

Mental Health Crisis Care: Salford 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 Salford 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 Salford, in particular those people who presented at accident and emergency departments and those people in crisis who were known to services and were receiving ongoing support from specialist mental health services.

Positive and proactive interagency and partnership working was a feature across mental health crisis pathways in Salford. We found that agencies including the local mental health trust, the acute hospital trust, local council, police, ambulance and local voluntary agencies including carers groups worked well together. There was a shared understanding and commitment to improving care and support to people experiencing a mental health crisis. This included developing a crisis helpline that was available 24 hours 7 days a week and extending the operational hours of community mental health teams to include late evenings and weekends. There was an emphasis on early intervention coupled with providing services that provided care in the least restrictive way.

Services were delivered by a number of partner agencies that were committed to working together to achieve the best outcomes for people who experienced mental health crisis. Operational policies and procedures supported the practice and delivery of services across mental health crisis pathways.

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

- **Care Pathways**

People experiencing a mental health crisis could present at accident and emergency in a number of ways including via ambulance, police, sent by their GP or self-referral. Front line staff, including reception staff was knowledgeable and sensitive to supporting people in crisis. In particular with those people who were regular attenders.

Triage assessments took place that were in line with national triage guidelines and included a risk assessment. Adults who presented in crisis received a “parallel assessment”. This comprised an initial assessment by acute nursing staff followed by an assessment from the mental health liaison team. Acute and mental health staff worked together, discussing assessments and agreeing the most appropriate response. This could be a referral to the home based treatment team or a request for an assessment under the Mental Health Act 1983. We saw this process worked well and we were told this meant that people were not kept waiting for long periods of time. A range of services were available to support people post assessment at accident and emergency, with the least restrictive option being preferred.

Partner agencies had developed a pathway to follow in response to people who left the accident and emergency department whilst waiting for treatment or during a

consultation. Additionally, a pathway had been developed for people who were frequent attenders or who frequently contacted emergency services. Meetings between professionals were periodically held to consider the most appropriate way of responding to and managing people's behaviours and this ensured a consistent approach by all staff.

- **Equality of access**

As part of this review we looked at how children and young people accessed services when experiencing mental health crisis. CAMHS services were provided by Central Manchester University Hospitals NHS Foundation Trust.

Children presenting to accident and emergency did not undergo a "parallel assessment" experienced by adults. Children had to be medically fit before a mental health assessment was undertaken, however children could be seen by CAMHS prior to medical fitness if an urgent mental health assessment was required. Children under 16 years of age were admitted to the PANDA unit based at Salford Royal Hospital. Young people aged between 16 and 18 years of age were generally seen by staff from the mental health liaison team based within accident and emergency and acute nursing staff.

Staff on the PANDA unit observed children and carried out physical healthcare checks but did not carry out mental health assessments. Children could stay on the unit for up to 48 hours, after which they would be transferred to a children's hospital in the Manchester area for further assessment or until a bed was found. When children were transferred between services a risk assessment was completed.

Staff we met and spoke with on the PANDA unit were compassionate when talking about children with mental health problems but did not feel that they were sufficiently equipped to care for them as they had not received mental health awareness training.

Sharing patient information about this age group was problematic and acute staff and staff from the local mental health trust were not able to access records held by the CAMHS team. CAMHS did not have electronic patient records and this was seen by staff as a hindrance to effective handovers.

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

- **Service provision**

People had access to a range of specialist mental health services 24 hours a day, seven days a week. These included a mental health liaison service and a home based treatment team. People who used the home based treatment service told us they had received visits up to four times a day and this had helped them in their recovery and avoided an admission to hospital. Additionally people in crisis could also access support via community mental health teams for adults and an older people's team. There were plans to extend the operating hours of these teams to late evenings and weekends.

People could also contact the local authority emergency duty team.

At the time of our inspection we found that a 24 hour telephone helpline was provided by the local mental health trust and run by mental health liaison team. Feedback from people who used the services on response times was variable. We discussed this with senior managers from GMW, who were aware of the limitations of the current service and confirmed that through redesign had funded a new 24/7 helpline for known service users. It is planned this will be operational by May 2015

- **Care planning and records**

We looked at a sample of six care plans and found these to be detailed. There was clear evidence that people who used the services had been involved in the development of care plans and were given a copy. Some people who used the service told us that they couldn't recall having had a care plan and only one person had an advanced directive. However carers we spoke with confirmed that care arrangements and care plans were in place and they had been included and consulted as part of the assessment process.

We saw comprehensive risk assessments and risk management was facilitated across teams that supported people in crisis. These were used effectively to manage crisis and avoid admissions to inpatient facilities. The sharing of electronic care records between the acute trust and the mental health trust allowed information including risk management and care plans to be shared.

We were told of positive working relationships between community mental health teams and GPs, with GPs telephoning the team to discuss concerns.

- **User involvement**

There was evidence of good service user consultation, particularly around commissioning arrangements and a range of service user forums were held to gather the views and opinions of people who used services.

A range of multi-agency meetings were held between staff to consider how the services was performing and how it could be developed further to meet the needs of people who engaged with mental health crisis services. These meetings included representation from mental health teams, the police and ambulance services.

Local strategic and operational arrangements

Relevant local strategic partners had built good relationships and meetings took place regularly between organisations involved in the commissioning and provision of mental health crisis services. The local area had developed an action plan to respond to the Crisis Care Concordat and many areas had been actioned.

We found that agencies including local voluntary agencies such as carers groups worked well together. There was a shared understanding and commitment to improving

care and support to people in crisis. There was a clear commitment to commissioning appropriate and quality services for people and this was done through partnership and service user engagement.

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 Salford both explored and supported a shift in focus from treatment to prevention services, with greater emphasis on community based services and supported the mental health wellbeing agenda on prevention.

There was a commitment from partner agencies to 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. Following a period of intensive consultation with commissioners there were plans to make available a number of crisis beds at a community location.

Joint training between accident and emergency staff, staff from the mental health liaison team and the police had supported a greater understanding of each other roles, duties and responsibilities and was complemented by a positive working relationship.

Areas of good practice

- Strong culture of partnership working supported by effective multi agency working between all providers and agencies.
- Triage and assessment processes within accident and emergency in line with national guidance.
- Pathways for managing to people who go missing from or who are frequent attenders at accident and emergency that provided a risk based response to patients' needs.
- Comprehensive care plans with chronological records related to each patient's care following admission to hospital.
- Reconfiguration of services within Salford to include, 24/7 helpline, the development of 24/7 mental health liaison team within accident and emergency and the development of a 24/7 home based treatment team ensuring access to support for people in crisis 24/7.
- Committed staff with good knowledge of patients they cared for and supported. This extended to involvement and consideration of the needs of carers.
- 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

- Training of staff including: in Mental Capacity Act 2005 and the Deprivation of Liberties Safeguarding training available for all staff; access to mental health awareness training for accident and emergency nursing staff, doctors and reception staff and staff on the PANDA unit. Inclusion of people who use services in the planning and delivery of mental health training to staff.
- Local strategic partners to consider how services are commissioned and delivered to ensure the needs of children and young people experiencing a mental health crisis are met.