**Rotherham Crisis Alternative Service Specification**

**November 2024**

**National/local context and evidence base**

Both the NHS Long Term Plan for Mental Health (2019) and National Service Framework sets an ambition for more comprehensive crisis pathways in every area that are able to meet the continuum of needs and preferences for accessing crisis care, whether it be in communities, people’s homes, emergency departments, inpatient services or transport by ambulances. A particular focus of the Mental Health Long Term Plan is around investment in complementary and alternative crisis services (sanctuaries, crisis houses etc). Staffing models for these types of services much include peer support workers and will requirement partnership with voluntary sector providers of all sizes.

Access to suitable crisis alternative provision in the form of access to a crisis house is a requirement of the Royal College of Psychiatrists QN-CRHTT Standards.

Rotherham’s Mental Health and Wellbeing Strategy main focus is on improving public mental health with a particular focus on early and responsive intervention. The crisis house will focus on those individuals who require immediate intensive support without delay whereby a community-based intervention may be more beneficial and appropriate than an acute mental health inpatient admission.

**Service Objectives and Outcomes**

The primary objective of the Crisis Alternative Service will be to provide a 24hrs / 7 days a week alternative option to an acute inpatient admission. The service will support individuals requiring a brief period of increased emotional and practical support in a supportive environment to enable them to navigate their current crisis. The service will offer short term overnight crisis support for individuals who are assessed as likely to benefit from a short term stay in a suitable crisis alternative provision to help them manage a mental health crisis.

In addition, where a patient is identified as clinically ready for discharge but the discharge is briefly delayed or will likely take place on a Friday when there is no care team available, agreement can be made to discharge the patient to the crisis alternative provision for a maximum of 3 nights, Friday-Monday.

The service activity will broadly fall into the following elements:

**Benefits**

* Providing the least restrictive environment for individuals requiring brief intervention environment to their home address.
* Personalised care that is recovery focussed.
* Effective partnership working between NHS secondary care and voluntary sector.
* Reduced pressure on acute inpatient beds for admission for brief crisis management.
* Reduction in out of area bed usage.

**Provider responsibilities**

The successful provider will provide or be required to:

* Overnight crisis accommodation for 1-2 people, up to a maximum of 7 days.
* Crisis accommodation that is staffed 24 hours/ 7 days per week with sleeping nights for one member of staff. Provider to review client suitability considerations to reflect the current staffing agreement.
* Appropriate staffing compliment to match the needs of the individuals accessing the service, for example, all male service users may require a male member of staff on nights.
* Adequately manage its staffing levels during the contracting period to provide safe and effective care to individuals during their stay.
* Develop and implement appropriate pathways and communication protocols as described in Appendix A that details:
  + How new referrals will be received and managed in a timely manner.
  + The admissions procedure, paperwork requirements etc.
  + Engagement with secondary care teams to agree visiting frequency, reviews for individuals before, during and after an individual’s stay.
  + How the provider will provide increased emotional and practical support to enable individuals to navigate their current crisis, documented in an agreed care plan.
  + Arrangements for safe storage and administration of medication and for emergency medical care (physical and mental health) during the individuals stay.
  + Plan an appropriate discharge with the individual and secondary care teams.
* Adhere to the latest government guidelines for COVID-19 providing staff with the appropriate PPE.
* Support individuals to access community resources to help address any presenting needs i.e. access to GP, housing, benefits, local support groups etc.

**Acceptance and exclusion criteria**

The acceptability of patients will be pertaining to the following criteria:

**Acceptance Criteria:**

* Referrals will be made on an individual basis for individuals presenting to mental health services who are assessed as likely to benefit from short term admission to crisis accommodation as an alternative to an acute inpatient admission, or to provide support to patients who are clinically ready for discharge but whose discharge is briefly delayed or likely to take place during a weekend.
* Crisis accommodation is suitable for a person requiring a brief period of increased emotional and practical support in a supportive environment to enable them to navigate their current crisis.
* Gatekeepers will aim to identify the most appropriate environment to meet the needs of the individual.
* Rotherham Residents aged 18 years and above.
* Must be able to be safely free of illicit drugs and alcohol for the duration for the admission.
* Service to be informed of any reasonable adjustment necessary to support the individual to access the service.

**Exclusion Criteria:**

* Crisis accommodation is not suitable for people presenting as acutely unwell or assessed to be an immediate or significant risk to themselves or others which would indicate the need for a higher level of intervention e.g. admission to an acute mental health ward.
* People who do not have a suitable destination to return to on discharge from the crisis accommodation.
* People who are assessed as required an admission longer than 7 days.
* People who do not have capacity to understand the rationale for admission.
* People who are not able to meet their self-care needs independently or with minimal prompting from provider staff.
* People who are not able to manage their own medication independently or without prompting and support from provider staff.
* Patients who are under 18 years of age.

**Interdependencies with other services/providers**

* Housing and Housing Related Support
* Wider community supports such as food banks, support groups etc
* Voluntary sector organisations i.e. peer support
* Other organisations, as appropriate

**Outcome Measures**

Use of an appropriate patient reported outcome measure completed on admission and discharge.

**Provider Reporting**

* Quarterly bed occupancy figures, total number of referrals, total number of accepted referrals, number of referrals declined and reasons for decline, referral reason, length of admission to crisis provision, discharge destination, referrals to other agencies and patient feedback.
* Summary of practical support provided during the admission and referrals to other agencies.
* Patient Reported Outcome Measures/Improvements

**Appendix A**

**Proposed Crisis Alternative Admission/Discharge Process**

**Access/Referral**

* Rotherham Crisis, Home Treatment or Hospital Liaison Teams to identify individuals who require a short term stay as an alternative to an acute mental health hospital admission or to provide support to patients who are clinically ready for discharge but whose discharge is briefly delayed or likely to take place during a weekend.
* Referral suitability will require to take into the consideration that the service will provide sleeping nights not waking nights.
* The service will operate 24hrs per day / 7 days a week.
* Referrals can be submitted, reviewed and accepted between 07.00 hrs and 21.00hrs.
* For all potential referrals to have an agreed referral form completed, an up to date FACE risk assessment and assessment and review suite documentation. These are to be shared with staff who are determining referral outcome.
* When/if accepted, an agreed transfer of care with time of arrival and hand over period to be agreed at point of acceptance.
* On admission to the unit a clinical entry to be written in the provider notes, any added/amended detail to the clinical documents to be shared along with a verbal handover.
* Agreement on length of stay (maximum of 7 nights- unless exceptional circumstances to be jointly agreed by RDaSH, the Provider and individual in receipt of services)
* Date of initial review to be agreed at point of admission.

**During stay**

* Patients not open to a community mental health team will continue to receive follow up support by the crisis/home treatment/hospital liaison team and an initial review arranged within the first 72 hours.
* Patients who are already open to a community mental health team will have a follow up assessment completed during the admission by a named lead professional/care coordinator or allocated team member and a review arranged within the first 72 hours.
* All review outcomes to be documented in the provider records and on RDaSH electronic records.

**Discharge**

* Admitting team (either Crisis/Home Treatment/Hospital Liaison or North/South locality community mental health team) to attend for a pre-discharge meeting the day before discharge to ensure any identified follow up interventions are in place and discharge arrangements confirmed.
* Communication with the patient to be maintained with the patient at all time during their stay.

**Monitoring process**

* RDaSH to review the service provision on a regular basis and to ensure that the requirement is being met. Clear channels identified for escalation of any operational issues with leads from the provider and RDaSH present.
* Individuals being admitted to crisis alternative provision will be agreeing to a short term stay for up to 7 days, which will be flexible to meet the needs of the individual.
* The individual must remain under the care of a community mental health team (RDaSH) or the Crisis /Home Treatment Team whose responsibility it is to proactively follow up the identified accommodation needs for individual patients in a timely manner.
* If there are issues with discharges to community settings this is to be flagged with RDaSH Leads.