Mental Health Crisis Care: Oxfordshire 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 Oxfordshire 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

Oxfordshire is the most rural county in the south east of England. Unemployment is low in the county. Oxford City has a high population of students due to Oxford Universities and the city also has a higher than average homeless population. Both these groups present challenges to the mental health services in how they engage effectively with them to deliver services.

Accident and Emergency services are provided by the Oxford University Hospitals NHS Trust from the John Radcliffe Hospital in Oxford and the Horton Hospital in Banbury. Mental health services are provided by Oxford Health NHS Foundation Trust (OH). Oxfordshire County Council, Oxford Mind and Restore also offer services to support people's mental health.

We looked at the experiences and outcomes of people experiencing a mental health crisis in Oxfordshire. In particular those people in crisis who presented at accident and emergency departments, people known to services and receiving ongoing support from specialist mental health services and people detained under section 136 of the Mental Health Act.

We found that there were strong structures in place supporting multi-agency working in crisis care across Oxfordshire. Meetings with representation from the local authority, local acute trusts, mental health trust, local CCG and other organisations including the police, ambulance service and voluntary sector organisations helped ensure that information and learning was shared across systems.

People experiencing a mental health crisis had access to a range of services, provided by staff committed to providing good care. Whilst there were mechanisms in place to seek feedback, people who used services and their carers told us they did not feel involved in decisions about development of services.

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

- **Care Pathways**

Policies were in place which covered emergency care pathways and involved the relevant partner agencies. OH provides an emergency psychiatric service (EDPS) to the accident and emergency department (A&E) at the John Radcliffe Hospital and the Horton Hospital. Additionally, Oxford University Hospitals NHS Trust has its own integrated Pyschological Medicine Service which provides psychiatric and psychological care to outpatients and inpatients at all of the trust's hospitals. Out of hour's emergency cover is provided from Oxford Health.

The EDPS and the Oxford University Hospitals use different electronic record systems.

Although some EDPS staff could access the Oxford University Hospitals system and can upload their assessments most staff had read only access to each other systems. This meant that staff may not always have up to date information about the risk to an individual or the risk that they may pose to others. Serious Incident reviews had identified elements of poor communication between the services. We saw that learning and actions had been put in place in response to these.

People we spoke with told us that the out of hours EDPS based at the John Radcliffe Hospital were reduced and waiting times to be seen in the accident and emergency department were extended. Staff at the Horton Hospital told us people who presented with a mental health crisis would frequently be delayed in receiving appropriate mental health assessment during out of hours and weekends. This meant people would often stay in the department overnight while waiting to be assessed, which added pressure to the resources within the department. We were told recruitment of three additional nurses to provide out of hours care had commenced.

A&E staff had a good understanding of caring for people attending in mental health crisis. We received positive feedback from people regarding the attitude of staff and care provided. There were separate rooms within the A&E departments that were used to carry out psychiatric assessments, ensuring privacy.

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

- **Access**

People could access crisis services through referral from their GP or if known to services they could contact their Adult Mental Health Team (AMHT) directly. The AMHT provide emergency assessment and treatment with staff working in locality teams from 7am to 9pm. Out of hours (OOH) between 9pm and 7am there was a reduced service provided centrally from the Warneford Hospital, run by OH.

People told us they were aware of how to contact crisis services if necessary, including who to contact in an emergency out of hours. Information was clearly signposted on the trust's website. A GP we spoke to was aware of the services available and how to refer a person to them.

- **Service provision**

People who experience mental health crises in Oxfordshire had access to a variety of community mental health services. For example the Luther Street Medical Centre, a specialist centre that homeless people can access for a variety of health services including mental health and addiction services. There was also a specific mental health service to support the large student population in Oxford City. This worked with the universities and colleges to provide a service to students.

People who used the home based treatment service told us they had received visits up to three times a day and had helped in their recovery. Additionally the Oxfordshire

Complex Needs Service provided a specialist day programme and community service for people with complex emotional or mental health difficulties. Access to services was through self-referral or GP referral.

- **Care planning and records**

We saw risk assessments and risk management plans were accessible to all services within OH. Two GPs we spoke with confirmed that the AMHT had sent them copies for their information and people's records. The electronic care records between the acute trust and the mental health trust were not compatible and they used different risk assessments. This did not allow information including risk management and care plans to be easily shared between the organisations.

We were told of positive working relationships between the AMHT and GPs, with GPs telephoning the team to discuss concerns.

- **User involvement**

People had the opportunity to provide feedback through various types of surveys. OH runs five service user forums for adults across Oxfordshire. These are held every three months and used to gather feedback on services from people who use them. However people who have a mental health illness and their carers told us they did not feel involved in the decision making process and were not listened to.

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

- **Access**

There are two health based places of safety (section 136 suite) in Oxfordshire. Access to the health-based places of safety was not restricted for any groups of patients, for example, under 18s or people with substance misuse issues.

- **Staffing**

Staffing was provided from the inpatient unit that the section 136 suites were attached to and we were told this did not cause shortages in the unit when the section136 suite was in use. Any shortfalls were covered by bank or agency staff. The mental health trust ensured staff had been trained to offer appropriate support to people accessing the section 136 suites.

Staff reported to us in both suites that there could be delays of up to several hours, for an Approved Mental Health Practitioner (AMHP) to attend to carry out an assessment. This was a particular problem out of hours when there were fewer staff and if several emergencies happened simultaneously. Similar delays in accessing section 12 doctors out of hours were reported.

- **Care pathways**

Policies were in place to ensure that people were assessed at the place which was most appropriate for them in a time of crisis. This ensured that least restrictive practices, such as the use of health based places of safety or police cells, were avoided where possible. Risk assessments were undertaken to ensure people and others were kept safe. They were used in the least restrictive manner.

We found that section136 paperwork had not always been fully completed, for example the time the section 136 had finished had not been completed. The mental health trust was aware of this and has put an action plan in place to address the concerns.

- **Street triage**

Within Oxford City a street triage service was run by OH and the local police where mental health workers worked alongside the police to help assess the risk a person may pose to themselves or others when in the community and signpost people to appropriate services. All agencies involved considered the service a success as it had reduced the number of people detained under a section 136 and taken to a health based place of safety. There were plans to provide a mental health worker in the Ambulance Clinical Coordination Centre.

- **Transport**

South Central Ambulance Service told us that police vehicles were no longer used and detained patients were always conveyed by ambulance. Staff at the health based places of safety told us that sometimes private ambulance services were used as South Central Ambulance Service was not always able to provide transportation at the time that it was needed due to pressures on the service.

Local strategic and operational arrangements

The local mental health and community services trust, clinical commissioning group, local authority and other relevant partners had built good relationships, and meetings took place regularly between organisations involved in the commissioning and provision of emergency mental health services. For example, the Problems in Practice Group met every four to six weeks to discuss interagency working issues that had arisen.

Key strategic partners had all signed up to the Crisis Care Concordat. An action plan had been developed and actions with specific dates for completion were due to be implemented throughout 2015.

The Oxfordshire Joint Health and Wellbeing Strategy 2012-2016 clearly prioritised mental health along with learning disabilities. This included an overall aim to increase access to psychological therapies during 2014-15. The local authority and Oxfordshire clinical commissioning group had a section 75 agreement in place which allowed the pooling of budgets to commission and provide mental health services across the county. Communication channels between organisations were clear and there was evidence of a commitment to sharing of information for example, the findings of the Oxfordshire

Healthwatch report into mental health and A&E experiences of students in Oxford and recommendations for improvement. This had encouraged stakeholders to review current services and consider how they could improve the experience of services for this group of people.

Partner organisations worked together to provide joint training. For example, mental health awareness training for police and ambulance staff was delivered in conjunction with staff from the mental health and community services trust. Joint training between local authority staff, mental health and community services trust staff and the police had supported a greater understanding of each other roles, duties and responsibilities.

People had the opportunity to provide feedback on all aspects of services via local and national surveys. The local agencies told us that this feedback was used to make continuous improvements to care delivery. However people who have a mental health illness and their carers told us they did not feel involved in the decision making process and were not listened to by either commissioners of services or the service providers.

Areas of good practice

- Strong multi-agency working and a commitment to looking at joint work to encourage positive outcomes for people in mental health crises.
- Consideration of diverse needs of different groups in the local area. For example, students and homeless people.
- No patient groups are excluded from either health based place of safety.
- The street triage service was widely seen as a valuable service. Since being commissioned fewer people had been admitted to a health based place of safety.

Areas for development

- Improved communication between the Psychological Medicine Service and EDPS to ensure patient information is available to all staff providing care and support, including out of hours.
- 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 are identified and action taken.
- Review availability of AMHP and section 12 doctor resource, particularly out of hours, to ensure timely assessments are undertaken.
- Effective engagement with people who use services and carers in the development of services.