Home Treatment Accreditation Scheme (HTAS)

Developmental Review Process

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Contents

Introduction to HTAS .......................................................... 4
Background .............................................................................. 5
Typology of Home Treatment teams ..................................................... 6
Standards Development Process .......................................................... 9
Diagram Showing Developmental Review Cycle ..................................... 11
Objectives .............................................................................. 8
The Standards .......................................................................... 8
The Developmental Review Process ..................................................... 10
Phase 1: Self Review ................................................................ 10
Phase 2: Peer Review Visit by an External Team ................................. 11
    Focussed Peer Review Visit - year 1 ............................................ 13
    Full Peer Review Visit – year 2 (optional) ...................................... 14
Activities and Support between Reviews .............................................. 15
    Standards Revision ................................................................ 15
    Peer Review Opportunities ......................................................... 15
    HTAS Annual Forum ............................................................... 15
    Email Discussion Group ............................................................ 15
    The College Website .............................................................. 15
How to Join HTAS ................................................................ 16
Contact the HTAS Project Team ....................................................... 17
Introduction to HTAS

The Home Treatment Accreditation Scheme (HTAS) was developed in collaboration between the College Centre for Quality Improvement (CCQI) and a panel of experts on Home Treatment Services. HTAS is a quality improvement and accreditation service for Crisis Resolution/Home Treatment teams, whose function is to provide home based acute care as an alternative to inpatient care.

Home Treatment teams are unique services and the HTAS review process attempts to address their needs. Key functions of such teams are gatekeeping acute inpatient admissions, offering a meaningful home-based alternative to acute inpatient admission and facilitating early discharge from acute inpatient wards.

Home Treatment teams are not all identical as they reflect local needs and interfaces. They should however have much in common, in terms of the difficulties they seek to address, the use of a recovery model, encouraging an enabling and empowering approach, using the full range of psycho-bio-social treatments including medication, psychological therapies, developing occupational and functional skills and working in close collaboration with service users and carers. Carers, in particular, potentially face an increased burden in home based acute care and good teams should pay particular consideration to carers and be mindful of the wider social environment. This is the essential difference between home based and hospital based acute care. In an increasingly competitive and financially constrained environment, there is a need to be able to improve and demonstrate quality of home treatment services to commissioners, clinicians, service users and carers. It has been widely demonstrated that Home Treatment teams can have a significant contribution to the Quality, Improvement, Productivity and Prevention (QIPP) agenda.

HTAS does this through:

- setting standards for the organisation and delivery of mental health services
- engaging with front-line staff and supporting them to measure their own team against these standards;
- recognising local achievement, including offering accreditation
- identifying areas for improvement;
- working with local teams to develop and implement plans for service improvement;
- working actively with other professional bodies, so that staff of all disciplines are engaged in the process;
- working in partnership with service users and carers, and encourage local mental health services to do the same;
- working with both NHS and independent sector services in the UK;
• encouraging mental healthcare staff from different services to support each other and share good ideas through peer-review, newsletters, email discussion groups, conferences and workshops.

**Background**

The work of the CCQI has created a new and enhanced role for clinicians and their professional bodies in raising standards. Its national initiatives engage directly with clinicians, managers, service users and carers and support them to take responsibility for improving local mental health services. More than 90% of mental health services in the UK participate in the work of the CCQI.

The panel of experts engaged in the development of the standards have worked for many years to improve the provision and standards of home treatment teams in the UK.

The introduction of Crisis Resolution Home Treatment (CRHT) services was one of the key elements in the 1999 National Service Framework for Mental Health; the NHS Plan (2000) made the provision of CRHT services a national priority; and the Department of Health’s 2002 Public Service Agreement included targets both for the number of teams and the number of people treated.

CRHT teams have been rapidly implemented across most areas of the country. £183 million was spent on providing CRHT services in 2006-07, an increase of 409 per cent in real terms since 2002-03. The Public Service Agreement target of establishing 335 teams was met by 2005. The target for treating 100,000 people a year was almost achieved with 95,397 reported episodes of CRHT provided to 75,868 individual people in the year to 31 March 2007.

Implementation of teams was overseen by the National Institute for Mental Health England (NIMHE) and, latterly, the National Mental Health Development Unit (NMHDU) who worked to develop standards and provide assistance with implementation. Under NMHDU there was a move to integrate the work of home treatment teams with inpatient services. Home treatment was increasingly seen as integral to the acute care approach, as encapsulated in the Acute Care Declaration (DH 2009). Since NMHDU ceased to exist, monitoring and ongoing development has been seen as the remit of local services.

There is a renewed focus at this time on home treatment teams to provide efficient and local services to those who can be cared for in their local communities. There is also a focus on ensuring the quality of associated acute inpatient services that are still necessary for some people experiencing an acute episode.
Typology of Home Treatment teams

Home Treatment teams formed an integral part of a comprehensive mental health service as defined by the National Service Framework for Mental Health (DH 1999). Originally termed ‘Crisis Resolution Home Treatment’ teams we have opted for the term ‘Home Treatment’ teams to better describe those teams within these standards. It is felt that this more accurately describes the key functions of such teams: namely gatekeeping acute inpatient admissions, offering a meaningful home-based alternative to acute inpatient admission and facilitating early discharge from acute inpatient wards. Whilst it is acknowledged that there is a ‘crisis’ component to these teams it is also the case that there is a ‘crisis’ component to all teams albeit at different levels of acuity and severity of disorder. The term ‘crisis’ associated with home treatment teams has led to misunderstanding about the roles and remit of different mental health services so has been omitted here, although the standards also apply to Crisis Resolution teams.

Home treatment teams form an integral part of the acute care pathway (Acute Care Declaration, DH, 2009). The beginning of the Acute Care Pathway is widely agreed to be when an individual is first referred to the Home Treatment Team (HTT). The end of the Acute Care Integrated Pathway is understood to be when they are transferred to another team or discharged from services following the acute phase or episode.

Acute mental health services care for those within specialist (secondary) mental health services currently experiencing, at risk of, or recovering from a mental health crisis of significant severity and acuity. These services are usually comprised of a number of key elements; home treatment teams, acute inpatient wards and psychiatric intensive care units (PICU). The relationships between the services are as important as the functions of the services themselves. There needs to be clear arrangements in place for the cohesive overall management and clinical leadership of acute care services.

Home Treatment Teams work with individuals who otherwise would have been at risk of admission to an acute inpatient ward, are deemed to be vulnerable to admission without intervention or can be helped towards early discharge from an acute inpatient ward to facilitate a better prognosis and continue their recovery journey. Where teams work with this target group there is evidence to suggest that there is a significant reduction in use of acute inpatient beds\textsuperscript{1,2,3}. There are no diagnostic criteria for inclusion; rather this is based on need, determined by the severity of a disorder and acuity of presentation and/or clinical risks.

\textsuperscript{1} Helping people through mental health crisis: The role of crisis resolution and home treatment services, National Audit Office, 7\textsuperscript{th} December 2007.
\textsuperscript{2} Efficiency in mental health services: Supporting improvements in the acute care pathway. NHS Confederation Briefing. February 2011 Issue 244.
\textsuperscript{3} Maximising Resources in Adult Mental Health. June 2010. Audit Commission.
The teams themselves are multidisciplinary in nature and a broad mix of complementary disciplines is deemed to be beneficial.

In order to perform their core functions it is usually recognised that teams have to have a minimum clinical staffing resource of 14 WTE clinical staff per 150,000 general population served. Areas of above average social deprivation such as some inner city areas will require greater resources. A key role is offering a meaningful alternative to acute inpatient admission; essentially a ward in the community, without walls. As such, a greater proportion of a team’s resources should be dedicated to home based acute care. There is no minimum or maximum period of home based care but 4 – 6 weeks is seen as optimum.

Teams can be physically located in the community or co-located with acute inpatient services. Some services have fully integrated acute care services with a single management and clinical leadership across the home treatment team and acute inpatient ward(s).

Teams should ideally operate 24 hours a day, 7 days per week, although it is recognised that in some areas this may not be practical and alternative solutions are sought, such as a responsive night on-call system. The key functions that should be available by home treatment teams 24/7 are gatekeeping and initial assessments.
Objectives

The purpose of HTAS is to improve the care provided by home treatment teams in the United Kingdom and Ireland.

It achieves this by:

- Reviewing home treatment teams.
- Creating a national network to support staff through:
  - the HTAS peer-review process;
  - HTAS Forum events
  - an email discussion group.
- Maintaining a database of standards for home treatment teams.

The Standards

The standards are drawn from a range of authoritative sources (the standards can be downloaded from our website www.rcpsych.ac.uk/HTAS) and also incorporate feedback from service user and carer representatives, a pilot study and experts from a range of relevant professions.

The full set of standards is comprehensive and some standards are aspirational; it is unlikely that any team could meet all of them. The standards are categorised as different types for the purposes of accreditation but teams participating in developmental review may also bear these categories in mind:

- **Type 1**: failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law;
- **Type 2**: standards that a team would be expected to meet;
- **Type 3**: standards that are desirable for a service to meet, or standards that are not the direct responsibility of the service.

It is quite common for teams participating in HTAS not to meet all type 1 standards in the first instance and this is not necessarily a cause for alarm; HTAS works with and supports teams to enable them to meet these standards within a reasonable timeframe, and also supports teams to improve on type 2 and 3 standards. Refer to the HTAS Accreditation Process document for details of the thresholds for accreditation.

*Note: In the event that HTAS finds evidence that the Trust’s (or other organisation’s) home treatment service threatens the safety, rights or dignity of patients, the Trust (or other organisation) will be informed, in writing, and is expected to take appropriate action. If the Royal College of Psychiatrists is not satisfied that appropriate action has been taken, it reserves the right to inform those with responsibility for the management of the service and/or the relevant regulatory body.*
The standards have been used to generate a series of data collection tools for use in the self- and peer-review processes. Some standards have not been included in the tools because they cannot be measured objectively and reliably.

There are several data collection tools because it is important that each standard is evaluated using the most appropriate method(s) and source(s) of information. The methods are described more fully in the sections below that describe the self-review and peer-review phases of the accreditation process.

**Standards Development Process**

The standards development process involves a review of currently available standards, regulatory guidance and relevant literature led by the professional staff at the CCQI. This is translated into relevant clinical standards by a multiprofessional standards development group including clinicians from, and users of, Home Treatment Teams. The standards are revised regularly with input from professionals in member services, service users and carers, and discussion with a multidisciplinary group of experts. This group works with the staff of the CCQI to develop standards and a review process that is relevant and acceptable to the clinical services, staff, service users and carers that HTAS intends to serve. In this way standards are hopefully seen as relevant and shared rather than externally imposed.
The Developmental Review Process

The timeline for a developmental review process is displayed in the diagram on page 11. Teams have the option of undergoing one or two years of developmental review before progressing to accreditation. This does not have to be stated at the time of joining the programme; teams can decide whether to proceed straight to accreditation in year 2 during their completion of year 1, with consideration of their ongoing progress. For more information about accreditation, see the HTAS Accreditation Process document.

Phase 1: Self Review

This is an opportunity for the local multidisciplinary team to review its local procedures and practices against the HTAS standards and make changes to their processes if desired.

At the beginning of the self review period, the local HTAS lead will be sent the current edition of Standards for Home Treatment Teams and the self review data collection tools. The latter must be completed and returned within three months.

The self review has a number of components. Unless otherwise stated, the tools are completed using direct web-based entry:

- **Carer Questionnaire**
  Carers will return these themselves, directly to the HTAS Project Team, using the ‘Postage Paid’ envelopes provided, or enter their responses via the HTAS website.

- **Service User Questionnaire**
  Service users will return these themselves, directly to the HTAS Project Team, using the ‘Postage Paid’ envelopes provided, or enter their responses via the HTAS website.

- **Team Manager Questionnaire**

- **Staff Questionnaire**

- **An Audit of Health Records**

- **A Checklist of organisational procedures and policies**

A summary of the results from the self review will be sent to the team following the end of the self review period, and will inform discussions at the visit by the peer review team.
Diagram Showing Developmental Review Cycle
(for example purposes only)

<table>
<thead>
<tr>
<th>Year</th>
<th>Month</th>
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<th>OPTION 2 Review process (one year development)</th>
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<td>Focussed Peer Review</td>
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<td>Peer Review report</td>
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Table 1: Developmental Review Cycle
Phase 2: Peer Review Visit by an External Team

The purpose of the one-day visit by a peer review team is to validate the self review findings and to provide a valuable opportunity for discussion, and for the review team members to share ideas, make suggestions, offer advice and give support.

The peer review visit will be scheduled for four to eight weeks after the self review data have been returned. Staff from other services participating in HTAS will be invited to act as members of peer review teams, and the team will typically consist of four members:

- Two professionals
- One member of the HTAS project team
- One service user or carer

If not all members of the peer review team arrive on the day, it may still be possible for the review to go ahead; this should be discussed with the HTAS Team. The team will have undergone specific training at the Royal College of Psychiatrists’ Centre for Quality Improvement.

The peer review visit includes interviews between the review team and staff in the home treatment team, service users and carers of the home treatment team and in some cases, colleagues from local inpatient and community mental health teams.

Only one peer review visit will normally be made to the team during each year of developmental review. If a further visit is required because it is identified that the team poses a threat to patient/staff safety, the re-visit will be charged at the rate of £600 +VAT per day.

Review visits which are cancelled by the host team will also incur a charge of £600 +VAT per day. Review visits which are cancelled by the HTAS Project Team, or for reasons beyond the control of the host team, will not incur a charge.

Two further data collection tools are used at peer review visits:

- Peer Review Carer Meeting Questionnaire (PRCM)
- Peer Review Service User Meeting Questionnaire (PRSUM)
Focussed Peer Review Visit - year 1

The focussed peer review visit takes place during the first year of developmental review, and is designed to help the team being reviewed (host team) discuss with peers and service users/carers:

- Their areas of achievement;
- Any areas they would like to improve;
- Key information about the running of the home treatment team and its local context.

The visiting team (review team) can help the hosts to identify areas to work on, and suggest ways to go about this, based on their own experiences.

The focussed peer review visit includes:

- Sharing of hosts’ and review team members’ service strengths and weaknesses;
- Review team members interviewing host team staff:
  * A discussion of key standards and associated self review data relating to the work of the home treatment team;
  * A discussion of the host team’s identified Open Discussion Topic: an area the host team would like to improve upon. The review team can offer support and advice based on their own experience;
- Review team members interviewing service users and carers who have used the service, using the PRSUM and PRCM tools;
- Feedback including of Areas of Achievement and Areas for Improvement.

Following on from the peer review day, the host team is provided with a peer review report containing their self review and peer review findings, and feedback from the review team.

The host team is encouraged to create an action plan addressing the Areas for Improvement, and to begin implementing changes to address these areas.

If the host team and the HTAS Project Team believe that the team is ready, the team may progress straight to accreditation the following year (see HTAS Accreditation Process). If not, the team may participate in a second year of developmental review, with a full peer review visit (see below).
Full Peer Review Visit – year 2 (optional)

If a team participates in the optional second year of developmental review, they will undertake a self review again, followed by a full peer review visit.

The full peer review visit has the same format as an accreditation review. It includes:

- Assessing the host team’s performance against the full set of standards
- Discussion of areas of achievement and areas for improvement

The full peer review visit includes:

- The host team introduces their service to the review team
- Review team members interview host team staff
  - Discussion of the self review Checklist
  - Discussion of the self review Health Record Audit
  - Discussion of the self review Staff Feedback
- Review team members interview service users and carers who have used the service, using the PRSUM and PRCM tools
- Review team members interview staff from inpatient and community mental health services, to discuss how the home treatment team effectively liaises with other services
- Review team rates each standard as Met or Not Met
- Feedback including of Areas of Achievement and Areas for Improvement

Following on from the peer review day, the host team is provided with a peer review report containing their self review and peer review findings, and their feedback.

The host team is encouraged to create an action plan addressing the Areas for Improvement, and to begin implementing changes to address these areas.

After the second year of developmental review, teams progress to an accreditation review in the following year (see HTAS Accreditation Process).
Activities and Support between Reviews

Standards Revision

HTAS undertakes a regular revision and update of standards to take account of new developments. Once the updated standards have been published, all member teams will be informed.

Peer Review Opportunities

As part of HTAS membership, staff members are invited to visit other home treatment teams as part of a peer review team. This enables the team being reviewed and the visiting team to share experiences, advice and good practice. Peer reviewers usually find the process a valuable learning experience and appreciate the opportunity to share ideas with teams outside their local area. It can be particularly useful to visit another team in advance of your own review.

In order to become a peer reviewer, trainees attend a one-day peer reviewer training day. Training days are held several times a year in various locations. Member services are required to put staff forward for training as part of their membership agreement.

HTAS Annual Forum

Each year HTAS organises a conference for members, including:
- Talks from keynote speakers in the field of crisis resolution and home treatment
- Presentations from member teams about innovations and examples of good practice in their teams
- Presentations from a service user perspective
- An update from the HTAS project team

Members receive free places to attend the conference, and paid places are reasonably priced.

Email Discussion Group

Throughout the period of accreditation, team staff will have access to advice and support from the Royal College of Psychiatrists and their peers through our email discussion group. Any member of staff from a member team can join the group by emailing HTASCHAT@rcpsych.ac.uk with the word ‘join’ in the subject line.

The College Website

HTAS member teams and their participation status will be listed on the Royal College of Psychiatrists’ website – www.rcpsych.ac.uk/HTAS.
How to Join HTAS

In order to join HTAS, teams complete:

- HTAS joining form – including contact and invoicing details. Please provide a purchase order number for invoicing if possible.

After completing this form, you will be contacted by the HTAS project team to agree a time to begin your self review period. As soon as your team is a member of HTAS, you may take advantage of all benefits of the network such as our Annual Forum, peer reviewing opportunities and the email discussion group.
Contact the HTAS Project Team

Nicky Buley
HTAS Project Worker
Tel: 020 3701 2653
Email: nicky.buley@rcpsych.ac.uk

Emma Copland
HTAS Deputy Programme Manager
Tel: 020 3701 2656
Email: emma.copland@rcpsych.ac.uk

Sophie Hodge
HTAS Programme Manager
Tel: 020 3701 2655
Email: sophie.hodge@rcpsych.ac.uk

Home Treatment Accreditation Scheme (HTAS)
Royal College of Psychiatrists’ Centre for Quality Improvement
21 Prescot Street
London
E1 8BB

HTAS@rcpsych.ac.uk
www.rcpsych.ac.uk/htas