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Trustwide Operational Policy for Crisis Resolution Home Treatment Teams and Bed Management

Lead executive	Director of Operations
Authors details	Head of Clinical Service - 0151 343 5505 Team Manager - 01625 508582 Acute Care Clinical Director - 0151 482 7854 Bed Management Hub Manager - 0151 482 7636

Type of document	Policy
Target audience	All CWP staff
Document purpose	This policy explains the function and purpose of home treatment and how the service will be delivered.

Approving meeting	Specialist Mental Health Business and Governance Care Group	Date 12-Feb-20
Implementation date	12-Feb-20	

CWP documents to be read in conjunction with	
HR22	Supervision and Appraisal policy
MP1	Medicine policy
CP40	Safeguarding Children policy
CP10	Safeguarding Adults policy
AMHWC1	West Clinical Service Unit SOP for Out of Hours Services
MP5	Clozapine Prescribing and Monitoring Guideline
CA3	Guidelines for the assessment and management of psychiatric emergency in young people under 18 years

Document change history	
What is different?	Inclusion of Health Care Partnership crisis care model and updated pathways and gatekeeping assessment
Appendices / electronic forms	Bed management process ERB/comminity bed provider information 16-19 service user pathways
What is the impact of change?	Improved consistent trustwide approach

Training requirements	Yes - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Community Mental Health Practitioners, Clinical Lead, Mental Health Practitioner, Community Mental Health Nurse
Corporate services	via discussion forum

External agencies	via discussion forum

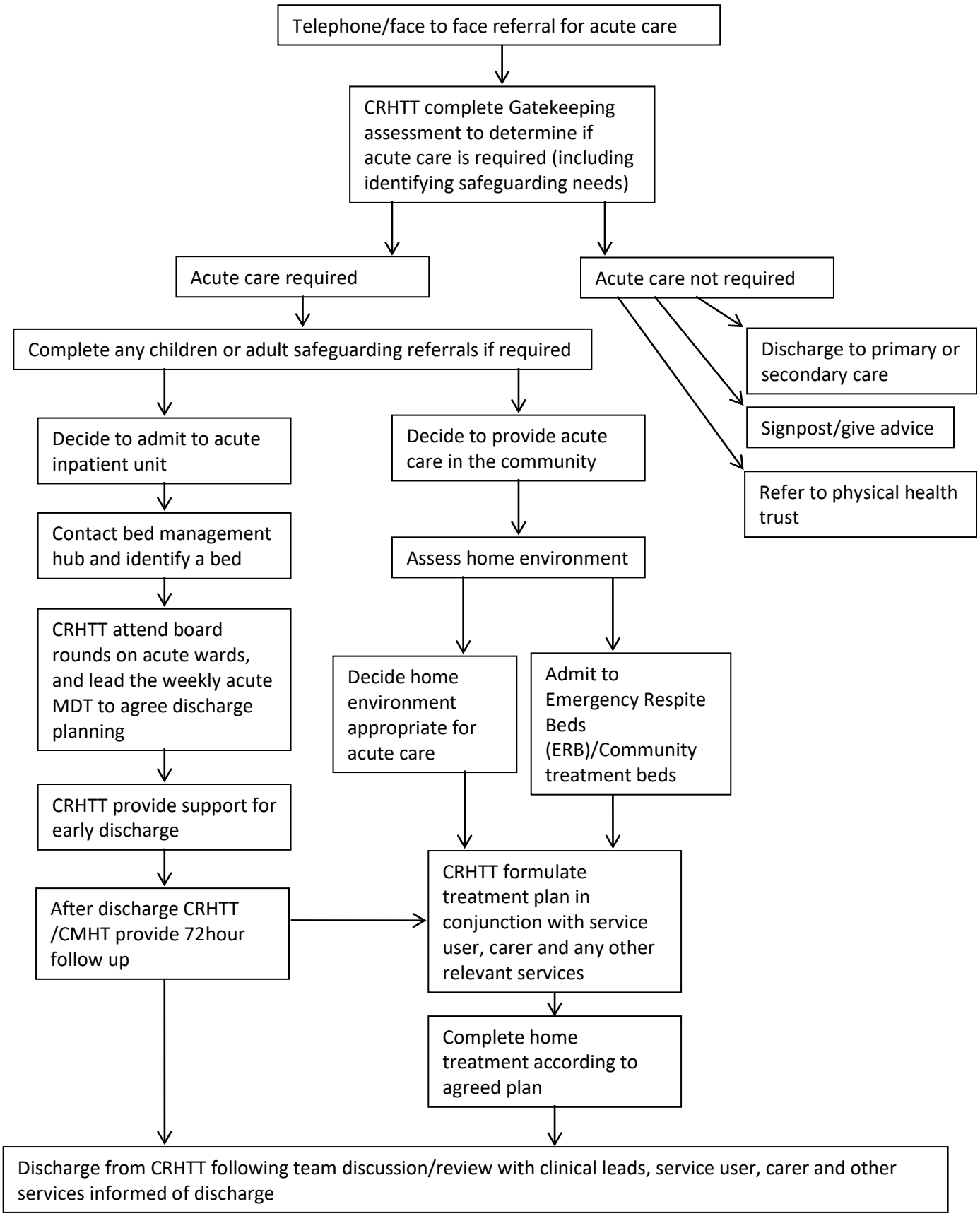
Financial resource implications	None

External references
1. Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis, Department of Health and Concordat signatories, 18 February 2014. 2. The Five Year Forward View for Mental Health, Mental Health Taskforce to the NHS in England, February 2016. 3. Health and Social Care Act 2012. [online] Available at: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted [Accessed 3 Oct. 2017]. 4. A National Service Framework for Mental Health, Department of Health, September 1999.

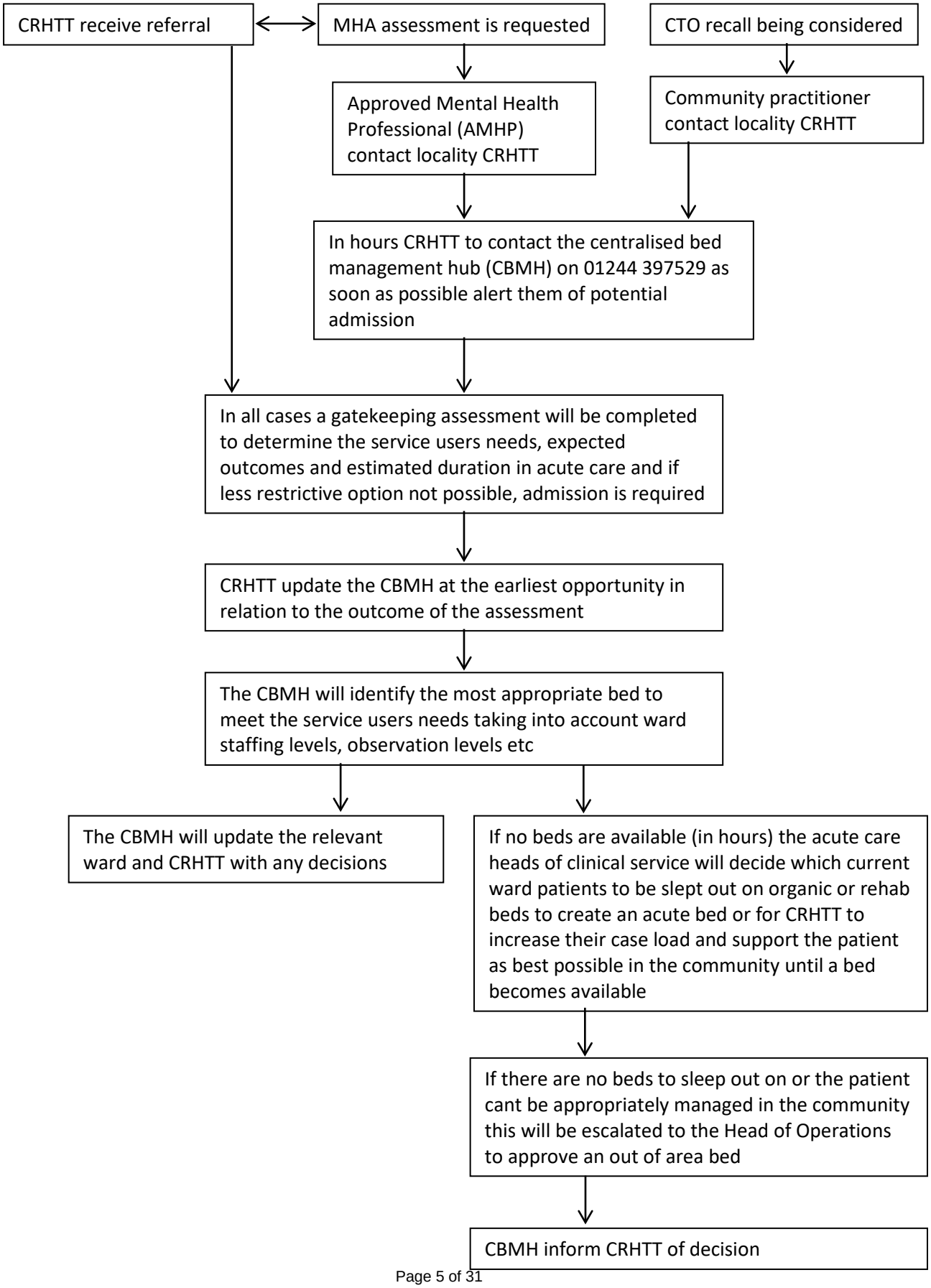
Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	Yes	Excludes under 16 year olds
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
No		
Is the impact of the document likely to be negative?	No	
- If so can the impact be avoided?	N/A	
- What alternatives are there to achieving the document without the impact?	N/A	
- Can we reduce the impact by taking different action?	N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

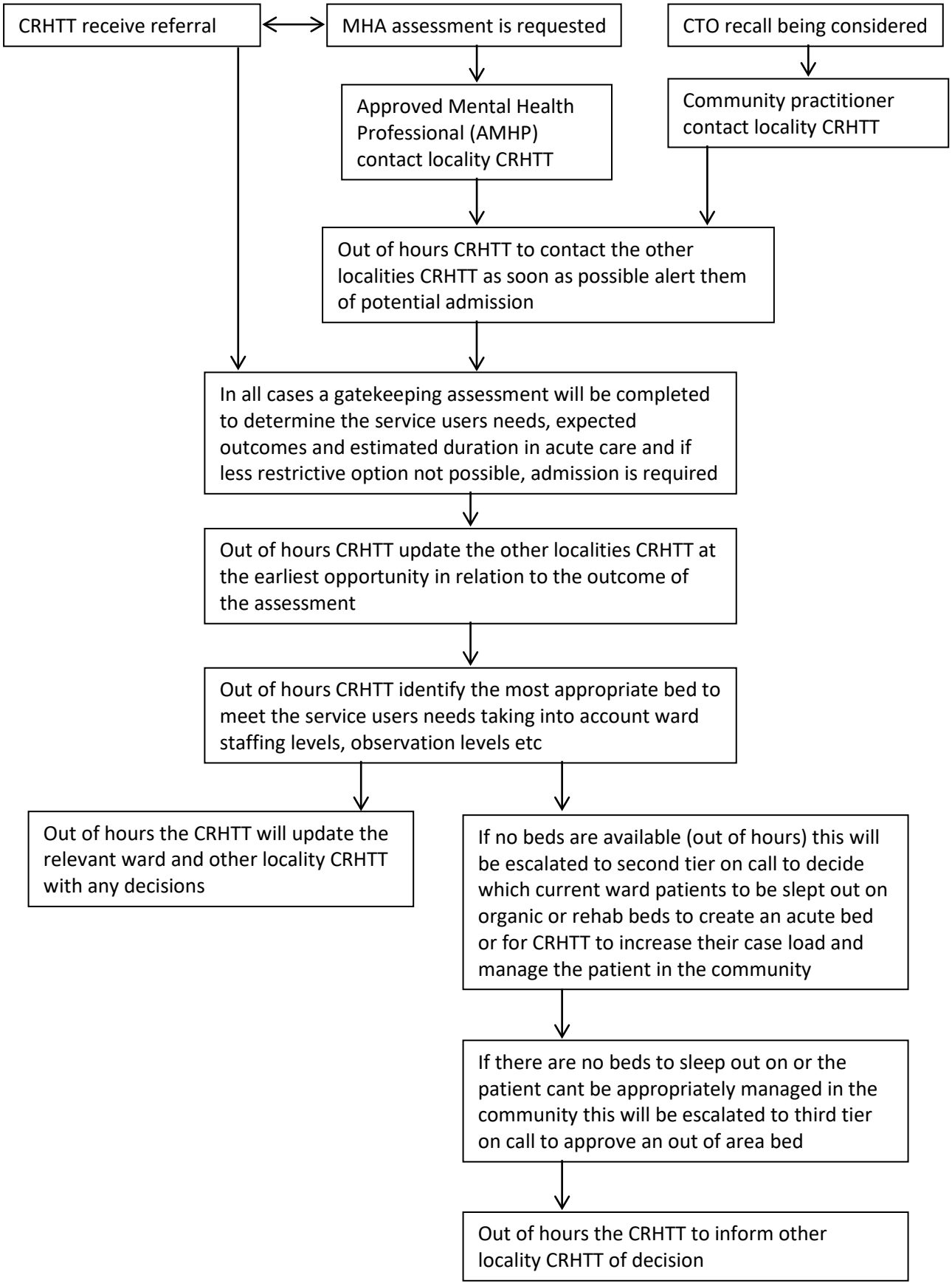
Quick reference flowchart 1 – Crisis Resolution Home Treatment Team Pathway
For quick reference the guide below is a summary of actions required.



Quick reference flowchart 2 – Bed Management Pathway (in hours admissions)

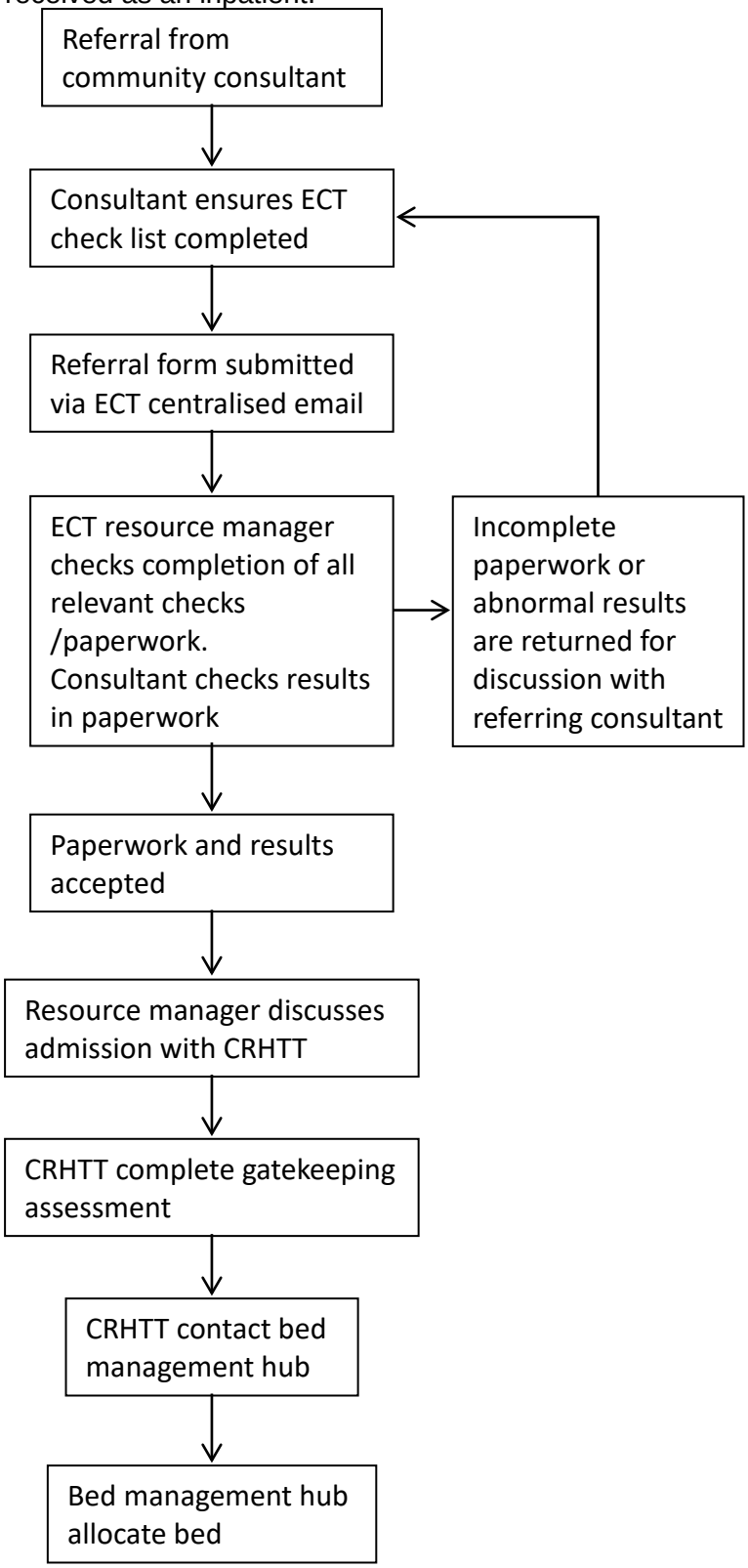


Quick reference flowchart 3 – Bed Management Pathway (out of hours admissions)

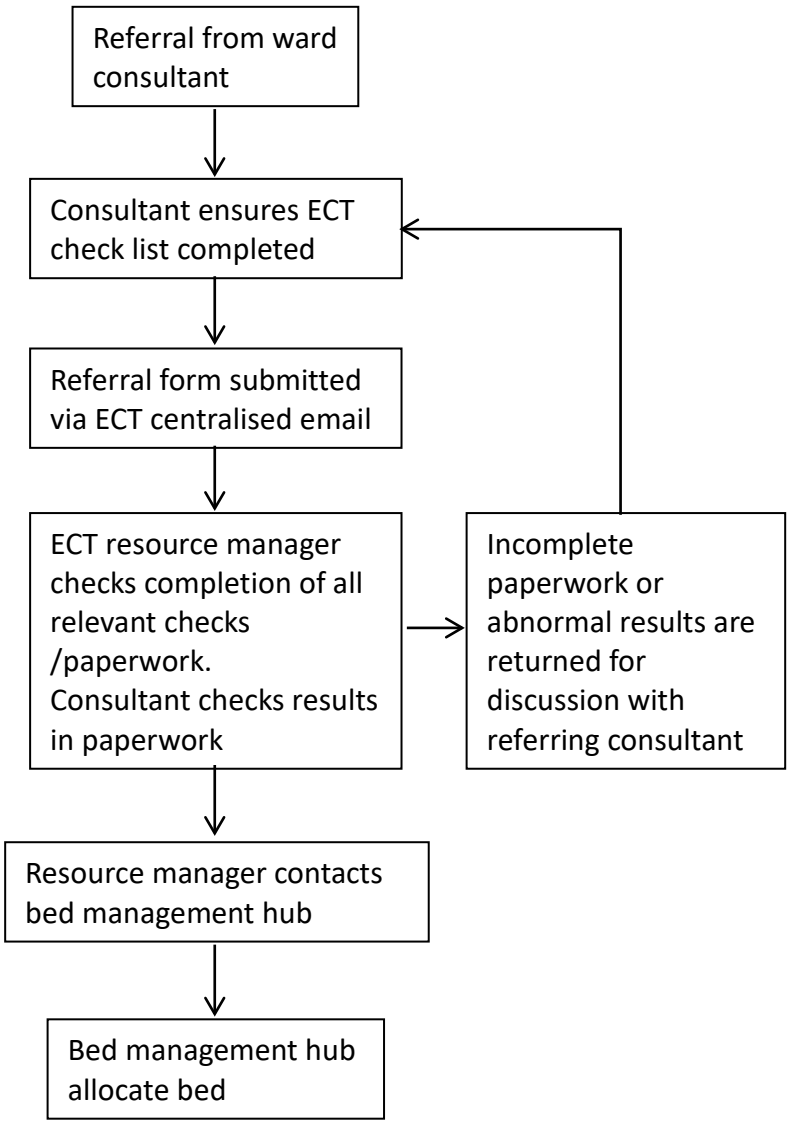


Quick reference flowchart 4 – Bed Management Pathway (Community ECT referrals)

Bed to be allocated where possible in West locality if patient has been prescribed ECT to be received as an inpatient.

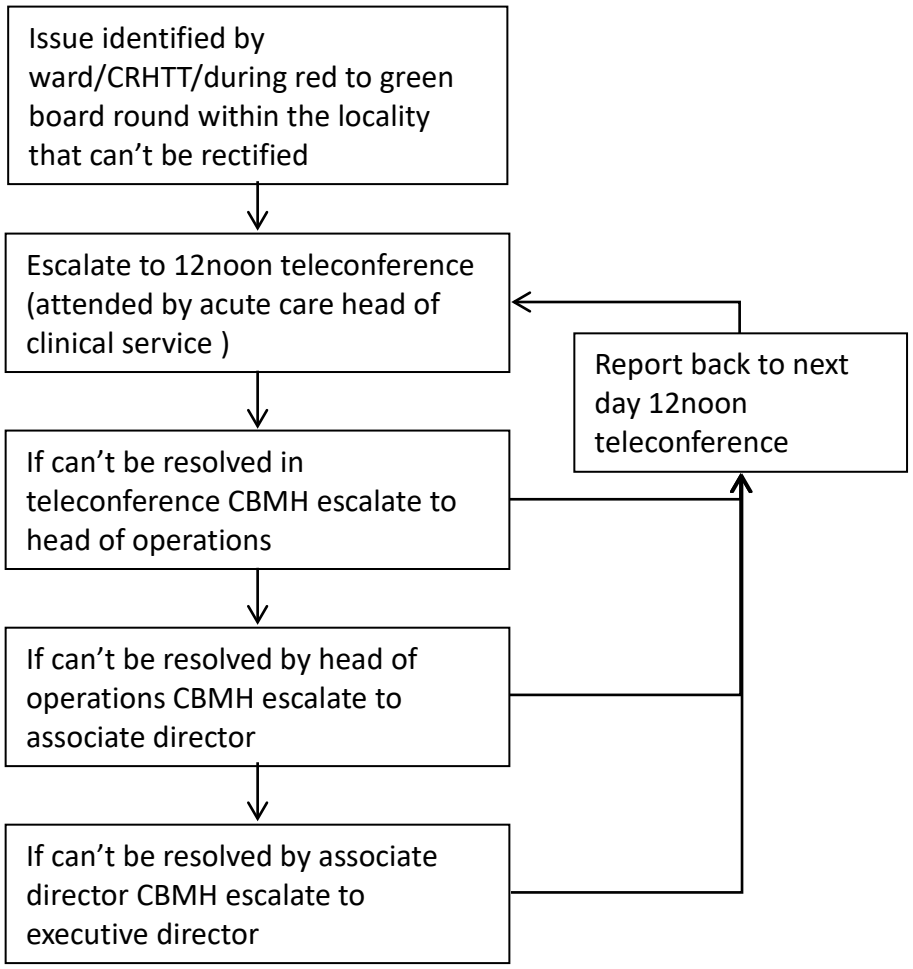


Quick reference flowchart 5 – Bed Management Pathway (Inpatient ECT referrals)



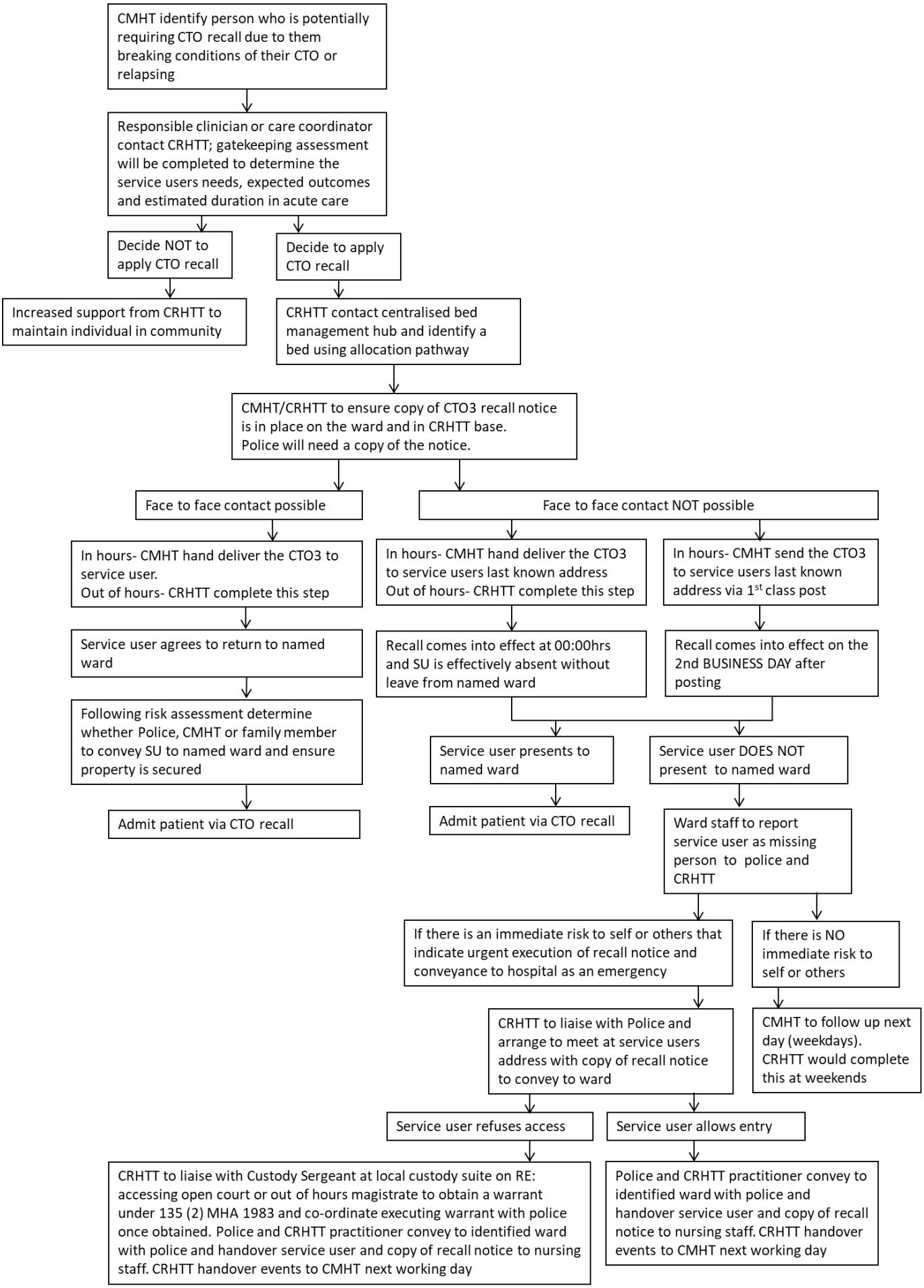
Quick reference flowchart 6 – Bed Management Escalation Process

If an issue is encountered which cannot be rectified and is delaying a service user's pathway out of inpatient care during normal working hours the following escalation process should be used:

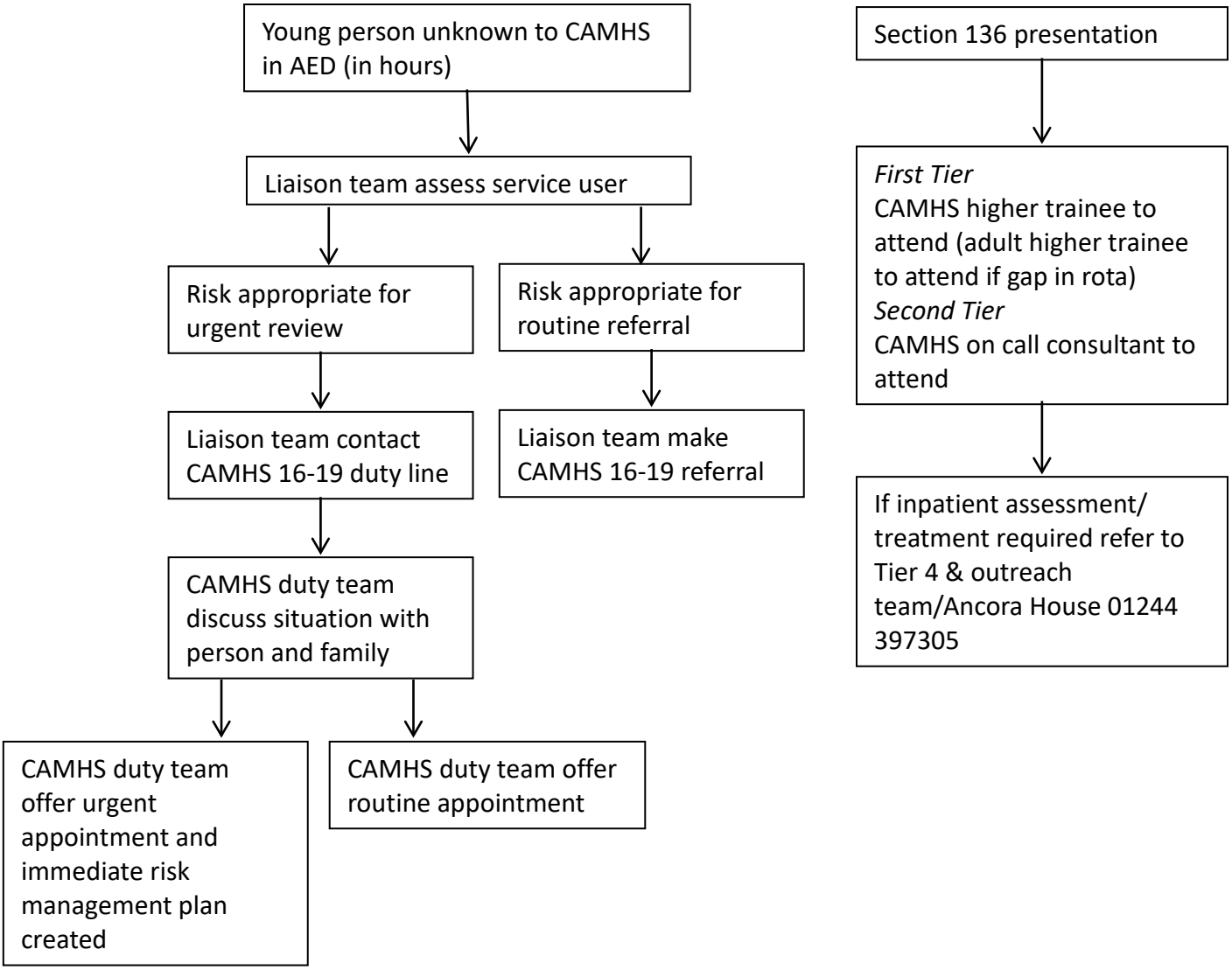


Outside of normal working hours the usual on call system should be utilised.

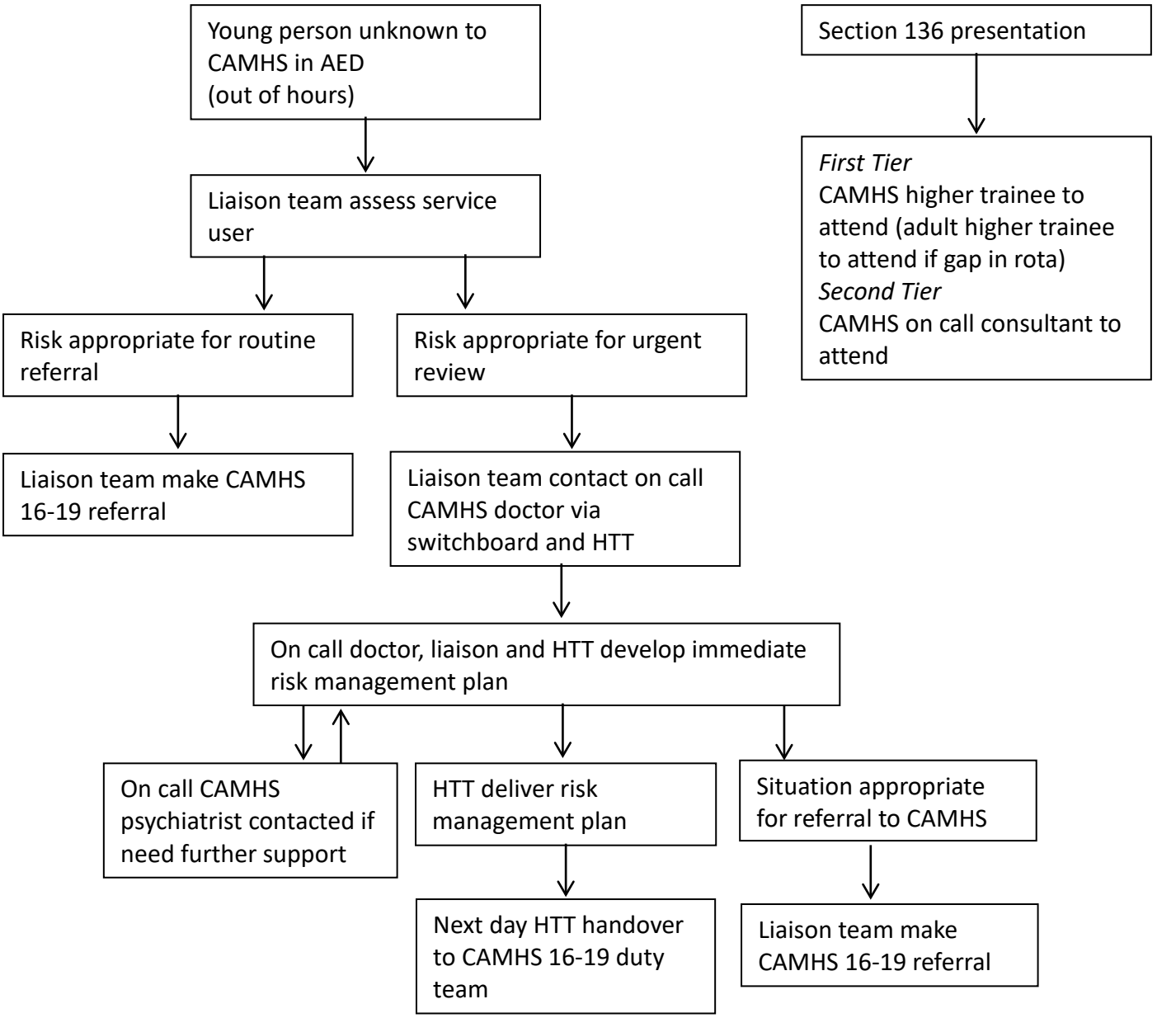
Quick reference flowchart 7 – Community Treatment Order (CTO) pathway



Quick reference flowchart 8 – Crisis support for 16-19 year olds accessing our services (unknown person – in hours)

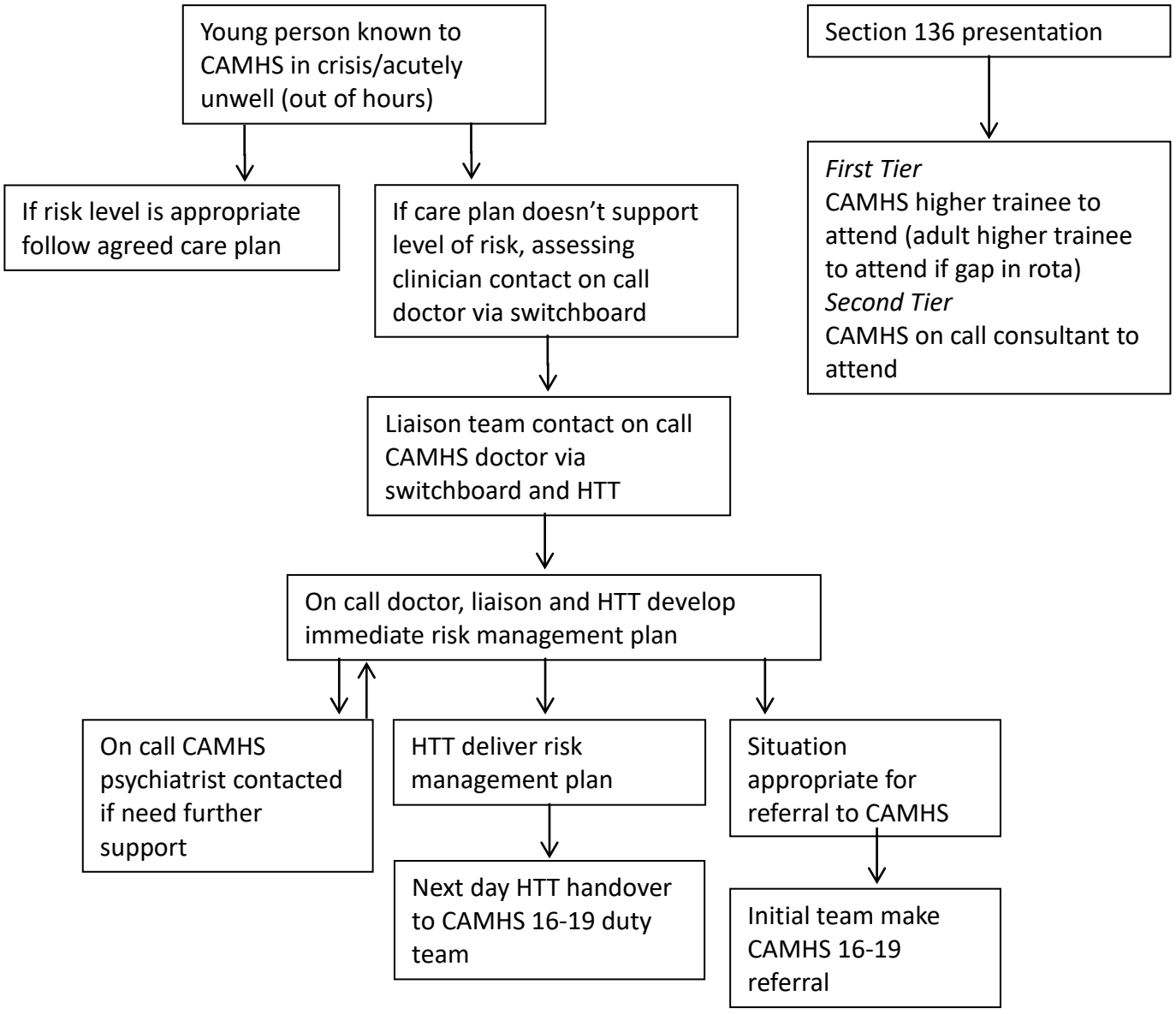


Quick reference flowchart 9 – Crisis support for 16-19 year olds accessing our services (unknown person – out of hours)



If inpatient assessment/ treatment required refer to Tier 4 & outreach team/Ancora House 01244 397305

Quick reference flowchart 10 – Crisis support for 16-19 year olds accessing our services (known person – out of hours)



If inpatient assessment/ treatment required refer to Tier 4 & outreach team/Ancora House 01244 397305

1. Introduction

The Crisis Resolution Home Treatment Team (CRHTT) was introduced as part of the National Service Framework (1999), and Department of Health Policy Implementation Guideline (2006). Since then Government developments including Parity of Esteem, The Five Year Forward View for Mental Health and the Crisis Care Concordat promote more accessible mental health services.

Service developments within CWP in response to difficulties in accessing acute mental health beds nationally have led to the introduction of the Acute Care Standards. The Acute Care Standards are a Trustwide agreement to provide a consistent pathway for service users who require interventions from the CRHTT and acute mental health wards.

2. Aims of the Crisis Resolution Home Treatment Teams

- to provide 24/7 gatekeeping for acute care referrals for access to CRHTT's and acute inpatient beds
- support early discharge from acute wards
- home treatment
- signpost to other appropriate services

The Centralised Bed Management Hub (CBMH) provides an administrative function that supports the allocation of adult mental health beds and the flow of people through the acute care pathway. The hub also includes the clinical leads from the CRHTT who clinically support the flow of people through the acute care pathway. The hub is overseen by a Head of Clinical Service (HOCS) who has overarching responsibility for this process. Appendix 1 outlines the CBMH support service process.

3. Service Description

Acute care is for people aged over 16 years presenting to mental health services who are experiencing a relapse of an existing or suspected mood and/or thought disorder who are describing an acute mental health crisis. The role of CRHTT is to triage acute care referrals via the gatekeeping assessment. The CRHTT will review people who may require an acute admission and consider if they can provide a less restrictive alternative to hospital admission. The team will assess people fitting the above criteria with co-existing learning disability in accordance with the GreenLight Toolkit.

4. Referrals to the service

The service can be accessed by the following:

- CMHT
- Early Intervention Service (EI)
- Courts via the Criminal Justice Mental Health Liaison Service
- Inpatient wards in order to facilitate planned early discharge
- Social Services Emergency Duty Team (EDT)

- Liaison Psychiatry/Accident & Emergency Department (A&E)
- Street Triage service
- Children and Adolescent Mental Health (CAMHS) 16-19 service
- GP out of Hours Service for Service Users currently under the care of CWP
- Crisis care facilities after in reach from CRHTT

In the event that a service user contacts the team, the team will triage the urgency and level of response. For all referrals:

- There will be a plan describing the purpose and goals of the referral and expected date of discharge from acute care. This will be reviewed during each CRHTT meeting or acute care meeting.
- The CRHTT will not decline referrals without a rationale or reaching an agreement with the referrer. This will be documented in the gatekeeping assessment.

Referrals from CMHTs:

- Service users will where possible, have had direct contact, preferably face to face contact, with the CMHT within the last working day. There will be exceptions to this.
- The plan of care will have been reviewed including; the Crisis and Contingency plan, the Comprehensive Assessment of Risk to Self and Others (CARSO) will have been updated if necessary with a risk event clinical note, and, a Health of the Nation Outcome Scale (HoNOS) from the referring team.
- There should be evidence that there had been an increase in contacts from the CMHT as part of the service users crisis response.
- The CRHTT are not an alternative for Care Coordinator none availability.

5. Exclusion criteria

This service is usually not appropriate for:

- Individuals under the age of 16 years unless they are known to another secondary mental health service e.g. EI.
- Mild to moderate mental health needs/disorder only.
- People with a diagnosis of substance misuse without a severe and enduring mental health condition.
- Expression of suicidal thinking may not be the sole indicator of need for CRHTT/acute care.
- Brain damage and other organic disorder, including dementia, unless there is a comorbid serious mental disorder which would benefit from CRHTT intervention.
- A crisis that is solely related to domestic/relationship issues with little to suggest a serious mental disorder.

6. Response times

There will be a response to the referrer within an hour. The type of response and time frame would be agreed with the referrer and depending upon the perceived risk where possible will take place within 4 hours.

48-72hour follow ups from the acute mental health wards can be provided by the team in the event that they are discharged without alternative secondary care referral for follow up within 48-72hours.

7. Gatekeeping

No admission can be made to an acute mental health inpatient bed, including direct admission to Psychiatric Intensive Care Unit (PICU) without the agreement of the CRHTT and the completion of a gatekeeping assessment. A gatekeeping assessment is completed on all referrals into CRHTT including all those referrals for admission. The outcome of the gatekeeping assessment will be documented in the electronic patient record and forms the initial stage of the acute care pathway. The gatekeeping assessment will contain information on why the service user requires acute care, what actions or changes are required as outcomes before the service user can be discharges from acute care and whether there are any family/environmental issues and can therefore be used to guide the service user journey within the acute care pathway. Once these outcomes have been achieved the service user may then no longer require intervention from acute care, via either the inpatient or CRHTT services. The gatekeeping assessment will be used to guide discussions within the daily red to green board rounds and weekly acute care meeting with key decisions being made based upon the information documented during this assessment. The gatekeeping assessment can be re-planned on each step of a service user's journey to track their pathway through acute services. CRHTT will not gatekeep the organic wards.

Practitioners will ask each service users consent to contact the relevant person/carer to obtain further assessment information and/ or their opinion of treatment plans. Contact details will be put onto the electronic patient record by the assessing Practitioner. If service users are not known to a community consultant, the CRHTT consultant will be involved in the individuals care. The CRHTT practitioners will request CMHT allocate care coordinators, where appropriate.

A bed will only be allocated to an individual following the outcome of an assessment (including Mental Health Act Assessments (MHA)). This is because the availability of an inpatient bed should not determine the outcome of the assessment. It is considered good practice that CRHTT staff discuss all MHA assessments in the community to ensure that community based treatment is not an option. If it is agreed home treatment may be an option for an individual the CRHTT should attend the face to face assessment. There can be exceptions to this based upon the judgement of the clinical team for example a person who was assessed outside the trust footprint or is well known to the practitioners and it would be detrimental not to commence treatment quickly.

CBMH will be responsible for the identification of a bed within acute mental health services 7 days a week. 8am until 8:30pm Monday to Friday, 8am to 4:30pm Saturday and Sunday; Quick reference flowcharts 2, 3 , 4 , 5 and appendix 2 outline the bed management pathways. Overnight until 8:30am this role is undertaken by the locality CRHTT. Quick reference flowchart 6 outlines the escalation routes for bed management.

Prior to considering the recall via a Community Treatment Order (CTO) the care coordinator or responsible clinician should first contact the CRHTT who will complete a gatekeeping assessment and consider additional support being provided by CRHTT to avoid the need for hospital admission. Serious consideration needs to be given to when the recall takes place as in most cases this should be a pre-planned situation rather than an emergency. In the event that additional support from CRHTT is not appropriate, CRHTT will contact the CBMH to establish whether a suitable bed can be identified. The full pathway is in Quick reference flowchart 7.

8. Acute Care System

The Acute Care Standards are an agreed Trustwide approach that outlines good practice for people during the pre-acute phase, inpatient episode and discharge. In order for the CRHTT to support service users in the community or to facilitate early discharge ongoing support will be required from the community mental health team involved in the case. The frequency and level of this support will be negotiated on a case by case basis.

CRHTT will attend acute inpatient wards on a daily basis to attend the red to green board round and lead discussions involving members of the MDT (pharmacy, occupational therapy, consultant, junior doctor, and registered ward staff). This will be a short meeting where discussions will focus upon the reasons for the service user being admitted to an inpatient environment and whether or not the situation has stabilised enough to consider the individuals acute care needs being met in the community with intensive support from CRHTT. The meeting will focus on blockages to discharge and actions will be assigned to those in the MDT to address the blockages. The board round will also review sections, observation levels, care coordination and treatment updates (Appendix 3 contains an explanation sheet for the red to green process and board round meetings). The CRHTT practitioner undertaking the ward in-reach role will provide feedback in relation to these discussions back to the bed conference call at 12noon each day. CRHTT will facilitate all discharges from acute wards, including discharges from PICU into the community.

CRHTT will support periods of overnight leave from wards when this is indicated as part of a specific discharge plan and where there is a planned discharge date. The appropriate duration of the leave will be agreed by the acute care team and the service user.

It is important to note that if the CRHTT feel that they are able to support a service user in the community there needs to be a sound clinical rationale for the discharge or period of leave not to go ahead. If there is any clinical disagreement in relation to this then this should be escalated to the HOCS immediately (or 2nd tier on call manager or on call consultant out of hours) who will review the case and agree a way forward.

9. Acute Care MDT Meetings

A weekly acute care MDT meeting should be held in each locality in order to discuss all service users occupying an acute mental health bed at the time and ensure that adequate plans are in place to work towards discharge. These meetings should be led by CRHTT and attended by the acute care MDT including CMHT representative, Consultant clinical

secretary, Pharmacy, Occupational Therapy and Clinical Commissioning Groups and Complex Recovery Assessment and Consultation (CRAC) team. The meeting should take place on either a Monday or Tuesday so that plans can be put into place for the coming week and early discharge meetings arranged. An action log will be produced and this will be monitored by the CRHTT through the red to green board rounds to ensure that all actions have taken place. Agreed discharges will be reported into the bed conference call at 12noon each day.

10. Planning contacts

Each service will have a system in place in order to plan the contacts required on a day to day basis.
In the event of a pressure within the team because of low staffing and/or increased case load, the contingency plan is:

- In discussion with the team managers and HOCS identify practitioners from areas with less acute demands who could support the teams with more acute need
- With the agreement of the team manager arrange additional staff by bank shifts or overtime.
- Identify what service user and carer contacts can be offered via telephone or attendance to a resource centre instead of a home visit.

If CRHTT are unable to contact the service user or carer over a designated time period and have concerns about the service users safety, CRHTT will inform the police/appropriate professional and may request they do a welfare check. This would be a last resort. If there is an immediate risk or danger to staff or others, then the staff member should dial 999 and ask for either the police or ambulance service depending on the emergency.

11. Interventions

A person centered care plan will be negotiated with service users and carers/family and a written copy of this will be offered to the service user. Interventions will be guided by the individuals care plan but can include the following:

- Comprehensive psycho-social assessment of mental health (if a trusted assessment has not been completed by the referrer).
- Gatekeeping assessment.
- Comprehensive assessment of risk – to self, to others, from others, vulnerability, neglect and physical health.
- Person centred and collaborative care.
- Diagnosis.
- Psychopharmacological treatments in accordance with National Institute for Health and Care Excellence (NICE) guidance; these may include medication reconciliations, active medication management and administration, introduction and titrations of new regimes, monitoring, testing.
- Psychological interventions in accordance with NICE guidance; these may involve psycho-education, cognitive behaviour therapy; activity scheduling, problem

solving, risk management plans, advance statements, wellness recovery action plan, emotional support.
- Carer psycho-education and support.
- Joint working with partner agencies to ensure access to holistic care and treatment.
- Access to inpatient facilities in a timely and supported manner.
- Supported early discharge from inpatient services, maintaining access to intensive support on a needs-led basis.

Each service will provide contact information about the CRHTT. This will be in the form of leaflets or business cards. This will be done by the clinician who has first contact with the service user.

12. Medication

The CRHTT can provide oral and intra-muscular medication as part of their contacts. A plan to support with medication would be agreed with the service user and family as part of the care plan.

Wherever possible and safe the service user will retain responsibility to keep their medicine. All medication held by CRHTT will be stored in a locked medicine cupboard in accordance with the Trust Medication policy.

13. Emergency respite beds (ERB)/Community treatment beds (CTB)

In a number of localities across the trust, service users can assess ERB/CTB if their home environment is not appropriate for home treatment to be delivered.

CRHTT will work closely with the bed provider; to inform them as soon as possible that there is a potential admission to support the provider staff in providing adequate and appropriate support for the service users and understand any changes to the service users condition while staying in the accommodation. The CRHTT will perform environment assessments of the accommodation bear any nuances in mind when placing service users in these buildings.

The CRHTT are responsible for the service users care while in the accommodation and will visit the ERB/CTB sites to review the service users daily. Appendix 4 contains the comprehensive information that CRHTT will provide to the ERB/CTB provider staff.

14. Beyond place of safety facility

The support workers within the CRHTT will provide in-reach support to any facility (sometimes referred to as crisis café) to assess people attending the facility and support the provider staff. Referrals into acute care will be accepted once CRHTT support workers have attended the café and assessed the individuals present.

15. Clozaril initiation

The service can support Clozaril initiation in the community in collaboration with CMHT and EI. The frequency will vary according to capacity. The trust Clozapine Prescribing and Monitoring Guidelines should be utilised.

16. Support to service users aged 16-19 in crisis

Service users aged 16-19 will often by under the care of the CAMHS 16-19 services. Quick reference flowcharts 8, 9 & 10 outline the pathways for crisis support to known and unknown service users ages 16-19. Further information can be found in Guidelines for the assessment and management of psychiatric emergency in young people under 18 years.

17. Outcomes

Each team will use the HoNOS as a clinical outcome measure. A service user outcome will also be collected.

18. Discharge from CRHTT

- This will be a MDT decision. Discharge planning will be discussed in the CRHTT MDT weekly meetings, daily handovers, and during care planning approach (CPA) review meetings. Referral to CMHT's for follow up contacts would be agreed at the MDT meeting with the consultant psychiatrist present. The CMHT would then be expected to offer an appointment to ensure transfer of care.
- On discharge CARSO, HoNOS and care plan will have been updated by clinicians during the episode of care.
- CRHTT will support overnight leave from wards only as part of a specific discharge plan. The duration of the leave will be discussed at the discharge planning meeting.
- Carers and relevant others must be considered prior to discharge.
- Discharge letters will be copied to the General Practitioner (GP), the service user should be offered if they wanted a copy, and other statutory agencies will be included.

19. Safeguarding

If there are either safeguarding concerns of an adult or child, the safeguarding team must be contacted for either action or information and a clinical note completed. The safeguarding screening tool within the electronic patient record must be considered and include children's details.

20. Supervision

All staff are obliged to receive supervision and appraisal as per trust and local authority policy.

21. Students

Students from either nursing or other allied health professionals will be offered placements.

1st year students would have an observational role. 2nd and 3rd years would be encouraged to be involved in interventions and documentation, as well as managerial experience.

22. Acronyms

Crisis Resolution Home Treatment Team (CRHTT)
Centralised Bed Management Hub (CBMH)
Head of Clinical Service (HOCS)
Multi-Disciplinary Team (MDT)
Community Mental Health Teams (CMHT)
Early Intervention Service (EI)
Emergency Duty Team (EDT)
Accident & Emergency Department (A&E)
Children and Adolescent Mental Health Services (CAMHS)
Comprehensive Assessment of Risk to Self and Others (CARSO)
Health of the Nation Outcome Scale (HoNOS)
Psychiatric Intensive Care Unit (PICU)
Mental Health Act (MHA)
Community Treatment Order (CTO)
Complex Recovery Assessment and Consultation (CRAC)
Care Programme Approach (CPA)
National Institute for Health and Care Excellence (NICE)
Emergency respite beds (ERB)
Community treatment beds (CTB)
Care Planning Approach (CPA)
General Practitioner (GP)
Approved Mental Health Professional (AMHP)

Appendix 1 - Centralised Bed Management Hub Process

The Centralised Bed Management Hub (CBMH) is in operation 7 days a week; 8am until 8:30pm Monday to Friday, 8am to 4:30pm Saturday and Sunday. Outside of these hours the allocation of beds is the responsibility of the CRHTT within each locality.

The main aims of the CBMH are as follows:

- To ensure that when a bed is required, that bed is identified within an appropriate timeframe, ideally less than 4 hours
- To co-ordinate all admissions and transfers between acute wards
- To receive issues and escalations from each ward/locality red to green board rounds which delay a service users journey
- Where issues are escalated themes are collated for analysis, actions allocated and where appropriate issues are further escalated for resolution
- To ensure that appropriate plans are in place for individuals occupying an acute inpatient bed so that a continuous throughput is maintained
- Access to specialised beds within CWP is monitored to ensure that delays in transition from acute to rehabilitation and secure services are kept to a minimum
- Undertake reviews for service users frequently admitted to acute services to establish what additional support can be provided in place of frequent admission to hospital ensuring that contingency plans meet the needs of the service user
- Monitor 28 day re-admission rates, admission and discharge rates, and occupied bed days per CCG
- Ensure gatekeeping assessments have been completed for acute admissions
- Ensure that gatekeeping assessments detail reason for admission and what would need to change to facilitate discharge within a timely manner

A) Daily Activities

At 8am (Opel 2, 3 and 4)

- Confirm no one is with a Liaison Practitioner or waiting for Liaison assessment

From 9.30am (Opel 2, 3 and 4)

- Red to green board rounds lead by the CRHTT to commence within each locality which should be undertaken on the following wards:
    - Central and East Locality; Mulberry Ward
    - West Locality; Beech Ward, Juniper Ward, Willow Ward
    - Wirral Locality; Lakefield Ward, Brackendale Ward, Brooklands Ward

By 11:30am (Opel 2, 3 and 4)

- Contact all acute wards to confirm patient numbers, admissions and discharges
- Contact older adult organic, learning disability assessment & treatment, rehabilitation and secure wards to establish current bed state and any planned changes
- Email this information to the CBMH team, CRHTT and acute care staff including Consultants, ward managers and Heads of Clinical Service (HOCS) before the 12noon teleconference

12 noon teleconference (Opel 2, 3 and 4)

- Conference call to be attended by CRHTT, HOCS (when in Opel 3 Head of Operations, Opel 4, Executive team member)
- Feedback to be provided by the CRHTT practitioner in-reaching to the wards in each locality from the red to green board rounds to confirm planned activity in and out of the wards
- This feedback should detail any discharges or home leave planned to take place that day or any discharge meetings due to be held
- Feedback to be provided by the CRHTT in each locality on any MHA or CRHTT gatekeeping assessments requested or ongoing in the community
- Discussion should cover bed capacity, patient flow, locality actions and any barriers to discharge
- Themed barriers to be collated and localities should escalate issues to the CBMH
- CMBH to allocate actions and to decide if further escalation is appropriate
- In Opel 3 and 4 CBMH to identify private beds available locally

4pm teleconference (Opel 3 and 4)

- Conference call to be attended by CRHTT, HOCS, Head of Operations (Opel 4, Executive team member)
- Feedback to be provided by the CRHTT practitioner in-reaching to the wards in each locality from the red to green board rounds to confirm planned activity in and out of the wards
- This feedback should detail any discharges or home leave planned to take place that day or any discharge meetings due to be held
- Feedback to be provided by the CRHTT in each locality on any MHA or CRHTT gatekeeping assessments requested or ongoing in the community
- Discussion should cover bed capacity, patient flow, locality actions and any barriers to discharge
- Themed barriers to be collated and localities should escalate issues to the CBMH
- CMBH to allocate actions and to decide if further escalation is appropriate

At 8pm (Opel 2, 3 and 4)

- Contact all acute wards to confirm patient numbers, admissions and discharges
- Contact older adult organic, learning disability assessment & treatment, rehabilitation and secure wards to establish current bed state and any planned changes
- Email this information to the CBMH team, CRHTT and acute care staff including consultants, ward managers and HOCS

B) Weekly Activities

Acute Care MDT meeting

The acute care team along with representatives from the wider MDT (including CRAC team, CMHT, EI) should meet weekly either on a Monday or Tuesday to discuss plans for the service users on the ward at the time and to pre plan early discharge meetings for the week ahead. These meetings should be attended by members of the acute care team

from both acute adult wards as service users may be transferred between wards during their acute care journey therefore an awareness of their care and treatment is essential to avoid delays. Time slots should be allocated for members of the CMHT to attend to be involved in the discussions surrounding service users from their particular team. It is envisaged that these meetings will take approximately 3 hours and will be chaired by a representative from CRHTT.

Frequent Attender Review Meetings

The CBMH will be responsible for identifying service users who have required multiple admissions to inpatient services and coordinating a multi-disciplinary review of these cases. These meetings will be held to support the care co-ordinator with the contingency planning process with a view to reducing the number of admissions or length of stay that the service user requires.

Information reporting

The CBMH will be responsible for collating issues and themes creating delays to patient's journey through acute care and sharing this with the Head of Operations, facilities and estates in a weekly report.

Appendix 2 - Bed Management for people accessing our services who may require admission to an area with more resources

Bed to be found in West and Wirral if the answer to all the following questions is yes

- The person is being detained under the mental health act (to the correct hospital)
- The person is presenting with extreme levels of aggression, hostility and agitation
- The HTT believe the person could not be safely supported on an open ward
- The HTT have discussed this person with the PICU team (if known to PICU)

The following things should be considered before deciding to place the service user in West and Wirral

- A physical condition is not contributing to the presentation needing a PICU
- Where will they be discharged to and will an admission to another locality delay or disrupt the discharge

Where possible service users should be moved back to their own locality once settled to facilitate discharge if there is a clinical need.

Appendix 3 - Red2Green board round explanation sheet

Red2Green Board Rounds - Acute Inpatient Care

Red2Green is a process and a set of principles to support patient flow, with a focus on identifying and resolving barriers and delays to progressing patients along their pathway.

By examining the **Red** and **Green** status of each patient during the **Red2Green** Board Rounds, it enables and empowers staff to identify internal or external delays and allocate same day actions to facilitate active intervention, treatment or discharge. This will avoid patients spending more time as inpatients than they need or require.

Determining a Red or Green Day

- Could the care or intervention the patient is receiving today be delivered safely and effectively in a non-inpatient acute setting or placement e.g. CRHTT, CMHT, EI, community care provider or carers?
- Would the person be admitted as an inpatient from the community based on their presentation today?

Additional questions to assist decision-making:

- What is the patient waiting for to progress to the next phase of their care? Assign same day actions.
- Has the reason for admission been addressed and are they ready for discharge to a more appropriate setting e.g. CRHTT? Assign same day actions.

A Red day is of non-value to the patient

- When the patient is receiving care that can be provided in a **non**-acute inpatient ward
- When the patient is **not** receiving active care or treatment that day
- When the requested / planned intervention or assessment does **not** occur = patient waiting

Examples:

- Waiting for an external placement e.g. housing, care home etc
- Waiting for assessment or decision from another team and no other work is possible to progress discharge that day e.g. CRAC / Rehab
- Waiting for first Clozapine dose when patient comes for titration and it is not given
- Waiting for take home medications

A Green day is of value to the patient

- When the patient is receiving care that can **only** be provided in an acute inpatient ward
- When the patient **is** receiving value adding acute care or treatment that da that progresses their journey towards discharge
- When everything planned or requeste gets done = patient is in receipt of active care
- When the result of an intervention is acted upon

Frequently Asked Questions (FAQs)

Red2Green is based on the principle that a person should not lose a day within the community due to waiting on an inpatient ward; it is NOT about Performance Management!

1. **Why can the person be identified as Green but still be acutely unwell?**
   Green doesn't mean ready for discharge, it means that they are able to progress along their treatment / discharge pathway i.e. there are no barriers in place to delay their progression and they are receiving active care or treatment that day that can only be provided in an acute inpatient setting.

2. **If a person is on leave, are they Red or Green?**
   The person will be Red. There must be a clear rationale and timeframe for the person to be on leave in accordance with the Acute Care Standards and part of a specific discharge plan, with a planned discharge date and full agreement by the MDT.

3. **If a person is awaiting a placement, are they Red or Green?**
   The person will be Red if all necessary treatment from the inpatient ward is complete and the barrier is the delay with the placement.

4. **If a person no longer requires acute inpatient care, are they Red or Green?**
   The person will be Red if all necessary treatment from the inpatient setting is complete, the person is more suitable for another team or service and the barrier is the delay for transfer to a more appropriate team/service.

5. **How do you distinguish between internal and external barriers?**
   An internal barrier is where CWP has control and can determine the next step e.g. facilitating discharge to the Home Treatment Team, Community Mental Health Team, Rehab or Low Secure Service.
   An external barrier is where CWP does not have control and cannot determine the next step e.g. awaiting an external placement or transfer to a team or service external to CWP.

6. **Can someone be Red and Green at the same time?**
   No. If they meet any of the red criteria described above they will be identified as Red. To be identified as Green they must meet all of the Green criteria described above.

7. **How should the actions and barriers be captured for the process?**
   In identifying your barriers think about breaking them down into individual steps so you are in a position to identify potential 'quick wins'.
   An example would be: a patient is requiring placement and the steps could include identifying suitable placements, arranging assessments, completing paperwork or awaiting funding panel.

Red2Green Board Rounds - Logistics

Frequency

- The **Red2Green** Board Rounds will take place **4 times per week** - Monday, Wednesday, Thursday and Friday morning at 9am.

- The Acute Care MDT Meeting will take place **weekly** on Tuesdays at 1pm and will incorporate **Red2Green** as part of the meeting. The Red2Green electronic patient record form will be completed in the same way as is completed at the morning **Red2Green** Board Rounds.

Membership of the Red2Green MDT

- The **Red2Green** Board Rounds MUST be attended by the following MDT:
  - Consultant and / or Senior Clinician
  - Junior Doctors
  - Nurse in Charge
  - Home Treatment Team
  - Occupational Therapist
  - Pharmacy

- The **Red2Green** Board Rounds will be led by the Senior Home Treatment Team lead.

- There should be a Clinical Secretary present at each of the **Red2Green** Board Rounds to document all information on the **Red2Green** electronic patient record Form. This will then be confirmed by the Senior Home Treatment Team lead leading the Red2Green meetings.

Functions

- Having the **Red2Green** Board Round in front of the Patient Board in the Ward Office is beneficial in being able to review patient information, including sections, observations levels, care coordination and treatment updates as part of the **Red2Green** discussions.

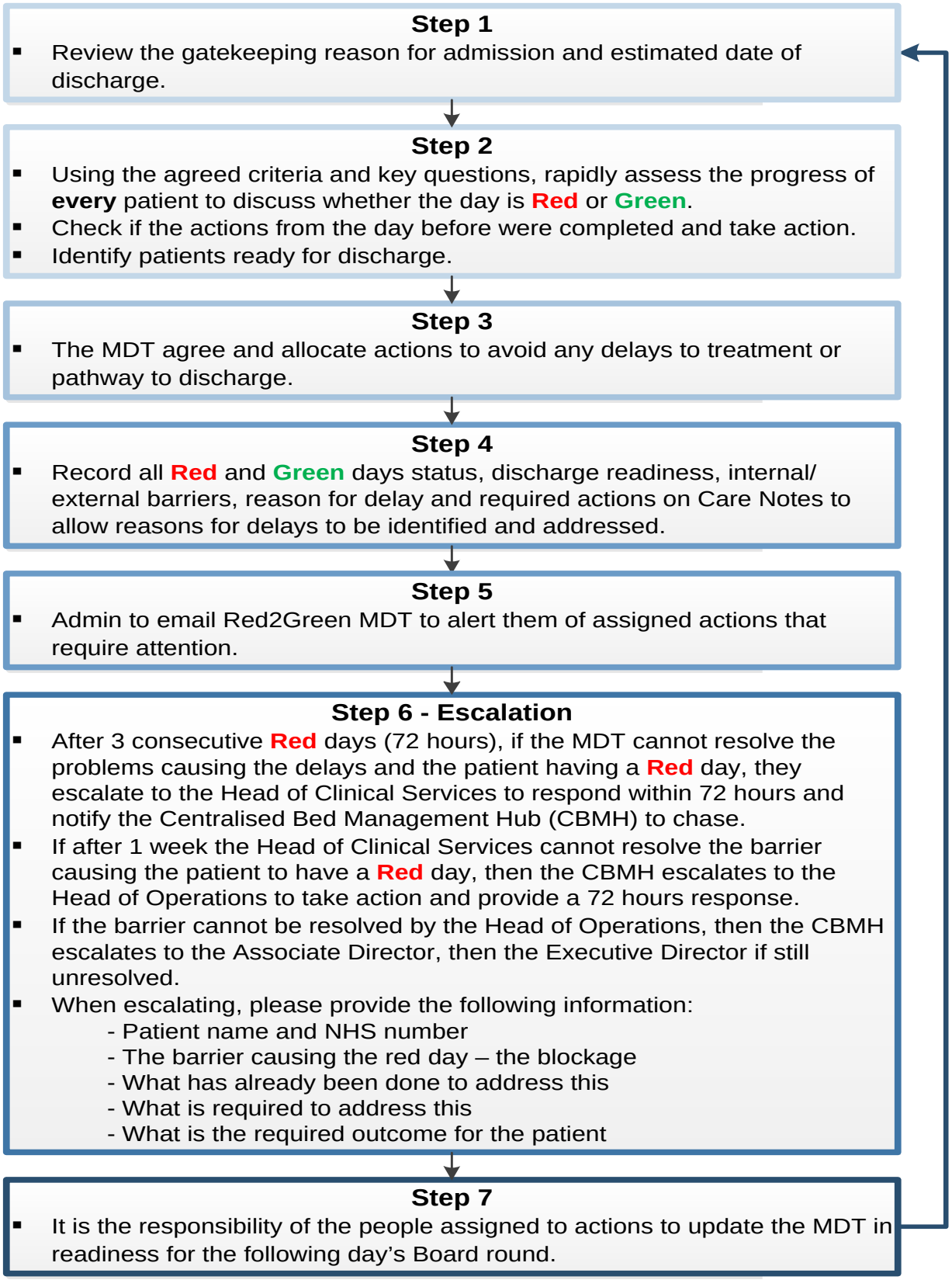
- However, as long as the information from the Patient Board is visible to the MDT during **Red2Green**, it is appropriate to hold the **Red2Green** Board Round away from the office.

Acute Care MDT Meetings

Acute Care MDT Meetings take place weekly in order to discuss all service users occupying an acute mental health bed and ensure that adequate plans are in place to work towards discharge. These meetings should be led by the Home Treatment Team and attended by the acute care MDT, including a Community Mental Health Team (CMHT) representative, Consultant Clinical Secretary and Complex Recovery Assessment and Consultation (CRAC) Team (with specific slots allocated to them for updates). Plans can then be put in place for the week and early discharge meetings arranged.

The **Red2Green** electronic patient record form will be updated to ensure that actions are monitored and progressed at the subsequent **Red2Green** Board Rounds.

Red2Green Board Round Flow Chart -
4 times per week plus weekly Acute Care MDT Meeting incorporating Red2Green



The R2G Steering Group will review SPC charts of Red days, LOS and barriers in order to identify variation, share good practice and agree any areas for quality improvement.

Appendix 4 - Emergency respite/Community bed provider information

Please follow the following guidelines when accessing an emergency respite or community bed.

Please record all of the below in a clinical note in the electronic patient record. This should prevent the need for separate paperwork.

It is imperative that we give ERB provider staff a copy of this electronic patient record entry urgently as they will not have any written information they can access.

- Complete current mental state
- Complete physical description i.e. height, weight, eye and hair colour
- Complete risk assessment of harm to self and others, including neglect. Identify any other Alerts recorded on the electronic patient record
- Gatekeeping assessment information
- Identify how Home Treatment Team and bed provider staff will manage these risks for service users in ERBs. Please inform provider staff what we require of them in managing these risks.
- Record whether the service user uses illicit drugs or alcohol or smokes
- Provide copy of Care Plan, particularly highlighting what we are asking provider Support Workers to do
- Provide a review date and time and who will complete this
- Record any allergies, including drug allergies
- Record any special dietary requirements e.g. are they vegetarian
- Record any medical conditions
- Record any mobility conditions, identifying any assistance which is needed
- Provide up-to-date medication sheet (copy can be obtained from GP), including any special directions and a supply of medication if possible

Also provide staff with a copy of the up-to-date demographic information, address and contact details, next of kin details, Community Mental Health Team contact etc.

When reviewing ERB stays:

- Update Care Plan and any Risks.
- Inform ERB staff of any changes, record same on the electronic patient record and provide staff with copy a.s.a.p. for their records