VERITA

IMPROVEMENT THROUGH INVESTIGATION

A review of themes identified during the independent investigation into the care and treatment of Mr B

A report for:
Sussex Partnership NHS Foundation Trust

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1. Introduction

In 2012 NHS South of England commissioned an independent investigation into the care and treatment of a client, Mr B, after he carried out a homicide. This was in accordance with guidance published by the Department of Health in circular HSG (94) 27 (updated in June 2005): *The discharge of mentally disordered people and their continuing care in the community*. The independent investigation was conducted by Verita and the report was published by NHS South of England in February of 2103.

Sussex Partnership NHS Foundation Trust (the trust) provided Mr B with care and treatment from 2008 until the serious untoward incident in 2010.

The independent investigation noted that the services in question (Brighton and Hove Mental Health Services) had undergone several service redesigns and changes in personnel from the time of the incident to the time of the investigation. As a consequence, one recommendation of the report was to conduct a follow-up review into the new services once they had come into operation.

The independent investigation identified a number of key questions for the follow-up review. These formed the basis of the review carried out in conjunction with the trust.

- How do the new service delivery models address the challenges of difficult-to-engage, risky clients?
- How do the teams liaise and interface with each other in managing risky patients at various contact points?
- What is the quality of the clinicians' risk assessment and management?
- How effectively are MHA assessments carried out?

The objective of the follow-up review was to work with the trust to explore the themes identified in the new team structures; and to identify what, if any, further action needed to be taken. This follow-up review should be considered a snap-shot of present services at the time of the review with recommendations as to how the trust can move forward.

The follow-up review was carried out by Verita Senior consultants Geoff Brennan (the main reviewer) and Kathryn Hyde-Bales using a methodology agreed with the trust. Verita were assisted by Emma Wadey, Sussex Partnership Foundation Trust Director of Nursing Standards and Safety. In Brighton, Interim Service Director John Child, and Service Manager Fiona Blair also helped with the review and we thank them.

2. Methodology

We collected information about the themes through a current case notes review and two focus groups.

2.1 Case note review

The main reviewer conducted a notes review of current cases on the trust's electronic care planning system (eCPA). The case notes review was designed to examine how services were managing the continuing care of difficult-to-engage, risky clients. The case notes review examined this care using the themes above.

A sample of cases in the assessment and treatment service (ATS) were reviewed because the independent investigation report found that the client had remained in this service during his period of care.

Cases selected were known to be difficult to engage and with some element of risk (as was the case with Mr B). The reviewer randomly selected five cases to examine in depth of the 10 cases the ATS service provided. In reviewing cases on the eCPA, the review was able to access information as it would be available to clinical workers in daily practice. Appendix 1 shows a summary of each case review.

2.2 Focus groups

Two focus groups were held at the trust. The first was for clinicians working directly with clients, the second for service managers. The trust sent out a letter of invitation and the terms of reference for the focus groups that had been drafted by us. The trust then co-ordinated who would attend.

Seven members of staff attended the clinician focus group. Eight attended the Senior Manager's group. The focus groups were recorded and a note of the meeting was circulated to all attendees.

2.3 Individual interviews

A meeting was also held between Service Manager Fiona Blair and Geoff Brennan to identify the specifics of the new service delivery models.

2.4 Documentary review

In addition to a case note review, the reviewers reviewed a number of trust policies and other documents.

- Sussex Partnership, *Brighton and Hove services information pack* (DRAFT 30/07/2013)
- Sussex Partnership, *Health records policy*
- Sussex Partnership, *Care Programme Approach policy*

- Sussex Partnership, A*ctive engagement incorporating did not attend (DNA) management policy & procedure*
- Sussex Partnership, *Brief referral guidance for assessment & treatment service*
- Sussex Partnership, *Assessment and treatment service in Brighton and Hove referral forms*
- Sussex Partnership, Brighton and Hove Health Overview Scrutiny Committee, minutes from 28 September 2011
- Brighton and Hove Integrated Care Service, *Annual review 2012*
- Brighton and Hove Wellbeing Service, *Risk management protocol.*
- Brighton & Hove City Council, *Information sharing regarding vulnerable adults: report of the overview and scrutiny panel*, March 2012
- Wellbeing/ATS Pathway review meeting: Meeting Actions Document, 10 February 2014.

3. Trust record-keeping systems

The trust record-keeping is discussed before the main themes of the report because it is a major issue that cuts across all the themes and warrants separate consideration.

The case note review revealed several problems with the trust record-keeping systems. We highlight them below.

3.1 Different record-keeping systems in different trust services

The Wellbeing service use System 1 as their record system. Assessment and Treatment Service and the Brighton Recovery Service use another electronic system. This is the clinical information system (CIS), but in practice is always referred to as eCPA. Acute inpatient services use a separate paper record system. The approved mental health professional service who are, managed by the local authority, use the eCPA.

It is not uncommon for different organisations to have different record-keeping systems. We were concerned that the eCPA system is not accessible by all trust services. Some, such as the inpatient services, use paper-based systems. This means that clients may have a number of different records across services. The transfer of information into eCPA relies on a separate entry or on uploading 'Word' documents. This is time-consuming and leads to the obvious risk of information not being communicated.

3.2 eCPA design

The eCPA system itself is a basic system for recording CPA information (assessment, care plans, reviews and risk). The present system has an additional "Case Note" option for recording daily contact plus the ability to scan and upload paper documents. It has a risk alert function where a specific risk can be highlighted when logging into a client's notes.

In everyday use, the eCPA information itself is basic and limited. The focus groups told us it was not possible to update a risk assessment: each new entry required a new assessment. In practice, most clinical staff record important information in the case notes section where they also refer to paper documents that are scanned and uploaded. Following a patient's clinical progress entails taking time to read multiple case notes entries and often cross referencing them with scanned documents.

In examining the eCPA review, evidence we reviewed both the risk assessment sections and the detailed accounts of risk and risk management in the case notes.

3.2.1 Comment

The system is not user-friendly. The focus groups told us that putting someone from “standard CPA” (taken to mean basic entry on the computer information system to “full CPA” (taken to mean full completion of all CPA records) takes so long that it is often completed incorrectly.

While the CPA sections are often sparse, the case notes and document repository are often large, so, while clinical documentation was often good, it was hard to find.

We found that information was often duplicated and specific information, such as discharge summaries, Mental Health Act assessments or specific correspondence, could be hard to find.

The service manager focus group told us that the system did not allow for easy analysis of records for quality monitoring purposes.

The trust knows about the issues with records and is in the process of completing a tendering exercise for a new provider operating a single electronic records system across all services. This is a welcome development, but it is unclear when any new system will come on line.

3.2.2 Finding

The trust’s clinical record-keeping systems are not fit for purpose. The present system does not allow easy communication of client need, care or risk. The trust is aware of this and committed to developing new systems

3.3 Interviews and Focus Groups

The themes and findings of our eCPA review were discussed and clarified in two separate focus groups: one for clinicians and one for senior managers.

Services have been the subject of a large number of reviews and structure changes over recent years (see below). The focus group for clinical staff said that members had found the changes stressful. The group did not always agree and we have taken care to reflect issues on which most participants agreed.

3.3.1 Comment

It was clear in the clinicians’ focus group that participants had found the changes in service since 2012 stressful. It was difficult to pinpoint the nature of this stress. We felt that the stress was partially due to specific changes in individual services combined with a general sense that services were working with high demand.

4. Developing the new service delivery models: An overview of the evolution Brighton and Hove Mental Health Services 2007 – 2014

Both the independent investigation and the follow-up review concerned the nature of Brighton and Hove Mental Health Services. We outline the changes and describe services at the time of this review.

The population served by Brighton and Hove mental health services has a high level of need compared with similar populations. Some features of the area are more common in major urban populations than in seaside towns. The transient nature of the population, high levels of substance misuse and pockets of social deprivation and disability are the most noted similarities.

A common theme during this review was changes to mental health services to meet both the needs of the local population and to respond to local changes in provision.

4.1 2007-2012

Before 2007, Brighton and Hove community mental health services were in seven distinct geographical areas, each with its own Community Mental Health Team (CHMT). These were multi-disciplinary teams that received referrals and provided support to primary care services in their area.

The service changed in 2007 when the seven geographical areas became three; East Brighton, West Brighton and Central Brighton. The resulting secondary care services provided a single point of access for clusters of primary care services. Each mental health service had an Access Team to manage the interface with primary care and a separate Recovery service for clients with more severe mental health problems needing care coordination under the Care Programme Approach (CPA). Therefore, a client needing care under the Care Programme Approach would be referred from the Access Service to the Recovery Service.

Brighton services were early adopters of “Improving Access to Psychological Therapies” (IAPT) for minor to moderate mental health needs. These services were placed under the remit of the Access Team.

This model of service had systemic problems. Access teams were overloaded and had difficulties with the referral and transition of complex and high-risk clients to the Recovery service for care under CPA. These systemic problems resulted in the Access Team managing complex and difficult cases for long periods and with some cases becoming stuck in this service.

4.2 Acute Care Review

Professor Keith Wilson conducted an independent review of the acute provision, including inpatient care, in 2009. The key recommendation of the review was that the overall number of acute mental health beds could be reduced from 95 to 76 after service redesign. Twelve of this 19-bed reduction would be younger adult beds and seven would be for older adults. The Trust put the changes into effect in 2011/12 after agreement with the then PCT in 2010.

Brighton and Hove Mental Health Community services were also redesigned in 2012 in light of the problems noted above. This has not been a single change, but a series of changes. The use of the word "evolution" was used in the focus groups to describe the changes. This was explained as there being an ongoing process of both major and minor changes to the service design over the past few years.

4.3 Present services 2014

Both at focus groups and in individual meetings, it was clear that evolution was continuing. This report will now focus on describing existing the services as they were at the time of the review.

Primary care services for the area are now clustered into seven groups. These groups now interface with secondary care services through two hubs: The East Brighton Hub and the West Brighton Hub (as opposed to the three mentioned earlier).

The primary care team no longer have a single referral point to mental health services. There are three entry points, depending on the severity of the condition and the urgency of the treatment need.

The three referral points are:

- mild to moderate mental health problems referred to the Brighton and Hove Wellbeing Service
- complex mental health needs referred to Secondary Care through the hubs Assessment and Treatment services (ATS)
- urgent assessments (4 hour) referred through the acute pathway to the Brighton Urgent Referral Service (BURS) or A&E liaison service.

4.4 Mild to moderate mental health problems - Brighton and Hove Wellbeing Service

For mild to moderate mental health needs, the primary care team should make a referral to the Wellbeing Service. The Brighton and Hove Wellbeing Service is under the general management of the Brighton and Hove Integrated Care Service (BICS).

BICS is a not-for-profit company formed in 2010 that operates across a number of clinical areas, not just mental health. It operates at the interface of primary and secondary care and can deliver treatment direct from primary care referral and/or

assist in signposting and referral to relevant secondary care services. BICS developed its primary care mental health service in 2012 with the creation of the Brighton and Hove Wellbeing Service. In order to do this, BCIS entered a partnership arrangement with Mind, Sussex Partnership NHS Foundation Trust and Turning Point.

The Wellbeing Service is a primary care-based service. It includes Primary Care Mental Health Practitioners who are allocated to primary care clusters under the management of the Brighton and Hove Wellbeing Service. The Wellbeing Service also provides talking therapies and community support. The Improving Access to Psychological Therapies (IAPT) service moved from the Trust to the Wellbeing Service as part of the 2012 changes.

4.5 Complex mental health needs - Assessment and Treatment services (ATS

For more complex mental health needs, primary care teams refer clients to secondary mental health services under the management of Sussex Partnership NHS Foundation Trust, which has integrated the Assessment and Treatment service and the Recovery service since 2012. All referrals to the service are initially sent for consideration (i.e. triaged) in the Assessment team but can be allocated straight to the Recovery service for care under CPA. The need for a referral from one team to another has been removed.

4.6 Urgent assessments - Brighton Urgent Referral Service (BURS)/A&E liaison service/ Inpatient care.

The third referral point is for situations when a client needs an urgent assessment due to immediate risk or acute need. For this type of need, primary care refers to the acute mental health service through the Brighton Urgent Referral Service (BURS) or Accident and Emergency Liaison team.

BURS is a new service that came into being in 2011 after the Acute Care redesign. It aims to provide a referral route for primary care with emergency assessment of a client within four hours. It can also take a direct referral from clients. Initially, BURS operated as a stand-alone service from 8am to 8pm. In 2013 additional resources were provided to allow the BURS function to continue from 8pm and 8am. Now, as well as operating as a separate service, from 8pm to 8am BURS function is taken over by the Mental Health Liaison Team at the local A & E, supported by the additional nursing resource. The 24 hour service was retitled as the Enhanced Brighton Urgent Referral Service (EBURS). EBURS does not generally take referrals of clients already known to ATS or recovery services.

The Crisis Resolution Teams (CRT) is part of Urgent Care Services, providing intensive assistance to people in acute crisis while still at home. These teams do not take referrals from primary care, but secondary care (i.e. trust) teams can make referrals to assist in the management of urgent referrals.

Any hospital admission should initially be to Mill View Hospital, Brighton. Inpatient provision was the subject of the separate independent review in 2009, mentioned above. The trust put the changes from the review into effect in 2011/12 after agreement with the then PCT in 2010. The EBURS team was also created during this process.

4.7 Additional Services

A range of support services operate across or between these referral pathways. These services are designed for specific needs (such as eating disorder or HIV) or to provide time-limited assistance between services. These were the main services identified in focus groups or in the case note review:

- Brighton and Hove Group Treatment Service: A therapeutic, structured group treatment programme.
- Lighthouse Recovery (The Allen Centre): offers a service for those with a personality disorder.
- Transition Team: offers short-term practical support across a number of services including assisting clients with support following discharge.
- Day services are now provided by third sector organisations following re-commissioning.

These teams provide specific care and treatment to clients on a time-limited basis. The care coordinator or referral team retain overall case management responsibilities.

4.7.1 Comment

This review found that the changes in services had been taking place since the time of the initial investigation and were likely to go on for some time. Major changes of services after review and redesign are often followed by minor changes as the new models are themselves reviewed. The realignment of secondary care consultant psychiatrists with the primary care clusters to provide better support to general practitioners is an example of a minor change. Service changes indicated in the Acute Care review of 2009, such as the management of older care and the operation of the BURS service (see above), have been or are now themselves under review. We do not know how these changes were being decided and monitored by the Trust.

4.7.2 Finding

Services at the trust continue to change. The process, monitoring and tracked decision-making around this programme of change needs to be clarified by the trust.

5. Findings of the review: answering the set questions

5.1 How do the new services delivery models address the challenges of difficult to engage risky clients?

The initial investigation found that various systemic factors contributed to Mr B remaining in the then Access service while his mental state deteriorated and his risk increased. His care was contained within the then Access service when he needed assessment and CPA care coordination under the then Recovery service.

This follow-up review spent a considerable amount of time looking at how well the services as described above interfaced with each other and how they managed the flow of difficult-to-engage risky clients from one service to another. The review also examined the pathway to acute services, including inpatients. Mr B did not access these at the time of his care but clients who are difficult to engage or risky often need access to these services.

The case notes review showed evidence that clinicians were actively addressing the challenges presented by clients who were difficult to engage or risky. It also indicated a good interface between services for these clients.

In two of the five cases the client had originally been referred to the Wellbeing service and received treatment in this service. Over time however, the clients had deteriorated and a referral to ATS was needed. Three of the five clients needed a Mental Health Act assessment and a remaining case required advice from the Mental Health Act team. There was evidence in clients' records of communication of risk and previous management between services (see next section).

The five complex cases showed evidence of good practice. One client who had a recognised need and motivation to receive psychotherapy was having this provided by the trust. In addition, there was clear communication between the psychotherapist and clinical team if and when vulnerability and/or risk increased. Other clients who were refusing to see workers were written to in a sensitive and appropriate manner. A follow-up plan and monitoring were in place for one client who did not meet the Mental Health Act Section Two criteria. The records clearly highlighted when the client's situation deteriorated and risk increased. There was also evidence in the records of use of support services (e.g. the Group Treatment Service and Transition Team) in responding to direct practical needs to further engage clients.

5.1.1 Comment

It is clear that Improvements have taken place in the flow and management of difficult to engage risky clients.

Key changes that help to address the challenges of difficult-to-engage risky clients have been:

- The relocation of IAPT to the Wellbeing service. The removal of IAPT gave a clearer remit to secondary care ATS and Recovery services.

- The integration of the ATS/Recovery services. This removed the previous block in the Access / Recovery split between services and allowed a care coordinator to be appointed at the referral stage.

We learned from focus groups that the triage of referrals to ATS had improved. A dedicated lead clinician now manages triage into the ATS/Recovery service. The approach to triage is more multi-disciplinary. There are, however, a number of referrals going to the wrong part of the system from primary care. The focus groups provided data that indicated a processing of the flow of referrals to ATS triage. This processing was said to be picking up patterns of inappropriate referral and managing these. Members of the clinicians focus groups who had experience of ATS triage said that the numbers of inappropriate referrals was “less than people think”, and the example was given of the previous day’s ATS triage which had only two inappropriate referrals in a total of 40.

5.1.2 Comment

The main systemic block to the responsiveness of new services (for difficult-to-engage and risky clients) seems to be the demand rather than the design of services. Both focus groups acknowledged a shift in skills mix in the new design with the transfer of experienced and skilled workers from the then ATS/Recovery service to the Wellbeing Service. This put pressure on those workers who remained in secondary care and who did not transfer to the new Wellbeing service. With funding from the clinical commissioning group, the trust has recruited new workers to the ATS/Recovery services. These workers have capped caseloads while they develop in the service. This is understandable, but puts extra pressure on established workers. Those in the clinical focus group were keen to highlight the knock-on stress. One described this stress as “the worst I have ever known.”

The focus groups stated that the acute services were working over capacity and had problems addressing the challenges of difficult-to-engage risky clients. The clinicians’ focus group stated that primary care expects an urgent four-hour assessment through the BURS service to be available at all times. This is not always possible, particularly in the late evening and night. This expectation leads to pressure on the ATS and AMHP teams to provide alternative urgent assessments. There is also consensus in both focus groups that the operation of the BURS service needed to be reconsidered because both ATS and the Approved Mental Health Practitioner Teams are being called in to complete urgent four-hour assessments.

Focus group members noted that the recent pressure on beds meant that they were difficult to find in times of need. A further complication in practice is the policy of

completing a separate paper referral to access acute services, such as inpatient beds or Crisis Resolution.

Acute service resources are stretched to their limit and this fluctuates over time. Clinicians agree that the Acute Care review of 2009 resulted in too many bed closures, although the need for beds was recognised to fluctuate. In response, the trust made arrangements with the Clinical Commissioning Group to commission emergency beds in private healthcare and review the operation of the BURS service.

5.1.3 Conclusion

The new service delivery models are more responsive to increasing risk. They are better integrated so that difficult-to-engage or risky clients are more likely to be reviewed and referred to the appropriate service. The triage of referrals to the ATS has improved. The number of clients referred back from ATS to Wellbeing has decreased. Difficult-to-engage risky clients are more likely to be care coordinated under the new model.

There is significant resource demand on ATS and recovery services. Clinical staff are stressed by the volume of referrals and work with difficult-to-engage risky clients

Acute services are working over capacity, particularly in relation to managing urgent referrals. Acute services are also at risk of communication difficulties when transferring clients to and from their service.

5.2 How do the teams liaise and interface with each other in managing risky patients at various contact points?

The eCPA notes review found evidence of the communication of risk across services. All five cases reviewed had required a referral from one service to another. In four of the five, this referral was from Primary Care/Wellbeing services to ATS either as the client's presentation became more severe and/or greater risk was identified.

One case involved a client who had previously been seen in Child and Adolescent Mental Health Services (CAMHS) and was now eligible for adult services. The client was refusing treatment and had not left the house for several months. The risk of neglect was clearly documented and communicated from ATS to BURS. This client was not appropriate for assessment under the Mental Health Act but the AMHP team were contacted by the clinical team to provide advice to the nearest relative.

Clients in two of the cases had received or were due to receive treatment from the Wellbeing service but their condition became more severe. The records showed that this gradual increase in risk was communicated across services.

One client with a psychotic condition had needed continuing monitoring under CPA for some time and also had a past inpatient admission with follow-up from the Crisis Resolution Team. The notes made clear that the client was again becoming unwell

and refusing treatment. The client had recently been assessed for possible detention under the Mental Health Act. He was assessed as not meeting the criteria for detention. A subsequent follow-up plan and monitoring were put in place. This process was clearly documented.

All the cases were continuing and all had records of monitoring in the case notes section of eCPA as well as letters communicating issues across a variety of services. There was evidence in the records of appropriate communication to primary care teams in all five cases. This was primarily in letters to the general practitioner outlining care, which were scanned and uploaded onto the system.

Focus groups confirmed the findings of the case note review that there are systemic issues between all parts of the system and Acute services. The trust does have Electronic Discharge Summaries on ECPA, but access is limited. For some clients who have had an inpatient admission, paper discharge summaries needed to be scanned into eCPA. Delays can occur while this is done, so care coordinators sometimes update the case notes. This means a duplication of effort. There is also the possibility of key information being omitted, although this did not happen in the cases reviewed.

The focus groups acknowledged that the interface between the services had improved, though issues of capacity and demand remained. This review was also informed in the interview with the ATS service manager of a "Wellbeing/ATS pathway review meeting" where continuing clinical and procedural issues were discussed. The minutes of one such meeting on 10 February 2014 show that interface issues between the services were discussed. The minute below shows that active risk management was also discussed:

> "3.5 Managing Risk
> Agreed that it would be helpful to strengthen the protocols for managing risky behaviour and to look at whether the ATS might put in place support to help some cases be contained in primary care that are not currently. To agree how clinically [sic] responsibility might be managed in such circumstances. To look at whether any further psychiatric input and support might be helpful. To also agree process that enables at risk clients to move more quickly from Wellbeing into ATS when this is required without repeating assessments unnecessarily."

This meeting was mentioned in the focus groups as a valuable interface between the Wellbeing and ATS service. It was well attended by senior managers and clinicians from each service and discussed areas pertinent to the themes of this review. The focus groups felt that this meeting had helped build the relationship between the two teams, in discussing cases and in looking at how the teams were functioning in relation to each other. The focus groups also highlighted that many workers in the Wellbeing service had previously worked in ATS and so knew how the service operated.

5.2.1 Conclusion

The interface between services has improved but difficulties remain around demand and capacity. The eCPA shows that information is passed between services in the form of letters, uploading of key documents on eCPA and phone and face-to-face handover and review.

The Wellbeing/ATS pathway review meeting is important. It is attended by senior staff and allows a range of interface issues to be evaluated with key actions identified and pursued.

5.3 What is the quality of the clinicians' risk assessment and management?

The case notes review indicated appropriate risk assessment and management for all five clients. As noted above, clinicians complete the risk assessment section of the eCPA, but detailed outline and management of risk can be found in the case notes section of the notes. The eCPA had limited capacity to clearly record and adjust risk assessment and management entries. One of the cases also has an appropriate risk alert prominently marked on the first page of the client's eCPA records.

All five clients reviewed appeared ambivalent about receiving care but also exhibited a variety of risk to themselves and others. Three of the cases involved a clear risk of suicide or self-harm. One case included a clear risk to others and the final case involved a risk of neglect and exploitation.

Workers in all five cases were clear about the risk and risk management plans. These risks were often being managed across a range of services and letters and records of phone calls to other workers showed that risk and management were being communicated.

The focus groups reported that the trust's risk policy was under review. The risk screening and assessment tools had been updated. The trust also conducted a regular audit of risk assessments and these indicated improvements.

5.3.1 Conclusion

The clinicians' risk assessment and management were clear and appropriate to the case. Information was not always easy to find because of the nature of eCPA,

5.4 How effectively are Mental Health Act assessments carried out?

Teams of practitioners who conduct Mental Health Act assessments must include medical practitioners and Approved Mental Health Professionals (AMHPs). Mental Health Act assessments are co-ordinated across Brighton by the Approved Mental Health Professional Service (AMHPS). A representative of this service attended the focus groups.

The AMHP service is provided 24 hours a day. It is mainly covered by a core group of AMHPs. These AMHPs are full-time workers employed by the Adult Social Care teams in the local authority and seconded into the trust. They do not cover the whole rota, and trust AMHPs (whose main role is working as practitioners in the trust's community services) work on a rota base a week at a time. The AMHPS representative in the focus groups said there are issues with covering unpopular shifts, such as nights. The trust reports that a few shifts have gone uncovered. The local authority is currently undertaking a consultation with the AMHP service around 'on-call' working at night to ensure the security of this service. The AMHPs seconded from the Local Authority have access to the eCPA under their honorary contact with the Trust. The AMHP service representative in the focus group said it had also been called upon to carry out emergency assessments as a "de-facto duty team" when clients were in urgent need of assessment, but known to services and therefore outside the present remit of BURS.

In the case notes review, three clients were seen by their clinical team as needing an assessment for detention under the Mental Health Act. In one other case the AMHPS service was contacted for advice at the carer's request.

The Mental Health Act assessments for the three cases were recorded in the eCPA. The paper records were scanned and uploaded onto the system. The assessments themselves were appropriate and thorough.

In one case (already mentioned), the client was known to services and experiencing a relapse of a psychotic illness. The AMHP assessing was aware of the background and history of the case, interviewed the clients and decided with the assessing team that detention under the act was not appropriate because the client seemed willing to engage in treatment. A subsequent plan was made with the client and communicated to the care co-ordinator. The process of assessment and management of care were clearly communicated in the eCPA. The client continued to refuse treatment despite his previous reassurances and the plan broke down. The care coordinator quickly made a re-referral for a Mental Health Act assessment.

5.4.1 Conclusion

The case notes indicate that Mental Health Act Assessments were conducted and recorded appropriately.

5.5 Overall conclusion and recommendations

Brighton and Hove Mental health Services have undergone a number of major and minor service reviews since 2007. The objective of this review was to identify how effectively the themes outlined have been embedded in the resulting new team structures and services and what further action, if any, needs to be taken.

We found improvements in the flow and management of difficult-to-engage risky clients between primary care service, Wellbeing and ATS/Recovery services. The service leads of Wellbeing and ATS/Recovery services are actively discussing interface issues between services. Demand on all services continues to be high.

Doubts remain about the capacity of Acute & Urgent Care services to provide cover for emergency four-hour assessments and Mental Health Act assessment and access to inpatient beds. The trust is aware of these issues.

The note-keeping systems are not fit for purpose. Clients have separate sets of notes and not all clients are on eCPA. Clinicians have found workarounds but these can make finding information difficult. The trust is tendering to overhaul the note-keeping system but any new system will not come on line for some time.

5.6 Recommendations

The Service Director Brighton & Hove should consider a simple update on all service reviews and clearly indicate any future changes deemed necessary. This should include objectives of change, time frames, actions and responsibilities.

The Director of Nursing Standards & Safety and service managers should address the continuing problems with note-keeping across services. They should devise an interim policy for transferring information to and from acute inpatient services until the new electronic system comes on line.

Appendix A: Case note review

	Case Summary	Brighton Services Involved	MHA?	Risk Assessment	Recent communication with GP
1	Female client. In MH services over 10 years. Initially seen in CAMHS, but now being treated by adult services. Not psychotic, but complex presentation-abuse trauma, OCD and behavioural issues. Client difficult to engage and has carers who are isolated and in need of services themselves.	CAMHS BURS ATS Police (Safeguarding issue.)	**Not seen** for assessment from MHA team, but advice for carer sought, given and documented.	**Yes**. Clear evidence of communication of risk between services Risk identified as client withdrawn, housebound and at risk of neglect. Also friction within the family and need for ongoing monitoring.	**Yes**. Client resistive of engagement, but updates to GP with summary of any meaningful contact.
2	Female client. In MH services for 4 years. Initially diagnosed and treated for common mental health problems within IAPT/Wellbeing services, but emergence of more severe form of mood/behavioural problem over time.	Wellbeing/IAPT (full course of CBT) Police/MHA Inpatient services CRHT BURS ATS	**Yes** 136 assessment Sec 2	**Yes.** Clear evidence of gradual increase in risk being communicated through services. Client at risk of self-harm and impulsive behaviour.	**Yes**. From both Wellbeing/IAPT and ACT.
3	Male client In MH services for over 10 years. Diagnosis of severe and enduring psychosis. Client unwilling to engage and comply with treatment. Presentation includes anti-social behaviour and drug and alcohol misuse. Case active with evidence of acute crisis at time of review.	MHA Inpatient services Day Hospital CRHT Recovery Services Housing Support services	**Yes** Previous Sec 2 and 3. Recently assessed for possible admission under section 2, but not completed and alternative plan formulated. This plan has not succeeded and reapplication for new MHA assessment in progress.	**Yes** Clear communication between services. Client has paranoid thoughts about neighbours and has actively disengaged from treatment. Risk ongoing and being monitored.	**No** Evidence of communication previously, but unclear who clients present GP is.
4	Female Client. Relocated to Brighton from London 3 years ago. Previously in receipt of care while in London. Move not planned so some delay in transfer of care.	Wellbeing/IAPT Transition Team ATS Psychotherapy	**Not needed**.	**Yes** Clear communication between services.	**Yes**.

	Initially seen by IAPT/ Wellbeing as case seemed to involve common MH problem. As complexity of presentation became apparent, client transferred to Assessment and Treatment Service. Client had received psychotherapy in London and wished to continue. This is now being provided within Trust. Client presents ongoing challenges due to fluctuating suicidal ideation.			Close monitoring of fluctuating suicide risk.	
5	Female client. Only in services a few years. Initially managed within primary care with medication advice. Recent crisis and safeguarding concerns have led to both admission and ACT follow up.	BURS CRHT A&E Liaison Inpatient services Day Hospital ATS Police (Safeguarding concern)	**Yes** 136 Sec 2	**Yes**. Clear communication within services. Client at risk of exploitation as well as self-harm.	**Yes.** Including clear communication of safeguarding issues.