REPORT ON SOUTH LONDON AND MAUDSLEY NHS MENTAL HEALTH TRUST

BY STEPHEN NIEMIEC

INTRODUCTION

I conducted this review during September and November 2004 on request from the Acting Commissioner, Ranghild Banton. The purpose of the review was to:

1. Test the current Adult Acute Service Crisis Services' configuration
2. To comment on the strengths and weakness of the components of crisis care
3. To make recommendations for future service development and direction

Reviews must take into account the whole system and this review contains information gleaned from substantive data, and personal and group interviews that occurred over a six-day period. At times senior clinicians, service users and managers of the service were interviewed on more than one occasion.

This review is a critical look at existing services; it is necessarily critical as it allows the identification of the various strengths as well as weaknesses within current service configuration. Without criticisms there is very little space created in which to develop, change or improve. It needs to be borne in mind however, that the critical view is not an attempt to assign blame or to demoralise, it is rather an opportunity to reposition one's view so that a different perspective may be gained when looking at a familiar landscape. In doing so, it is hoped that the resolve necessary to undertake difficult tasks will be strengthened for senior managers, clinicians and commissioners.

CONTEXT

In order to accommodate the modernisation agenda of the NHS mental health services have had to reorganise the way they function. The National Service Framework threw into stark relief longevity of service models against a new agenda of specialisation, encouraging more focussed services. Of particular importance early on in the development of specialist services, were Crisis Resolution and Home Treatment Services(CRHTS). These teams increase and standardise access, crisis response and resolution providing targeted in-reach into the community as an alternative to hospital-based admission. The evidence is that users strongly prefer home-based treatment when compared to hospital admission but importantly, CRHTs improve the quality of care during acute phases of illness and can be more sensitive to ethnic and cultural needs.

The boroughs of SLAM services encompasses some of the most deprived areas within England and in fact all boroughs are within the worst 10% of the 354 English local authorities on employment and income measures. In addition, a portion of non-white groups in Lambeth, Southwark and Lewisham was 25%. There is therefore good reason to assume that Crisis Resolution and Home Treatment Services would be able to make a significant impact within this catchment area.

PROCESS

During my multiple interviews with people I was careful to mark out my observations and invited people to comment upon these observations to check their validity. As interviews progressed, and more data became available, we were able to "test" emerging formulations giving people the opportunity to challenge or build upon the developing ideas. In this way a 'density' of data lead to a common understanding so that a conceptualisation of the service was gained. In general, I would make the following observations.

Despite good attempts by managers and senior clinicians to provide a very good service, the overall service appears fragmented. There has been specific emphasis placed upon reduction and out of area treatments, which is a position to be applauded. However, the Crisis Resolution and Home Treatment Service has not focussed nearly enough upon providing assessment and home treatment functions. The above has been sacrificed to support an emphasis on bed management in clearing beds at the tail end of admissions rather than at the front end of adult acute units.

My observation is that the acute care system is in crisis due to a number of factors, which I have listed below:

(a) There are multiple points of entry for those people requiring urgent care. Patients can enter urgent pathways via Accident and Emergency, CREST, Emergency Clinic (EC) or CMHTS. There would be several advantages to controlling these gateways so that greater consistency and more focussed approaches to assessment and care are delivered. Patients who present at EC are often assessed on more than one occasion should admission be considered necessary. This appears unnecessary, as any admission assessment should be undertaken by CREST alone. Urgent or crisis assessments should not be undertaken by CMHTs apart from care co-coordinated individuals for whom mental health act assessment is required and if local protocol allows, for CREST to be involved in that.

The CREST team falls short of effective crisis resolution and home treatment arrangements for the area they serve, particularly given the high levels of deprivation. Although the team size matches the PIG guidelines I believe there is sufficient reason to increase investment to allow for increased deprivation, and the higher MHA detention rate within the Borough.

CREST is unable to operate 24 hour a day assessment team with insufficient numbers of patients on Home Based Treatment (HBT) as an alternative to hospital admission.

CREST have focussed upon early discharges (FEDS) from adult acute units in an attempt to reduce out of area admissions which has reduced OATS but in doing so sacrificed home based treatment (HBT) which makes the largest impact on bed occupancy.

(b) The Emergency Clinic has a confused remit, providing a section 136-assessment area, a drop-in clinic and a pre-admission unit for the rest of the adult acute MHS, the multiplicity of roles leads to ineffectiveness e.g. if a patient on a section 136 is particularly disturbed the EC is forced to close precluding all other activities.

The EC acts as a perverse incentive for the neighbouring Acute Trust not to develop improved Accident and Emergency facilities for patients presenting with psychiatric problems.

It is quite apparent that there is an inequity of utilisation of the EC by some sectors of the Trust. This appears related to "risk averseness" by those CMHTs who over-utilise EC as a first port of call, rather than themselves. Clinical activity reporting from the EC gives a very clear picture of the distribution of CMHT utilisation of EC.

(c) Feedback from staff across the service confirms findings that there is very little joined up approaches to care within the Adult Acute area. The service is fragmented. All staff and service users I met with held this perception.

The staff from all areas I met were also highly motivated, skilled people who wanted the best for the patients and operated with much good will.

The Adult MHS responds to pressure without sufficient focus on clinical need.

The adult inpatient units are pressured with high occupancy levels there being a particular emphasis upon FED (for early discharge) as a way of clearing empty beds. This worries some of the clinicians and managers, as this work appears to remain outside the realm of care co-ordination. This points to a much larger problem, which is that some CMHTs appear to be outside the loop of adult acute care, which further adds to the fragmentation issue.

Demand upon the EC for case management support varies from CMHT to CMHT.

(d) Psychiatric services are not mainstreamed into general health care, which is the normal course of events in most other Trusts where Accident and Emergency is typically the first port of call for someone requiring urgent psychiatric assistance. The situation that has been allowed to continue from Kings A&E, in the emergency clinic, has in one sense acted as a perverse incentive for the local accident and emergency departments in that they have never been in the position where they have had to develop effective processes for all people who would be presenting with psychiatric or mental health problems, partially because of history, but also due to the proximity of the EC. Although Accident and Emergency services are busy and a reasonable proportion of people they see have mental health problems, they are under considerable pressure and are exerting considerable pressure upon the Mental Health Trust to meet the four-hour targets. In my view

there needs to be much greater spirit of co-operation between Accident and Emergency and the Mental Health Trust staff.

(e) It is questionable if Section 136s should be assessed on MHS sites rather than in Accident and Emergency Departments.

(f) Inpatient occupancy is often over 100% placing bed management under stress.

(g) Joined pathway development is required across all teams within the Adult Acute service based upon clinical need rather than just pressure.

(h) Information produced in activity reports is of a very high standard.

DETAILED EXPLANATION

1. The CREST team was established in 2001 in the Northern Borough area and in the South of the Borough in 2003. There is 14 staff per team at a cost of £1.155 million (excluding medical costs). If we apply PIG (2001) guidelines for Crisis Resolution and Home Treatment teams the size of the local team for an adult population of 230,000 would be 30. However recruitment problems have prevented all posts being filled. The high local deprivation of the area may well be a case for increasing the complement especially during the early phase of comprehensive system re-engineering. The higher rate of MHA compulsory admission in the London area needs to be taken into account also and including the CREST, if possible, into the circle of MHA assessment might decrease numbers of detentions. In Newcastle and North Tyneside the CATs were able to reduce MHA admissions by 25% despite the fact that they are not the sectioning team. This is an example of how working at the front end of admission units effects occupancy. Over the years the Newcastle and North Tyneside Crisis Assessment and Treatment Service have reduced occupancy by 40% allowing a 35% in bed provision across the Trust.

2. Comments from teams interfacing with CREST are that they have difficulties with referrals, in particular some CMHTs comment they are forced to see people urgently (within 24 hours) because CREST are too busy attending to bed management work.

   There will be knock-on effects for those CMHTs having to complete this type of work, namely continuing care needs will be sacrificed to attending urgent or crisis referrals. In turn, this produces more crises over time and encourages service users to attend the EC because they feel they get more response from EC staff. This perverse capacity circle requires dismantling along with a reinvigoration of CRHT services to respond to the incoming referrals in order to assist the remainder of the MHS to focus its continuing care energies more appropriately. CMHTs on the other hand need to open their doors to existing users to access them when required. Easier access is more likely to lead to fewer crisis and after-hour presentations.

In my experience CRHTs ought to be able to respond to requests by GPs and others by seeing 80% of people within two hours, twenty-four hours a day provided they are deemed to be in a psychiatric crisis. The advantages of a twenty-four hour service are consistency across the time span, a simplified referral pathway, and reduction of duplication effort from other services.
Additionally there are concerns regarding clinical supervision and case management of those within the assessment and brief treatment teams (ABT). Although this split within CMHTs is likely to produce a better chance of continuity of care for those on enhanced CPA, the positives are not likely to be gained if ABT teams are taking inappropriate work or maintaining long-term treatment. A clearer remit is required along with case managed input via closer supervision from senior clinicians and or team managers. This is likely to increase intake capacity of ABTs.

3. Although the CREST team gate-keep admission wards they do not (yet) offer sufficient HBT to alter occupancy significantly. An area of local success however is the reduction in out of area treatments (OATS), which has reduced significantly reducing the cost burden of the Trust. The burden of bed management has fallen upon CREST with subsequent focus upon providing for early discharges (FEDS) at the cost of HBT, which has been shown to have the most impact upon bed occupancy. FEDs in other parts of the UK and Internationally comprise 15% to 20% of CRHT workload and do not significantly reduce occupancy.
Bed management becomes even more wrought when there are high levels of inappropriate long-term placements in adult acute wards and more needs to be done to ensure that adult acute beds (the most expensive resource) are utilised for acutely unwell patients rather than as accommodation. The national picture is similar unfortunately but I would suggest that a broader view of capacity management be established so that people who stay longer than 30 days or are likely to stay longer than this, are identified early. Early identification allows transitions of care to be planned earlier or that capacity issues can be planned rather than come as a surprise and therefore become a further source of frustration.

4. However, multiple gateways for admission exist and CREST spend a great deal of time conducting assessments for admission on top of assessments that other clinicians and teams have already completed. It is acknowledged that these assessments need to occur in order to ascertain suitability for HBT, but there seems little point to this activity if there is no capacity to provide HBT. Entry points into the wards do require effective management to prevent unnecessary admissions, however as previously mentioned the focus on avoiding OATs at the tail-end of admission prevents HBT becoming a success at the front-end. Research conducted by Hoult, and Hopkins, Niemiec (2004) indicates a significant preference by service users for HBT and if admission can be avoided altogether then that becomes a win-win.

5. The EC provides one such point of entry via walk-ins and Section 136. There are only a few other areas in the UK that utilise sites on Mental Health facilities for this purpose. Local arrangements always differ of course but there is need for more consideration of this in the local patch because of:

Firstly most Trusts consider this provision clinically unsafe as it works counter the notion of mainstreaming mental and physical services together which frequently interface within Accident and Emergency Departments. The advantage of the latter is the ability to rule out organic factors in a presentation and to subject people (when necessary) to physical tests. Secondly when things go awry (not common but they do) there is a much higher risk of negative outcome without sufficient equipment and personnel especially when people are undergoing physiological changes e.g. intoxication, or when someone reveals they have taken an overdose. Although the Accident and Emergency department is adjacent to the EC, transport via ambulance is required. This increases the risk if time is of the essence.

6. The future of EC has been discussed in many forums over the last few years stimulated in part by Lambeth planning to withdraw their portion of funding threatening the viability of the clinic in its current state. In a recent options paper published in July 04 the working party established six out of nine functions currently carried out by the EC that could be managed more appropriately by other service components.

6.1 That report identified three components of care, which would be difficult to replicate:

"People who were so unwell that they would abscond while awaiting assessment at Accident and Emergency.

People who required immediate crisis intervention

Service users with personality disorder and other issues that create engagement difficulties."

In discussing these issues there is now an enhanced PLN service in Kings Accident and Emergency department who could(conceivably along with local protocols) MHS, Social Services EDT, Police and security contribute toward MHA 136 assessments.
There are not sufficient rooms or appropriate rooms for psychiatric/mental health assessment but that doesn't mean there shouldn't be especially in the light of £500,000 incentive funding following 4-hour time wait time assessments. If Kings Accident and Emergency is not the appropriate place at this time perhaps another Accident and Emergency department could be utilised through shared funding/staffing arrangements in an existing and established unit such as St Thomas Hospital.

Immediate crisis intervention should be available via Accident and Emergency, CREST, and other emergency services.

In the absence of a specialist service for personality disorders it is always likely that psychosocial eruptions occur. This group of patients are characteristically experiencing affective shifts that only experienced and well-trained clinicians can contain. Providing multiple points of contact for these

individuals usually creates more contact not less, which should only be condoned if that contact leads to resolution. Case management is required with crisis plans and agreed contacts should problems be encountered. Emergency clinics in general are not a suitable environment for long term management of these people, and in fact may encourage regression

7. Some Mental Health Units within Accident and Emergency departments e.g. St Thomas's report a satisfactory working arrangement, however these Units are placed within general hospital sites. This throws into stark relief the notion that 136s are taken to a place of safety as suites off General Hospital sites increases the risk to patients if, or when, things go wrong. Secondly such units create potential "drop off" points for the Police who usually regard themselves as too busy to sustain presence with a 136 patient. The uptake from 136 to committal is 49%(n=32) in a recent six-month audit undertaken by Dr George Smuckler, a further (22%) were admitted informally (n=14) and 29%(n=19) discharged. Sixty-five s136s in six months averages at one presentation every 2.7 days, not a significant volume of work and if the work rate were this low, transfer to another area would not create too much transfer of effort or resources.

8. Cost of the EC is £607K excluding medical costs. The remit of the EC is complex acting as a drop-in centre 24/7, a Triage Ward, and a 136-assessment area. It is frequently used as a first contact point for service users on enhanced CPA according CMHT managers indicating a lack of responsiveness on the part of CMHT duty systems. It is worthwhile noting that the St Giles continuing care one team have twice the utilisation of EC (450 patients) than does CC2 (210) the next nearest is St Giles ABT at (364). Lowest utilisation is from CC2 within Southwark but utilisation from Lambeth service users is less than 42%. Significantly, but in a limited audit 52% of EC presentations attended on more than one occasion in one month.

   It is an extremely busy unit seeing 2942 people between April 2002 and March 03 and 2218 between May 03 and March 04. The cause of the reduction is unclear but is likely to be linked to the instigation of CREST. 48% of presentations are after-hours and 52% within hours suggesting that the EC is inappropriately used because CMHT duty systems should be the first point of contact for a case managed individual. Also there are a significant number of presentations that are EC follow-ups (ECFUs), which in one audit totalled 28% of people seen. All presentations to the EC do not necessarily lead to assessment with 87% of people undergoing an assessment within the same audit period. 53% of attendees are self-referrals, 40% are new patients

9. The major proportion of referrals to CREST is from the EC (37.5%) and the inpatient wards suggesting that there is natural link with the EC. Referrals from the wards are for early discharges (FeDs).

   E.C. Staff report that patients often stay overnight in E. C. There are no bedrooms or washing / showering facilities. The ER itself is a low ceiling basement floor with a central large room and several rooms feeding off. It is,

in my opinion highly unsuited for overnight stays and I can only reflect that if one of my family members were admitted there I would be most concerned.

10. The Department of Health mental health incentive schemes announced on the 23rd January 2004 was to highlight the importance of supporting people in crisis and, in particular, to integrate all the elements of round the clock crisis provision. The offer of financial incentives to Accident and Emergency departments was based upon meeting improvement targets to meet 4 hour deadlines and is significantly larger than that offered to Mental Health Trusts. Mental Health volumes attending Kings Accident and Emergency in one brief audit period were 40% of total people seen between Accident and Emergency and the EC. It is understandable that Accident and Emergency departments do not wish to become the focus of all psychiatric presentations but in other parts of the country this is exactly what occurs as there are few middle tier services available to service users. In Newcastle and North Tyneside the two Accident and Emergency departments provide 40% of referrals for the Crisis Assessment and Treatment service, similar numbers occur in Victoria, Australia.

FORMULATION

The situation described in the executive summary is really a reflection of whole system stress. Through combined interviews, triangulating "where we are", via observation reporting, reflection and establishing shared meaning, the staff interviewed agreed that the system was in crisis and (in the main) responds to pressure. The current adopted level of response helps only in the short-term however. Typically in such systems the same conversations occur regarding referrals, treatment, burden of care, transitions of care and exit strategies. The potential for perverse incentive development is high and difficult to contain or manage. In addition because of a fire-fighting approach to problem solving there is very little capacity for the whole system to develop solutions as there is little room for the development of strategy and to focus on need and then quality. Effective utilisation of CRHTs as described by Kennedy (2003) with model fidelity, (Niemiec and Tacchi, 2003) ameliorates significant pressure off the whole system of care so that capacity for future development can occur. Each component of the service experiences stress and has capacity issues. In Southwark this occurs because there is duplication of delivery, each part of the service is doing what other parts of the service should be doing. There needs to be a strengthening of clinical pathway design from the patients, families and clinicians perspective so that greater coherence in service design exists. The MHS needs to make sense to the patient and to the staff group. This allows differences in functionality between teams accounting for a greater degree of specialisation, reflecting the modernisation agenda. It is not possible anymore for teams to be all things to all people, if indeed that nirvana ever existed.

RECOMMENDATIONS

That a whole systems view be adopted to achieve solutions that have been created elsewhere in the UK, and to achieve that, the following is recommended:

1. That CREST has increased investment to provide an increase in HBT.

2. AOT consider working 7 days a week (reduce burden on CREST during weekends).

3. CMHTs increase their focus upon Inpatient in-reach encouraging(FEDS) with CREST support.

4. Dedicate local wards to local people (after occupancy lowered).

5. CMHTs cease urgent work so CREST can pick this up, but reduce their reliance upon the EC to back them up.

6. CMHTs develop internal capacity for senior duty clinicians to provide access for known service users as a first stop in place of EC, Mon-Friday 9-5pm.

7. Close EC and develop sec 136 facilities in Kings / place CREST within EC and combine 136 with CREST/ (see options paper).

8. Plan for commissioning after-hours telephonic support is developed.

9. It may be necessary to appoint a project manager to facilitate a whole system major project, whose main focus would be joining up the adult mental health service in consultation with users and staff that meets demand, but also focuses upon quality which is supported by senior management and clinicians.

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OPTION ONE

CLOSE EC

- A&E MAIN AFTER HOUR CENTRE
- 136 SEEN AT A&E OR ST THOMAS HOSPITAL
- MOVE 136 RECEPTION TO ST THOMAS OR EARLY INPATIENT UNIT UNTIL IN MEANTIME

ADVANTAGES

1. Shift 600k to CREST (18 G Grade equivalents)
2. 24 hour manned crisis service
3. Increase Home Based Treatment with reduction in bed occupancy
4. Dedicate local beds to local people
5. Commence some For Early Discharge activity with CMHTs
6. CREST see urgent first up assessments
7. CMHT in reach into wards
8. Case-managed individuals present to local CMHT and seen by Duty Worker
9. Simplifies pathways
10. Removes pressure of CMHTs to do urgent assessments
11. Increase medical input into CREST/A&E
12. Mainstreaming of psychiatry and A&E
13. Positive investment following 4 hour targets
14. 136s seen in mainstreamed environment
15. Makes whole system invention
16. Standardisation of crisis response
17. Balance the use of Duty across CMHTs

DISADVANTAGES

1. Lose a historical part of service (some users prefer EC)
2. Drop-in function lost (but this could be taken up by day hospital and CMHTs)
3. A&E will need to increase investment in mental health facilities

OPTION TWO

CLOSE DAYTIME FUNCTIONS OF EC. COMBINE EC WITH CREST AFTER-HOURS. DAYTIME 136S GO TO A&E. PLAN TO MOVE 136S TO A&E PERMANENTLY.

Do

ADVANTAGES

1. Increase resources into CREST with decreased bed occupancy
2. Increase Home Based Treatment component
3. CREST undertakes all urgent assessments
4. Standardised response to crisis

Same as option 1 (excluding 8)

6. Targeted after-hour support for service users

DISADVANTAGES

1. Loss of drop-in function
2. Lead to possible difficulties between services at points of transition
3. Complex patient pathway
4. Non standardised 24 hour response to crisis presentations
5. Might not lead to

OPTION THREE

MAKE EC TRIAGE WARD
FOR UP TO 3-4 PATIENTS

ADVANTAGES

1. Cease drop-in facilities in EC and CMHT pick up

2. Increase bed state

3. Continue to receive 136s
4. Eases bed pressures in the short-term

DISADVANTAGES

1. Create another bottle-neck in an already choked system

2. Nothing changes, pressure remains unchanged

3. Would require investment – ? expensive option

4. Relies on bed being occupied all the time therefore no real improvement to whole system

5. A&E does not get the opportunity to develop mental health facilities

6. Bed occupancy problems continue.

OPTION FOUR

- CONTAIN EC WITH CREST
- EC BECOMES CREST BASE

ADVANTAGES

1. Maintain culture of 50 years duration
2. Increase investment in acute care

DISADVANTAGES

1. No change to the whole system
2. No impacts felt at local level
3. Increased tension between CMHTs and EC (CREST)
4. Confused remit of EC is not clarified
5. Investment opportunities for A&E possibly lost
6. Combining two busy teams does not assist CMHTs or Adult Acute wards.

OPTION FIVE

MAINTAIN EC (DO NOTHING)

ADVANTAGES

- Historical unit maintained

DISADVANTAGES

- Nothing changes (as in executive summary)
- Continue to work with reduced funding