Care Quality Commission

Mental Health Crisis Care: Shropshire Summary Report

Date of local area inspection:
26 and 27 January 2015

Date of publication:
June 2015

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 Shropshire 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

Shropshire is a predominately rural county. The county borders Powys, Wales, which creates challenges when discharging patients to Wales and when accessing out of hour and community services. Shropshire also surrounds the Telford and Wrekin local authority.

The county's mental health services for adults are provided by Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT). Mental health services for children are provided by Shropshire Community Health NHS Trust. This review focused on Shropshire although the report will make reference to Telford and Wrekin where appropriate.

The local accident and emergency departments, located at the Royal Shrewsbury Hospital, Shrewsbury and Princess Royal Hospital, Telford are operated by Shrewsbury and Telford Hospitals NHS Trust (SaTH). The mental health trust (SSFT) provides liaison services (RAID) in the two local accident and emergency departments operated by the acute trust, as well as a service to assess patients accommodated on the wards.

We looked at the experiences and outcomes of people experiencing a mental health crisis in Shropshire in particular those people in crisis who presented at accident and emergency departments. We found that adults who presented at accident and emergency received care that met their needs. However, the pathways for children and young people were less robust.

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

Our key findings were in relation to:

- **Care Pathways**

We found clear pathways were in place between accident and emergency and the Rapid Assessment Intervention and Discharge (RAID) team. Patients were assessed within a timely manner and defined pathways followed in relation to referral to community services if required. Accident and emergency staff and the RAID team worked well together and viewed each other as colleagues. The RAID team provided ongoing training and support for accident and emergency clinical staff.

We found challenges around offering a service to children and young people. Children under the age of 16 years were referred to Child and Adolescent Mental Health Service (CAMHS). Children aged between 16 and 17 years were seen and assessed by the RAID team, with support from the CAMHS team. Due to the delays in being assessed, children and young people would be admitted to paediatric or adult wards in the acute hospital, neither of which were necessarily the most suitable place, as staff did not always have the skills to care for children in crisis.

- **Sharing of information**

We found that SSSFT and SaTH used different systems for recording electronic information. However, SaTH had recently changed their system, and the RAID teams were able to access this system. Staff told us this had improved sharing of information as they were able to view a patient’s past medical history. The RAID team assessed patients using an evidenced and well designed risk assessment, which was scanned into the electronic notes for SSSFT and filed in the accident and emergency records for SaTH.

We found that CAMHS used a stand alone system, that was different to the one used by their trust, the Shropshire Community Health NHS Trust. CAMHS staff told us they were unable to review a child’s records out of hours, as they had no access to the system. This meant they were not fully informed when they carried out an assessment.

- **Staffing**

The RAID teams which supported both accident and emergency departments were adequately staffed, with an appropriate skill mix. The teams consisted of a consultant psychiatrist, clinical health psychologist and operational manager (providing support for both teams), specialist nurse practitioners (self harm and older people/dementia) and nurse practitioners. RAID team members were also supported by 24 hour consultant cover provided by SSSFT. The RAID team, which was co-located within the hospital, was accessible 24 hours a day, 7 days a week at the Royal Shrewsbury Hospital. We found there was no difference in the service provided out of hours or in hours for patients who attended the Royal Shrewsbury Hospital.

The RAID team at the Princess Royal Hospital (Telford and Wrekin Local Authority Area) were also co-located in the hospital but only available daily from 8am until 8pm.Out of hours was covered by the mental health crisis team. The crisis team was based approximately 10 minutes away by car, and covered all of the Telford and Wrekin area during the out of hours period.

We found there were inequalities in the service provided for patients attending accident and emergency at the Princess Royal Hospital as target times were not always met by the crisis team during out of hours.

The recent CQC inspection of SaTH identified that both accident and emergency departments were not operating at the required staff levels, due to qualified nurse vacancies. Bank and agency staff were used to cover shortfalls. Neither of the accident and emergency department had sufficient whole time equivalent nurses with specific paediatric qualifications. There was no evidence to suggest the staffing levels impacted on outcomes for patients. However, it did mean that staff could not always be released to attend training provided by the RAID team regarding caring for patients with poor mental health.

We found that the needs of children and young people who presented in accident and emergency were not always met in a timely manner. When a referral was made to

CAMHS after 12 noon, the child or young person would not be seen until the following day, or after the weekend, depending on what day they attended accident and emergency. This was because CAMHS were not commissioned to provide an out of hours service and consequently there was a delay in children been seen and assessed if not admitted within normal hours.

- **Inpatient care and transport**

The Redwoods Centre in Shrewsbury provided acute inpatient care for adult patients with a mental health need. As admission to this unit was facilitated through the Crisis team, patients assessed as requiring admission sometimes had to wait in accident and emergency until a suitable bed was found.

There were no inpatient beds available for children and young people in Shropshire, and children were placed out of county. Children were therefore admitted to a paediatric or adult ward until a suitable place was found. The children's wards had recently been relocated from Shrewsbury to Telford. Children presenting at accident and emergency in Shrewsbury would have to be transferred over to Telford by ambulance.

We were told that patient transfers could also be problematic and delays often occurred. Routine transfers were organised through non-emergency patient transport services. Acutely ill or distressed patients would be transferred by West Midlands Ambulance Services. Out of county transfers were organised through a private ambulance provider.

- **Provision of services prior to presenting to accident and emergency**

Although care for people experiencing a mental health crisis within accident and emergency worked well, we were told this was not always the case for pre-hospital or post discharge care. Accident and emergency staff, RAID staff, ambulance staff and CAMHS staff told us patients and families often presented at accident and emergency as they had been unable to access the support they needed in the community to prevent the crisis occurring.

We also found there was a shortage of respite beds for patients. There were no inpatient beds for children or adolescents within Shropshire. Although a number of units were available for adults in Shropshire, demand for these places was high.

Local strategic and operational arrangements

Shropshire County Clinical Commissioning Group and Shropshire Local Authority were responsible for commissioning mental health services.

We found there was a shared commitment across partners for the principles and work of the Crisis Care Concordat. Although this work was at an early stage, an action plan had been developed which included specific target dates for completion of activities. This included recognition within the concordat that significant improvements were required around the use of section 136. Partners had also recognised that they needed to work more closely with the third sector, to identify the service and support available to people

in the community.

Shropshire and Telford and Wrekin CCGs had worked together to bid for NHS England monies to create a Pilot Mental Health Crisis Helpline. We were told the helpline would be operational by March 2015. The aim of the helpline will be to increase information sharing between service users, carers, all services, GPs, the police and ambulance service. The helpline will also be used to manage risk to patients in crisis due to greater knowledge through information sharing, and would be for all age groups from five plus years. Partners were very positive about the introduction of the helpline.

There were clear pathways in place between accident and emergency, the wards and the RAID team. There was also a pathway in place for section 136, although the RAID team were not involved with this. Operational staff in accident and emergency and the RAID team were familiar with the pathways. The effectiveness of the RAID team and response times were monitored and discussed at the monthly multiagency meeting. A formal review of the service was being undertaken by the University of Chester.

The partners had recognised the challenges associated with discharging patients back into the community who live in Powys, Wales. Powys operates a service from 7am-7pm on weekdays, and 11am-7pm at the weekend. Shropshire CCG were in discussion with Powys regarding delayed discharges, community services open to Powys patient and CAMHS emergency treatment.

Areas of good practice

- There was a well-integrated Liaison Psychiatry service provided through the RAID team. There was an effective working protocol between the accident and emergency department and the RAID team, supported by clear pathways for the RAID team to follow in relation to adults.

- There were good working relationships between the RAID team and the accident and emergency staff. The RAID team provided training and support for accident and emergency staff regarding caring for patients with poor mental health.

- There were no breaches in the RAID team targets for seeing adult patients with accident and emergency or on the wards. Any breaches that had occurred were related to the out of hours crisis team at the Princess Royal Hospital.

- Monthly multiagency meetings were held to discuss any operational issues regarding the service and had begun to look at frequent attendees and the development of preventive plans.

- Despite the limitations of the accident and emergency departments, the privacy and dignity of children, young people and adults in crisis or who had self-harmed was respected. Examinations took place in cubicles with doors, so that privacy was maintained. If cubicles with doors were unavailable, patient interviews took place in the relatives’ room.

Areas for development

- . Clarify the emergency care pathways for children and young people experiencing a mental health crisis to support appropriate and timely assessments.

- For local strategic partners to consider how the commissioning and delivery of services supports accessibility and availability for all, at all times including out of hours.

- Information sharing so that staff involved in the care of patients in crisis have access to relevant information, including electronic systems, at all times.