Care Quality Commission

Mental Health Crisis Care: Barnsley Summary Report

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This inspection was carried out under section 48 of the Health and Social Care Act 2012. This gives CQC the power to assess how well services work together, and the effectiveness of care pathways, rather than the quality and safety of care of one single provider. Under Section 48, CQC has no power, to rate a service or services.

This report describes the key findings from CQC's local area inspection of health and social care providers delivering care and support to people experiencing a mental health crisis within the local area of Barnsley Metropolitan Borough Council. Where appropriate, it references the role of the police force, voluntary organisations and commissioners.

The report assesses the services available through different providers within the council's local authority area. This is based on a combination of what we found when we inspected, information from our national data review on mental health crisis care, and information provided to us from patients, the public and other organisations. Using the key lines of enquiry (KLOE), we have made narrative judgements on the health or social care services, but the report should not be seen as a sole judgement on any one provider.

The findings of this inspection have been used to inform our national report on mental health crisis care in England. They will also be available to CQC inspectors when they undertake future inspection activity in this area.

Summary of findings

Overall summary

We looked at the experiences and outcomes of people experiencing a mental health crisis in Barnsley, in particular those people who presented at accident and emergency departments.

We found that services provided to people experiencing a mental health crisis in Barnsley were delivered by a number of partner agencies that were committed to working together to achieve the best outcomes for people with an emphasis on early intervention and identifying people's needs at the earliest opportunity.

Accident and emergency services are provided at Barnsley Hospital by Barnsley Hospital NHS Foundation Trust and mental health services by South West Yorkshire Partnership NHS Foundation Trust that included Kendray Hospital.

Across the pathway we found a dedicated and committed staff group who demonstrated a willingness to develop and provide services for people in crisis. Staff were passionate about their roles and responsibilities and this was observed across all teams we met. The sharing of electronic care records between the acute trust and the mental health trust remained a challenge but this was high on the agenda of both the commissioners and providers.

People who experience a mental health crisis and who present to Accident and Emergency

- **Care pathways**

When people presented at accident and emergency a triage assessment took place that was in line with national triage guidelines and included a risk assessment. People were first seen by acute nursing staff who then alerted colleagues from the mental health liaison team if they had concerns about a patient's mental health. The mental health liaison team was managed by the local mental health trust and provided mental health assessments and support to patients over the age of 18 years with a functional mental health illness. We found that the vast majority of patients were seen within a four hour period of them arriving at the hospital or in a community location.

There were pathways in place to respond to the needs of patients who went missing from the accident and emergency department, which included taking a description of the patient and completing a risk assessment before making the decision to alert police and emergency services about the patient's disappearance.

A significant and substantial piece of work was in place for frequent and high users of emergency services, including attendance at accident and emergency, contacting emergency services and out of hour's primary care services. Yorkshire Ambulance service in partnership with other agencies and providers had established a 'High

Intensity Users Group' that met monthly to look at patients who were high users, to discuss ways of responding and managing these patients including developing an individualised care plan for people. The group was established in September 2012.

- **Referrals from accident and emergency**

Following assessments in accident and emergency, a range of treatment options were available to people requiring further care and support. These included transfer to the clinical decisions unit where they could remain for up to 48 hours with support provided by the mental health liaison team. If individuals were known to the home based treatment team then contact would be made to alert the team of the patient's presence on the unit. There were clear protocols in place between the emergency department, acute and mental health, substance misuse service and alcohol services.

Individuals who experienced a mental health crisis could also access help and support from the Intensive Home Based Treatment Team (IHBTT) who operated 24 hours, seven days a week. The team offered home visits and telephone support and also attended all mental health act assessments. Risk assessments and crisis plans were in place for people who were known to the team and these were used effectively to manage and support people through crisis and help reduce the need for hospital admission.

- **Access**

Within the Barnsley area there was a section 136 suite located at Kendray hospital. We were told that due to staffing shortages on the wards that staff were not always available to staff and manage the section 136 suite and that it was sometimes closed. When the unit was closed people on a section136 section were taken to the accident and emergency department at Barnsley Hospital. Whilst acute staff were making the best of what resources they had, the bay they were using to accommodate individuals on a section 136 was not a designated place of safety and was not suitable for vulnerable detained patients. For example we observed free standing equipment, cords and a number of ligature points.

Staff told us that Approved Mental Health Practitioner (AMHP) cover was well organised but that there were problems in accessing section 12 doctors during day time hours and particularly on a Friday afternoon. Evenings and night time periods were less problematic because a rota of section 12 doctors was in place. The lack of availability of section 12 doctors impacted on the time it took to complete a mental health assessment of patients detained on a section 136 order.

A 'Street Triage' project was being piloted in the Barnsley area. At the time of our inspection the pilot had been running for one month. We received positive feedback on the scheme, including that it had been successful in reducing the number of section 136 detainees and reduced the attendance of police officers at accident and emergency and custody suites. Police and staff from the mental health liaison team told us it was successful because, '…people are getting the help they need there and then.'

Local strategic and operational arrangements

The local mental health trust, acute trust, the joint commissioning team (Local Authority and CCG), local authority, police and ambulance services had built good relationships and meetings took place regularly between organisations involved in the commissioning and provision of emergency mental health services. It was noted the social work team located at Barnsley Hospital were not involved or included in discussions at this level. The local area had developed an action plan in place to respond to the Crisis Care Concordat and many areas had been actioned and others were well on their way to being met.

Partners had worked and continued to work in developing a number of strategies to support people in crisis and there was a clear recognition of the importance of early intervention when people experienced mental health crisis, of working together and a consistent approach.

The Joint Strategic Needs Assessment for Barnsley supported a shift in focus from treatment to prevention, with greater emphasis on community based services and there was a clear strategic vision and agreed way forward to improve mental health and wellbeing of working age adults and older people with functional mental health problems. This meant supporting people in the least restrictive way and as a consequence of this and through working closely with commissioners a range of community services had been developed to support people to remain in their homes and avoid admission to hospital, for example, the Intensive Home Based Treatment Team, the 'Street Triage' scheme and a single point of access (SPA) pilot underway to look at how patients accessed service from primary care.

We found that joint training between accident and emergency staff, staff from the mental health liaison team and the police meant that a greater understanding of each other roles, duties and responsibilities had developed and this was complemented by a positive working relationship. Similarly we found that staff from the local mental health trust provided training in basic mental health awareness to junior doctors in accident and emergency, nursing staff and other staff to assist them in their understanding of people with mental health problems.

Governance arrangements ensured there was plenty of opportunity to monitor and review service provision and this included monthly High Intensity User Group meetings. The group met monthly to discuss and consider the most appropriate way of responding to and managing people's behaviours and this ensured a consistent approach by acute hospital staff, staff from the local mental health trust, the police and ambulance services.

Areas of good practice

- Strong multi-agency working between acute hospital staff, mental health staff, police, ambulance, commissioners and local authority staff. This was underpinned by a strong commitment to working towards the principles of the Crisis Care Concordat.

- Dedicated staff group who demonstrated a willingness to develop services provided for people in crisis. Staff were passionate about their roles and responsibilities and this was observed across all teams we met.

- People known to mental health services have 24 hour access to Intensive Home Based Treatment Team (IHBTT) via telephone. The team had a gatekeeping role in respect of inpatient beds. The impact of the team meant that people were supported in their homes and hospital admission was avoided.

- A successful 'Street Triage' pilot was in place which had already impacted on the number of people who were subject to a section 136 order and admissions to accident and emergency.

- A significant piece of work was being done in respect of patients who were high uses of emergency services, known as the High Intensity User Group.

- Joint training initiatives between acute trust staff, mental health trust staff and police had led to an understanding of each role in supporting people who experience mental health crisis

Areas for development

- Local partners to ensure adequate provision of health based place of safety. This should include recording the occasions when and reasons for people having been turned away from the section 136 suite has been denied and the reason for this. Regular review and monitoring of the data collected should form part of the quality monitoring arrangements.

- The local authority hospital social work team should be included in partnership working arrangements. The hospital social work team are frequently the first point of contact when a clinical decision to discharge a patient has been made. They have input with all patient groups that present at accident and emergency including patients with mental health crisis.