Care Quality Commission

Mental Health Crisis Care: Sandwell 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 Sandwell 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

Sandwell is a metropolitan borough in the West Midlands which is part of a larger area to the north and west of Birmingham known as the Black Country. The borough comprises six smaller towns and has a population of just over 300,000. The borough is densely populated and, because it is well served by transport links, other large population centres are close by and accessible.

The borough is considered to be in the 20% most deprived areas of England. The population of Sandwell is diverse with around 70% white, 19% Asian, 6% black and 5% of people who describe themselves as mixed race or in another ethnic group.

Acute and secondary health care, including accident and emergency (A&E), is provided by the Sandwell and West Birmingham Hospitals NHS Trust (SWBH but referred to below as 'the acute trust'). The borough's mental health services are provided by the Black Country Partnership NHS Foundation Trust (BCPFT but referred to below as 'the mental health trust').

The main acute hospital that includes accident and emergency (Sandwell General Hospital) and the principal mental health location that includes mental health wards and the place of safety for patients detained under section 136 (Hallam Street Hospital) are closely located just outside the centre of West Bromwich.

We looked at the experiences and outcomes of people experiencing a mental health crisis in Sandwell. In particular those people in crisis who presented at accident and emergency departments, people known to services and receiving ongoing support from specialist mental health services and people detained under section 136 of the Mental Health Act. Overall, people experiencing a mental health crisis in Sandwell benefitted from services that were safe, effective and caring.

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

People who presented at the acute trust's accident and emergency department with a mental health problem could have their mental health needs assessed alongside their physical needs. This assessment took place in the Oak Unit that was co-located within accident and emergency. This unit was a 24 hour mental health assessment and intervention service staffed until 11pm by the Mental Health Liaison Team (MHLT) and, currently, after 11pm by the crisis team. The unit was designed to provide a quiet and calm environment away from the potentially anxiety provoking environment of accident and emergency. Staff were proud of the service they offered and were working with a neighbouring service to support development of best practice. Staff also reported that the operation of this unit had supported physical and mental health being considered as equal priorities.

- **Access**

Patients presented at accident and emergency, where any physical injury would be attended to before being referred into the Oak Unit. In addition, patients under the influence of drugs or alcohol and patients who were particularly disturbed were also

managed in the accident and emergency department until such time as they could be seen in the Oak Unit or by the crisis team.

We heard mixed views from patients and carers we spoke to. Most people described wholly positive experiences but we learned of several instances of people being left for lengthy periods in accident and emergency without being seen by the Oak Unit staff. We also received a number of reports of people not being able to get through to speak to the crisis team after 8.30pm. For example, one person reported to us that they had been told to ring the police as the crisis team were unavailable. A recurring theme from patients and carers was that the Oak Unit was a good, caring service once they got there but that accessing the service was often too big a problem.

- **Care pathways**

Protocols used in the Oak Unit were clear and person-centred. Assessments were driven by, and recorded on, a comprehensive 'common assessment tool' which followed a care programme approach. Our review of case notes and interviews with staff showed safe and effective assessments and interventions.

The service referred patients onwards according to their assessed needs, either to one of the mental health trust's community teams, the patient's GP or one of a number of other local specialist groups such as local drug and alcohol services. In a crisis patients could also be admitted as an in-patient to a bed in the mental health trust's adjacent Hallam Street Hospital.

Whilst the Oak Unit was providing a positive, responsive service for adult patients who presented at accident and emergency, this service was not available for children and young people. Younger patients remained in the accident and emergency department and were seen by the crisis team. At the time of our inspection, a new, extended Child and Adolescent Mental Health Services (CAMHS) response service had just been implemented in response to a recognised service gap. However, this had only been running for two weeks so it was too early to measure its effectiveness. We noted that the ambulance service and the NHS 111 out-of-hours service were unaware of the existence of the new service for young people.

- **Information sharing**

Staff told us they thought the liaison between them was effective and safe and that information was shared efficiently and openly in individual cases. We noted, however, that there were significant gaps in the electronic recording of risk on the computer system so risk assessments carried out in one part of the service were not electronically available to staff in other parts of the service.

For example, if someone presented out-of-hours, the crisis team would be unable to access certain information that would help in the assessment process, such as notes from the community teams, social care notes, medical records and detailed risk assessments. Patients who shared their experiences with us highlighted that they often had to repeat themselves as information they had previously supplied did not seem readily available when moving to another part of the service.

Risks to patients were assessed using established risk assessment tools with management plans produced in response to any identified risks. We saw that the mental health trust learned from safety incidents and took action where appropriate. However, there was no structured, strategic, multi-lateral approach to data gathering and safety

monitoring across partner organisations.

- **Staffing**

There was an adequate skill mix across both the crisis team and the Oak Unit and this was supported by safe, joint operational protocols that were understood by both teams. At the time of our inspection, the Oak Unit was staffed until 11pm as a result of some additional funding allocated for the service. Ordinarily, however, this service would end at 5pm and hand over to the crisis team. As the crisis team covered a range of services, not only the Oak Unit, additional staff had been recruited to help address the expected increase in demand when the additional funding ceased.

Patients and carers we spoke to told us that they felt there was not enough staff and that some staff lacked the skills and knowledge to carry out the job. We learned, anecdotally, of a number of incidents of people waiting so long in accident and emergency to be seen that they would often leave and go home.

The Oak Unit staff offered training in mental health to student doctors and other accident and emergency staff. However, there were no other arrangements for joint agency training and no training in mental health at all for NHS 111 staff.

People who experience a mental health crisis and who require access to and support from specialist mental health services

- **Access**

A range of different types of service were provided to people with mental health needs in Sandwell which were focused on providing largely community based support through community mental health teams (CMHT). There were also a variety of non-NHS services that provided different types of support to people in different circumstances, including residential accommodation for people in a crisis.

Predominantly, these services helped individuals with a developing short-term crisis by intensive treatment and support outside hospital through their respective care co-ordinators and with the intention of avoiding hospital admission. This included daily home visits to people if required.

This level of support was offered to individuals who were experiencing a mental health crisis during normal working hours, 9am to 5pm. Outside of these hours the options for adult patients included contacting the crisis team through the single point of access or by presentation at accident and emergency. For children and young people out-of-hours crisis care was accessed through the local authority social care emergency duty team.

It was acknowledged by both operational and managerial staff that the CAMHS service was hampered by the lack of in-patient beds locally. We heard of several examples where young people had had to be accommodated in different parts of the country, sometimes as far away as Yorkshire or Norfolk. Furthermore, and until just two weeks before our visit, the CAMHS service only saw new patients up to 11am. This had recently been extended to 5pm. Commissioners told us that they intended to continue to support the extended hours for the CAMHS service although it was not clear how its effectiveness would be assessed.

Support to people with learning disabilities was provided through the learning disabilities team who had access to psychiatrists, mental health nurses and occupational therapists

through their links with the CMHTs. In addition we saw that the CCG and the learning disabilities service had been exploring a number of ‘hospital avoidance models’ in use in other parts of the country with a view to adopting such a model in Sandwell.

- **Information Sharing**

Staff members in both the CMHTs and the crisis team spoke of good, open relationships with each other and said they could pick up the phone and hand over information at any time. Where possible, assessments were carried out jointly between the crisis team and specialist teams and this was the point at which the most useful information was exchanged by word-of-mouth. We learned of examples of case conferences that had been held where the CMHT and the crisis team had been represented where this had worked well.

During normal working hours hand-over of information about individuals was effective. However, if hand-over was out-of-hours information sharing was limited due to the incompatibility of the computer systems used by different teams or by not fully utilising the systems available.

A common concern we received from patients and carers was that they had to repeat information when moving from one part of the service to another. Staff we spoke with acknowledged that the common assessment tool was frequently repeated and this was due to lack of information on the computer system.

GP’s representatives we spoke with reported that they were not always aware of information about patients and felt that there was a need for primary and secondary care organisations to work more closely together.

- **Support for carers**

Support was offered to carers through a specific service that carried out assessments of their needs and provided support on either a one-to-one basis or as part of a group. This service was very highly regarded and had provided carers with practical and emotional support that enabled them to cope with their relatives and their illness. We saw that carers were seen as very much part of the assessment and treatment process and were involved alongside their relatives in the assessment of risk. Carers were referred directly to this service and were seen within 72 hours of their relative’s crisis. Furthermore, the carer’s team had direct access and could make referrals to the crisis team.

- **Staffing**

We found that there was a broad disciplinary mix of professionals within the community mental health teams providing a focus on crisis prevention. Staff reported they had some difficulty in accessing psychiatrists as they were not based within the teams. A new initiative had been introduced with the aim of offering out-patients appointments within one week. However, if urgent medical assistance was required patients were referred to the crisis team.

Some concerns were voiced to us about a decline in Approved Mental Health Practitioners (AMHP) numbers and difficulties in recruiting and how this would impact on capacity. The management of AMHPs had recently moved under the local authority’s social work department. The implications of this were not yet clear although two additional AMHPs had been recruited for deployment to the crisis team.

People who experience a mental health crisis and who are detained under Section 136 of the Mental Health Act

- **Street Triage**

Since November 2014 a street triage initiative had operated in the area between the hours of 10am and 2am on Sunday to Thursdays and between 10am and 3am on Fridays and Saturdays. This was a response vehicle staffed by a police officer, an ambulance crew member and an AMHP. There was a street triage risk assessment form in use that enabled the crew members to log and consider risk factors such as the patient's risk history, offending history, substance use, social circumstances and medication. This was based on information obtained by the staff members from their own systems and databases whilst travelling to or shortly after arriving at an incident. It enabled the team to consider the nature of any risk they presented to themselves or to others and to determine whether the person was in need of a more comprehensive crisis assessment.

We found that there was still some lack of understanding about the precise role of the street triage unit owing to it being a relatively new initiative. For example, we learned of a recent incident where the street triage unit had been directed to the Oak Unit by the crisis team for a particular patient but had then been turned away on arrival.

Although the programme was in its infancy staff we spoke to believed the implementation of the street triage unit had been effective in reducing the use of section 136 and attendances at accident and emergency. Data was collected by the police to help evaluate the service. To date no information about people's experience of the street triage had been gathered by the service. We found some uncertainty in patients' understanding of the street triage. For example, one patient told us they were not sure if the car had been called to provide transport home or to the hospital, was confused about its purpose and found the experience of answering questions in a car distressing.

- **Access to health based place of safety (HBPoS)**

The HBPoS at Hallam Street Hospital was well equipped, clean, bright and comfortable. The suite could only accommodate one person at any one time and so there was a risk, albeit minimal, that it would be unavailable if more than one person reached the threshold for section 136. For example, we noted that on one occasion the suite had been used for seclusion of a person who was an in-patient at Hallam Street and so was not available for use for patients detained under section 136.

We were told that the lack of beds for children and young people had been problematic. For example, we heard of an occasion when a young person aged 16 years was detained under section 136 and taken to the HBPoS. On that occasion the documents required to admit the person could not be completed owing to the lack of a suitable placement, meaning that a police officer had to remain at the place of safety until such a bed was available.

Local strategic and operational arrangements

We heard from stakeholders that there was a historical underlying sense of frustration about a perceived lack of a joint strategic approach. The differences in the size and

boundaries of the populations that each strategic stakeholder had responsibility for and other demographic factors meant that there were difficulties in establishing what the precise strategic needs of the area were. We noted, for instance, that a joint strategic needs assessment had not been carried out across all the stakeholders. There were examples of strategic planning to address specific issues and operational groups to monitor issues including compliance with aspects of the Mental Health Act. However we found variability in the level of multi-agency engagement.

Our discussions with the group of key stakeholders demonstrated that there was a general optimism that things were changing and that strategic relationships were improving. For example, although the Crisis Care Concordat had yet to be formally signed up to by the key stakeholders at the time of our inspection, there was broad agreement for the principles and it had been a key influencing feature in some of the thinking behind recent initiatives; including the intended enhanced CAMHS service, the street triage initiative and the deployment of additional AMHPs to support the crisis team.

During our inspection we found that multi-agency training did not take place, despite a clear recognition of its benefits from practitioners and managers. However, we did see evidence that agencies had developed their own training to ensure their operational staff had a heightened awareness of mental health crisis. For example, the police had developed their own training in relation to exercise of their powers under section 136.

We found that the public were periodically engaged in consultation in respect of the mental health provision in the area. For example, we saw that between November 2013 and February 2014 the mental health trust and the CCG had embarked on a public consultation about the provision of a single point of referral for primary care and a multi-disciplinary community treatment approach. This consultation helped to shape the current provision of community mental health care in Sandwell. In addition, a service user forum, developed under the ‘Time to Change’ campaign (set up by the charities MIND and Rethink Mental Illness to challenge mental ill health stigma and discrimination) had been created.

Areas of good practice

- Highly motivated, committed work force with good working relationships between the mental health trust, the acute trust and the emergency services.
- The Oak Unit was an innovative, well regarded service that provided a quiet and calm environment for people experiencing a mental health crisis requiring assessment.
- Timely responses from AMHPs and section 12 doctors in relation to admission under section 2 of the Mental Health Act within 3 hours of a patient presenting at A&E and also in undertaking section 136 assessments.
- The separately commissioned carer’s team providing support and advice to carers that was very highly regarded by carers and patients alike.
- The implementation of a street triage unit providing professional mental health advice to police dealing with people with possible mental health problems.

Areas for development

- Development of key strategic relationships to support an area response to providing appropriate care for people experiencing a mental health crisis in Sandwell.
- A more structured, strategic approach to data gathering and safety monitoring to enable the impact of safety incidents to be assessed and learning to be shared across strategic partners.
- Increased opportunities for multi-agency training.
- For local strategic partners to consider how the commissioning and delivery of services supports accessibility and availability for all, including children and young people.
- Use of information systems to support effective and timely sharing of information between staff and services across Sandwell providing care and support to people experiencing a mental health crisis.
- Clarification of the remit of the street triage unit and roles and responsibilities of relevant partner organisations together with agreed protocols for its operation.
- Development of collection of information to support robust evaluation of the effectiveness of the street triage unit.