Care Services Direct
Quality Account
2009/10

The Oakwell Centre, Kendray Hospital
Part 1- Statement by the Board

I am pleased to present the first Quality Account for Mental Health Acute Services provided by NHS Barnsley’s Care Services Direct (CSD) provider services. With this report we aim to make information about the quality of Mental Health Acute Services delivered by CSD available to members of the public. Our hope is that by reading this account you will have a clearer picture of the work we are doing to continuously improve the quality of the services we deliver.

At CSD, our vision as an organisation is to-
‘be consistently recognised as a leading NHS provider of excellent Health and Social Care community based services which put people at the heart of everything we do’.

One of our main values which underpin this vision is to deliver high quality and accessible services to support individual and community wellbeing.

Our commitment to quality has been reflected in some of our recent achievements in Acute Mental Health provision-

- Implementation of the Productive Mental Health ward on the Oakwell Unit identified that the number of hours per day of nursing resource was taken supervising garden areas for patient access to smoking facilities. In consultation with service users, scheduling of smoking time was introduced. This has increased 1:1 time spent between nurse and service user, released 13.5 nursing hours per day, reduced the number of violent and aggressive incidents and improved patient well being through reduced smoking and increased access to fresh air.

- Opening of a 6 bedded psychiatric intensive care unit which will support us in caring for service users closer to home and reducing the numbers treated out of area.

We are committed to continue our journey to excellence, and we have well established systems of integrated governance to assure the quality of our services. Increasingly, we are involving Service Users and Carers in helping us judge how we are doing and how we can improve.

Priorities for 2010-11
As broad themes, we will be focusing our efforts for quality improvement in 2010-11 in the following priority areas:

- Clinical effectiveness,
- Safety and reliability and
- Patient experience

In addition to this, we are undertaking the following internal audits for 2010-11:

- Suicide prevention audit
- NICE guidance prescribing and monitoring in Bi-polar disorder
- Fidelity and best practice IHTT
- Level of gate keeping IHTT

Sean Rayner
Chief Operating Officer, Care Services Direct
Part 2

Priorities for 2010-11

As broad themes, we will be focusing our efforts for quality improvement in 2010-11 in the following priority areas:

- Safety and reliability,
- Patient experience and
- Clinical effectiveness.

Safety and reliability

- The Patient Survey

An action plan regarding findings from the Patient Survey was developed to improve patient safety.

The actions included:

- Work on the pathway of care which includes the handover of key information is underway through the rapid improvement program.
- The Intensive Home Treatment should be more involved with discharge planning to more fully to take into account the home situation

The actions were undertaken through the rapid improvement project.

Project Aims

- Timely discharge through planned interventions from admission to meet patient need
- Improve communication between different interfaces, promoting a more seamless approach
- Defining roles and responsibilities of staff on Acute Wards under new ways of working

72 hour MDT review led to the development of a 72 hour review planner in which a 72 hour review would be arranged inviting all relevant professionals including community mental health representatives along with the service user and relevant carers.

A six month audit of clinical records from inpatient admissions (pre-introduction of the 72 hour review planner) to look at these processes has been undertaken. There will also be the introduction of a care pathway document (at least covering the first 72 hours of admission) onto inpatient wards (including PICU).

The findings of the audit will be measured against outcomes from a second audit of clinical records from admissions occurring later this year to consider the impact of the 72 hour review planner and the introduction of the care pathway document. The initial audit, once analysed will also highlight current practice around the identified processes involved in the patient journey and allow for interventions to improve the quality of practice and the care delivered.
Patient Experience

- Ward Rounds
At community meetings service users regularly expressed dissatisfaction with the ward round process common complaints being;

“Care meeting was postponed without explanation”
“They did not spend enough time with the doctor due to him having to see someone else”.
“Clients felt they did not see doctor enough”
Other agencies and professionals who attend the meetings had similar concerns.

Using the productive ward as a tool kit for change, a launch date was arranged for Tuesday 27th April 2010 to look at the process of the ward round.

The outcomes for this day were as follows

1. What is the vision of a GOOD ward round?
   ‘Right’ people attending
   Forward planning – diaries
   Chaired
   Up to date information
   Service users involved
   Advocacy service
   Carers
   Preparation before meeting – right person
   Timed
   Structured
   Content checklist

2. Barriers and blocks to change
   Protected time after MDT to sort out actions
   Lack of clinical information system (computer – Rio)
   Different organisations and computer systems do not integrate
   Getting professionals to attend
   Not having a dedicated room

3. Examples of ideas that have worked
   Rio – computer system
   MDT planner
   Prioritising people to talk about in depth
   Using a projector in ward round – link to Rio
   Using technology
   Ask service users what they want
   How will we evaluate
   Timing
   Service user satisfaction questionnaires

A series of drop in sessions were then arranged to canvas views and consider areas to change.
Activity follows were also used as a way of looking at how time was apportioned as detailed below.

Activity follow

Date of meeting 3\textsuperscript{rd} June 2010
Total length of meeting = 40 minutes
Number of clients seen =

Care planning with nursing team = 6 minutes = 15%

Discussion – own prompt = 16 minutes = 40%
- external prompt = 18 minutes = 45%
- ward round discussion away from patient = 21 minutes = 53%
- ward round discussion with patient = 19 minutes = 47%
Care planning with patient = 9 minutes = 23%
Patient communication = 13 minutes = 33%
Relative Liaison = 3 minutes = 8%
Location – MDT meeting room

Date of meeting 14\textsuperscript{th} June 2010
Total length of meeting = 39 minutes
Number of clients seen = 2

Care planning with the nursing team = 18 minutes = 46%
Discussion – own prompt = 13 minutes = 33%
- external prompt = 16 minutes = 41%
- ward round discussion away from patient = 27 minutes = 69%
- ward round discussion with patient = 12 minutes = 31%
Care planning with the patient = 5 minutes = 13%
Patient communication = 12 minutes = 31%
Relative liaison - 0
Location – MDT meeting room

From this, key points and areas for changed were established.

An action plan for change is currently being developed and it is envisaged that changes to the ward round will be in place by autumn 2010.

The effectiveness of the changes will be monitored by community meetings and the Acute Care Forum as well as the Productive Ward project board.

**Clinical Effectiveness**

- Supervision
This project evaluates a resource package that was developed to assist clinical supervisors integrate evidence-based practice and recovery values into their supervisory practice The provision of such a package was hoped would improve
the quality of clinical supervision to the extent that there was an improvement in the up-take of clinical supervision by the mental health nursing workforce of NHS Barnsley Care Service Direct (CSD).

There has been much written about the theory-practice gap and despite the significant progress that has taken place with regards to accessibility to research evidence it appears largely ignored by nurses (Alexander 1982, Rolfe 1996, Crookes & Davies 2004). The Chief Nursing Officer in her recommendations for mental health nursing (2006) put forward her vision that clinical supervision could become a vehicle to assist with the embedding of an evidence-base into clinical practice and also with regards to the modernisation of mental health services, the integration of ‘recovery values’.

This posed two problems for CSD’s mental health service, how to effectively utilise clinical supervision to deliver this aspiration and also how to promote a culture of receiving regular clinical supervision within the mental health nursing workforce.

The evaluation which followed an action research methodology consisted of:-

- an audit to measure the extent of up-take of clinical supervision by community mental health nurses which provided a baseline and then was repeated at the end of the study to measure any change.
- three focus groups which asked community mental health nurse clinical supervisors about the impact of the resource package on their practice
- a postal questionnaire to community mental health clinical supervisors asking about the impact of the resource package on their practice.

Clinical Supervisor Resource File Contents:

<table>
<thead>
<tr>
<th>Section</th>
<th>Contents</th>
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<tbody>
<tr>
<td>1</td>
<td>Incorporating evidence-based practice and recovery values into clinical supervision in mental health practice using the emerging best practice framework.</td>
</tr>
<tr>
<td>2</td>
<td>Policy for implementation of recovery model incorporating physical well-being. Includes physical health pathway and medication monitoring guidance.</td>
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<td>3</td>
<td>Supervision policy and Standards for Supervision in Clinical Practice.</td>
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<td>4</td>
<td>Engagement - Assessments and Strategies</td>
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<td>Assessment Pathway/Tools</td>
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<td>6</td>
<td>CPA Policy and Best Practice in Managing Risk (2007)</td>
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<td>7</td>
<td>Well being Recovery Action Plans (WRAP) and Early Signs Scale/Card sort (Birchwood et al, 2000).</td>
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<tr>
<td>8</td>
<td>Coping strategies in psychosis (card sort)</td>
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<td>9</td>
<td>Care planning and record-keeping in mental health CPA documentation process flow. NMC Record Keeping Standards</td>
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<td>10</td>
<td>Professional codes of conduct.</td>
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<td>11</td>
<td>Medicines Management</td>
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<td>12</td>
<td>Staff Support Service</td>
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<td>13</td>
<td>Antenatal and postnatal Mental Health</td>
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<tr>
<td>NIHCE CG45 revised 2007</td>
<td></td>
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<td>14</td>
<td><strong>Anxiety</strong>: Management of anxiety (panic disorder with or without agoraphobia and generalised anxiety disorder) in adults in primary, secondary and community care.</td>
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<td>NIHCE CG22 amended 2007</td>
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<td>15</td>
<td><strong>Depression</strong>: Treatment and management of depression in adults, including adults with a chronic physical health problem.</td>
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<tr>
<td>NIHCE CG23 (90/91) updated 2009</td>
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<td>16</td>
<td><strong>Depression in adults with a chronic physical health problem</strong>: Treatment and management.</td>
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<tr>
<td>NIHCE CG91 2009</td>
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<td>17</td>
<td><strong>Bipolar Disorder</strong>: The management of bipolar disorder in adults, children and adolescents in primary and secondary care.</td>
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<tr>
<td>NIHCE CG38 2006</td>
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<tr>
<td>18</td>
<td><strong>Medicines Adherence</strong>: Involving patients in decisions about prescribed medicines and support adherence.</td>
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<tr>
<td>NIHCE CG76 2009</td>
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<tr>
<td>19</td>
<td><strong>Personality disorder</strong>: Anti-social personality disorder. Treatment, management and prevention.</td>
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<tr>
<td>NIHCE CG77 2009</td>
<td></td>
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<tr>
<td>20</td>
<td><strong>Personality disorder</strong>: Borderline personality. Treatment and Management.</td>
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<tr>
<td>NIHCE CG78 2009</td>
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<tr>
<td>21</td>
<td><strong>Schizophrenia</strong>: Core interventions in the treatment and management of schizophrenia in primary and secondary care.</td>
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<tr>
<td>NIHCE CG1 (2002) updated 2009 now CG82</td>
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<tr>
<td>22</td>
<td><strong>Eating Disorders</strong>: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders.</td>
</tr>
<tr>
<td>NICE CG 9 2004</td>
<td></td>
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<tr>
<td>23</td>
<td><strong>Obsessive-compulsive disorder</strong>: Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder.</td>
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<tr>
<td>NICE CG31 2005</td>
<td></td>
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<tr>
<td>24</td>
<td><strong>Post-traumatic stress disorder</strong>: The management of PTSD in adults and children in primary and secondary care.</td>
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<tr>
<td>NICE CG26 2005</td>
<td></td>
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<tr>
<td>NICE CG16 2004</td>
<td></td>
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<tr>
<td>26</td>
<td><strong>Personalisation including individualised budgets</strong></td>
</tr>
<tr>
<td>27</td>
<td><strong>Web based information</strong></td>
</tr>
</tbody>
</table>

**Affixed to back cover**  Mental Capacity 2005 and Deprivation of Liberty (DoL) CDRom Code of Practice
Support and Update Sessions

These sessions have been developed to support clinical supervisors in their practice and the topics have been chosen by our clinical supervisors.

4th December 2009 – Incorporating a recovery values through clinical supervision (one day session) Guest speakers – Jane Taylor Recovery Team Leader and Nicola Speight Well-being Practitioner

15th March 2010 - Incorporating a recovery values through clinical supervision (one day session) Guest speakers – Jane Taylor Recovery Team Leader and Nicola Speight Well-being Practitioner

30th April 2010 – Introduction to the clinical supervisors resource file (2 hour session)


4th August 2010 – Topic and speaker yet to be determined.

Statements of Assurance from the Board

Review of services

During 2009/10 Care Services Direct provided Acute Mental Health Services for the population of Barnsley. Acute Services include in patient wards and also home based treatment as an alternative to hospital admission.

Care Services Direct has reviewed all the data available to them on the quality of care in the Acute Mental Health Service provided.

The income generated by the service reviewed in 2009/10 represents 5.4% of the total income generated from the provision of NHS services by Care Services Direct for 2009/10.

Participation in clinical audits

During 2009/2010 one national clinical audit and two national confidential enquiries covered the Acute Mental Health Service provided by Care Services Direct. However as part of the wider organisation the acute inpatient service will have benefited from the learning from other national audits such as psychological therapies audit and dementia audit.
“The national confidential enquiries that Care Services Direct was eligible to participate in during 2010 are as follows;

- West London Trust Review
- Robert Francis mid staffs

The main learning point was that the governance arrangements Care Services Direct were strong forums to raise issues and develop services.

The learning with regard to strong leadership and raised standards has facilitated the development of clinical lead posts and increased focus on the basics of practice such as privacy and dignity and nutrition which are part of the clinical audit schedule.

In addition, the reports of 31 local clinical audits were reviewed by the provider in 2010 and Care Services Direct has identified actions for each audit which are monitored through local governance groups. Specific mental health audits include the suicide prevention audit, aspergers audit, recovery model audit and various medication audits.

Clinical audit is intrinsic to practice and forms a baseline for improvements in practice and service delivery and the lessons learned are fed back through local governance arrangements and best practice forums such as medicines management and professional forums.

The clinical audits proposed for next year within this business unit only form a small percentage of the trust wide audit schedule, which also includes relevant audits such as;

- Privacy and Dignity
- Nutrition
- Tissue viability
- Infection Control
- Falls
- Self Care
- Record Keeping
- Personal and oral hygiene
- Health promotion

Research

The number of patients receiving NHS services provided or sub-contracted by Care Services Direct in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was nil.

To surmise, The Acute Mental Health Services provided by Care Services Direct in 2009/10 did not recruit any patients to participate in research. However, Care Services Direct has a strong ethos of post registered education and to this end, all
practitioners undertaking research as part of a study also input to service
development.

Although there is no completed research for the period 2009/10, there is a current
ongoing research project with regard to the efficacy of Cognitive Behavioural
therapy within an inpatient facility.

Goals Agreed with Commissioners

An additional 0.5% of Care Services Direct Acute Mental Health contract value in
2009/10 was conditional on achieving quality improvement and innovation goals
agreed between Care Services Direct and the Partnership In Action commissioner.

Further details of the agreed goals for 2009/10 and for the following 12 month
period are available on request from the Business Performance Manager /
Contracts Manager.

What others say about Care Services Direct

Care Services Direct is required to register with the Care Quality Commission and
its current registration status is registered. Care Services Direct has no conditions
on registration. The Care Quality Commission has not taken enforcement action
against Care Services Direct during 2009/10.

Care Services Direct is not subject to periodic reviews by the CQC.

Care Services Direct has not participated in any special reviews or investigations
by the CQC during the reporting period.

Data Quality

NHS Barnsley submitted records during 01/04/09 to 31/03/10 to the Secondary
Uses service for inclusion in the Hospital Episode Statistics which are included in
the latest published data.

The percentage of records in the published data which included the patient's valid
NHS Number was:
99.9% for admitted patient care
95.84% for out patient care.

The percentage of records in the published data which included the patient's valid
general Medical Practice Code was:
99.93% for admitted patient care
99.99% for out patient care

Care Services Direct’s score for 2009-10 for Information Quality and Records
Management, assessed using the Information Governance Toolkit was 63.33%
Care Services Direct is part of NHS Barnsley and submits the Primary Care Trust Information Governance Toolkit (IGT) not the Mental Health Trust IGT. A percentage score was calculated on 10 requirements where the Primary Care Trust IGT was identical to the Mental Health IGT requirements requested in the toolkit. These requirements are: 401, 403, 405, 408, 501, 504, 509, 511, 601 and 602.

Care Services Direct was not subject to the Payment by Results clinical coding audit during 2009-10 by the Audit Commission.
Part 3- Review of Quality Performance

The mental health acute care business unit provides a number of key services as an integral part of Barnsley Care Services Direct. These are primarily related to crisis resolution and home treatment, psychiatric liaison service, acute admission wards, and a psychiatric intensive care unit.

The vision within Barnsley is;

To be consistently recognised as a leading NHS provider of excellent Health and Social Care community based services which put people at the heart of everything we do.

The values which Barnsley Care Services Directs hold are to be an organisation which:

- Delivers high quality and accessible services to support individual and community wellbeing.
- Respects and recognises the contribution of all our staff.
- Values common sense and supports people to make their own decisions.
- Makes best use of resources and provides value for money.
- Supports staff to be able to continuously improve and provide safe and innovative services
- Demonstrates commitment to the community by offering opportunities to local people or businesses wherever possible
- Recognises the importance of partnerships to strengthen our service
- Embraces the principles of the NHS Constitution, values diversity and promotes equality through its services.

Acute Care in Barnsley is endeavouring to develop services in line with this vision by using service improvement models and governance tools as highlighted in the following text.

Star Wards
The Oakwell Centre had an open day last year to launch Star Wards which is a project which works with mental health trusts to enhance mental health inpatients’ daily experiences and treatment outcomes.

- To highlight the experience of inpatient environments from the perspectives of both patients and professionals
- To offer the opportunity to find out about some of the most promising initiatives for improving inpatient care
- To draw together practical doable ways of combining a positive, hopeful recovery-oriented approach to inpatient care with realistic risk-taking and risk management
- To refresh and re-invigorate participants with new ideas and optimism

“We discover, celebrate, share, publicise and inspire excellence in inpatient care, and there is plenty of that all round the country. Our members use and adapt our
resources to stimulate and structure therapeutic and enjoyable daily programmes for inpatients in the full range of wards

The AIMS Accreditation Process

The AIMS accreditation process incorporates elements that research has demonstrated to be effective in bringing about quality improvement. It gives encouragement to identify and prioritise problems and set achievable targets for change. Membership of AIMS can help wards meet the Care Quality Commission’s Standards for Better Health and to conform to NICE guidelines and National Service Frameworks.

Member services are supported through a 12-month review process that incorporates:

- self-review, including carer, patient and staff questionnaires;
- a one day peer-review visit;
- a recommendation of accreditation status by the AIMS Accreditation Advisory Committee;
- Ratification of accreditation status by the Royal College of Psychiatrists' Education, Training and Standards Committee.

Accreditation is valid for up to four years, subject to satisfactory completion of an annual self-review.

The Productive Mental Health Ward

The Oakwell centre is undergoing The Productive Mental Health Ward: Releasing time to care. The NHS Institute for Innovation and Improvement has been working with nurses and therapists to develop ways to increase the amount of direct care time given to patients in mental health wards. The Productive Mental Health Ward programme is designed to help achieve this by improving the effectiveness, safety and reliability of mental health wards.

Sites that have helped develop and test the programme report that their expectations have been exceeded and that their staff have been empowered and enthused to make challenging changes to the way they work. Adopting The Productive Mental Health Ward will enable local providers and commissioners to compare the performance of their local mental health facilities with that of others, learn from the best and make positive improvements for patients. An example of a piece of work is shown below.

Releasing Time to Care

- The implementation of a Productive Ward team and the weekly Productive Ward meetings allowed us to brainstorm ideas, identify potential problems and develop plans.
- During one meeting we looked at how we could release time to care
The nursing team reported that patients were frustrated at not being able to access staff to facilitate leave or to carry out nursing interventions.

16.5 hours nursing time per day was used to supervise the garden area with one member of staff, 30 hours with two members of staff.

It also allowed the patients to smoke between the hours of 6 am and 12 midnight.

As a result they could not carry out any other nursing intervention.

We identified that a huge amount of nursing resource was taken up supervising our garden areas to facilitate patients access to smoking facilities.

Due to changes in law and the Governments focus on health and well being we decided to review our current smoking arrangements.

From the meeting it was agreed that this would be reviewed to improve therapeutic interventions and patient well being.

The nursing team suggested that the opening times of the garden area for smoking should be reviewed.

The plan was agreed that the smoking times in the garden area would be reduced to one period of 15 minutes per hour between the hours of 6 am and 12 midnight.

**Identified Problems**

- The times were restrictive
- It was perceived that it would deny people access to fresh air
- It may affect the therapeutic day
- It may increase the incidence of violence and aggression

**Solutions**

- Access to fresh air is available at all times, with access to four garden areas.
- Liaison with the therapy team enabled the time slots of the therapeutic activities to be rescheduled.
- Questionnaires were used to gather patient feedback.
- Weekly community meetings allow patients to express their concerns.
OUTCOMES

Results from clients garden questionnaire regarding smoking October 2009

<table>
<thead>
<tr>
<th>Number of responses</th>
<th>15 MINUTE SLOTS PER HOUR</th>
<th>OPEN ALL THE TIME</th>
<th>30 MINUTES PER HOUR</th>
<th>SPECIFIED TIMES</th>
<th>FOR FRESH AIR NO SMOKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Series 1</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>

OUTCOME

Activities completed due to time released to care

- 1:1 session
- Direct care
- Walking group
- Supervised exercise
- Eat well training
- Supervised exercise
- CBT assessment
- PSI assessment
- Smoking cessation training

The results show that the patients are satisfied with the new ways of working
• It has increased the amount of 1:1 time spent with the allocated nurse and the patient, it has released 13.5 hours nursing time per day
• There has been a reduction in the amount of violent and aggressive incidents due to releasing more time to care
• It has improved patient well being, patients smoking less
• It has released staff to complete training programmes, such as smoking cessation, health eating programmes
• It allows more varied activities in the garden areas

Rapid Improvement Programme
The NHS Institute for Innovation and Improvement’s acute adult mental health admissions and psychiatric intensive care teams work with NHS mental health teams to identify practices and behaviours that contribute to efficient and high quality care.

Barnsley was one of up to two trusts from each SHA region in England selected to have the opportunity to join the Rapid Improvement Programme to work with the NHS Institute’s mental health team who will provide free support for units to embed an agreed improvement in these pathway areas based on the Focus on work

Project Aims

• Timely discharge through planned interventions from admission to meet patient need
• Improve communication between different interfaces, promoting a more seamless approach
• Defining roles and responsibilities of staff on Acute Wards under new ways of working

Project Measures

• Reduction in length of stay - outcome measure
• Reduction in delayed discharge – outcome measure early discharge – IHTT - outcome measure
• Length of time to contact Care Co-ordinator and arrange necessary care review – process measure
• Reduce length of stay
• Focused care
• Effective communication
• Care Co-ordinators engaged
• Promoting early discharge through IHTT working effectively
• Seamless process

Bigger Picture – Links?

• Reconfigure Care Pathways and Packages
• Bed occupancy measure
• Reducing cost: out of area/early discharge reporting
• Payment by results
• Quality Care Standards: Productive Ward/Star Wards
• Aims
• Accommodation
• Activity monitoring

Links to Organisational Measures

Care Service Direct strategic objectives

• To be the provider of choice in Barnsley and increase our market share in other locations where appropriate and desirable
• Ensure the organisation is financially sound offering services that are good value for money
• Deliver safe, effective and efficient services for patients service users and carers
• Deliver services that enable people to be cared for in their own homes and communities for as long as possible taking into account their wishes and those of their carers
• Ensure the organisation is financially sound offering services that are good value for money
• Ensure that staff in the organisation have the required skills and competencies to compete successfully in a commercial market

PIA Strategic objectives

• Ensure the organisation is financially sound offering services that are good value for money
• We will develop a plan to repatriate those people currently placed out of authority where possible through people directing their own support to ensure they are cared for as close to home as possible

The rapid improvement program discussion group highlighted “timely discharges” in acute adult inpatient services as the main focus for quality improvement in patient care. The group looked at the “patient journey” throughout inpatient services using case studies and discussion groups (involving staff from all disciplines of the MDT including care coordinators from community mental health teams).

This was to identify the process of admission or the “care pathway.” Along side the work of the rapid improvement program, the intensive home based treatment team identified the positive impact of improved communication and seamless working with inpatient services on both reducing the duration of admission and improving the quality of patient care/patient journey by clearly identifying the reasons and objectives for the admission.

This resulted in the permanent allocation of an IHBTT link worker to work within the MDT. As part of the development of this role and through discussion within the
rapid improvement program group, the importance of a “72 hour MDT review” led to the development of a 72 hour review planner in which a 72 hour review would be arranged inviting all relevant professionals including community mental health representatives along with the service user and relevant carers.

The purpose was to highlight the reasons for admission (supported by the admission care plan completed by IHBTT), and what plan of care is needed to ensure a timely discharge can be facilitated. Whilst the positive impact of the 72 hour review process has been clear to see, the earlier analysis through case studies and discussions with staff working across mental health services highlighted that there were many other processes involved throughout a service users admission that influence the ability to ensure timely discharges. These were not only critical in terms of whether they actually occurred (such as the 72 hour review) and the timing of these processes but also the quality of these processes for example clearly defined risk statements and consideration of all options of care including leave.

Each of these processes can be measured and the rapid improvement program group plan to conduct a 6 month audit of clinical records from inpatient admissions (pre-introduction of the 72 hour review planner) to look at these processes. There will also be the introduction of a care pathway document (at least covering the first 72 hours of admission) onto inpatient wards (including PICU).

The findings of the audit will be measured against outcomes from a second audit of clinical records from admissions occurring later this year to consider the impact of the 72 hour review planner and the introduction of the care pathway document. The initial audit, once analysed will also highlight current practice around the identified processes involved in the patient journey and allow for interventions to improve the quality of practice and the care delivered.

**Mental Health Sports Team**

This project challenges social inclusion surrounding service users suffering with mental health problems in the Barnsley area. Currently there are a limited amount of supported activities in mainstream facilities available for individuals, by increasing the availability of activities we will increase the number of participants and in turn reduce the stigma and inequalities currently experienced by people with mental health issues. We aim to develop each individual’s skills and knowledge to enable them to take part in meaningful activity and occupation. This will assist the employment and social inclusion objectives within the Commissioning for Mental Health and Wellbeing for Barnsley document.

Poor levels of physical health and fitness along with obesity are widely recognised as key issues for people with mental health. By increasing the physical activities available locally we can raise awareness, increase engagement and make these services sustainable for the future.

The main focus is to open up educational and employment opportunities for groups and individuals. Through working with NHS Barnsley, BMBC and other local businesses, service users can form relationships, increasing awareness and reducing the stigma of mental health. Enabling individuals to build confidence and
self esteem and to develop the skills required to gain employment. Sessions are monitored by attendance, course qualifications and voluntary work. As an example, since starting the football initiative in August 2009, 13 service users have attended on a regular basis including a weekly training session at Oakwell Football Club. Service Users have taken advantage of two European tournaments and competitive league fixtures are also being played on a monthly basis. Four service users have now successfully completed their FA Coaching Qualification, volunteering for their own team and one has subsequently gone on to a cadet scheme working for NHS Barnsley. None of the 13 service users has been admitted or treated by mental health services during this time. By delivering this same service with other sports across Barnsley, more service users will benefit from these opportunities.

**Recovery and Wellbeing in Acute Care**

A programme has been developed for acute unit nursing assistants to deliver a physical wellbeing programme

This includes:

- Physical well-being assessment and awareness training
- Physical observations
- Smoking cessation
- Nutritional screening
- Obesity management
- Motivational interviewing

The outcomes which the programme wishes to achieve include that an admission contributes positively to patients long term health goals. These are not just “mental health” admissions but take a more holistic approach. Patients admitted will all have physical wellbeing assessment and opportunity to work on health goals. There is also the aim improve staff morale, role development and job satisfaction.

Audit is being developed through the other programmes that are ongoing (Rapid Improvement Plan, Productive Ward etc.) that incorporates record keeping, recovery and wellbeing implementation.
Comments from the Commissioner

Partnership in Action (PiA), the joint commissioning unit for Barnsley adult health and social care, confirms to the best of its knowledge the accuracy of the information contained within the Quality Account.

Mental health clinical performance reports are provided on a monthly basis to commissioners, and are considered by the Quality Review Group, on a quarterly basis. This presents the opportunity to comment on and challenge the data provided. A mental health contract meeting, between CSD and commissioners, is also held on a quarterly basis and is where key service developments are reported and discussed. Commissioners also attend the CSD service re-design board.

The reduction in the numbers treated out of area is to be welcomed. Further work is to be undertaken in respect of provision for those currently out of area. CSD and PiA are working together to address this issue and rehabilitation into the community. Work on the accommodation pathway will support this process. We welcome the building of clearer links between acute services and community services including the recovery team.

Comments from the OSC

The Scrutiny Commission was pleased to receive a copy of the Care Services Direct Quality Account for 2009/10 and appreciates the invitation to comment. The Commission originally visited the Oakwell Centre prior to its opening and was impressed to see the range and type of services which were to be provided. The Commission welcomes the recent review of supervision of smoking time within the Productive Mental Health ward on the Oakwell Unit which has led to increased contact time between staff and service users and also the opening of a 6 bedded psychiatric intensive care unit. These two recent achievements are commendable as they will mean improved service user satisfaction. It would appear that the Quality Account is comprehensive and representative and no concerns have been raised with the Commission in respect of any services provided within the acute setting.