

# Mental Health Crisis Care: Lambeth 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 Lambeth. 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

Lambeth is an inner London borough comprising 21 wards located in six town centres. It is one of the most densely populated boroughs in the country with a rapidly growing population who are relatively young, highly diverse and mobile, with areas of significant deprivation. About a third of adults registered with a GP in Lambeth are white British and about 20% are from a black African, black Caribbean or other black background including mixed black heritage. Although people's general health is improving specific health challenges remain, including inequalities in mental health care.

Mental health services in Lambeth and Southwark are provided by South London and Maudsley NHS Trust (SLaM). The local accident and emergency departments are located at King's College Hospital (Southwark) and St.Thomas' Hospital (Lambeth).

We looked at the experiences and outcomes of people experiencing a mental health crisis in Lambeth in particular those people in crisis who presented at accident and emergency departments and those who are detained under section 136 of the Mental Health Act.

Commissioners had various collaborative working initiatives and met regularly with various local groups. However, feedback from BME communities was that they do not feel listened to and that their needs were not taken into account when commissioning services. Commissioners had recognised the need to invest in supporting communities to engage as a priority.

We found that care pathways were clear for people who experienced mental health crisis and presented to accident and emergency. People were assessed within a timely manner and there were clearly documented referral processes for further care and support. Health based places of safety were suitable environments and appropriate processes were in place to keep people safe.

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

- **Primary Care**

The Lambeth Collaborative Hub acts as the new front door to mental healthcare for people in the north of the borough. It is expected this facility will be extended across all of Lambeth from mid-2015. The Hub works within primary care with referral to specialist, secondary care if appropriate and is multidisciplinary with social workers, psychiatric nurses, occupational therapists, peer supporters and community support guides. At present referral to the Hub could only be made by GPs, however in April 2015 it will be open to self-referrals.

We spoke with two GPs including the mental health lead for the Clinical Commissioning

Group (CCG) who were positive about mental health provision under the new model. They were aware of mental health crisis pathways and said they had good support from mental health specialist services. For example they could telephone psychiatric consultants or mental health liaison workers if they were unsure about a referral. We also saw the CCG had organised training and awareness sessions for GPs, for example on dual diagnosis.

Feedback from service users was mixed in relation to contact with their GP when in crisis. Some people were positive about their GPs with one person describing their GP as a “life saver”. Whilst another person told us that when they went to see their GP they were told that nothing could be done to help them as they were not unwell enough, they then ended up in crisis and had to present to accident and emergency.

People in crisis also had access to a peer support help line that was run by a voluntary sector organisation. The service was available Monday to Friday 8pm to 12am and Saturday and Sunday 8pm -2am.

- **Care pathways**

We found that care pathways were clear for people who experienced mental health crisis and presented to accident and emergency. Patients were assessed in a timely manner and there were clearly documented referral processes. The mental health team were contacted as soon as a patient had been triaged as having potential mental health problems. The psychiatric assessment was carried out at the same time as any physical assessment. This model of parallel clinical and psychiatric assessment enabled clinical staff to work together, share information and facilitated joint decision making at an early stage. A consultant psychiatrist could be accessed for advice 24 hours a day including an adolescent psychiatrist.

Assessments and treatment were carried out in facilities that were private. In the accident and emergency ward at Kings Hospital there was a separate area where people who present with a mental health crisis were assessed and treated. The service users we spoke with had mixed views about their experience of accident and emergency. Communication was an issue raised and having to repeat their story to different members of staff was experienced very negatively when people were in crisis. However, on the whole, people said they were treated well and got good care.

- **Information sharing**

Integration of the psychiatric liaison teams within the accident and emergency department was well established with good cross team training and communication between staff. The mental health liaison teams ensured that information on how to refer individuals to other services was shared with the appropriate teams. Accident and emergency staff worked closely with the addiction counsellor who was based at the hospital and the local community mental health teams.

There were protocols covering out-of-hours of provision and information sharing arrangements between the liaison and out-of-hours teams. Agreed referral timescales

and service standards were in place, and the mental health liaison team were able to demonstrate that service users and referrers were satisfied with delivery against them.

There was evidence that people who self-harmed were not stigmatised within the departments. We saw research had been carried out into patterns of self-harm by ethnicity and adolescents, to inform service planning and the results were widely shared with hospitals and relevant services.

- **Training**

The mental health liaison team provided ongoing training and support for accident and emergency clinical staff as part of their induction and on dedicated training days. The department had recently run a multidisciplinary simulation training event and also provided training for security staff to increase their knowledge of mental health conditions and help them to support patients. The ambulance service had undertaken joint training with SLAM and the police, from which they have produced a joint training video. There was a recognition that the police would benefit from additional training.

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

- **Access**

Access to the health-based place of safety was not restricted and patients with more challenging needs, for example, people who were intoxicated, were not turned away. The place of safety suites were suitable environments and documentation showed that patients were kept safe and that staff aimed to minimise restrictions and length of stay. Clinical entries were detailed and the section 136 paperwork was in order.

Lambeth have a street triage team that works closely with the police. The project has been operational since 31 March 2014 and is funded for one year. A mental health nurse is located at the Maudsley Hospital and provides 24 hour telephone advice for police officers and face to face assessments during certain times of the day. This means that if the person is known to the service the nurse can advise police on the most appropriate action.

- **Transport**

Individuals were regularly transported by police car (approximately two thirds) and fairly commonly by ambulance with a police escort. We were told that caged vehicles were only used in exceptional circumstances under section 136. This was confirmed in the trust's audit. We found that neither the police or the ambulance service collected any data broken down by ethnicity.

- **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 places of safety at all times.

Staff demonstrated an understanding of how and when to apply relevant legislation governing consent and decision-making, and recognised the difference between lawful and unlawful restraint practices. In addition an understanding of how to make decisions in line with Mental Health Act 1983 and the Code of Practice, and were supported in this by appropriate training, policies and procedures. However, some patients and carers told us their past experience of being detained under section 136 had been traumatic and had involved unnecessary restraint. Service users were highly critical of police in this respect.

There had historically been limited opportunities for joint training between mental health staff and the police. The street triage pilot however included training for police and we were told consistently this had been well received.

### **Local strategic and operational arrangements**

Commissioning plans, reflected national strategies and were informed by the needs of the population. There was an overall approach to integration and prevention with clear evidence of service user involvement. A Crisis Care Concordat action plan had been developed and was being progressed.

Commissioners told us they was a clear focus on preventing crisis and early intervention and had commissioned peer support services in the community to reflect this, such as the Living Well Partnership and Mosaic. Service users told us they greatly valued this type of service. Inpatient beds were usually available but the ambulance service and the police told us they felt that more crisis beds were needed for adults and children. Commissioners were in the process of setting up a crisis house which would provide additional crisis beds for Lambeth.

We saw meetings took place regularly between organisations involved in the commissioning and provision of mental health services. However, some people from BME communities reported that they do not feel listened to and that their needs were not taken into account when commissioning services. The Lambeth commissioner had built good relationships with a number of local organisations which represented various vulnerable groups and tried to ensure that these groups were represented at all forums. There was recognition of the need to invest in supporting communities to engage as a priority.

### **Areas of good practice**

- Commissioning peer support services in the community, such as the Living Well Partnership and Mosaic that were greatly valued by service users.

- Integration of the psychiatric liaison team with the accident and emergency department was long-established with good cross team training and communication.
- Good collaboration between hospitals to research relevant issues to inform service planning. For example, patterns of self-harm by ethnicity and adolescents.
- Implementation of a street triage team that works closely with the police. This means that if the person is known to the service the nurse can advise police on the most appropriate action.

## Areas for development

- To seek and act on feedback from BME service users. Include representation from BME communities at all co-working and commissioning service forums
- Collection and review of information on use of section 136, by ethnicity, by the police and ambulance service.
- Review the practice of using police cars to transport people experiencing a mental health crisis.
- Increased training for police in partnership with other stakeholders.