Regulation and mental health crisis care

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CQC mental health crisis review

Focuses on ***the experiences and outcomes of people at a time of mental health crisis.***

- The aim is to develop our approach to monitoring, inspecting and regulating the quality, safety and responsiveness of crisis care.
- A care pathway approach to look at how different organisations and agencies work together for three groups of people:
  - **Key Group 1:** People who present to accident and emergency (including a focus on those who self-harm)
  - **Key Group 2:** People who requires access to and support from specialist mental health services
  - **Key Group 3:** People who are detained under Section 136 of the Mental Health Act

Elements of our thematic work

Phase 1: building our evidence base

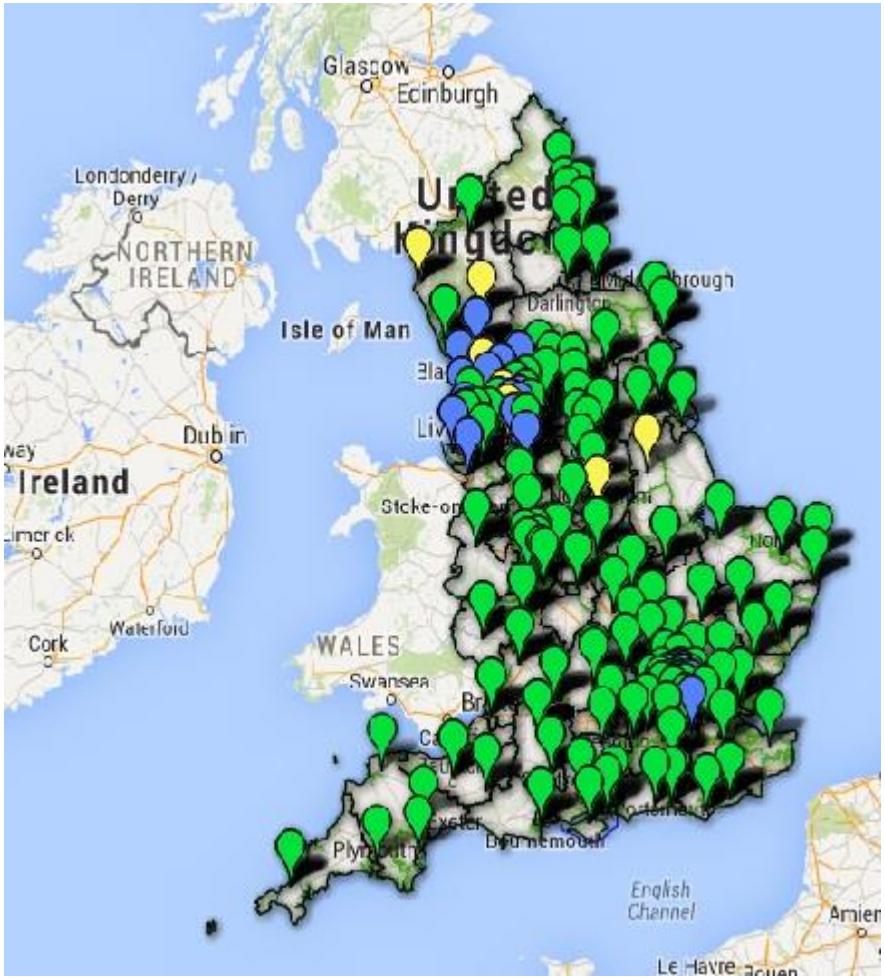
- Survey to map health-based places of safety
- Public call for evidence
- Review of national data

Phase 2: local area inspections

We are will conduct 15 local area inspections:

- November 2014 to February 2015
- We have selected areas where we expect there to be a range of quality with respect to care pathways
- We will assess for both good and poor practice

Health-Based Places of Safety: online map



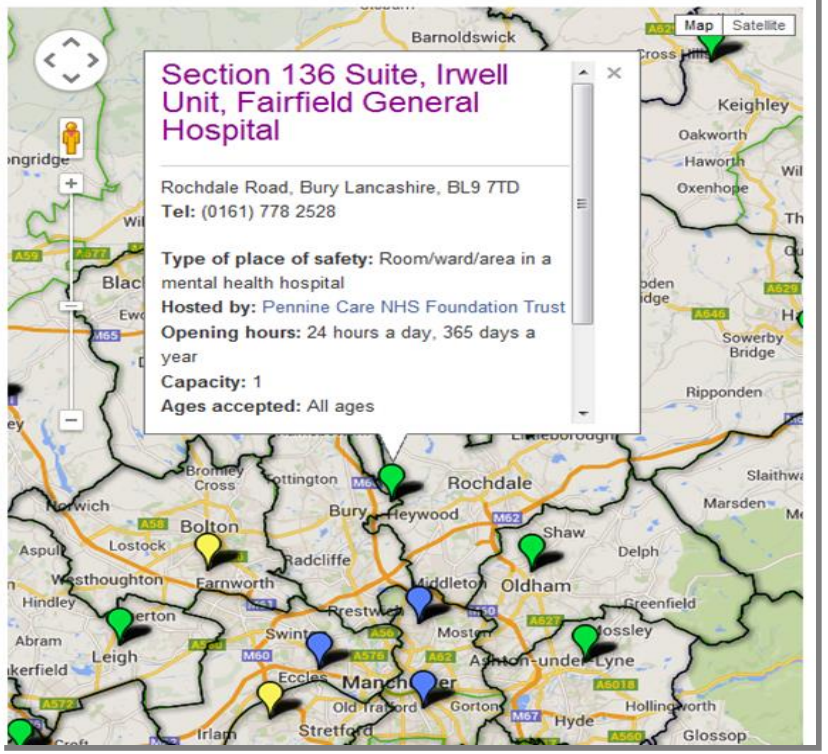
Geographical information

Show these boundaries on the map:
Local authority ☑
Clinical commissioning group ☑
Police force ☑

Ages accepted

Show places of safety accepting people aged: --Select--

Reset map (refreshes page)



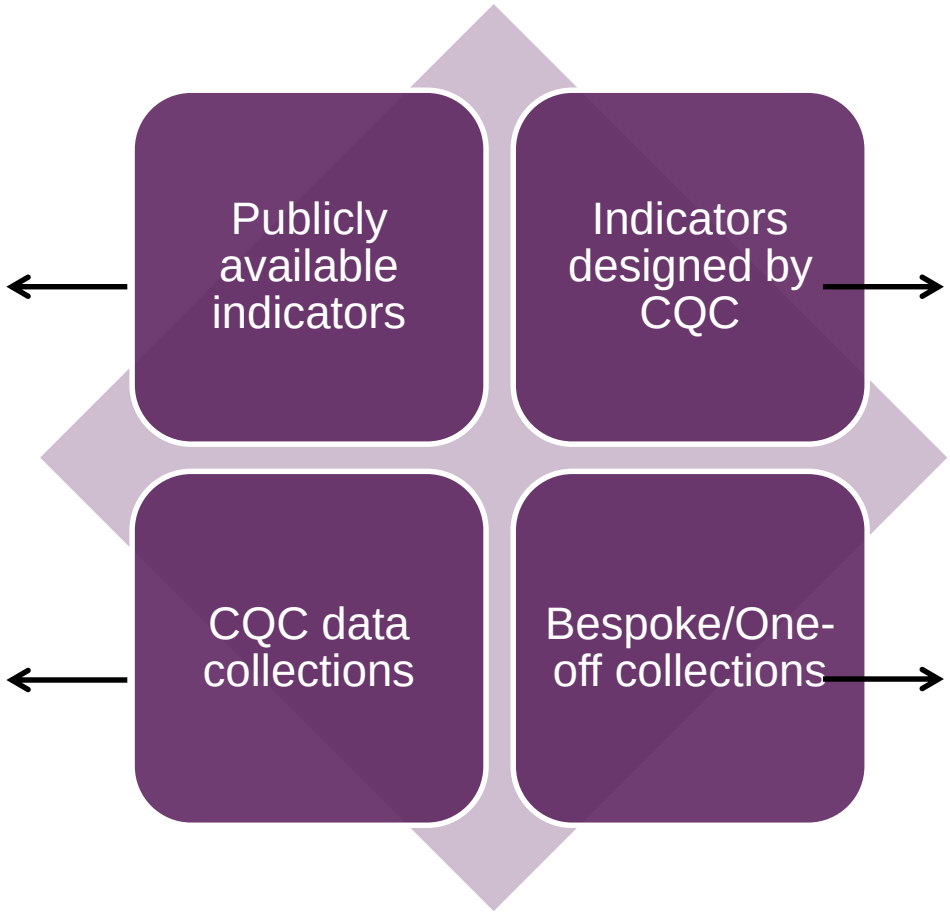
Health-Based Places of Safety Report: key findings

1. Too many places of safety turn people away or require them to wait for long periods with the police because they are full or there are staffing problems.
2. Too many providers operate polices which exclude young people, people who are intoxicated, or people with disturbed behaviour.
3. Too many commissioners do not fulfil their responsibilities for maintaining oversight of s136 pathway.
4. Too many providers are not appropriately monitoring their own service provision.

Health-Based Places of Safety Report: recommendations

1. We have asked all agencies involved in s136 to review the findings and take appropriate action over the next year.
2. Thirteen specific recommendations for providers, CCGs, health and wellbeing boards, multi-agency s136 groups, local authorities, NHS England
3. Commitments from CQC to continue to update the online map, publish the survey data, and use the survey findings to develop our approach to inspecting place of safety and to inform upcoming inspections.

Data Sourcing for Review



- IAPT
- Community Activity Returns
- Fingertips

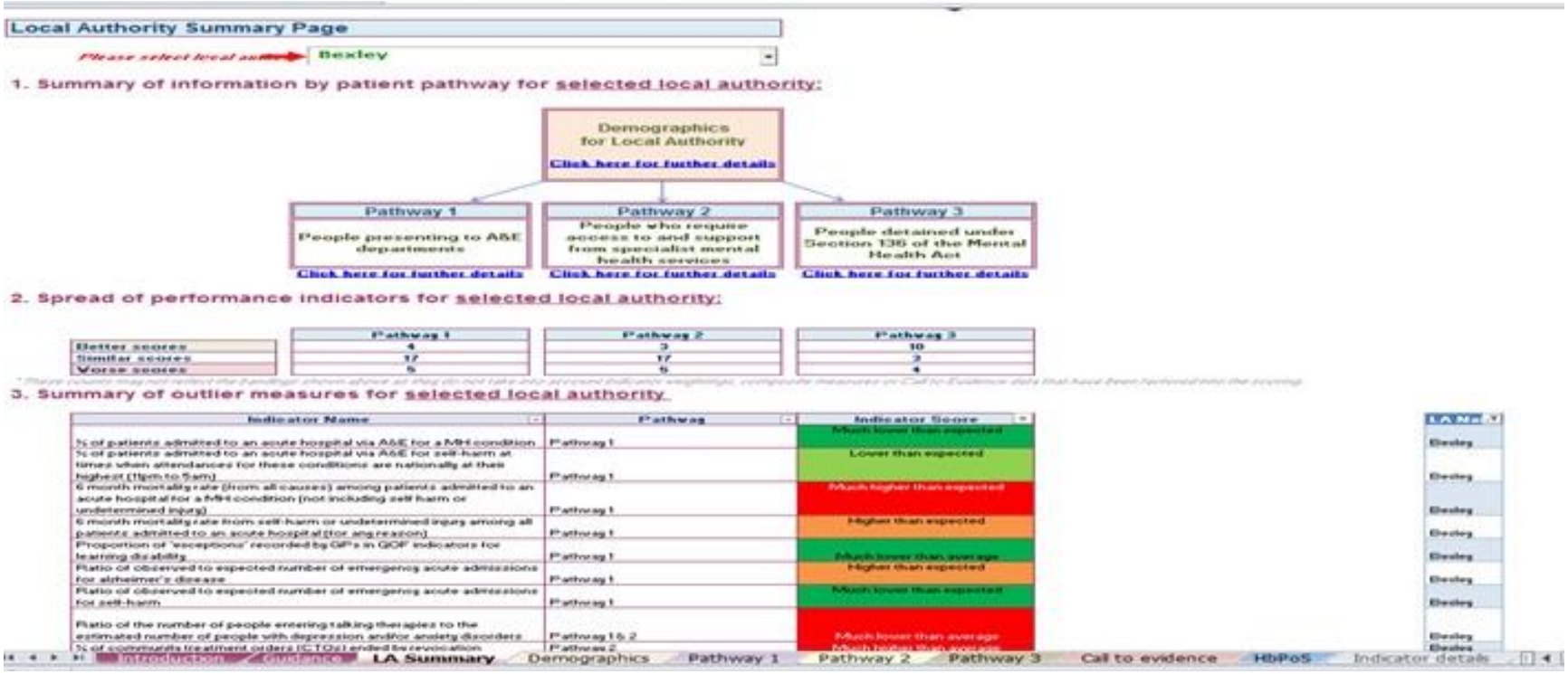
- HES-MHMDS linked analysis

- MHA visit database
- MHA notifications

- HBPoS Survey
- Call for evidence
- MIND FOI request to CRHTs

Local area analysis – share your views!

- Could help those developing Mental Health Crisis Concordat local area declarations and action plans
- http://www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review



Phase 2 Selection Areas: Key Group Focus

	Local Authority Area	Accident and Emergency	Specialist MH Service	S136	Focus to include
1	Waltham Forest				Substance misuse
2	Barnsley				Older people
3	Shropshire				Children/YP
4	Southampton				Children/YP
5	Sandwell				Learning disability
6	Salford				Children/YP
7	Kent				Older people
8	Northamptonshire				BME
9	Lambeth				BME
10	Oxfordshire				Substance misuse
11	Ealing				BME
12	North East Lincolnshire				Learning disability
13	Sefton				Older people
14	Windsor and Maidenhead				Substance misuse
15	Essex				Learning Disability

CQC's comprehensive inspections: What are we doing differently?

- Larger inspection teams including **specialist inspectors, clinical experts**, and **experts by experience**
- **Intelligent monitoring** to inform when and what to inspect
- Inspections on our **five key questions** about services
- Identified **core services** that we will always assess
- **Key lines of enquiry (KLOEs)** as the overall framework for a consistent and comprehensive approach
- **Ratings** to compare services and highlight where care is outstanding, good, requires improvement and inadequate

Completed so far: 16 mental health Trusts and one large independent mental health provider

CQC's five key questions

We ask these questions of all services:

Is it …Safe?	Are people protected from abuse and avoidable harm?
Is it…Effective?	Does people's care and treatment achieve good outcomes and promote a good quality of life, and is it evidence-based where possible?
Is it…Caring?	Do staff involve and treat people with compassion, kindness, dignity and respect?
Is it…Responsive?	Are services organised so that they meet people's needs?
Is it…Well-led?	Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?

Ratings

- We rate each service on each of the five key questions:

  (Safe? Effective? Caring? Responsive? Well led?)

- Four-point scale:
  - Outstanding ☆
  - Good ●
  - Requires Improvement ●
  - Inadequate ●

Trust 1 ratings grid

	Safe	Effective	Caring	Responsive	Well led	Overall
Forensic	Inadequate	Requires Improvement	Good	Inadequate	Inadequate	Inadequate
Specialist services	NA	NA	NA	NA	NA	NA
Adult Community	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Crisis	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Older People	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Psychiatric Intensive care & s136	Inadequate	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Acute Admissions	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Rehab	Inadequate	Good	Good	Good	Requires Improvement	Requires Improvement
Provider	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Inadequate

Overall provider rating

Trust 2 ratings grid

	Safe	Effective	Caring	Responsive	Well led	Overall
Adult Community Services	Good	Good	Good	Requires Improvement	Good	Good
Community Health Inpatient Services	Good	Good	Good	Good	Good	Good
Children and Families	Requires Improvement	Good	Good	Good	Good	Good
End of Life	Good	Good	Good	Good	Good	Good
Older People	Good	Good	Outstanding	Good	Good	Good
Perinatal	Good	Good	Good	Good	Good	Good
CAMHS	Requires Improvement	Good	Good	Good	Good	Good
Adult Community MH Services	Requires Improvement	Good	Good	Good	Good	Good
Eating Disorders	Good	Good	Good	Good	Good	Good
Rapid Response Liaison Psychiatry	Good	Good	Good	Good	Good	Good
Crisis	Good	Good	Good	Good	Good	Good
Longstay	Requires Improvement	Good	Good	Good	Good	Good
Adult Inpatient	Requires Improvement	Good	Good	Good	Good	Good
PICU	Good	Good	Requires Improvement	Good	Good	Good
Forensic	Good	Good	Good	Good	Good	Good

Overall provider rating

	Safe	Effective	Caring	Responsive	Well-led	Overall
Provider	Requires Improvement	Good	Outstanding	Good	Good	Good

Findings from inspection: crisis care

For example, findings from an inspection in early 2014:

- Many people being taken to police cells or local A&E instead of to a **health-based place of safety**
- Variable availability of **section 12 doctors**
- Limited **out of hours support** for service users; including long waits to see a psychiatrist
- Absence of a local **PICU** leading to distressed patients being transported long distances from home area and nurses spending many hours looking for a bed
- Risks to patient safety due to **poor monitoring and coordination** between crisis and community mental health teams

How could the crisis review help improve how we regulate and inspect?

- New summary statements of ‘what is good’ – e.g. for liaison psychiatry services, crisis home treatment teams, health-based places of safety and section 136 (MHA) to inform regulatory assessments
- Development of specific lines of enquiry for mental health crisis care that can be used where there is evidence of concerns
- Further testing of tools that can track a person’s journey along a pathway of care with a specific focus on crisis and for assessing areas of multi-agency / cross-sector responsibility
- New indicators we can use to monitor the quality of service provision
- An evidence base for future inspections