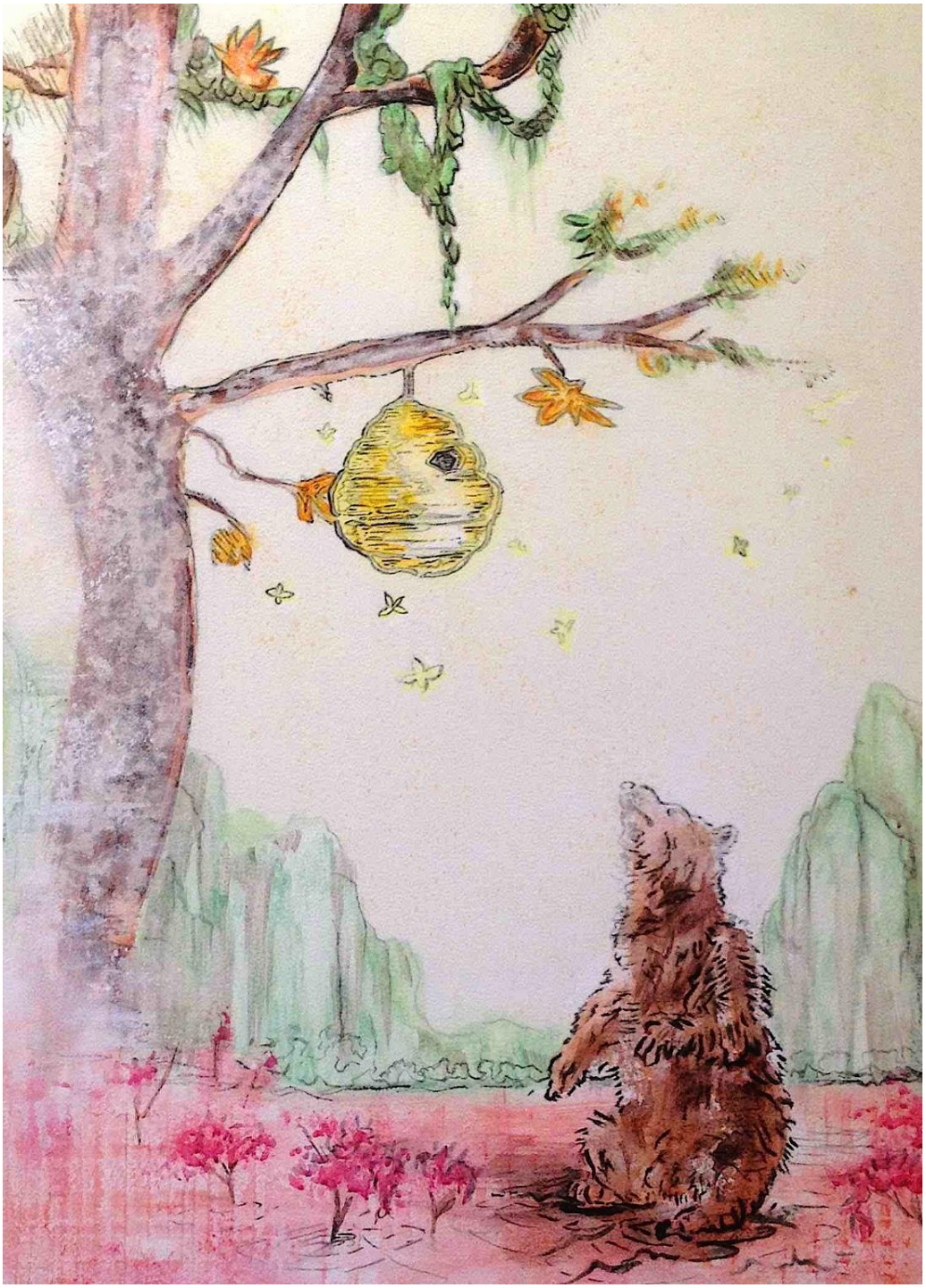
HTAS
HOME TREATMENT
ACCREDITATION SCHEME
CCQI

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS



Home Treatment Accreditation Scheme

National Report 2020

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Detail from hospital Rooms Phoenix Unit project,

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Courtesy of the artist and Hospital Rooms

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PREFACE/FOREWORD

There have been significant developments since the Home Treatment Team Accreditation Scheme (HTAS) was established in 2012 and the first national report publication in 2015.

The crisis resolution and home treatment teams (CRHTTs) in the mental health acute pathway have been developing and focusing on the core work of providing quality treatment for people in crisis at their home.

The models and configuration of CRHTTs vary widely; however, the HTAS network and peer-review process ensure accredited teams have a good model of care and evidence of good practice. The evidence base suggests that good quality and higher specification services may reduce the need for inpatient admissions, provide a better experience overall for people in crisis and support retention of links with community and life skills. Crisis resolution and home treatment services that work faithfully to a model which incorporates gatekeeping and adhere to fidelity of crisis resolution and home treatment provision have been associated with reduced admission rates with an associated reduction in costs.

From the last report in 2015, membership to HTAS has grown from 26 teams to over 56 teams. The standards set by the HTAS have continued to undergo adaptions to ensure up to date areas of practice are at the forefront of crisis resolution and home treatment. The HTAS network has provided a national platform for sharing ideas and learning by way of special interest days, annual forums the peer-review visits and the email discussion forum, HTAS-CHAT.

Challenges remain in some teams, especially in relation to staffing levels, training and potentially high caseloads. This report expands on these issues and we hope you will find it useful.

Finally, I would like to acknowledge and thank the peer-reviewers, patient and carer representatives and the HTAS project team for contributing to the quality improvements in the CRHTTs.

Dr Pranveer Singh

Consultant Psychiatrist and Chair of the HTAS Advisory Group, Essex Partnership University NHS Foundation Trust

INTRODUCTION

Since the first national report there has been a number of key developments related to crisis resolution and home treatment teams that have informed both the development of HTAS standards and service delivery of crisis resolution and home treatment teams (CRHTTs). Reports have described how difficult it is for people to get access to help when they need it during a mental health crisis (National Audit Office. Mental Health Services: preparations for Improving Access. London. Department of Health and NHS England; 2016). In its thematic review of crisis care, Right Here, Right Now, the CQC found that only 14% of people surveyed felt they were provided with the right response when in crisis, and not even half of all areas were able to offer a 24/7 response for people experiencing a mental health crisis.

The improving acute inpatient psychiatric care for adults in England, interim report 2015, emphasized the need to ensure CRHTTs are adequately resourced to offer intensive crisis resolution and home treatment as an alternative to an acute inpatient admission.

The National Confidential Inquiry into Suicide and Safety in Mental Health (2016) noted the numbers of suicides under CRHTTs increased over the report period. Recent estimates indicate that there are now around two to three times as many service user suicides under CRHTTs. This highlights the importance of reducing suicide in this setting. CRHTTs are now a priority area for suicide prevention work.

Much of the pressure on beds can be attributed to insufficient support in the community and a lack of alternatives to hospital (The Commission on Acute Adult Psychiatric Care 2015). The UCL CORE study examined the operation of 75 CRHTTs across England and found that there was not a single area where the average performance across teams scored 'good' in relation to best practice. Performance was poorest in relation to being able to respond quickly to referrals and offer frequent visits. In 2014/15 the number of contacts CRHTTs had with service users fell by 6% (Health and Social Care Information Centre 2015b).

The current NHS five year forward view recommends expansion of CRHTTs across England to ensure that: A 24/7 community-based mental health crisis response is available in all areas, these teams are adequately resourced to offer intensive crisis resolution and home treatment as an alternative to an acute inpatient admission.

The COVID-19 pandemic has presented unprecedented challenges for CRHTTs. Services have had to make adaptions to their ways of working to enable qualitative response and management of risks whilst protecting their own health. During such times, HTAS has been instrumental in providing guidance by way of webinars and by publishing best practice principles to support service delivery.

The Home Treatment Accreditation Scheme (HTAS) was established in 2012 to support the quality improvement of crisis resolution and home treatment teams in the UK. It is one of over 20 networks within the College Centre for Quality Improvement (CCQI) within the Royal College of Psychiatrists.

The Review Process

Teams undertake a period of self-review and data collection, where they assess their procedures, policies and practices against the HTAS standards. Data is also collected from the following sources:

- Staff questionnaire
- Patient questionnaire
- Friends, family and carer questionnaire
- Health record audit.

The self-review data is then collated and validated during a one-day peer-review visit. The peer-review team includes a member of the HTAS team, colleagues from other crisis resolution and home treatment teams in the UK and a service user or carer representative.

The findings from the review process are then collated into a report. Teams seeking accreditation are presented to our accreditation committee for review. You can find the details of the Accreditation Committee in Appendix 3. To be awarded accreditation, teams must meet 100% of type 1 standards, 80% of type 2 standards and 60% of type 3 standards.

Teams can also choose to undertake a developmental review process, which allows them to join the network and be involved in quality improvement before going through the accreditation process in a later year.

HTAS AIMS

HTAS aims to ensure that people who experience mental health crises and their family/carers receive high quality care from their crisis resolution/home treatment team, with fair access for all. We recommend that crisis resolution and home treatment teams might achieve this by following some of our core principles:

- People experiencing a mental health crisis should receive timely care in the least restrictive environment suitable for them.
- Pharmacological and bio-psycho-social treatments should be considered equally.
- People experiencing a mental health crisis and their families or carers should be supported to be involved in making decisions about their care as fully as possible.
- Families or carers of those experiencing a mental health crisis should be supported appropriately in their own right, and involved with their loved one's care as much as possible.
- Nobody should be admitted to an inpatient mental health ward without the knowledge of the home treatment team.
- The home treatment team should work with staff from inpatient mental health wards to ensure that people are discharged from the ward as soon as clinically possible.
- Home treatment team staff should be appropriately trained and supported to carry out their jobs competently, safely, and with regard to their wellbeing as practitioners.
- Care from the home treatment team should be available to all regardless of age, disability, sex, gender reassignment, marital status, maternity, ethnicity, religion or sexual orientation, and the team should reach out to underrepresented groups.
- The home treatment team should have good links with other mental health and physical health services, and social care.

There were 28 crisis resolution and home treatment teams in England who were reviewed against the 3rd edition of HTAS standards and received a peer-review visit between November 2018 and February 2020. Of these 28, 26 peer-review visits were accreditation reviews and two, developmental.

The data in this report is based on the findings from the team's report following their peer-review visit and not the final report after being presented at the Accreditation Committee.

This report begins with an executive summary, followed by the full review findings, including recommendations against each section of the HTAS standards. Findings from this have been compared to findings from the first HTAS national report, published in 2015. You can find the previous report on our website. https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/htas/htas-publications-and-links

Throughout this report, you will find 'jargon busters'. These are to help ensure everyone can read this report and fully understand the language used.

JARGON BUSTER

Crisis resolution and home treatment teams

Some teams are named as 'crisis resolution', others as 'home treatment', and some as a 'crisis resolution and home treatment team'. These teams all treat people with severe mental health problems outside hospital - in their own homes or in suitable residential facilities.

Service users

Also known as patients. People who are under the care of the team and receive treatment.

Carer

Also described as a friend or family member. A person who looks after a person with mental health problems. In this document the term usually refers to an informal carer, e.g. a relative or friend.

Developmental Review-Process

This is an in-depth look into a service, to support on-going improvement, who may not meet the required standards to achieve accreditation.

EXECUTIVE SUMMARY

On average, teams met 90% of the 3rd edition of HTAS standards following the team's peer-review visit.

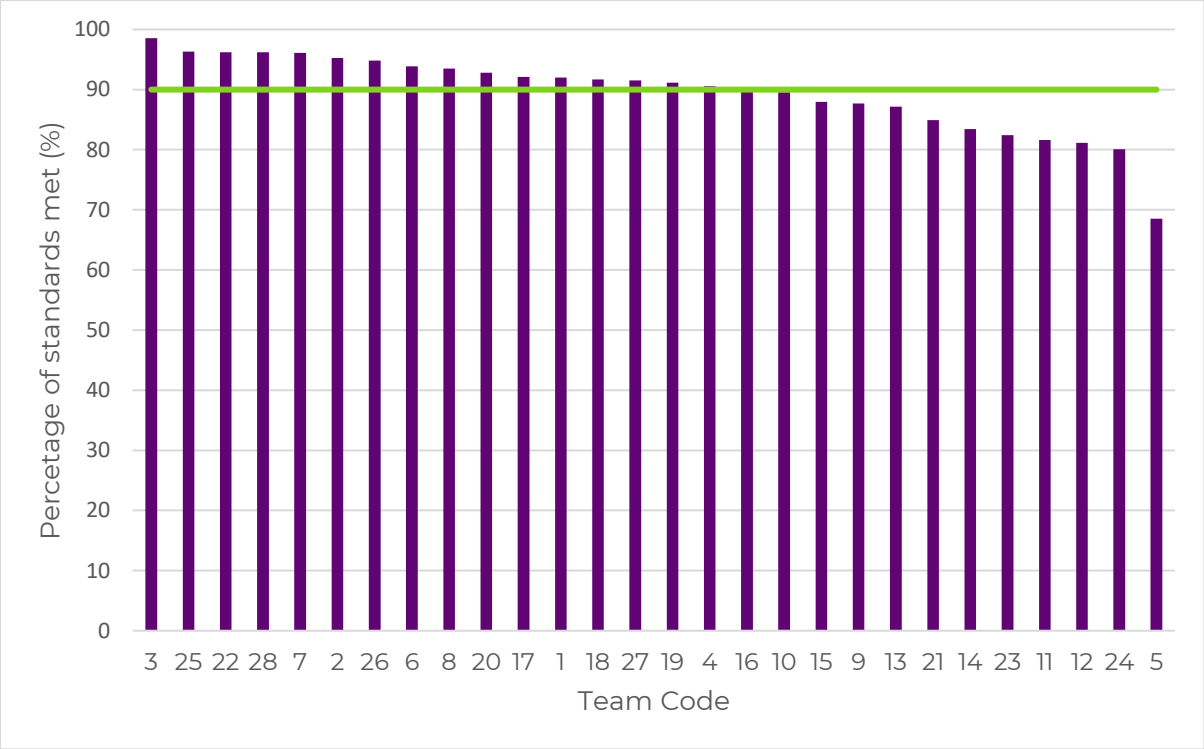


Figure 1. The overall percentage of standards met by each team following the peer-review visit. The green line shows the average percentage of standards met.

Type 1 standards

Type 1 standards are defined as: Failure to meet these standards would result in a significant threat to service user safety, rights or dignity and/or would breach the law. These standards also include the fundamentals of care, including the provision of evidence based care and treatment.

On average, teams met 92% of type 1 standards.

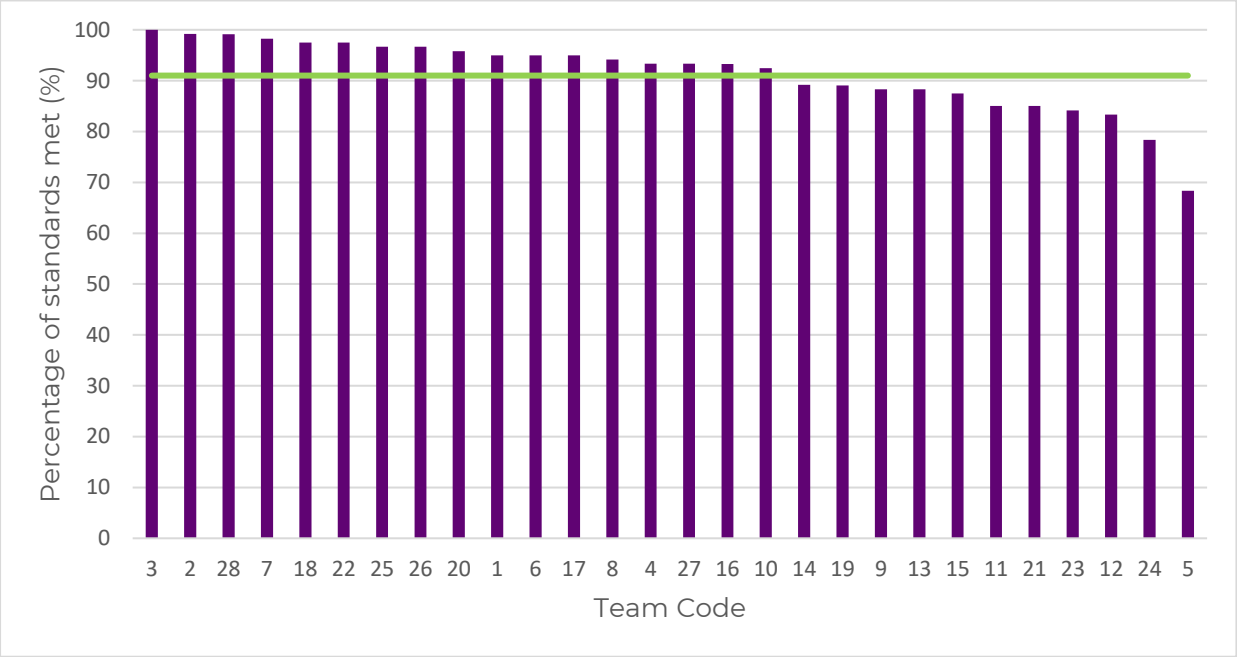


Figure 2. Percentage of type 1 standards met by each team following the peer-review visit. The green line shows the average percentage of standards met.

Type 2 standards

Type 2 standards are defined as: standards that an accredited team would be expected to meet.

On average, teams met 88% of type 2 standards.

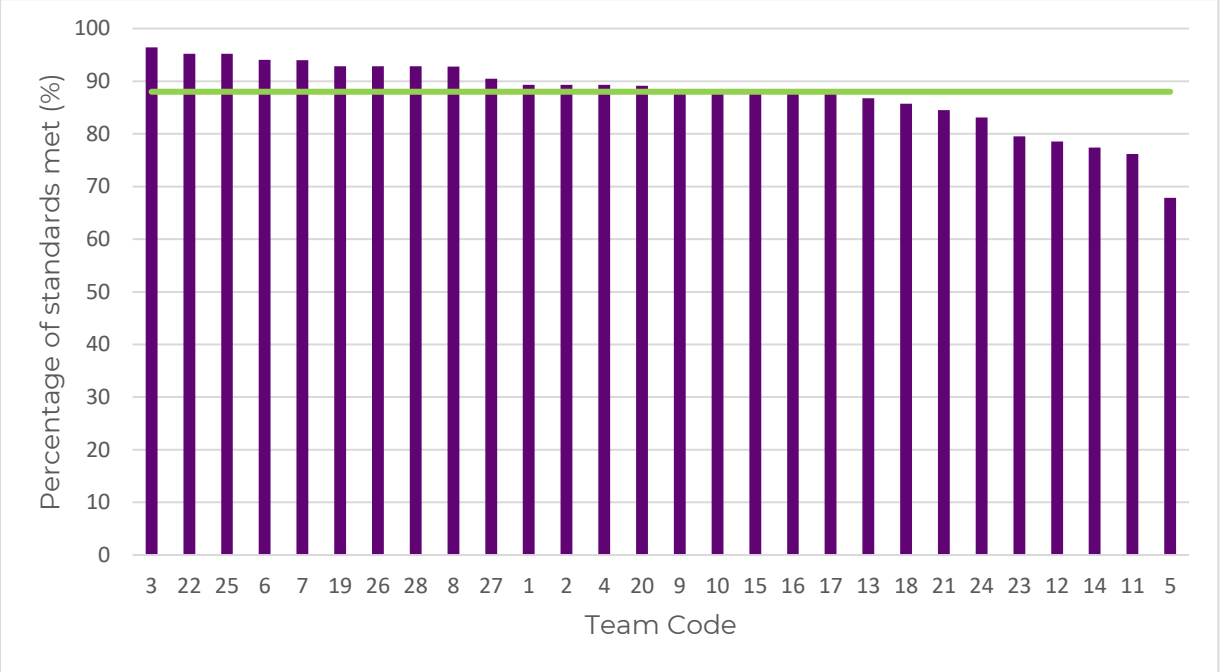


Figure 3. Percentage of type 2 standards met by each team following the peer-review visit. The green line shows the average percentage of standards met.

Type 3 standards

Type 3 standards are defined as: standards that are aspirational, or standards that are not the direct responsibility of the team.

On average teams met 82% of type 3 standards.

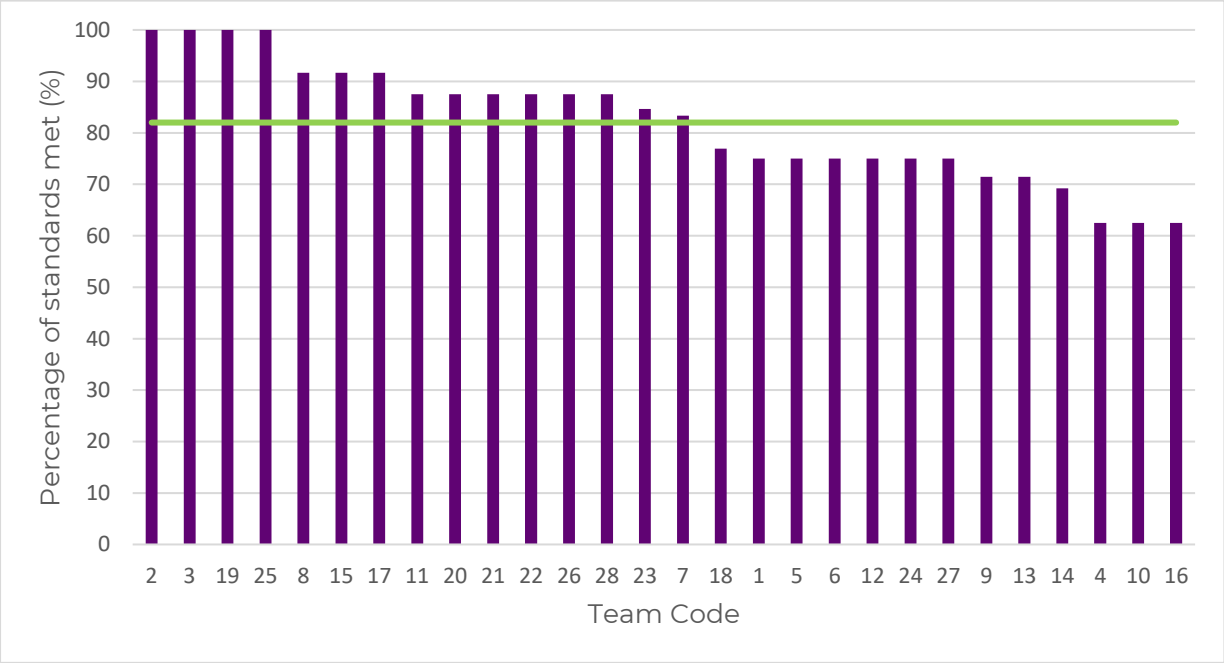


Figure 4. Percentage of type 3 standards met by each team following the peer-review visit. The green line shows the average percentage of standards met.

Teams had a mean caseload of 33 service users, ranging between 12 and 52. The mode was 25 and the median, 28. Please note, some teams operate under different models adapted to local services and have "hubs", thus they submitted higher caseloads and staffing.

The mean number of staff members (in whole numbers) in each team was 31, ranging between 18 and 50 staff members. The mode was 23 staff members, and the median, 29.5.

All 28 teams had nurses, support workers and administrators within their multi-disciplinary team (MDT). Most teams included psychiatrists and social workers. Around two thirds of teams had occupational therapists, psychologists, and nurse prescribers. Just over half of teams had pharmacists. However, the majority of teams, 89%, did not have peer support workers.

Table 1 shows a comparison of data from the 3rd edition of standards with the first HTAS national report, 2015. The data indicates that caseloads have increased along with staffing. The average number of service users seen within the last two weeks has not significantly increased, however the average time between referral and first assessment has doubled. NHS England guides on CRHTTs do not stipulate a response time, hence the duration between referral and first assessment is unlikely to be uniform in all services. Over the past few years CRHTTs have been subject to national focus, inviting wider accessibility and broadening acceptance criteria, such as self-referrals. Other NHS services such as ambulance, primary care and triage services have also had direct referral lines to CRHTTs, making these services more accessible.

JARGON BUSTER

Caseload

This is the number of service users receiving crisis resolution and home treatment.

Peer support worker

A service user or carer employed by the team to support other service users and/or carers.

Dedicated sessional time

An agreement that a member of staff works a certain number of hours per week for the team. This should be written into their job description. A session is half a working day.

Multi-disciplinary team (MDT)

A team made up of staff from different professions.

	2015 n = 19 *n = 18	2018 - 2020 n = 28
	Mean	**Mean**
Caseload	26	33
Number of service users seen within last 2 weeks *	35	37
Average time period between referral and first assessment	7 hours	18 hours
Number of staff working in the team	27	31

Table 1: Mean of crisis resolution and home treatment teams' contextual information from 2015 and 2020 rounded to the nearest whole number.

Staffing breakdown

This data is from the team's self-review.

Less than half of teams had dedicated sessional time from an occupational therapist in our 2015 report, compared to 68% of teams in 2018-2020 who had dedicated session time from an occupational therapist in 2018-2020.

In 2015, 37% of teams had dedicated sessional time from a pharmacist, this has increased to 61% of teams in 2018-2020. 47% of teams in 2015 had dedicated sessional time from a nurse prescriber which increased to 68% in 2018-2020.

In 2015, 100% of teams received dedicated sessional time from registered nurses and psychiatrists. 100% of teams reviewed against the third edition of HTAS standards included nurses, however 96% of teams included a psychiatrist.

In addition, one team received dedicated sessional time from a peer support worker in 2015, which increased to three in 2018-2020, although, a higher number of teams were reviewed against this edition of standards. This does not reflect how many have access to peer support workers for example, through the Trust.

Profession	Percentage of teams receiving sessional time (2015)*	Change	Percentage of teams receiving sessional time (2018-2020)**
Occupational therapist	42%	↑	68%
Pharmacist	37%	↑	61%
Nurse Practitioner	47%	↑	68%
Support Worker	84%	↑	100%
Psychologist	58%	↑	71%
Administrator	90%	↑	100%
Peer Support Worker	5%	↑	11%
Registered Nurse	100%	⇄	100%
Psychiatrist	100%	↓	96%
Social Worker	95%	↓	82%

Table 2. Percentage of teams who reported they had dedicated sessional time from each profession between 2015 and 2018-2020.
* Based on 19 teams
** Based on 28 teams.

SECTION 1: SERVICE PROVISION AND STRUCTURE

On average, teams met 50 of 55 standards in this section (92%).

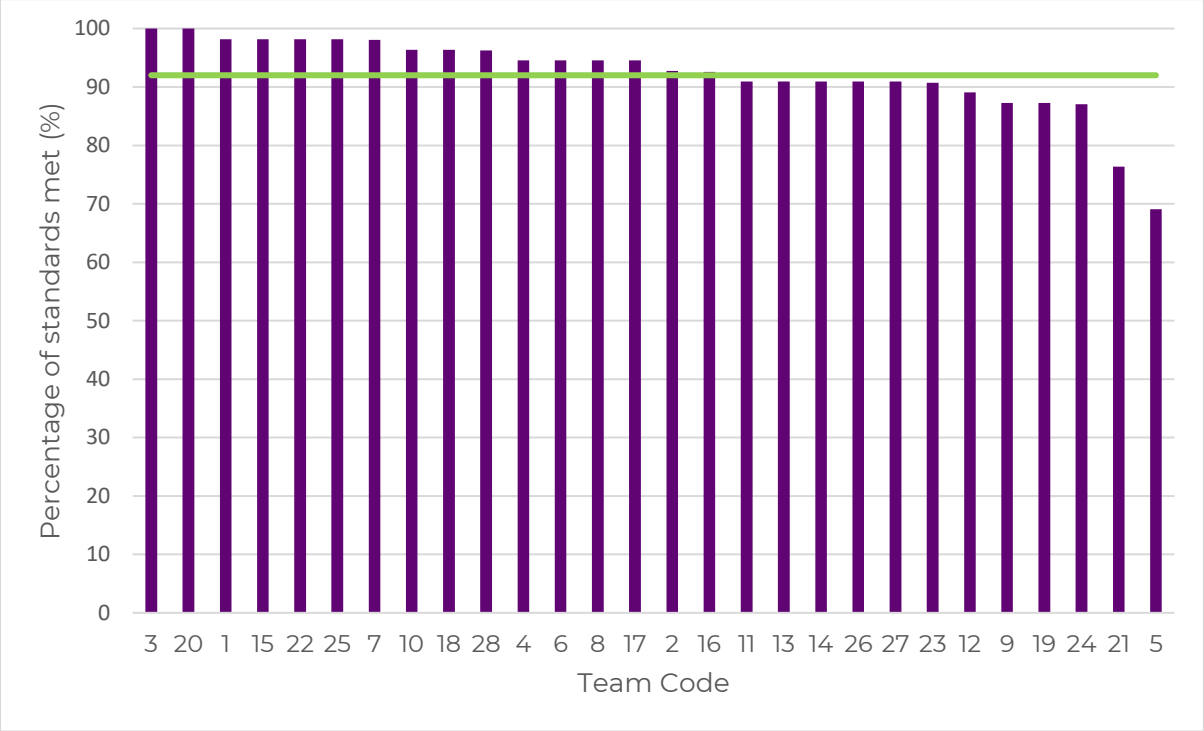


Figure 5. Percentage of standards in section 1 met by each team.

65% of service users reported in the self-review survey they were informed on how to access advocacy services.

Thank you for supporting me.

56% of service users reported in the self-review survey they were given information on how to raise concerns, complaints and compliments.

I am alive because they have visited and helped me.

Extremely grateful for the team and this service. The visits have given be hope each day.

I found visiting the team invaluable, they were patient, understanding and encouraging.

Key findings

It was found that for all teams, service users were able to access specialist help from drug and alcohol services.

In all teams, staff would arrange for users to access screening, monitoring and treatment for physical health problems and include this in service users' care plans.

All teams had the capacity to conduct two home visits over a 24-hour period.

Most teams continuously audit service provision and outcomes, including feedback from service users and their families/carers.

Around two thirds of teams, were responsible for gatekeeping all acute inpatient beds via face-to-face contact.

Just over half of teams, collected data on the safe prescription of high-risk medications.

One of the most commonly not met type 3 standards in this section was service users and their families/carer being involved in service planning and development on an annual basis. 61% of teams reported this takes place.

JARGON BUSTER

Gatekeeping

Where a crisis resolution and home treatment team provides a face-to-face assessment to anyone at risk of admission to a psychiatric ward, to ensure they are treated in the least restrictive environment possible. Crisis resolution and home treatment is provided as an alternative to hospital admission.

High-risk medicines

Medications that, at therapeutic doses can cause significant side effects.

SECTION 2: STAFF, APPRAISAL, SUPERVISION AND TRAINING

On average teams met 43 of 52 standards in this section (83%).

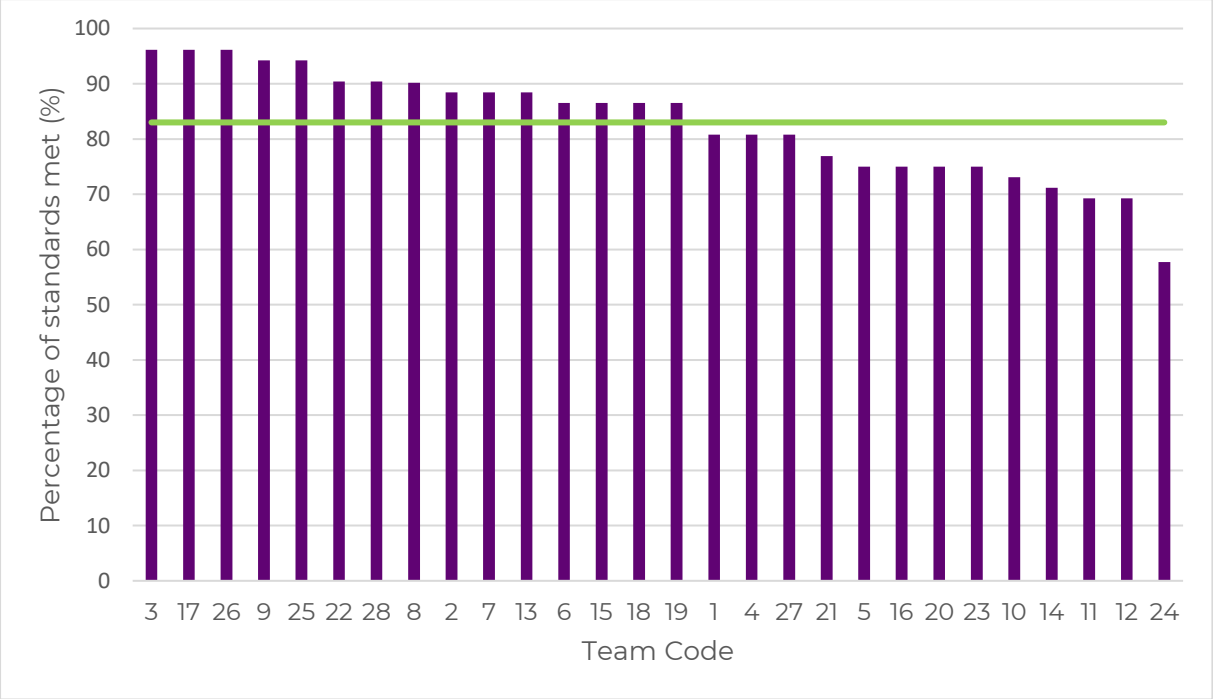


Figure 6. Percentage of standards met in section 2 by each team.

58% of staff reported in the self-review survey that service users and carers are involved in delivering training to the team.

86% of staff reported in the self-review survey, they had received training in carer awareness, family inclusive practice and social systems.

71% of teams reported in the self-review process they had service users and/or carer representatives involved in the interview process for recruiting staff members.

25% of teams reported they had access to peer support workers.

Key findings

It was found in all teams that managers promote positive risk-taking to encourage service users' recovery and personal development.

Around two thirds of teams had access to reflective practice groups at least every six weeks to think about team dynamics and develop clinical practice.

In just over half of teams, staff had received training in basic counselling skills. This is compared to around three quarters of staff (not including managers) in 2015.

Half of teams reported staff receive individual line management supervision on a monthly basis and around two thirds of staff received clinical supervision on an individual basis, monthly.

JARGON BUSTER

Reflective practice

A forum between colleagues to study and evaluate the way one works with the aim of improving.

Clinical Supervision

A process whereby a manager meets regularly with staff to review their work (Skills for Care, 2020). Thus, clinical supervision refers to this process within the context of healthcare, with staff who work directly with service users.

Line Management

A process that provides an opportunity for staff to evaluate their performance, set objectives that align with the organisation's objectives and needs of the service, and identify areas for further training and development. It is carried out by a supervisor with authority and responsibility for the supervisee (Care Quality Commission [CQC], 2013).

SECTION 3: ASSESSMENT, CARE PLANNING AND TRANSFER OR DISCHARGE

On average teams met 46 of 49 standards in this section (95%).

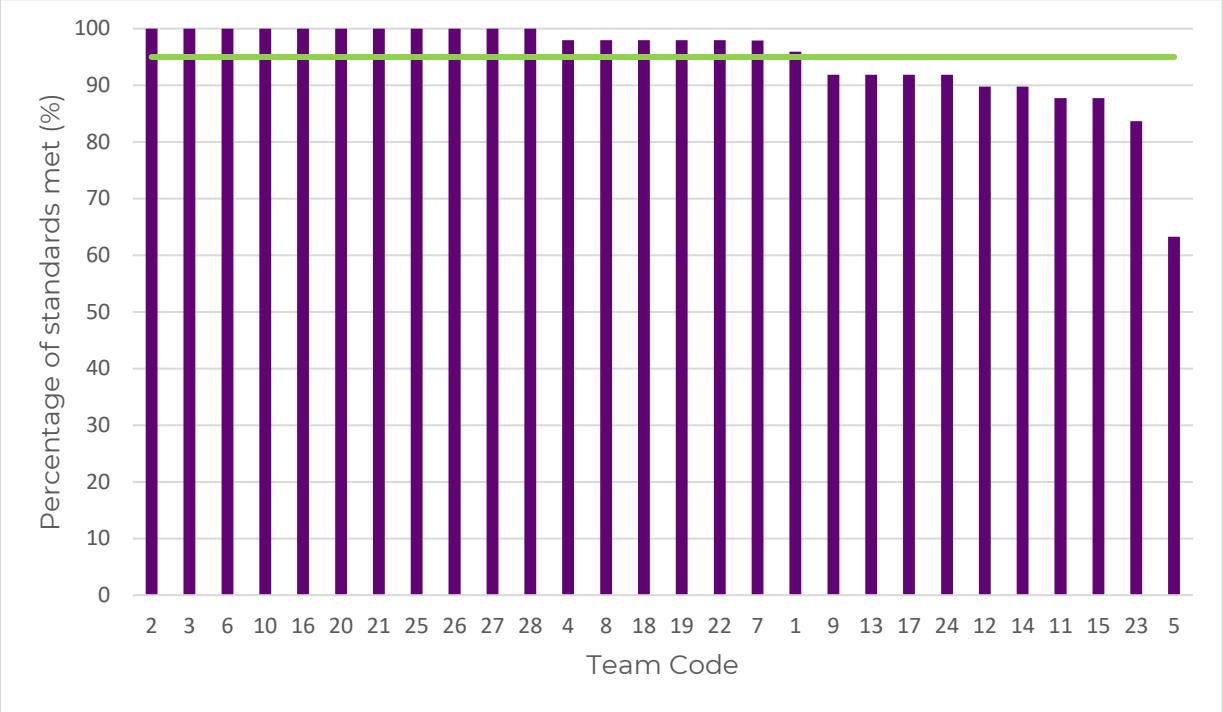


Figure 7. Percentage of standards in section 3 met by each team.

68 % of teams met standard 6.2.1 “service users and carers reported they were offered a copy of their care plan and had the opportunity to review this” following the peer-review visit.

94% of service users responded yes in the self-review survey, when asked “have you been involved in decisions about your care and treatment?”

44% of service users reported in the self-review survey they were provided with a copy of their care plan.

> *I wrote my care plans with the nurse that visited me most.*

Key Findings

All teams worked within the Care Programme Approach (CPA) framework or equivalent.

In nearly all teams, service users were actively involved in shared decision making about their care and treatment.

Around three quarters of teams offer a Wellness Recovery Action Plan, My Crisis Plan or similar, to all service users.

In over three quarters of teams, service user's consent to the sharing of clinical information outside the team was recorded.

In around a third of teams, service users and family/carers reported they were not offered a copy of the care plan with the opportunity to review it.

JARGON BUSTER

Care Programme Approach (CPA)

A way of coordinating care for people with mental health problems and/or a range of different needs.

Wellness Recovery Action Plan

Designed with the service user, stating everyday activities they can do to keep well, and triggers or warning signs that they are becoming unwell.

Carer Representative

A person who looks after a person with mental health problems, who has been with working the local team and supports in delivering training.

Co-Produce

Ongoing partnership between people who design, deliver and commission services, people who use the services and people who need them.

SECTION 4: INTERVENTION

On average teams met 50 of 61 standards in this section (89%).

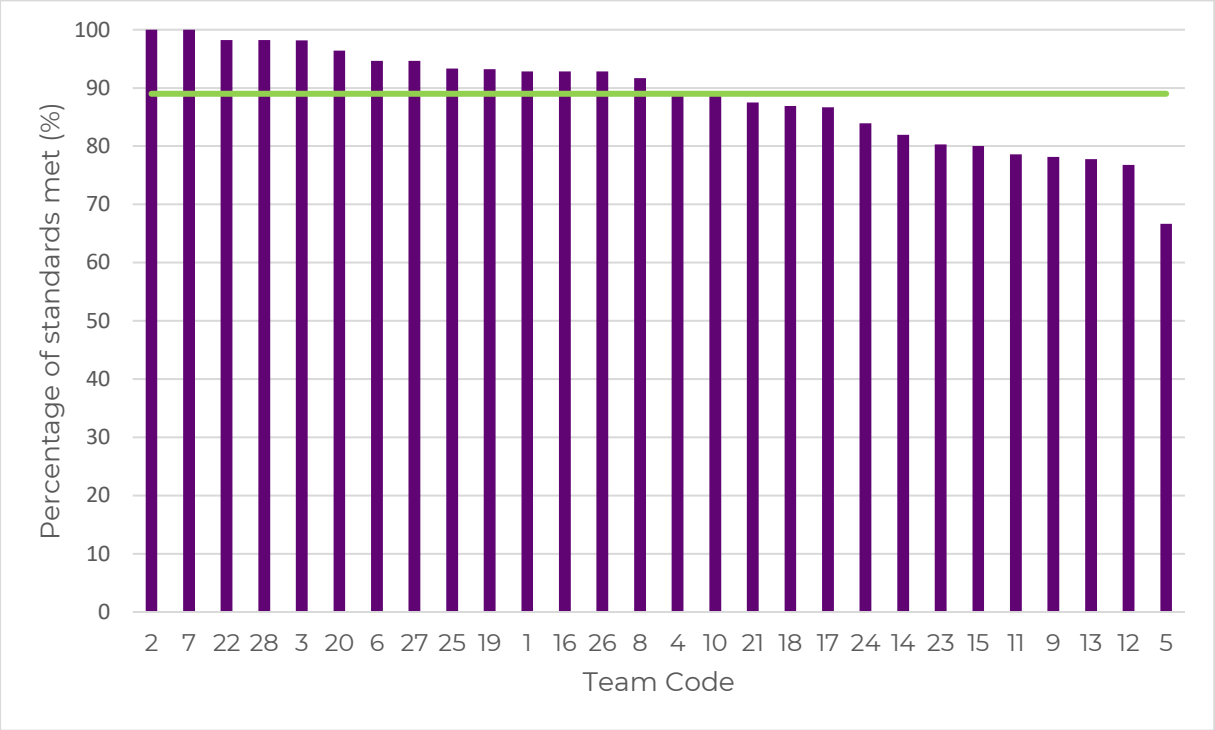


Figure 8. Percentage of standards in section 4 met by each team.

83% of service users responded "yes" in the self-review survey when asked if they were asked where they would like to meet for their assessment.

"The home visit team are an essential body of people who help in so many ways, not only to the patient but also the carer."

"Thank you for supporting me."

"I am alive because they have visited and helped me."

"I feel included and supported by the team at all times."

63% of carers reported in the self-review survey, they were offered individual time with staff members.

Key findings

In all teams, service users and carers reported staff treated them with compassion, dignity and respect.

Nearly all teams provided service users and their families/carers with a number they can call for help, 24 hours a day.

In around two thirds of teams, service users reported they knew who was overseeing their care and how to contact them, similar to the findings in the 2015 report.

Just over half of teams advised carers how to access a statutory carers assessment and offered a referral to a carer support service.

A third of teams have access to a crisis house, which is similar to the findings in the report from 2015.

JARGON BUSTER

Statutory carers assessment

A way of coordinating care for people with mental health problems and/or a range of different needs.

Carer support service

A local service which may provide information, individual support and peer support for carers.

Crisis House

A non-hospital residential home for people experiencing an episode of severe mental ill health. Stays are short term and provide a break for family/carers.

Carers lead

A staff member within a team nominated to promote recognition of, and support for, carers.

REVIEW OF THE 2015 NATIONAL RECOMMENDATIONS

Different teams were reviewed in this 2018-2020 report to the 2015 report. The results below may be due to different services joining the network and undergoing a review process, along with standards being reviewed and developed to continue to support services in on-going quality improvement.

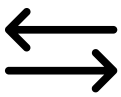
Training in carer awareness

In the report published in 2015, less than two thirds of staff (64%) had completed training in carer awareness, family inclusive practice and social systems in the crisis resolution and home treatment team. Ensuring that staff are adequately trained in carer awareness could be a first step in improving support for carers.

It was found in this report, that training had increased and staff had received training in carer awareness in 75% of teams.

Physical health reviews

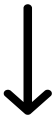
The first national report in 2015 reported "The case note audit data showed that physical health reviews had been completed for less than 90% of service users. It is important that a service user's physical health needs are met as well as their mental health needs."



In this report, 86% of teams had recorded a physical health review taking place.

Ensuring service users know who is responsible for their care

In 2015 it was found that "All team managers said that all service users had a dedicated named worker, however less than three quarters of service users and carers were aware of the person in the team who was responsible for their care. While it is not expected that a service user's named worker will attend every visit, it is important that they know who they are should they need to contact them."



In 68% of teams reviewed against the 3rd edition of HTAS standards, service users reported knowing who was overseeing their care.

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Please note: standard 7.5 is not included in the 4th edition of HTAS standards

MOST COMMONLY NOT MET TYPE 1 STANDARDS

Below are the five most commonly not met type 1 standards from the 3rd edition of HTAS standards.

12.22: All staff have received training in recognising and communicating with service users with special needs, e.g. cognitive impairment or learning disabilities.

12.3: All staff have received training in basic counselling skills.

Guidance: This could include, but is not limited to, CORE competency framework for CBT for depression and anxiety, Skills for Health competency framework for humanistic counselling or Gerard Egan's 'The Skilled Helper'.

23.8: Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency.

Guidance: This should be offered at the time of the service user's initial assessment, or at the first opportunity.

7.5: The service collects data on the safe prescription of high-risk medications such as: lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines. The service uses these data to make improvements and continues to monitor the safe prescription of these medications on an ongoing basis.

11.2: All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body.

Guidance: Supervision should be profession-specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications.

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Please note: standard 7.5 is not included in the 4th edition of HTAS standards

RECOMMENDATIONS

The following recommendations are made for crisis resolution and home treatment teams based on the most commonly not met type 1 standards:

- A recurring theme on the peer-review visits is that there is a scope to improve on training in recognising and communicating with people with special needs including learning disabilities and cognitive impairments. Staff should be trained to have full awareness as set out in the Mental Health Problems in People with Learning Disabilities NICE guidelines.
- Training for identifying needs, enabling the right care for people with cognitive impairments is widely available as outlined in NICE guidelines for assessment, management and support for people living with dementia and their carers.
- Basic counselling skills should be included as part of new staff members induction into the team.
- Training should be repeated regularly to account for staff changes, and to refresh staff knowledge.
- All staff should be able to access clinical supervision on a monthly basis. Supervision should also be recorded and be provided on an individual basis.
- During times of service developments, teams should monitor changes to teams and ensure systems are based on the sound research evidence related to CRHTTs.
- Services should offer service users and their family members/carers, with service user permission, copies of the care plans with an opportunity to involve in care planning. This is then recorded in service user care notes.
- The report notes increase in caseloads and reduction of staffing in some teams. It is recommended that CRHTTs consider implementing a system to ensure consistent staffing levels that are able to provide care as set out in the HTAS standards.
- Teams should have a carers' lead who could assist with the following:
    - Information on how to access a statutory carers assessment should be included in carer's information leaflets.
    - Having a carer representative deliver training and co-produce information that is provided to carers.
    - To embed service users and carers involvement in organisation and development of the CRHTT.

APPENDIX 1: TEAM BREAKDOWN

Below is a full breakdown of the standards met by each team.

	Percentage met overall	Percentage standards in section 1 met	Percentage standards in section 2 met	Percentage standards in section 3 met	Percentage standards in section 4 met	Percentage type 1 standards met	Percentage type 2 standards met	Percentage type 3 standards met
1	92	98	81	96	93	95	89	
2	95	93	88	100	100	99	89	100
3	99	100	96	100	98	100	96	100
4	91	95	81	98	89	93	89	63
5	69	69	75	63	67	68	68	75
6	94	95	87	100	95	95	94	75
7	96	98	88	98	100	98	94	83
8	93	95	90	98	92	94	93	92
9	88	87	94	92	78	88	88	71
10	90	96	73	100	89	92	88	63
11	82	91	69	88	79	85	76	88
12	81	89	69	90	77	83	79	75
13	87	91	88	92	78	88	87	71
14	83	91	71	90	82	89	77	69
15	88	98	87	88	80	88	88	92
16	90	93	75	100	93	93	88	63
17	92	95	96	92	87	95	88	92

	Percentage met overall	Percentage standards in section 1 met	Percentage standards in section 2 met	Percentage standards in section 3 met	Percentage standards in section 4 met	Percentage type 1 standards met	Percentage type 2 standards met	Percentage type 3 standards met
18	92	96	87	98	87	98	86	77
19	91	87	87	98	93	89	93	100
20	93	100	75	100	96	96	89	88
21	85	76	77	100	88	85	85	88
22	96	98	90	98	98	98	95	88
23	82	91	75	84	80	84	80	85
24	80	87	58	92	84	78	83	75
25	96	98	94	100	93	97	95	100
26	95	91	96	100	93	97	93	88
27	92	91	81	100	95	93	90	75
28	96	96	90	100	98	99	93	88

APPENDIX 2: TEAM DETAILS

The teams are listed in alphabetical order, with the team name first followed by the trust/organisation.

Berkshire East Crisis Resolution and Home Treatment Team, Berkshire Healthcare NHS Foundation Trust

Bexley Home Treatment Team, Oxleas NHS Foundation Trust

Boston Crisis Resolution and Home Treatment Team, Lincolnshire Partnership NHS Foundation Trust

Bromley Crisis Resolution and Home Treatment Team, Oxleas NHS Foundation Trust

Cheltenham Crisis Resolution and Home Treatment Team, 2Gether NHS Foundation Trust

City and Hackney Home Treatment Team, East London NHS Foundation Trust

Croydon Home Treatment Team, South London and Maudsley NHS Foundation Trust

East Cornwall Home Treatment Team, Cornwall Partnership NHS Foundation Trust

East Crisis Resolution and Home Treatment Team (Rochford), South Essex Partnership University NHS Foundation Trust

Gloucester Crisis Resolution and Home Treatment Team, 2Gether NHS Foundation Trust

Grantham Crisis Resolution and Home Treatment Team, Lincolnshire Partnership NHS Foundation Trust

Hambleton and Richmond Crisis Resolution and Home Treatment Team, Tees, Esk and Wear Valleys NHS Foundation Trust

Isle of Wight Crisis Resolution and Home Treatment Team, Isle of Wight NHS Trust

Islington Crisis Resolution and Home Treatment Team, Camden and Islington NHS Foundation Trust

Newcastle and Gateshead Crisis Resolution and Home Treatment Team, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

North Camden Crisis Team, Camden and Islington NHS Foundation Trust

Oxleas Intensive Home Treatment Team for Older People, Oxleas NHS Foundation Trust

Redditch/Bromsgrove and Wyre Forest Home Treatment and Assessment Team, Worcestershire Health and Care NHS Trust

Scarborough, Whitby and Rydedale Crisis Resolution and Home Treatment Team, Tees, Esk and Wear Valleys NHS Foundation Trust

Sheffield City Wide Home Treatment Team, Sheffield Health and Social Care NHS Foundation Trust

Stroud and Cirencester Crisis Resolution and Home Treatment Team, 2Gether NHS Foundation Trust

Telford and Wrekin Crisis Resolution and Home Treatment Team, South Staffordshire and Shropshire Healthcare NHS Foundation Trust

Tower Hamlets Home Treatment Team, East London NHS Foundation Trust

West Cornwall Home Treatment Team, Cornwall Partnership NHS Foundation Trust

West Crisis Resolution and Home Treatment Team (Basildon), Essex Partnership University NHS Foundation Trust

West Hampshire Acute Mental Health Team, Southern Health NHS Foundation Trust

Worcester, Malvern and Wychavon Home Treatment Team, Worcestershire Health and Care NHS Trust

York Crisis Resolution and Home Treatment Team, Tees, Esk and Wear Valleys NHS Foundation Trust

APPENDIX 3: ADVISORY GROUP AND ACCREDITATION COMMITTEE

Advisory Group

Pranveer Singh, Consultant Psychiatrist and Chair of the HTAS Advisory Group, Essex Partnership University NHS Foundation Trust

Alice Murphy, Social Worker and AMHP, Camden and Islington NHS Foundation Trust

Bryn Lloyd-Evans, Senior Lecturer, University of College London

Georgina Mills, Senior Mental Health Nurse, South Essex Partnership University NHS Foundation Trust

Luke Sullivan, Senior Clinical Psychologist, South London and Maudsley NHS Foundation Trust

Sean Boyle, Lead Practitioner, Cheshire and Wirral Partnership NHS Foundation Trust

Kapil Bakshi, Deputy Medical Director and Consultant Psychiatrist, Norfolk and Suffolk NHS Foundation Trust

Janet Seale, Carer Representative, HTAS

Ingrid Baldwin, Carer Representative, HTAS

Accreditation Committee

Alex Kitromilides, Consultant Psychiatrist, Camden and Islington NHS Foundation Trust

Catherine Khorshidian, Consultant Clinical Psychologist, Worcestershire Health and Care NHS Trust

John Robinson, Patient Representative, HTAS, RCPsych

Kerry Turner, Clinical Team Leader and Chair of the HTAS AC, Essex Partnership University NHS Foundation Trust

Sally Brazier, Occupational Therapist Essex Partnership University NHS Foundation Trust

Darren Gargan, Nurse Consultant, Tees Esk and Wear Valleys NHS Foundation Trust

Dieneke Hubbeling, Consultant Psychiatrist, South West London and St George's NHS Mental Health Trust

Emmeline Lagunes-Cordoba, Specialty Doctor, Camden and Islington NHS Foundation Trust

Yvain Rumalean, Consultant Psychiatrist, Berkshire Healthcare NHS Foundation Trust

Grace Wood, Patient Representative, HTAS

John Robinson, Patient Representative, HTAS

No.	Type	Standard
SECTION 1: Service Provision and Structure		
Policies and protocols		
1.1	1	Clear information is made available, in paper and/or electronic format, to service users, family/carers and healthcare practitioners on: o A simple description of the service and its purpose; o Clear referral criteria; o How to make a referral, including self-referral if the service allows; o Clear clinical pathways describing access and discharge (and how to navigate them); o Main interventions and treatments available; o Contact details for the service, including emergency and out of hours details. **Guidance:** *This information is co-produced with service users*
1.2	1	Staff members follow a lone working policy and feel safe when conducting home visits.
1.3	1	Staff members follow inter-agency protocols for the safeguarding of vulnerable adults, and children. This includes escalating concerns if an inadequate response is received to a safeguarding referral.
1.4	1	Confidentiality and its limits are explained to the service user and their family/carer at the initial assessment, both verbally and in writing. **Guidance:** *This includes transfer of service user identifiable information by electronic means. This includes sharing information outside of the clinical team and confidentiality in relation to third party information (for family/carers)*
1.4.1	1	All service user information is kept in accordance with current legislation. **Guidance:** *This includes transfer of service user identifiable information by electronic means. Staff members ensure that no confidential data is visible beyond the team by locking cabinets and offices, using swipe cards and having password protected computer access*

1.4.2	1	Assessments of service users' capacity to consent to care and treatment are performed in accordance with current legislation.
1.5	1	Protocols are reviewed *at least* every 3 years.
1.6	1	The team understands and follows an agreed protocol for the management of an acute physical health emergency. **Guidance:** *This includes guidance about when to call 999*
1.7	1	The team follows a protocol to manage service users who discharge themselves against medical advice. This includes: Recording the service user's capacity to understand the risks of self-discharge; Putting a crisis plan in place; Contacting relevant agencies to notify them of the discharge; Following locally agreed protocols.
1.8	1	Systems are in place to enable staff members to quickly and effectively report incidents and managers encourage staff members to do this.
1.9	1	Staff members share information about any serious untoward incidents involving a service user with the service user themselves and their family/carer, in line with the Duty of Candour agreement.
1.10	1	Lessons learned from untoward incidents are shared with the team and the wider organisation. There is evidence that changes have been made as a result of sharing the lessons.
1.11	2	Services are developed in partnership with service user and family/carer representatives. **Guidance:** *This might involve service user and family/carer representatives attending and contributing to local and service level meetings and committees*
Access		
2.3	2	The acceptance criteria ensure that self-harm, substance misuse, dual diagnosis, learning disability or personality disorder are not barriers to appropriate team response.
2.5	2	The team is able to triage direct referrals from people who are experiencing a mental health crisis of a nature and degree that would otherwise necessitate hospital admission, and/or their families/carers.
2.6	1	The team is able to respond to requests for assessment from Accident & Emergency departments, mental health liaison teams and Single Point of Access services, or to signpost to appropriate assessment facilities.

Referral to other services		
3.1	2	The team is able to refer to child and family support services including child protection if necessary.
3.2	2	The team has protocols governing links with out-of-hours telephone response services, where applicable.
3.3	1	The team facilitates access to independent advocates to provide information, advice and support to service users, including assistance with advance statements.
3.6	1	Service users with drug and alcohol problems have access to specialist help e.g. Drug and alcohol services.
3.7	1	Staff members arrange for service users to access screening, monitoring and treatment for physical health problems through primary/secondary care services as appropriate. This is documented in the service user's care plan.
Equality and diversity		
4.1	1	The service has a local strategy in place to promote and monitor equality and diversity, prevent discrimination and to address any barriers to access.
4.3	1	Policies and procedures are assessed for equality impact *at least* every 3 years, to ensure equality of service.
4.5	1	24 hour access to interpreters who are sufficiently knowledgeable and skilled to provide a full and accurate translation is available. **Guidance:** *In exceptional circumstances, and after careful consideration, family members may act as translators. Particular consideration is given to any young carers fulfilling this role*
Initiating assessment		
5.1	1	The team has an agreed response time for accepting referrals, and the outcome is agreed with the referrer.
5.1.2	2	The team provides service users and family/carers with information about expected waiting times for assessment and treatment.

5.2	1	The home treatment team, or another specialist mental health service, is able to undertake assessment 24 hours a day, 7 days a week. If assessment is delegated to another service out-of-hours, the home treatment team is fully aware of those assessments, and monitors their quality.
5.3	1	The team has the capacity to allow for two home visits over a 24-hour period.
5.5	1	The team is able to conduct assessments in a variety of settings.
Liaison with other services		
6.2	1	The team works closely with acute inpatient care, including gatekeeping and facilitating early discharge. **Guidance:** *This can be achieved by operational policies, ward rounds, joint acute care reviews, supported leave arrangements, sharing the same base location, shared consultant responsibility or shared acute care workers*
6.3	1	There is a written acute care pathway which has been locally developed and agreed, that ensures continuity of care between services. **Guidance:** *This includes interactions with primary care, Accident & Emergency, community teams and inpatient care, psychiatric intensive care units and crisis beds*
6.5	1	The team gatekeeps all acute inpatient beds via face-to-face contact with service users.
6.7	2	If hospitalisation is required, the service user is informed of the reasons why home treatment was not appropriate, the purpose, aims and outcome of the admission, and their expected length of stay.
6.10	1	The service user and their family/carers are involved in discharge planning from acute inpatient services to the home treatment team.
6.11	2	The team offers home treatment on transfer from acute inpatient services within 24 hours of discharge, where clinically indicated.
6.11.1	1	The team considers the increased risk of suicide post-discharge from hospital and offers home treatment, or other forms of support, based on individual need.
6.12	2	The home treatment team is able to transfer care to a community mental health team as required.

6.13	2	Local information systems are capable of producing accurate and reliable data about delayed transfers from the home treatment team to the community mental health team, and action is taken to address any identified problems.
6.14	3	When service users are transferred between community services there is a meeting in which members of the two teams meet with the service user and their family/carer to discuss transfer of care.
6.14.1	1	When service users are transferred between community services there is a handover which ensures that the new team has an up to date care plan and risk assessment.
6.15	2	Representatives from the team regularly attend community mental health team meetings, or routinely meet to exchange information.
6.16	2	Health records can be easily accessed by other teams who may be involved with the service user's care during the episode. **Guidance:** *This could include psychiatric liaison teams, Accident & Emergency, acute inpatient wards and primary care*
6.17	1	The team follows a joint working protocol/care pathway with primary health care teams. **Guidance:** *This includes shared prescribing protocols with the GP, the team informing the GP of any significant changes in the service user's mental health or medication, or of their referral to other teams*
6.18	1	The service/organisation has a care pathway for the care of women in the perinatal period (pregnancy and 12 months post-partum) that includes: • Assessment; • Care and treatment (particularly relating to prescribing psychotropic medication); • Referral to a specialist perinatal team/unit unless there is a specific reason not to do so.
6.19	2	The service has a formal link with an advocacy service for use by service users.
6.20	1	There is active collaboration between Children and Young People's Mental Health Services and Working Age Adult Services for service users who are approaching the age for transfer between services.
Audit		

7.2	2	The team continuously audits service provision and outcomes, including feedback from service users and their families/carers.
7.3	2	Service users and their families/carers are involved in service planning and development of the team at least once a year.
7.4	2	The standard of care provided is audited to ensure it is consistent 24 hours a day, 7 days a week. **Guidance:** *Standards should be maintained if fewer staff work out of hours, or if the responsibility for home treatment passes to another team out of hours*
7.5	1	The service collects data on the safe prescription of high risk medications such as: lithium, high dose antipsychotic drugs, antipsychotics in combination, benzodiazepines. The service uses these data to make improvements and continues to monitor the safe prescription of these medications on an ongoing basis.
7.6	2	The service's clinical outcome data are reviewed at least 6 monthly. The data is shared with commissioners, the team, service users and family/carers, and used to make improvements to the service.
Feedback		
8.1	1	There are policies and procedures for managing complaints.
8.2	2	Service users and their family/carers are encouraged to feed back confidentially about their experiences of using the service, and their feedback is used to improve the service. **Guidance:** *Feedback is independently sought (i.e. not by the clinical team). Their feedback is triangulated with other feedback to make it as accurate as possible. Staff members are informed of feedback from service users and family/carers*
8.3	1	Outcomes of referrals are fed back to the referrer, service user and their family/carer (with the service user's consent) in writing. If a referral is not accepted, the team advises the referrer, service user and their family/carer on alternative options.
8.3.1	2	The team sends a letter detailing the outcomes of the assessment to the referrer, the GP and other relevant services within a week of the assessment.
SECTION 2: Staff, Appraisal, Supervision and Training		

The multidisciplinary team		
9.0	1	The service has a mechanism for responding to low/unsafe staffing levels, when they fall below minimum agreed levels, including: • A method for the team to report concerns about staffing levels; • Access to additional staff members; • An agreed contingency plan.
9.01	1	When a staff member is on annual leave or off sick, the team puts a plan in place to provide adequate cover for the service users who are allocated to that staff member.
9.02	2	Service user or family/carer representatives are involved in the interview process for recruiting staff members. **Guidance:** *This could include co-producing interview questions or sitting on the interview panel*
The team has dedicated sessional time from:		
9.1	1	A team lead.
9.2	1	Registered mental health nurse(s).
9.3	2	Social worker(s).
9.6	2	Support worker(s). **Guidance:** *An unqualified professional, e.g. healthcare assistant, OT support worker, psychology assistant, etc.*
9.7	2	Pharmacist(s).
9.8	1	Consultant psychiatrist(s).
9.9	3	Non-medical prescriber(s).
9.4	1	Services demonstrate that input from occupational therapists is sufficient: to provide an occupational assessment for those service users who require it; to ensure the safe and effective provision of evidence based occupational interventions adapted to service users' needs.

9.5	1	Services demonstrate that input from psychologists and accredited psychological therapists is sufficient: to provide assessment and formulation of service users' psychological needs; to ensure the safe and effective provision of evidence based psychological interventions adapted to service users' needs through a defined pathway.
9.5.1	2	Services demonstrate that input from psychologists and accredited psychological therapists is sufficient to support a whole team approach to the provision of a stepped care model that provides service users with the appropriate level of psychological intervention for their needs.
The team has access to:		
9.10	2	Peer support worker(s). **Guidance:** *A service user or carer employed by the team to support other service users and/or carers*
9.11	2	Approved mental health professional(s) (AMHPs).
9.12	2	The team has access to adequate administrative assistance to meet their needs.
Induction		
All staff receive a formal induction programme, by the end of which they understand the functions of the team, including:		
10.1	1	The principles of home treatment services.
10.2	1	The home treatment model and its implementation in the local context.
10.3	1	The roles and responsibilities of team members and staff in other services.
10.4	2	Team managers and senior managers promote positive risk-taking to encourage service user recovery and personal development. They ensure staff members have appropriate supervision and MDT support to enable this.
10.5	1	New staff members, including bank staff, receive an induction based on an agreed list of core competencies. **Guidance:** *This should include arrangements for shadowing colleagues on the team; jointly working with a more experienced colleague; being observed and receiving enhanced supervision until core competencies have been assessed as met*

10.6	2	All new staff members are allocated a mentor to oversee their transition into the team.
Appraisal and supervision		
11.1	1	All staff have an annual appraisal and personal development planning.
11.2	1	All clinical staff members receive clinical supervision at least monthly, or as otherwise specified by their professional body. **Guidance:** *Supervision should be profession-specific as per professional guidelines and be provided by someone with appropriate clinical experience and qualifications*
11.2.1	2	All staff members receive line management supervision at least monthly.
11.2.2	2	Staff members in training and newly qualified staff members receive weekly line management supervision.
11.4	1	Staff members, service users and family/carers who are affected by a serious incident are offered post-incident support.
11.5	2	Staff members are able to access reflective practice groups at least every 6 weeks where teams can meet together to think about team dynamics and develop their clinical practice.
11.5.1	3	Staff have received training in reflective practice and training in maintaining a psychologically informed environment.
11.6	2	Psychiatrists in the team regularly attend team meetings.
11.7	3	Staff members work well together, acknowledging and appreciating each other's efforts, contributions and compromises.
11.8	1	The service actively supports staff health and well-being. **Guidance:** *For example, providing access to support services, providing access to physical activity programmes, monitoring staff sickness and burnout, assessing and improving morale, monitoring turnover, reviewing feedback from exit reports and taking action where needed.*
11.9	1	Staff members are able to take breaks during their shift that comply with the European Working Time Directive. **Guidance:** *They have the right to one uninterrupted 20 minute rest break during their working day, if they work more than 6 hours a day. Adequate cover is provided to ensure staff members can take their breaks*

11.10	1	Staff members feel able to challenge decisions and to raise any concerns they may have about standards of care. They are aware of the processes to follow when raising concerns.
Staff training		
Staff members receive training consistent with their role, which is recorded in their personal development plan and is refreshed in accordance with local guidelines.		
12.1	2	All staff have received training in delivering crisis resolution/home treatment interventions. **Guidance:** *This may include psychosocial interventions, conflict resolution/de-escalation, engagement and activity scheduling, solution focussed brief therapy, family and social systems interventions, person-centred, values-based practice and strengths, and skills to respond appropriately to self-injurious or suicidal behaviour*
12.2	2	All staff have received training in carer awareness, family inclusive practice and social systems, including carers' rights in relation to confidentiality.
12.3	1	All staff have received training in basic counselling skills. **Guidance:** *This could include, but is not limited to, CORE competency framework for CBT for depression and anxiety, Skills for Health competency framework for humanistic counselling or Gerard Egan's 'The Skilled Helper'*
12.4	2	All staff have received training on medication as required by their role. **Guidance:** *This could include storage, administration, legal issues, encouraging concordance and awareness of side effects*
12.5	1	All practitioners who administer and/or deliver medication are assessed as competent to do so on an annual basis.
12.7	1	All staff have received training on the use of legal frameworks, such as the Mental Health Act (or equivalent) and Mental Capacity Act (or equivalent).
12.8	1	All staff have received training in risk assessment and risk management. **Guidance:** *This includes: Safeguarding vulnerable adults and children; Assessing and managing suicide risk and self-harm; Prevention and management of aggression and violence; Prevent training; Recognising and responding to the signs of abuse, exploitation or neglect*
12.9	2	Staff members can access leadership and management training appropriate to their role and specialty.

12.10	2	All staff have taken part in team building annually, and training in colleague support and working within the team framework. **Guidance:** *This should occur at least once a year*
12.13	2	All staff have received training in alcohol and substance misuse.
12.14	1	All staff have completed their statutory and mandatory training. **Guidance:** *This includes equality and diversity, information governance, basic life support*
12.15	1	All training is monitored, reviewed and evaluated regularly.
12.16	2	Service users and family/carers are involved in delivering staff training face-to-face.
12.18	1	The team provide a repertoire of symptom- or problem-specific psychologically informed interventions. **Guidance:** *This includes, but is not limited to, anxiety management, relapse prevention, de-escalation intervention and graded exposure*
12.19	2	The team can provide a repertoire of NICE-recommended, formulation-based specialist psychologically informed interventions. **Guidance:** *This includes:* • *CBT for psychosis, bipolar disorder, and severe depression/ suicidality* • *family interventions for psychosis and bipolar disorder* • *DBT, MBT, CAT or schema-focussed therapy for personality disorder.*
12.20	2	All staff have received training in developing collaborative care plans and crisis plans.
12.21 N	1	All staff have received training in physical health assessment. **Guidance:** *This could include training in understanding physical health problems, physical observations and when to refer the service user for specialist input*
12.22	1	All staff have received training in recognising and communicating with service users with special needs, e.g. cognitive impairment or learning disabilities.

SECTION 3: Assessment, Care planning and Transfer or Discharge		
Consent and confidentiality		
13.1	1	The service user's consent to the sharing of clinical information outside the team is recorded. If this is not obtained, the reasons for this are recorded.
13.2	1	If the service user does not wish any information to be shared with their family/carers, staff regularly check whether they are still happy with this decision.
13.3	1	The team follows a protocol for responding to family/carers when the service user does not consent to their involvement.
13.4	1	Service users' preferences for sharing information with their family/carers are established, respected and reviewed throughout their care.
Before the assessment		
14.1	1	The assessment includes a screening to establish if home treatment is appropriate for the service user and their family/carers. **Guidance**: *This should include consideration of whether the service user lives alone, and the associated increased risk of suicide*
14.2	1	The service user's primary carer(s), or lack thereof, is identified and recorded.
14.3	2	The service user, their family/carers and relevant others, e.g. their GP, are invited to be involved in the assessment.
14.4	2	The service user is asked who they would like to be present during the assessment.
14.5	2	Possible relationship tensions are taken into account when organising the assessment.
14.6	2	The team ensure that the service user and their family/carers understand the purpose of the assessment.
14.7	2	The service user is informed at the assessment that home treatment is a brief intervention, the average length of time they can expect to be involved with the team and the nature of the team approach.

The routine assessment		
The routine assessment gathered from multiple sources includes:		
15.1	1	An investigation into the nature of the crisis, and the presented problems.
15.2	2	The identification of immediate social stressors and social networks. **Guidance:** *If this is not possible at the first point of contact, it should be completed as soon as possible as part of the ongoing assessment*
15.3	2	Psychiatric history including past records and family history. **Guidance:** *If this is not possible at the first point of contact, it should be completed as soon as possible as part of the ongoing assessment*
15.4	1	A comprehensive evidence based assessment which includes: Mental health and medication; Psychosocial needs; Strengths and areas for development.
15.5	1	The identification of the clinical signs and symptoms, including ability to self-care, if mental health problems are found.
15.6	1	A physical health review takes place as part of the initial assessment, or as soon as is practically possible. The review includes but is not limited to: Details of past medical history; Current physical health medication, including side effects and compliance with medication regime; Lifestyle factors e.g. sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use.
15.7	2	An assessment of practical problems of daily living. **Guidance:** *If this is not possible at the first point of contact, it should be completed as soon as possible as part of the ongoing assessment*
15.8	1	A documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers: Risk to self; Risk to others; Risk from others.
15.9	2	The identification of the person for whom it is a crisis, other people affected by the crisis and associated risk to them. **Guidance:** *If this is not possible at the first point of contact, it should be completed as soon as possible as part of the ongoing assessment*
15.10	1	Identification of dependants and their needs, including childcare issues, and any young or adolescent carers. **Guidance:** *This includes the names and dates of birth of any young people*

15.11	2	A social assessment. **Guidance**: *This includes education and employment*
15.13	1	A multidisciplinary assessment of the service user's needs.
15.14	1	A multidisciplinary assessment of the service user's level of risk.
15.15	2	Planning for supported transition to other services.
15.17	1	All service users have a documented diagnosis and a clinical formulation. **Guidance:** *The formulation includes the presenting problem and predisposing, precipitating, perpetuating and protective factors as appropriate. Where a complete assessment is not in place, a working diagnosis and a preliminary formulation is devised*
15.18	1	The service user and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment.
Care planning		
16.1	1	The team works within the CPA Framework, or equivalent.
16.2	1	Every service user has a written care plan, reflecting their individual needs. Staff members actively seek to collaborate with service users and their family/carers (with service user consent) when developing the care plan. **Guidance:** *The care plan clearly outlines:* *Agreed intervention strategies for physical and mental health; Measurable goals and outcomes; Strategies for self-management; Any advance directives or statements that the service user has made; Crisis and contingency plans; Review dates and discharge framework*
16.2.1	1	The service user and their family/carer (with service user consent) are offered a copy of the care plan and the opportunity to review this.
16.4	1	There are systems in place to ensure that the service takes account of any advance directives or statements that the service user has made. **Guidance:** *These are accessible and staff know where to find them*
16.5	2	Service users' existing crisis plans are identified, utilised by the team and shared with family/carers where appropriate, in the event that they require home treatment.
16.6	1	Managers and practitioners comply with agreed minimum frequencies of clinical review meetings.
16.7	1	Service users are actively involved in shared decision-making about their mental and physical health care, treatment and discharge planning and supported in self-management.

Risk management		
17.1	1	The team formulates ongoing risk assessments and risk management planning, in collaboration with people and their families/carers, which is reviewed at each contact. **Guidance:** *This should include suicide risk awareness and coping strategies where appropriate*
17.1.1	1	Risk assessments and risk management plans are updated according to clinical need or at a minimum frequency that complies with national standards, e.g. College Centre for Quality Improvement specialist standards or those of other professional bodies.
17.3	2	The family/carers are routinely offered the opportunity to meet separately from the service user to discuss risk management.
17.4	1	If a service user does not attend for an assessment, the assessor contacts the referrer. **Guidance:** *If the service user is likely to be considered a risk to them self or others, the team contacts the referrer immediately to discuss a risk action plan*
17.5	1	The team follows up service users who have not attended an appointment/assessment or who do not want to engage as per local policy. **Guidance:** *This could include making a phone call, sending a letter, visiting service users at home or another suitable venue, using text alerts, or engaging with their family/carers proactively. If service users continue not to engage, a decision is made by the assessor/team, based on service user need and risk, as to how long to continue to follow up the service user*
17.6	1	Staff are aware of the DVLA regulations (or equivalent) regarding driving and advise service users receiving home based treatment accordingly.
Recovery		
18.1	3	A Wellness Recovery Action Plan (WRAP), My Crisis Plan, or similar, is offered to all service users. **Guidance:** *These plans focus on the service users' strengths, self-awareness, sustainable resources, support systems and distress tolerance skills and should reference the management of transitions.*
Discharge planning		
19.1	1	Involvement of the team is time-limited, and people are discharged when acute care is no longer necessary.
19.2	2	The home treatment team begins discharge planning at the point of assessment, and this is communicated to relevant parties.

19.3	2	The team is able to facilitate discharge and transfer of care to an appropriate service, dependent on clinical situation and local service provision. **Guidance:** *This could include primary care, assertive outreach teams, early intervention teams, continuing care and other mental health services*
19.4	2	The service user and their family/carers are informed as early as possible of when their care is going to be transferred from the team.
19.5	1	A clear discharge plan is given to the service user on discharge, and sent to all other relevant parties within 48 hours of discharge. This plan includes details of: • On-going care in the community/aftercare arrangements; • Crisis and contingency arrangements including details of who to contact; • Medication, including monitoring arrangements; • · When, where and who will follow up with the service user as appropriate.
19.6	2	Families/carers are informed and involved when discharge is planned. **Guidance:** *This includes what contact they can expect and how to plan themselves for the event*
19.8	1	Clinical outcome measurement data is collected at assessment and discharge, as a minimum.
19.8.1	2	Staff members review service users' progress against service user-defined goals in collaboration with the service user at the start of treatment, during clinical review meetings and at discharge.
SECTION 4: Interventions		
Planning visits		
20.1	1	The team contacts the service user and their family/carers to agree on contact times, frequency and duration of contact.
20.2	1	Service users and their families/carers are informed about unavoidable delays and told when to expect a response.
20.3	2	The service user reaches an agreement with the team about where they would like their assessment to take place.

20.4	3	If located in a rural area and no alternative can be arranged, the team has the ability to conduct visits remotely. **Guidance:** *Visits could be conducted via, for example, Skype or FaceTime.*
Contact with the team		
21.1	2	Service users know who is overseeing their care in the home treatment team and how to contact them if they have any questions.
21.3	1	Service users and their families/carers are given a direct contact number they can call for help, 24 hours a day.
21.4	1	Staff have their ID badge available on their person whilst working.
21.5	1	Staff members treat service users and carers with compassion, dignity and respect. **Guidance:** *This includes respect of a service user's age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.*
21.6	1	Service users feel listened to and understood by staff members.
21.7	1	Service users do not feel stigmatised by staff members.
21.8	1	Staff members are knowledgeable about, and sensitive to, the mental heath needs of service users from minority or hard-to-reach groups. This may include: Black, asian and minority ethnic groups; Asylum seekers or refugees; Lesbian, gay, bisexual or transgender people; Travellers.
21.9	1	When talking to service users and family/carers, health professionals communicate clearly, avoiding the use of jargon.
21.10	1	Service users are asked if they and their family/carers wish to have copies of letters about their health and treatment.
Information for service users		

22.0	1	Service users (and their family/carers, with service user consent) are offered written and verbal information about the service user's mental illness and treatment. **Guidance:** *Verbal information could be provided in a 1:1 meeting with a staff member or in a psycho-education group. Written information could include leaflets or websites*
22.1	1	Information for service users and their family/carers is written simply and clearly, and can be provided in languages other than English (ensuring cultural relevance if necessary). It is available in easy-to-use formats for people with sight/hearing/cognitive difficulties or learning disabilities. Audio, video, symbolic and pictorial materials, communication passports and signers are used as necessary.
22.2	2	The team provides information and encouragement to service users to access local organisations for peer support and social engagement. This is documented in the service user's care plan and includes access to: Voluntary organisations; Community centres; Local religious/cultural groups; Peer support networks; Recovery colleges.
22.3	2	Service users and their families/carers are routinely provided with information on their care plan, including comprehensive information about their medication.
22.4	2	Before discharge, crisis plans are reviewed and explained to the service user, with the involvement of their care coordinator (where allocated), and support is provided to complete these.
22.5	2	The team can signpost on to agencies who will advise on how to create an advance directive, if requested.
22.6	1	Service users are given accessible written information which staff members talk through with them as soon as is practically possible. This includes: • Their rights regarding consent to care and treatment; • How to access advocacy services (including independent mental capacity advocate and independent mental health advocate); • How to access a second opinion; • How to access interpreting services; • How to raise concerns, complaints and compliments; • How to access their own health records.

22.8	1	Service users are given verbal and written information on their rights under the Mental Health Act if under a community treatment order (or equivalent) and this is documented in their notes.
22.9	1	Service users are offered personalised healthy lifestyle interventions, such as advice on healthy eating, physical activity and access to smoking cessation services. This is documented in the service user's care plan.
22.10	1	The team supports service users to access advice and support with finances, benefits, debt management and housing. **Guidance:** *The team should have joint working protocols with relevant organisations.*
Support for carers		
23.1	1	Carers/family (with service user consent) are involved in discussions and decisions about the service user's care, treatment and discharge planning.
23.2	2	Carers/family are offered individual time with staff members to discuss concerns, family history and their own needs.
23.3	2	The team provides carers/families with carer's information. **Guidance:** *Information is provided verbally and in writing (e.g. a carer's pack). This includes the names and contact details of key staff members in the team and who to contact in an emergency. It also includes other local sources of advice and support such as local carers' groups, carers' workshops and relevant charities*
23.4	2	If necessary, a dedicated worker is able to provide support to family/carers separate from the needs, and presence, of the service user.
23.5	2	The team creates a plan around the whole family/group of carers, so that responsibilities of care are divided fairly.
23.6	2	Carers/family are able to access support through the team. **Guidance:** *This could be through the provision/sign-posting to carer support networks or groups. It could be through the provision of a designated staff member dedicated to carer support*

23.8 M	1	Carers are advised on how to access a statutory carers' assessment, provided by an appropriate agency. **Guidance:** *This should be offered at the time of the service user's initial assessment, or at the first opportunity*
23.9	2	Carers are offered a referral to the Carer Support Service.
23.10	1	If the carer is 25 or under, contact with Young Carer, or Young Adult Carer services is facilitated.
23.11	2	The team ensures that children and other dependants are supported appropriately.
23.14	2	Families/carers are given information on mental health problems, what they can do to help, their rights as carers and an up to date directory of local services they can access.
Medicines management: Staff awareness		
24.1	2	The team has a nominated medicines management lead.
24.4	1	There is a written policy governing self-administration, including supervision of the service user and recording.
24.5	2	There is a written policy governing the removal and gradual reintroduction of medicines in situations where there is an acute risk of suicide or self harm.
Medicines management: Medicines reconciliation		
25.1	2	Everyone under the care of the team has a medicines chart, and if medicines are administered or supervised by the team, this is recorded on the chart.
25.2	2	On admission to the home treatment team, a team member contacts the service user's GP to obtain a copy of their medicines records. **Guidance:** *This includes current medicines for mental and physical health, medicines history, recent laboratory results and any other issues which may impact on medicines*
25.3	1	When a service user is discharged from the home treatment team, a detailed account of the medicines prescribed is provided to their community mental health team and general practitioner.

Medicines management: Prescription and administration		
26.1	2	The team has rapid access to medication, 24 hours a day.
26.2	1	The team has 24 hour access to prescribing advice from a consultant psychiatrist or independent NMP.
26.4	1	Medication reviews take place at a frequency according to the evidence base and individual need. **Guidance:** *This includes an assessment of therapeutic response, safety, side effects monitoring using a standardised tool and adherence to medication regime.*
26.5	1	Service users who are prescribed mood stabilisers or antipsychotics are offered and encouraged to have the appropriate physical health assessments at the start of treatment (baseline), at 6 weeks, at 3 months and then annually (or 6 monthly for young people) unless a physical health abnormality arises.
26.6	1	When medication is prescribed, specific treatment goals are set with the service user, the risks (including interactions) and benefits are reviewed, a timescale for response is set and service user consent is recorded.
26.7	1	When service users experience side effects from their medication, there is a care plan, which has been developed with the service user, for managing this.
Medicines management: Support for carers		
27.1	2	The plan for managing medication concordance is agreed with family/carers, and reviewed regularly.
27.2	1	Service users (and their family/carers, with service user consent) are helped to understand the purpose, expected outcomes, interactions, limitations and side effects of their medications and to enable them to make informed choices and to self-manage as far as possible.
27.3	3	Service users, family/carers and prescribers are able to contact a specialised pharmacist and/or pharmacy technician to discuss medications.
Psychosocial interventions: psychological interventions		

28.2	2	Service users and their families/carers can be signposted to gender-specific services. **Guidance:** *For example women- or men-only groups*
28.4	2	The team is able to provide a range of therapies to service users and their family/carers based on need. **Guidance:** *Interventions could be drawn from the following approaches:* *1. Cognitive Behavioural Therapy (CBT) approaches including Dialectical Behaviour Therapy (DBT) and Mindfulness-Based Cognitive Therapy (MBCT)* *2. Psychodynamic approaches including Interpersonal Psychotherapy (IPT) and Cognitive Analytic Therapy (CAT)* *3. Psycho-educational approaches* *4. Solution-Focused Brief Therapy (SFBT)* *5. Problem-Solving approaches* *6. Family Interventions for Psychosis* *7. Motivational Interviewing* *8. Person-Centred approaches* *9. Systemic approaches* *10. Stress management* *11. Supportive counselling* *12. Relapse prevention*
28.5	1	All staff members who deliver therapies and activities are appropriately trained and supervised.
Psychosocial interventions: Social interventions		
29.1	1	The team supports service users to undertake structured activities such as work, education and volunteering. **Guidance:** *For service users who wish to find or return to work, this could include supporting them to access pre-vocational training or employment programmes. This is managed through the care plan*
29.2	2	The team supports service users to continue to attend community resources where this has been assessed for risk, such as faith communities and Alcoholics Anonymous.
29.3	2	Written information is offered to service users and their families/carers about transitional support services. **Guidance**: *This includes mentoring, befriending, mediation and advocacy.*
Crisis houses		

30.1	3	The team has access to a crisis house.
30.2	3	Crisis house facilities are aware of the therapeutic aims of crisis resolution/home treatment.
30.3	3	The team liaises with crisis houses. **Guidance:** *This should include communication protocols, visiting frequency, reviews, etc.*
30.4	3	Clinical responsibility while the service user is in a crisis house is clearly defined.
30.5	3	Responsibility for the storage and administration of medication while the service user is in a crisis house is clearly defined.
30.6	3	There are arrangements for emergency medical care while the service user is in a crisis house.

APPENDIX 5: HTAS EVENTS, ACTIVITIES AND DEVELOPMENTS

Network Past Events

- HTAS Annual Forum, 06 November 2018
- Peer-reviewer training, 16 January 2019
- Special Interest day on personality disorders, 03 June 2019
- Peer-reviewer training ,19 July 2019
- Peer-reviewer training, 31 October 2019
- HTAS Annual Forum, 05 November 2019
- Webinar series, March-May 2020

Network Activities

- HTAS Autumn/Winter Newsletter 2019
- Membership survey
- HTAS Spring/Summer Newsletter 2020

Network Developments

Newsletter

We have relaunched the HTAS newsletter. You can find the latest publications on our website https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/htas/htas-publications-and-links. The newsletters are an opportunity to share information, learning, and service developments.

Patient and carer involvement

In 2019, the RCPsych developed a 'Working Together' model, for working with patient and carer representatives. Patient and carers are currently an integral part of the work of the CCQI, visiting and reviewing mental health services, participating actively with committees and standards development groups and contributing to CCQI events and conferences. It is our view that CCQI should mainly engage with patients and carers where:

- They wish to co-produce, as equal partners, on our service accreditation and audit work. It is proposed that:
- We maintain the same amount of patient and carer involvement in the work of the CCQI but reduce the overall number of patients and carers working with CCQI.

By working more closely with a smaller group of patients and carers, we believe we could better support them to collaborate with us to deliver high quality work. Patients and carers working with CCQI would do so under appropriate contracts within the College which will ensure the core entitlements of the National Minimum Wage and relevant rest breaks and holiday entitlements under the Working Time Legislation.

HTAS has recruited five representatives who are involved in supporting the network by representing patients and friends, families and carers' views and providing feedback to services. Our representatives are part of peer-review teams attending peer-review visits, events, part of the Accreditation Committee and Advisory Group, and participate in creating our newsletters.

Webinars

In response to the COVID-19 pandemic, HTAS held a series of five webinars throughout April and May. You can find the recordings on our website https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/htas/htas-webinars The aim of the webinars were to share information, learning and best practice amongst crisis resolution and home treatment teams.

Developmental peer-review option

Since the last national report publication in 2015, HTAS has now implemented a developmental review option. This enable teams who may not be meeting the required number of standards to be recommended for accreditation, to join the network and be involved in quality improvement. The developmental review process is similar to the accreditation process; however, teams are not presented to the Accreditation Committee following the team's peer-review visit. Instead, they receive the final report and are able to use the findings to make improvements. Teams can undertake a developmental review annually, before going through the accreditation process.

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