**Agenda Item**

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| Report to: | **Social Services and Health Scrutiny Committee** |
| Date: | **7 May 2003** |
| By: | **Chair of Project Board** |
| Title of report: | **Scrutiny Review of Mental Health Act (1983) Assessment Process** |
| Purpose of report: | **To present the outcomes of the review and propose recommendations for improvement in services.** |

**RECOMMENDATIONS**

**The Committee is recommended to consider the report of the Project Board and make recommendations to Cabinet for comment and County Council for approval**

## 1. Financial Appraisal

1.1 The Board considers that considerable progress in implementing the five recommendations in this report can be made by the establishment of a Joint Commissioning Team for Mental Health and commitment from all key agencies to make the necessary improvements. Recommendations 3, 4 and 5 may require additional resources and these will become available from the release of funding currently used to purchase out of county and private acute and psychiatric intensive care beds.

## 2. Supporting Information

2.1 The attached report contains the findings and recommendations of the Project Board. Supporting documentation is in the Members' Room.

2.2 The Project Board comprised Councillor Trevor Webb (Chairman), Councillor Mary McPherson, Councillor John Garvican and Dr Steve Jones (East Sussex County Healthcare NHS Trust).

2.3 The Board sought the views of a wide range of stakeholders, conducted a comparative survey with nearest statistical local authority neighbours and considered other ways of securing services.

2.5 The Committee is recommended to receive the Project Board's report for submission to Cabinet for comment on 3 June and County Council for final approval on 22 July 2003 .

COUNCILLOR TREVOR WEBB, CHAIR OF PROJECT BOARD
Contact Officer: Bernardine Bacon Tel No. 01273 481751

# Scrutiny Review
# Mental Health Act (1983) Assessment Process

## Appendices

## 1-10

7 May 2003

East Sussex County Council

**Scrutiny Review**
**Mental Health Act (1983) Assessment Process**

**Appendices Section**

*Appendix 1*

**Issues raised by the Social Services management investigation and the particular concerns tackled by this review and its scope.**

1.1 ASWs in East Sussex have been in dispute for some time with management on their terms and conditions of employment and particularly their pay.

1.2 Following a review of the problems by Social Services management, it became apparent that Social Workers are generally under a lot of pressure because of:

- Rising caseloads caused by cases seeming to take a longer time to complete. Cases were becoming more complex or there were delays in Doctors, ambulance or police services attending.
- In Hastings and Rother bed availability was a problem and some patients were being conveyed to London hospitals.
- GPs preferred to attend assessments after surgeries.
- Difficulty in ASW recruitment and retention which was further exacerbating the pressures.
- A shortage of Section 12 trained GPs was creating a problem in Eastbourne

1.3 For these reasons Social Service management took an holistic view of matters. In 2002, an action plan was produced.

1.4 This review is part of this action plan. It is aimed at improving the MHA assessment process in which ASWs play an important co-ordinating role. However the scope was to take a 'whole systems' approach.

1.7 Particular concerns were:

- ❖ Whether all emergency referrals were genuine or were being used as a way of shortcutting access to mental health services.
- ❖ Why assessments are sometimes not carried out jointly between ASWs and doctors.
- ❖ Approved Doctors are often unavailable.
- ❖ If doctors work in private clinics, under the Mental Health Act, they cannot sign the medical recommendation for admission to beds at these places because of a conflict of interest. This can reduce bed availability in the local area – causing referral outside of East Sussex which is not good for the patient or relatives.
- ❖ Sometimes ASWs are involved in allocating people to health service beds.
- ❖ Sometimes ASWs go to patients with little knowledge of the case because the record is not available. Sometimes they are alone with them for a considerable period – perhaps while waiting for the police or ambulance service to arrive. This is a risk to staff personal safety. A review of how risk is managed in this process is required including making record more accessible.

- ❖ There are problems in communicating with police and with bed managers – both who are required to respond quickly to MHA assessments
- ❖ Ambulance response times.
- ❖ Practice around conveying of people.

## 2. Scope

2.1 This review is about:

- the system of referral and assessment of clients/patients
- how the risks to staff, clients/patients and the community are managed
- the conveying of clients
- the availability and location of beds when people are detained
- the effectiveness of interagency working.

2.2 The review covers the service to the point that the patient is conveyed to an appropriate inpatient bed, paperwork is handed over for care and the patient accepted. It looks at what helps and what hinders the effectiveness and efficiency of the service.

The emphasis is upon:

- securing the best possible outcome for clients/patients with the resources that are available.
- gaining improvement and best use of resources rather than seeking cost savings.

2.3 Particular issues of concern are:

- ❖ ASW recruitment and particularly retention issues.
- ❖ Engaging the other agencies involved in the assessment process – particularly involving them at Board level for this review and in the consultation process.
- ❖ Multi-agency working – it is supposed to be an integrated service but is it efficient and are people working together for the best quality service possible?

2.4 The review does not cover the pay and conditions of ASWs.

**Mental Health Act Assessment Process - Scrutiny Review**
**Patient and relatives names have been changed**

**TYPICAL CASE STUDY ONE** **Patient Name: Michael**

This Mental Health Assessment was referred by the community mental health nurse, O. ASW received the referral at 3:35pm. O informed ASW that she had got Michael an emergency out patient appointment with Dr A at 1:30pm. After seeing Michael both agreed that he should be admitted. O informed ASW that Michael was willing to become an informal patient, however when she approached bed management they were not willing to look for a bed without a Consultants agreement. O had tried to track down Dr B, but could not. Ward round was being covered by Dr C and no other information could be obtained from Dr B's secretary.

ASW understood from O that Michael had left the building because O asked him to attend A&E and wait there. Michael had visited A&E yesterday and was seen by Dr D. O informed ASW that Michael had left A&E without the matter being resolved. Michael obviously did not want to attend A&E and left Gambier House. O and Dr A then decided to refer for a Mental Health Assessment. After O had given ASW the above information ASW said that it was inappropriate to refer for a Mental Health Assessment when someone was willing to become an informal patient. O then broke down in tears and began having a nosebleed.

ASW telephoned CMHT manager – in a management meeting.

ASW telephoned bed management – said ASW was being referred a Mental Health Assessment because Dr B was unavailable to agree an admission. Bed management would not look for a bed without a Consultant's agreement.

ASW telephoned clinical director – he was in Eastbourne and so was Dr B.

ASW telephoned Dr D – he was unavailable until 4:30 p.m. – not at Conquest Hospital.

ASW then telephoned CMHT manager on his mobile and interrupted the management meeting. ASW gave him the above information and he said he would call back.

ASW attempted to speak to Dr A who was in clinic and could not be interrupted.

ASW requested the Social Work file and the Community Mental Health Nurse file on Michael – neither could be found.

Telephone call from CMHT manager – he informed ASW that Dr A needed to speak to Dr E as he was covering (no-one had this information) and that Dr B would agree to an admission if Dr A thought Michael needed to be admitted and that they needed to speak to each other. It was also agreed that ASW would go out with an Access and Response Doctor.

Telephone call to ASW from Dr D at 4:30 p.m., he said that he did not think Michael needed to be admitted when he saw him yesterday but he would be quite happy to talk to the other doctor. After seeing Michael, if we thought he needed to be Sectioned he would consider completing a paper but this would have to be done tomorrow given the time and the fact that he was not at the Conquest Hospital.

Telephone call by ASW to bed management to let them know a visit would be made to Michael today. Answerphone - left message.

Telephone call by ASW to Access and Response – no doctors available/gone.

ASW then visited Dr A as clinic was over. ASW found that Dr E had already telephoned him but Dr A did not link this with Michael and so nothing was achieved by their telephone conversation. When ASW discussed Michael, Dr A said that a Mental Health Assessment had to be done today and that he did not think that Michael would agree to become an informal patient and that ASW would have to telephone the on-call doctor.

Whilst there, bed management telephoned and requested information about Michael which was faxed to her but she could not look for a bed until she knew who would be going out, (this is because many of our doctors work for Private Clinics and Hospitals and because of a conflict of interest, cannot refer patients to these establishments), and when the assessment would take place. As ASW could not give her this information, she asked ASW to call 'Woodlands' when the assessment had been completed.

**5:15**

ASW decided to call the Emergency Duty Service. ASW spoke to EDS who informed ASW that they could not refer for a Mental Health Assessment because there was now a policy for Mental Health Act Assessments referral and that it had to be done Manager to Manager. This was an impossibility given the time. EDS manager also left the Emergency Duty Service but could be contacted by mobile. EDS social worker was willing to hear referral/circumstances. ASW read him letter from Dr A and referral – and conflicting views of CMHN, Dr A and Dr D. He did not think the Mental Health Assessment needed to be done today. Lengthy discussion and EDS agreed to accept referral as a "might happen" and that ASW would organise Mental Health Assessment tomorrow.

ASW telephone call to Michael's sister who informed ASW that her father (Mr G) is the eldest of her parents and gave ASW his telephone number and address.

ASW telephone call to Mr G – not up yet due to running a pub. Will call back in twenty minutes.

ASW telephone call to Mr G – aware that his son has not been well and does not object if he has to be detained.

ASW telephone call to Dr D – agreed for assessment to take place at 12:30 p.m.

ASW telephone call to Dr C – agreed to meet at the home.

ASW telephone call to O – mobile switched off – left message for her to contact ASW urgently.

ASW telephone call to bed management – let them know that we are going out at 12:30 p.m.

Telephone call from bed management – bed identified in London – have not accepted him but we need to contact Mr Z. Also informed ASW that Michael can be violent and does have previous convictions.

ASW telephone call to police – requested assistance.

ASW telephone call to Ambulance – will not come out until assessment completed, but did give reference number.

ASW had long discussion with O who said that Michael is more than likely to be in at 12:30 p.m.

**1 p.m.**

All present – Michael would not open the door and it took them about half an hour to get him to open it – O had come to help out with this and was successful.

Interview – Michael stated clearly that he wanted to kill himself, did not think life was worth living – no food in his flat, had neglected his personal hygiene and was storing his medication. Agitated but not aggressive. He was also not able to discuss why he had absconded from A&E and Gambier House.

Agreed that Michael met criteria for Section 2. Needed to get police due to his absconding. Police did arrive but no ambulance – another two hours to wait. Police could not hold on and it was agreed that we would take Michael to the police station to wait. Medication now with Protection of Property because we could not get it to the police station to go with Michael.

Social worker, ASW back up, organised Protection of Property because Michael had lost his keys and we could not secure the flat. Whilst at the police station social worker telephoned and said they had found a very large amount of medication – agreed that Protection of Property would take this in his protection.

Stayed at police station until 4:10 p.m. when ambulanced serviced notified us that there was another three hours wait for one. Custody cells full so police agreed to transport to London Acute Ward. Whilst there, they telephoned Michael's father and let him know where Michael was.

**Mental Health Act Assessment Process - Scrutiny Review**
**Patient and relatives names have been changed**

**TYPICAL CASE STUDY TWO** **Patient name: Linda**

Linda, 49, is divorced and has four children; the eldest two children do not live with her. Linda has twins aged 12 years, who are currently being cared for by Mary (eldest child aged 25 years).

**Reason for referral**

Police were called to Linda's son's address after she had become "violent and hostile" towards him. Linda's family feel their mother was experiencing a "breakdown mentally". The family had informed the police that this behaviour was out of character for their mother. The police were unable to reason with Linda, the family requested the police took her to Accident & Emergency Department as they felt she needed medical treatment. The police managed to persuade Linda to attend A & E. The police were unable to use Section 136 as they had entered private property. Upon arrival the police stated that Linda assaulted a nurse she then went on to try and assault police officers.

Linda was arrested at 01.00 hours for ABH and taken to Hastings custody. The police reported that Linda continued to try to assault the police. Whilst the Forensic Medical Examiner (FME P) attempted to examine Linda, she attempted to assault him and had to be restrained. Dr L requested a Mental Health Act Assessment.

**Assessment at 15:00**

Attended Hastings police station with Dr M and Dr L. ASW saw Linda in the cell; police felt it was unsafe to take her out into the interview room. Linda was pacing up and down in the cell. She screamed at the doctors and told them to leave as "I can't let men look at me, go away, I'll ******* hit you". Linda was extremely elated. To prevent any assaults both doctors left the cell. Linda pulled her dress up and took this off she had no underwear on, it appeared that she had put these down the toilet.

Linda agreed to speak to ASW. She stated that "you're a woman, you're safer than those bastards". I had to request from the police that a female officer remained in the cell with me. Due to my own safety I stood by the cell door. Linda was extremely elated she was unable to sit still. I asked her to put her dress back on, which she did however she did not pull this down sufficiently to cover the lower part of her body. Linda had pressure of speech, flight of ideas she stated that she had cancer of the brain, breast, lungs, skin and that every time a man looked at her this made her "die more, don't you see they are killing me when they look at me". Linda started to cry and scream at this point she pulled her dress down.

The interview clearly agitated Linda she stated "shut the door, men are going to look, they are watching me, they are killing me". ASW was concerned for own safety and that of WPC and was not prepared to remain in the cell with the door closed. Linda was becoming more agitated. For this reason ASW ended the interview.

**Consultation with Nearest Relative at 16:30**

ASW telephone conversation with the nearest relative, Mary. Mary advised ASW that she was the eldest child. Linda lived alone with her 12-year-old twins. For this

reason ASW believed Mary to be Linda's Nearest Relative within the meaning of the Mental Health Act.

Mary stated that her mother had recently disclosed to family members that her father had sexually abused her as a child. Linda's mother apparently had a heart attack when this information was disclosed. Over the past three days Mary stated that her mother hadn't slept, eaten or maintained her "usual high standard of personal hygiene". She has been so angry with everyone she ran at me and punched me; I can't remember my mum hitting me before". Mary agrees that her mother needs to be in hospital and did not object to application for Section 2. ASW advised Mary of her rights as Nearest Relative.

**Conclusion**

Linda has a history of amphetamine misuse. At the time of assessment she was extremely agitated, hostile and suspicious. She kept removing her clothing, including underwear. Linda was threatening to harm any man who came near her or looked at her. Her speech was pressured; her thoughts were paranoid and delusional in content. She believed she had cancer all over her body. The police have repeatedly restrained her. At the time of assessment ASW did not believe she had the ability to agree to look at alternatives or voluntary admission and she clearly stands in need of assessment due to mental disorder and ASW does not believe this could be achieved unless she receives in-patient care. ASW also feels that a police cell was not the appropriate environment for Linda, she had taken her clothes off and had been naked. A TV monitor appeared to be recording her actions whilst in the cell and this could be observed by anyone visiting the police custody.

**Application for Section 2 completed.**

Bed available in a London hospital. As Linda physically and verbally hostile, she is also extremely vulnerable. She has assaulted a nurse and police officer and attempted to assault others.

Transport in an ambulance felt unsafe especially as journey to London required. Discussion with police they agreed to escort with WPC's and accepted Delegation of Authority to Convey. T/C hospital confirms bed on Ward. The police agreed to contact the hospital to advise on expected time of arrival.

**18:40**

T/C Mary advising of events and gave information and contact details for hospital ward. ASW asked Mary if she needed any support caring for the twins. Mary confirmed the twins were staying with family members and no intervention was needed in helping. Mary also confirmed that Linda has no pets and her home is secure.

**22:00**

T/C hospital - spoke to staff nurse and advised Linda had arrived safely and was asleep due to medication.

**Mental Health Act Assessment Process - Scrutiny Review**
**Patient and relatives names have been changed**

**TYPICAL CASE STUDY THREE** **Patients name: Gary**

Aged 33 years, lives in a residential care home. Gary was referred by the Community Psychiatric Nurse due to Gary's visit to the CMHT and smashing a window there. The nurse had spoken to him and felt that he was thought disordered.

I then received a telephone call from Dr L at police station. Gary has been arrested for criminal damage under PACE. Dr L felt Gary needed to be assessed under the Mental Health Act.

Gary has a long history of mental illness but has not taken medication for some years. He has failed to attend appointments with his psychiatrist and his Care Co-ordinator. He has been assessed under the Mental Health Act on a couple of occasions but has never met the criteria. The file on Gary states that he misuses 'pot' but there is no evidence of this.

***16 September***
Arranged a Mental Health Act Assessment to be carried out at the police station at 3:45 p.m. with Dr L, who has previous knowledge, and GP.

Telephone call to bed management who informed ASW that the police were dealing with him. Informed bed management of the referral – stated that there is a warning on social services file and faxed information.

**4:15**
ASW interviewed Gary in his cell and not in the police surgery because of his mental state – he was shouting at the walls. Gary was convinced something was going through is head and did not want to discuss anything else. Gary was unable to answer questions about what happened at the CMHT but did state that people were laughing at him. Gary did not think he needed to be in hospital.

All agreed that he met the criteria for a Section 3 as he needed treatment. ASW telephone call to nearest relative who was very concerned about his brother.

**6:15**
ASW telephone call to bed management – still no bed and was advised that the court will have to deal with him. Gary would be far better off in the hospital wing at Lewes prison than in custody cells. ASW advised that she would be passing this on to EDS (Emergency Duty Service).

**6:35**
ASW telephone call to EDS advised them of the situation. All papers completed and with custody sergeant and bed management would contact EDS if bed identified. EDS said that they might call ASW back when they had a bed to so that she could complete papers as to where Gary was going. ASW agreed to this.

**7:30**
EDS telephoned to bed management – bed still not found – they had looked everywhere and were now giving up, stating once again that the court would have to deal with him. EDS telephone call to ASW to let her know what the situation was. ASW unable to pick this up again tomorrow as she is due to do another Mental Health Act Assessment.

**17 September 2002**
**9:45**
Case picked up by another ASW (Z). Telephone call to ASW who informed her that Mr Y from the court assessment scheme would be seeing Gary before writing a report for the court. However, assessment already completed, application unable to be completed due to no bed being identified.

ASW visited Hastings Court and met with Mr Y who would let the court know of Gary's assessment and would contact ASW as soon as there was an outcome. Collected Section papers from Custody Sergeant.

**11:30**
Telephone call from Z who informed ASW that Mr Y had seen Gary and feels that he needs to be in hospital. Chris will be recommending to the court that Gary remain in the custody cells until a bed has been found.

Telephone call to bed management – answerphone – left a message stating Mr Y's recommendation.

**12:05**
Telephone call from bed management who told me that they were in contact with Mr Y and the next time they would be in contact with all the relevant people is when there is a bed.

**3:30**
No response from bed management - telephone call to nearest relative to let him know that no bed has been found. Telephone call to Magistrates Court. They have withdrawn the matter and released Gary. Telephone call to Mr Y – requested that he fax me his report.

**3:50**
Telephone call from bed management to tell me what ASW already know. They have still not found a bed but assured ASW they would search on a daily basis. Telephone call to Inspector – not in – left a message.

**4:15**
Completed risk alert forms and spoke to C. P. N. as advised by Z. Passed back to Z.

**18 September 2002**
**8:30**
Message advising bed at Unit. T/C confirmed bed available.

**8:40**
Gary now at home and refusing entry. T/C police advised ASW would be returning to court for Section 135 (2) and will need police assistance if warrant obtained. T/C brother. Left message on answering machine.

**10:30**
Attended court. Obtained Warrant Sec135(2).

**10:45**
T/C brother. He feels Gary needs to be in hospital. Brother gave ASW Gary's mobile number and advised ASW that they have another brother living in London. Advised ASW would keep the family updated on the situation. Also discovered that this brother is not the Nearest Relative.

T/C to other brother. Phone turned off. T/C A. P. to advise that information for Nearest Relative was incorrect.

**11:10**
T/C the police were advised inspector would contact ASW as soon as possible. Explained to the police if Gary is home we will need police transport to London also advised I have a warrant.

**11:50**
T/C to police and advised that ASW would be grateful for someone to call her to arrange visit and transport. Was advised someone will call her back.

**12:05**
T/C from Mr Y, Call Centre (police) advising someone will call her back.

T/C from Inspector advising that the police can meet ASW for a briefing in 30 mins. The police were unable to arrange transport to London. However, Gary will be taken into custody whilst transport arranged.

ASW met police. Gary lives in 5th floor flats – another resident gave them access to main door. Gary opened his door. He was stating that "These f***ing Americans are coming". ASW explained he had been detained under Section 3 and that the court had given me a warrant. Gary stated that "you paid the ******* judge you *****". He kept laughing in mid-sentence. Understandably he was angry at the intrusion. Due to his hostility and aggression the police handcuffed him. ASW ensured his property was safe, closed windows and took his keys which the police returned to Gary. Gary was taken to Hastings Custody.

ASW followed police van – met with Inspector. He agreed to arrange police transport to London. Agreed with the police officers that the ambulance was not suitable due to Gary's aggression.

Escorted Gary in police transport whilst on route. Gary removed his clothes and started to masturbate – the police requested several times that he put his clothes back on. Gary then urinated in the police van. Gary did not remain seated, he stood up several times and rocked the van. Upon arrival at the Clinic staff took over the care of Gary.

Whilst travelling down Gary's brother telephoned on ASW mobile. He informed ASW he didn't want his brother moved to London. ASW explained Gary needed an intensive care bed and none were in the Hastings area. John became verbally aggressive – "Look don't mess with me, if you think my brother's bad – wait until you meet me". ASW asked him if that was a threat. He told ASW "Take it however you like". ASW explained that was escorting Gary and advised him that the ASW who assessed Gary would contact him, as ASW could not hear due to the fact ASW was in a police van. ASW did apologise to his brother that no local beds were available, he hung up the phone.

T/C X – passed information requesting she contact the brother to discuss the situation, as ASW was unable to do this in the back of a police van.

**19 September 2002**
T/C X She had spoken to family – write up to follow.

end

**Mental Health Act Assessment Process**
**Scrutiny Review**

**Case notes**

**Supplied by Laurence Dodd, Tenby House**

We have looked through records and considered the issues of Mental Health Act (MHA) assessments at Tenby House. As you would expect, the experiences have varied, and have seemingly often been dependent upon other circumstances in terms of how effectively and speedily the assessment process occurs.

We have listed below the eleven MHA assessments that have occurred at Tenby over the last two years – I have highlighted particular areas of concern from our perspective, and these are usually around lack of available beds, transport to hospital, and a more general note the difficulty of getting someone into hospital when it is apparent to the staff here that this needs to happen. However, given that it is taken for granted that the process of organising a MHA assessment always takes some time, often with ASWs travelling some distance, and the fact that there is always difficulty finding a bed, it would also be true to say that the process itself is usually handled well.

The following examples of MHA assessment at Tenby House are taken from incident books – names have been excluded for client confidentiality.

**1. November 2002.**

Seadoc contacted 22.20 hours. 01.00hrs the following day to doctors arrived, client agree to hospital admittance voluntarily. I doctor left. 01.15hrs ASW also arrived. **The doctor and ASW spent time in the office, leaving client and staff confused as to what was happening**. Ambulance requested at 01.45hrs, arrived at 03.05hrs. ASW and doctor had left by 02.00hrs.

**2. August 2002**

19.05hours Seadoc contacted as client felt unsafe. 19.20 hrs phone call received informing staff that the on call psychiatrist would assess client at Accident & Emergency. Client and staff attended A&E, on call psychiatrist spent an hour assessing client. Hospital admission was deemed necessary. A bed was available at Eastbourne Clinic, **but there would be a six hour wait for an ambulance**. Decision made for staff to accompany client in a taxi.

**3. May 2002**

Clients behaviour had become increasingly bizarre. MHA assessment, client declined voluntary admission so was placed under Section 3. Client stated he would appeal against this. Client escorted off project by 5 policemen and transported to Blackheath Hospital, in London, since no bed was available locally.

At the same time, 2 doctors and ASW conducted a MHA assessment on another resident who again declined informal admission and was admitted to Woodlands under Section 3, taken there by Police accompanying him in an ambulance. The bed at Woodlands had already been secured for this client, when he was initially seen the previous evening by an on-call psychiatrist.

**4. May 2002**

Staff concerned regarding the deterioration of a client's mental health. Client's CPN visited and expressed same concerns. Client attended an OPA and a MHA assessment was arranged for the following day. This took place and the client was admitted to hospital under Section 3. **Not sufficiently unwell to be sectioned**. Beds unavailable in local area.

**5. January 2002**

Client was visited by doctor, refused to be admitted. 17.45hrs CRS contacted and arrived 18.30hrs. Doctor arrived at 19.00hrs and CRS left. At 19.40hrs doctor arranged for MHA assessment. Between 22.30hrs – 23.05hrs professionals arrived. Assessment took place in client's room at one point locked professionals in the room. **All agreed, including the client that hospital admission was required**. **00.30hrs. No beds available.** Staff were advised to contact bed manager in the morning and if there were any problems in the night to contact police. 00.40hrs professionals left.

Next day a bed was found at Blackheath Hospital, awaiting an ambulance and requested escort. CRS tried to organise a Section 3 as client could still refuse voluntary admission. 14.00hrs MHA assessment carried out and client placed under Section 3. **Still awaiting transport**. 19.00hrs 2 police officers arrived. 19.30hrs ambulance arrived and client was escorted to Blackheath hospital.

**As can be seen from this example, due to difficulties with bed availability and transport, this client remained on project for twenty hours from the time he was originally assessed. There was also a five and half hour wait from the time of the second assessment. This had considerable impact on the rest of the client group and staff.**

**6. August 2001**

Client had been up all night, threatening a fellow client. 11.40hrs initial assessment, client in agreement with hospital admission. 13.20hrs a bed had been found but client now adamant that they would not go into hospital. 15.00hrs decision made for further assessment with a view to sectioning client. 18.00hrs relevant professionals carried out assessment and client placed on Section 2. 21.00hrs client escorted to hospital by ambulance, police and social worker.

**This was a particularly volatile incident. It took six hours for the assessment process to unfold – a very difficult time for everyone here.**

**7. May 2000**

CPN visited client in the morning agreed for MHA assessment, which took place at 16.30hrs. Client deemed not sectionable. Later that day client presented as more unstable with violent acts, eventually spending the night in a police cell. Following day client was placed under Section 2 and admitted to the Cygnet Wing, Blackheath Hospital.

**8. May 2000**

**Seadoc visited client on two consecutive days. MHA assessment finally took place in the afternoon of the following day.** Client placed under Section 3 but remained at Tenby House for another 2 hours whilst waiting for an ambulance.

End

8 December 2002

***Appendix 2***

**Policy and practice context**

a) Apart from the MHA and accompanying national code of practice, an ASWs duties and practice are outlined in the County Council's ASW handbook. Also, there are a number of policies that impact upon the management of the service, the most significant for this review being the jointly agreed 'pan Sussex' code of practice on the Conveyance of Patients.

b) Recently a National Framework for Social Care has been developed and there are Social Service Inspectorate standards for mental health services.

c) To practice as an ASW, professional Social Workers need to have undertaken additional training and successfully completed rigorous assessment by the County Council. This allows them to practice for 5 years. This training is topped up at regular intervals and ASWs have to undergo re-approval after 5 years to continue to practice.

d) Their role and duties are covered by the 1983 Act and accompanying national Code of Practice.

e) The police operate to the code of practice under the Police and Criminal Evidence Act (1984) PACE when detaining a person at a police station.

*Appendix 3*

## 1. Consultation - detailed findings

1.1 Whilst it was clear that all agencies had dedicated staff who were all attempting to do their best, time resource and conflicting work pressures were resulting in a less than satisfactory situation. This was particularly so for ASWs, as the service co-ordinators, and service users and their relatives.

The Social Services Inspectorate Report 'Detained'* (a report on the Inspection of Compulsory mental health admissions; 2001) provided a useful set of headings to analyse findings from the review. These are used below. (* included in the supporting information in the Members' Room)

The following is a summary of perceptions and viewpoints expressed.

### 1.2 Responsiveness of service

1.2.1 A sense that there is a rising number of cases which are taking a longer time to process. Data collected appears in appendix 5.

1.2.2 There are more complex cases and with potentially greater risk

1.2.3 Time delays are caused by poor communication between agencies, lack of staff availability and lack of common priority given to the service (particularly from police, ambulance and bed managers)

1.2.4 ASWs cite cases of delays getting through on the telephone to the police service although the police dispute this.

1.2.5 Service is less good outside 9-5 hours – EDT has too little resource for what it is expected to do.

1.2.6 Numbers of ASW practitioners are falling (43 in 1997, 37 in 2000 and 27 in 2003).

1.2.7 There is a shortage of Section 12 Psychiatrists – particularly in Hastings and Rother area and in section 12 GP's in the Eastbourne area.

1.2.8 There are differences in problems and practice across the County e.g. in Ouse valley Psychiatrists seem to take the lead in cases whilst in Hastings GP's are less willing to give cases priority.

### 1.3 Referral and assessment

1.3.1 ASWs feel in an isolated position. They can find it difficult to co-ordinate assessments because other agencies do not treat it as a priority.

1.3.2 ASWs take a longer time than necessary per case not only due to delays but because of a lack of local mental health acute beds. More often, particularly in Hastings and Rother, the client/patient is conveyed outside of the area – often to London. This can result in the ASW not returning to base until several hours after work on the assessment first started. Even in these cases, the ASWs prefer to escort the patient and handover the patient and their paperwork to the hospital staff.

From April to December 2002, 38 patients out of a total of 339 admissions were transported to London from the east of the county.

1.3.3 Due to other agencies not giving the work priority ASW are put at greater risk when undertaking assessments. They can attend a client /patient alone without a good knowledge of the case. They can be waiting for up to three hours for the ambulance or police to arrive. During this time they can be waiting on mobile telephones for a response. The battery can become exhausted leaving the ASW with no means of further outside contact. This long wait can further exacerbate the patient's condition – which may be unstable and highly anxious, so raising the risk to the ASW.

This seems more prevalent in Hastings and Rother and the ASWs have written to management declaring their concerns.

1.3.4 For section 136 cases (police pick-up) assessment takes place in police cells – a 'place of safety' all agencies believe this is a stressful and undignified place and alternatives should be found.

## 1.4 Conveyance and admission

1.4.1 Conveyance by ambulance is not always fit for the purpose. Paramedical support for mental health patients is rarely needed. Also ambulance service priorities are for acute 'life and limb' cases. This explains delays. All agencies are agreed that for the majority of cases a more suitable and available vehicle/service should be sought. Conveyance in police caged vans can increase the patient's paranoia.

1.4.2 The view was that conveyance to beds outside of county or area is not positive for the clients/patients welfare. This is also costly in ASW time if they accompany the patient. Given ASW pressures, it was questioned whether ASWs were best placed to do this and whether other agency staff or health care staff could be involved.

1.4.3 Once attending, Ambulance Service staff are good and provide a sensitive and calming influence

1.4.4 Although, Police are perceived as good by ASWs, clients/patients feel they can be heavy handed. It was suggested that Police need more training to understand mental health issues. It was agreed to best direct this at sergeant level as they are the most influential upon operational policing.

1.4.5 There is perceived to be an acute mental health bed shortage in county. There are no Psychiatric Intensive Care Unit (PICU) beds in the county. Both these factors create the need for out of county admissions.

1.4.6 Service users are concerned with delays, use of ambulance to convey in all instances, use of police cells and out of area conveyance. Ambulance and uniformed staff serve to stigmatise the patient and can exacerbate feelings of anxiety and paranoia.

## 1.5 Care planning and care management

1.5.1 Record keeping systems are inconsistent across the County. The systems are not fully integrated between social services and health services. Consequently, records are not always available to ASWs when needed – especially to help assess risk.

1.5.2 Whilst there is personal safety guidance for ASWs there is inadequate risk management built in to the provision of service. Because of the urgency of a

case, understaffing and the lack of co-ordination of service support, ASWs can too often be left isolated and vulnerable with clients/patients.

1.5.3 There are individual differences in practice across the county e.g. in bed management, responsiveness from doctors and police.

1.5.4 Clients/patients and their carers and relatives often do not know what is happening or going to happen. More information, reassurance and dialogue are needed before, during and after the assessment process.

1.5.5 Carers and relatives want more involvement in individual care planning.

1.5.6 There is not enough involvement of housing services staff in care planning for post discharge. More involvement could have an influence upon preventing further cases of compulsory admission – helping with a smooth transition from care to home and sustaining their independence there as part of the individuals care plan.

### 1.6 Inter-agency collaboration

1.6.1 There is little evidence of joint business planning between agencies i.e. goal and target setting, monitoring of progress and reviewing outcomes

1.6.2 There is little evidence of joint management of integrated budgets across agencies. Like the place of safety issue it is discussed but progress needs to be quickened.

1.6.3 There are a number of agreed practices between agencies e.g. conveyance policy but there is little evidence of joint monitoring to check that these are working effectively and efficiently.

1.6.4 There was evidence of interagency meetings at higher management levels and evidence of joint practitioner working between health and social care. However, police, ambulance and housing staff were not integrated into regular meetings and joint training seminars on mental health issues. This would be helpful to improving the effectiveness and efficiency of the mental health assessment process.

### 1.7 Equitable provision and anti-discrimination practice

1.7.1 Case statistics are kept on gender but there is no easily accessible information relating to ethnicity or age – which could guide service planning and the monitoring of anti-discriminatory practice (required by Law under the Race Relations Amendment Act 2000).

This was also important in the light of the fact that staff reported a higher incidence of adolescents and younger adults being referred for MHA assessment.

### 1.8 Staff development and training

1.8.1 Professional ASW training was good and used to recruit and retain ASWs. It could be used to a greater extent to attract and retain more ASWs from the East Sussex County Council Social Work population e.g. from Children's and Families services.

1.8.2 There is some evidence of joint inter-agency training/seminars. The service was not fully utilising this as a means to develop plans and good practice and monitor the quality of service delivery. Examples of helpful topics to improve service are given in appendix 8.

### 1.9 Organisation and management

1.9.1 Service data is kept but this is not actively used to monitor performance/trends as a means to planning service changes and improvements.

1.9.2 Service goals were not jointly set between agencies and nor with joint budgeting in mind. For Social Services these were seen as 'aspirational'. Work was in hand to collaborate with other agencies to make them realistic and achievable.

1.9.3 Better linkages needed to be forged between top level service/strategy goals and service 'on the ground' so that the service could continually improve. Without this linkage, problems remained unresolved e.g. out of area conveyance is due to a lack of local acute beds – is this caused by 'bed blocking' and do preventative services need improving to free beds up?

1.9.4 Users, carers and their relatives want more of a voice – to be consulted on service provision and their satisfaction with it.

1.9.5 The voluntary sector is keen to work in partnership with the statutory agencies in the area of MHA assessment. Voluntary sector representatives feel that there is a communication gap and that they could do more on a formal basis e.g. supporting patients, carers and relatives as a measure to help prevent compulsory admissions.

1.9.6 It was clear from consultations that, in the area of MHA assessment, service users, their relatives/carers and staff want a service that:

- minimises distress to the user/patient and their relatives;
- minimises risk of physical and psychological harm to users, staff and the public;
- is completed in an appropriate time with the minimum of delay but avoiding crisis management where this is not necessary; and
- provides individualised care according to need, as far as resources will allow.

1.9.7 The findings support the conclusion that the service, taken as a whole, is not achieving these aims.

***Appendix 4***

**Suggested template for risk management**

| Risk level | 1 high risk | 2 medium risk | 3 low risk |
|---|---|---|---|
| Definition of risk | | | |
| ASW response | | | |
| Co-worker support response (health and social care) | | | |
| Conveyance/Ambulance Response | | | |
| Police response | | | |
| Bed management response | | | |
| Performance Indicators - response times | | | |

*Appendix 5*

## 1. Service information

### 1.1 Number of staff

1.1.1 As at October 2002, there were 23.8 full time equivalent day time Approved Social Workers. In addition there were four ASWs based in the Forensic Mental Health Service at Ashen Hill, Hellingly. The ASWs work on 3 rotas as follows:

- Hastings and Rother 7 staff
- Eastbourne and Wealden 12 staff
- Ouse Valley including Lewes 4.8 staff

1.1.2 In addition the Emergency Duty Service, which on weekdays operates from 5.00pm to 8.30am, has two ASWs available before midnight and one ASW after midnight. On the weekend and public holidays, two ASWs are on duty 9.00am to midnight and one ASW midnight to 9.00 am. This service also encompasses the Brighton and Hove area.

### 1.2 Assessments – cases, hours and averages 2002

| Area | fte ASW Staff | Cases In year | Average per month | Average per ASW fte per year | Hours Spent in year | Average per ASW fte per year | Hours per case |
|---|---|---|---|---|---|---|---|
| Hastings and Rother | 7 | 139 | 17 | 20 | 854 | 122 | 6 |
| Eastbourne and Wealden | 12 | 250 | 25 | 21 | 997 | 83 | 4 |
| Ouse Valley | 4.8 | 46 | 6 | 10 | 322 | 67 | 7 |
| Emergency Duty Team/Service | 3 | 240 | 27 | 80 | 357 | 119 | 2 |

***Notes to table:***

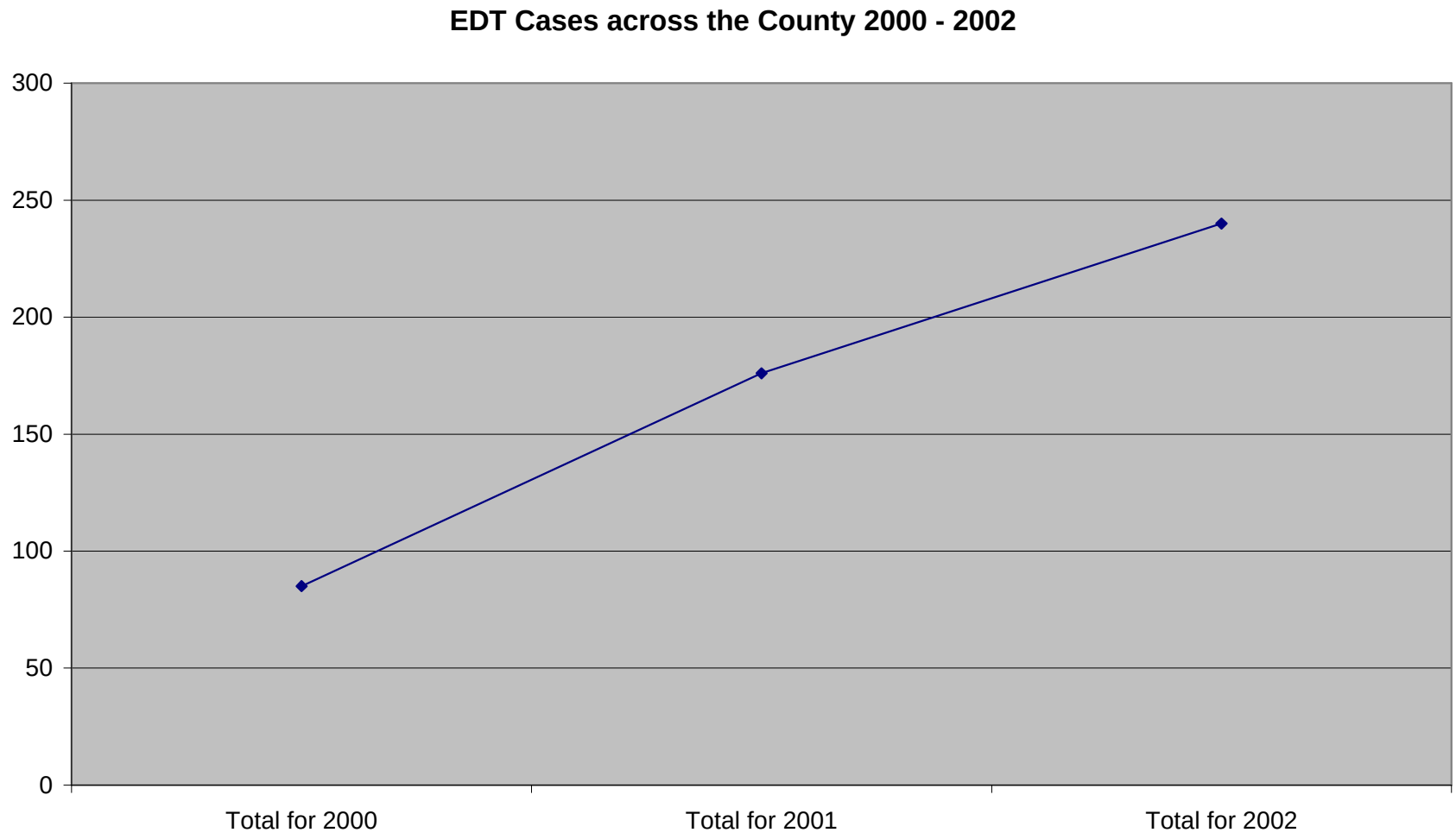
- *The Hastings & Rother Area and the Ouse Valley Area only provided statistics from January to August so the figures are based on 8 months rather than 12.*
- *The Eastbourne & Wealden Area only provided statistics from January to October so the figures are based on 10 months rather than 12.*
- *The Emergency Duty Team statistics incorporate figures from 2 areas (Hastings & Rother and Eastbourne & Wealden). The Hastings & Rother Area gave statistics for January to August and the Eastbourne & Wealden area gave statistics for January to October. These have been aggregated in the table. Staffing levels are based upon paragraph 7.1.2 above.*

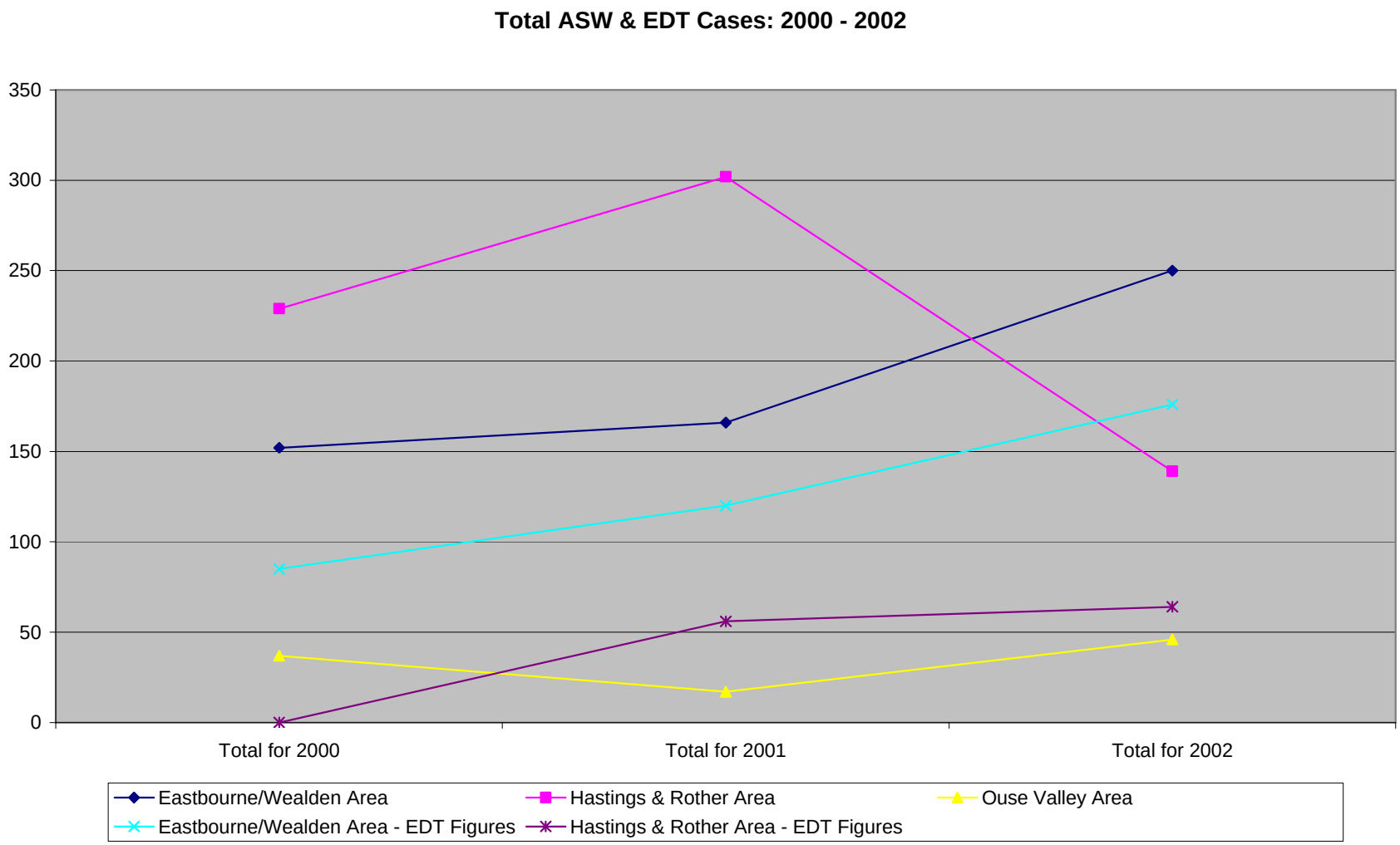
1.2.1 For Hastings and Rother the figures are not too indicative of demand in that, because of short staffing, the EDS service is giving greater support than in past years. This is indicated by the fact that the number of cases in Hastings and Rother in 2001 was 300.

Attached charts showing:

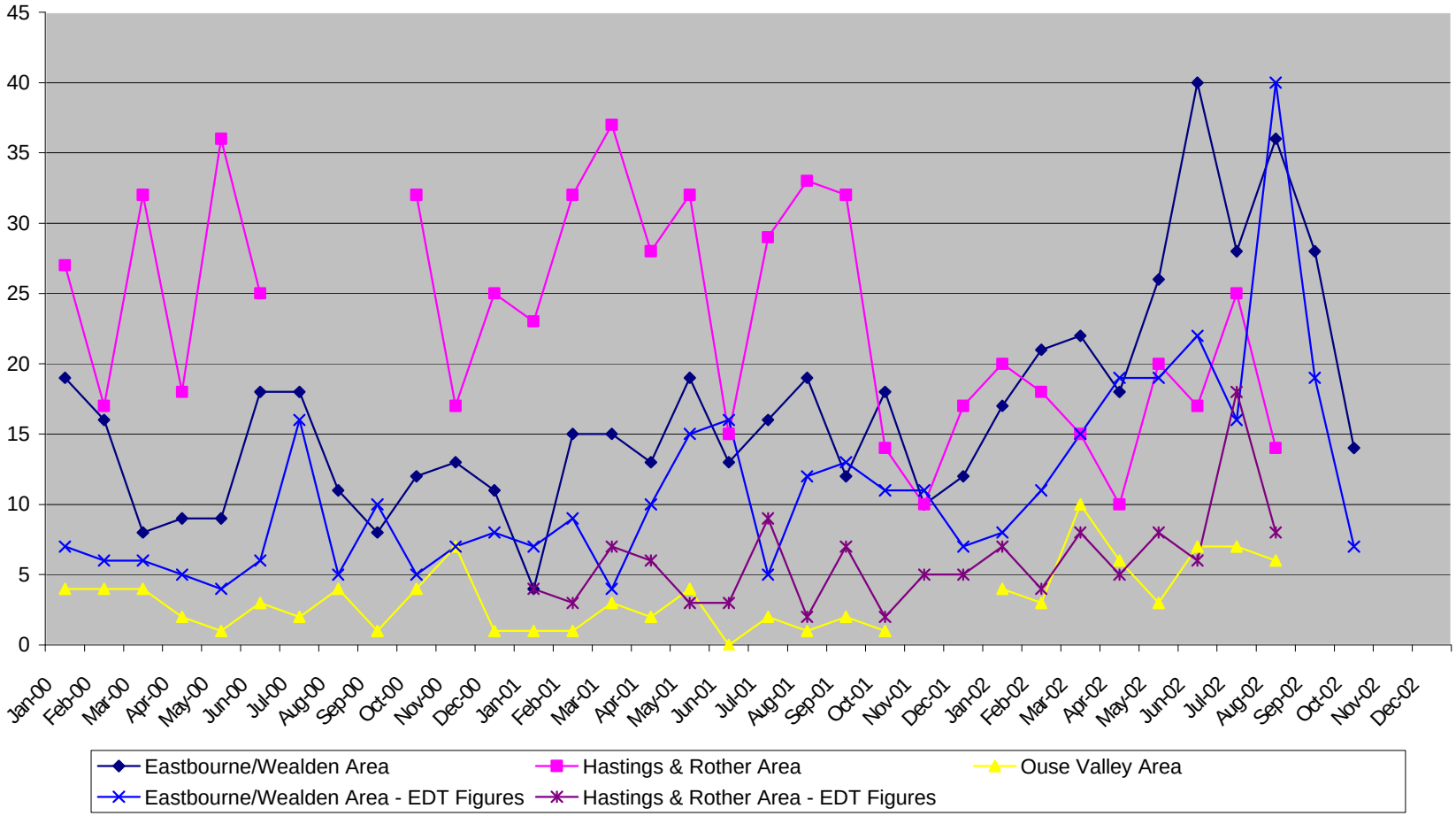
- Cases across the county 2000-2002
- Cases 2000-2002 by month
- Cases 2000 – 2002 by year
- Hours worked 2000 – 2002 by month
- Hours worked 2000 – 2003 by year
- Cases 2000 – 2003 by gender

**Appendix 5**

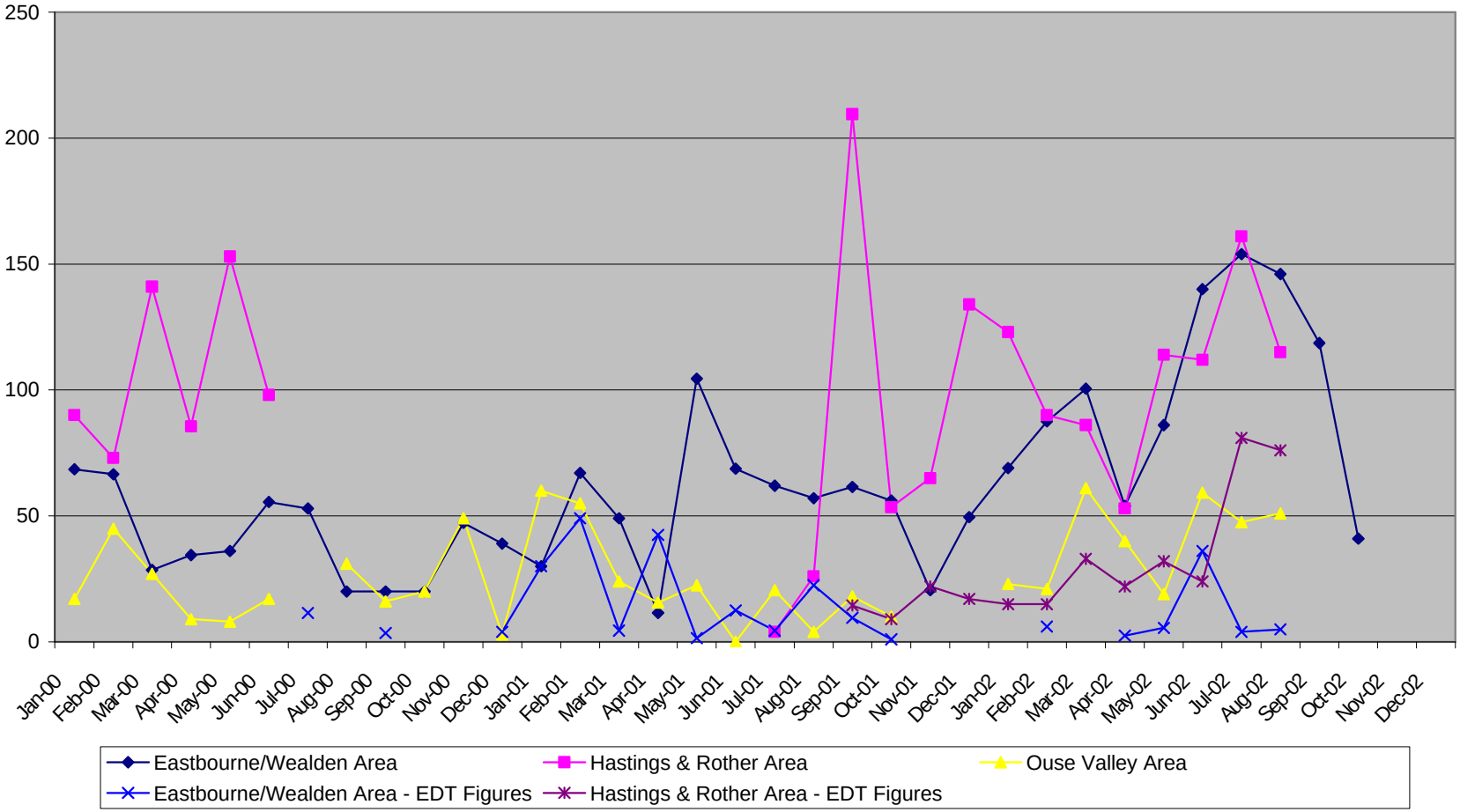

EDT Cases across the County 2000 - 2002
300
250
200
150
100
50
0
Total for 2000
Total for 2001
Total for 2002

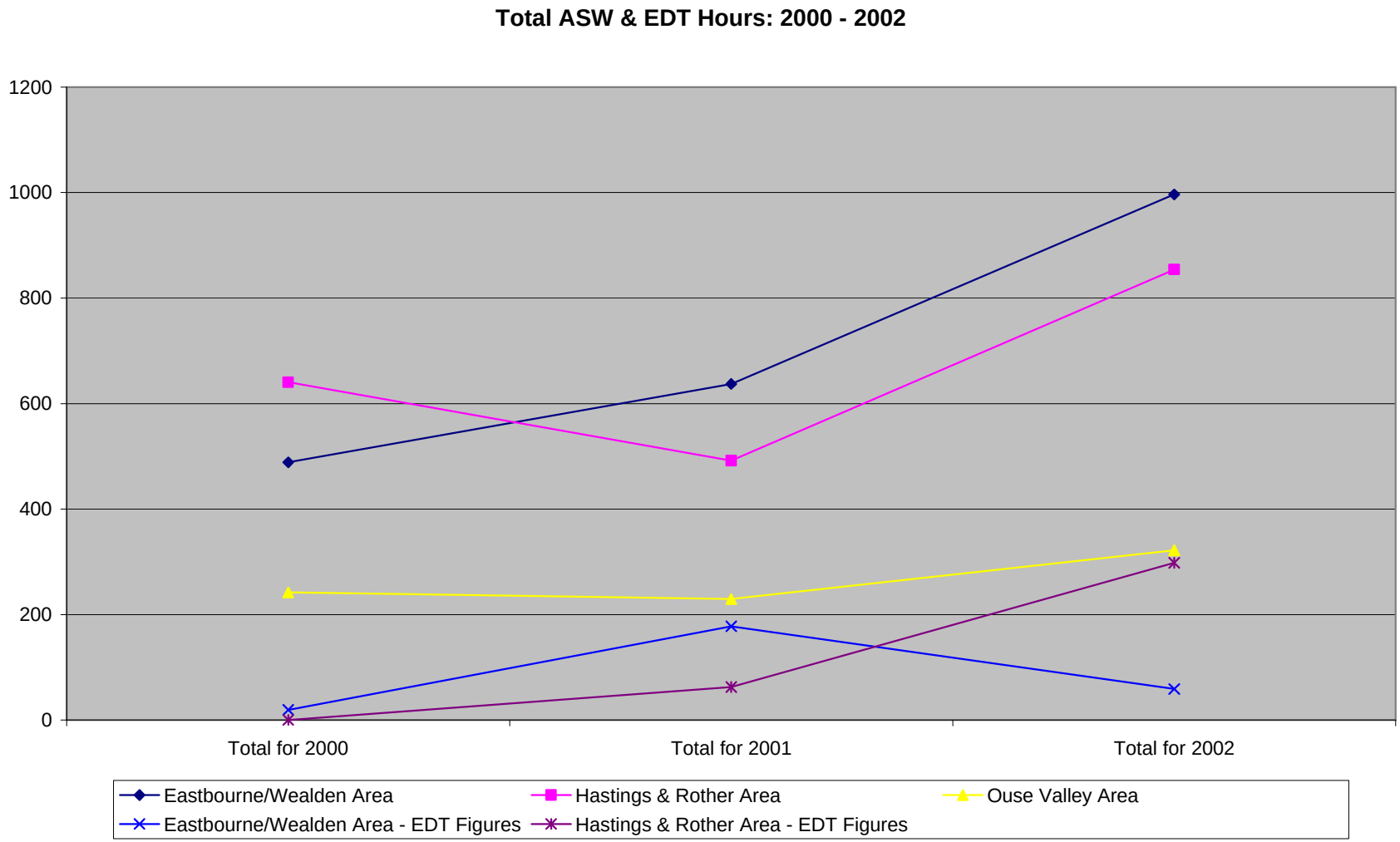

Total ASW & EDT Cases: 2000 - 2002
350
300
250
200
150
100
50
0
Total for 2000
Total for 2001
Total for 2002
Eastbourne/Wealden Area
Hastings & Rother Area
Ouse Valley Area
Eastbourne/Wealden Area - EDT Figures
Hastings & Rother Area - EDT Figures

## ASW & EDT Cases: 2000-2002

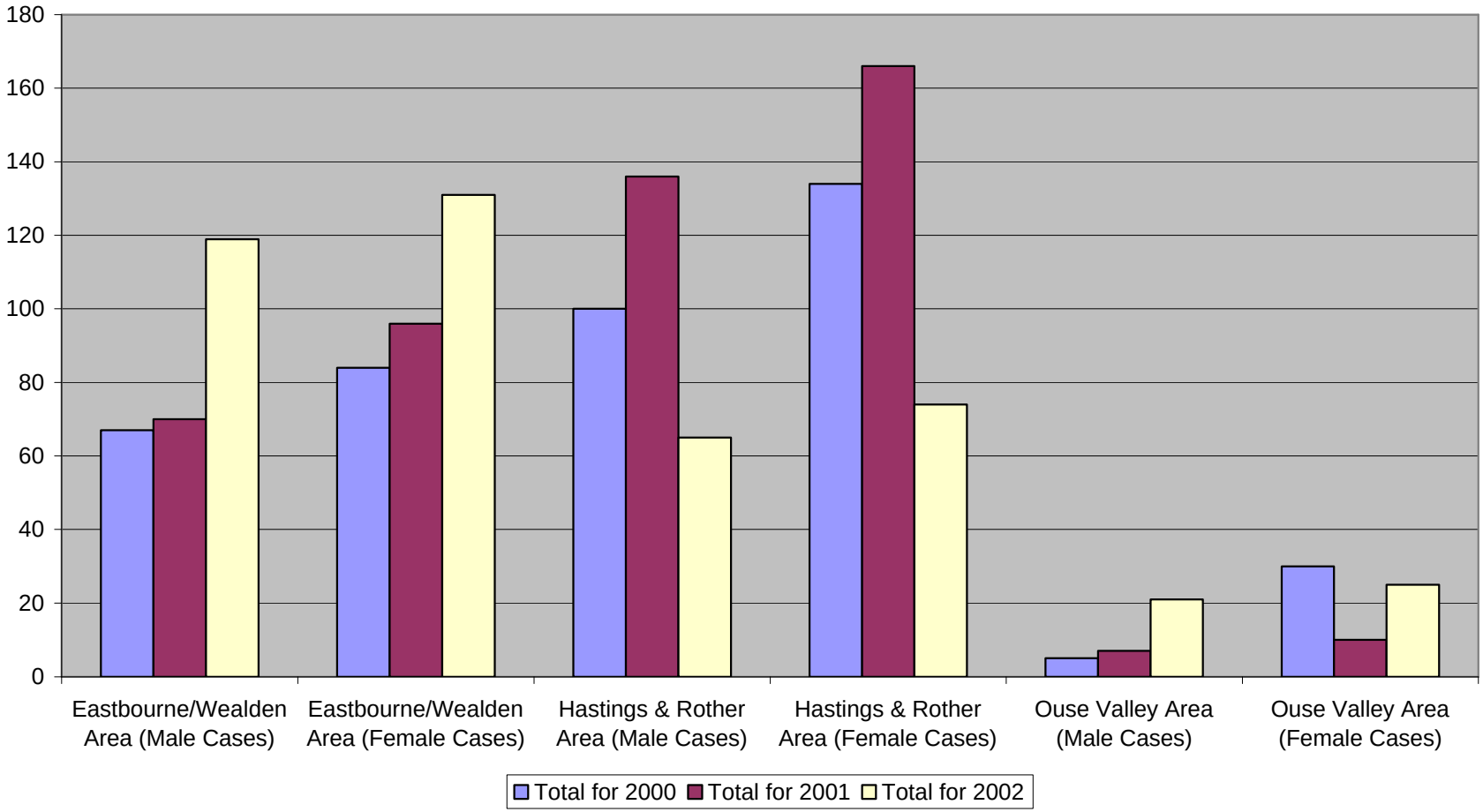


## ASW & EDT Hours: 2000 - 2002




Total ASW & EDT Hours: 2000 - 2002
1200
1000
800
600
400
200
0
Total for 2000
Total for 2001
Total for 2002
Eastbourne/Wealden Area
Hastings & Rother Area
Ouse Valley Area
Eastbourne/Wealden Area - EDT Figures
Hastings & Rother Area - EDT Figures

**Analysis of Male/Female Cases: 2000 - 2002**



*Appendix 6*

## 1. Bed availability

### 1.1 NHS inpatient and specialist supported accommodation

| Unit | Service type | Beds | Comment |
|---|---|---|---|
| Ashen Hill | Medium security | 20 | Serves E. Sussex B&H and W. Sussex |
| Southview | Low security | 20 | Serves E. Sussex B&H and W. Sussex |
| Rosslyn | Forensic rehab | 4 | Serves E. Sussex B&H |
| Woodlands | General acute inpatient | 33 | Serves east of county |
| Dept of Psych. | General acute inpatient | 50 | Serves west of county and some beds used by east of county |
| Westbourne | General acute inpatient | 9 | Provided by South Downs for Lewes/Ouse residents |
| Amberstone | Nurse staff accommodation | 24 | Mainly serves west of county |
| Tenby House | Supported accommodation | 12 | Mainly serves east of county |
| Cedar House | Supported accommodation | 10 | Mainly serves east of county |

### 1.2 Purchase of services in the private sector

(activity up to month 9 of the current year)

| Unit | Service type | Episodes | Comment |
|---|---|---|---|
| Various | Medium security | 24 | Tend to be longer stay up to 2 to 5 years |
| Various | Low security | 21 | Typical length of stay up to 1 to 2 years. |
| Various | Intensive care | 44 | Short length of stay, typically 2 to 6 weeks |

***Notes:***

- There are typically 10 to 15 East Sussex residents in Special Hospitals (Broadmoor, Rampton, Ashworth)
- There is a much wider range of accommodation that provides levels of support (mainly residential homes) which are not included. The East Sussex Social Services spend on residential care for people with mental health problems is much higher than the national average.
- There is a major cost issue associated with the high level of spot purchasing in the private sector. The cost of the activity listed in the table above is about £5.8 million. (The cost of intensive care beds is about £1.4 million) There has been a threefold escalation in cost of activity in the private sector over the last four years.

*Appendix 7*

**Comparative Study – analysis of findings**

1.1 A summary table of findings from the group of authorities studied is attached.

1.2 From the information, a number of conclusions were drawn:

- Better statistics on caseload are kept by some other authorities and these are used actively to monitor and manage the service.

- There appears to be a healthier ratio of ASWs to caseload in other authorities.

- There is less frequent conveying of patients out of their county.

  From April to December 2002, 38 patients out of a total of 339 admissions were transported to London from the East of East Sussex.

1.3 There were a number of good practice points made:

**East Sussex**:

- ASWs meet regularly in each area and with psychiatrists and bed managers to discuss practice and problems.
- The service have resourced a high quality children and adolescents mental health service.
- Integrated management of health and social care have created a number of joint policies.
- Forging three Trusts into one in the County has created greater flexibility in the service e.g. Hastings patients being conveyed to beds in Eastbourne instead of out of county
- Crisis and response teams and the Sanctuary in the east of the County are good examples of preventative care reducing the potential cases of compulsory admission.

**Bedfordshire**

- Have a strong section 136 policy – with designated rooms in the acute units as places of safety. Also a doctors' rota introduced for out of hours section 136 referrals. Joint 136 Steering Group in place with police and ambulance representation.
- Multi agency conveyance policy. Agency staff can act as escorts.
- No ASW works alone – there is a rota for back-up support. Community Mental Health Nurse are expected to attend where they are the person's care co-ordinator.
- Monthly statistics show ethnicity, age etc and are used at 6 weekly ASW meetings.
- Joint health and social care seminars – more difficult to get the police to attend – although will do so for PACE and section 136 issues.

**Brighton and Hove**

- have an out of hours team from 3pm to 11pm with one ASW which provides continuity between day and night staff
- have two dedicated ASW staff providing rapid response to referrals

- Out of hours staff delegate task to ambulance, police or Nurses to convey patients out of City.

**Cornwall**

- Have an interagency performance monitoring and management system.

**Hampshire**

- Mental Health Best Practice Handbook.
- Recruited a Practice Development Worker and Mental Health Training Communicator

**Kent**

- The ASW (Mental Health Award) training scheme is very good, as is the Post Qualifying structure of which it is a part. Progressing through the Post Qualifying structure is rewarded with increments in salary. Getting to Senior Practitioner depends on Post Qualifying training, rather than on vacancies arising.

**Surrey**

- Maintain and use a comprehensive range of case statistics including age and ethnicity.
- Transport Policy agreed with all the MH Trusts, Surrey Police & Surrey Ambulance Service - copy could be sent if interested.
- Comprehensive programme provided by our MH Practice Development Centre (PDC) for refresher training for ASWs.

**Warwickshire**

- Mental health strategy targets and single line managed service between Social services and PCT
- Joint lone working policy
- User empowerment and involvement projects (two)
- Three year joint training plan informed by users and voluntary sector involvement. Also self-assessment tool used by staff
- Established a joint commissioning post for mental health services – begun mapping service specifications for managing performance**.**

**West Sussex**

- have an agreed bed management policy within West Sussex Health and Social Care NHS Trust and a commitment to keep patients within County.
- Currently planning a service user evaluation of ASW service
- Have a cross county ASW best practice group
- Use the intranet to provide training resources for ASWs
- Analyse case statistics by age, gender, source of referral, time of referral, and where admitted to hospital. Also keep statistics by area of cases per 10,000 of the population.

| **Appendix 7**<br>**Comparator information** | | | | | |
|---|---|---|---|---|---|
| **County** | **ESCC** | **West Sussex** | **Hampshire** | **Cornwall** | **Bedfordshire** |
| | Pop: 493,000 | Pop: 763,400 | Pop: 1,256,000 | Pop: 501,267 | Pop: 560,000 |
| **Performance indicators 2001/2002:** | | | | | |
| A6 Psychiatric readmission rates | 10.7% | 13.3% | 14.8% | 19.6% | 13.9% |
| B17 Average gross hourly cost for home care for adults and older people | £13.80 | £15.00 | £11.90 | £11.40 | £12.90 |
| B15 Average gross weekly expenditure on supporting adults with mental illness in residential and nursing care for | £372 | £405 | £401 | £255 | £448 |
| C27 Admissions of support residents aged 18-64 to residential/nursing care. Per 10,000 population 18-64. | 3.6 | 4.0 | 1.9 | 3.0 | 3.5 |
| C31 Adults with mental health problems helped to live at home. Per 1,000 population aged 18-64. | 1.0 | 1.5 | 3.2 | 2.2 | 2.9 |
| Number of Mental Health Act assessments for compulsory admission<br>2000<br>2001<br>2002 | <br>515<br>662<br>576 (Jan to Aug) | <br>694<br>746<br>611 | <br><br><br>525 (1 Oct 01 to 31 Mar O2) | <br>No information available | <br>219<br>177<br>201 |
| Number of ASW<br>2000<br>2001<br>2002 | 5/100,000 pop.<br><br><br>23.8 fte | 8/100,000 pop.<br>52 headcount<br>54 headcount<br>63 headcount | 4/100,000 pop.<br><br><br>51 headcount target 5/100,000 | 7/100,000 pop.<br>40 fte<br>32 fte<br>36 fte | 4/100,000 pop<br>27 fte 31 h/c<br>22 fte 26 h/c<br>19 fte 20 h/c |

| County | ESCC | West Sussex | Hampshire | Cornwall | Bedfordshire |
|---|---|---|---|---|---|
| ASW total hours on cases of compulsory admission under the Mental Health Act | | Information not available | Estimated 4 hours per assessment | Information not available | Information not available |
| ASW recruitment and retention difficulties | | Not yet. ASWs paid x2 increments following job eval. and assessment with UNISON. No market supps. as yet. | Yes – several years. Working hours increasing, longer assessments, lack of resources. Increase workloads | Review pay grades, link higher pay scales to involvement in out of hours rota and satisfactory casework perf. | Yes – ASWs receive 2 additional increments. All staff receive 3% Recruitment and Retention payment |
| What is you bed profile for mental health services? | 182 total beds (No PICU beds) | 475 total beds (includes 14 intensive care and 130 acute) | No information available | No MH residential beds. Some provision purchased from private sector. 3 psychiatric hospitals in Cornwall, moving to 2 hospitals in near future. Limited sanctuary provision. | For adults under 65: 24 acute beds in south of the county, including 6 detox. Beds. Access to additional beds at a hospital in Buckinghamshire. 48 acute beds in north of county |
| Do you have to convey patients across or out of County/area | Yes | 42 (6.8%) | Yes – 2000/2001 total numbers of placements 145. In county 107 and out of county 38. | Conveyed to one of 3 psychiatric hospitals within county. | Only a couple of times within last 12 months as local bed availability has improved. Prior to this, probably 2 or 3 times a month |

| County | ESCC | West Sussex | Hampshire | Cornwall | Bedfordshire |
|---|---|---|---|---|---|
| Number of assessments<br>During office hours<br>Outside<br>Not known | | 2000/2001<br>71%<br>28%<br>1% | <br>419<br>106<br>(1 Oct 01 to 31 Mar 02) | | |
| Expenditure on Mental Health | | | Earmarked Mental Health Funds for 2002/2003 £2.5m. Total cost supporting mental health residential care in 2000/2001 was £2.7m. | | |
| Does your authority operate a 24 hour, 7 day week Mental Health Act assessment process service | | Yes | Yes | Yes | Not quite. Mon-Fri EDT finish at 6am and daytime services start at 8.45am. |

| County | | Brighton & Hove | Surrey | Kent | Warwickshire |
|---|---|---|---|---|---|
| | | Pop: 260,000 | Pop: 1,059,015 | Pop: 1,332,000 | Pop: 505,885 |
| **Performance indicators 2001/2002:** | | | | | |
| A6 Psychiatric readmission rates | | 10.7 | **W** 14.4% **E** 7.9% | E 22.4% W 14.5% | 10.2% |
| B17 Average gross hourly cost for home care for adults and older people | | £11.30 | £13.10 | £12.00 | £15.30 |
| B15 Average gross weekly expenditure on supporting adults with mental illness in residential and nursing care for | | £328 | £420 | £388 | £370 |
| C27 Admissions of support residents aged 18-64 to residential/nursing care. Per 10,000 population 18-64. | | 5.2 | 2.3 | 3.2 | 2.0 |
| C31 Adults with mental health problems helped to live at home. Per 1,000 population aged 18-64. | | 3.3 | 3.6 | 2.2 | 2.5 |
| Number of Mental Health Act assessments for compulsory admission<br>1999-2000<br>2000-2001<br>2001-2002 | | <br><br>221<br>219<br>224 | **EAST** - 175 April to Sept 2002 45% female and 55% male. 2% under 18. 13% over 65.<br>**WEST** – 166 April 2001 to March 2002. 50% male and 50% female 4% under 18, 17% over 65 | <br><br><br><br>1516 | <br><br>435<br>429<br>not available |

| County | | Brighton & Hove | Surrey | Kent | Warwickshire |
|---|---|---|---|---|---|
| Number of ASW<br>2000<br>2001<br>2002 | | 8/100,000 pop.<br><br><br>21 | 6/100,000 pop.<br><br><br>64 | 4.5/100,000<br><br><br>60 hc (56.82 fte) | 6/100,000 pop.<br>37 hc<br>34 hc<br>33 hc. 30.5 fte |
| ASW total hours on cases of compulsory admission under the Mental Health Act<br>2000<br>2001<br>2002 | | | | | Not available |
| ASW recruitment and retention difficulties | | Currently an honorarium scheme of payment in existence to recognise the ASW duties and to assist with retention of staff | Difficulties recruiting ASWs. Access to affordable housing the biggest issue. £1,500 retention supplement, £2,000 start up payment. Commitment to training, career opps. 'Growing own' | | Difficulty recruiting to new posts that require SW to work on rota and out of hours. Strategies to improve R&R: greater focus on dev. opps and support through recruitment of supervisor mentors £750 additional payment for ASW on rota. Payment being reviewed and expect move to 2 increments for ASWs. |

| County | | Brighton & Hove | Surrey | Kent | Warwickshire |
|---|---|---|---|---|---|
| What is you bed profile for mental health services? | | | | East Kent – 183 younger adults, 117 older people<br><br>West Kent – 229 younger adults. 222 older people | 3 inpatient units – Rugby, Nuneaton, Warwick. Ongoing problems with bed occupancy. High number of out of county placements. PCT are investigating. Suspect consultant behaviour is a contributing factor. |
| Do you have to convey patients across or out of County/area | | Occasionally. During the day, ASW many accompany patient. OOH staff will del. task to police/amb. or bank nurse, as staff are needed to remain in city for op. tasks | | Yes. Out of area placements are a problem | No data. Have to convey out of county. Currently in discussion with Ambulance Service and Police over conveying high risk patients. |
| Number of assessments<br>During office hours<br>Outside<br>Not known | | | 83% completed within 1 day. 2% more than 3 days. EDT undertook 151 assessments in 2001 and 181 in 2002 | | |
| Expenditure on Mental Health | | | | | |

| County | | Brighton & Hove | Surrey | Kent | Warwickshire |
|---|---|---|---|---|---|
| Does your authority operate a 24 hour, 7 day week Mental Health Act assessment process service | | 9am to 5pm. Day ASW rota, comprising 2 full time dedicated ASW staff with additional 2 ASW staff from day teams who prioritise ASW referral.<br><br>3pm to 11pm OOH team 1 ASW. Last referral taken at 9.30pm.<br><br>After 11pm all referrals taken by ESCC EDS service. | | Yes. Delivered Out of Hours by a dedicated OOHS covering Kent and Medway. | Yes. In hours mental Health Act Assessments are undertaken by ASW on rota. Out of hours via EDT. |

***Appendix 8***

**Priorities for joint working, training, seminars**

The following are service priorities to work on:

- Risk management system as in recommendation 1 of this report.
- Improving communication, most importantly between ASW and Doctors, police and bed managers.
- Improving performance management – top level service goal setting, pooled budgeting, through joint monitoring and end of year review.
- Agreeing service performance indicators, the monitoring process and how this feeds into the above.
- Improving the conveyance service.
- Agreeing an in-county care policy including appropriate beds and places of safety.
- Improving user/relative and carer consultation.
- Improving liaison with housing providers, independent sector and the voluntary sector in service and care planning.

***Appendix 9***

**Suggested service performance indicators:**

Area and County analysis of:

- Number of cases
- Hours on cases
- Average hours per case
- Ratio of ASWs to cases and ASWs per 100,000 population
- ASW hours per person
- Response times of key agencies to standard agreed
- Out of County conveyance/where conveyed to
- Training targets e.g. ASWs, other Health Care staff, Police
- Age, gender and ethnicity mix of service users

*Appendix 10*

**Suggested service review analysis framework**

**Scrutiny Review on Mental Health Act Assessment process**

**1. Responsiveness of service**

- Information and access to service
- Swiftness of response to need
- Provision of service according to need – is this satisfactory?
- Are there adequate staff resources to provide services adequately?

**2. Referral and assessment**

- Efficiency and timeliness of service
- Inter-agency communication and working - particularly ASWs and Doctors
- Are ASWs able to perform their co-ordinating role effectively?
- Are ASWs and other staff safe?
- Are carers involved?
- Is the place of assessment fit for purpose?
- Is there adequate provision for a place of safety?
- Are users happy with this service?

**3. Conveyance and admission**

- Is the conveyance service fit for purpose – vehicles, personnel?
- Is the conveyance service efficient?
- If there is risk of violence or non-compliance do the police respond well?
- Is the admission process efficient?
- Can a local bed be found every time?
- Are users happy with this service?

**4. Care planning and care management**

- Does the records management process support the above?
- Are there risk management processes in place?
- Are there consistent service standards across the county and across agencies?
- Are housing needs taken into account when detaining someone?

**5. Inter-agency collaboration**

- Is there joint business planning – target setting – monitoring – reviewing?
- Is there integrated budget management across agencies?
- Inter agency protocols and procedures and service standards?

**6. Equitable provision and anti-discrimination practice**

- Does the service monitor cases in line with ethnicity, age, gender?
- How do staff from all agencies implement equalities policies e.g. in training and information/access?

**7. Staff development and training**

- Is staff development fully utilised as a means to retain/motivate staff?
- Are there joint inter-agency training/seminars to share and improve practice?

**8. Organisation and management**

- Is there regular and ongoing consultation with users and carers to inform business plans and service quality?
- Is performance and service data routinely maintained to inform management across all agencies?
- Does the service jointly plan services – set goals, targets and monitor/review their achievement?
- Does management tie in their planning, decisions, actions with what is happening operationally e.g. in recruiting and retaining ASWs or doctors?
- Is there evidence of partnership working across agencies and with the voluntary sector?

End

# Scrutiny Review
# Mental Health Act (1983) Assessment Process

## Report by the Project Board:

Councillor Trevor Webb
Councillor Mary McPherson
Councillor John Garvican
Dr Steve Jones, Service/Executive Director,
East Sussex County Healthcare NHS Trust

7 May 2003

East Sussex County Council

**Scrutiny Review**
**Mental Health Act (1983) Assessment Process**

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**Appendices Section** **(held in the Members' Room)**

## 1. Objective

1.1 This scrutiny review, commissioned by the Social Services and Health Scrutiny Committee in September 2002, is part of an action plan which was developed by Social Services management following an investigation into problems being experienced by Approved Social Workers. The objective of the review is to make recommendations which will improve the Mental Health Act assessment process in which Approved Social Workers play an important co-ordinating role. Appendix 1 details the issues raised by the Social Services management investigation and the particular concerns tackled by this review and its scope.

## 2. Introduction

2.1 Under the Mental Health Act (MHA), Approved Social Workers (ASWs) have the legal duty to co-ordinate MHA assessments.

2.2 The process also involves two doctors, one of whom must be trained in mental health work (called 'Section 12'). The other is usually the person's General Practitioner (GP). Their recommendations are on the medical and psychiatric condition of the person. Compulsory detention in hospital may follow if there is a recommendation from the doctor and the ASW agrees to make the application.

2.3 Compulsory detention in hospital will be a last resort. Having gathered the facts the ASW will look for the least restrictive alternative. The ASW will consider the wider social factors and implications for the person in making a decision. Finally, there is the need to find a bed and co-ordinate care for the person. This responsibility lies with the Primary Care Trust and provider NHS Trust. It involves the Section 12 doctor directly liaising with the local bed manager or providing the ASW with advice for them to do so as part of their co-ordinating role.

2.4 In an emergency situation one doctor can undertake the assessment with the ASW. However, this is rare.

2.5 The Ambulance Service is generally used for conveyance. The Police can be involved to assist at the person's home, to help convey someone to hospital, or where they have arrested someone under section 136 of the MHA. Once at the police station, a police forensic medical examiner will see the person and make a judgement whether to call an ASW to begin a mental health assessment. This is expected to be undertaken in a 'place of safety'.

2.6 ASWs are required to coordinate input from a range of agencies, including specialist doctors, GPs, Ambulance Service, Police and hospital bed managers. However, they have no control or authority over the availability of any of these agencies. They also take responsibility for staying with the client until the assessment is complete and, where necessary, conveying the client to a suitable bed.

2.7 The policy and practice context is detailed in Appendix 2.

## 3. Overview

3.1 It was clear from consultations that, in the area of MHA assessment, service users, their relatives/carers and staff want a service that:

- minimises distress to the user/patient and their relatives;
- minimises risk of physical and psychological harm to users, staff and the public;
- is completed in an appropriate time with the minimum of delay but avoiding crisis management where this is not necessary; and
- provides individualised care according to need, as far as resources will allow.

3.2 The findings support the conclusion that the service, taken as a whole, is not achieving these aims.

3.3 The efficacy of the overall assessment and the risks to which ASWs may be subjected are directly affected by the combined responsiveness of all the agencies involved and the availability of resources to meet the needs of clients with mental health problems.

3.4 The Board concluded overall that the current arrangements are inadequate to provide a modern responsive service and that developments to affect improvements have been slow.

3.5 The Board was impressed with the commitment of staff across agencies but considered that there are unreasonable demands currently placed on ASWs which must be addressed from a multi-agency standpoint. The assessment of mental health appeared to the Board to be a low priority area for all key agencies, despite the increasing incidence of mental health disorders in the community.

3.6 Service users and carers want to be more involved in determining service provision and be invited to give feedback on satisfaction with services.

3.7 There are variations in practice, strengths and weaknesses across the county. Following the establishment of the single county wide organisation, East Sussex County Healthcare NHS Trust in April 2002, bed management improved across the county. However, there is still a disproportionate use of resources on private sector beds and out of county beds.

3.8 The current capacity and configuration of the ASW service does not match the demand for services, particularly after 5.00pm and at weekends.

3.9 It was also clear that most of the other 8 authorities surveyed had more ASWs relative to caseload numbers and as a ratio of population.

3.10 Some authorities are making efforts to join up the day, evening and night services.

3.11 Some other authorities had better facilities for a place of safety and bed provision, although information was patchy. 3 of 8 authorities surveyed needed to convey patients to beds out of county on a significant scale.

## 4. Summary of findings and recommendations

Six key themes have been identified. (Appendix 3 contains the detailed findings.)

### 4.1 Stronger commissioning arrangements

4.1.1 The current commissioning and provider roles within mental health are unclear.

4.1.2 Hastings and St Leonards Primary Care Trust assumed a lead role for mental health across East Sussex from April 2002. However, the Board could not establish how far this extended to the full commissioning of services across the County.

4.1.3 East Sussex County Healthcare NHS Trust is the main provider of mental health services working in an integrated way with Social Services.

4.1.4 The Board understands that a Joint Commissioning Team for Mental Health is to be established across Social Services and Health. However, there is no planned date for its commencement.

4.1.5 The Board considers that:

- a lack of definition in commissioning and providing services; and
- a lack of co-ordination of commissioning arrangements across the County

have contributed to a lack of focus and pace in the development of services. In turn, this affects the efficacy with which approved ASWs are able to coordinate mental health assessments and secure appropriate beds and care for patients.

4.1.6 Moreover, given the above, the Board is concerned that the recommendations for improvement from this review may not be taken forward across East Sussex in the co-ordinated and consistent manner required.

4.1.7 Nevertheless, steps are being taken to create clearer commissioning and service provider arrangements for mental health in East Sussex.

**The way forward**

4.1.8 The Board welcomes the proposal to establish a Joint Commissioning Team consisting of appropriate management representation from all the Primary Care Trusts in East Sussex together with East Sussex Social Services. The Board notes that the Team's officers will maintain accountability to their respective Health Boards and to East Sussex County Council Cabinet.

4.1.9 This arrangement should overcome the problems and concerns above and the Board concludes that they should be put in place as soon as possible.

4.1.10 This report, therefore, assumes the following arrangements:

- Ultimate responsibility for implementing the recommendations in this report will rest with the Cabinet and Health Boards.

- Planning improvement based on the recommendations in this report and monitoring that this happens will rest with the Joint Commissioning Team which will secure the mental health services needed across the health and social care spectrum.

- Direct service action to implement the recommendations in this report is the responsibility of the provider services in Health and Social Services.

4.1.11 A multi-agency plan of action to improve the mental health assessment process, based on the recommendations in this report, should be developed by the Joint Commissioning Team and delivered by the appropriate providers. See recommendation 6.

**Recommendation**

**R1** **The Director of Social Services and the Chief Executives of Primary Care Trusts serving East Sussex to agree the terms of reference and ensure a Joint Commissioning Team for Mental Health Services is operative by October 2003. This Team will drive through the improvements recommended in this report. (See page 18)**

## 4.2 Response to cases and risk management

4.2.1 There are cases where ASWs are exposed to an unacceptable degree of risk. Case studies and anecdotal evidence point toward risk to the community too.

4.2.2 For police, ambulance and doctors, service quality is patchy across the areas (in terms of their responsiveness and approach to cases). This creates difficulties for the ASW co-ordinating the assessment. A common comment amongst ASWs was 'the quality of the response depends upon who you get hold of'.

4.2.3 Police and the Ambulance Service give mental health issues a low priority. ASWs cite the fact that they often have difficulty getting through on the telephone to gain support. The ASW Operations Manager is currently gathering data to support their case. The Police did not recognise that there was a problem getting through on the phone.

4.2.4 Also, increasingly, compulsory admitted patients appear to be younger – with multiple diagnosis. However, data is not easily accessible on this. Whilst the Children's and Adolescent Mental Health service is high quality - the links to adult services in terms of joined-up service planning were not clear.

**The way forward**

4.2.5 The ASW should not be expected to attend cases alone if there is risk involved.

4.2.6 The ASW is responsible for making the assessment of risk based upon the best possible information that is available. The ASW will alert the help and support needed accordingly.

4.2.7 The service standards for response times should be set for ASWs and agreed with all agencies in accordance with the conveyance policy. ASWs should develop a risk assessment protocol (see Appendix 4) for:

- **High risk cases**
- **Medium risk cases**
- **Low risk cases**

4.2.8 Given the current circumstances where police cells are used as places of safety, all section 136 cases should receive high priority by all agencies. Recommendation 4 addresses the need for an appropriate place of safety. Without this provision currently, no patient should be kept in a police cell for longer than is absolutely necessary.

4.2.9 With all agencies working to agreed service standards this will ensure:

- Risk is managed consistently for all.
- Service standards are clear and consistently worked to by all.
- Communication between agencies is clear and efficient.
- Delays in responding are minimised.
- The service response is appropriate to need.
- Service performance can be monitored against standards.
- Service performance can be reported clearly across all agencies.

- Reasons for any shortfall in service performance can be pinpointed and worked upon.

4.2.10 Two points needing particular attention are:

- To improve communication between police and ASWs to enable the above standards to be met.

- To improve ASW access to patient records so that an accurate pre-assessment of risk can be made. The advantages of modern information technology need to be harnessed whilst maintaining patient confidentiality.

4.2.11 A model of the template for risk management is given in Appendix 4.

**Recommendation**

| | |
|---|---|
| **R2** | **The Joint Commissioning Team to ensure the development of an agreed service response system based upon effective risk management. All agencies to commit to work to it and the agreed performance standards within it. Completion date December 2003 (see page 18).** |

### 4.3 Consistency of service quality over the 24 hour day, seven days a week

4.3.1 ASWs are stretched, isolated and taking a long time per case because of a lack of integration of service between agencies. They are in law expected to co-ordinate a service where they are dependent on staff from other agencies who treat mental health as a low priority.

4.3.2 This is exacerbated by problems finding suitable Section 12 doctors, finding beds within the county and then, when allocating patients outside the county, the ASW's worthy commitment to travel with the patient.

4.3.3 Related health service workers are not expected to support the MHA assessment process at present despite the fact that ASWs need support and protection from the risks of lone working.

4.3.4 ASW levels in East Sussex are relatively low (see Appendix 7 which shows comparative data of ASW's per 100,000 population and against caseload numbers). However, numbers have improved in the first part of 2003 to 29 i.e. from 5 to 6 per 100,000 of the population. From the comparative survey this level of resourcing would appear to be in the lower quartile.

4.3.5 Although patients often need support or assessment in the evenings, nights and at weekends, this is when the service is most stretched because of the wide range of work undertaken and the geographical area covered by the Emergency Duty Team. This issue is a particular concern in the east of the county.

4.3.6 There are problems in communication and handover between day services and Emergency Duty Team – it is not a seamless service for the user.

4.3.7 Appendix 5 details East Sussex service information.

4.3.8 The comparative evidence points to interesting practice in other authorities which may merit further investigation.

**The way forward**

4.3.9 This should involve modernising the whole service and not simply a recruitment drive for ASWs and a reconfiguration of existing ASW rotas. Particular work is needed to:

- Involve related Mental Health and Social Care workers in rota systems so that they support ASW trained social workers and prevent lone-working e.g. Community Psychiatric Nurses, staff from Children's and Family Services Division (Children and Adolescent Mental Health Services particularly).
- Integrate the Emergency Duty Team and daytime ASWs into one seamless approach.
- Ensure sufficient section 12 doctors are available to meet the service standards.
- Look for alternative shift pattern options e.g. breaking the 24 hour day into 2 or 3 'on-call' shifts.

- Research alternative pay incentives and rewards options to support the modernised approach.
- Investigate alternative trained staff for escorting patients in cases of out-of-county conveyance so that ASW time could be put to better use.
- If more ASW's are needed, recruit more to train from the Children's and Family Services Division (Children and Adolescent Mental Health Services particularly).

**Recommendation**

| | |
|---|---|
| **R3** | **The Joint Commissioning Team to ensure the deployment of sufficient staff to meet the service standards agreed in recommendation 1 and the patterns of demand over 24 hours a day through seven days a week. Completion date March 2004 (see page 18).** |

## 4.4 Conveyance of patients

4.4.1 Despite a jointly agreed conveyance policy, there is evidence that it is not being fully implemented. There are sometimes major delays in waiting for the Ambulance Service and it is clear that their national priority is acute 'life and limb' cases.

4.4.2 The Ambulance Service had particular concerns about using a paramedic ambulance for out-of-county conveyance – primarily because of time taken for these journeys and the subsequent cost.

4.4.3 All parties, including users, agree that a full paramedic ambulance is only appropriate for the most high risk cases where physical injury is evident or highly likely.

4.4.4 In other cases a cheaper, more accessible and fit-for-purpose vehicle would be better. Patients approved of this suggestion. Some patients are worried about the stigma of an ambulance at their home.

4.4.5 The Ambulance Service was agreeable to play a lead service role in providing vehicles and training staff who do not need to be fully trained ambulance personnel.

**The way forward**

4.4.6 The method of transport and type of staff employed should be appropriate to the requirements of the individual case and able to meet the response standards.

4.4.7 The Ambulance Service, as the service provider, should work closely with the Health and Social Care agencies to put in place suitable contracting arrangements. As the Ambulance Service is a pan-Sussex service, West Sussex Health and Social Care agencies may need to be involved in achieving this recommendation.

4.4.8 In developing appropriate contracting arrangements:

**the vehicle should be designed to** –

- Maintain the patient's dignity and not stigmatise mental health problems in a negative way.
- Protect the driver from harm or attack by passengers.
- Protect the patient from inflicting self-harm.
- Allow for appropriate restraint, as needed.
- Communicate with Police or ambulance control in case of crisis.

**the driver should –**

- Carry agreed formal identification.
- Wear a uniform that signifies their role but not one that stigmatises mental health problems in a negative way.
- Be trained by Ambulance Service staff in health and safety, first aid, calming and defusing techniques.
- Be trained by Ambulance Service staff in advanced and defensive driving techniques.
- Be trained by Health and Social Care staff in mental health issues.

| | |
|---|---|
| **R4** | **The Joint Commissioning Team to ensure the development of a cost-effective conveyance service that is fit for purpose and meets different needs of the users. Completion date June 2004 (see page 18).** |

## 4.5 Places of care and safety

4.5.1 There are no place of safety arrangements in East Sussex other than using police cells. All parties do not think this is an appropriate place. It is not dignified for the patient and can contribute to their distress and paranoia.

4.5.2 Resolving this issue has not been progressed as quickly as required.

4.5.3 There are problems allocating patients with acute psychiatric problems to beds within East Sussex. There has been a threefold escalation in cost of activity in the private sector over the last four years.

4.5.4 It was not clear whether some of the patients in acute inpatient units could be moved on more quickly to supported accommodation, so freeing up these beds.

4.5.5 There is no psychiatric intensive care provision (PICU) in East Sussex and patients have, therefore, to be allocated out-of county, mainly to London.

4.5.6 As many as 10% of cases are being allocated out-of-county beds although data is sketchy and unreliable on this.

4.5.7 What is clearer is that the NHS spent £5.8 million on purchasing private sector bed provision (£1.4 million of which was on intensive care beds provision) between April and December 2002. (Appendix 6 details bed availability in East Sussex and purchase of services in the private sector.)

4.5.8 There is a growing number of children and adolescents with mental health related problems. Services were being reshaped to tackle the demands and complexities of these cases.

4.5.9 There are indications that other authorities have greater commitment to in-county mental health provision and have addressed place of safety provision, PICU provision and maintaining access to local acute inpatient beds. In other authorities there is evidence of active monitoring where patients are detained.

**The way forward**

4.5.10 The following four aspirations were included in the service plan for 2002/2003. These projects should be taken forward and established as firm targets in the 2003/2004 service plan.

**4.5.10.1 The creation of one or more appropriate 'places of safety' in the County**

Positioned to serve Hastings/Rother and Eastbourne/Wealden areas - so that patients brought in by the police under section 136 of the MHA can be assessed in a calmer and more dignified environment than a police cell.

**4.5.10.2 The improvement of access to local acute inpatient beds and, thereby, a reduction in cases of out-of-county conveyance and care.**

Both the care provision in the community and care planning practice need reviewing to achieve this. More effort may be needed in care planning to

move patients on to suitable alternative accommodation/care services so that acute inpatient beds are not blocked by patients who could be cared for in the community. If adequate provision is not available this will need resolving.

The housing authorities and the independent sector should be involved in helping achieve this target.

4.5.10.3 **The creation of Psychiatric Intensive Care (PICU) provision in East Sussex.**

The findings have shown how much is being spent on private care beds because there is a lack of PICU beds in East Sussex and problems accessing acute inpatient beds. This money could be better invested in a medium term programme of improvement to achieve effective in-county provision.

4.5.10.4 **Improvement in patient care for young people with mental health problems.**

A recurring theme from the consultations was an indication that the number of young people with mental health related problems is increasing. There are beds available in Colwood, Haywards Heath, West Sussex but the unit is often not able to respond quickly enough to demand.

The Board concluded that there is a lack of accessible suitable in-patient NHS beds in the county for young people with mental health related problems.

**R5 The Joint Commissioning Team to ensure the development of a joint policy and appropriate plans for in-county care provision for compulsorily detained patients. All agencies to commit to work to it and the agreed targets within it. Completion date September 2004 (see page 18).**

## 4.6 Managing performance and driving improvement

4.6.1 Agencies are not working to the same goals or priorities. There are issues to resolve on joining up budgets or working to a common performance management framework.

4.6.2 Progress has been slow on addressing key issues such as pooled budgeting and resolving a suitable place of safety in the county.

4.6.3 There is limited evidence of all agencies working to share, develop and jointly own common practice e.g. through seminars, working parties. The comparative evidence points to better practice in other authorities.

4.6.4 There are gaps in useful service data. The lack of accessible and robust data e.g. on costs, service user information, makes it difficult to justify a certain course of action.

4.6.5 Data, where it exists, is not readily available.

4.6.6 The comparative evidence points to better practice in other authorities.

4.6.7 In some areas, users and carers consider that there is limited user consultation with them. This is both at the individual care planning level and at the broader level of contributing to service planning.

4.6.8 Housing providers, (Borough, District, independent sector and voluntary sector) want more of a voice in care planning and management. The comparative evidence points to better practice in other authorities.

**The way forward**

4.6.9 There are four parts to the performance cycle and the core agencies must work together, bringing in the other agencies as needed, to achieve:

4.6.9.1 **Effective service planning – clear setting of targets and service standards**

Recommendations 2 to 5 should be written into service plans for 2003/04. Also, to drive the achievement of these targets and service standards, pooling budgets and joint financial management should be considered as priorities.

4.6.9.2 **Effective implementation of plans – meeting targets and service standards**

Regular joint practice and development events should be held to cascade service plans, report service monitoring data and to develop good practice. Four events per year is recommended and appendix 8 shows the priorities to work on.

The Police need to be more fully engaged. It would help to target their involvement in Section 136 issues and the place of safety matter as a start point – as other authorities have done. Also, directing training

awareness and involvement at Duty officer/Sergeant level will be important to achieving service improvement.

Greater use could be made of e-learning, the intranet and perhaps the creation of an extranet.

4.6.9.3 **Effective monitoring and reporting of performance against plans**

Collecting, collating, analysing and reporting on service performance data/indicators needs to be more thorough and consistent. Appendix 9 suggests performance indicators to use.

This needs to be done on a systematic basis. The primary and secondary agencies must be clear why the data is being collected, analysed and reported on. They must also be clear on their commitment and their contribution to achieving service plans and performance – especially the Police, PCT's and Ambulance Service.

4.6.9.4 **Effective review and feedback to Members, management and the community**

Near the end of financial year (February 2004) it is recommended to:

- Consult with users, carers, relatives and voluntary agencies on progress with a view to giving them an input into service planning for 2004/05.

The Board considered that consultation on a wider front on mental health services could be more thorough and systematic i.e. carried out on a regular basis to enable interested parties to have a voice in order to facilitate service improvement and the construction of service plans to best meet needs.

- Undertake an audit using the framework developed in Appendix 10 as a basis.

**R6** **To achieve, maintain and continuously improve upon the above service standards and targets in recommendations 2 to 5, the service must strengthen the performance management process.**

**Joint Commissioning Team should establish an action plan by December 2003 to achieve recommendations 2-6. (See page 18)**

## 5. Implementing the recommendations

5.1 Recommendation 1 is the joint responsibility of the Director of Social Services and the Chief Executives of the four Primary Care trusts. The Board considers this should be expedited as a matter of urgency.

5.2 Action to achieve recommendations 2-5 should be identified and commissioned by the Joint Commissioning Team and taken by the appropriate provider services in Health and Social Care. Due to the need to work jointly with other agencies (Police, Ambulance and Housing) it is considered that the Joint Commissioning Team will also have an important facilitating and coordinating role to play.

5.3 The Joint Commissioning Team will take overall responsibility for proactively managing and monitoring performance and driving improvement and this is reflected in recommendation 6.

5.4 Until the Joint Commissioning Team is established, the recommendations in this report should be taken forward by the lead commissioning bodies in Social Services and Health.

5.5 Monitoring reports on the progress of the recommendations and improvements achieved to be submitted by the Joint Commissioning Team to the Health and Social Care Partnership Board and Social Services and Health Scrutiny Committee at 6 monthly intervals from January 2004.

A summary of the recommendations and target dates for completion is given overleaf.

**Summary of recommendations:**

| Recommendation | Agencies involved | Complete by: |
|---|---|---|
| R1. The Director of Social Services and the Chief Executives of Primary Care Trusts serving East Sussex to agree the terms of reference and ensure a Joint Commissioning Team for Mental Health Services is operative by October 2003. This Team will drive through the improvements recommended in this report**.** | Health and Social Care, Primary Care Trusts | **October 2003** |
| | | |
| R2. The Joint Commissioning Team to ensure the development of an agreed service response system based upon effective risk management. All agencies to commit to work to it and the agreed performance standards within it. | Health and Social Care, Primary Care Trusts, Police, Ambulance Service | **March 2004** |
| | | |
| R3. The Joint Commissioning Team to ensure the deployment of sufficient staff to meet the service standards agreed in recommendation 2 and the patterns of demand over 24 hours a day through seven days a week. Completion date March 2004. | Health and Social Care, Primary Care Trusts, Police, Ambulance Service | **March 2004** |
| | | |
| R4. The Joint Commissioning Team to ensure the development of a cost-effective conveyance service that is fit for purpose and meets different needs of the users. | Health and Social Care, Ambulance Service, West Sussex Health and Social Care | **June 2004** |
| | | |
| R5. The Joint Commissioning Team to ensure the development of a joint policy and appropriate plans for in-county care provision for compulsorily detained patients. All agencies to commit to work to it and the agreed targets within it. | Health and Social Care, Primary Care Trusts, Housing, Independent Sector | **September 2004** |
| R6 To achieve, maintain and continuously improve upon the above service standards and targets in recommendations 2 to 5, the service must strengthen the performance management process.<br><br>Joint Commissioning Team should establish an action plan by December 2003 to achieve recommendations 2-6. | Health and Social Care, Primary Care Trusts | **December 2003** |

## 6. Methodology

6.1 From October 2002 to February 2003 Board members consulted a number of stakeholders, service providers interested parties and service users.

6.2 The Board also arranged and attended two workshops – one multi-agency and the other for all East Sussex ASWs.

6.3 In addition the Project Manager met with each of the area ASW groups.

6.4 The Project Board met on 8 occasions between October 2002 and April 2003.

6.5 The Project Manager met with the Service Managers on several occasions to gather information and clarify issues.

6.6 Also a comparative survey was undertaken with the following authorities: in

- Brighton & Hove, Kent, West Sussex and Surrey as neighbours.
- Hampshire because it has recently completed a best value review of mental health
- Warwickshire and Bedfordshire because they best match the ESCC profile
- Cornwall because it is the best matching authority that received an excellent CPA rating and a three or four rating for adult social services.

The results are attached in Appendix 7.

## 7. Councillors, managers and officers involved in the review

**Project Board**
Councillors:
Trevor Webb (Chair)
Mary McPherson
John Garvican

Dr. Steve Jones – Service/Executive Director, East Sussex County Healthcare NHS Trust

**Officers:**
Martin Searle, Project Manager
Bernardine Bacon, Scrutiny Lead Officer
Sam White, Scrutiny Support

**Service Managers**
Phil Gander, Head of Specialist Services, Mental Health Services
Kate Dawson, Operations Manager, Mental Health Services

***(Appendices section held in the Members' Room. Copies available from Sam White, Scrutiny Support. Telephone (01273) 481581 or e-mail: sam.white@eastsussexcc.gov.uk)***