Mental Health Crisis Care: Essex 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 Essex County 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

Essex is a large county bordering London and has a number of points of entry for visitors from outside of the country including Stansted Airport and Harwich Port. These presented additional challenges to providers in terms of understanding, responding and meeting the needs of people whose first language may not be English.

The county's mental health services are provided by two NHS trusts serving two distinct geographical areas. This review focussed on the north of Essex. We looked at the experiences and outcomes of people experiencing a mental health crisis in Essex. In particular, people known to services and receiving ongoing support from specialist mental health services and people detained under section 136 of the Mental Health Act.

There was a strategic and operational focus across partners to improving the experiences of people who experience a mental health crisis with a shared commitment to the principles of the Crisis Care Concordat. Although some people experienced difficulties and delays in accessing services, the care they received met their needs.

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

- **Care pathways**

Care pathways were clear for people who experienced mental health crisis once they had been accepted into the mental health services Crisis Team. However, people experienced disparities in accessing care. Care pathways for people from primary medical services into the mental health system were being piloted and initial findings were that appropriate action was taken to support people with mental health needs. However, we did find variance in the quality of referral information provided by primary medical services to the Improving Access to Psychological Therapy Team (IAPT). This presented challenges and potential delays to people receiving appropriate and timely mental health assessments and interventions.

- **Access to services**

Healthwatch reported people valued their GP service as a route for people to access mental health services. However, we found not all practice staff understood how best to meet the needs of someone presenting with a mental health crisis.

People not known to the Crisis services were referred to their GP or presented at accident and emergency departments to access emergency care. People known to Crisis services or recently referred to the services were provided with a crisis card. The card provided details of how to access emergency mental health specialist advice and other helpful contact details about available services. This included two telephone helplines.

We spoke with people who had tried to contact the Crisis Team and some who had used the service. They told us they expected a response from a trained person who would understand and assist them to manage their immediate needs. However, they told us the phones were not always answered and some people reported finding the staff insensitive and dismissive. As part of our inspection we attempted to call each of the helplines on two different days but on each occasion we received no response and were invited to leave a message.

Two people we spoke with reported receiving high phone bills on calling the Crisis Team or the Trust phone lines, one amounting to £59 and another £29. The helplines were not free but commissioned to provide low cost calls from BT lines. However, for mobile users costs vary by network and type of contract. There were no alternative numbers provided to people or call back services offered by the advisors as standard. North Essex Partnership NHS Foundation Trust (the Trust) and Mid Essex Mind told us they did not make any profit from the calls.

Our findings reflected those of Healthwatch who reported that service users found a gap in crisis mental health provision on Friday to Mondays during out of hour's periods. We also called the North Essex Resource and Information Line for mental health and the Essex Social Care Emergency Team a number of times on a Sunday but on each occasion reached an answerphone or a message asking us to call back later.

Where people had been assessed and found to not meet the thresholds required to access the Crisis Team alternative community provision was available through services such as the First Access Specialist Treatment Team (FAST Team). This team had identified a gap in their service provision for people of working age, and were intending to provide group work sessions in the evenings to address this. However Healthwatch reported people wanted shorter referral times to receiving support and a patient told us they experienced a delay in receiving support.

- **Care planning and user involvement**

We found that some case assessments were insufficiently personalised and failed to fully reflect the patient's individual needs and details of care. Healthwatch identified that Essex mental health patients wanted to feel valued, listened to and supported by professionals who had an increased understanding and training in mental health. People had a strong desire to avoid retelling painful stories and valued continuity of care which was likely to engender trusting and knowledgeable relationships.

There was no systematic approach to asking people about their experiences to inform service delivery. Healthwatch made similar conclusions regarding the provision of mental health services to people in Essex. A patient commented "There are a lot of assumptions in the service about the patient needs and wants and that's not the way it should be. It should be about asking us what do we need and what do we want."

- **Staffing**

The mental health trust had experienced a real term funding reduction of 12% over five years whilst demand for the mental health services had grown along with people's

expectations. Staff shortages were acknowledged by the management and staff we spoke with on specialist wards. Vacancies had been advertised and offers had been made for some positions, but some posts remained vacant. The use of bank staff for some patients was a concern as one patient commented, “bank staff, need to have familiarity (with the patients), we need to feel comfortable.” Staff told us permanent staff often filled additional shifts to avoid the use of bank staff not known to the patients. The trust had introduced the Journey Programme intended to maximise skills and knowledge, which was in its infancy at the time of our review.

There were insufficient numbers of Approved Mental Health Practitioners (AMHP) within the trust. The recruitment and training process was on-going and long and costly, requiring a staff member to commit fully to six months training with the possibility of a further six months for additional training and shadowing. With an aging work force, retention of existing AMHPs had also presented a further challenge recognised and being activity addressed by the trust in partnership with their commissioners.

Some training was provided by organisations to their staff, although it was acknowledged this could be improved and extended to more staff groups. Although partners spoke of a commitment to deliver joint training programmes relating to mental health we found little evidence of joint training being delivered.

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

- **Access to health based place of safety**

People with an identified immediate mental health need who had been detained under section 136 received timely and appropriate access to services. Although we were told some difficulties and delays in assessments were experienced when people required an interpreter or where people presented intoxicated.

A recently introduced street triage team operated on Friday, Saturday and Sundays between 18:00 hours and 02:00 hours. At the time of our reporting the street triage had commenced in the north of the county and had been employed for two weekends with 15 contacts recorded. The street triage programme consists of two vehicles operating in the north of Essex and two vehicles in the south of the county staffed by police officers and mental health professionals. Early findings indicated that eight people had been successfully diverted from the section 136 suites. Where people required assessment at a section 136 suite, clinical teams reported improvements in the quality of the information being relayed to clinical teams. This included the person’s name, enabling clinical staff to search the patient record for information known to them and details of behaviours the person was presenting with.

- **Transport**

Staff reported that police vehicles were used to transport people to the section 136 suites although on no occasion had a caged vehicle been used. Whilst transporting people using police vehicles is accepted under the joint policy relating to section 136 there had been a recent drive to increase the use of ambulance transport.

- **Staffing**

We found occasions when insufficient staffing resulted in section 136 suites having to be closed. At the Linden Centre there is a bleep holder who can assist with section 136 and an hourly rotation of staff in line with the trust's observation policy. This hourly rotation of had the potential to require frequent exchange of information between staff and also heighten anxiety for the patient. At the Lakes a "floating" member of staff worked across the two wards and could assist with staffing the Section 136 suite if required without having to take staff from the ward. Additional resource was provided by a twilight member of staff between 5pm and midnight.

It was acknowledged by the trust and commissioners that they had experienced difficulties with the availability of section 12 doctors and carrying out timely assessments. This had been aggravated by the billing complications relating to the assessment payment for persons out of area. One section 12 doctor reported that they, personally, no longer assessed people from outside Essex due to experiencing difficulties obtaining payment. A clinical commissioning group administrative hub had been proposed to address the complexities of obtaining payment for the section 12 doctors.

Local strategic and operational arrangements

Three Clinical Commissioning Groups, North, East and West Essex jointly commission mental health services. The commissioning strategy focuses on four key areas;

- To improve mental health through the development and active promotion of well-being and prevention services,
- To improve access to services thus reducing waiting times for assessment and treatment,
- To develop agreed pathways for mild, moderate and severe need
- To maintain peoples mental health post-treatment through better primary and community care services.

We found there was a shared commitment across partners for the principles and work of the Crisis Care Concordat. The introduction of the street mental health triage programme was an example of how partners were working together to ensure more timely and appropriate care of people experiencing a mental health crisis. Although, in its infancy it was believed to have reduced the number of people inappropriate detained in police cells and reduced section136 detentions and subsequent assessments.

Commissioners understood the demographic challenges presented by a growing population within the north of Essex. Specialised mental health provision was commissioned to meet the needs of specific groups including services for Colchester's military community ; Rainbow Unit providing support for acutely ill mothers their children under one year old; The St Aubyn Centre, an adolescent inpatient unit.

All partner agencies acknowledged the challenges of tackling discrimination of patients with mental health needs, especially with limited specialist mental health staff who were

experiencing increasing demands for their services.

Joint policies were agreed between relevant partner agencies (Essex Police, Essex County Council, North Essex Partnership University NHS Foundation Trust and South Essex partnership NHS Foundation Trust), such as the joint policy on the procedures relating to persons sectioned under section 136 of the Mental Health Act 1983 . These were known to operational staff and appropriate admission document was supplied to the Mental Health Act administrator. However, there was an absence of monitoring by individual agencies or collectively overseen by commissioners to identify potential barriers and therefore disparities in service delivery.

Areas of good practice

- Committed, caring and professional staff who employed the least restrictive means of caring for people.
- Implementation of the street triage teams. The improved information shared with staff ahead of attendance allowed them to consider risks and identify how best to meet the person's needs.
- Strong working relationships between section 136 staff and the police, supported by monthly liaison meetings to review issues and concerns.
- Services to meet the needs of specific groups. For example, services for the military community.
- Strategic recognition and commitment by partner services to address barriers to people experiencing mental health crisis receiving timely and appropriate assessment and care.

Areas for development

- Improved access to crisis services for people known to the service or recently referred. People need to be aware of the response capacity of the service and alternative means of accessing crisis services if staff are unavailable.
- Evaluation of and improvements in the responsiveness of the out of hours telephone helplines.
- Engagement with people using services to support improvements to care and

development of services that meet the needs of the population.

- Development of multi- agency training to support partnership working and increased knowledge and skills of staff.

- Increased knowledge within primary medical services on the routes into crisis mental health services. All practice staff should be able to support and refer people in crisis to appropriate crisis mental health services.

- Ensure assessments are individualised to reflect people's needs and inform the consistent management and delivery of their care across services. For example, assessments should be sufficiently individualised to aid the Crisis and Trust Line staff to best support patients, at a time when they are vulnerable.