Mental Health Crisis Care: Ealing 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 the London Borough of Ealing. 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 Ealing, in particular those people in crisis who are detained under section 136 of the Mental Health Act.

We found that there were strong structures in place to ensure multi-agency working across the crisis care pathways in Ealing. The local authority, local acute trusts, mental health trust, local CCG and other organisations such as the local borough police, ambulance service and voluntary sector organisations had meetings to ensure that information was shared across systems. Policies were in place which covered emergency care pathways and these involved different agencies in the local area.

There were also meetings between agencies which related to specific areas, such as involvement with the police services. Liaison police were based at the St Bernard's Hospital site. These police officers acted as a point of contact with the mental health trust and, by being based locally, ensured that information was shared between the local police and the trust in a timely and effective manner. They assisted when queries arose regarding the use of section136 and assistance in information sharing and referrals to the police regarding incidents on the wards.

The mental health trust provided liaison services in the local accident and emergency department at Ealing Hospital which effectively coordinated immediate responses to presenting mental health emergencies.

People who used crisis services had access to support through a 'hotline' which was available through the day and night. The trust had also established a telephone line for GPs to discuss presenting concerns directly with psychiatrists.

Agencies, including Ealing Council, the local mental health trust and acute hospital trust, had been involved making a commitment to enacting the Crisis Care Concordat and had developed the North West London Integrated Delivery Plan which had specific target dates established to check that this was happening. Agreed actions were followed up at meetings with named responsible individuals.

People who are detained by police under section136 and taken to the health based place of safety in Ealing were provided with safe, effective care which was delivered by agencies across the local authority area committed to working together.

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

We found that the police and mental health trust had monthly meetings to ensure information was shared effectively across the organisations. There were also meetings

that took place across London and involved all the mental health trusts in the London area and the Metropolitan police which was able to coordinate and ensure consistent responses to people being detained under section136 of the Mental Health Act.

The mental health trust had carried out an extensive and thorough audit of the section 136 admission process and the subsequent actions taken. This meant that they were able to develop strategies and improvements on the basis of information which was collected. This process was still relatively new.

Approved Mental Health Practitioners (AMHPs) did not routinely meet with people who did not go on to have a Mental Health Act Assessment. This was contrary to the Mental Health Act Code of Practice and action to address this was taken during our visit.

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

Access to the health-based place of safety at St Bernard's Hospital, Wolsey wing was not restricted for any groups of patients, such as, under 18s or people with substance misuse issues. When there was no availability within the place of safety, people were taken to the adjoining wards that had appropriate staffing to ensure their needs were met until they were assessed. This meant that people were not turned away from accessing a place of safety and no one had been taken to a police cell due to a lack of the availability of a health-based place of safety in the last year. This was reflected in the survey carried out by CQC of Health Based Places of Safety which indicated that in 2013 no one had been unable to access the place of safety because it was in use, it had never been used for another purpose which had impacted on acceptance of patients and it had never been closed to be used as an additional inpatient bed.

- **Staffing**

Staffing cover was provided to the place of safety on a 24/7 basis. Staff were moved from inpatient wards when necessary and there was a cover manager responsible for the health based place of safety at all times. Staffing on the wards accounted for this additional responsibility so that the place of safety was staffed sufficiently at all times it was in use whilst not adversely affecting staffing levels on the wards.

Approved mental health professionals (AMHPs) we spoke to told us that there could be delays in undertaking assessments particularly at night. This was often due to a number of emergencies happening simultaneously. We were also told about delays in accessing section 12 approved doctors.

Staff based in the mental health trust were involved in delivering training to the local police service. This ensured that the local police had basic mental health training. However, service users were not specifically involved in this training.

- **Transport**

Conveyance of patients was not routinely by ambulance as there were issues regarding the availability of ambulances provided by the London Ambulance Service. The mental health trust had bought two vehicles which could be driven by their own staff to facilitate

conveyance and minimise the use of police vehicles. There were times that police vehicles were used but there were active attempts to minimise this.

Local strategic and operational arrangements

The local mental health trust, clinical commissioning group, local authority and other relevant parties had built good relationships and meetings took place regularly between organisations involved in the commissioning and provision of emergency mental health services. The local area had developed an action plan in place to respond to the Crisis Care Concordat. This involved work across North West London including neighbouring CCGs and trusts.

Locally, the Joint Strategic Needs Assessment which was produced to cover the local area had a chapter relating to Mental Health which focused on preventative work. We saw that the areas which had been highlighted in these plans had been actioned with a Mental Health Transformation Board looking at the needs of the locality. People who used services and their carers had good representation within these groups to ensure that their voices were heard. We saw that the local health economy within Ealing was committed to providing a comprehensive service for people in their communities.

Areas of good practice

- People could consistently access place of safety in the Wolsey Wing, St Bernard's Hospital, if they were detained by the police under section 136. No groups of patients were excluded from health based place of safety such as people under 18 or people who were intoxicated. This meant that admissions into police stations were avoided.

- Strong multi-agency working and a commitment to looking at joint work to encourage positive outcomes for people in mental health crises with all the involved agencies committed to working on solutions.

- Well-developed and effective hospital liaison services which shared information effectively with primary care services.

- Comprehensive auditing of section 136 experiences and pathways undertaken by the mental health trust which could feed into service improvement.

- Development and progress towards implementation of the Crisis Care Concordat which had identified and defined targets and included work across a number of local authorities and both acute and mental health trusts to ensure a cohesive service could be delivered to people in west London.

- Flexibility in approach to staffing of health based place of safety with the scope to take staff from adjoining ward areas when necessary. Staff were not solely

assigned to the place of safety but this was prioritised when needed. Consideration of the health based place of safety was accounted for in determining the required staffing numbers on the wards.

Areas for development

- Develop work on joint training initiatives including input from service users and carers.
- Further development of identified alternatives to inpatient admissions.
- Ensuring that monitoring of use of the Mental Health Act Code of Practice is embedded in internal processes so that where there are lapses these can be identified and addressed.
- Reducing delays in undertaking assessments overnight by ensuring availability of AMHPs and section 12 doctors.