QUALITY NETWORK FOR CRISIS RESOLUTION AND HOME TREATMENT TEAMS NEWSLETTER

Edited by:
Rachel Wyness,
Project Officer, QNCRHTT

WELCOME

Welcome to September 2021 edition of the Quality Network for Crisis Resolution and Home Treatment Teams (QNCRHTT) newsletter!

It has now been over 18 months since the QNCRHTT team began working at home. It has been a learning curve moving all of our activities online, and is not something I could have imagined doing prior to the pandemic. In August, we had our own team away day, which was a wonderful opportunity for the team to (safely) get together, and for some it meant seeing our office at 21 Prescot Street for the first time.

Since our last newsletter in April, we have held a special interest day on COVID-19 and CRHTTs, and Pranveer Singh, Consultant Psychiatrist and Chair of the Advisory Group has written an article, which can be found on page 2, on the results of our members survey on the impact it has had.

We have a number of articles in our newsletter, including an article looking at the length of stay for patients on inpatient settings, another on a holistic approach to patient care and one on improving the quality and efficiency through home treatment.

We have a number of upcoming events and activities, you can find out more on page 8.

I would also like to thank all of our members, our newsletter contributors and patient and carer representatives for their continued support for the network.

Cassie Baugh, Programme Manager, QNCRHTT

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The Impact of the Covid-19 Pandemic on Crisis Resolution and Home Treatment Teams

Author: Dr Pranveer Singh, Consultant Psychiatrist and Chair of QNCRHTT Advisory Group

The Covid-19 pandemic has resulted in exceptional challenges and concerning times for patients and services. QNCRHTT conducted an online survey of members from between March and April 2021 to understand the impact of the pandemic on Crisis Resolution and Home Treatment Teams and how they have responded to it. A total of 21 teams completed the survey, the results of which are displayed below:

Results

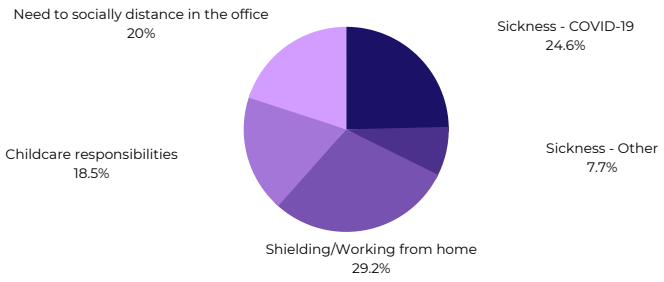
Has COVID-19 impacted on the team/delivery of service? (1 - not at all, 5 - significantly)

21 Responses **Average - 3.38**

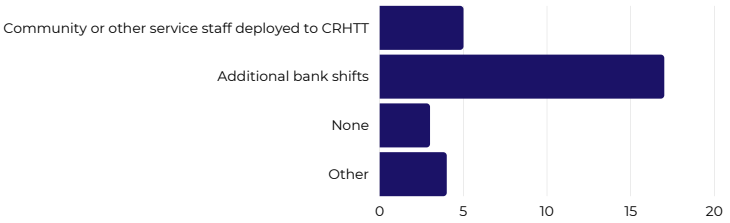
Has COVID-19 impacted on staffing levels within the team? (1 - not at all, 5 - significantly)

21 Responses **Average - 3.24**

What has this been due to? (Tick all that apply)



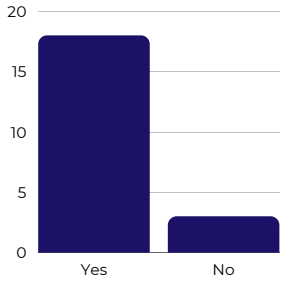
How has the team responded in order to maintain regular staffing levels? (Tick all that apply)



Has COVID-19 imapacted on the ability to conduct face-to-face visits with patients? (1 - not at all, 5 - significantly)

21 Responses **Average - 2.71**

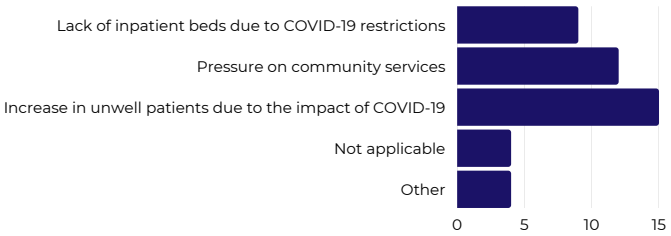
Have the team used alternative methods in place of some face-to-face visits (e.g. Zoom, Microsoft Teams)?



Has COVID-19 impacted the threshold of patients accepted onto the team's caseload? (1 - not at all, 5 - significantly)

21 Responses **Average - 2.62**

What are the main reasons? (Tick all that apply)



Has this led to the team now providing care for a larger number of clinically unwell presentations at home, in comparison to normal times? (1 - not at all, 5 - significantly)

21 Responses **Average - 3.29**

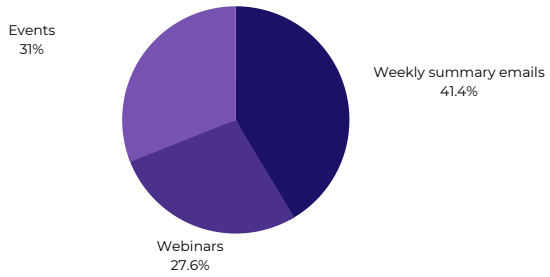
Has COVID-19 impacted on the emotional well-being of staff members? (1 - not at all, 5 - significantly)

21 Responses **Average - 3.33**

How has the team responded to support staff well-being?

- Staff support twice a week
- Regular catch-up and informal meetings
- Regular staff supervision
- Offering psychologist-led reflective practice sessions
- Weekly COVID support group
- Fitness challenges
- Increased handovers
- Wellbeing resources provided by the Trust
- Lunchtime yoga sessions
- Encouraging staff to take annual leave

What have you found useful from QNCRHTT? (Tick all that apply)



Key points

- CRHTT's ensured that people continued to have access to crisis and home treatment services within the challenging environment
- Although, there was a substantial adverse impact on service delivery, adaptations were made to practice, including the introduction of remote consultation/working.
- As a priority, attempts were made to maintain regular staffing levels.
- The teams and staff obtained support from various sources and made use of local and national guidance.

Discussions and implications for practice

A total of 21 teams responded to the questionnaire. The results suggest that for most of the teams COVID-19 had an impact on the delivery of the service. These consisted of a reduction in staffing levels, sickness related to covid-19, shielding/working at home, childcare responsibilities and disruption due to the need to maintain social distancing. The majority of teams were able to implement measures to maintain staffing levels present at the regular times. In some cases, face to face visits were reduced and remote methods were used in place of home visits.

In addition, the threshold for providing home treatment was increased. The most common reason for this was an increase in unwell patients, followed by pressures experienced by community teams, as well as the reduction of beds due to the need for social distancing.

Staff reported that their emotional wellbeing was affected by the pandemic. Teams brought in a range of measures to help with this and staff reported receiving a variety of support from the Trust, the team itself, and QNCRHTT, where weekly emails were found the most useful.

The pandemic has both short term and long term implications. It is noted that the mental health burden has increased during the pandemic. CRHTT's are one of the key services that support the most unwell people by treating at home. Whilst the services are being restored, in order to serve the needs of our patients we will need to continue to provide high quality care.

Follow us on Twitter to keep updated with the latest news and events from the network and the College:

@rcpsychCCQI

Length of Stay Analysis to Evaluate Quality and Efficiency of Care within Home Treatment Teams

Author: Dr David Mirfin, Consultant Psychiatrist, Southwark Home Treatment Team

Background

Length of stay data is widely used within acute inpatient settings to identify barriers to discharge and ensure flow within the system, however, is not fully established within home treatment settings.

Method

Data was obtained from trust electronic systems with patient ID and length of HTT episode over the last 12 months. Case notes for those with the longest lengths of stay were analysed further, capturing frequency of contacts, joint reviews, medical and psychological reviews. Timelines were mapped (see figure 1) and themes were identified through analysis of case notes with potential areas of improvement in the areas of both quality and efficiency of care. Through reviewing multiple timelines in synchrony, clearer patterns about the care provided are apparent which helps highlight areas of good practice and potential learning. This information was then used to guide service development.

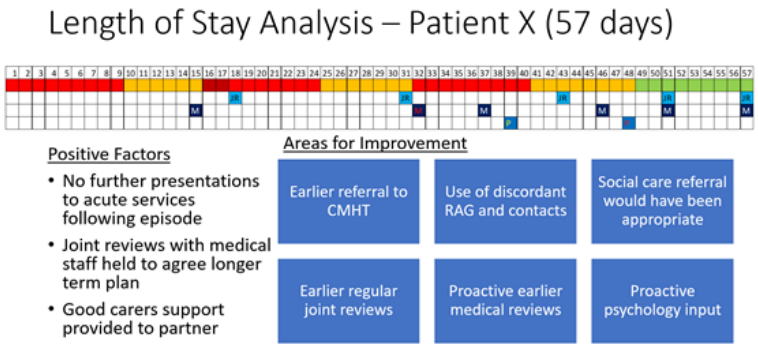


Figure 1 – An example Length of Stay Analysis with a total episode length of 57 days. Timeline colours indicate frequency of contacts (ranging from twice daily in dark red to every three days in green)

Results

Themes identified in our initial analysis included: regularity of joint reviews with CMHT's, proactive medical and psychology review, considering wider social support (including referrals for re-enablement), offering more interventions for relapse prevention in alcohol dependence and early referrals to onward discharge pathways.

Over the past year there has been an improvement in flow and reduction in length of stay within the team with no adverse impacts noted in the quality of care.

Interventions implemented in the last year include daily MDT zoning meetings (to improve senior support for new assessments and deteriorating patients), weekly senior caseload review (to review the HTT caseload for senior oversight over current risks, discharge pathways and frequency of contacts) and allocation of all patients to a HTT doctor with regular proactive medical reviews.

Conclusions

The implementation of Length of Stay Analysis can reveal new insights into the quality and efficiency of care and has a role in the evaluation of HTT to develop areas of focus for service improvement and ongoing monitoring. This work continues to develop and at present we have undertaken this analysis on a limited dataset however we plan to continue to expand this further and evaluate this on an ongoing basis. Similar work could be expanded to those with short lengths of stay to understand where there were issues with engagement and/or early admission how this could have been reduced or prevented. This data could be used to develop proactive care planning following a HTT episode and has the potential to reduce further relapses (and potentially admissions and/or HTT episodes).

FOCUS: A Holistic Approach to Patient Care

Authors: Robert Hodges, Higher Assistant Psychologist, **Lauren Dawson**, Advanced Nurse Practitioner, **PC Margo Mallinson**, Operational Mental Health Advisor for Scarborough - North Yorkshire Police and **Dr. Stephen Donaldson**, Highly Specialised Clinical Psychologist

The government and local services in the UK have taken a systematic approach to service provision and individual care needs by working in partnership. However, Booker et al (2014) found that those with complex needs may attempt to contact multiple services hoping to get their needs met even though the service may not be appropriate to their needs. Understandably, services try to reach the best outcome by redirecting service users to the appropriate provision. The literature in relation to "frequent attenders" has been well established (Wiklund-Gustin, 2011). Such contacts can put services under significant strain preventing appropriate service access for others potentially leading to a shortfall within service offers. In turn frequent attenders may find this invalidating or not feel listened too, which can understandably increase distress and paradoxically lead to further frequent attendance with an alternate service, as they try to communicate their needs and have these met. Goodwin et al (2003) noted services may accidently harm individuals by repeating or replicating previous past traumas of poor attachments. Overall this creates a further vicious cycle of contact with wider services (Pirkis et al, 2016). Research has shown this cycle can have a personal cost to the patient and services. It is noted, for example, that frequent callers cost the NHS £18.8 million in 2019 (London Ambulance Service NHS Trust, 2020).

Focusing on Collaborative Unmet Needs and Solutions (FOCUS) was set up in (2016) and is designed to support vulnerable individuals with mental health problems who have made repeated attempts to get their complex needs met. FOCUS is ever growing and currently represents North Yorkshire Police, Tees, Esk and Wear Valleys Mental Health Foundation Trust, North Yorkshire County Council, non-statutory Mental Health Services, Yorkshire Ambulance Service and Scarborough Survivors.

FOCUS meetings are patient-centred and involve co-creating with the individual a multi-agency plan. The aim is to create a safe place for the individual to express their needs by working together in a person-centred way through creating a collective and collaborative community approach. By holding this collaborative stance, FOCUS aims to ensure service users have a voice in their wider care and are actively involved in the decision making process, in turn creating a shared "my plan" across services.

The importance of patients having healthy attachments is well documented (Holmes, 1993, Goodwin et al 2003). Through creating a healthy therapeutic alliance in wider services, FOCUS has supported vulnerable individuals to share their needs in a way that may not have been previously possible to communicate, thus addressing their psychological and safety needs (Maslow 1954).

Preliminary data suggests that through using FOCUS we have observed a 56% reduction in Crisis Resolution and Home Treatment contacts, a 40% reduction in Liaison contacts, 50% reduction in MHA/136 admissions and a 48.6% reduction in police contacts, with repeat attendance continuing to show reduction over time. What has been observed is that this approach creates effective service and patient driven care, by creating a collective safety around the service user where they feel held, understood, cared for and validated within their care system.

Whilst further research is needed, FOCUS aims to develop and expand upon the current approach by incorporating drug and alcohol services and building wider agency involvement of statutory and non-statutory agencies as it is acknowledged that only 24% of mental health care is covered by the NHS (McAndrew, et al 2020). It is anticipated that by further developing FOCUS we will ensure that service users always remain at the heart of what we do, enhance their empowerment and create a sense of containment and collective safety where change can be made.

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HTAS CHAT is moving to Knowledgehub!

The HTAS chat has officially moved to Knowledgehub!

On Knowledgehub you can find a range of information and connect with other home treatment and crisis resolution teams.

You will have access to the:
Forum - Here is the discussion group. You can post questions (threads) and respond to others.
Library - Here you can find resources and documents relevant to QNCRHTT members.
Events - Here we will post our upcoming events and activities.

To request to join the group, simply click here.

Improving Quality and Efficiency through the Introduction of Home Treatment Team Senior Caseload Review

Authors: Dr Charles Comley, Associate Specialist, **Dr David Mirfin**, Consultant Psychiatrist, **Nicola Cotton**, Clinical Service Lead and **Katie Fifield**, Advanced Nurse Practitioner, Southwark Home Treatment Team

Background

The impact of the COVID-19 pandemic and response has led to vastly increased pressures on NHS services. The ability to provide a high quality and efficient service to patients becomes more difficult as resources are stretched beyond a certain point. High caseloads tend to be self-perpetuating as clinician time is diverted to the immediate tasks of existing patient contacts, and longer handovers.

We observed some patients were not being discharged at planned discharge meetings due to concerns around mental state or risk. A high frequency of contacts per patient tended to persist beyond the clinical indication and this was associated with an increased length of stay.

Protracted admissions and high frequency of contacts potentially could dilute the clinical focus away from patients with more acute and severe needs.

Method

From March 2021 we started holding weekly senior caseload reviews in addition to the usual weekly multi-disciplinary team meeting.
The meeting is one-hour in duration and attended by the Clinical Service Lead, Advanced Nurse Practitioner and the team Consultant.

The meeting occurs remotely through Microsoft Teams, enhancing flexibility and allowing access to relevant information and email, 'Teams' channel communications during the meeting.

We review the progress, risk assessment, current care plan, and discharge pathway for each patient under the team. Timely targeted interventions – e.g. medical or psychology assessments are arranged, and outstanding tasks followed up, including referrals to CMHTs or other services, and following up on referral outcomes, and joint review dates. We also review the acuity status and visit frequency for each patient.

Results

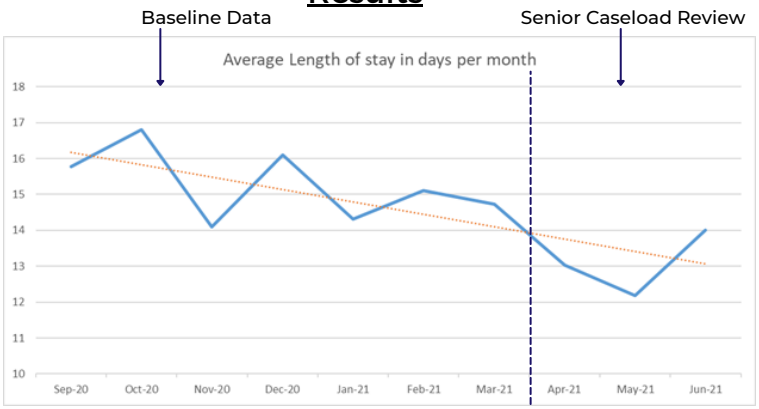

Figure 1 – Illustrates the average length of stay in days for patients admitted to Southwark Home Treatment Team per month since September 2020.

Since introduction we have observed a reduced average caseload per month, reduced average length of stay (Figure 1), and a reduced frequency of contacts per patient (Figure 2).

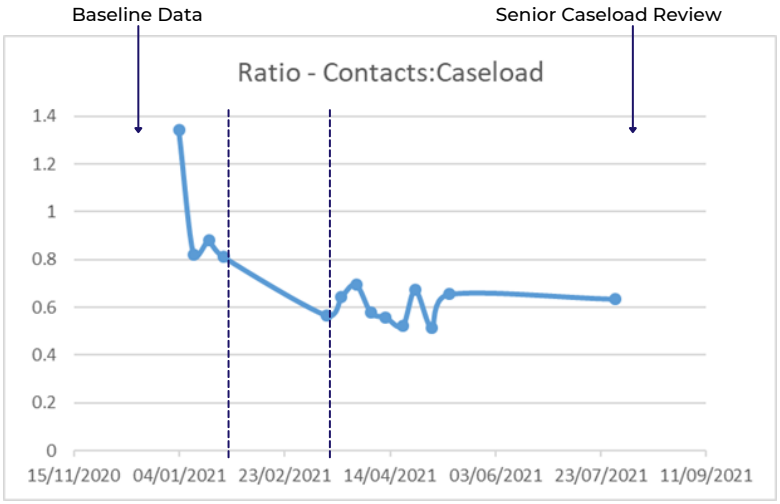

Figure 2. Plots the ratio of total daily clinical contacts to total caseload – reflecting a reduction in frequency of contacts per case. This has persisted since the intervention (starting in March 2021).

There has been an improved senior awareness of the caseload with regular review of complex cases, and an increased proportion of successful discharges. We have noted improved staff morale

from the reduced frequency of visits, and ability to provide focused, high quality patient contacts. As a result of reduced frequency of contacts there has been an associated cost benefit of around £300/day following each meeting. We have not noted any increases in readmissions or other adverse outcomes.

Conclusions and Learning Points

The implementation of regular senior caseload reviews has resulted in clear improvements in the quality and efficiency of care with reductions in frequency of contacts and reduced length of stay with associated cost benefits as well as earlier identification of patients deteriorating in mental state.

The use of Microsoft Teams enhanced the flexibility and productiveness of the meetings, allowing tasks to be attended to during meeting. Meeting in the middle of the week avoided 'busy' times ensured regularity and integrity of meetings.

In retrospect it would have been advantageous to collect data on failed discharges & activity levels at an earlier stage of implementation.

UPCOMING EVENTS

Standards Revision

Have your say in the new edition of the HTAS Standards this Autumn!

The first stage of the process is an e-consultation which is **open now**. You can feedback against the current standards through our online Google document. The consultation closes on **30 September 2021** so be sure to have your say by then.

Following this, we will be holding a half-day workshop:
Date: Tuesday 19 October 2021
Time: 12.30 - 4.00pm
Where: Online via Zoom
Booking: Please complete this short online booking form.

Peer-Reviewer Training:

Date: Thursday 18 November 2021
Time: 1.30 - 4.00pm
Where: Online
Booking will open in the coming weeks, keep an eye out on your emails and KnowledgeHub.

Calling Suicide What it is

Author: John Robinson, Patient Representative

When I worked mainly with people with profound learning disabilities, I found that some countries had hardly changed how they referred to their clients in over 40 years. In contrast, others changed them frequently, worrying about political correctness etc. The interesting thing about this was that it was not related to the quality of provision.

I recently looked into the term that the NHS uses for suicide (grouping it with other fatalities), "Untoward Incidents" and began to feel uneasy at this.

Why do we not call it suicide?

I can understand when it has not been proven, but most are proven to be suicide. According to the Oxford Dictionary, "untoward" means: 'perverse, awkward or unlucky".

These terms seem to me to be most unsuitable, so why have they been chosen and by whom?

Perhaps in calling a spade a spade, we can face the issues around this a bit more realistically.

60 SECONDS WITH: KARISHMA TALWAR

Job Title:
Deputy Programme Manager

When you joined the College:
December 2018

Tell us a little bit about your role:
I work across two quality networks; PLAN and QNCRHTT (HTAS). My role is to support the project team and our Programme Manager, Cassie, in overseeing various aspects of the networks, as well as keep in touch with our member services and lead peer-reviews.

What were you doing before you joined the College?
I was completing an MSc in Integrative Counselling and Coaching at the University of East London.

If you could learn anything new, what would it be?
I've owned a guitar for about 10 years and spent about 10 minutes trying to learn it, so probably that.

What superpower would you like to have and why?
Teleportation, easily. To be able to travel the world without leaving a mark and get to places without the long-haul flights, and avoid the train!

What was the title of the last book you read?
I have had three on the go for months. I finally finished Pursuit of Love recently though - a classic.

What is your favourite comfort food and when was the last time you had it?
Any and all fried Indian snacks, and about 4 days ago...

What three things would you take with you if you were stranded on a desert island?
A Kindle, an inflatable kayak, and a pillow.

Tell us an interesting fact about yourself that few people would know about:
I once climbed a mountain overnight to see the sunrise. It was completely foggy when we finally made it up, and the climb down was less fun – still beautiful though!

What is the one thing you wish people knew more about?
How to speak to your friends/family who might be struggling with their mental health

What is your favourite quote/saying?
"One person's annoying is another person's inspiring and heroic" – Leslie Knope, Parks and Recreation

QNCRHTT are Recruiting - Join our Advisory Group!

The QNCRHTT Advisory Group is currently recruiting for individuals from the following specialties:

- Nursing
- Pharmacy
- Social Work

The Advisory Group comprises professionals who represent key interests and areas of expertise in the field of Crisis Resolution and Home Treatment.

The purpose of the group is to advise and further the work of QNCRHTT, whose purpose is to improve the quality of Home Treatment Teams by supporting standards-based peer-review and accreditation.

If you are interested in applying for please contact the team at QNCRHTT@rcpsych.ac.uk to ask for the Application Form and Terms of Reference. You can also download them from KnowledgeHub here.

The deadline for applications is Friday 24 September 2021

Would you like to feature in one of our upcoming newsletters?

Articles may be about:
- Area of good practice
- An achievement/award
- A quality improvement project
- An area of research
- Response and learning during COVID-19.

We are also looking to include a segment on testimonials from QNCRHTT member services, describing their experience of working with QNCRHTT and the impact accreditation can have on the team.

If you would like to contribute to the newsletter please email us at: QNCRHTT@rcpsych.ac.uk.

USEFUL LINKS

CARS
www.cars.rcpsych.ac.uk

College Events
www.rcpsych.ac.uk/events

Department of Health
www.doh.gov.uk

Institute of Psychiatry
www.iop.kcl.ac.uk

National Institute for Health and Clinical Excellence
www.nice.org.uk

Centre for Mental Health
https://www.centreformentalhealth.org.uk/

Contact the team

We love hearing from our members and helping to facilitate communication amongst our teams — after all, it's what being part of a network is all about!

QNCRHTT shared mailbox:
QNCRHTT@rcpsych.ac.uk

College Address:
21 Prescot Street
Whitechapel
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E1 8BB

Find all updates related to the network on the College website.