NHS
Yorkshire and the Humber
Clinical Networks

Yorkshire and the Humber Mental Health Network

Yorkshire and the Humber Urgent & Emergency Community Mental Health Network

7th March 2018

- **Charlotte Whale and Sarah Boul Quality Improvement Managers charlotte.whale@nhs.net and sarah.boul@nhs.net**
- **Twitter: @YHSCN_MHDN #yhmentalhealth**
- **March 2018**

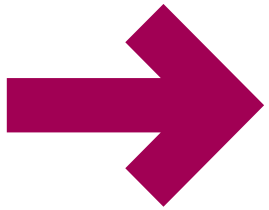
NHS
Yorkshire and the Humber
Clinical Networks

Yorkshire and the Humber
Mental Health Network

Welcome and Introductions

Adrian Elsworth, Clinical Chair

Yorkshire and the Humber Clinical Networks



Agenda

NHS
Yorkshire and the Humber
Clinical Networks

13.30	**Welcome, Introductions & Update**	**Aadrian Elsworth Clinical Chair Yorkshire and the Humber Clinical Networks**
13.40	**Service Presentation: Harrogate Older Adults Crisis Team**	**Dr Gena Hearnshaw TEWV NHS Foundation Trust**
14.00	**Question and Group Discussion session: Older adults crisis response**	
14.20	**Group session Options for the group to decide on the day; • Frequent attenders to A&E CQUIN – year 2 • Economic Evaluation: Demonstrating savings**	**Led by Adrian**
14.40	**The CORE Fidelity Review process & Discussion**	**Louise Thomas Dr Claire Bullen Foster North West Coast Strategic Clinical Networks**
15.05	**Questions and Group Discussion session: Y&H CORE Reviews**	
15.30	**Close**	

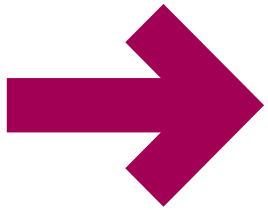
NHS
Yorkshire and the Humber
Clinical Networks

Yorkshire and the Humber Mental Health Network

Harrogate Older Adults Crisis Team

Dr Gena Hearnshaw

TEWV NHS Foundation Trust



THE RRICE TEAM
A STEP TOWARDS AN MHSOP CRISIS SERVICE

Gena Hearnshaw

Consultant MHSOP

STRUCTURE

* BACKGOUND
* DEVELOPING THE SERVICE
* THE FUNCTION OF THE SERVICE
* IMPACT ON THE WIDER THE SERVICE
* SATISFACTION
* CONSLUSION

INTORDUCTION

* Over the past 40 years, there has been a marked reduction in inpatient psychiatric.

* 2000 North Yorkshire Health Improvement Plan: Need to develop intermediate care.

INTORDUCTION

* In August 2003 in North Yorkshire, 26 older people were deemed fit for discharge but occupying beds.

* This meant that 50% of the elderly mentally ill (EMI) beds were not available for emergency or urgent patients.

EVIDENCE

* Evidence at the time to support home treatment for older patients with mental health problems was not as strong as for working-age adults,

* Joy et al (2006) reviewed crisis intervention studies and found that patients' and relatives' satisfaction was higher with home care than inpatient care.

* This Cochrane Review showed that crisis intervention reduced hospital admission or time spent in hospital, repeat admissions and disengagement with mental health services.

EVIDENCE

Systematic reviews on cost effectiveness were inconclusive, but Burns et al (2001) demonstrated lower treatment costs compared to standard inpatient care and identified six essential components of community-based services:

* Home environment;
* Skill mix;
* Psychiatrist involvement;
* Service management;
* Caseload size;
* Health and social care integration.
* There was little support for 24-hour services

DEVELOPING THE SERVICE

* Funding was secured for a multidisciplinary/multi-agency team.
* To assess, treat and support EMI patients in their own home or place of residence.
* Recruitment to the rapid response intermediate care elder person's mental health (RRICE) team, began in October 2004.
* The team became fully operational in April 2005.

DEVELOPING THE SERVICE

* One of the first appointments was the community services manager, who had a background in social care.

* Team: Mental health staff nurses, HCAs, occupational therapists, physiotherapists, social workers, community care officers and psychiatrists.

*

DEVELOPING THE SERVICE

* The RRICE team is based in Harrogate and covers the Harrogate and Rural district.

* The area's rural nature presents significant transport and communication challenges.

DEVELOPING THE SERVICE

RRICE accepts referrals for:

* Older adults who have a functional mental health issue
* A degenerative organic dementia
* Adults under 65 with dementia;
* Older adults who are facing a crisis, where the primary cause is deterioration in their mental health.

What RRICE does

* The National Service Framework for Older People (Department of Health, 2002) defined intermediate care as

* *'a range of integrated services which will promote faster recovery from illness and prevent unnecessary admission to hospital, to support timely discharge from hospital and maximise independent living'.*

What RRICE does

Objectives were to:

* Provide a single point of contact for urgent mental health assessments (within four hours of referral);
* Prevent inappropriate admission to hospital or 24-hour care facilities;
* Support clients in 24-hour care facilities.
* Support timely discharge from psychiatric inpatient units.

What RRICE does

Referrals are accepted from

* healthcare and associated professionals
* referrers must have seen and assessed patients within the previous 72 hours.

RRICE carries out an initial holistic assessment of patients' needs within 24 hours.

What RRICE does

A programme of intensive care intervention is agreed.

* This may include up to four visits a day for an initial period of up to 12 weeks;
* The average is 4–6 weeks of intervention.
* In urgent cases, RRICE will respond within four hours.

ASSESSMENT AND TREATMENT

The initial assessment uses basic tools, such as the

* Ace r,
* Barthel's Index of Activities of Daily Living (BAI),
* Geriatric Depression Scale,
* Falls screening
* Carer strain

.

ASSESSMENT AND TREATMENT

* Staff use a range of skills,

* RRICE also provides families with an educational intervention.

Impact of the service

RRICE set itself the following targets:

* To offer a seven-day-a-week service,
* 365 days of the year;
* To discharge 25% of clients in the first year,
* 35% in the second year
* 50% in the third year;
* To facilitate timely access to services;
* To impact positively on bed occupancy.

Impact of the service

* The targets for discharging were met in the first two years.
* However, it then reached a plateau, with 37% discharged back to GPs in the third year.
* On average, 84% of referrals are seen within agreed timeframes.

Impact of the service

* The service's effect on bed occupancy has proved difficult to measure.
* Anecdotal evidence suggests bed occupancy has reduced.
* There are no waiting lists for admission to older people's psychiatric inpatient units.
* No older people are admitted to working age adult wards.

Satisfaction with the service

A qualitative questionnaire was sent out.

* Most referrers appeared to be satisfied with the service they received and, in particular, with the outcomes of the episodes of care.
* Most patients and/or carers expressed satisfaction with the service, and carers were particularly pleased with response times and the support they were offered.

Satisfaction with the service

Those surveyed were asked how the service could be improved.

* Referrers found the referral process difficult at times.
* Some service users and carers felt the RRICE team should be involved for longer.
* In some cases, there were gaps between the team finishing and other services taking over. there were too many people visiting, which was confusing and intrusive.
* All respondents said communications could be improved.

Satisfaction with the service

Improvements have been made based on the data collected.

* There are timeframes and structure for written and verbal communication
* Patients are referred to other services before discharge from RRICE to try to ensure there is a handover/overlap period.
* Where possible, choice is offered on the number and gender of staff visiting patients at home.

Conclusion

* Pressures on bed occupancy in the hospital environment were reduced following RRICE's introduction.
* Data collected suggests intermediate care interventions are effective in reducing symptoms of distress, the effects of social isolation and preventing unnecessary admission to inpatient facilities

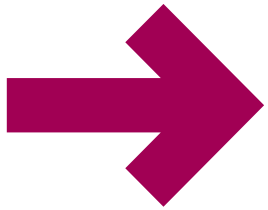
THE FUTURE

* Developing Advanced nurse practitioners
* Looking towards a 24 hour service .

NHS
Yorkshire and the Humber
Clinical Networks

Yorkshire and the Humber Mental Health Network

Question and Group discussion session: Older adults crisis response



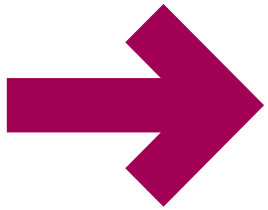
Yorkshire and the Humbe
Mental Health Network

NHS
Yorkshire and the Humber
Clinical Networks

Group Work Session

Frequent attenders to A&E CQUIN: year 2

Economic Evaluation: Demonstrating savings



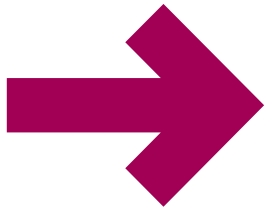
Yorkshire and the Humbe
Mental Health Network

NHS
Yorkshire and the Humber
Clinical Networks

The CORE Fidelity Review process

Louise Thomas
and
Dr Claire Bullen Foster

North West Coast Strategic Clinical Networks



Opening the door to improved outcomes

NHS
North West Coast
Strategic Clinical Networks

Improved health and wellbeing through collaborative working across
Cheshire, Merseyside, Lancashire & South Cumbria

Crisis Resolution Home Treatment Teams- CORE Fidelity Peer Reviews

Dr Claire Bullen Foster, NWC SCN Adult MH Clinical Lead and Louise Thomas, NWC SCN Quality Improvement Programme Manager

Background

The Five Year Forward View for Mental Health implementation guide which was published in September 2016, stated that the majority of CRHTTs are not currently sufficiently resourced to operate 24/7, with caseloads above levels that allow teams to fulfil their core functions of a community-based crisis response and intensive home treatment as an alternative to admission.

By 2020/21, CRHTTs in all areas should be delivering in line with best practice standards as described in the CORE fidelity criteria. To support the required expansion over this period, all areas should review their current provision during 2016/17 against CORE standards and develop plans to ensure full compliance by March 2017.

Our Approach

NHS
North West Coast
Strategic Clinical Networks

The North West Coast Strategic Clinical Network worked in collaboration with the 5 Mental Health Trusts across the area:

- North West Boroughs
- Mersey Care
- Cheshire and Wirral Partnership
- Lancashire Care Foundation Trust
- Cumbria Partnership Foundation Trust

- Developing a peer review process utilising the 39 point CORE fidelity Scale, which was developed by UCL to help support areas to review their current service provision against the CORE fidelity criteria.
- Each Mental Health Trust provided a review team, made up of CRT practitioners that would undertook the peer review.

Approach continued

- The reviews involved interviews of CRT managers, CRT staff, Service Users and Carers and looked at case notes, local policies and procedures including staff training, recruitment procedures and Standard Operating Policies.

- The information gathered during this process was then cross referenced with all the available information and applied to each area of the CORE fidelity criteria.

- The review team then scored the service against the CORE fidelity scale*

* For each item, a score of 5 = excellent fidelity; 4 = good fidelity; 3 = fair fidelity. A mean score of more than 4 per item = good model fidelity; more than 3 = fair model fidelity.

Overview of CORE Fidelity Review Findings- Common Themes

The CORE Fidelity peer reviews found a number of common themes across the whole of the North West Coast. These are:

- The CRHTTs are not operating 24 hours 7 days a week
- The CRT has systems to provide consistency of staff and support to a service users during a period of CRT care
- The CRT provides a thorough induction programme for new staff and ongoing training and supervision in core competencies for CRT staff
- The CRT reviews, prescribes and delivers medication for all service users when needed

Cheshire and Merseyside- Common Themes

NHS
North West Coast
Strategic Clinical Networks

The CORE fidelity reviews found that the Cheshire and Merseyside Mental Health Trusts had a number of common areas of development. They are:

- The CRTs are not currently full multi- disciplinary staff team
- The CRTs are currently unable to access a range of services to help provide an alternative to hospital admission for service users experiencing mental health crisis
- The CRTs do not provide frequent visits to service users
- The CRTs do not have a psychiatrist or psychiatrists in the CRT team, with adequate staffing levels

Next Steps

- Local MH Trusts to develop service improvement plans which will assist them to improve their overall fidelity score and develop a high performing CRHTT service.
- Looking at opportunities for Collaboration across C&M STP
- Looking at developing a common definition for ‘what is a crisis and what should CRHT Teams work with across the STP’ to ensure consistency and reduce variation
- Undertake a further CORE fidelity review in 12 months’ time to measure whether any improvements that are made during this time have impacted upon the CORE Fidelity scores that have been given during this process.

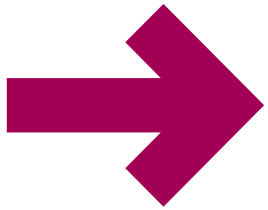
Any questions?

Thank you

NHS
Yorkshire and the Humber
Clinical Networks

Yorkshire and the Humber Mental Health Network

Question and Group discussion session: Y&H CORE Reviews



NHS
Yorkshire and the Humber
Clinical Networks

Yorkshire and the Humber Mental Health Network

Thank you for Attending!

Please remember to fill out your evaluation forms!