Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE
HOME BASED TREATMENT TEAM

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CHANGE RECORD

Version	Date	Change details
1.0	*01.02.2023*	*New SOP required for the service and as part of the requirement from a recent SI investigation. Approved at MH Division Practice Network (1 Feb 2023).*
1.1	*22.11.2023*	*Minor amends including:* *Addition to 9.0 care planning - carers are given…* *Updated 11.0 crisis pad section* *Addition to 16.0 discharge/transfer section* *Approved by Divisional Clinical Lead sign-off (Kayleigh Brown – 22/11/23).*

Contents

1. INTRODUCTION

The Mental Health Home Based Treatment Team (HBTT) consists of a distinct multidisciplinary team of health professionals providing care, support, and clinical interventions for individuals (Service Users and their families / carers) requiring treatment for mental health and social crisis need who are registered with a Hull or East Riding of Yorkshire GP. The HBTT operates on a 7-day basis between the hours of 08:00 and 20:30. The HBTT work alongside the Mental Health Advice and Support Team (MHAST) and Mental Health Crisis Intervention Team which both offer 24/7 access to mental health support offering an effective, least restrictive alternative to acute mental health inpatient care.

The HBTT philosophy has the focus upon crisis interventions that can be implemented as an alternative to hospital admission. Having a choice in treatment and recovery options is crucial in tailoring the specific needs of a person within their own individual crisis. Coupled with this, the HBTT recognises the importance of families and carers around the individual, and the HBTT can offer extended holistic support in helping families and cares understand the crisis of the individual, and their role in supporting, taking care of needs for respite.

Treatments offered may include medication (if required) and psychosocial interventions including comprehensive physical health monitoring and provision of psychological / social skills to promote recovery and promote relapse prevention and practical support for social difficulties impacting upon mental health. These can be delivered in either the persons home, designated supportive dwelling or via face-toface contact at Miranda House. Telephone interventions and reviews of care by face to face contact and median communication such as Upstream or Microsoft Teams are also part of the HBTT process, as is liaison with other health and social care professionals and the persons GP as part of the care process, to promote early transfer of care.

The level of support and intervention will reflect the degree of risk and need identified through assessment and agreed in the planning phase with the service user, their carer, and significant others. This will be detailed in the care plan, which will be reviewed at least weekly by the named worker.

The team works to provide people with safety, recovery, and social inclusion, and adheres to the principles of honesty, openness, and integrity. The service user's experience should be central to the workings of mental health services and the team provides personalised care that recognises each person’s unique path to recovery.

HBTT is an integral part of the Care Services that are integrated within Mental Health Acute Care. These include Mental Health Liaison Services. MHCIT also have strong links and networks with adult Mental Health Community Services, Police, Addiction services, GP surgeries and social care services. This integrated approach aims to ensure a comprehensive and seamless service to users and their carers during periods of mental health crisis.

Our commitment is to ensure that HBTT is delivered in a person-centred, compassionate, least restrictive way, promoting safety and wellbeing at the forefront of care. The HBTT aims to offer a needs-led service, providing responsive mental health interventions, delivered in a way that empowers people to build on their strengths, promote recovery & resilience, while supporting their families.

The background to Home Based Treatment as an intervention

The NHS Long Term Plan (January 2019) identified services such as Emergency Departments (Accident and Emergency), General Practitioners, Primary Care Services, Community Mental Health Services, IAPT services, Liaison Psychiatry Services, Early Intervention Services, Police, statutory and non-statutory services work to ensure smooth transitions for service users between care pathways. Crisis is often a normal human response to abnormal situations and events, distress if often the outcome of a crisis regardless of its source. Interventions therefore need to be tailored to meet the needs of individuals and those closest to them, in the immediate circumstances.

The primary objective for Mental Health Crisis Intervention Team (MHCIT) and the Home-Based Treatment Team (HBTT) is to mitigate against harm, including harm to self, harm to others, harm from others and potential unintended harm from our interventions and to help support the individual in their recovery and minimise distress using a bio psychosocial model. Support and stabilisation of mental health can enable people to be transferred earlier from inpatient wards and receive treatment within their homes (as an alternative) whilst still experiencing an acute phase of an illness, high risk period or ongoing distress.

The inception of Home-Based Treatment (Early Intervention) Teams was initially introduced as an alternative to acute admission within the NHS Plan (Department of Health 2000), where early intervention was posited an extensive change to the healthcare system at the time, introducing assessment of crisis, crisis care planning, intensive support, medication, practical help, and family / carer support.

Crisis care focuses upon psycho-social interventions that build emotional resilience in service users as well as awareness of relapse prevention. Respite for carers has also emerged as a theme in crisis work and the links to the community services for continuation into community care post crisis.

HBTT consider all the options available and aim to work collaboratively to find the best outcome with service users and carers to help the individual to support recovery, promote stabilisation of mental health and address potential risk. HBTT 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 could have a detrimental impact on wellbeing, whereas for others it may be the most appropriate option.

It is therefore vital that the functioning and stabilisation interventions provided by HBTT takes place within the context of effective partnerships with service users, their family and identified carers, also including all other community care providers, as detailed in the Five Year Forward View, (NHS England October 2014).

2. SCOPE

This document should be used for the daily running and procedural support of the HBTT Team and is for all employees of Humber Teaching NHS Foundation Trust who work within the MHCIT substantively and temporarily via the trust bank system. The document will cover all staff working within this area including admin (bands 2, 3 & 4), Support Workers (SW) band 2, Healthcare Assistants (bands 3), Registered Associate Practitioners (RNA) (Band 4), Associate Practitioners (AP) (band4), registered multi-professional clinicians (Bands 5 and 6), clinical leads (Band 7), Service Manager & Advanced Clinical Practitioner (Band 8a) and the Psychiatrist.

3. DUTIES AND RESPONSIBILITIES

Psychiatrist – Overarching medical responsibility for the care provision in the HBTT service. The role includes medical assessment and medical opinion, support for collaborative medical and clinical decision making in this area of the service. The role is dynamic and responsive, including prescribing of medication, medical medication optimisation and support for symptom and management of mental illness and mental health crisis experienced by Service Users.

Service manager – They will have overarching responsibility for the running of the service and ensuring key performance indicators are met. The service manager will oversee any incident investigation and complaints procedures associated with the service. The service manager will delegate day to day running of the service to the clinical leads.

Senior Clinical Lead – They will have overarching clinical responsibility for the running of the service. The Senior Clinical Lead will work collaboratively with the Service Manager.

Non-medical Prescribers (NMP) **–** within HBTT the NMP provides clinical assistance with medication related interventions and related prescribing issues. The NMP may be required for patient reviews and support the psychiatrist in HBTT by use of supplementary prescribing and review of prescribed medication.

Team manager – Working with the service manager, the team manager will support with performance indicators and holds responsibility for recruitment, staff absence monitoring and training requirements for the individuals working in this team.

Clinical leads – The HBTT clinical leads oversee the functioning HBTT Team on a day-to-day basis and support the general running of the team from a clinical

perspective. They will ensure direct robust multidisciplinary discussion and decision making and be able to escalate and problem solve when the service is unable to provide the service as agreed. The Clinical Lead will also oversee the referral / discharge process and provide inter-professional contribution to specialist clinical meetings for complex clinical cases, provide interventions within specific complex clinical cases and support the learning in practice initiative profile of the service.

The Clinical Leads - will model the 'Caring, Learning & Growing' Humber Teaching NHS philosophy in daily practice, setting and auditing clinical standards while initiating project work to drive continual service improvement. The Clinical Leads also undertake clinical performance audit and provide supervision directly to the Registered Clinicians and provide regular clinical performance reporting to the Service Manager.

Multi-professional registered clinicians – these are experienced clinicians from a variety of disciplines who are responsible for leadership of the shift, allocation of duties, compilation of care plans in partnership with the service user and family / carer. They also deliver clinical interventions aligned to their sphere of specialism, such as nursing, social work, or occupational therapy. These clinicians also provide supervision to the RNA's, AP's and HCA's.

Registered Nurse Associate (RNA) – is a newly developed accredited and registered clinical role in HBTT team. The RNA works to promote health and prevent ill health, provide supervision to band 2 & 3 staff, complete risk assessment, review care plans, administer medication, provide psychological interventions to improve crisis stabilisation, and contribute clinical opinion to the HBTT care pathway.

Associate Practitioners (AP) – provide holistic and practical interventions utilising recognised psychological tools and practical help. The role is to further enhance the stabilisation process by assertive engagement and rapport building with a psychological focus upon delivering self-help skills within the service users to promote emotional resilience.

Healthcare Assistants (HCA's) – the healthcare assistants are responsible for providing holistic support to HBTT patients, as directed by the registered clinicians. The HCA's provide practical support and assertive clinical interventions both over the phone and by face-to-face contact with service users. HCA's also contribute to MDT discussion and support the general running of the day to day allocated clinical tasks and planned interventions to promote stabilisation of mental health.

Administrators – the administration team are responsible for electronic referral management, ensure all Lorenzo and monitoring processes are completed and other ad-hoc administrative duties as required by the team.

To support all staff, the service ensure that everyone has an allocated supervisor, has access to weekly reflective practice sessions informal and formal incident reviews and service specific induction process and competency pathway. The service also facilitates weekly staff meetings, and additional meetings including band

or profession specific meetings, such as Band 6 weekly meetings and monthly Band 4 meetings.

Appendix E provides a further detailed profession-specific overview of the above roles and responsibilities.

4. PROCEDURES

4.1. Inclusion criteria to be considered for referral to the HBTT service.

- Service users aged between the ages of 18 to 65 years of age and have been triaged and assessed via the MHCIT process (see MHCIT SOP) or currently being seen by a secondary level mental health service.
- Service users registered with an GP in the Hull or East Riding ICB (It is however appreciated that there may be circumstances, for example temporary residents, students etc where this is not the case. Once triaged and assessed by MHCIT a gatekeeping discussion with the HBTT may be required at point of referral to establish if HBTT is the correct course of action to meet any identified crisis stabilisation need.
- The service user will need to have been contacted and reviewed by the referrer on the same day, with updated clinical information available such as mental health assessment and clinical risk assessment (see agency / source specific referrals below).
- Service users considered to have mental capacity to understand and engage with any treatment options available, as well as HBTT as an intervention.
- A referral will not be declined solely based on a service user lacking capacity. A clinical discussion will take place with the MDT to review suitability for the person to access the HBTT. Consideration will be given to specific decisionbased capacity assessments and acting in the service users best interests.
- Service users considered to be at significant risk to self, for example suicide, self-harm, social vulnerability, severe self-neglect, and potential harm to others related to relapsing mental ill health.
- Service users considered suitable for hospital admission unless a least restrictive alternative, such as HBTT, is thought to be viable to meet immediate and short-term mental health need.
- Have a clinical presentation within care clusters 5-17 (NHS 2016).

4.2. Referral routes into HBTT (See also gatekeeping process below).

4.2.1. Generic referral criteria to be considered for referral for Home Based Treatment (all agencies/ sources):

- Consideration and inclusion of overarching principles of NICE Guidance 53 transition between inpatient mental health settings and community or care home settings.
- Risk assessment and risk management strategies that are detailed and include recognised relapse signs associated with the service user.
- Information regarding any medication concordance issues.

- Specific support needs and identified interventions.
- Information of any interventions known to prevent further deterioration of known relapse (risk / relapse plans, known relapse signatures).
- Carer involvement and carer need with contact details.
- Follow up to treatment plans for re-engagement with the referring agency / CMHT including management of risk escalation that may require admission to inpatient services / further gatekeeping decision making.
- Language, cultural and sexuality / gender considerations regarding communication needs.
- Nearest relative contact details.
- Any identified safeguarding need and if this has been escalated.
- The service user demonstrates the mental capacity to understand and agree to the referral to HBTT, with formal mental capacity assessment if undertaken to establish this.
- A referral will not be declined solely based on a service user lacking capacity. A clinical discussion will take place with the MDT to review suitability for the person to access the HBTT. Consideration will be given to specific decisionbased capacity assessments and acting in the service users best interests.

4.3. Agency specific referral guidance and criteria in addition to the above:

4.3.1. MHCIT referrals: (Crisis assessments and routine mental health assessments):

- Internal transfer form, (Appendix B) with fully completed triage and mental health assessment, including risk assessment, care cluster, ReQoL, and DAST / AUDIT screening tools.
- A full clinical rationale for referral to HBTT will need to be summarised within the assessment, outlining the treatment consideration and expectation of the HBTT as a treatment option.
- A clear discharge point from HBTT needs to be agreed to support a focus upon the crisis stabilisation work or support required.

4.3.2. Mental Health Act and Section 136 Mental Health Act (MHA) referrals and admissions:

- Admission: If a patient has been assessed under the MHA (including Section 136 assessments) or has a Community Treatment Order (CTO) recall in place, the HBTT clinician or (MHCIT clinician out of hours) should complete the gatekeeping triage form to reflect the outcome of the assessment and identification of the admission.
- HBTT: A patient may be referred to the HBTT as part of the clinical outcome of the Section 136 Mental Health Act assessment if this has been considered by the assessing team as a safe and least restrictive / appropriate clinical option, that the patient and Nearest Relative has been involved in the decision-making process and this is evidenced within the section 136 documentation.
- In these circumstances it may not have been possible to capture all the generic referral criteria, however the section MHCIT 136 risk assessing

clinician (136 coordinator) will provide the standard 136 paperwork and gatekeeping documentation as per Humber Teaching Foundation Trust Section 136 Policy and MHCIT SOP. (See policy index below)

4.3.3. CMHT & PSYPHER referrals for weekend support or joint working:

- At point of referral, in addition to the generic referral criteria above, HBTT will request / encourage joint visit between HBTT and CMHT or PSYPHER to review need and suitability for HBTT weekend support or joint working to take place. The gatekeeping process will also need to be referred to if consideration is being made in connection with inpatient admission. HBTT will examine if alternative treatment strategies could be considered such as medication review or extra support that can be provided via the CMHT or PSYPHER. If this has not been possible then CMHT / PSYPHER will need to review, he patient either the day before or on the day of referral, update the FACE risk assessment and Care Cluster, and provide a clear clinical rationale for referral for HBTT and indication of contingency planning should the patient not engage with HBTT. If accepted the HBTT team will complete the internal transfer form to record the referral discussion and rationale for acceptance. Any decisions to decline a referral should also be recorded within clinical notes, including the rationale for the decision and those consulted in reaching the decision. Throughout the process of weekend support or joint working, the CMHT / PSYPHER will continue to retain keyworker/care coordinator status for the service user. In these circumstances the HBTT intervention would serve as an addition/add on to the existing care and treatment plan.

4.3.4. PMHCN (Primary Mental Health Care Nurses)

- Patients known to PCMHN should be escalated within their relevant CMHT as their needs increase, for a higher level of intervention to take place. If there has been no evidence of escalation in care needs and the patient is presenting in crisis, the PCMHN should discuss with HBTT to determine an appropriate way forward and formulate the least restrictive options of care provision.
- If it is determined that HBTT cannot safely manage the patient needs and an admission may be required, the MHCIT should complete a crisis assessment to determine the patient needs, ideally with the key worker of the PCMHN if possible, and the gatekeeping process undertaken.
- If the patient has received a crisis assessment, the MHCIT clinician should discuss with HBTT the outcome of the assessment for a gatekeeping triage (if outside of normal hours of work for HBTT, MHCIT would be responsible for completion of this document).

4.3.5. Homeless Mental Health Team (HMHT).

- For service users already under the homeless team HBTT can offer specific mental health crisis stabilisation, working in a joint working process. The generic referral criteria must be met as above and a specific contingency plan if the service user is of no fixed abode or any strategies to overcome any known barriers to communication. As with all referrals where admission is

being considered, the gatekeeping process and documentation needs to be completed.

4.3.6. Inpatient / ward referrals.

- The generic referral information will be required including extra information such as internal transfer form, Immediate Discharge Record (IDR) updatedisk assessment. HBTT to fill in the transfer form via clinical discussion with the referrer to examine what is expected of HBTT, what are the longer-term plans and predicted needs following the period of Home-Based Treatment.
- 3 day follow up: Home Based Treatment can be incorporated into the 3-day follow up protocol at point of discharge from inpatient settings to ensure that follow up targets are achieved. Working alongside the inpatient units, the 3 day follow up process is initiates by a central performance hub which oversees that the 3 day follow up performance target is met.

4.3.7. Hospital Mental Health Liaison Service (MHLS)

- There is a dedicated 24-hour A&E Hospital Mental Health Team who provide a service to services users presenting at Hull Royal Infirmary (HRI) or Castle Hill Hospital with self-harm behaviour, acute mental illness, or emotional distress.
- Following full mental health assessment via MHLS a service user can be referred for consideration of HBTT. HBTT (or MHCIT out of hours) will undertake the gatekeeping process, the gatekeeping form and record the rationale for decision making.
- Service users who have 'open' referrals to both MHLS and MHCIT/HBTT requires a discussion between the services to establish the most appropriate pathway for the individual service user. Again, the discussion and rationale for the decision is to be recorded in the service users' clinical notes on Lorenzo, and the gatekeeping process below is to be followed.

4.3.8. Complex Emotional Needs Service referrals for service users with a keyworker.

- Referrals for HBTT can be made from the CENS team, providing the requirement for crisis support is aligned with a formulated clinical management plan where an emerging crisis point may need a specific, time limited intervention to help a service user manage the crisis point.
- HBTT recognise that some management plans may indicate that a brief admission to inpatient services is recognised as a therapeutic intervention, to provide containment of the crisis.
- The gatekeeping process is to be followed to ensure the least restrictive option of HBTT has been considered and the rationale for decisions recorded and any up-to-date management plan has been referred to.
- It is also important that the management plan is adhered with to support consistency of approach, however HBTT may not be suitable in some instances where consistency (of regular contact by a specific HBTT clinician for example) can be provided, due to the human resource profile of the HBTT service.

4.3.9. Service users known to mental health services that do not have a keyworker or whose keyworkers do not undertake care co-ordination functions. (See also the MHCIT SOP)

- Patients who are known to services such as DBT / liaison psychiatry for example but have no identified keyworker, or who have a keyworker whose role does not include care co-ordination functions should be referred to the MHCIT in the first instance for a possible crisis assessment as per the MHCIT SOP.
- The MHCIT will take the referral and organise a triage of their needs to determine the urgency of the crisis response.
- Once triage completed involving the opinion of the referrer where possible.
- Once the patient has received a crisis assessment the MHCIT clinician will discuss the outcome with the HBTT for a gatekeeping triage and complete the gatekeeping triage document. (If outside of HBTT working hours, MHCIT are responsible for completion of this document.
- Any further exceptions to the above will be considered by the HBTT on a case-by-case basis for any service with a specialist remit.

4.3.10. External agencies or services outside of Hull & East Riding area (Service users registered with Hull or East Riding GP)

- The HBTT team consider referrals from external agencies should the referred service user be registered with a Hull or East Riding GP but has come to the attention of agencies outside of our area and be presenting in crisis.
- Referrals such as these may include a variety of individual circumstances, such as travel, holiday, studentship, or temporary residence such as a designated safe house or be with family or friends out of area.
- It is expected that the referring agency contacts MHCIT in the first instance to gather background clinical information of the service user as part of the referral to establish if the service user is already known to our services or is in receipt of mental health services.
- For all service users the referring agency will have to provide comprehensive mental health and risk assessment and the background / circumstances in which the service user has come to the attention of the referrer.
- To be considered for HBTT, the gatekeeping process (below) will be active, and consideration needs to be made upon if the service user is intending to return here to their local address to receive any proposed treatment (HBTT).
- MHCIT and HBTT can advise on individual circumstances at point of referral.

4.3.11. Referrals for other temporary residents.(Service users not registered with a local GP or Humber Teaching NHS Foundation Trust).

There may be circumstances whereby service user temporarily resides within the Hull and East Riding area, such as students, holiday makers, asylum seekers and those having a period of respite with family / carer within Hull & East Riding area but come to the attention of support services in connection with a relapse of mental health or crisis presentation.

- It is expected that the referring agency contacts MHCIT in the first instance to initiate the triage and assessment process, consider other primary care or support service options and speak directly with the service user.
- The generic referral criteria (4.2) above will need to be met.

- HBTT can only be considered as a treatment option once mental health assessment and risk assessment is completed, and the gatekeeping process (See below) has been undertaken.
- The out of area GP will need to be identified, and all details of Nearest Relatives (if identified) are known, including communication routes.

4.3.12. Other information and considerations pertaining to the referral for HBTT process or considered within the gatekeeping process.

5. MENTAL CAPACITY ACT

- As per the Mental Capacity Act 2015, it is assumed that every adult over 16 has full legal capacity to make decisions for themselves at the time that the decision needs to be made.
- If at any point the mental capacity of the service user is doubted or absent HBTT clinicians will be required to document the decision-making process by completing a Mental Capacity Assessment form located in the MHA and legal tab in Lorenzo and recording the details of the question pertaining and the decision that needs to be made at the specific point in time, including gatekeeping decision making (see below).
- Guidance: By completing a Capacity Assessment form, we can fully capture if someone has or lacks capacity for a specific decision, this will give the individual practitioner a lot more cover and security in the event of an untoward incident.

Here are a few examples when we should consider undertaking a capacity assessment and documenting it on the relevant form.

a) If deciding to admit someone informally, but there is some doubt as to whether the patient had the capacity to consent to that admission or not, the Capacity Assessment form can be completed, with the decision being ‘Should patient A be admitted informally to inpatient unit B”. The decision maker is the person undertaking the assessment. The form is straightforward but means that we can capture the specifics of how you came to confirm the patient had capacity or indeed lacks it. One can also consider use of copy and paste into any communication sheet being completed as well.

b) A completed capacity form will help when there is a risk that the admitting unit are querying capacity when the bed is initially being arranged. Remember that the capacity assessment is time and decision specific, so it would not be an issue if when assessment is carried out, they have capacity but this changes in the future.

c) If the police or ambulance service bring in a patient already under HBTT care to Miranda House on an informal basis, but on arrival we have concerns about their capacity, a capacity assessment can also help with documentation of what we

tried to do to support a person, especially if they are trying to leave Miranda House.

d) A capacity assessment may help with a best interest's decision to try and persuade / stop someone leaving Miranda House while considering referral for more formal assessment under the Mental Health Act.

e) During a (HBTT) home visit: if mental capacity of the service user is doubted then the capacity assessment needs to be completed as part of the escalation and referral process for Mental Health Act assessment. It is important to be decision specific and consider the mental capacity of a service user to be able to understand or accept HBTT as a treatment option.

6. GATEKEEPING

6.1. Gatekeeping process.

Gatekeeping is the process of a clinically formulated decision making to facilitate the most appropriate, least restrictive outcome, to meet the needs of the service user. Within Humber Teaching NHS Foundation Trust the MHCIT and HBTT are at the forefront of the gatekeeping clinical decision-making process. At an operational level the Bed Management Team can also be involved in the process in respect of balancing capacity and demand of the inpatient services.

The overarching objective of gatekeeping process is to ensure equity to access appropriate care in the correct setting which supports the needs of service user, their family & carer(s) at a specific point in time.

The primary objectives for MHCIT and HBTT as a service is one of public safety and safeguarding.

Any clinical interventions or care pathways being considered by MHCIT and HBTT for service users in need of crisis support need to consider the potential for:

- Minimising distress.
- Minimising any risk of immediate harm to self.
- Minimising risk of harm to others.
- Minimising the potential of risk of harm from others.
- Reducing any potential impact of harm or deterioration in mental health, to vulnerable people, their family, or carers.

By undertaking effective gatekeeping and considering all options available HBTT (MHCIT if out of hours) can enable service users to be transferred 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.

HBTT can mirror the care and treatment interventions offered by inpatient wards, in a community setting by delivering:

- Clinical and social interventions (outlined below).

- Continual risk management and care planning with the service user as a central point in the care pathway.
- Working in partnership with other agencies and services to enhance early transfer of care in a timely manner.
- Focus upon the surroundings of the service user, finding creative ways forward in promoting early recovery from distress and the crisis point.
- Recognising the important role that family and carers play in the stabilisation and recovery processes.

HBTT recognise that complex dynamics occur within relationships and different parties can have different views on needs and care/intervention required. However, it is important to give space to patients and carers to gain a clear understanding of the needs of both to arrive at a practical and effective solutions.

6.2. The gatekeeping process and considerations.

It is good practice to contact HBTT (MHCIT out of hours) as early as possible when an escalation of care needs is evident for a patient. The HBTT can formulate a plan to address short term interventions in conjunction with any pre-formulated care plans that may already be in place. The aim being to promote the recovery from emotional distress and crisis, support the service user / family & carer(s) with the common aim of stabilisation from the point of crisis, and re-engagement with current services. This may include inpatient services and community services.

6.2.1. Gatekeeping formulation.

The clinical considerations and actions to be undertaken by HBTT to inform the gatekeeping formulation:

- Evidence of clinical decision making which shows debate surrounding the pros and cons of the gatekeeping decision, with reference to the considerations around risk management, considering all available historical and contemporary risk and safety related information.
- Any acute or chronic physical health problem, illness or disability that is influential in the gatekeeping decision, including immediate need for medical intervention.
- Known historical or contemporary / emerging red flag indicators.
- Issues of mental capacity, and the wishes of the service user.
- Previous and historical mental health / illness of the service user.
- Any pre formulated clinical opinion or management / risk relapse plans.
- MDT opinion to support complex case / frequent attender gatekeeping decision.
- The perspective of the family, Nearest Relative and carer to the service user. We recognise the importance of the perspective this this can bring to the gatekeeping decision.
- There needs to be defendable consideration of any service offered that may have a detrimental effect upon recovery, and contingency strategy to be explored, with evidence of MDT discussion and routes to safety for the service user recorded within the clinical notes and the immediate crisis management plan and shared with the service user.
- Recording of all rationales for decision-making, in clinical notes and completion of the Humber Teaching NHS Gatekeeping form.

- The FACE risk assessment has been updated (by a clinician with contemporary knowledge such as the referrer, community keyworker or MHCIT / MHLS assessor) to support the gatekeeping decision-making formulation.

6.2.2. Additional gatekeeping processes

There may be circumstances where the face-to-face gatekeeping process is not required, as community treatment is not deemed as a viable alternative to inpatient care. Examples of these could be:

- Service users recalled on Community Treatment Orders
- Service users on leave under section 17 of the Mental Health Act (Patients in the Community) 1995
- Planned transfer of cares from Specialist Units.
- Where a MHA assessment has already taken place and the decision has been agreed to admit formally to hospital, HBTT clinical staff will still be required to complete the front and back sheets of the Gatekeeping pack, including times of MHA activities and time of admission etc.
- If a Doctor has commenced the recommendations of the MHA section and then the service user agrees to an informal transfer of care. As the Doctor has already begun to carry out an assessment and has felt that formal transfer of care would be appropriate it would not be clinically appropriate for the Service User to be seen by MHCIT staff and may delay the service user receiving appropriate care and treatment.
- Planned transfer of care for service users who are returning from out of area (their initial transfer of care will have been expected to have been gate kept).
- Planned transfer of care for service users who are returning from a short transfer of care to the acute trust from one of our wards, where the plan was for the service user to return to the ward once treatment was completed by the acute trust.

6.2.3. Gatekeeping exceptions

- In all care events, assessment of need is required however there may be some instances where this may not have been completed. In these circumstances a statement explaining the rationale for transfer of care and the reason why a faceto-face assessment was not deemed necessary should be recorded in the clinical notes. This will involve a comprehensive clinical discussion between HBTT (MHCIT out of hours) and where possible between clinician and the referrer, to ensure all options/possible outcomes have been considered, providing a supportive, compassionate, and least restrictive outcome for the patient.

6.2.4. Gatekeeping outside of normal working hours

- The HBTT service operates 7 days per week, between 08:00 to 20:30. Outside of these times the responsibility for the gatekeeping process, discussion and recording falls to the MHCIT, this is to ensure that patient need, and the decisionmaking process is undertaken in a timely manner and any potential delays (delayed by decision-making) are minimised.

6.2.5. Gatekeeping: expectations from Referral Routes to inform the gatekeeping discussion and formulation.

6.2.5.1 MHLS:

- It is expected that a conversation between MHLS assessing clinician will occur with HBTT/ (MHCIT out of hours) to explore the reasons for referral for admission and to explore all least restrictive options, providing an opportunity to assess for HBTT interventions. A further face to face gatekeeping assessment will not be required, as the patients has already been assessed by an appropriately skilled clinician, during their crisis.
- The receiving HBTT (MHCIT out of hours) clinician should not insist on awaiting completion of all paperwork before this discussion is had, as this can cause unnecessary delays to the patient's care, identification of intervention and impact on capacity/waiting times in A&E etc. It is also expected that the service user will have completed any hospital treatment and therefore either medically fit or expected to be medically fit for transfer when this contact occurs.
- The gatekeeping triage form should be completed by the receiving clinician either in HBTT (MHCIT out of hours), ensuring all least restrictive options have been considered and the expectations of what the referral for an admission would achieve from the patient and professional perspective.

6.2.5.2 CMHT:

- If the patient is known to a treatment team such as a CMHT it would be expected the MHLS clinician would have had a discussion with their keyworker (in working hours) if practicable to do so, to explore escalation of care within this service before discussion with HBTT or possible admission takes place.
- CMHT Patients who are known to a key worker and under the care of the CMHT often present with escalating needs in the days leading up to a crisis point and admission for inpatient care. Should the needs of the patient become more intensive, or concerns are expressed by family/carers, it would be expected for the key worker or duty clinician (if the key worker is unavailable) to contact HBTT to discuss the escalating situation, following their own review of the patient and situation.
- For the purposes of gatekeeping a planned joint face to face review can be planned with the HBTT, CMHT, patient & family, in the coming days to determine a collaborative plan of care, identifying the least restrictive options first, but with parameters agreed for further escalation to admission if required. There may be more than one joint meeting which occurs during this time of increased need and acute presentation.
- The gatekeeping triage form should be completed by the receiving clinician, ensuring all least restrictive options have been considered and the expectations of what the referral for an admission would achieve from the patient, family, and professional perspective. The key worker (or duty clinician) would be responsible for updating the FACE risk assessment, cluster tool, ReQoL and the care plan (as required) and this should be reflective of the current level of need and presentation.

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6.2.5.3 Other service users. (See MHCIT SOP)

- If a service user is unknown to services or has no open referrals, they should follow the MHCIT SOP pathway for assessment. If the patient has received a crisis assessment, the MHCIT clinician should discuss with HBTT (MHCIT is the decision maker out of hours) the outcome of the gatekeeping triage.

7. HBTT ELECTRONIC WALLBOARD AND ZONING PROCESS (Appendix F)

- The HBTT team office houses a clinical case management system by way of computer operated zoning system, viewable locally. The purpose of this is to aid clinicians to track the service users through a pathway of treatment, focussing upon differing areas of care intensity, categorised by three distinctive zones, Red, Amber and Green (zones) as a way of managing the clinical priority.
- The wall board is primarily operated by the shift coordinator. The wallboard is used for shift management and allows for the allocation and tracking of specific clinical duties and responsibilities. The wallboard is also used for MDT reviews, care plan reviews and re-zoning activity as a service user moves through the Home-Based Treatment care pathway.
- The electronic wallboard is auto saved in use and is also save as a PDF file to the Humber Teaching NHS Foundation Trust 'V Drive' for secure data storage at the end of each shift. This is to make a direct clinical record of the daily clinical activities for the purposes of internal audit and as evidence of clinical activity should this be called upon for formal investigation purposes.
- Contingency planning: in the event of file corruption, the previous shift caseload and work activities is captured on PDF file format for view only as a reference. The HBTT caseload is also viewable via the Lorenzo system, where the team can access, action, and amend clinical service user records both as normal day to day practice and in the event of corruption of the main HBTT wallboard.

8. THE HBTT CLINICAL TREATMENT PATHWAY

8.1. First contact.

The first contact is a specific initial identified contact with the service user (can be telephone or face to face) to commence the HBTT care pathway. The first contact is arranged once the referral to HBTT has been received and accepted. At the point of referral, the HBTT accepting clinical (shift coordinator / clinical lead) on duty will discuss the clinical risk and urgency outlined in the referral to expedite a timely response.

The content of the first contact includes:

- Introduce the HBTT service,
- Clarification of referral and expectations,
- Formulation of clinical response
- Formulate rationale for Home Based Treatment.
- Physical health observations • Health Improvement Profile (HIP)
- Carer's screening.
- Audit and DAST (if required/ not already completed by referrer)

- Care plan and goal setting.
- Psychological tools identified.
- Discharge planning considerations.
- Contact details for support including out of hours information / telephone numbest and crisis pad.
- Information sharing consent recorded.
- Summary Care Record consent recorded.

8.2. Core HBTT interventions and treatment.

HBTT clinical engagement: Talking through difficulties with the service user, carers and family, identifying treatment goals, identifying and making the service user aware underlying resources and offering practical, emotional support, is key to HBTT practice. The formation of a therapeutic relationship between clinicians and service users is fundamental in promoting trust to nurture crisis stabilisation.

8.3. Interpersonal skills pertaining to the HBTT and service user in emotional distress and mental health crisis.

HBTT clinical staff adapt and implement interpersonal communication skills to:

- Build rapport quickly by adapting interpersonal communication skills within the recognised phases of the human response to crisis (Caplan 1964):
    a) Acute phase.
    b) Adjustment phase.
    c) Integration phase.
- Reduce emotional distress through active listening, empathy, and show creative understanding to promote insight for the service user.
- Impart, and gather information to show plan interventions, create a space for skill development and tools for self-help to nurture emotional resilience within the service user, carer, and family.
- Ensure safety thought the intervention process, reviewing risk elements, referring to and updating FACE risk assessment, care plan and MDT support for complex decision making and contracting safety strategies with the service user.
- Use the therapeutic relationship to action plan ways forward with the service user, family & carer while maintaining an objective clinical perspective as the service user works through the crisis point towards resolution.
- Plan transfer of care with mutual agreement of the service user, ensuring timely referrals to external and internal agencies are action, and followed up to instil hope and continuity with care delivery.

8.4. Assessment as a continual process

The process of HBTT intervention is one of continual assessment and reassessment. HBTT clinical staff use assessment skills and psychological tools to help the service user develop insight into the crisis or stressful situation, recognise psychological and physical aspects of health & wellbeing and identify strategies for resolution.

8.4.1. MDT Multi-Disciplinary Team working as continual assessment of changing need.

- HBTT meet as an MDT daily to review the current caseload and plan the daily contacts. Clinical case discussions are also undertaken to ensure that decisions are owned and agreed in a team forum and are recorded as such. Smaller MDT discussion take place through the day where required to address any immediate arising concerns, clinical changes or zoning requirements and discharges.
- All ongoing clinical assessments can be discussed, and action planned if required.
- The daily MDT is the central source of clinical decision-making, supported by differing agencies and disciplines including external agencies such as DAP or RENEW, who attend via MS Teams meetings.
- The MDT also discuss and plan discharges from HBTT, and referral on to external , primary or secondary services.

8.5. HBTT and physical health assessment:

- Assess records and interpret physical health symptoms, utilising the
- NEWS2 / SBARD is undertaken at the first opportunity, and the result may incur further ongoing physical health assessment including escalation to MDT for clinical opinion and action if results are out of normal range as indicated as an outcome of the tool.
- Health Improvement Profile (HIP) is undertaken to provide full physical screening for all patients on the HBTT caseload.
- Other means are available to gather physical health information with the service user such as:
- Summary Care Records (with consent of service user).
- GP Connect: HBTT can examine patient record to examine areas such as:
    a) Allergies and reactions
    b) Clinical reports
    c) Any encounter reports
    d) Immunisation status
    e) Medication record
    f) Observations ongoing
    g) Any current problems and
    h) Referral details.

8.5.1. HBTT Risk assessment:

- HBTT identify and work with any escalating risk or any safeguarding concerns connected to the service user.
- The FACE risk assessment is examined at referral to HBTT
- The FACE risk assessment is updated or reviewed:
    a) At any changes in risk presentation uncovered within part of the HBTT core interventions.
    b) As part of MDT review if any aspect of risk has changed
    c) As part of the rezoning process as discussed above.
    d) As part of gatekeeping considerations, prior to admission of required.
    e) As part of any discharge planning process, including a summery to GP
    f) As part of any referral on to a community service.

8.6. HBTT clinical crisis and treatment interventions and practical help.

HBTT recognise that multiple approaches are required in combination to address the needs of the service user in crisis as a whole 'person'. Coupled with practical help and support, HBTT aims to help the service user gain skills and insight into the selfmanagement of emotional distress and symptoms of mental ill health and develop emotional resilience and stabilisation.
These are categorised into the following aspects or domains of the person:

8.6.1. Biological interventions:

Medication optimisation: HBTT can work with the service user to work towards medicine optimisation via such approaches as:

- Checking what medication the service user has access to, how this is being taken such as regularity and concordance with active prescribed medication.
- Safe storage and administration of medication as per Humber Teaching NHS Foundation Trust Medicines Management Policies, Procedures and Guidelines.
- Side effect assessment and monitoring utilising recognised side effect rating scales.
- Phlebotomy.
- ECG.
- Medical review / Non-Medical Prescriber (NMP) review (see NMP SOP).
- Retrieval and disposal of expired / un-utilised medication (with consent of service user).
- Help with collecting prescriptions and attending appointments in connection with medical or pharmacological intervention.
- Clozapine initiation and monitoring in the community.
- Smoking cessation advice.
- Weight management advice.

8.6.2. HBTT Psychological interventions:

- Solution focussed interventions.
- Using workbooks, worksheets, and psychological tools to promote selfstabilisation, insight, and skills to manage symptoms of distress.
- Anxiety, techniques to reduce distress and impart self-help techniques.
- Working with mood, identifying fluctuations in moods and techniques to promote emotional balance.
- Developing self-confidence and assertiveness where crisis has impacted upon this.
- Developing interpersonal skills to communicate needs, improve family communication and strengthen relationships with others.
- Psychoeducation of sleep hygiene techniques.
- Psychological tools to work with cognitive aspects of panic, mood and behaviour.
- Behavioural activation techniques.
- Psychological tools for living well such as manging stress, giving time to selfcare etc.

8.6.3. Social interventions:

- Identification of social stressors and provision of ways towards recovery.

- Psychoeducation to family as an intervention to promote understanding of symptoms of distress and illness.
- Finding solutions to financial and housing difficulties,
- Carer's assessment and referral to carer services
- Help with attending appointments with HBTT and other services allied to the crisis need.
- Providing information of sources of help specific to the social circumstances surrounding the crisis point.
- Access to food and clothing resources, such as food banks and vouchers.
- Liaison with housing providers and temporary accommodation agencies.
- Liaison with Social Services for ongoing care assessment / Care Act assessment.
- Other practical help if required, help with other appointments, obtaining items etc if required for the purpose of crisis reduction or stabilisation.

9. CARE PLANNING

HBTT works with the service user to formulate a HBTT care plan to provide a professional structure to the interventions to be provided. As part of the formulation HBTT involve service users, their families, and carers (if consent is forthcoming) into the care process to ensure that the crisis care provision encompasses the family and carer needs.

9.1. The HBTT care plan model includes and addresses the following aspects:

- service user's perspective,
- clinicians' perspective.
- Views of carers and family (if consent gained)
- Clear goal setting with SMART objectives (Specific, Measurable, Achievable, Relevant and Time bound. (Multiple goals can be included)
- The outlines of the care pathway (how are we going to get there)
- The citation of a timely care plan review, date copied to HBTT main wallboard.
- Identification of individuals / clinicians or agencies that are going to help.
- Clear plan of appointments via either face to face sessions, telephone contacts, home visits or upstream (video) appointments.
- Clear identified interventions, such as:
- Psychological tools to be used with rationale.
- Medical or NMP review with rationale.
- Social care appointments.
- Arrangements for any joint working.
- Contact numbers for supporting agencies.
- Contingency and relapse planning.
- How might the service user feel when starting to relapse, what are the signs?
- What helps the service user?
- Who can the service user speak to?
- What do professionals think will help at a point of relapse?
- The views of family and carers, how might they become involved (if service users consenting)

- Any indication that there may be an Advanced Statement in place.
- Dates and time of support agencies available.
- Date of care plan reviews.
- Care Plan signed and dated by service user and registered clinical staff member, and carer where possible/relevant.

Carers are given general factual information, both verbal and written about:

- The mental health diagnosis
- What behaviour is likely to occur and how to manage it
- Medication – benefits and possible side effects
- Local inpatient and community services
- The Care Programme Approach (CPA)
- Local and national support groups Carers are helped to understand:
- The present situation
- Any confidentiality restrictions requested by the patient
- The patient's treatment plan and its aims
- Any written care plan, crisis plan or recovery programme
- The role of each professional involved in the patient's care
- How to access help, including out of hours services

Carers are given:

- The opportunity to see a professional on their own
- The right to their own confidentiality when talking to a professional
- Encouragement to feel a valued member of the care team
- Confidence to voice their views and any concerns they may have
- Emotional and practical support
- An assessment of their own needs with their own written care plan (i.e. if the patient has a serious mental illness or learning disability.

9.2. HBTT, networking with agencies and communication services.

The HBTT can attend and contribute to:

- Keyworker reviews where consideration for HBTT has been identified.
- Contribution to joint working practices with community service the aim of HBTT as a short-term stabilisation intervention.
- Attendance at clinical meetings and complex case reviews.
- Referral on to specialist agencies, such as RENEW, ERP, DAP etc.

9.3. Record keeping

- All clinical records are accessed and stored with electronic Trust based server Lorenzo. Access to clinical information is available 24 hours per day 7 days per week. HBTT service user information is therefore available outside of HBTT working hours should a HBTT service user come to the attention of MHCIT or the HMHT out of hours.
- Clinical and medical staff are to recognise the Humber Teaching NHS Foundation Trust guidelines for record keeping and record al clinical entries within the guidelines outlined.

10. ALCOHOL AND SUBSTANCE MISUSE

Alcohol screening procedure (See Policy Identification of Alcohol Misuse) So prevalent is alcohol misuse that NICE (2010) recommends that NHS professionals should routinely carry out alcohol screening as an integral part of practice. Short, validated screening tools (i.e., questionnaires) should be utilised to identify those who misuse alcohol and should be integrated into assessment and review documentation

Humber Teaching NHS Foundation Trust services will systematically screen for alcohol misuse using validated screening tool/questionnaire chosen from the following:

- Alcohol Use Disorders Identification Test - Consumption scale (AUDIT – C; Bush et al, 1998)
- Alcohol Use Disorders Identification Test - Interview Version (AUDIT, Saunders et al, 1993)
- All those who score positively for alcohol misuse should be:
  - Notified that they are, or recently have been, drinking at levels or in a pattern which may have increased their risk of health or social problems
  - Advised that cutting down on drinking will reduce risks associated to alcohol
  - Offered further information on the risks of alcohol (leaflets, websites) and where to get further advice/help
  - Considered for needing a referral to alcohol services for further assessment, advice and/or treatment.
- Those positive for alcohol misuse using shorter screening AUDIT-C should be offered the Full AUDIT.
- All those thought to be alcohol dependent (e.g., AUDIT score 16 or more), or who typically drink more than 15 units of alcohol daily, should be:
  - Considered at risk of alcohol withdrawal symptoms and should be assessed by a competent clinician, particularly when restricted from alcohol (i.e., on transfer of care to hospital) as the individual may require medication to manage alcohol withdrawal symptoms and parenteral vitamins to avoid complications associated with abrupt cessation of alcohol (See Guideline - G349 Alcohol Withdrawal on Psychiatric Wards).
  - Considered in need of specialist comprehensive assessment and possible need for structured treatment and referred to alcohol services where the service user service user agrees.

Adults Scoring: Maximum score of 12 with a score of 5 or more indicating hazardous/harmful drinking

Young People: A score of 3 or more may indicate hazardous/harmful drinking and a score of 5 or more consider comprehensive assessment – with positive alcohol use in young people always consider safeguarding

Positive Score: If trained, and feasible, HBTT to consider application of full AUDIT and follow guidance or referral on to RENEW (Hull) or East Riding Partnership (East Riding).

10.1. Further Comprehensive Assessment of alcohol use.

Those service users who score 16 or more on the AUDIT or who are suspected of experiencing complex alcohol misuse should receive a comprehensive assessment of their alcohol misuse by a trained healthcare professional. The comprehensive assessment should consider multiple areas of need, be structured in a clinical interview, use relevant and validated clinical tools, and cover the following areas:

- Alcohol use, including consumption: historical and recent patterns of drinking (using, for example, a retrospective drinking diary), and if possible, additional information (for example, from a family member or carer)
- Dependence, including history of:
- evidence of tolerance (needing more alcohol over time to get the same effect)
- withdrawal symptoms (nausea, tremor, sweats, anxiety, delirium tremens, seizures, sleep problems, make use of the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar))
- strong desire/compulsion to take alcohol (i.e., craving/urge to drink)
- inability to control the use of alcohol
- preoccupation with the obtaining, using and recovery from alcohol – other activities/priorities diminished
- Persistent use of alcohol despite evidence of harmful consequences and problems.
- Supplement the assessment with the use of the Severity of Alcohol Dependence Questionnaire (SADQ)
- Alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
- Other drug misuse, including over-the-counter medication
- Physical health problems: particularly attention should be paid to a history of recent falls, head injuries, possible neurological problems, nutrition and dietary intake
- Psychological and social problems
- Cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- Readiness and belief in ability to change.
- Alcohol-related problems (using, for example, Alcohol Problems Questionnaire [APQ])
- Other drug misuse, including over-the-counter medication
- Physical health problems: particularly attention should be paid to a history of recent falls, head injuries, possible neurological problems, nutrition and dietary intake
- Psychological and social problems
- Cognitive function (using, for example, the Mini-Mental State Examination [MMSE])
- Readiness and belief in ability to change
-

10.2. Breath test

Breath tests can form part of assessment and safety/management plans, however in isolation do not define level of dependence. Caution should be taken with severely dependant persons, as they may have a high breath reading when they begin to experience withdrawal symptoms.

10.3. Substance use

- So prevalent is drug use that all healthcare professionals, wherever they practice, should be able to identify and carry out a basic assessment of people who use drugs (National Institute for Health & Care Excellence (NICE) 2007).
- NICE recommends that mental health and criminal justice settings, routinely ask service users about recent legal and illicit drug use, including type, method of administration, quantity, and frequency.
- People who misuse drugs may present with a range of health and social problems other than dependence, which may include (particularly with opioid users):
  - Physical health problems (for example, thrombosis, abscesses, overdose, hepatitis B and C, HIV, and respiratory and cardiac problems)
  - Mental health problems (for example, depression, anxiety, paranoia and suicidal thoughts)
  - Social difficulties (for example, relationship problems, financial difficulties, unemployment and homelessness)

All service users* on assessment and/or transfer of care should be asked about recent legal and illicit drug use, including:

- type
- Method of administration
- Quantity
- Frequency

- All service users must be made aware that asking them about drug use is a routine part of the care we offer. This is required as drug misuse informs the treatments that we offer and where indicated may influence the medications prescribed.
- The Brief Screen for Drug Misuse has been adapted from an international tool (ASSIST: WHO, 2010) to support services undertake a basic assessment of drug misuse. This tool has been incorporated into mental health assessments across the organisation

10.3.1. Brief screening of substance misuse

Outcome of the brief drug misuse questions must be shared with the service user and reported to all those responsible for their care.

The precise interventions to consider will need to take account of other factors:

- Outcome of mental health and risk assessment
- Age of the service user
- Pregnancy
- Parental responsibility
- Safeguarding advice

This action may require seeking specialist advice, assessment and/or treatment. The outcome of the screening tool should not be used in isolation, but health and social care staff should consider:

- All those service users reporting use of a substance once or more over the last year should receive feedback on the risks of use and information on where to access further help and support if needed
- All those reporting intravenous (I.V.) use should receive information on the risks of injecting behaviour
- All those reporting monthly or more frequent use should be asked about their drug misuse routinely as part of their care plan
- A health or social care professional should consider seeking a specialist comprehensive assessment of drug misuse where a service user reports, monthly or weekly use of drugs.

10.3.2 A further specialist comprehensive assessment should be obtained where drug use is:

- daily or almost daily
- less frequent than daily but there are additional specific concerns (i.e., young person, pregnant, high-risk behaviour)
- involving I.V. or high-risk routes of administration

Ciwa-b benzodiazepine withdrawal schedule rating scale
Clinical Opiate Withdrawal Scale (COWS)

11. CRISIS PAD: INTERFACE WITH THE CRISIS PAD (SEE CRISIS PAD SERVICE AIMS AND OBJECTIVES)

The crisis pad (managed by MIND) operates out of Wellington House, Beverley Road Hull, 7 evenings a week between 18.00hrs and 02.00 The service is for adults over the age of 18. Children and organic presentations have been considered as exclusions to the service. No other exclusions have been identified although risk factors need to be considered as does degrees of intoxication before consideration to refer.

12. WORKING WITH FAMILIES AND CARERS.

The HBTT strongly support working closely with families and carers and recognise the important role they play in the recovery and stabilisation process for the service user. Obtaining information from and listening to the concerns of families and carers (where identified and consent from Service User provided) are key factors in determining the care needs of the service user and the needs of the carers themselves. The needs of carers are considered throughout the entire service from referral in to discharge, and HBTT provide information to carers (carers pack) and referral on to carer agencies for both Hull & East Riding areas.

The HBTT staff undertake regular training in understanding carer needs, and the clinical leads and team leader undertake regular audit of carer activity and interventions within the HBTT, utilising feedback form carers to inform and improve clinical practice standards.

13. EMERGENCY CIRCUMSTANCES

When any service user in receipt of HBTT indicates an immediate and urgent physical health need, (i.e., overdose, serious relapse of physical health etc) HBTT will escalate this by advising that the service user attends Accident & Emergency Department (A&E) and arrange suitable transport via emergency ambulance is required. HBTT should then contact MHLS and advise of a service user who will be attending A&E and provide a handover to the team member. The HBTT staff will update the HBTT shift coordinator.

14. SAFEGUARDING AND ESCALATION OF SUSPECTED SAFEGUARDING CONCERN

Any member of the HBTT suspecting concern of the safety and welfare of a service user should refer to the Safeguarding Adults / Children Policy and Procedures for guidance. The Humber Safeguarding Team can are contacted in the first instance in order to raise the concern(s) and provide guidance in connection with further formal safeguarding escalation.
Safeguarding Adults web pages for Hull City Council and East Riding of Yorkshire Council are also sources of information and guidance. Any referral to the Safeguarding Adults Team is completed as a matter of priority. This information is shared with the relevant agencies or organisations, which have a legitimate relationship with the patient on a “need to know” basis such as the patient’s registered General Practitioner.

All Safeguarding documentation is filed in the patient’s record under the safeguarding tab on Lorenzo. The patient is also discussed at earliest opportunity during the Multi-disciplinary Team (MDT) meeting and a record of actions undertaken, including all follow up actions.

15. DISENGAGEMENT FROM HBTT

Reasons for disengagement are varied and may include poor insight, deterioration, or acuity of mental ill health, increasing helplessness or hopelessness, lack of capacity, transport difficulties, substance misuse or safeguarding concern. For others it may simply be that they have reached a stage in their recovery where they no longer feel that they need to engage with services. To promote the health, safety and wellbeing of all service users and others, it is vital that disengagement from service is considered seriously and that responses from the HBTT service are consistent and proportionate to any measured or perceived risk.

The following standards are designed to guide staff in the approach to be taken for those at risk of disengagement.

For staff working with a service user who has disengaged; or plans to disengage the following actions will be undertaken:

- Review of recent and historic risks; including any history of disengagement.
- Discussion with the service user (where possible) to identify the reason for disengagement.
- Discussion with the MDT, including Consultant Psychiatrist to determine the level of need and risk.
- Consideration of the mental state of the service user or any factors which may affect the capacity of the service user to make the decision to disengage from service.
- HBTT to contact GP surgery to ascertain any attendance / non-attendance with primary care sources.

Following the MDT discussion appropriate action to attempt to reengage the service user should be taken; this may include, but is not limited to:

- Contact via telephone.
- Unannounced home visit (if this is a no access visit a calling card must be left requesting contact to team).
- Contact with the nearest relative/carer or significant other, where appropriate.
- Letter inviting the service user to contact the service.
- Reference to known risks such as absconding or poor engagement history. This is likely to require a more assertive and proactive approach to attempting to contact the service user and may involve going to places they are known to frequent, liaising with any other professionals/agencies involved in their care and/or other options available. Consideration will also be given to what 'engagement' means to the individual.
- An assertive engagement approach will be undertaken which is persistent, positive and proactive yet stops short of being invasive or controlling.

If actions to reengage are unsuccessful then a discussion with the clinical lead and/or Consultant Psychiatrist should take place to consider further management which may include:

- Consideration of the actions taken and any further informal attempts to re-engage the service user.
- Relevance of a formal assessment under the Mental Health Act if felt to be appropriate providing there is sufficient evidence that a least restrictive alternative can be undertaken.
- Immediate review of risk and concerns around mental health.
- If face to face at time of disengagement, then encourage service user to stay and complete the risk assessment process and finalise any unfinished care plan treatment goals.
- Consider MCA and best interests of the service user, and record capacity decision making within designated pro forma on LORENZO system.
- Attempt to contact service user via phone, risk and mental health presentation at triage will determine the urgency of this.
- If unable to achieve contact via telephone an unannounced home visit to be conducted (depending on risk/areas identified). If risk is considered 'very severe' then to consider escalation to police welfare check.

- Also consider contacting nearest relative/significant other, referrer / community keyworker and GP to be completed.
- All clinical decision making to be discussed within MDT
- If further attempts are required, then a *contact* letter to be sent to the service user to contact the MHCIT, then placed on an access plan. If the service user does not respond, transfer of care process to be completed and GP letter forwarded.

16. DISCHARGE / TRANSFER OF CARE PROCESS

Discharges to / transfer of care of the service users are to be underpinned by the overarching principles outlined in NICE guidance NG53.

Any transfer of care process is to be formulated by MDT discussion, involving discussion surrounding the purpose of the original referral, what treatment objectives were identified and achieved, any outstanding treatment need. The service user / family / carer will be fully informed throughout the process of transfer of care, the crisis plan including strategies for self-help, ways of coping and contact numbers for the follow up service(s) including information for carers.

All decisions will require clear clinical documentation and other agencies involved in the service users care, including summary letter to GP, with action plan should any further service be required.
A focus upon the wider aspects of service users such as gender, sexual orientation, disability, and cultural / spiritual needs should be considered and include in the overall transfer process between services.

Where an individual's ongoing support or intervention plan is to be delivered by an external agency (whether that is an established relationship or a new referral), the discharging clinician is responsible for liaising with that service to ensure that the provision is clinically appropriate and available to meet the identified needs. This allows the clinician and service user to formulate an alternative plan, prior to discharge, if required. There may be circumstances under which there is a strong clinical rationale to facilitate the service user in managing their own care/self referral, in those instances a rationale for not liaising with the external agency must be documented.

16.1. Specific agency discharge to / transfer of care processes:

16.1.1. Primary care counselling Let's (Talk Hull) and The Emotional Wellbeing Service (East Riding)

- Specific referral forms for Primary Care Counselling to be completed by HBTT.
- Updated risk assessment (HBTT).
- Clinical rationale and formulation, discussed within HBTT MDT to support the referral.

- Care cluster to be within parameters of the primary care services (Care clusters 1-4)
- Evidence that the service user has been involved in the decision making and has consented to the referral, and has been made aware of any choices / alternatives that may be available such as private sector therapy, specialist support groups etc.
- Service user is aware of contact details of the primary care agency they have been referred to.
- Service user to have discharge plan, recorded on Lorenzo, showing routes to safety (MHAST / MHCIT numbers etc) should relapse of mental health / crisis reoccur.
- HBTT to advise all other parties involved in the care of the service user that the HBTT care episode has concluded, and that discard has been actioned. HBTT to ensure record of such communication is on Lorenzo.
- HBTT to provide a summary of the care provided to the service users usual GP, showing treatment undertaken, results and outcomes achieved, advice on contingency planning, and the service(s) that HBTT are transferring to.
- All documentation of transfer / discharge to include contact details of HBTT.
- HBTTT psychiatrist to update GP with medical opinion and medication summery.
- NMP / Medic to advise and update GP of any further review of medication undertaken.
- HBTT to advise of any follow up strategies that may follow the transfer, such as joint inter-agency meetings or reviews that are already a planned part of the transfer of care process.

16.1.2. CMHT (PMHCN) / PSYPHER

Referrals to the CMHT's, PMHCN's and PSYPHER will involve the following processes from HBTT:

- HBTT to refer the service user via internal referral form (Appendix B) providing a clear rationale for referral.
- HBTT shift coordinator to contact the respective CMHT / PSYPHER for clinical discussion in support of the referral.
- HBTT to provide MDT clinical opinion and formulation of service user need to be considered by the CMHT (PMHCN) or PSYPHER.
- HBTT to update FACE risk assessment.
- Care cluster updated by HBTT to reflect current clinical presentation.
- Clear indication of any other referrals to external or specialist agencies already undertaken or indicated, such as trauma services, specialist psychotherapy services or Complex Emotional Needs service (CENS).
- Evidence that the service user has been involved in the decision making and has consented to the referral, and has been made aware of any choices / alternatives that may be available such as private sector therapy, specialist support groups etc.
- Service user is aware of contact details of the CMHT / PSHPHER team they have been referred to.
- Service user to have transfer of care plan, recorded on Lorenzo, showing routes to safety (MHAST / MHCIT numbers etc) possible known relapse signs

and coping strategies to utilise should relapse of mental health / crisis reoccur.

- HBTT to provide a summary of the care provided to the service users usual GP, showing treatment undertaken, results and outcomes achieved, advice on contingency planning, and the service(s) that HBTT are transferring to.
- All documentation of transfer / discharge to include contact details of HBTT.
- HBTT psychiatrist to update GP / CMHT / PSYPHER with medical opinion and medication summery and any further review of medication expected.
- NMP to advise and update GP / CMHHT / PSYPHER of any further review of medication undertaken or expected.
- HBTT to advise CMHT / PSYPHER of any follow up strategies that may follow the transfer, such as joint inter-agency meetings or reviews already planned that are part of the transfer of care process.
- HBTT to contribute to any invitation for clinical discussion with CMHT of PSYPHER required to support the referral and clarify clinical details if required.
- HBTT clinical lead to support referral process, providing senior clinical rationale if required in instances where the referral may require further clarification.
- HBTT clinical lead to undertake weekly audit of referrals, assist with ensuring the referral on is active and being actioned by the respective team referred to.
- HBTT to update the service user and GP with the progress (acceptance or declination) of the referral.
- HBTT to advise admin team of the outcome of the referral for the referral to be reconciled administratively.

17. SIGNPOSTING

HBTT have access to and make regular use of an extensive and constantly updated catalogue of external, non-statutory organisations, voluntary sector organisations, voluntary support groups and condition specialist support agencies that can be referred to for complementary support either during or post crisis.

18. LONE WORKING PROCEDURE ON AND OFF SITE

Risks to staff members: risks should be identified at the point of receipt of referral and have been communicated within the internal referral process (internal referral decision making and form). Risks can also be ascertained from examination of any alerts (historical as well as contemporary) identified within Lorenzo. These risks can be personal (directly from the service user) from a carer or known associate or may be environmental. Due to potential risks posed by service user contact within a hospital and community setting, lone working procedures should always be adhered too. Please see HFTT Lone working policy.

Local protocols from lone working are as follows:

- When risk to visiting is identified, this should already be recorded as an alert on Lorenzo and the sections of the initial referral, triage, and assessment processes within MHCIT. The risk identified and what protocols will be put in place to manage this. (see MHCIT SOP).
- Service users name should be placed in red writing on the electronic wallboards in the HBTT office to indicate risk to visiting.
- When risks to visiting are identified, the preference would be to see the service user at a team base and where possible, Miranda House. This is not always possible due to presentation and in these instances the following should be adhered to:
- The staff member should indicate on the staff signing in/out boards in the HBTT office at Miranda House, the address of where they are going, the service user whom they are going to see, time of departure, time of expected arrival back at base, and a contact number they will be available on. Where there is no whiteboard to place this information onto, the staff member should contact the shift coordinator, or designate and inform them of the information listed verbally. The person receiving the information should document this for their records. The shift coordinator should always be made aware of a staff member leaving site and attending a service users' home/another site.
- The shift coordinator should then contact the staff member on the contact number provided if they do not return/contact you by the time estimated.
- The staff member should make every effort to contact the coordinator to inform them if the plan changes/time changes or there is new information that has come to light.
- In certain circumstances, the staff member may not be able to contact the coordinator due to presentation of the service user and in these instances should follow the trusts Lone Working Policy and escalate the situation as required.
- All staff members are to keep in their mobile phone under the name AAA the MHCIT emergency phone number which is 01482 336145. If unable to contact someone on this number, the staff member should contact 999 in an emergency.
- Local procedure dictates that when the emergency phone rings, that staff on shift immediately cease other activity and answer the phone as soon as possible, as this is an emergency (located in MHCIT office).
- Should the staff member not return to site and be uncontactable, the coordinator is to raise this to clinical lead on duty or on call manager and consider the use of contacting next of kin and the police.

- When seeing a service user on a trust site, lone working procedures should continue to be adhered to.
  - Service user should be seen in an appropriate room on the site.
  - Staff member should ensure they have surveyed their environment before inviting in the service user and take note of exits, chair positioning and alarm systems.
  - Staff member should always remain in close proximity to the entrance to the room and any alarm points available
  - Should risk escalate, the staff member should attempt de-escalation if appropriate and/or remove themselves from the room to protect their safety.
  - Staff to use the alarm points to contact for help as required.
  - When seeing a service user at Miranda House; the 136 suite and interview rooms are fitted with the pinpoint alarm system. Staff should ensure they have acquired a pool alarm kit from reception before seeing the service user. The staff member should ensure they test the key fob to ensure it is working correctly and carry this with them at all times during their consultation. This fob is to be activated as required and assistance will be provided from MHCIT and Avondale staff. Once the consultation is complete, the key fob should be returned and signed back in at reception for further use.
  - Staff should ensure they have enquired about and adhere to all local procedures at other sites they may be working from.
- Staff should always consider the use of a second person attending visits and assessments with the staff member and arrange this accordingly.
- Any incidents of aggression should be documented on Lorenzo, including creating an alert, inform the shift coordinator/clinical lead, report via Datix, consider report to the police as required.
- Staff who witness or are subject to physical or verbal aggression should be offered supervision and a de-brief session at the earliest opportunity. Clinical staff are to update alert on LORENZO if required to reflect the nature of the alerts and update risk assessment information to reflect the context of the alert.

19. CLINICAL AUDIT

The clinical leads (band 7) undertake regular clinical audits to provide data on team performance, reporting to the service manager on a monthly and quarterly basis. The clinical leads undertake the following audits:

- Triangle of care: this audit pertains to the quality of carer services provided with the HBTT. The audit is performed monthly, outcomes shared with the service manager.
- Care plan audit: This is also undertaken monthly, and a random sample of HBTT care plans are selected and scrutinised for quality and comprehensive care delivery. Feedback is given to the clinicians involved and the audit outcomes are shared with the service manager.
- Case note audit: Audit performed monthly one randomly selected care pathway, from triage, assessment, referral on, care plan and care delivery with feedback provided to the clinicians involved and outcome provided to the service manager.

20. STAFFING ESTABLISHMENT

The standard total for daily staffing of the Home Based Treatment Team is:
6 x Qualified / Registered practitioners (multi agency)
4 x Unregistered practitioners / HCA's and TNA's (multi agency)

21. REFERENCES

Caplan G. (1964) Principles of preventative psychiatry. New York. Basic Books.

The NHS Long Term Plan (January 2019)

Department of Health (2000) The NHS Plan: A Plan for Reform. The Stationary Office.

Hardy S, Gray R, White J (2018) Health Improvement Profile: A Manual to Promote Physical Wellbeing in People with Severe Mental Illness. Keswick M & K Limited.

Mental Health (Patients in the Community) Act (1995).

National Health Service (2016) Care Clustering Booklet. NHS England Publications Gateway Reference: 04421.

National Institute of Clinical Excellence (NICE) (2016) Transition between inpatient and mental health settings and community or care home settings.

APPENDIX A: Related Policies/Procedures/Guidelines

The following policies are to be read in conjunction with this home-based treatment operational policy.

Avondale Clinical Decisions Unit SOP	Avondale Clinical Decisions Unit SOP21035.pdf (humber.nhs.uk)
Bed Management SOP	Adult and Older Adults Bed Management SOP22-017.pdf (humber.nhs.uk)
Complaints and PALS Policy	Corporate Policies, Procedures and SOPs (humber.nhs.uk)
Confidentiality and Code of Conduct	Corporate Policies, Procedures and SOPs (humber.nhs.uk)
Consent Policy	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Caldecott and Data Protection Policy	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
CPA Policy and Procedural Guidance	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Clinical Risk Assessment, Management and Training Policy	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Consent to Treatment SOP	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Duty of Candour Policy and Procedure	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Supervision Policy – clinical practice and non-clinical (page 10)	Corporate Policies, Procedures and SOPs (humber.nhs.uk)
Safeguarding Adults Policy	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Safeguarding Children Policy	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Medicines Management Policies, Procedures and Guidelines.	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
EPMA Community Policy (CLOZAPINE)	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Discharge and Transfer Policy	Clinical Policies, Procedures and SOPs (humber.nhs.uk)
Mental health Triage Crisis Intervention SOP	Clinical Policies, Procedures and SOPs (humber.nhs.uk)

APPENDIX B: Internal Transfer Form

Internal Transfer Form

All fields are mandatory

Patient Name	NHS Number
Referring Clinician & Team	Receiving Clinician & Team
Date of Referral	Time of Referral
Clinical Discussion & Risk (self and others)	
Rationale for Decision	
Any Areas of Disagreement	
Plan (including what to do if unable to contact) **Check the care cluster has been updated to reflect the transfer**	

APPENDIX C: HBBTT Medic Review Request

HBTT MEDIC REVIEW REQUEST

Service User name:	NHS Number:
DOB:	**Allergy status**:
Referring clinician: Date of assessment:	Present in MDT discussion Date of discussion:

OUTCOME OF 1st CONTACT AND REASON FOR MEDIC REVIEW:
What medication is currently being taken (prescribed/not prescribed)? Has it been effective? Has it been tolerated (please explain any side effects of ADRs)? Has it been adhered to as prescribed? Please state doses and length of time medication has been taken for
Relevant medication and medical history. What has been effective, if not why not? (Include doses, time taken and if Service User adhered to regime)
What are you seeking from this review?
What is the Service User wanting from this review?
Outcome of MDT discussion?

APPENDIX D: HBBTT Occupational Therapy Referral

Home Based Treatment
Occupational Therapy Referral

Name:

NHS Number:

Please identify within the checklist what the occupational therapist can assess and/or provide intervention for. Please provide further information where need is identified.

Intervention	✓	**Further information**
Daily living skills assessment (Personal care, meal preparation, shopping, medication management, money management, domestic tasks and processing skills)		
Home assessment (adaptations to environment, mobility, tranfers, equipment prescribing and motor skills)		
Habituation (Routine, structure, activity planning, balance and roles)		
Volition (Interests, choices, goal setting, graded exposure and social inclusion)		
Interaction skills (Verbal and non-verbal communication)		

Please highlight priority level: High / moderate / low

The weighting towards Occupational Therapy need will be influenced by the need for engagement in life roles, rehabilitation strategies, improved quality of life, daily living skills or lifestyle changes and following discussion with the Occupational Therapist.

Any other information needed before visiting (including concerns or risk areas):

Referrer:
Designation:
Date:

APPENDIX E: Roles Of Staff

Role of the Admin staff

- Completion of electronic referrals indicated following the outcome any crisis triage or assessment or internal referral to HBTT.
- Ensure all Lorenzo and referral monitoring processes are completed.
- Complete specific administrative duties as required by the clinical team.
- Handling incoming telephone calls, forwarding these to the appropriate clinician.
- Process HBTT Team specific emails.
- Collect clinical audit data where required.
- Input information onto IT systems / spreadsheets and databases.
- Support clinical staff in administrative systems.

Role of the Support Worker

- Contribute to care delivery via telephone and face to face.
- Forge trusting therapeutic and supportive contact with service users as allocated.
- Provide support to other clinical staff via chaperone visits if two-person face to face contact is indicated.
- Contribute to MDT clinical case discussion.
- Input information onto IT systems / spreadsheets.

Role of the band 3 Healthcare Assistant (HCA)

- Answer clinical and general phone calls.
- Contribute to MDT clinical case discussion.
- Adhere to delegated clinical tasks defined within care plan for individual service users.
- Contribute to care delivery & deliver specific clinical stabilisation interventions via telephone and face to face contact, utilising instruction indicated with care plans.
- Undertake physical health observations and record / escalate findings.
- Complete Health Improvement Profile (HIP) process and documentation.
- Utilise interpersonal skills to foster trusting and supportive therapeutic relationships with service users as a clinical intervention.
- Input clinical information onto IT systems / spreadsheets.
- Undertake comprehensive physical health monitoring and observations, recording findings in clinical systems, escalating findings to qualifies clinical staff.
- Undertake carers liaison working.
- Provide support to other clinical staff via chaperone visits if two-person face to face contact is indicated via prior risk assessment / clinical alerts.
- Provide information to service users and their family / carers within sphere of responsibility, such as leaflets and worksheets as part of their care delivery process.

Role of the band 4 Registered Nursing Associate (RNA).

- Undertake ‘first contact’ with service users.
- Orientating service users to the process of HBTT
- Make clinical contribution to MDT.
- Undertaking physical health checks upon service users.
- Acting within sphere of professional responsibility to escalate concerns of physical health and risk immediately within MDT.
- Compile care plans in collaboration with the service user.
- Record all clinical observations, care plans, clinical correspondence on LORENZO.
- Provide clinical leadership.
- Support HBTT shift coordinator in balancing workload demand.
- Provide feedback and information to referrers and stakeholders where required.
- Provide supervision to HCA’s.
- Attend meetings aligned to specialist registered discipline.

Role of the band 4 Associate Practitioner (AP)

- To provide psychosocial interventions, skills and self-help techniques to service users and their family / carer to promote crisis stabilisation.
- Develop therapeutic working relationships that promote a sense of trust within service users.
- To provide guidance to HCA’s in care delivery in line with care plans.
- Contribute to MDT clinical discussion.
- Champion the use of psychological tools and interventions within the HBTT.
- Provide practical help with recovery, such as assisting service users with navigating the HBTT and follow-on care pathway, working within structure of the assigned care plan.
- Undertake physical health checks and report findings to MDT.

Role of the band 5 (all disciplines)

- Undertake ‘first contact’ with service users.
- Orientating service users to the process of HBTT
- Contribute to MDT discussion.
- Undertaking physical health checks upon service users.
- Acting within sphere of professional responsibility to escalate concerns of physical health and risk immediately within MDT.
- Compile care plans in collaboration with the service user.
  (Nursing) dispensation and administration of prescribed medication to service users.
- Record all clinical observations, care plans, clinical correspondence on LORENZO.
- Provide clinical and operational leadership.
- Support HBTT shift coordinator in balancing workload demand.
- Use leadership to support clinical decision-making to resolve differences of clinical opinion.

- Provide feedback and information to referrers and stakeholders where required.
- Undertake duties and aligned within specialist registered discipline.
- Attend meetings aligned to specialist registered discipline.
- Engage in and contribute to external clinical case discussion where invited.
- Provide supervision to HCAs.

Role of the band 6 (all disciplines)

- Adhere to HBTT care pathway
- Act as ‘first contact’ with service users.
- Undertake, produce, and disseminate care plans.
- Support shift co-ordinator in shift management.
- Escalate any delays and blockages to clinical leads.
- Undertake ‘first contact’ with service users.
- Orientate service users to the process of HBTT
- Contribute to MDT discussion.
- Undertaking physical health checks upon service users.
- Acting within sphere of professional responsibility to escalate clinical risk concerns immediately within MDT.
- Compile care plans in collaboration with the service user.
- (Nursing) dispensation and administration of prescribed medication to service users.
- Record all clinical observations, care plans, clinical correspondence on LORENZO.
- Provide clinical and operational leadership within the HBTT team.
- Lead on identified specialism with the service.
- Support HBTT shift coordinator in balancing workload demand.
- Use leadership to support clinical decision-making to resolve differences of clinical opinion at a senior level.
- Provide feedback and information to referrers and stakeholders, clinical leads where required.
- Provide supervision to Band 5 clinical staff.
  Attend external clinical MDTs, inpatient service referrals, Care Programme reviews, case conferences and service discharge meetings where HBTT are required or invited.
- Undertake duties aligned to specialist registered discipline.
- Attend meetings aligned within specialist registered discipline.
- Engage in and contribute to external clinical case discussion and conferences where required.

Role of the shift coordinator band 6 (all disciplines)

- Take and provide handovers to MHCIT at commencement and end of shift in connection with HBTT service users.
- Be point of contact for incoming referrals to HBTT.
- To be always available to support the team with clinical decision making throughout the shift.
- Liaise with external agencies and teams in referrals process.

- Provide clinical leadership and liaise with the clinical lead where senior opinion is required.
- Delegate tasks to the team on duty at the time and monitor completion.
- Delegate breaks for staff.
- Ensure completion of shift log (electronic wallboard).
- Monitor whereabouts / times of staff clinical contacts to ensure staff safety.

Role of the band 7

- Provide clinical and operational leadership
- Overview caseload management of the HBTT as a service.
- Acts as a point of senior clinical contact across the HBTT / MHCIT service.
- Support shift coordinator in balancing workload demand.
- Use leadership to support clinical decision-making to resolve differences of clinical opinion at a senior level.
- Provide feedback and information to referrers and stakeholders, clinical leads where required.
- Provide supervision to Band 6 clinical staff including Bank Band 5/6 clinicians in connection with HBTT clinical matters.
- Attend external clinical MDTs, inpatient service referrals, Care Programme reviews and service discharge meetings where HBTT are involved or invited in order to support early discharge from inpatient settings.
- Undertake clinical audit as required, reporting to service manager.
- Attend meetings aligned to specialist registered discipline.
- Support team leader with operational issues if required.

APPENDIX F: Home-Based Treatment Electronic Wallboard Data Areas

The Home-Based Treatment electronic wallboard data areas:

Patient identifying data

Locality / demographics

Referral date

Alerts (as recorded on LORENZO)

Care cluster

Care plan review date

Next planned contact

Actions summary Medic

review requested.

NEWS2 Completed?

HIP (Heath improvement Profile)

Carer's screening completed.

Safeguarding needs

Discharge plan

Psychology tools in place

Occupational Therapy input identified

Carer support identified and actions.

APPENDIX G: ReQoL

ReQol (Recovery Quality of Life) Outcome Measure

- The ReQol outcome measure is a requirement for all NHS Trusts as part of the 5 year forward plan. Can be used at multiple time points to build a picture or tell a story about recovery
- Can be used to support formulation, care planning and transfer of care
- Can be used to inform conversations between clinicians and service users
- Can be used to guide and focus the sessions
- Provide the service user with hope and a way forward

The aim of the ReQol is:

- To develop a brief measure of recovery and quality of life for users of mental health services to complete themselves
- To work collaboratively with service users and clinicians to produce a measure that captures issues that are important to them

HBTT will complete the ReQol as part of each 1st contact and repeat again towards the end of a Service User's treatment or transfer of care and be inputted into Lorenzo.

Carer referral details:

Carer's Information and Support Service (Hull): chcp.carersinfo@nhs.net
01482 222 220

East Riding Council Carer's Support Service: ERcarers@eastriding.gov.uk
0800 917 6844

Hull and East Yorkshire Mind: info@heymind.org.uk
01482 240 200
Heymind.org

Carers Trust (online):
Carers.org

Carers UK
0808 808 777 Carersuk.org