MH - 2012

# MENTAL HEALTH ANNUAL REPORT 2011-2012

## EXECUTIVE SUMMARY

The London Ambulance Service identified improving mental health care as a priority for the service in 2011-2012 and in 2012-2013. It is specifically highlighted in the Operating Framework and appeared in our CQUIN scheme from our commissioners in 2011-2012.

Mental health is a public health issue. Mental illness is the largest single source of burden of disease in the UK. No other health condition matches mental illness in the combined extent of prevalence, persistence and breadth of impact. Consequently, this is a significant component of our clinical work.

Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour. Mental illness has not only a human and social cost, but also an economic one, with wider costs in England amounting to £105 billion a year. Despite its prevalence and importance, mental health is not prominent across public health actions and policy. Public health strategies concentrate on physical health and overlook the importance of both mental illness and mental well-being. That is why the Government and the London Mayor have decided to raise the priority.

In September 1999, the Government decided that mental health should have the same priority as coronary heart disease in their programme of National Service Frameworks which laid down models of treatment and care which people will be entitled to expect in every part of the country. The National Service Framework for Mental Health (NSF-MH), published by the Department of Health in late 1999, set a ten-year agenda for improving mental health care in England. Subsequent policy statements and guidance, including NICE guidelines, have supplemented the Framework and added to the overall scale of the task.

In February 2011 the NSF-MH 1999 was replaced by *New Horizons: A Shared Vision for Mental Health* - a cross government programme of action to improve the mental health and well-being of the population and the quality and accessibility of services. *No health without mental health* is the Coalition Government's strategy for mental health. This strategy set out six shared objectives to improve the mental health and well-being of the nation, and to improve outcomes for people with mental health problems through high quality. One of these six objectives is that 'more people will have a positive experience of care and support'.

Patients with a mental health disorders make up approximately 9 per cent of the Service's work load, and improvements in this area have received wide spread support from patients. Although these callers make up only a small percentage of our

work, mental health calls can be time consuming for responding call takers and assessing and deciding on the disposition of calls is not always straight forward. We know that mental health is important for patients from our discussions with them in patient forums, Local Involvement Networks (LINk) and Overview and Scrutiny Committee (OSC) and patients widely support us in making improvements in this area.

## PATIENT SAFETY AND QUALITY 2011-2012

Many view quality health care as the overarching umbrella under which patient safety resides. Patient safety is the cornerstone of high-quality health care. Much of the work defining patient safety and practices that prevent harm have focused on negative outcomes of care, such as mortality and morbidity. However, we also believe that we need to focus not just on complaints, but the full range of enquiries received from patients and the public, as well as incident reports from other health and social care agencies.

The Trust is required to ensure that there are systems and processes in place to provide assurance that services they are commissioned, contracted and provide are safe and of a high standard. Good patient safety and quality systems should include the following elements as a minimum, Incident and near miss reporting , Use of information , Patient Feedback & Involvement , Complaints, concerns and compliments , Clinical Audit , Good leadership and management systems , A robust approach to organisational development , A performance management framework . Many of these systems are already in place within the trust and will be monitored throughout the coming year.

## SERIOUS INCIDENTS 2011-2012

The Serious Incident group considered four incidents regarding mental health patients. One was declared as a Serious Incidents and three were considered but found not to meet the criteria.

### *Declared Incident One (P38111)*

This incident involved a patient who was found hanging by the Metropolitan Police who contacted us for support. On investigation it was revealed that we had visited the patient twice the previous day. The incident was declared as an SI as we had been unable to link the calls and that it was considered that there were signs of serious mental health issues that were missed by staff and the organisation.

### *Undeclared Incident One (P39636)*

The incident was not considered until the 2012-2013 year but the incident occurred in 2011-2012. This was concerning a child under the age of 18years with a history of self harming behaviour by taking overdoses. There was a delay in the dispatch of an ambulance following a mental health professional call who was looking to assess the patient under the MHA (1983). Due to frustration at the delay in the dispatch of a

vehicle, the social worker reassessed the situation and cancelled the MHA assessment. The patient died the following day. The serious incident concluded that the ownership of the incident was with the employer of the social worker who reassessed the situation but we would cooperate with any investigation requirements.

*Undeclared Incident Two (53390)*

This was regarding an incorrect triage for a patient referred via the CAD link. The patient was hanging and the call was incorrectly triaged as a C3 but as our response was within 4.18 (and therefore technically responding within an A1 category) no harm fell to the patient. The learning was undertaken at a local level

Undeclared Incident Three (54310)

This incident concerned a member of the Patient Transport Team (PTS) who was assaulted by a patient from a Mental Health Trust. Whilst the incident was significant and support and learning was extended to the PTS team the incident had occurred due to the inadequate assessment by the Mental Health Trust and the lead for the incident fell to that Trust.

## COMPLAINTS

Unfortunately, it was not possible to evidence the number of PALS referrals or complaints between October 2010 and April 2012 as the case management system (Datix) does not currently have a mental health coding within it. However, Patient Experiences Department regularly seeks assistance from Kudakwashe Dimbi, our Clinical Adviser for Mental Health, in relation to clinical advice pertaining to mental health issues. This may be to respond to an incident identified by a member of staff, an external agency referral, PALS enquiries or complaints. We have also assisted Acute Trusts with reports when an external Serious Incident has been declared with NHS London. In the last 6 months since joining the trust, our Clinical Adviser for Mental Health has responded to twelve such request from the Patient experiences department.

One such incident where advise was sought from the Clinical Advisor for Mental Health related to a 79year old female, insulin dependent diabetic, BM 2.7, BP100/40 She was dehydrated and her GP who was on scene at time of the 999 call had undertaken blood tests the day before which indicated that she was in acute renal failure but she was refusing to go to hospital. An assessment was carried out under the Mental Capacity Act (2005) indicating that she was incapacitated. The crew had called the police for assistance but they declined to attend stating they had no more powers than the crew and the GP had as the patient was in their own home. The Clinical Adviser for Mental Health reviewed the incident, clarified the Mental Capacity Act (2005), Mental Health Act (1983) and what powers are available to our clinical staff when a patient who is incapacitated is in need of life saving treatment and insured that this was fed back as developmental learning.

A second incident involved a mental health patient who was unhappy with the service provided to him by the Trust. The patient had initially approached the Metropolitan Police Service about what he considerd to be the disproportionate number of police officers deployed to his house on the day of the incident. A 999 call was received in our Emergency Operations Centre at 20.48, from the patient who was expressing suicidal intention. The call handler ascertained the address and telephone number and selected protocol 25 (*Psychiatric/Abnormal behaviour/Suicide attempt*). The patient had also disclosed to the call handler that on the last occasion an ambulance crew had attended him he produced a Samurai sword. When asked if he had the Samurai sword with him, he had said no but then said that he had "*kitchen knives*".

The call hander spent one hour and five minutes on the telephone with the patient and the Quality Assurance review concludes that he acted in a sensitive and professional manner. She also informed him that we had notified the police who were also enroute to the patient's residents.

It was explained to the patient and his advocate that clearly given the apparent circumstances the situation remained potentially volatile and the police were kept informed throughout. We also confirmed that we have no influence about the number of police resources that are dispatched to any given incident and this remains solely a matter for the police .We did however clarify the information that appears to have influenced their decision on this occasion. It was also offered to the patient and his advocate the option to devise an emergency care component to his community care plan which he agreed with. Our Clinical Adviser for Mental Health took this work further liaising with the appropriate Mental Health Trust and agreed that certain information could be held on our system and matched against the patient's which would be made available to the attending ambulance staff, or alternatively arrangements can be made that contact should be established with the Mental Health Trust in the event of a 999 call being received from the patient.

## PATIENT EXPERIENCE

We always look to use any feedback we receive as a chance to learn, and so improve the service we provide to our patients. We have been receiving patient feedback through patient forums and closely working with patient representatives as well as complaints and compliments.

We completed a patient experience survey jointly with Central & North West London Mental Health Trust. The sample was patients who have used the London Ambulance Service in a mental health crisis in the Boroughs of Westminster, Brent, Kensington & Chelsea, Harrow and Hillingdon.

A total of 78 patients were interviewed over the phone about what they thought about the service they received from the London Ambulance Service and what their experiences had been, our role and our plans for the future, how they perceive us as an employer and what experience they have had of using our service. The results of the survey generally indicated that we are providing a good service with the vast majority of participants saying that they felt satisfied with the care they received from the London Ambulance Service. There however remained a small number of respondents who are dissatisfied with the service. Main areas of patient dissatisfaction appeared to be around the conduct of crew around the respondents.

An analysis of the results helped us to focus on patient satisfaction and improving the care our frontline staff give to patients with in a mental health crisis.

We have also received valuable feedback from health professionals with the main theme being frustration at delays in dispatching resources or delays in conveyance of mental health patients.

## CLINICAL AUDIT

A comprehensive audit of mental health care was also undertaken in 2011-2012 by the Clinical Audit Research Unit. Good practice was identified in this clinical audit with ambulance crews obtaining the history of the patient's presenting complaint for almost all patients. Past psychiatric and general medical history were also obtained for the large majority of patients (93% and 94% respectively). Allergies and medications were also documented for the majority of patients (80% and 78% respectively), although there was room for improvement. Whether the patient had a current Psychiatric/Community Psychiatric Nurse or Approved Social Worker was considered for just over half of patients (54%).

When assessing the patient's mental state, good practice by ambulance crews was identified when assessing the patient's condition, behaviour and ability to communicate. These assessments were conducted for 92% of patients. The patient's thoughts were sought and reported in most cases.

Areas of practice where the need for improvement was identified included the use of the capacity tool and the completion of safeguarding referrals. The capacity tool was used for just over a tenth of patients who refused a specified course of action or treatment. A safeguarding referral was not completed for any patient. It is important that ambulance crews consider completing a safeguarding referral for patients with a mental health disorder as they may be vulnerable.

## SUMMARY OF PATIENT EXPERIENCE

Overall, many areas of good practice have been identified with the majority of mental health related calls having a good outcome. There are however some areas for improvement; specifically the completion of safeguarding referrals where indicated,

and the use of the capacity tool as well as the absence of dedicated provision for mental health, making it difficult to fully meet the needs of mental health patients; for example where the needs to convey a patient having a mental health act assessment competes with the mainstay of demand.

## ACTIONS TAKEN TO IMPROVE MENTAL HEALTH CARE

All this evidence has fed into the development of a mental health action plan and the creation of the Clinical Advisor for Mental Health post. The following highlights some of the improvements made.

- The Mental Health Committee was launched in 2011 and is chaired by our Director of Health Promotion and Quality, Steve Lennox who is also a Registered Mental Nurse. The committee is responsible for driving the Trust's Mental Health Action plan and meets every 2months.
- Mental health has been a priority for the Trust since 2011 and has been specifically highlighted in the Operating Framework and appeared in our CQUIN scheme from our commissioners in 2011-2012 and our commissioners are partners on the Mental Health Committee.
- In February 2012, the Trust recruited a mental health expert, Kudakwashe Dimbi to the Clinical & Quality Directorate team to lead some of the improvement work within LAS. We believe we are the first ambulance service to appoint a Registered Mental Health Nurse specifically to an ambulance service.
- The Trust continues to progress with its involved mental health action plan. Achieved recent action points include the negotiation of appropriate care pathways that will be made available for patients who call 999 in the future. As part of the mental health action plan, Steve Lennox, Director of Health Promotion and Quality and Emma Williams have met with Directors of Nursing at all of the ten Mental Health Trusts that provide acute mental health care across London and have agreed what the pathways should be. To date, we have successfully negotiated six Appropriate Care Pathways (ACP) with mental health providers which will allow us to access their specialist mental health teams. Trusts who have signed theses agreements so far are, Barnet, Enfield & Haringay Mental Health NHS Trust , East London Foundation Trust, North East London Foundation Trust, Camden & Islington Mental Health Trust, South West London & St Georges Mental Health Trust (SWLSG) and Oxleas Mental Health Trust . Our clinical adviser for mental health continues to negotiate the remaining ACPs with the outstanding four trusts.
- Our clinical advisor for mental health has also started to work closely with the Clinical Hub staff and has been able identify gaps in knowledge. She continues to work on up-skilling the Clinical Hub to enable our advisers to offer more appropriate advice to frontline crews and patients.
- We are currently actively involved in the creation of the mental health directory of services (MH-DoS). It is hoped that the Trust will be able to access information on the DoS resulting in successful onward referrals.

- We have significantly improved our engagement with multi-agency teams with regular attendance to Metropolitan Police Service meetings, London Approved Mental Health Professional (AMHP) leads network meetings and Mental Health Trusts meetings.
- A new protocol for how we respond to calls from Approved Mental Health Professionals (AMHPS) or doctors to attend Mental Health Act assessments in the community was launched on the 20th March 2012. This protocol was agreed following a meeting held between Trust representatives, AMHPs and the Metropolitan Police Service (MPS) where concerns were raised in relation to the difficulties and inconsistencies of booking Trust vehicles to attend mental health assessments and transport requests. The aim of this protocol is to create a service that ensures privacy and dignity of the patient, improves reliability, allows us to deploy staff with the right level of competency for each individual case and ensures the safety of the patient and staff. Overall we have received positive feedback with some boroughs rating the process as "excellent" with ambulances coming within the specified response times, even earlier in some cases. The new protocol has been well received by our colleagues in Mental Health Trusts and we are continuing to receive some very positive feedback on our performance.
- In terms of education, Our Education Centre Manager, Brian Craggs is currently involved with an initiative from South London & the Maudsley Mental Health Trust to produce a training DVD with the LAS and the MPS dealing with acute behavioural disturbance/positional asphyxia, this is still work in progress. He has also completed updating the training package for the new Apprentice Paramedic course.
- A mental health e-learning package is available for Trust staff on dealing with mental health presentations. The mental health e-learning package is available for staff via "LAS LIVE", the virtual learning environment. 289 staff have completed the E-Learning Module to date. This package is currently in the process of being reviewed with a possibility of changing some of the content.
- A new Mental Health Clinical Performance Indicator was intoroduced on 1 April 2012 and has been developed in collaboration with the clinical leads in mental health.
- A Core Skills Refresher (CSR3) has been completed and currently awaiting a re-launch date. The CSR3 contains sessions on the Mental Capacity Act and a general refresher on mental disorders as per JRCALC guidelines.

## FUTURE PLANNING

In recent years, the London Ambulance Service has used additional funding made available to us to invest in staff recruitment and training and in modernising the ambulance fleet. In the year 2012-2013, Alcohol has been identified as a priority and appears as a CQUIN from our commissioners. In 2011 approximately 10% of all call outs to the London Ambulance Service in Westminster were classified as alcohol related (London Analyst Support Site provided by the CDRS).

The rate of alcohol related hospital admissions has almost doubled in the last decade in London and England. Therefore the mental health work stream will now focus attention on aspects of alcohol work.

## ALCOHOL RECOVERY CENTRE

In 2010 and 2011 Westminster City Council, the PCT and the London Ambulance Service commissioned an Alcohol Recovery Centre in Soho (SARC). The primary aim was of diversion of intoxicated patients from hospital to a safe place to sober up with access to medical care should it be needed. We aim to focus on the SARC and concentrate on health promotion, healthy choices and healthy lifestyles among the people of London, focusing particularly on those most in need, to prevent ill health and dependency.

## CRISIS PLANS

Improving links with mental health trusts to ensure that known patients are taken to familiar places as much as is reasonably possible and that accurate handovers are given to hospital staff is another key focus this year for the Trust. Work is already in progress with six Appropriate Care Pathways having been already agreed. Our goal is to have agreed crisis care pathways for LAS use with all the ten mental health trusts across London and to continue engaging with Mental Health Trusts in the provision of quality care.

## EDUCATION

The current mental health e-learning package is in the process of being reviewed. We aim to include in the revised package risk assessment case studies/scenarios and more up to date mental health information including the Mental Capacity Act (2005). We also aim to use team leader updates as an avenue for disseminating knowledge and information on current issues in mental health .

## SAFEGUARDING

Safeguarding referrals in mental health is now part of the monthly CPI and is recorded on the safeguarding dashboard that is overseen by the safeguarding committee. Improvements are already being seen but this will receive a focus of attention in 2012-2013.

## CONCLUSION

The Trust has long identified a risk that ambulance crews failing to appreciate the significance of psychiatric illnesses will lead to patients with undiagnosed mental health disorders remaining unrecognised and their illness unmanaged. The Trust has also highlighted that there is a risk of staff not recognising safeguarding indicators and therefore failing to make a timely referral for vulnerable patients and safeguarding children referrals within this patient group. The ambulance service attends patients who may or may not have received a formal diagnosis for a mental health disorder. Patients presenting with a mental health disorder, attended by the

LAS, may not all have insight into their problems, regardless of whether or not they have been formally diagnosed. This may affect whether a patient is willing to accept assessment and treatment from an ambulance crew.

Assessing and treating patients who present with a diagnosed or suspected mental health disorder is extremely challenging in the pre-hospital setting as the nature and presentation of the patient's condition will vary greatly in each case. Although some training is being provided to staff, this is limited to the speciality or related subjects e.g , self-harm, dementia, etc.

Complaints from patients with mental health problems are often the most time-consuming, one of the drivers in the Patient Experiences Department developing a close relationship with the Independent Complaints Advocacy Service. When complications do arise, they need to be thoroughly investigated and collaboration sought with external agencies as necessary. The outcomes are used as developmental learning and to inform guideline reviews. It is important to get the patient the help they require in a timely and safe manner for both our staff and the patient. This can be achieved with fully trained staff who are able to carry out risk assessments to inform their decision making and partnership working with external agencies to provide the best care to our clients.

The overriding principle is timely conveyance with trained, competent, and caring staff, to maximise better outcomes for mental health patients