journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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# Crisis 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.

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 Clinical Care Group) and Hambleton and Richmond, Harrogate and Ripon Rural areas, York and Selby and Scarborough Whitby Ryedale (North Yorkshire, York and Selbey 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 patch. We are also in the catchment area for the largest concentration of armed forces personnel in the UK (Catterick Garrison) With over 7,500 staff, we deliver our services by working in partnership with service users and their carers, local authorities and clinical commissioning groups, 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) in which crisis services are openly accessible and numbers available to all on the NHS pathfinder website. This has helped improve access to crisis services and diverted individuals from emergency departments whilst protecting the public from Covid-19 transmission.

A single free phone crisis central line was implemented Trust wide alongside professional numbers for Gp's and other stakeholders. The line provides access to all age response within the respective care groups.

A Listening and mental health support line are in situ covering Teesside and Durham and Darlington locality- part of the NHS England transformation funds to support alternative crisis options and are accessible via the central crisis line.

The age range that TEWV CRHTs predominantly work with are those aged 16 years and over, however most teams deliver crisis intervention to those over 65 years (functional). There are also commissioned Child and Adolescent Mental Health Crisis Teams and Older Persons crisis teams in some localities. In North Yorkshire and York an 'all age' SPA is in situ however separate CRHT's deliver the all age ambition. 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 work collaboratively with colleagues in other specialities.

There are three main locality 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 Mental Health Crisis Care Concordats (February 2014) and NHS Long Term Plan (2019).

CRHT teams are generally made up of mental health professionals such as Mental Health Nurses and Consultant Psychiatrists, Psychologists 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 localities may also have nurse consultants, community matrons and/or service managers alongside the leadership team. It is out aim to have peer support workers within all the teams 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.

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, Improving Access to Psychological Therapies (IAPT) services, Liaison Psychiatry 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- working with service users, carers and stakeholders/partners.

Service users who are admitted to acute mental health inpatient wards 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, July 2015).

## 1.2 Background

Crisis is best defined by the person experiencing it. For the purpose of this document, crisis is defined as the interruption of an individual's normal life.

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 if often the outcome of a crisis regardless of its source. The primary objective for CRHTs is to minimise harms including harm to self, harm to others, harm from others and potential unintended harms from our intervention in line with the Harm Minimisation Policy and to help support

the individual in their recovery and minimise distress using a bio psycho social model. CRHT's teams can enable people to be discharged earlier from inpatient wards and receive treatment within their homes (alternative) whilst still experiencing an acute phase of an illness, high risk period or ongoing distress.

Most service users 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. 'Intensive' home treatment can be provided in a range of settings and is not restricted to the individual's home.

Crisis services consider the options available and work collaboratively to ensure the best fit with service users 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 service users and carers to gain a clear understanding of the needs of both.

For some, hospital can be damaging, whereas for others it may be the most appropriate option.

Care must be individualised, collaborative and based on each individual'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 possible 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 service users and their carers/families.
- 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 service users and their carers and should be co- created.
- We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers/family as equal partners.
- We will listen, learn, improve, and innovate together with our communities and will always be respectful, compassionate, and responsible.
- 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 carry out 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 QNCRHTTs 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 working collaboratively, flexibly and innovatively together to deliver crisis services and explore alternatives to crisis services as set out by the Long-Term Plan, 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.

**Our values of Respect, Compassion and responsibility**

Living our values is very important during a time of crisis. This policy helps ensure we do this by showing respect to patients and their families, 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, always receptive (listening) to how much information a person may want, and in what kind of format and a partner in their 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 carry out 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 individuals 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, intensive home-based treatment, and alternatives to admission, to service users and their carers/families. Our ultimate aim is one of minimising harm to self, from others, harm to others and potential unintentional harms, for example unnecessary admissions, 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 advice and support for a mental health need 24/7, regardless of age or where they live.

- Ensuring service users 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 of values of compassion, respect, and responsibility.
- Helping service users to achieve recovery (as defined by the service user)
- Being able to reach us again simply and quickly.

# 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, managers and clinicians within the services, the crisis network, service development group 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 in line with the national Quality Network CRHT standards (formally known as 'Home Treatment Accreditation Standards' (HTAS) for CRHT's) and core fidelity principles.

## 3.2 Roles and Responsibilities –

| Role | Responsibility |
|---|---|
| Locality Senior Management Team/Leaders | • Ensure services work to and within the policy guidelines/crisis pathways with patients, carers and families and that the policy is implemented. |
| CRHT staff/workforce | • Adhere to and work within the framework of the operational policy, other supporting policies and procedures, Trust values and crisis pathway, engage in future consultation, engagement, and feedback. |
| Urgent Care Pathways Lead | • Policy lead responsible for updating the policy, leading consultation, and providing advice and guidance on crisis care standards, advising on aspects of policy and crisis pathway. |
| Clinical Networks | • Oversight of the policy and guidance, support of crisis pathway and processes. |

# 4 Aims of the service

The CRHT will:

- Appropriately screen and triage at the point of contact and provide a very urgent clinical response/ assessment within 4 hours 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 carers in the assessment process and with referral to the CRHT.
- If assessment undertaken and IHT deemed appropriate provide a period of assessment of mental health needs in line with the quality standards work.
- Act 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 service user until the crisis is resolved and there is no longer a role for the CRHT. The CRHT will facilitate contact/referral with services that promote recovery
- To provide a carer contact for all individuals who are receiving IHT
- Where hospitalisation is necessary and there is a clear rational for admission, 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 intensive home treatment at the earliest opportunity
- 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 and referrers regarding all support available and communicate the outcome of any triages/signposted agreed.
- Undertake facilitation and attendance to Section136 detentions/mental health act assessments and liaison with Street triage teams (or equivalent named – police response teams) and liaison psychiatry teams to consider offer of intensive home treatment as an alternative to inpatient admission (where appropriate).
- When a situation arises involving CTO recall within working hours the CRHT should be made aware of the potential recall and there should be liaison between the Community Team 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 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 transfer from an NHS Mental Health Trust – this must be an in-patient transfer e.g. direct from other 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 MOD beds at West Park Hospital

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 intensive home treatment 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 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 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 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 PARIS 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 & who carried out the assessment to be clearly recorded and if within the 24-hour time of admission then can be counted – otherwise will be classed as a breach

- 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 via a central freephone line. Calls will be screened and referrals 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 direct individuals to the most appropriate service identified to meet their needs.

It is important that an individual 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 can work collaboratively with an individual. It is also expected that, for self-referrals, the crisis team clearly discusses consent and assesses capacity to engage. Sometimes an individual may not be able to consent to assessment and/or chose not to engage with the CRHT for various reasons.

Staff will:

- Triage the individual and level of need (as supported by the UK Mental Health Triage tool).
- Provide telephone advice to the referrer/carer to inform care and treatment and then may:
- Provide a rapid response, face to face assessment as per clinical priority of need.
- Determine any preferred communication methods with the individual/referrer.
- Signpost to alternative services.
- Alternative options if an individual does not wish to engage and may lack capacity (mental health act assessment)
- There is also an urgent care DNA/WNB 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.

The CRHT can be accessed by the following:

- Self-Referral.

**Individuals and their respective families and/or carers/friends can contact their respective CRHT team via telephone if they have concerns. They will then be triaged using the agreed Triage assessment tool for any intervention felt necessary.**

- Any Mental Health Services including all Community Intervention Teams currently operational within TEWV NHS Foundation Trust and external. For these individuals, it is expected that the respective community intervention team will have increased their own input in collaboration with the service user prior to referral and will be triaged in the same way as other referrals to agree what intervention is required.

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 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., unconscious, grossly intoxicated we will remain in contact with the referrer 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.
- Accident and Emergency Departments/Acute Hospitals/111
- Social Services/Emergency Duty Team
- Police/Forensic Medical Examiner working in custody suites/Street triage teams
- Improved Access to Psychological Therapies (IAPT)
- Non-Statutory Agencies
- Any specialist services whereby intervention required is essential, for example: Early Intervention Teams work with a client group who have a high risk of admission and or complex needs and risk. All new service users presenting with psychosis and under the age of 35 who are assessed initially by CRHT will be referred to EIT 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 team. 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.

## 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).
- For patients with possible puerperal psychosis, CRHT can request that perinatal team/worker accompany them at urgent assessment – perinatal duty worker will endeavour to attend.

# 6 Assessment

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, Very Urgent, Urgent and/or Routine.

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

Before arranging the assessment, as much collaborative information will be sought from the 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 psycho social assessment of the individual. Carer and family views are gathered and are integral to the assessment process.

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

An interpreter may be needed for some individuals, and staff should always consider the most appropriate methods of engagement and communication with those who have protected characteristics.

**Initial assessments in the community will *normally* be carried out 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 should be based on clinical need, risk, safety, resource, and teamwork. In most circumstances' joint assessment in collaboration with other professional colleagues from other teams will be appropriate.**

The active involvement of families and carers is encouraged and information from families and carers will be taken into account unless confidentiality overrides such.

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.

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

- Intensive Home treatment – with a view to further period of assessment followed by a formulation of need
- Direction/signposting to other services and/or agencies

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 is 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 and 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.

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

Following assessment, the referrer will be informed of the outcome and of any recommendations, both as soon as possible verbally and/or, in writing within **24hrs.** Where no further involvement is required 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 Intensive Home Treatment /Intervention

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.

Intensive home treatment will be determined and based on **any** of the following:

- Distress level
- Impact on functioning
- Potential for harm

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 Community Intervention Team, 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 overall treatment plan includes providing interventions at the individual's home or alternative environment.

**During the initial 72 hours of IHT there will be at least a minimum daily face to face to contact (via registered professional or professionals) to assess the mental health needs with the individual, carer/families with review after this period to aid and further formulate the care and treatment plan. After this, the individual will be visited regularly, and the number of visits and level of input will be discussed with them based on their needs.**

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

The CRHTs operate a team working system, which in effect means that members of the team are aware of the issues concerning each individual and their care plan. This ensures

that the individual does not need to repeat his/her 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.

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 agreed communication with the individual may also compliment 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.**

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

## 7.1 Discharge from Inpatient Ward/3Day Follow Up

An integral role of the CRHT is to facilitate and support discharge from acute Inpatient wards for individuals 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 community intervention teams 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 wards to identify patients that no longer require continued hospitalisation but may benefit from IHT.

**Where intensive home treatment can be facilitated the CRHT will arrange to see the individual within 24hours of discharge from the ward and/or commencement of intensive home treatment.**

**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 from a CRHT, Care Coordinator or relevant other professional whom the patient is known too. (NCISH, October 2017)**

# 8 Care and Safety Planning

All patients referred to a CRHT following triage (Catogaries 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 is 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 Harm Minimisation 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.

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

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 harm minimisation 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.

The Care/Safety Plan will detail:

- The person's perspective and understanding of what is happening and their needs, perspective, and preferences. Reflecting the formulation/reviews undertaken.
- Any differences in opinions between the individual, 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 individual, 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

If appropriate to include recovery-oriented goal setting at an appropriate e.g. transitioning from wards into the community and home treatment. To be linked with community teams and care coordinators

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

**Individual's open to IHT should always be involved with and offered a copy of their care and safety plan within 72 hours and this should be documented in the care record that this has been done.**

**Any care/safety planning will actively involve the individual, considering the views of their family and carers. Upon discharge/transition copies of relevant plans should also be provided at the time to the patient/family/carer (as consenting) and within 24hrs to relevant others/GP.**

# 9 Physical Health

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. General physical health will be managed by the general practitioner; IHT will support the service user to access primary care services as required and identify and needs, liaising 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.

## 9.1. Management of Medicines/ Medication Management

The prescription of medication is a key part of the role of the CRHT's. Medical staff and Non –Medical Prescribers (NMPs) can prescribe medication. 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 individuals administering their own medication in line with the prescription, but are not able to administer it or offer any advice (unless specifically trained). Subsequently any physical health need is assessed and monitored being reflected within the care/safety plan. Addressing such needs may also be undertaken jointly with the individuals' GP, other acute care providers, social care and/or community intervention teams and liaison/information sharing should be undertaken.

- Where possible IHT will support service users to manage their own medication.
- The team can 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.
- The team will adhere to any prescribing guidance in situ for example antipsychotic monitoring guidance.

## 9.2 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.

# 10 Care Co-ordination/Lead Professional

**Whilst a service user is receiving Intensive Home Treatment the CRHT will act as Care Co-ordinator and allocate a named person who will act as Care Co-ordinator on CPA, unless the person is already active to a Community Intervention Team (CIT or CMHT) and has an identified Care Co-ordinator.**

# 11 Review of Care and Treatment

**The care provided to individuals is reviewed on a daily basis and is discussed fully in team huddles and formulation meetings which are documented and entered into the electronic Health Care record system.**

The Safety Summary, Safety Plan, Care Plan and Formulation are regularly reviewed by the team 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).

## 11.1 Planning for Discharge/Transition

When the crisis has resolved or becomes manageable and the individual no longer requires the involvement of the CRHT, discharge will be negotiated, which is effectively planned from the outset of the contact. 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 individual and their family/carers are fully aware of on-going care arrangements including the GP.

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

- Coping strategies have been explored with the individual, their family and carers.
- 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 service user's care to another service, a discharge summary will be written, and a copy sent to relevant professionals and the individual and/or carer if requested within 24hours.**

- Transfers to other services should be undertaken swiftly, safely, and collaboratively with the relevant workers/teams in line with the CPA Policy.

# 12 Shift Coordinator Role and Function

The Shift Co-ordinator 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 intensive home treatment continue to be met.

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

Each 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 leader 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 in mind.

Shift Co-ordinator /designated other will contact all acute wards in their locality daily to explore options for any potential discharges and IHT support also liasing with Bed managers.

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

# 13 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 individuals 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 Co-ordinator/lead 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.

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

There will be a weekly clinical review meeting led by the team manager or delegated facilitator, individuals that have been on caseload for 7 days will be reviewed within this meeting.

At the end of each shift all progress will be recorded, and any significant event will be discussed with the Shift Coordinator.

**Team Meetings.**

Monthly team meetings take place within each CRHT, chaired by the Team managers/nominated staff member on a regular basis as part of the Trust's Governance arrangements.

Monthly group supervision and any reflective practice sessions open to all clinical and non-clinical staff should be promoted within the teams and teams should work to the Trust supervision policy.

The Trust has Clinical Care Group Urgent care meetings, Interface meetings and an Urgent Care Network to share good practice, develop core standards and network with colleagues within and across Urgent Care. This also links with the regional Liaison and Crisis Networks, Crisis Care Concordats, and other related meetings internally and externally.

Some of the CRHTs have attained Home Treatment Accredited Standards (HTAS) now known as the QNCRHT which focus upon national best practice, those that are not accredited are working towards this status and should work within these standards regardless.

# 14 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.

The Care Act 2014 sets out statutory responsibility for the integration of care and support between health and local authorities. 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 is who is experiencing, or at risk of, abuse or neglect; and as a result 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.

Staff are provided with regular Safeguarding training from both internal and external agencies such as TEWV or Local Authority, and this is reflected in their dashboards.

Each crisis service has access to Safeguarding Teams within TEWV as in addition to one of their local Authorities' own safeguarding arrangements.

# 15 Lone Working

Crisis team staff must adhere to their local lone working arrangements to support the health, safety and wellbeing of staff and service users. 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 utilised instead of home residences to ensure safe working practice and reduce harm.

# 16 Record Keeping

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

Standards as set out in documentation processes should be adhered to by all staff.

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.

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 service user 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 and care plans and receive copies of letters (should they wish) from the team.

# 17 Meeting Carers' Needs

**Carer Champions are identified in each CRHT and can provide separate supportive appointments to relatives or carers of those receiving IHT.**

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

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.

## 17.1 Listening to/involving Service Users, Carers and Staff

Each individual and their family members utilising the CRHT should be given the opportunity to provide feedback of their experience with the team. The feedback both good and bad allows us to continually evaluate our service. This can be achieved by key named workers within the teams as carer supports, at IHT appointments, via the leadership team

Feedback obtained from forums is also used to inform and develop practice, contribute to audit and assurance, improve staff wellbeing and quality outcomes.

Training, education, recruitment, and service improvements should involve individuals and carers with lived experience.

# 18 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 don't |

| | |
|---|---|
| | follow the conditions or you 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 theirs 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 can't make decisions for yourself, how you can ask someone else to make decisions for you and who can make decisions for you if you haven't planned ahead. |
| 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.<br><br>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.<br><br>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 short period of time. |
| 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) | 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.<br><br>Secondary mental health services include the Community Mental Health Team (CMHT), Assertive Outreach Team and Early Intervention Team.<br><br>You should get:<br><br>• a full assessment of your health and social care needs<br>• a care plan<br>• regular reviews<br>• a care coordinator who will be responsible for overseeing your care and support. |
| Care Coordinator (CC) | 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're 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)<br><br>A care coordinator could be any mental health professional, for example:<br><br>• a nurse<br>• a social worker<br>• another mental health worker.<br>This is decided according to what is most appropriate for your situation.<br><br>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.<br><br>They may be: |

| | |
|---|---|
| | • social workers<br>• nurses<br>• occupational therapists<br>• 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 Colledge 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 working with regional teams to support the commissioning of health care services. |
| Paris | Tewv's electronic patient recording system. |
| 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's usually a hospital but can be your home. A police station should only be used in an emergency. |

# 19 Related Documents

Care Programme Approach and Standard Care

Lone Working Policy

Safeguarding Adults

Safeguarding Children

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

Deprivation of Liberty

Harm Minimisation

Positive Behaviour Support

Inter Hospital Transfers

Admission Transfer and Discharge framework

Missing Person Procedure

Trauma clip

Autism Strategy

Green Light Project

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.

# 20 How this policy will be implemented

- The policy will be published on the Trust's intranet and website and on the staff bulletin.
- Line managers will disseminate this policy to all Trust employees through a line management briefing and discuss at their team meetings.
- The Urgent Care Pathways Lead will circulate the link to the operational policy when published and discuss at the Trust-wide Urgent Care Network.

## 20.1 Training need analysis

| Staff/Professional Group | Type of Training | Duration | Frequency of Training |
|---|---|---|---|
| New staff to CRHT to undertake Trust and local induction into team | Formal and informal induction, supervision, mentoring, networking | As agreed with manager | Upon joining the Trust/Team and via ongoing idenfied 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/localities to attend the Trust-wide Crisis Network. | Network, discussion, shared learning, feedback, presentations, training | 1.5. hrs. | Bimonthly meetings |

## 20.2 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.<br>Associated case note audits within teams/localities.<br>Any Trust wide audits with Urgent Care Pathways Lead involvement.<br>(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.<br>Daily monitor of breeches.<br>Review and monitoring of IIC crisis line call data, missed calls and unawered calls, heatmaps, trends and complaints.<br>Peer review visits and audit.<br>Director led visits and feedback.<br>Audit of Documentation standards and pathway including triage tool/clinical priority and docuemntaion quality.<br>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 (HTAS standards). | Teams and staff to work to standards and aim for accreditation by the QNCRHTT/peer review. | QNCHTT formal accreditation awarded and assessed accordingly via peer reviews. |

# 21 References

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 (October 2017). Annual Report: England, Northern Ireland, Scotland, and Wales

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

NHS Long term plan (2019) NHS England

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

UK Mental Health Triage Tool

**Link to QNCRHTT guidance – link (accessed on 23rd November 2022)**
Practice guidelines for Crisis Lines and CRHTTs (rcpsych.ac.uk)

# 22 Addendums for Localities

## 22.1 Durham and Darlington

**Crisis Service Operational Policy – Durham and Darlington Service Addendum**

**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**

<table>
<tr><th colspan="2">Durham</th><th colspan="2">Darlington</th></tr>
<tr><td colspan="2">- Combat Stress (Veteran's Mental Health Charity)<br>- Eclipse (Translation Service)<br>- Moses Project<br>- Relate</td><td colspan="2">- Carers Together<br>- Change Grow Live<br>- DISC<br>- Early Help<br>- The Junction<br>- My Sister's Place</td></tr>
<tr><td>- Alice House Hospice<br>- The Artrium<br>- Community Campus 87<br>- Hartlepool Action Recovery Team<br>- Hartlepool Carers<br>- Hartlepool Voluntary Development Agency<br>- The Haven<br>- Lifeline<br>- Mesmac<br>- Parents in Need of Support (PINS)<br>- Police Liaison Officer<br>- SAFA<br>- 13 Housing<br>- The Tramsheds<br>- West View Resource Centre</td><td>- Bereavement Care<br>- New Horizons<br>- Stockton Carers Service<br>- Stockton Navigation Project</td><td>- Bankruptcy<br>- Barnados<br>- Cargomm<br>- Church Housing<br>- Connections<br>- Eclipse<br>- Erimus housing<br>- Fairbridge Project (Princes Trust)<br>- Hope North East<br>- Hospice<br>- Mesmac<br>- New Horizons<br>- Positive Action Teesside<br>- Relate<br>- Red Cross<br>- Riverside (Veterans)<br>- Sahara<br>- SAFA<br>- Shaw Trust<br>- Stages<br>- Sure Start<br>- Victim Support</td><td>- EVA<br>- Fairbridge (Princes Trust)<br>- Hospice<br>- ManShed<br>- Red Cross<br>- Veterans Service<br>- Salvation Army<br>- Transformation Challenge Team<br>- Women's Support Network<br><br>Carers support group, Stonham, Disc, MIND, Insight, Drug and Alcohol</td></tr>
</table>

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.
- Crisis Care Concordat meetings
- Urgent Care Network- Tewv
- Regional NENC Liaison and Crisis Network

**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.
- Recent uptake for qualified staff who have begun their NMP training which will support and enhance prescribing across the locality.

## 22.2 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/liaising with appropriate services as required. The team will carry out 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, advanced practitioners, 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 somewhat 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, advanced practitioners, 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 liaising with other services as appropriate.
The assessment team may, on occasion, carry out 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 (mid-2016)**

| **Area** | **Total** | **Age 16-64** | **Age 65+** |
|---|---|---|---|
| Tees Valley | 669900 | 416100 | 124700 |
| Hartlepool | 92800 | 57600 | 17500 |
| Middlesbrough | 140400 | 89200 | 22300 |
| Redcar & Cleveland | 135400 | 81600 | 29600 |
| Stockton | 195700 | 122900 | 34400 |

## 22.3 North Yorkshire and York

### Crisis Service Operational Policy NY&Y

### 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

- All CRHTT's accept referrals from current service users, carers, self-referrals from those not known to services, as well as professionals from TEWV and

external agencies. We 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, dependant on individual need.

- The CRHTT's operate an all-age free phone 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 is manned 24 hours 7 days a week by dedicated crisis staff. Callers will have the option to select the crisis team local to their area, however in the event that the chosen team are unable to respond to the call will transfer to an available telephone line located in one of the other teams.

- 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 carry out 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 possible alternatives have been explored in accordance with the least restrictive approach. In the event hospital admission is required, the CRHTT maintain 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 offer in-reach/recovery at home into the inpatient wards for those patients within each individual teams 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<br>- Andy's Man Club Scarborough<br>- Woman's wellbeing club<br>- Scarborough Disability Action Group (DAG)<br>- Carers plus Yorkshire<br>- First light Trust<br>- North Yorkshire Horizons<br>- Broadacres |

| |
|---|
| - Citizens Advice Bureau<br>- Local Authority/Social Care, STR Workers, Living Well Team<br>- Northern Lights Therapy Service Scarborough<br>- Age UK Scarborough<br>- Advocacy Alliance<br>- Mental Health Matters<br>- Mind<br>- Recovery College<br>- Samaritans<br>- Rainbow Centre<br>- Foundation Housing, Horton Housing<br>- IDAS<br>- Safer Neighbourhoods and Community Impact Team |

**External Partner Agencies**

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

| **Across Hambleton and Richmondshire** |
|---|
| - Carers Resource centre including young carers<br>- Citizens Advice Bureau<br>- Local Authority/Social Care (North Yorkshire County Council) including STr workers, Living Well team.<br>- North Yorkshire mental health helpline<br>- North Yorkshire Horizons (Substance Misuse) |

| |
|---|
| - The Living Rooms including the Man Shed<br>- Phoenix House, Catterick (Help for Heroes)<br>- RELATE<br>- Combat Stress<br>- Independent Domestic Abuse Service (IDAS)<br>- Samaritans<br>- MIND/centrepoint<br>- Mental Health Police Liaison officer<br>- The Clock, Thirsk<br>- Broadacres<br>- Hambleton District Council<br>- Herriot Hospice Homecare |

| **Across Harrogate** |
|---|
| - Carers Resource centre, East Parade<br>- Citizens Advice Bureau<br>- Local Authority/Social Care, STR Workers,<br>- The Orb<br>- Mind<br>- Claro enterprises<br>- Samaritans<br>- Springboard / Homeless project<br>- No second night out<br>- 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.

## 22.3.1 Harrogate MHSOP Service Addendum

**MHSOP Crisis and Home Treatment Team (CRHT).**

**Service Outline & Structure**

- Persons over 65 year 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 are in need of urgent or rapid response to their mental health needs. The team aim 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 persons designated place of residence – 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 carry out 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 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 particular 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 a lot 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<br>- Citizens Advice Bureau<br>- Local Authority/Social Care, STR Workers,<br>- Mind<br>- Claro enterprises<br>- Samaritans<br>- Dementia Forward<br>- Alzheimer Society<br>- North Yorkshire Horizons<br>- ARCH (Acute response and rehabilitation- community and hospital) Team<br>- SDS (Supported discharge service) Team – Harrogate District Foundation Trust<br>- 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 RCT/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.

# 23 Document control (external)

To be recorded on the policy register by Policy Coordinator

| | | |
|---|---|---|
| Date of approval: | 14 December 2022 | |
| Next review date: | 05 October 2024 | |
| This document replaces: | COP-0017-v4 Crisis Operational Policy | |
| This document was approved by: | Name of committee/group | Date |
| | Trustwide Crisis Service Group | 26 September 2022 |
| This document was ratified by: | Name of committee/group | Date |
| | Management Group<br><br>Executive Directors | 21 September 2022 (requested changes)<br><br>14 December 2022 |
| An equality analysis was completed on this document on: | September 2021 | |
| 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<br>Team addendums updated<br>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.<br><br>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:-<br>Minor amendment to reflect current practice within Trustwide Crisis Teams use of new national clinical priority standards and UK mental health triage tool. Updated references to job titles and assurance groups.<br>(Plus changes requested by Management Group on 21 Sept 2022)<br>Updated LD paragraph (During office hours…) section 5.<br>Addendums updated. | Ratified |

# Appendix 1 - Equality Analysis Screening Form

| | | | | | | |
|---|---|---|---|---|---|---|
| Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc. | Crisis Teams – Trust Wide | | | | | |
| Policy (document/service) name | Crisis Operational Policy v4 | | | | | |
| Is the area being assessed a; | Policy/Strategy | / | Service/Business plan | | Project | |
| | Procedure/Guidance | | | | Code of practice | |
| | Other – Please state | | | | | |
| Geographical area | 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 | 10th September 2021 | | | | | |
| End date of Equality Analysis Screening | 22nd September 2021 | | | | | |

**You must contact the EDHR team as soon as possible where you identify a negative impact.**

| |
|---|
| 1. Who does the Policy, 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.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

| | | | | | |
|---|---|---|---|---|---|
| **Race** (including Gypsy and Traveller) | No | **Disability** (includes physical, learning, mental health, sensory and medical disabilities) | Yes | **Sex** (Men, women and gender neutral etc.) | No |
| **Gender reassignment** (Transgender and gender identity) | No | **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) | No | **Age** (includes, young people, older people – people of all ages) | No |
| **Religion or Belief** (includes faith groups, atheism and philosophical belief's) | No | **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) | No | **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) | No |

**Yes** – Please describe anticipated negative impact/s

**No** – Please describe positive impacts/s

Interpreting services to be accessed and arranged as required via protocols for each locality considering patient and carer needs, staff should not use family members as interpreters. All CRHT staff to be familiar in how to access the interpreting service.

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 record keeping policy 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 used at all times.

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 those individuals can continue to take medication at this time. Staff can access support and advice via the chaplaincy team and specialist chaplains.

Physical disability – to assess and consider any impact planning care accordingly and jointly where necessary.

Those with a learning disability - to refer to local procedures and policies for inter disciplinary working. Staff should also assess and put in place reasonable adjustments for those with a learning disability/autism.

Deafness – at present as service users may not be able to contact the service directly, a potential negative impact has been identified. This should be picked up in the accessible information standard work that is being undertaken, BSL interpreters should be used for those whose first language is BSL. The use of family, friends and carers will also be used to help the service user make contact with the service but will not replace a BSL interpreter . The Trust is considering an alternative telephony system with requirements that will address and support the accessible information standard and improve access for these groups further. This has been approved in principle with suggested requirements which would address, however a review of crisis services has been commenced and the single points of access/operational models prior to any agreement.

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 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.

| | | | | |
|---|---|---|---|---|
| **3.** Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.?<br>**If 'No', why not?** | **Yes** | | | |

| | | |
|---|---|---|
| **Sources of Information may include:**<br>• Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc.<br>• Investigation findings<br>• Trust Strategic Direction<br>• Data collection/analysis<br>• National Guidance/Reports | | • Staff grievances<br>• Media<br>• Community Consultation/Consultation Groups<br>• Internal Consultation<br>• Research<br>• Other (Please state below) |

| |
|---|
| 4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership |
| **Yes** – Please describe the engagement and involvement that has taken place |
| Trust wide engagement has been undertaken relating to the crisis operational policy. This includes feedback and comments from the Service Development Managers for the specialties across the Trust, previous Recovery leads, Trauma leads, Autism Strategy Manager, Crisis Network, Equality and Diversity team and Acute Care Forum along with local authority partners and Experts by Experience. |

| | |
|---|---|
| 5. As part of this equality analysis have any training needs/service needs been identified? | |
| yes | Web ex/ause of attend anywhere – exploration of technology Trust wide to support the above protected characteristics.<br>Depending on future telephony and technology options chosen staff will require further training in these developments once agreed and implemented. Promotion of alternatives to crisis have been promoted and used.<br>The deaf and hearing lead E Chan has also linked in with the Crisis Network and teams and has meet with the Urgent Care Lead for updates.<br>Autism awareness training has been encouraged for all urgent care staff. |

A training need has been identified for;

| | | | | | |
|---|---|---|---|---|---|
| Trust staff | Yes | Service users | No | Contractors or other outside agencies | No |

**Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so**

# Appendix 2 - 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 | Wide consultation and feedback over a period of 5 months |
| | Has relevant expertise has been sought/used? | yes | Via leads within Trust |
| | 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 |
| **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 | |
| | Are supporting documents referenced? | yes | |
| **6.** | **Training** | | |
| | Have training needs been considered? | yes | |
| | Are training needs included in the document? | yes | |
| **7.** | **Implementation and monitoring** | | |

| | Title of document being reviewed: | Yes/No/ Not applicable | Comments |
|---|---|---|---|
| | 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 |
| | Have Equality and Diversity reviewed and approved the equality analysis? | yes | Updated by lead |
| **9.** | **Approval** | | |
| | Does the document identify which committee/group will approve it? | Yes | |
| **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 | |