CareQuality Commission

Mental Health Crisis Care: Windsor and Maidenhead Summary Report

Date of local area review:
Onsite 22 - 23 December 2014

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 the Royal Borough of Windsor and Maidenhead. 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

Windsor and Maidenhead is a unitary authority and the only royal borough in England outside London. It is situated in southern England close to Heathrow airport. The area is a mixture of towns and rural areas. The population is similar to national averages for older people and working age people. Though there is a slightly higher than average number of pre-school and school age children in the Borough.

We looked at the experiences and outcomes of people experiencing a mental health crisis in Windsor and Maidenhead, in particular those people in crisis who are detained under section 136 of the Mental Health Act.

Agencies across the local authority area were committed to working together to improve care for people who experience a mental health crisis. Structures were in place that enabled multi-agency working between all key stakeholders. Meetings were held to ensure that information was shared across agencies and policies were in place that covered emergency care pathways that involved different agencies in the local area.

People who experienced crisis had access to support through a central point of entry (CPE) service. This was available to take calls throughout the day and night and provided a clear and simple route of access to the services. This included GP referrals and self-referrals. One GP we spoke with told us that they had found the service invaluable in supporting the people they referred to CPE. The mental health teams told us that the CPE effectively screened and triaged referrals and that the majority of referrals they received were appropriate.

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

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

There are three health based places of safety at Prospect Park covering Berkshire. Access to all three health-based places of safety was not restricted for any groups of patients, for example, under 18s and people with substance misuse issues. There had been no delays in accessing a place of safety since August 2014.

Staff at Wexham Park Hospital told us that due to a recent reconfiguration there was no longer a place of safety close by. This meant at times the hospital had problems with conveyancing a person should they need to access such a service. This delayed the person accessing the appropriate emergency mental health services.

- **Monitoring and Audit**

The police and mental health trust held regular meetings to ensure information was

shared across the organisations and a consistent response for people being detained under section136 of the Mental Health Act. The police reported a 20% increase in section 136 detentions in the Windsor and Maidenhead area over the previous year. They reported that there was only one other area within Thames Valley where section 136 detentions had increased.

The trust recorded and monitored the times assessments started for people detained under section 136 of the Mental Health Act. Having identified that some people were experiencing delays additional staff were recruited that resulted in improvements in how soon people are assessed.

- **Staffing**

Due to the re-configuration of the services that included an increase in staffing levels we found sufficient staffing in the section 136 suite. There were staff available to support the section 136 suite and enough section 12 doctors and Approved Mental Health Practitioners (AMHPs) were available to carry out assessments under the mental health act with minimal delay. Police supported the staff at the section 136 suite if required. A carer told us that “The police can be very good; it was the police that contacted us the next day to see if we were OK not the mental health service.”

Training to trust staff, section 12 doctors, and AMPHs was well supported by the mental health trust and enabled staff to fulfil their roles in staffing and assessing people who used the section 136 suite. Joint training was also offered to trust staff, police and ambulance staff regarding section 136 and health based place of safety. This supported cross agency working and improved understanding of each agencies role.

- **Transport**

Conveyance was routinely by ambulance. However staff at the section 136 suite told us that ambulances were not always available due to the demands on the South Central Ambulance Service. This meant that police conveyed people to a place of safety when required.

Local strategic and operational arrangements

The local mental health trust, clinical commissioning group, local authority and mental health charities had built good working relationships. Regular meetings took place between organisations involved in the commissioning and provision of emergency mental health services. Agencies had been involved in making a commitment to enacting the Crisis Care Concordat and had developed an integrated delivery plan which had specific target dates established to review progress made.

Locally, the Joint Strategic Needs Assessment which was produced to cover the local area had a chapter relating to Mental Health which highlighted areas for development for Windsor and Maidenhead. For example, people who have mental health problems as well as other health problems may not have access to comprehensive support.

Staff in accident and emergency at Wexham Park Hospital told us they experienced delays in accessing psychiatric liaison services. One staff member told us they could wait for one hour or three hours for a staff member to attend and assess a person. Others told us that this could be much longer between the hours of 11:00pm and 07:00am.

The mental health trust regularly engages with people who use the service through questionnaires, trust website, user groups and other listening events. The trust had been holding patient, public and carer big conversations meetings to allow people to have their say on services and make suggestions. However when we met with carers they told us, they felt not listened to and in some cases that their views were not respected.

Areas of good practice

- Good multi-agency working and a commitment to joint working to facilitate positive outcomes for people in mental health crisis.
- Undertaking audits and taking action to address findings that resulted in better services and support to the section 136 suite.
- Positive working relationships with the police at both strategic and operational levels.
- No groups are excluded from health based place of safety.
- Streamlined 24 hour access to services through the Central Point of Entry service.

Areas for development

- Development of joint training initiatives including input from service users and carers. For example, police and GP training.
- Review of psychiatric liaison service response times to the accident and emergency department at Wexham Park.
- Review processes in place that gather feedback from carers to ensure these are effective in listening and responding to their needs.
- To investigate why the number of section 136 detentions have increased and if appropriate put actions in place to address this.