GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Cardiff and Vale University Health Board	**Reference Number:** UHB 296 **Version Number:** 1 **Date of Next Review**: 8th Oct 2018 **Previous Trust/LHB Reference Number:** N/A

CRISIS SERVICE DISCHARGE TO COMMUNITY MENTAL HEALTH TEAM (CMHT) PROCEDURE

Introduction and Aim

This document outlines the process by which a service user's care will be safely transferred from the Crisis Services to the Community Mental Health Teams, the time scale in which the transfer should occur and the person(s) responsible.

Objectives

Safe transfer of care from the Crisis Services to the Community Mental Health Team.

Scope

This procedure relates to all people who require discharge from the Crisis Service to a Community Mental Health Team.

Equality Impact Assessment	An Equality Impact Assessment has not been completed as this Procedure is in support of: The Operational policy for Integrated Community Mental Health Teams (C&V UHB 2012) Crisis Resolution and Home Treatment Team Policy (C&V UHB 2012) which has a valid EQIAs.
Documents to read alongside this Procedure	• The National Confidential Inquiry into Suicide and Homicide by People with Mental illness (DOH 2013) • The Operational policy for Integrated Community Mental Health Teams (C&V UHB 2012) • Crisis Resolution and Home Treatment Team Policy (C&V UHB 2012)
Approved by	Mental Health Policy Group Adult Mental Health Patient Quality & Safety Clinical Board Quality & Safety
Accountable Executive or Clinical Board Director	Clinical Board Director for Mental Health
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Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	08/10/2015	07/04/2016	New document

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Crisis Service

Discharge to CMHT Procedure

Rationale

The development of the Crisis Resolution & Home Treatment Service has allowed clients suffering an acute psychiatric crisis to be treated in their own homes, as an alternative to inpatient admission. Prior to the introduction of the Crisis Resolution & Home Treatment Service, service users received inpatient care on an acute unit and on discharge some were followed up by the appropriate member of the Community Mental Health Team (CMHT). Those service users receiving post discharge follow up care via the CMHT would have been offered an Out Patient Appointment within 1-2 weeks following discharge. In the report '*The national Confidential Inquiry into Suicide and Homicide by People with Mental Illness' (DoH* 2013), it is recommended that follow up should be within 7 days post discharge, as post-discharge suicides were most frequent in the first two weeks after leaving hospital and 23% of suicides by community patients within 3 months of hospital discharge. Therefore, best practice would be to offer a follow up appointment, with a member of CMHT staff, within this timeframe.

Care Co-ordination and Care and Treatment Plan Reviews

The Mental Health (Wales) Measure 2010 places duties on mental health service providers to appoint care coordinators and develop a care and treatment plan for a person who is receiving secondary mental health services. Part 2 of the measure also prescribes the form and content of the care and treatment plan.

Part 3 of the measure gives the right to former users of secondary mental health services to self refer directly for an assessment of their mental health.

The care and treatment plan must be proportionate to the need and the risk of the person who is receiving secondary mental health and will be based on an ongoing assessment and review of the level of need and risk.

Secondary mental health services will include those provided by inpatient mental health units and crisis services.

As the Crisis Resolution & Home Treatment Service offers an alternative to in-patient admission, it follows that all service users under the care of the Crisis Resolution & Home Treatment Service will also be subject to Parts 2 and 3 of the measure.

The regulations to part 2 also require that there is a review held, as a minimum, at least once on an annual basis.

Review of the care and treatment plan and discharge planning will form an integral part of the service users' care. Liaison with other involved agencies will take place early in any work undertaken to ensure continuity of care.

It is also expected that a review should be held as soon as reasonably practicable when there are any significant changes to health or social needs, if there are changes to the identified risk level of the individual, including awareness of any new information. This will also include when there are changes to levels of care including transfers or discharges between teams.

A formal review will be undertaken as soon as practicable:

- Following admission to hospital or other inpatient services, but no later than 4 weeks.
- Prior to planned discharge,
- As soon as reasonably practicable following unplanned discharge
- Upon request from the service user, carer or significant other
- Upon request from care coordinator or service provider

If the person has been admitted to hospital, or is receiving support from the CRHTT a review of care and discharge planning should occur as soon as practicable following admission.

This will include consideration of whether the person will remain within secondary mental health community services and who the care coordinator will be if not previously identified.

A formal and clear record will be made at each occasion of review including changes to care and treatment plans and any updates to assessments (including risk assessment).

Procedure for discharge from Crisis Services to CMHT

1. Following a crisis services case review with the service user their family or carer, a provisional discharge date should be set.
2. In consultation with the service user their family or carer and the care co-ordinator the provisional date should be converted to an agreed discharge date.
2. A review must take place, prior to discharge, and form 3 must be completed as part of the weekly Case Review process. The Risk Assessment must be updated as part of the discharge process by the Crisis Service. The review will take into account the needs and views of the service user, care co-ordinator and any others involved in the service user's care.
3. A clear plan must be in place detailing post discharge follow up: this should include the date and name of the next CMHT contact, be recorded in a Discharge Summary on PARIS and sent to the client's GP within 48 hours.

4. The CMHT follow up contact must be within five working days of discharge from the Crisis Resolution & Home Treatment Service in the same way as it would be from In-patient services. Contact must be recorded as “direct client contact”. In some rare cases this might be telephone contact; however this must be discussed and agreed as appropriate by the MDT or the Integrated Manager of the CMHT. Any DNA’s to follow up must be discussed and a decision for further follow up appointments agreed at the next MDT.

5. The Crisis Resolution & Home Treatment Team will liaise directly with the Care Co-ordinator to arrange the follow up appointment, or, in their absence due to annual leave, sickness etc., the Integrated Manager of the relevant CMHT.

6. For service users Care Co-ordinated by the Crisis Resolution & Home Treatment Team, the CMHT will allocate a new Care Co-ordinator, within 14 days prior to discharge from the Crisis Service. The service user will remain the responsibility of the Crisis Resolution & Home Treatment Team until this process is complete.

7. If the crisis service concludes that discharge to Primary Care is appropriate, the CMHT will not provide follow up care, including the 5 day follow up

8 Service users who are being discharged from crisis services and who do not require follow up within secondary mental health services, must be informed of their rights of self referral under part 3 of the measure by the crisis service at the point of discharge.

Audit

In order for Paris reports to be accurate, the crisis service will ensure that all referrals and assessments are closed in a timely manner, and a discharge case note completed on the day of discharge from the crisis service, to allow for accurate statistics to be gathered.

CMHTs must ensure that follow up contacts are recorded as a “direct client contact” to allow for accurate data collection through Paris reporting systems.