuring the least restrictive principles of care and treatment are achieved.

4.0 Eligibility criteria

- Adults 18 years and above with a severe functional mental illness of such severity that without CRHTT intervention acute hospital admission would be necessary.

- Service users presenting with severe mental illness who may also have a substance misuse and/or alcohol problems (dual diagnosis).

- Service users presenting with significant mental health relapse indicators. The objective is to prevent further relapse and crisis leading to an acute inpatient admission.

- Service users registered with a Sussex General Practitioner (GP)

- Service users not registered with a Sussex GP but resident in Sussex. For those visiting Sussex CRHTT will contact the 'home' service to ensure care is appropriately coordinated and to agree responsibilities. All details will be appropriately recorded on carenotes to enable the 'home' CCG to be invoiced.

- Service users who are eligible for treatment by a Sussex service under national Responsible Commissioner guidance. *Who Pays? Guidance (NHS England 2020).* Furthermore, 'The safety and well-being of patients is paramount. No necessary assessment, care or treatment should be refused or delayed because of uncertainty or ambiguity as to which NHS commissioner is responsible for funding an individual's healthcare provision'.

- CRHTT is not targeted at people whose support needs and treatment are solely associated with drug or alcohol dependence, learning disability, neuro developmental or dementia related. CRHTT will however engage with those service users who also have a secondary functional mental health issue which would otherwise lead to an acute mental health hospital admission.

5.0 Referrals

- Can be made by any registered mental health professional who has assessed a person felt to be in mental health crisis or experiencing a severe mental health relapse which without intensive support may worsen and lead to an inpatient admission. Best practice is that a referral to CRHTT comes via a senior clinician in the first instance, to ensure all alternative support has been provided.

- Can be made by acute mental health inpatient hospitals including Extra Contractual Referral (ECRs) to facilitate supportive discharge from hospital. (Appendix 3)

- Wherever possible CRHTT will agree a 'trusted assessor' approach in which service users are directly taken on to the CRHTT caseload, thereby avoiding

repeated assessments and ensuring timely commencement of care and treatment. As part of the discussion with the referrer the intervention and input from the CRHTT is agreed and service users currently under SPFT will have an UpToDate care plan. (Appendix 1 ATS pathway)

- Some areas have local agreements to accept direct referrals from GP surgeries as outlined in the local CRHTT protocol attached to this policy.

- All referrers should have had meaningful contact with the service user within the last 24 hours and where possible the assessment should be conducted face to face. In the unlikely event a face to face appointment has not been possible CRHTT will negotiate with the referrer how best to support the service user.

- It is important that an individual understands the rationale and purpose of a referral being made to CRHTT.

- Referrals should be made by contacting the CRHTT Shift Coordinator by telephone or in person as soon as possible after the service user has been seen and CRHTT support considered appropriate.

- All referrals require:

    - Robust up-to-date risk assessments including documented acute and urgent care needs.
    - Accurate demographic and contact details for the service user and support network where appropriate.
    - SPFT referrers - Agreed assessment such as the Carenotes Adult or MHLS format and case note. Risk assessment and existing Carenotes assessment and care plan updated for service users already under SPFT.
    - Non SPFT – agreed proforma.

- Some referrals will be (where deemed appropriate) and following a screening discussion either by telephone or face to face between the referrer and CRHTT, determine that intensive support is not required. In these instances, CRHTT will signpost the referrer to an alternative service.

5.1 CRHTT pathway for community referrals

- Following referral, the shift coordinator will allocate a Band 6 or higher grade CRHTT staff member and another colleague to undertake the first visit/assessment.

- The allocated band 6 or higher staff member is responsible for ensuring all documentation is completed according to Trust policies and standards, is available on Carenotes and communicated within the team through handovers.

- Staff undertaking assessments and interventions must follow the Trust's Lone Working Policy and any other local protocols.

- Following this first appointment/assessment CRHTTs will communicate in writing the outcome of any initial assessment and agreed plan with the service user, their GP and the referrer.

6.0 Gatekeeping

- Gatekeeping adult acute inpatient bed requests is an essential core function of CRHTT. All service users who potentially require admission must be assessed by the CRHTT or delegated gate keepers who must be involved in the decision-making process prior to liaising with the 24- hour SPFT Bed Management service. This is to:

    - Ensure all patients are treated within the least restrictive environment consistent with their clinical needs.

    - To optimise the use of inpatient beds.

    - Ensure equity of access to an alternative to hospital admission for patients and families.

- Good practice suggests this gatekeeping function should include consultation with the Responsible Clinician (RC) and community team.

- Exceptions to this gatekeeping requirement are service users admitted to hospital following a Mental Health Act assessment (MHAA) when CRHTT intervention has been actively considered and those being recalled under a Community Treatment Order (CTO). CRHTT must be notified of all pending MHAA's and the least restrictive option of support discussed. CRHTT will support the out of hours CTO recall process when required.

- Mental Health Act Assessments, including S136 assessments in a Hospital Based Place of Safety (HBPoS), should where possible be attended by a member of the CRHTT.

- In practice and in accordance with local arrangements, CRHTT may delegate this gatekeeping function to other teams within the urgent care pathway including the 24-hour MHLT service, Haven and the Senior Nurse Practitioner who is available outside of CRHTT working hours, hence covering the gatekeeping function 24 hours per day. All options of appropriate care and support are considered during

this process which may include a referral being made to the ATS or other community service.

7. Providing support for service users in the community pending a bed in an acute mental health hospital being identified.

- A core function of CRHTT is to undertake or delegate the gatekeeping of all admissions to acute adult mental health inpatient units (section 6).

- AMHPs are delegated gate keepers for CRHTT following a MHAA. An AMHP will therefore speak directly to the 24-hour bed manager rather than contacting CRHTT/SNP.

- In the event of a bed not being immediately available for a service user waiting in the community, the AMHP, who has CRHTT Trusted Assessor status will contact CRHTT according to the AMHP Trusted Assessor referral pathway to provide and coordinate interim support arrangements as an alternative until a bed is identified. (Appendix 2)

- If the service user is refusing to engage with CRHTT, CRHTT will nevertheless accept the referral, being the central service for coordinating support and ensuring family and carers where applicable are supported. In such a situation the AMHP will in the first instance have explored all alternative avenues of agreeable interim support during the MHAA. All information will be robustly communicated between services and the need for admission may be escalated

- Where an inpatient admission has been agreed via the CRHTT gate keeping function but a bed is not immediately available, the CRHTT will be responsible for coordinating and providing support to the service user and their family and carers who are in the community. If waiting for a bed for more than 24 hours CRHTT will complete an Incident Report (IR1)

- Support will involve (where appropriate) effective collaboration between all parties which may include the service user's lead practitioner, AMHP and any or all of the service user's support network. All practitioners (regardless of service) must ensure effective communication is kept at all times.

- The nature and degree of support and rationale for decision making must without exception be fully documented on carenotes and contact will be at least daily. The necessity for hospital admission will be reviewed at each contact by each visiting clinician (regardless of service) within the agreed and documented collaborative support plan.

- Any service user in the community and being supported by CRHTT whilst waiting for admission will be discussed during the twice daily CRHTT handovers. The team will liaise with the SPFT Bed Management Team/Out of Area (OOA) service.

- All service users awaiting admission and with the agreed support in place will be discussed within the local Care Delivery Service (CDS) Urgent daily bed demand call.

- If the CRHTT (with others where appropriate) are unable to safely support a service user in the community they will immediately escalate concerns to senior managers and clinical bed leads.

- CRHTT may have to increase the intensity of contacts and support from other parts of the urgent care pathway may be used such as the Haven.

7.1 Conveyance to hospital for service users being supported in the community.

- Informal admission – CRHTT (or the service providing support as per documented plan) will explore all transport options with the service user and their family. All decisions will be risk assessed and documented on carenotes.

- Formal admission – CRHTT will advise the AMHP service of bed location who will make the application and arrange conveyance.

8.0 Supportive Hospital Discharge

- As a core function of CRHTT the supportive discharge process identifies and works with service users in hospital (including out of area placements – see appendix 5) to support their return home to continue with their recovery.

- Each CRHTT will identify individual staff to lead on supported discharges. Some teams may allocate this role on a daily basis whereas others will have a permanently established discharge coordinator role or Facilitated Early Discharge (FED) nurse to support links between the ward teams and CRHTT. They will be highly visible on the ward and where appropriate introduce themselves and their role to all newly admitted service users. They will attend MDT reviews with the ward consultant psychiatrist, contribute to the discharge planning process where appropriate and have knowledge of any barriers to discharge.

- Under normal circumstances hospital discharges will be planned however this may not always be the case, for example when a patient discharges themselves against medical advice. Ward and CRHTT staff will discuss and evidence base all clinical decision making and if appropriate CRHTT will put in place arrangements to assess and support service users when this does occur.

- The role of CRHTT is to assess the appropriateness of CRHTT supportive discharge. This assessment will contribute to the wider ward MDT decision making regarding discharge and will include when appropriate the views of any relevant carers, family/friends. Where there is a disagreement regarding a plan for a patient referred for supportive discharge and this cannot be resolved then senior advice should be sought.

- CRHTT intervention will continue until the service user's mental health has improved to a state where they can either be transferred to secondary mental health services or referred back to their own GP.

- It should not be the case that CRHTT become primarily focussed on transfers from wards as this will dilute their ability to divert referrals which may otherwise lead to admission. CRHTT must be available to provide treatment, support and interventions for service users in their own home.

8.1 Referrals for supported discharge

- Any referral for supportive discharge may be taken by the CRHTT shift coordinator or supportive discharge worker. The referral should be promptly allocated for assessment. The CRHTT will open an episode of care at this time.

- A supportive discharge referral may be made at any point during a service user's hospital admission. (Appendix 3 - OOA placements)

- The referral should be made by a ward registered nurse or medical practitioner. The referral should be accompanied by a risk assessment which will include a risk formulation and management plan completed within the past 24 hours.

- The referred service user should be aware of the supported discharge referral and demonstrating a willingness to engage with the service. Discharge planning must be demonstrated on Carenotes including evidence of family, friends and carers as appropriate being involved in discharge planning.

- In order for supportive discharge to take place there must be evidence to show that the presenting risks and symptoms of the service user that indicated their hospital admission have reduced to a point where home treatment is safe for the service user, their family/carers and CRHTT.

- Following the supported discharge assessment and acceptance on to the CRHTT case load, the service user is given CRHTT contact details and advised how to access support out of hours. An agreed care plan with a time of the first CRHTT community contact is given and an updated risk assessment is completed with the ward staff.

- The first CRHTT home visit will be undertaken within 24 hours of discharge by one Band 6 (or higher) clinician and another staff member. The risk assessment will be fully updated to reflect the service user having been discharged from hospital and the CRHTT care pathway will continue as per detailed in section 5.1.

8.2 72-hour hospital discharge follow up – see Appendix 4

- CRHTT are responsible for following up <u>all</u> service users discharged from an inpatient unit including all out of area (OOH) placements over the weekends/public holidays (totalling 3 days or over).

- In some areas this responsibility may be delegated by CRHTT to other parts of the urgent care pathway such as the Haven in Brighton. Please see local protocols attached to this policy.

- The nature of this 72 hour follow up (telephone or face to face) is according to discussion with the discharging ward and robust discharging risk assessment and rationale being documented.

- CRHTT may support the ATS when appropriate to follow-up people into the evening of day 3 where contact has not been possible and service user is within the local area. If appropriate, follow-up can be handed back to the ATS on day 4 for further follow-up attempts over the next 4 days.

9.0 Treatment, support and interventions

- An episode of care with CRHTT will involve the team visiting frequently, supporting and including the service user's social network where appropriate and staying involved until the crisis is resolved. Transitional support will be provided where

appropriate at which point the service user may be handed over to on-going care where required.

- The CRHTT is a multidisciplinary team with a bio – psychosocial model of care. As far as possible treatment will be provided in the person's own environment with as little disruption to their normal routines as can be managed.

- CRHTT will complete a HONOS coding for all service users admitted to CRHTT and again when discharged from the team.

- The CRHTT will consider the physical health and substance misuse needs of the service user and ensure collateral information is gathered, and an up-to-date medication and care summary is received from their GP or via their hospital discharge summary for supported discharge.

- For all service users under the care of CRHTT, the following will be monitored and reviewed at each contact:

  • Risk
  • Mental State
  • Collaborative care planning with service user and carers
  • Response to medication & side effects of treatment
- Physical health when required
- Social needs such as housing where applicable

- Examples of interventions:

  - **Biological**
    • Prescribing of and administering treatment with medicines
    • Monitoring levels of medicines and side effects
    • Medicine reconciliation
    • Phlebotomy
    • Referral for routine and specialised blood screen tests
    • Electrocardiogram
    •Physical and wellbeing monitoring -BP/Weight/Nutrition/Smoking cessation
    • Referrals to substance misuse services
    • Clozapine initiation & monitoring
    • Referral for ECT
    • Referral for additional tests –EEG/ MRI/CT/Hormone profile etc

  - **Psychological Interventions**

- Supportive counselling
- Solution focused interventions
- Review with Clinical psychologist
- Distress tolerance group work
- Cognitive Behavioural Therapeutic based interventions
- Motivational interviewing
- Peer led coaching
- Family psychoeducation
- Neuro psychometric tests as required
- Relapse prevention / crisis planning
- Medication management and adherence

- Group treatment.

- **Social**
  - Social systems interventions
  - Open Dialogue
  - Benefits and employment advice and support
  - Care Act assessment
  - Housing advice
  - Referral for occupational therapy activity of daily living assessment
  - Practical support with daily living activities

  Carers assessment support

9.1 Care plans

Trust Care Plan Standards must be adhered to at all times

- A safe and effective care plan should be developed in collaboration with the service user in line with needs, goals and interventions identified by and with them. This care plan will be documented on Carenotes the same day and updated via progress notes following each visit.

- The care plan should reflect service users concerns and their perception of current risks. It should be reviewed weekly and updated following a change in care, a review or incident. This must include the service user and carer if appropriate

- The care plan should include any advanced decisions/statement where these are known. Where appropriate and with the service users consent, their carer, family or friends should be given a copy.

9.2 Virtual Consultations

- Unless clinically indicated and evidenced, all service users placed in the red zone should be seen face to face.

- When planning assessments and interventions consideration will also be given to using alternatives forms of contacts in addition to face to face meetings. These can include virtual consultations using such platforms as Attend Anywhere or telephone.

- Service users' preferences, risk factors, safety, clinical need and type of intervention will be considered when assessing whether to use virtual consultations or face to face. When appropriate this will involve carers/family agreement.

- A combination of face to face and virtual meetings may be used within care planning. It must not be the case that all contact relies solely on virtual means.

9.3 Zoning

- CRHTTs have a zoning system in place. This Red, Amber and Green (RAG) system is used to reflect assessed risk and associated intensity of CRHTT contact. All service users will be in the Red Zone for the first 72 hours.

    - **Red Zone** – High risk. This generally involves at least daily contact. Anything less than this intensity must be noted according to evidence based clinical decision making.

    - **Amber Zone** – Medium risk. This zone denotes a reduction in assessed risk but recognises that risk nevertheless remains and CRHTT intervention is required. This involves at least twice weekly visits in accordance with noted evidence based clinical decision making.

    - **Green Zone** – Low risk. This zone denotes that the service user is ready for transfer of care from CRHTT. The frequency of visits will be lower and in accordance with noted evidence based clinical decision making. If there is any delay in transferring the service users care to the ATS this will be escalated to the CRHTT Team Leader immediately.

- Zoning status and number of weekly contacts must be displayed clearly for all the CRHTT to view. Zoning must be reviewed at each visit and any change accompanied by an up-to-date risk assessment and documented clearly on Carenotes.

10.0 Family/Carer support and involvement

- CRHTT will work closely with an individuals' support network including family, friends and carers, gaining their views and where appropriate support their

involvement in care planning and risk management. Consent to share information should always be sought and documented.

- The Triangle of Care principles should be adhered to, to establish a 'therapeutic alliance' between the service user, professional and carer. This will promote safety, support recovery and sustain wellbeing.

- Family, friends or carers should be offered the chance to meet with CRHTT privately – particularly during assessments and care planning.

- Carer assessments should be offered and family, friends or carers should be signposted to carer support and local groups where appropriate.

- On occasion service users may not wish for information to be shared with others, however, this must not stop CRHTT from gaining the views of family, friends and carers.

- CRHTT staff should be aware of and work in line with the Trust's Data Protection & Confidentiality including Family and Friend Carers Confidentiality Policies.

- CRHTT will use Carenotes to document all family, carer and friend involvement and must ensure all contact details are accurate.

11.0 Safeguarding children and adults

11.1 Safeguarding Children

- As part of its work in safeguarding and promoting the welfare of children, Sussex Partnership NHS Foundation Trust has a statutory duty under Section 11 of the Children's Act (2004) to protect children from harm.

- Safeguarding children and adults and the promotion of the welfare of children is everyone's responsibility. This applies to all staff of all grades at the Trust who come into contact with either children, young people or adults who have contact with children. It is important to consider the impact an adult's mental health may have on a child or young person.

Safeguarding and promoting the welfare of children is defined in Working Together to Safeguarding Children (HM Gov 2018) guidance as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development

- Ensuring children grow up in circumstances consistent with the provision of safe and effective care.
- Taking action to enable children to have the best outcomes

It should be custom and practice to be inquisitive about a family and to enquire about the wellbeing of children. If you have concerns please discuss with your safeguarding lead, you may need to consider a referral to children's social care in the area the patient resides. If you refer you will need to seek consent unless the concern may put the child or young person at unreasonable risk. You should also raise this as an alert on carenotes so it is transparent for all accessing the records. It is important to seek support from SPFT's dedicated safeguarding team who will be happy to assist and you must copy us into any referrals that are made.

Please refer to the Trust's Safeguarding Children Polices for further details and guidance.

Safeguarding Children's Policy

For further information contact the SPFT Safeguarding team:

safeguardingteam@sussexpartnership.nhs.uk

11.2 Safeguarding Adults

Having policy and procedures to safeguard adults is a legal requirement under Section 42 to 47 of the Care Act and something which ensures a better proportionate, timely and professional approach is taken when adults are at risk. Staff will follow Sussex Safeguarding Adults Policy and Procedures, and the Trust Safeguarding Adults Policy.

- A member of staff who believes that there is an adult safeguarding concern should:

- Talk to the adult concerned about their views and wishes and address an immediate risks (secure forensic evidence as necessary)

- Discuss the concern with their manager or with another senior colleague if the manager is not available

- Raise the concern with the local authority using the relevant procedures for each local authority area.

- Report the concern as an Incident following Trust policies and procedures

- Take immediate action to ensure the safety of the person at risk following Trust

- Risk assessment policy and procedures

- Record actions taken on Carenotes and set up the safeguarding flag alert in line with standard operational procedures, or record in the appropriate clinical record system for the service.

- Once a concern has been raised the member of staff/ lead practitioner /ward or community team should:

- Actively co-operate with the Lead Enquiry Officer in undertaking the investigation.

- Ensure the ongoing safety of the person at risk following Trust procedures in relation to the management of risk.

- Work with the Lead Enquiry Officer to achieve an outcome that reflects as far as possible the wishes of the person at risk whilst ensuring safety and complying with relevant legislation

https://sussexsafeguardingadults.procedures.org.uk/

https://policies.sussexpartnership.nhs.uk/clinical-3/safeguarding-adults-at-risk-policy

For further information contact the SPFT Safeguarding team:

safeguardingteam@sussexpartnership.nhs.uk

12.0 Handovers and case load management

- Handover takes place two times daily at the beginning of each shift (local variations in times exist). Every person on the case load in zone red including service users being supported whilst waiting for a bed must be discussed at handovers. A further handover will take place between the CRHTT and SNP in accordance with local protocols. Service users zoned in Amber and Green will be discussed twice weekly at an MDT handover which will be referred to as a zoning meeting.

- The shift coordinator or delegated person chairs the handover meeting to ensure it is run on time and all staff are involved in discussions. Discussions and actions must be entered onto the Carenotes system during handover. Two members of staff are to utilise the Carenotes system simultaneously to ensure notes are entered in a timely manner during the handover.

- If staff are unable to attend the handover, the shift coordinator must ensure they are fully briefed

- Care Plan Review meetings are extended weekly multidisciplinary meetings to review each patient in more detail and share in collaborative decision making about treatment and risk with the Consultant Psychiatrist present.

- Staff should come prepared to care planning MDT's and between the staff present on duty be able to present a brief synopsis and update of the service users on the caseload and contribute effectively to decision making and planning of care.

- Staff must entitle the top of the note: “Care Plan Review”

- Staff must ensure a note is made of whether the Psychiatrist is present. If the Psychiatrist is present then wherever possible, the Psychiatrist enters any relevant notes under their own name.

- Any cases which are considered complex either by individual clinicians and/or raised during the handover are to be escalated immediately to medical staff. The Consultant Psychiatrist, together with the clinical team hold any risk, with final decision-making around care being planned by the Consultant or their clinical delegate if they are unavailable at the time.

12.1 Service user team board

- The shift co-ordinator will update the white board on a daily basis to reflect any changes and ensure the information is also recorded on Carenotes. Teams may include further information as outlined in local protocols however as a minimum the board will include:
    - Service user’s first name and identification number
    - Service user’s age
    - Zoning including number of weekly visits
    - Lead Practitioners name
    - CRHTT core team
    - Locality of residence
    - Date accepted on to the CRHTT case load
    - Safeguarding status
    - Honos
    - Date of next risk and care plan reviews

12.2 Record keeping

- Clinical records are electronic based through Carenotes which is shared Trust wide and available 24 hours a day.

- All records must be kept on Carenotes and in keeping with Trust wide policy and standards.

12.3 Operational procedures for unanswered telephone calls

- If a service user does not respond to a planned telephone call, leave a clear answer phone message if facility is available and/or text message if possible. Message should detail who is calling and leave a number on which the service user can contact the team. If not able to leave a message, set a time during the next shift to attempt contact again. If contact is still not made, consider an unannounced call at the services users address.

12.4 Operational procedures for "Did Not Attend" appointment home visits

- If a service user does not attend a planned appointment at the CRHTT premises, call them on available telephone numbers and rearrange. If no response, follow procedure above.

- If the service user is not at home when attending a planned home visit, discreetly leave a note on CRHTT headed paper to state the date and time attended and ask service user to contact team within a certain time frame. Should the service user not respond within a stated time period, attempt telephone call and follow procedures detailed previously.

- Staff should aim to ensure the referrer and other involved agencies remain updated and involved. Consideration must be given to contacting members of the service users' social system including their Next of Kin and GP.

- In all cases a team discussion should take place taking into consideration risk factors and / need for a police welfare check if appropriate.

- If the decision has been reached that the risk is sufficient that there are concerns for the welfare of the service user, staff will summon police assistance. When confirmation of police undertaking a welfare check have been received in the form of a CAD number, this will be documented in the service users case notes notes and a time agreed of six hours after which if no contact has been received back from police, then CRHTT staff must follow this up with the police.

12.5 Complaints

- Complaints will be dealt with according to the Trust Complaints Policy and allocated to an appropriate manager or senior clinician to investigate. Managers and senior clinicians when appropriate should attempt to resolve complaints informally, whilst still informing the Trust Complaints department.

13.0 Transfer from CRHTT caseload

- Planning for transfer must start from acceptance onto the CRHTT caseload and service users should always be made aware of the short-term nature of CRHTT intervention.

- The decision to transfer service users to community-based services, primary care or to refer to acute services will always be based on an assessment of risk and a review of the care plan. This will be reviewed during the CRHTT handovers in addition to the weekly MDT discussions and the community service involved in planning.

- All lead practitioners (where allocated) must remain involved in a service user's care and discharge planning process whilst under CRHTT.

- Transfer planning must, other than in exceptional circumstances, involve the service user and their identified key contact, family, friends and carers as appropriate. At least 48 hours' notice of intended discharge must be given.

- CRHTT will inform the ATS in writing of the patients transferred from CRHTT to ATS care.

14.0 Staffing

- The structure of CRHTT services will be based on the Mental Health Policy Implementation Guide (2001) and staffed to 14.0 wte clinical staff per 150,000 general population. With the recent financial investment into urgent care services, CRHTT staffing may exceed this and staffing is adapted to local need and in accordance with local policy and commissioned service specifications.

- A key element of any team is skills and competencies. A multidisciplinary team allows for a variety of approaches and interventions. The CRHTT may include the following professional disciplines:

    - Team Leaders from any registered professional background
    - Senior Clinicians
    - Social Workers
    - Discharge Coordinators
    - Mental Health Nurses
    - Non-medical nurse prescribers
    - Graduate Mental Health workers
    - Senior Support Workers
    - Peer Support Workers
    - Nursing Associates
    - Psychiatrists
    - Psychologists
    - Pharmacy technicians
    - Administrative staff
    - CBT Therapists
    - Assistant Psychologists
    - Volunteers
    - Occupational Therapists

- All clinical staff of all disciplines will have a common orientation and generic role within the service and will be interchangeable in tasks performed.

- Responsibility for the allocation of resources and duties in the team will lie with the team leader and these will be congruent with the skills and abilities of the staff on the team.

- All CRHTTs aim to have a gender balance on each shift in order to provide choice to male and female service users in terms of carrying out assessments, home visits.

- The CRHTT administrators play an integral role both in terms of supporting the clinical staff and data collection. Core tasks include populating data forms on Carenotes, which are used to provide data for both internal and external reporting; ensuring essential information is completed on the Carenotes e.g. risk assessments and closing community episodes. The administrators ensure the CRHTT's have easy access to stationery, clinical supplies, and forms/information leaflets for service users.

14.1 Training and Development of Staff

- All staff will receive an induction and are required to complete training in keeping with the Mandatory Training and Induction Policy. In addition, there is a commitment to staff development and education through the use of:

    - Annual appraisals
    - Professional training programmes
    - Clinical and managerial supervision
    - Reflective practice groups
    - Role specific development/apprenticeship programmes
    - Input and support from service user and carer groups and members
    - Continued professional development including revalidation processes for qualified nurses and social workers
    - Preceptorship programmes

15.0 Equality, Diversity and Human Rights

- Sussex Partnership NHS Foundation Trust is committed to being an organisation, which promotes equality of opportunity and is free from unlawful discrimination on any grounds in line with the Equality Act 2010.

- Our aim is to achieve a service that will be truly representative of all sections of society where patients feel safe and their dignity is respected. The Trust provides

equality and fairness for all in our services and we do not discriminate on grounds of:

- Gender (including sex, marriage and civil partnership status, pregnancy, maternity, gender re-assignment)
- Race (including ethnic origin, colour, nationality and national origin)
- Disability
- Sexual orientation
- Maternity
- Religion, religious beliefs and similar philosophical beliefs
- Age

Respecting the rights of the individual service user and balancing those rights and responsibilities of the staff looking after them has always been an integral part of the delivery of mental health services. The Human Rights Act 1998 is a law that came into force in October 2000. From this date for the first time, it has made it unlawful for any public authority, in this case Sussex Partnership, or any of its staff to breach many of the fundamental rights and freedoms contained in the European Convention on Human Rights

16.0 Critical Service Links

16.1 The CRHT service is integral to the other elements of Acute and Urgent Care and has formal links to the following internal services:

- Assessment and Treatment (ATS) Teams
- Early Intervention in Psychosis (EIP) Teams
- Learning Disability and Neurodevelopmental Services
- Mental Health Liaison Services (MHLT)
- AMHP duty services
- Dementia Crisis Services and SOAMHS Teams
- 136 Crisis Pathways including Street Triage, Health Based Places of Safety, Havens and Urgent Care Lounges
- Children and Young People Teams to support transitions and provide specialist advice when younger people need support

16.2 CRHTTs will link to the following external services:

- Police Local Authority Liaison Officer
- Substance misuse services
- Local Authority Child Protection
- Local Authority safeguarding vulnerable adults
- Housing departments
- Voluntary Sector Services including Staying Well - Staying Well provide out-of-hours mental health crisis prevention services across Sussex. Open 7 days a

week, these services provide evening and weekend, recovery-focused support to help people manage their mental health, stay well and prevent crisis.

17.0 Development, Consultation and Ratification

- This policy has been consulted upon with a range of stakeholders including the MDT, Service Directors, Clinical Directors, Nurse Consultants and other clinical staff working in urgent care services. This policy has been ratified by the Clinical Policy Forum.

18.0 Monitoring Compliance

- Good practice suggests that regular and frequent audits of compliance with this policy will be undertaken. These will be undertaken where required by the Team Leads and Service Managers in collaboration with their locality clinical audit lead.

- This policy will be reviewed every two years to ensure that any audit findings, trends or lessons revealed through patient and staff related Incident reports and their associated action plans are addressed. Reviews will also take account of changes in national standards, policies and guidance.

- The review will utilise the results of various audits, patient and carer feedback, CQC, Mental Health Act visits, learning from serious incidents and complaints. This information will assist in the future development of the services.

19.0 Dissemination and Implementation of Policy

- The Policy team will place updated versions of this policy on the trust's intranet. The Trust's Partnership Bulletin will alert stakeholders to the issuing of the policy and any subsequent revised versions.

- Service Managers will ensure the clinical staff are alerted to this issue, reissue and review of versions of this policy and that training requirements - as set out in section 17.1 of this policy are complied with.

20.0 References

- Five Year Forward View for Mental Health, NHSE (2016) https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

- Guidance Statement on Fidelity and Best Practice for Crisis Services, Department of Health (2007)
- Home Treatment Accreditation Scheme (HTAS) Standards for Home Treatment and Crisis Resolution Teams - Fourth Edition (2019) www.rcpsych.ac.uk/htas
- NHS Long Term Plan – Adult Mental Health Services, NHSE/I (2019) https://www.longtermplan.nhs.uk/online-version/chapter-3-further-progress-on-care-quality-and-outcomes/better-care-for-major-health-conditions/adult-mental-health-services/
- The Mental Health Policy Implementation Guide. Department of Health (2001)
- Who Pays? Determining responsibility for NHS payments to providers, NHSE/I (2020) https://www.england.nhs.uk/wp-content/uploads/2020/08/Who-Pays-final-24082020-v2.pdf
- NICE Guidelines and Guidance - www.nice.org.uk :-

- Psychosis and schizophrenia in adults: prevention and management (2014)
- Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (2011)
- Borderline personality disorder: recognition and management (2009)
- Depression in adults: recognition and management (2009)
- Bipolar disorder: assessment and management (2014)
- Transition between inpatient mental health settings and community or care home settings (2016)

- Sussex Multi-Agency Policy and procedures for Safeguarding Vulnerable Adults (2015)
- Sussex Child Protection and Safeguarding Procedures (2016)
- DH/Home Office/NHSE – Crisis Care Concordat (2014)

21.0 Cross-referenced clinical policies

- Mandatory Training and Induction Policy
- MHLT Service operational policy
- Adult acute policy
- Bed management policy
- Suicide prevention policy
- ATS policy
- Clinical risk policy
- Safeguarding children policy
- Safeguarding adult policy
- DNA policy
- Lone working policy
- Confidentiality Policy
- Carers and confidentiality

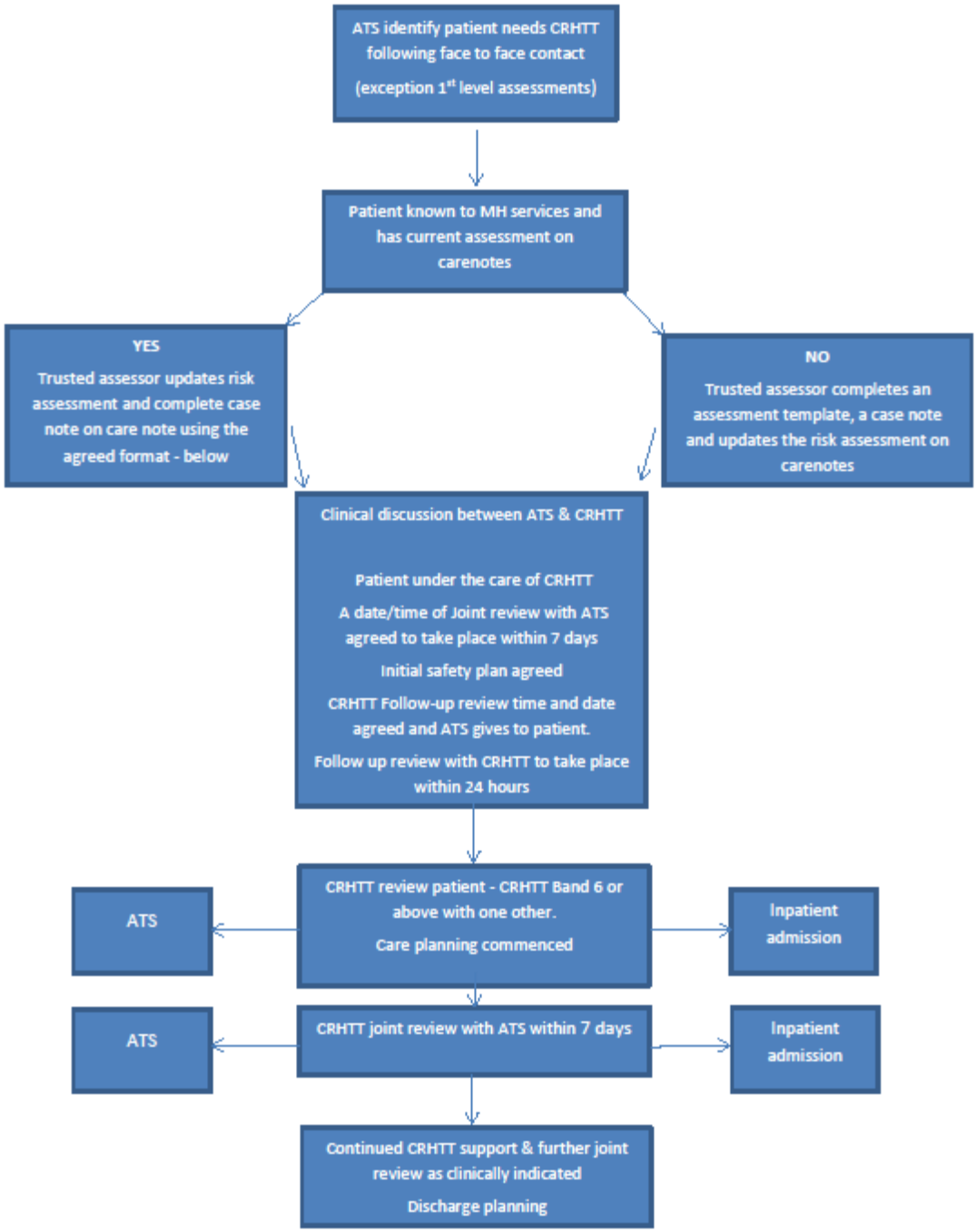
22.0 Appendices

- 1. ATS Trusted Assessor Pathway Flow Chart
- 2a. Pan Sussex AMHP Outline Report
- 2b. AMHP Trusted Assessor Case Note Format
- 2c. AMHP Trust Ax Pathway
- 3. Referral Guidance for OOA Placements
- 4. 78 Hour Follow Up CQUIN Guidance
- 5. ATS Trusted CRHTT Case note Prompts and Format
- 6. Gate Keeping Case note Prompts and Format

Appendix 1

NHS
Sussex Partnership
NHS Foundation Trust

Trusted Assessor flow chart



CRHTT Chichester local proces author: Team leads, Amy Sergeant and Lauren Maclean March 2021

NHS
Sussex Partnership
NHS Foundation Trust

Case note template

A case note with the heading **"Trusted Assessor"** within the case note there should be

- Mental State Examination (appearance/behaviour/mood/thoughts/perceptions/capacity etc.)
- Risk statements (relevant to the patient)
- Any other relevant information that supports the assessment (for example a change in social circumstances)
- Aim and Objectives of acute care

There will continue to be a clinical conversations and plans for the lead practitioner to remain involved throughout the patients' admission to CRHTT.

CRHTT Chichester local proces author: Team leads, Amy Sergeant and Lauren Maclean March 2021

Appendix 2a

AMHP Outline Report – to be completed and made available immediately – uploaded under MHA tab on Carenotes

(To be used at time of admission to hospital/ CRHTT trusted assessor pathway – MH1 forthcoming asap)

<table>
<tr><td>Name of AMHP:

Tel No:</td><td>Date:</td><td colspan="2">Time:</td></tr>
<tr><td>Name of Patient:</td><td>DOB:</td><td>LAS No:</td><td>CIS No:</td></tr>
<tr><td>Address:

Tel:</td><td colspan="3">Nearest Relative Name/family/carer

Contact details:

Contacted Yes/No</td></tr>
<tr><td>GP Details:</td><td colspan="3">Care Co-ordinator Details:</td></tr>
<tr><td colspan="4">Legal Status/ Presentation and Reason for Application/CRHTT intervention</td></tr>
<tr><td colspan="4">Identified Risks: - I suggest using headings this will ensure all areas of risk are covered and not assumed (particularly pertinent for CRHTT who may be transferring the information and also requesting an ECR from time to time. The risk assessment needs to be very robust in all circumstances and in particular when there is a transfer between services.

COVID 19 screening

Suicide

Self-Harm</td></tr>
</table>

Aggression **Neglect** **Drugs/Alcohol** **Safe Guarding** **Deterioration/medication concordance** **Absconding (for those admitted)** **Re CRHTT support – contingency planning should service user not engage with CRHTT and/or refuse infomal admission**
Any practical matters concerning the patient which the ward/CRHTT needs to know (dietary, religious and cultural requirements, pets, money, keys, contact with others etc):

Date the full AMHP Report (MH1) will be sent to the Ward/CRHTT:	**Signature of AMHP:**

Appendix 2b

THE AMHP TRUSTED Ax MODEL PILOT IS CURRENTLY IN PLACE BETWEEN SPFT AND B&H ONLY. WEST AND EAST SUSSEX AMHP SERVICES WILL JOIN IN DUE COURSE

CASENOTE PROMPTS/FORMAT

COVID 19 SCREENING TO BE UNDERTAKEN AND DOCUMENTED AS PER CURRENT PROCESS

All patients via the AMHP Trusted Assessor model are accepted by CRHTT/SNP OOH. The outline AMHP report must be completed in all circumstances for those not already under CRHTT (verbal handover pending report will be accepted) and must meet the threshold for CRHTT intervention.

AMHP Trusted Ax – Least Restrictive option - CRHTT/SNP case notes

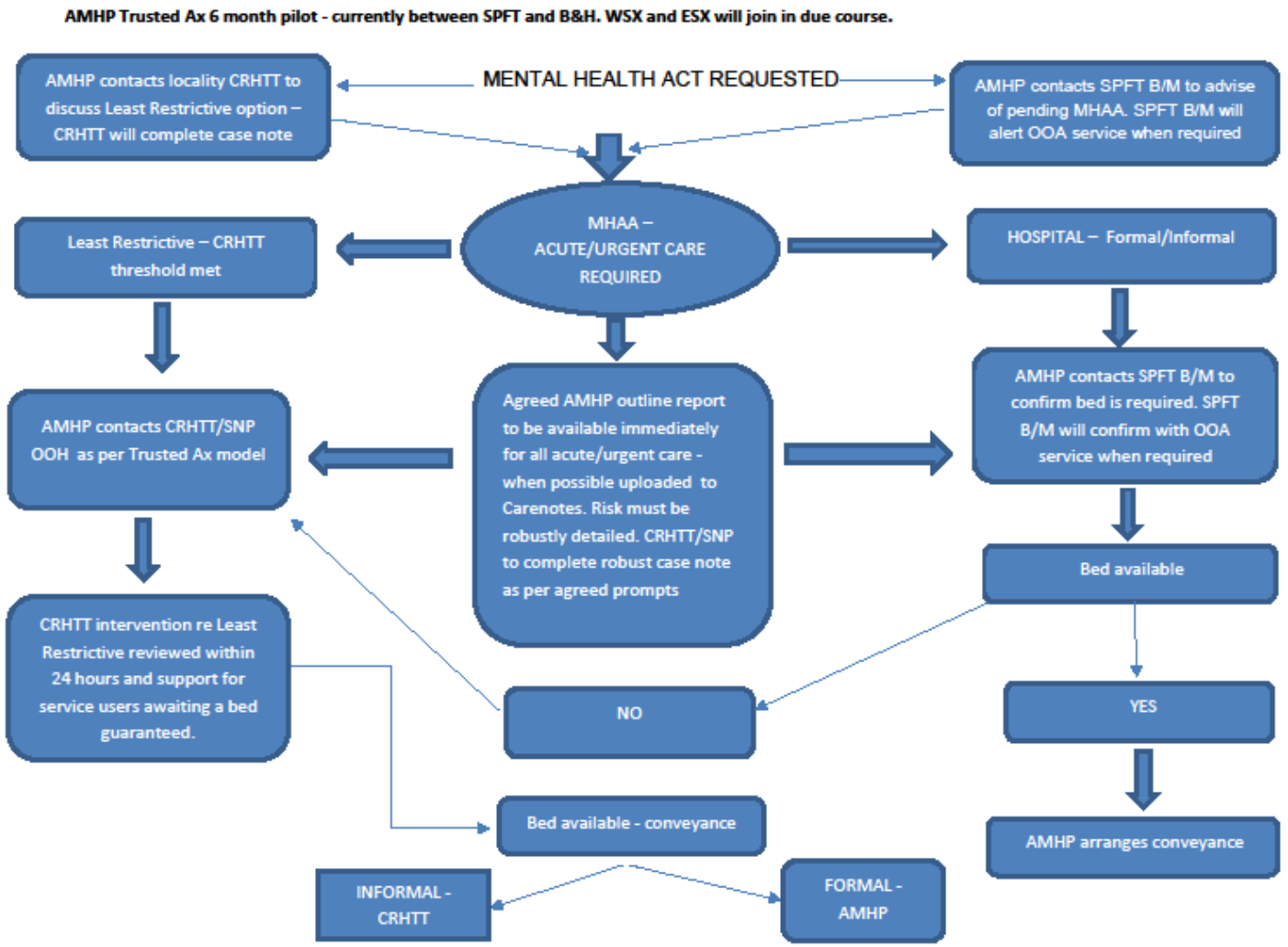
- Is agreed AMHP outline report fully completed and available - must include robust risk assessment?** If patient is already under CRHTT, verbal information will be accepted pending report.
- Are all contact details correct including carer/family?
- Is the patient agreeable to receiving CRHTT support?
- What is the reason for CRHTT intervention/support?
- Has the patient/family got CRHTT contact details and is aware of how to access support OOA?
- Note management and safety plan including time of first CRHTT contact (if OOHs patient to be advised that CRHTT will contact in the morning to arrange a time to visit)
- Note – contingency planning if patient refuses to engage with CRHTT e.g consider back to AMHP for further MHA consideration.

Service user to be opened under CRHTT

AMHP Trusted Ax model – supporting patients who are waiting for a bed – CRHTT/SNP OOH

- Has agreed AMHP outline report been fully completed and is it available – must include robust risk assessment? And update re CRHTT providing interim coordination and support.
- Are all contact details correct including carer/family?
- Is the patient agreeable to receiving CRHTT support?
- Has the patient/family got CRHTT contact details and are they aware of how to access support OOA?
- Note management and safety*** plan including time of first CRHTT contact (if OOHs to be advised that CRHTT will contact patient/family in the morning to arrange a time to visit)
- Note – contingency planning if patient refuses to engage e.g Informal, consider back to AMHP for further MHA consideration. Formal, escalate concerns via SPFT bed management and Operational leads.

Service user to be opened under CRHTT


AMHP Trusted Ax 6 month pilot - currently between SPFT and B&H. WSX and ESX will join in due course.
MENTAL HEALTH ACT REQUESTED
AMHP contacts locality CRHTT to discuss Least Restrictive option – CRHTT will complete case note
AMHP contacts SPFT B/M to advise of pending MHAA. SPFT B/M will alert OOA service when required
MHAA – ACUTE/URGENT CARE REQUIRED
Least Restrictive – CRHTT threshold met
HOSPITAL – Formal/Informal
AMHP contacts CRHTT/SNP OOH as per Trusted Ax model
Agreed AMHP outline report to be available immediately for all acute/urgent care - when possible uploaded to Carenotes. Risk must be robustly detailed. CRHTT/SNP to complete robust case note as per agreed prompts
AMHP contacts SPFT B/M to confirm bed is required. SPFT B/M will confirm with OOA service when required
Bed available
CRHTT intervention re Least Restrictive reviewed within 24 hours and support for service users awaiting a bed guaranteed.
NO
YES
Bed available - conveyance
AMHP arranges conveyance
INFORMAL - CRHTT
FORMAL - AMHP

Appendix 2c

Appendix 3

A member of
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NHS
Sussex Partnership
NHS Foundation Trust

Web: http://www.sussexpartnership.nhs.uk

Date: 17 March 2021

Referral guidance for ECR providers for supported discharge assessment from Sussex Partnership NHS Foundation Trust Crisis Resolution and Home Treatment Teams (CRHTT)

Sussex Partnership (SPFT) have robust procedures for supported discharge assessments for patients in acute hospital beds within the Trust. This service is also available to patients in out of area placement beds. This guidance is to assist all providers in accessing our crisis team.

1) We would request that out of area placements consider at every ward review whether supportive discharge with the crisis resolution and home treatment team (CRHTT) is appropriate and if the clinical criteria for intensive community support is met. CRHTT are able to support a patient to be discharged earlier than if this specific resource was not available. If unsure please liaise with the patient's local crisis team to discuss (details below).

2) If supportive discharge via the CRHTT is considered appropriate, please contact the relevant CRHTT directly and request an assessment. Please ensure that when referring to CRHTT all up to date clinical and risk information is available and able to be shared to support a patient's ongoing care plan.

3) The CRHTT assessments may be face to face or via a virtual platform – this will be discussed during the referral process.

Contact details below.

CRHT	CONTACT NUMBER	TEAM LEAD	SERVICE MANAGER
Worthing	0300 304 2157	Zoe Greatorex	Sarah Piper Elena Riseborough
Chichester	01243 791 909	Lauren Maclean	
Eastbourne	01323 438 279	Lynn Huggins	Donna Beard
Hastings	0300 304 0253	Alan Young	Tracy Albrow
Crawley	01293 590 440	Coralie Jays	Steven Rowley
Brighton & Hove	0300 304 0081	Phil Lamble	Kirstin Mcaulay

Appendix 4

Sussex Partnership NHS
NHS Foundation Trust

72-HOUR FOLLOW-UP GUIDANCE (August 2019)

Discharge must not take place unless a qualified clinician has been identified to undertake 72-hour follow-up

- **All service users discharged from our inpatient units, including ECR beds where the person is not transferred to a Trust inpatient ward, must be followed up, in person (face to face or by telephone), within the first 72-hours of discharge.** ***NB – the day of discharge is Day 0 and any contact on this day is not used for the outcome measure. The follow-up contact must be between 00:01 hours on Day 1 and 23:59 on Day 3. There are no allowances for weekends and/or Public Holidays.***
- **Good practice should be that follow-up starts on day 1 wherever possible.**
- **For service users that cannot be contacted within the first 72 hours following discharge, follow-up must be completed within 7 calendar days.**

Planning Discharge/Follow-up Contact

Step 1 – Discharge Planning Meeting	• The person responsible for the follow-up contact will be identified prior to the discharge planning by ward staff. The staff member's name and the date and time of follow-up that is agreed must be documented at the discharge planning meeting. • Contact information: including address, address for the next 7 days (if different to usual address), telephone numbers, next of kin/carer details to be confirmed at planning meeting and updated on Carenotes. • As part of this planning, consideration to face-to-face or telephone contact will be agreed by the MDT. • Above to be documented as a casenote in Carenotes by the ward (summary heading – "72 hour follow up arrangements") and in Carenotes diary by the person undertaking the follow-up to avoid confusion and for clarity. • Evidence of a full handover of care to the local community team must be recorded in Carenotes for service users discharged out of area, within the UK.
Step 2 - Contact	• Actual Contact – complete and outcome a diary appointment form in the usual way using 04-7-day follow up as an event (activity tab in Carenotes) • Attempted Contact(s) – complete CPA7 record form (activity tab in Carenotes)
Step 3 – Escalation	• Ward or ATS to request that CRHT attempt to follow-up people into the evening of day 3 where contact has not been possible and service user is within the local area. If appropriate, follow-up can be handed back to ATS on day 4 for further follow-up attempts over the next 4 days.

72-hour Follow-up Responsibility

Position at Discharge	Follow-up Responsibility
Discharge from ECR bed to place of residence	CRHT or ATS (SPFT member of staff liaising with the ECR placement needs to arrange this follow-up). This follow-up should be face to face
No ATS or CRHT involvement on discharge eg discharged abroad or out of area	Discharging ward

Discharge over weekends/public holidays (totalling 3 days or over)	CRHT
Discharge to general hospital ward	Mental Health Liaison Team
Discharge from Dementia Ward over a Bank Holiday Weekend	Discharging ward

Exceptions – *these are accepted by NHS Improvement*

Exception Description	Reporting Process and evidence required
Service users with an advanced stage dementia diagnosis who are discharged from a dementia ward to a Care Home – a proxy contact is valid	The appointment should be pre-planned by the Trust in agreement with the Care Home. Evidence of the follow up by the Trust clinician, with either the patient, or the Care Home staff should be recorded as a 04-CPA7 follow up diary appointment on Carenotes by the Trust clinician.
Patient discharged to another NHS Psychiatric Inpatient Facility or private PICU or Private Mental Health Acute Ward	Record of transfer (including full name and address of ward or unit) to be recorded clearly in Carenotes.
Deceased	Carenotes process for recording notification of death to be followed.
Where legal precedence has forced the removal of the patient from the country	Clear clinical notes relating to the circumstances of this removal to be added to Carenotes.
Discharge from SPFT Ward directly to Prison	Clear clinical note relating to the arrangements for discharge to prison.

Working Principles

In the event that the planned follow up appointment does not take place, all reasonable efforts must be made to contact the patient. Reasonable efforts must include ALL of the following as a minimum and be evidenced in the patients' record using the CPA7 Record Form (activity tab in Carenotes):-

1. Documented telephone call.
2. Letter encouraging the patient to contact an identified ward / team / person to be sent/delivered.
3. Where the patient's home address is known, 2 visits to their residence.
4. Where the patient has a known carer, an attempt to contact the carer by phone.

July 2019

East Sussex CDS Leadership Team

Contact: Janet Lombardelli/Jacky Flatt

Appendix 5

ATS/ URGENT CARE TRUSTED Ax MODEL - CASENOTE PROMPTS/FORMAT

COVID 19 SCREENING TO BE UNDERTAKEN AND DOCUMENTED AS PER CURRENT PROCESS

All patients taken on by CRHTT/SNP following discussion and via the Trusted Ax route are under the care of CRHTT immediately.

- Is agreed Trusted Ax documentation fully completed* and available - including robust risk assessment?
- Are all contact details correct including carer/family?
- Is the patient agreeable to receiving CRHTT support?
- What is the reason for CRHTT intervention/support ?
- Has the patient/family got CRHTT contact details and is aware of how to access support OOA?
- Arrange date and time for joint review with patient (within three days)
- Note management and safety plan including time of first CRHTT contact (if OOHs patient to be advised that CRHTT will contact in the morning to arrange a time to visit)

Patient to be opened under CRHTT.

*variations across the trust include case note/Adult Ax/MHLS

Appendix 6

GATE KEEPING CASE NOTE PROMPTS AND FORMAT

COVID 19 SCREENING TO BE UNDERTAKEN AND DOCUMENTED AS PER CURRENT PROCESS

Gatekeeping - hospital admission. – to be completed by CRHTT/SNP and where applicable by delegated gatekeepers e.g AMHP/MHLT/Haven

- Has a F2F gatekeeping assessment been completed by CRHTT – if not why? *e.g AMHP, under CRHTT already, other part of urgent care such as Haven, not in the interest of patient to go through another assessment, risks too high.*
- Have all community options been considered prior to admission?
- What is the purpose of admission and potential length of stay?
- Any barriers to discharge?
- Confirm referrers contact details
- Are all contact details correct including carer/family?

CRHTT contact bed manager as per current process.

All SPFT gate keeping hospital admissions must be captured using the codes 01 Assessment and 04 Gatekeeping together – this will ensure that the correct data is captured for the Dashboard. AMHP to complete case note.