Modernising Mental Health Services

Inspection of Mental Health Services
The Social Services Inspectorate (SSI) is part of the Directorate for Children, Older People and Social Care Services in the Department of Health. SSI assists Ministers in carrying out their responsibilities for personal social services and exercises statutory powers on behalf of the Secretary of State for Health.

We have four main functions:

• to provide professional advice to Ministers and central government departments on all matters relating to the personal social services;
• to assist local government, voluntary organisations and private agencies in the planning and delivery of effective and efficient social care services;
• to run a national programme of inspection, evaluating the quality of services experienced by users and carers; and
• to monitor the implementation of Government policy for the personal social services.
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Introduction and Summary

Introduction

1.1 Modern mental health services should be responsive to the complex needs of each individual and their family. They must be safe, sound and supportive. They should promote independence and be provided equitably to people of all ethnic backgrounds. Local councils need to work closely with health and other partners across complex financial and organisational boundaries to deliver services in this way.

1.2 The environment in which mental health services have been developed has been dynamic. The introduction of the Government’s modernisation policies for both social services and mental health services has been at a time of great change. Many councils had only recently been formed following the reorganisation of Local Government. NHS provider trusts had been reorganised and the balance of power in the NHS as a whole had been shifting markedly. This inspection was carried out in 19 councils between June 2000 and September 2001, and was undertaken at an early stage in the modernisation process.

Summary

Service Users and Their Services

1.3 Much direct work with service users was valued by them. This was particularly true where work recognised their abilities as well as their needs and where it acted as a lifeline at a time of difficulty and as a passport to a range of helpful services.

1.4 In all councils, most service users expressed generally positive levels of satisfaction with the way that they were treated by staff. There were also examples of innovative services which promoted independence and positive lifestyles. These were particularly valued by their users.

1.5 There were some good examples of outreach, community support and similar services which operated flexibly and which attended to the practicalities of service users’ lives. These teams set out to rehabilitate people into their communities. Service users were very satisfied with and benefited from these services.
1.6 The majority of services, however, were not explicitly focused on rehabilitation and good practice tended to be the result of past opportunistic development. This had been stimulated and maintained by local champions rather than by more recent and strategic approaches to service development and management. Services also tended to be poorly co-ordinated and publicised.

1.7 Services generally started from a low baseline, both in terms of their quality and availability. Most councils were serving only some of their communities well. There were consistent deficits in crisis intervention, supported accommodation, assertive outreach, and in developing capacity in the independent sector. A lack of access to appropriate support outside traditional ‘office hours’ was also a concern in most councils.

Future Prospects

1.8 In some councils, the prospects for improvement from their low baseline were promising and they had begun to work effectively with their partner agencies. All councils were engaged with local health communities and other key stakeholders in joint planning and management mechanisms (Local Implementation Teams (LITS) or their equivalents) to deliver the Mental Health National Service Framework (NSF). The nature and level of that engagement varied, however, and higher levels of commitment were associated with greater levels of modernisation and better overall performance.

1.9 In some councils however, prospects for improvement were disappointing and in all councils there still remained much to be done to modernise services effectively.

1.10 Prospects were better in the few councils where both the social services and mental health services modernisation agendas were being addressed in mental health services. In most councils, attention was only being paid to the mental health services modernisation agenda, and services were being denied the benefits of the social services modernisation programme. Prospects for improvement were poorest in these councils.

1.11 It was clear that the introduction of the NSF and the arrangements for its performance management had been a strong and welcome driver for change. It had provided clarity about the service and policy outcomes to be achieved and the way to implement change locally. In some councils there was evidence that the NSF had changed the relationship between social services and health communities markedly for the better. Relationships in some areas, however, remained guarded and less productive.

Joined-up Working

1.12 Councils were also working hard to develop joint approaches to service delivery and management. Many had achieved the co-location of fieldwork
teams and some had achieved joint management arrangements at first line and senior levels. Work on the use of the flexibilities outlined in the Health Act was at an early stage, although most services were considering their use. Some had developed plans to consolidate joint working – usually in parts of services rather than in services as a whole.

1.13 In all areas, further attention needed to be given to some basic managerial issues to ensure that modernised services were safe. There were particular problems in establishing:
- clear line management and supervisory arrangements;
- new conditions of service for staff; and
- robust operational procedures for joint working.

Children’s Needs

1.14 Insufficient attention was given to identifying and managing children’s needs and working effectively with the councils’ children’s services. We had concerns about the failure to address children’s needs appropriately in most councils.

Black and Minority Ethnic Communities

1.15 Equality issues required further attention, particularly to ensure that the needs of black and minority ethnic communities were met and that services were provided in culturally competent ways.

1.16 Councils consistently had equality policies concerning workforce and service delivery, and most expected similar policies to be in place in organisations from which they commissioned services. Some councils were using national benchmarks to measure and successfully improve performance.

1.17 Even in councils with a robust general approach to equality issues, mental health services performance was poor and much remained to be done to develop culturally competent approaches to service delivery and management, particularly in joint services. There were consistent and concerning deficits in joint approaches to:
- the recommendations of the Stephen Lawrence Inquiry Report and The Race Relations (Amendment) Act (2000);
- understanding and responding to the needs of different communities;
- mapping the service workforce;
- identifying and responding to patterns of representation of different communities in different services;
• engaging black and minority ethnic community views in planning and policy development; and
• staff training and management support.

The Care Programme Approach (CPA)

1.18 CPA arrangements were poor and service users were not at their centre in most councils. The CPA was properly integrated with care management in only a few services and most fell short of arrangements specified in national guidance. Significant progress was required to ensure that coordinated care arrangements were robust and effective. Common areas where attention was needed were:
• standard setting and audit;
• involving service users;
• information systems;
• the CPA as a whole system approach to care rather than as a mechanism for managing reviews;
• ensuring holistic practice geared to rehabilitation and social inclusion;
• diversity issues;
• holistic approaches to assessment and care planning; and
• systematic and assertive approaches to identifying carers, and to assessing and reviewing their needs.

1.19 The nature and quality of risk assessment and management (including contingency planning) were the cause of concern in many councils.

1.20 Services also appeared unwilling to identify and learn either from best practice elsewhere or from national guidance.

1.21 There were, none the less, some individual examples of sound assessment and care planning, and some very sensitive work in respect of equality issues.

Planning and Performance Management

1.22 Planning in all councils was firmly focused on the implementation of the Mental Health NSF. Further work was required to ensure that planning and management also contained a social services modernisation (particularly a commissioning and performance management) focus. Plans generally failed to address:
• significant areas of services, including the independent sector and wider council and health services (including education, learning disability and housing);
• market management strategies; and
• the promotion of social inclusion and independence through rehabilitation.

1.23 Performance management was significantly underdeveloped in mental health services. Very few councils expected mental health services to be subject to performance review. Service reviews were therefore very poorly developed and in most councils had not happened.

1.24 Few councils had ensured that mental health services were explicitly linked to corporate performance plans and many services were without performance targets. Some individual services had developed business (or similar) plans, but most had done this in isolation from the aims and objectives of the wider mental health service and from those of the council as a whole. Similarly, some mental health services had developed business plans but these tended not to incorporate national social care or local council objectives.

1.25 Services overall were better where more of the elements of performance management were in place and where they were co-ordinated. Mental health services were a long way from being able to demonstrate that they were engaged in a process of continuous improvement.

Factors found to Promote Modernisation

- Clear and credible leadership with visible and active support of senior managers
- A known and understood joint vision
- Engagement in focused planning and implementation structures which include representation from all stakeholders
- Addressing basic management issues in joint services such as conditions of service and line management and supervisory arrangements
- Effective representation of wider social services responsibilities in planning (particularly child care responsibilities) and ensuring that arrangements discharge them safely
- Application of performance management regimes
- Services and care practice which place service users at their centre and which promote independence
- Valuing diversity (particularly promoting culturally competent services)
- Robust and evidence based approaches to risk assessment and management.
- A commissioning approach applied to all relevant services; including a focus on cost and effective market management of mental health services as a whole
- Clear responsibility for co-ordinated care arrangements and a whole system approach which is performance managed
Policy Context

1.26 The Mental Health Act (1983) and the National Health Service and Community Care Act (1990) had been the main focus for councils in the discharge of their statutory duties in respect of adults who experienced difficulties with their mental health. These had been complemented by guidance from the Department of Health concerning joint agency planning and working, particularly with health services commissioners and providers and also with other relevant agencies.


1.28 The Government’s expectations of health and social services in working with adults with mental health problems were set out in some detail in:

- *Modernising Mental Health Services* (1998);
- *National Priorities Guidance* (1998);
- *Mental Health National Service Framework* (1999);
- *Effective Care Co-ordination in Mental Health Services* (1999);
- *The NHS Plan* (2000); and

1.29 The National Service Framework placed particular emphasis on:

- the delivery of high quality treatment and care which is known to be effective;
- the needs of adults from black and minority ethnic communities and other groups who are known to be particularly disadvantaged;
- services being well suited to those who use them and non-discriminatory;
- services being accessible so that help is available when and where it is needed;
- the effective co-ordination of services from different agencies; and
- the empowerment and support of staff.

1.30 The National Service Framework also:

- set national standards and defined service models for promoting mental health and treating mental illness;
- put in place underpinning programmes to support local delivery; and
- established milestones and performance indicators against which progress within agreed timescales will be measured.
1.31 Further guidelines had also been produced concerning service models and approaches to planning, workforce development and public health.

1.32 This policy framework placed the responsibility on social services (either as lead or as partner) to provide or commission services which are:

1.33 This involves promoting independence, providing services consistently and equitably, and putting service users at the centre of care systems on.

### Reading the Remainder of this Report

1.34 This chapter outlined the policy context of this inspection and summarised its findings.

1.35 Chapter 2 provides a checklist of key issues to help councils to audit their mental health services and to assist in comparing their performance with that found nationally as they pursue modernisation.

1.36 Chapters 3 to 6 report and evaluate inspection findings. The themes are:

- users and their services;
- the needs of black and minority ethnic communities;
- co-ordinated care arrangements; and
- future prospects.

1.37 Appendix A sets out the standards and criteria used in all councils to evaluate performance, and Appendices B and C outline the methods we used, the Inspection Design Team and people we consulted.

1.38 Appendix D states where the inspections took place and from where the individual local inspection reports can be obtained.
Improving Services

2.1 This chapter consists of a checklist of key issues identified by inspections. It is intended to help councillors and managers to audit their mental health services, and to assist in comparing their performance with that found nationally as they modernise mental health services.

Checklist

2.2 How can you be sure that service users are satisfied with services and that your staff treat them with respect?

2.3 Do your services promote autonomy and positive lifestyles; do they attend to meaningful occupation, rehabilitation, social inclusion and the practicalities of everyday life?

2.4 Does the supply of services match demand for them?

2.5 Are service users positively engaged in care processes?

2.6 Are you developing services which match the models contained in national guidelines and which are known to be effective?

The Needs of Black and Minority Ethnic Communities

2.7 Do your staff and managers understand the particular needs of the members of your black and minority ethnic communities, and are they responding to them in culturally competent ways?

2.8 Do you know the nature of the communities you serve and how they understand mental ill health?

2.9 Are your services culturally competent; do your staff and managers understand the issues associated with culture and mental ill health, and do they have the skills to act on that understanding?

2.10 Are you using nationally recognised benchmarks and guidance to evaluate and improve performance?

2.11 Do you have a robust and common approach to diversity issues?
2.12 Are you consulting with black and minority ethnic communities in developing your plans?

Co-ordinated Care Arrangements

2.13 Does the Care Programme Approach (CPA) equate to care management for people with mental health problems in your service?

2.14 Do your CPA arrangements:
   • constitute a systematic approach to care as a whole or are they focused on reviews?
   • place service users at their centre?
   • effectively address standard setting and audit?
   • incorporate consistent, evidence-based and robust approaches to the assessment and management of risk?

2.15 Do you have joint information systems with your health partners, and are they rationalised and modernised?

2.16 Do you have a systematic approach to the identification of carers (including young carers) and the assessment of their needs?

Looking to the Future

2.17 Are you an active partner with health and other key stakeholders in implementing the NSF?

2.18 Is there effective representation in planning mechanisms of service users, carers, the independent sector, and black and minority ethnic communities?

2.19 Are you consulting effectively with your black and minority ethnic communities?

2.20 In developing joint working and joint management arrangements with health partners, are you attending to:
   • operational policies for teams and individual services?
   • employment terms and conditions for staff and managers?
   • policies on complaints?
   • line management and supervisory arrangements?

2.21 Are you addressing both mental health and social services modernisation agendas in mental health services; in particular, do you have an appropriate emphasis on:
• commissioning (including market management and attention to costs and continuous improvement)?
• performance management?
• promoting independence?

2.22 Are relationships between mental health services and children’s services sufficiently robust to ensure that:
• the needs of children are identified and managed appropriately?
• parents with mental health problems have their needs identified and are supported through child care processes as partners?
Context

3.1 Two key central themes of policy are that mental health services should:
- be shaped around the needs and wishes of their users; and
- safely promote service users’ autonomy.

3.2 There are also specific requirements in the Mental Health National Service Framework (NSF) to have or to be developing:
- appropriate services available to users who require them, 24 hours a day;
- assertive outreach; and
- crisis support.

3.3 The wishes of service users have been well researched and publicised. These include services:
- having credibility in the eyes of service users;
- being reliable;
- helping with the practicalities of life; and
- acting as stepping stones to social inclusion and an ordinary life, not as a gateway to social exclusion and a poor quality of life.

3.4 We hoped to find a good range of services which treated their users with respect as equal partners, which were clearly focused on their needs and which were safely promoting their autonomy.

The National Picture

3.5 Over 500 people on social services fieldworkers’ caseloads responded to our postal questionnaire. In addition, we interviewed over 300 service users, either individually or in groups, without staff being present.

3.6 The majority of service users who responded to the survey were satisfied with the way they were treated by staff and found them to be approachable, reliable and well informed (see Table 1 over).
Table 1: Service users who responded positively about social services staff

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<tr>
<th>Service</th>
<th>Always(%)</th>
<th>Usually(%)</th>
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<tr>
<td>Do staff treat you with courtesy and respect?</td>
<td>59</td>
<td>24</td>
</tr>
<tr>
<td>Do staff seem to be well informed?</td>
<td>43</td>
<td>33</td>
</tr>
<tr>
<td>Are staff reliable?</td>
<td>45</td>
<td>29</td>
</tr>
<tr>
<td>Are staff easy to talk to?</td>
<td>50</td>
<td>27</td>
</tr>
<tr>
<td>Do staff listen to you?</td>
<td>50</td>
<td>29</td>
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Source: Social Services Inspectorate survey of service users, 2000-01

3.7 There were wide variations in the levels of satisfaction and dissatisfaction between councils. In one council, 90 per cent of service users expressed satisfaction with the way they were approached and treated by staff, while in another only 50 per cent were of the same view. Levels of satisfaction were highest in a council which had developed and implemented a customer service strategy and in another which had conducted a Best Value Review.

**Good Practice**

**Customer Service**

Enfield council had launched a customer service policy in autumn 2000. Fifteen customer commitment leaflets for services across the council were developed, including two for the social services group. Two policy documents were also produced: one for the council and the other for customers of the council.

A further leaflet *Better care. Higher standards charter – Improving services for adults and carers who need care and support in Enfield* was published jointly with the Health Authority in summer 2000. This leaflet detailed the values and priorities underpinning the charter which included treating people with courtesy, honesty and respecting their dignity.

3.8 Service users’ comments in the survey and in interviews included:

*Well of course I am still quite depressed and feel awful at times but I know that if things go wrong I can rely on my social worker. Out of all the people involved in my case it is my social worker who is the best.* (Hammersmith and Fulham)

*My social worker is very reliable and treats me like an equal human being.* (Bedfordshire)

*My social worker’s approach to me has been understanding, objective and most importantly non-patronising.* (Reading)
3.9 We asked service users if they were given choices about services and service responses, and if they were involved in service evaluation. Only 66 per cent reported that they were offered choice and only 36 per cent said that they were involved in service evaluation.

3.10 In interviews with service users, we asked them if staff had asked them how they wished to be addressed. Few service users said that they had been asked and many reported that they wished to be addressed in ways which, in their communities, conveyed more respect.

3.11 It was clear that fieldworkers and other service staff regarded reliability, courtesy and respect as important aspects of their professional practice and culture. With few exceptions, they were not supported in practising in this way by policy or procedure, and specifically focused management attention was poor. In this sense good practice was permitted but not encouraged.

3.12 Where customer service is left as a professional ethic then the underlying inequalities in the relationship between service users and service staff are reinforced and equality in relationships is harder to achieve. A failure to attend to customer care was clearly associated with lower levels of service user satisfaction.

Promoting Autonomy and Positive Lifestyles

3.13 There was a reasonable range of services in all councils. Those which were most highly valued by service users were those which attended to:

• the practicalities and realities of everyday life — including accommodation, finance and budgeting;
• daily life being meaningful; and
• rehabilitation and social reintegration — including personal and interpersonal skills.

3.14 Almost without exception, services expressed a strong commitment to promoting independence and we found some good examples in most councils where this had been achieved effectively.

3.15 Similarly, there was a good general emphasis in most mental health services on attending to the practicalities of everyday life. Performance was best where services also supported service users in ordinary community facilities such as education and leisure to promote autonomy.

3.16 Most councils had services which focused on people with the highest level of needs and engaged with them in long term support — these tended to be specialist community support teams. Most councils also had services which could be deployed in the shorter term — these were generally unqualified social work staff deployed in community mental health teams.
Good Practice

Promoting Autonomy and Positive Lifestyles

In Hammersmith and Fulham, a specialist independent sector domiciliary support service had recently been re-commissioned for people on the Care Programme Approach. This service attended to the practicalities of users’ lives and could work alongside them in cooking, cleaning, budgeting, personal care and gardening.

There were also two workers who prevented hospital admission by concentrating on accommodation and welfare benefits.

In Bedfordshire, the Community Outreach Team focused explicitly and effectively on the quality of life of its service users. It proactively attended to practicalities such as finance and actively promoted independence.

In Dudley, a needs-led community support service worked flexibly to help maintain and rehabilitate users in the community, including people living in residential care. It provided flexible responses to meeting daily living needs, setting up a new home, accessing services, and leisure and educational facilities.

In Leicester, both the Case Management and Intensive Community Support Teams attended to the practicalities of service users’ lives. The latter team had a published and monitored aim to “... assist service users to establish themselves in independent accommodation, to maintain that independence and to experience a quality of life that they find acceptable.”

Some councils also had specialist day services to focus on rehabilitation.

Good Practice

Day Services

In Southend, the Queensway Activity Centre was a multi-user group day service located in the centre of the borough. It offered tailored packages of training and support from a wide range of rehabilitative areas. These included life and social skills, community living skills, assertiveness, anxiety management and leisure.

The Centre was well connected with local educational establishments and voluntary organisations, and was developing services outside traditional opening hours.

All of these services were consistently praised by their service users and there was much good work to help service users to maintain or achieve acceptable lifestyles and to remain in their communities. Performance was best when services had clear rehabilitative aims and goals concerning lifestyle or quality of life and where performance was managed.
When such services were not available, the lives of many service users revolved around the use of specialist mental health services and their main daily contacts were with other users of these services. Many reported that their lives lacked stimulation and a sense of inclusion in their communities. Mental health services as a whole were a long way from demonstrating that they were effective in promoting social inclusion and positive lifestyles for all their users.

**Employment**

Some services contained or had access to employment schemes. These included services which provided:

- sheltered employment;
- skills training; and
- support in open employment.

These schemes had been developed in both health and social services and many contained explicit rehabilitative aims. They were consistently valued highly by their service users and were the subject of much praise especially for their direct assistance in achieving social integration and meaningful occupation.

Performance was best in services that had included people with mental health problems in New Deal and Welfare to Work initiatives.

**Good Practice**

**Employment Schemes**

In Harrow, two employment services emphasised a welfare-to-work approach based on flexible options and individual support. One had developed detailed personal development plans and could identify service users who had graduated to suitable jobs.

In Leicester, a Local Exchange Trading Scheme (LETS) had been established in the west of the city. At the time of the inspection there were 30 members involved in buying and selling practical services through a time bank rather than through the use of money. This service was being developed by a core group of service users with the assistance of a paid co-ordinator. The overall aim was to enable people to move into meaningful occupations and, where possible, paid employment.

In Dudley, an employment service had been established in 1999, funded through joint finance to develop opportunities for people who were ‘work ready’ to gain open paid employment and financial independence. This included training and work preparation, job tasters and work...
experience, and support in obtaining and retaining paid employment. A number of social firms had also been developed as part of this project and plans were in hand to access New Deal and European Social Fund Moneys for further developments.

In Leeds, in 1997, social services and MIND organised a conference on employment. This resulted in the formation of an employment consortium comprising representatives from the health authority, the community trust, a local college, the employment service, social services, the voluntary sector and two service users. A co-ordinator from the consortium had been appointed and a strategy and action plan developed.

The project expected to employ two service users as trainers to work with employers. The aim was to encourage the introduction of ‘reasonable adjustments’ in the workplace under the Disability Discrimination Act 1995.

3.23 Performance was best where services were:

• training or retraining in specific skills for employment;
• addressing interpersonal and ‘social’ workplace issues;
• working closely with employers and employees to prepare individual placements;
• working closely with employers’ organisations to ‘open’ and support the local employment market; and
• offering continuing support to both employee and employer.

Supported Accommodation

3.24 Supported accommodation was also highly valued by service users. Levels of such accommodation and its quality varied considerably between councils and in all there were insufficient levels to meet demand. Performance was best in councils which had started to develop schemes earlier using moneys available through past government initiatives (for example Joint Finance and Mental Illness Specific Grants (MISGs)) and who were more actively engaged in the current ‘Supporting People’ initiative.

Out of Hours Services

3.25 Most services were open only during normal office hours. All councils had some services which were available outside these times. This mostly involved day services extending their hours into some evenings and/or weekends. Where this was done it was appreciated by service users.
3.26 Most community support and assertive outreach services regularly undertook planned work during the evenings, at weekends and on bank holidays. This was again appreciated by service users.

3.27 Some services, however, had achieved opening outside traditional hours only at the expense of services during traditional hours. For example, a service might have started operating on Saturday mornings but was now closed on Tuesday afternoons. Where this occurred it was the cause of great dissatisfaction.

3.28 In most councils the main service available for unplanned work was an emergency service offering Approved Social Work assessments usually through an emergency duty team. As Figure 1 shows, only 45 per cent of the fieldworkers who responded to our questionnaire considered emergency out of hours arrangements to be either good or very good. Councils had a long way to go before they could show that people on the CPA had ready access to appropriate services.

Figure 1: Fieldworkers’ views of emergency out of hours arrangements

Not Stated 13%

Poor/Very Poor 13%

Average 29%

Very Good/Good 45%

Total Respondents= 412
Source: Social Services Inspectorate Survey of Fieldworkers – 2000-01

3.29 Practice was variable, however, and in some councils specialist advice and counselling were available or planned. All councils were addressing the development of ‘24 hour access’ in their NSF Implementation Plans.

Crisis Intervention

3.30 In addition to social services emergency teams, in some councils Community Psychiatric Nurses (CPNs) also provided emergency cover. In these cases this service appeared to be poorly advertised and in one council social workers were not aware of it.
Some councils had, however, developed crisis intervention teams and in one this was complemented by a befriending/advocacy service commissioned from an independent sector organisation.

All councils were addressing the development of crisis intervention mostly using models acknowledged nationally to be successful.

### Assertive Outreach

Most councils operated or contributed to an assertive outreach service for some if not all of their communities. Progress was slower in those councils relating to multiple health services trusts.

These teams were well focused on people with severe and persistent mental health problems who had previously had difficulty in maintaining consistent contact with the services they needed.

All councils had plans to ensure that their assertive outreach services were properly developed according to models which were nationally agreed to be effective. In some areas, however, the local understanding of the nature, role and function of assertive outreach was significantly underdeveloped and bore little resemblance to those which underpinned national models.

**Good Practice**

**Assertive Outreach**

In developing an assertive outreach service Bedfordshire was building on the experience and expertise of an already existing social services outreach team. Nationally accepted models were being used to ensure that developments were both evidence-based and tailored to local needs.

Performance, as with community support team functions, was better in areas which had developed similar long-term engagement functions (for example care management teams) in the late 1980s using MISG and Joint Finance. Councils needed to ensure that models of service in the national guidelines were properly considered in NSF implementation.

### Services for Carers

In our survey, only 31 per cent of the 264 carers who replied said that they had received services to support them in their caring role.

There were generic carers’ centres, mostly in the independent sector, some of which had specialist workers or services for mental health and (to a lesser extent) young carers. Where these centres existed they were highly regarded.
Good Practice

Carers’ Services

In Leicester, a joint initiative between the National Schizophrenia Fellowship and the Sainsbury Centre for Mental Health had established a ‘Carers Education Support Project’. This was supported fully by local key agencies and was providing a robust education and support programme for carers. Similar schemes were run in Bedfordshire and other councils and carers who were involved in such schemes reported high levels of satisfaction and positive outcomes for themselves and those for whom they provided care.

3.39 Many NSF implementation plans included attention to the development of services for carers.

Service Users – Experiences of Care Planning

3.40 The requirement to modernise co-ordinated care arrangements offered mental health services a further opportunity to place service users at the centre of care processes. This should have ensured that service users were able to make full and meaningful contributions to key decision-making processes – particularly assessment and care planning activity undertaken on their behalf.

In order to achieve this, services must pay close attention to the management of key meetings in care pathways, particularly their:

• location;
• timing;
• language used;
• recording; and
• format.

3.41 Systematic attention was also required to be given to properly supporting service users, including pre-meeting preparation, support during meetings and debriefing.

3.42 Some CPA policies recognised this and contained strong statements about placing service users at the centre of co-ordinated care arrangements. Few, however, provided guidance or training about how to achieve this and performance depended upon the stance taken by individual workers or, occasionally, teams.
3.43 Only 39 per cent of service users in our survey said that they were always invited to care planning meetings although a further 21 per cent said that this usually happened. Thirty-five per cent reported that they were either never or sometimes invited.

3.44 Only half of the service users in the survey reported that they had at some time been told that they could have the support of a friend or advocate at meetings.

3.45 The difficulties posed to service users by care processes included:
   • use of professional jargon which was not explained to them in terms they could understand;
   • the use of clinical settings where there were large numbers of professionals present who were not known to the service user;
   • having to wait outside the meeting room while professionals held a ‘pre-meeting’ about them;
   • receiving copies of revised care plans through the post following meetings they were not aware of;
   • assessments only being conducted in team bases; and
   • meetings focusing exclusively on past risk behaviour.

3.46 Conversely, some service users with complex needs and in vulnerable situations were receiving services but were not aware of any assessment or care plan.

3.47 Our examination of case records found that only:
   • 62 per cent of assessments recorded service users views;
   • 17 per cent of assessments were copied to service users;
   • 18 per cent of care plans recorded service users’ agreement or disagreement;
   • 23 per cent of care plans were copied to service users; and
   • 61 per cent of reviews involved the service user.

3.48 Councils were a long way from being able to demonstrate that service users were supported through CPA processes or were involved meaningfully in building their care plans.

3.49 This chapter has looked at the experience of service users and some of the services they use.

3.50 The next chapter looks at how services ensured that the needs of their black and minority ethnic communities were met and the service provided to do this.
What was now required for all services was that users and carers should have good access to services appropriate to their needs. This required good quality holistic assessment and care planning. This is addressed in Chapter 5.

**Key Messages**

3.52 Most service users felt that they were treated with courtesy and respect by staff who they regarded as being well informed and reliable.

3.53 Many services actively promoted autonomy and positive lifestyles. These services were especially appreciated by their users. Those which were the most successful attended to:
- meaningful occupation;
- rehabilitation and social integration; and
- the practicalities of everyday life.

3.54 Further efforts were required to ensure that these approaches were systematic and were supported by policy, and that the supply of these services was sufficient to meet needs.

3.55 Greater attention was needed to ensure that service users were positively engaged in care processes.

3.56 Mental health services were actively developing crisis intervention, assertive outreach and other required services outside traditional office hours; greater efforts were necessary to ensure that services developed in accordance with models understood nationally to be effective.
Black and Minority Ethnic Communities

4

Context

4.1 It has been understood for some time that black and minority ethnic groups along with other minority groups (for example those defined by their sexual orientation), experience particularly acute difficulties in their relationships with mental health services. This has included different patterns of representation of different communities in different types and models of service.

4.2 The Mental Health National Service Framework (NSF) paid particular attention to the equalities agenda for mental health services, and the Report of the Stephen Lawrence Inquiry and the Race Relations (Amendment) Act have further raised the profile of black and minority ethnic groups.

4.3 We hoped to find services which valued the diversity of the communities they served and that ensured that access and treatment were equitable, particularly for black and minority ethnic communities.

The National Picture

4.4 The approach of councils to equalities and their actual performance varied considerably. Strategy and services tended to be better in councils with larger black and minority ethnic communities but there was no clear correlation. The position was extremely poor in councils which relied almost entirely on the professionalism of their front-line staff. It was worse where social services equalities policies and initiatives had not been implemented in joint services. The key factors associated with good performance were:

- strong political ownership and scrutiny;
- strong policies containing standards and targets covering both personnel and service delivery issues;
- the performance management of those objectives in mental health services (in both in-house and commissioned services);
- good levels of representation of black and minority ethnic community perspectives (informed by an understanding of mental health issues) in joint service planning;
- the use of nationally recognised benchmarks and guidance such as the

- good managerial support (including training and inter-agency problem solving) for front-line workers; and

- the existence of services which understood the specific disadvantages experienced by members of black and minority ethnic communities in mental health service systems and which had the ability to act on that understanding to address those disadvantages.

None of these elements on their own was sufficient to ensure that the needs of black and minority ethnic communities were met and that services were acting in culturally competent ways. However, the better performing services possessed more of the characteristics than the poorer performers.

**Strategy**

4.6 For councils to value diversity and to attend to the needs of their black and minority ethnic communities they require clear and strong strategic ownership. We found that levels varied considerably. In the most effective councils this commitment was high and evident in corporate plans and objectives. It was also evident in some political scrutiny structures.

4.7 Most councils were using the Commission for Racial Equality standards to set targets for future development. Again, the levels councils regarded themselves to have achieved and the levels at which the targets were set varied considerably. There was, however, good practice here.

**Good Practice**

**Strategic Approaches to Racial Equality**

Hammersmith and Fulham had developed specific corporate and departmental project management groups comprising senior managers and black staff. These groups had developed action plans to achieve CRE level 4 status and integrated the Stephen Lawrence Inquiry Report recommendations. Agreed actions included:

- building racial equality objectives into the job descriptions and performance indicators for managers;

- developing progress reports for managers and councillors;

- the publication of policies and achievements; and
• the development of an approved list of external suppliers based upon their compliance with equality requirements.

Bedfordshire Health Authority had produced an accessible equalities ‘Toolkit’. This allowed managers to readily audit care pathways, and their organisations to ensure cultural competence.

Dudley Council required departments to produce equal opportunities action plans, which were the subject of scrutiny by a lead member for equal opportunities. Key issues which required attention were responses to the Stephen Lawrence Inquiry Report as an integral part of Best Value Reviews. Monitoring of the implementation of plans was the responsibility of a departmental steering group, which included senior representation from all the divisions of the social services department and the Black Workers Forum.

4.8 In some councils, corporate targets were reflected in social services plans but they were rarely seen in mental health services plans. In most cases, therefore, they remained aspirational in mental health services.

4.9 Furthermore, progress on joint (rather than unilateral) approaches to equality issues were considerably less well advanced. We found that there was an informal ‘division of labour’ under which equality and diversity issues were regarded as being the business of social services and not of the service as a whole. This tendency was seen at all levels, from the allocation of cases in community teams to strategic planning.

4.10 As a result, the approach to equality issues in joint planning was not good and the needs of black and minority ethnic communities were not well addressed in key strategies. Even in councils with a robust general approach there was a tendency for good practice not to continue in the new joint services unless specific attention was paid to it in transitional arrangements. There was a risk of joint services becoming less rather than more culturally competent.

4.11 What was lacking in mental health strategy formulation was a robust joint understanding of:

• the actual contemporary demography of the populations they served;
• how different cultures regard mental ill health and the impact of this on their needs; and
• the way services should be planned and delivered to accommodate these understandings.

Mapping Representation in Services

4.12 Few councils had mapped the representation of black and minority ethnic communities in their own or in joint services.
4.13 The recording of ethnicity in care management/CPA activity was satisfactory in only 67 per cent of the case files we examined. Most councils were attending to this in their adult service as a whole, but there was great uncertainty about the ability of newly emerging joint CPA monitoring systems to capture this information. Most new information systems were able to capture ethnicity in referrals but few were able to map ethnicity in care pathways beyond that point.

4.14 Ethnicity was, however, generally recorded in systems developed to monitor activity under the Mental Health Act (1983). Here there were some examples of information produced regularly which highlighted patterns of representation and (to a lesser extent) outcomes. This did not, however, receive proper managerial attention and was not used as a part of a wider mapping of representation or other strategic planning activity.

4.15 Many councils required that the services they directly provided and those that they commissioned should record the ethnicity of their service users. Indeed, many services reported that they recorded such information, whether it was required or not, as part of their individual approaches to business planning. Again, however, this information was not used strategically for the purposes of mapping representation or for planning and commissioning more generally. There was, however, some good practice in this area.

**Good Practice**

**Community Profiling**

Leeds Council had established Community Involvement Teams in each of its primary care localities. These teams were working alongside the Sainsbury Centre for Mental Health to produce locality profiles.

**Representation in Planning and Development**

4.16 There was some representation of black and minority ethnic perspectives in key joint planning groups and this tended to be through members of specialist independent sector services. Generally:

- it was not clear whether members were representing black and minority ethnic communities or the independent sector or both;
- infrastructures to assure effective consultation to underpin representation were not robust; and
- representatives tended to be of junior status compared to the representatives of the main agencies.

4.17 These factors severely inhibited mental health services’ ability to learn
effectively and to ensure that they were:
• consulting with black and minority ethnic communities; and
• using specialist knowledge of the interface between culture and mental health.

Workforce Profiling

4.18 There was a similar picture in respect of councils’ performance in profiling their workforce. The NSF required that mental health services’ workforce profiles should ‘match’ those of the communities they served and that strategies should be in place to achieve this. Performance in this area was generally poor.

4.19 Most councils were monitoring new appointments but few had surveyed their workforce as a whole. As a result, profiles were generally partial.

4.20 Some social services mental health services had, however, profiled their own mental health services’ workforce and had developed strategies to match them to their communities. Good examples of this were in Leicester and in Hammersmith and Fulham.

4.21 What was missing consistently was a whole service approach across health and social services, and there was no profiling in jointly located or managed services.

Sensitivity of Services

4.22 There were specialist services in most councils, particularly but not exclusively in those with larger black and minority ethnic communities. There were also specific sessions in mainstream social services (usually in day services) tailored to the needs of black and minority ethnic communities. The majority of specialist services, however, tended to be small organisations in the independent sector, staffed and managed by members of black and minority ethnic communities. This reliance on the independent sector existed irrespective of the size of councils or the size of the black and minority ethnic communities they served.

Good Practice

Specialist Services

The Reading Mental Health Resource Centre provided an outreach service to Asian and African Caribbean communities.

In Dudley, the Saqoon Project provided specialist advocacy and support. It had been established in response to concerns voiced in Asian communities about the accessibility of mainstream services.
In Enfield, the Ebony People’s Association supported black service users, carers and families, and promoted a better understanding of mental health issues in African Caribbean communities.

4.23 These services tended to have been developed as a result of particular local initiatives undertaken by local black and minority ethnic communities or (more usually) by black and minority ethnic social services front-line staff. What was lacking was an alignment of specialist services to an overarching population needs assessment and an overall service strategy.

4.24 Being in the independent sector was also experienced as something of a mixed blessing by services. We found that there were clear benefits, including easier access for users, who regard mainstream services as being ‘white’, and the ability to change quickly in response to changes in need.

4.25 We also found that there were disadvantages, including:
- financial uncertainty and the inability to plan for the medium to long term;
- difficulties in securing sufficient managerial and other support infrastructures;
- a tendency for mainstream services to refer service users on the basis of their ethnicity rather than on the basis of need; and
- a lack of opportunity to learn good business and managerial practice from peers.

4.26 There were also clear potential disadvantages for councils and mental health services where specialist services are commissioned rather than directly provided. These included:
- a reduced ability for mainstream services to learn about culturally sensitive practice; and
- the need to establish and maintain mechanisms separate from line management arrangements to ensure that management and planning were properly informed by specialist black and minority ethnic operational perspectives and realities.

4.27 These services also had a unique understanding of the nature of the communities in which they operated and unless they were specifically consulted this understanding was lost to strategy formulation.

4.28 Performance was best where the creative tension between the independent sector and social services was recognised and managed. In these situations independent sector organisations were:
• properly supported by ‘liaison’ officers in social services;
• properly consulted and involved in strategic planning;
• clear about what perspectives they were representing; and
• had effective mechanisms for ensuring that their unique perspectives were properly integrated into strategic planning.

Fieldwork

4.29 There was a good quality specialist black and minority ethnic fieldwork service in Bedfordshire, located within an outreach service. Generally, however, fieldwork was delivered through non-specialist fieldwork teams.

4.30 Fieldworkers in all councils consistently expressed high levels of commitment to attend to issues of equality and there were many individual examples of excellent anti-discriminatory or anti-oppressive practice. However, care practice generally was far less positive. (This is discussed more fully in the next chapter.)

4.31 Most councils offered staff training in equality issues; for example in cultural awareness or valuing diversity or anti-oppressive practice, and much of this training was of good quality.

| Good Practice |
| Training |
| In Leicester there was a wide range of equalities training to support black staff and promote good service delivery. This included a rolling programme of workshops focusing on the Stephen Lawrence Inquiry Report. |

4.32 However, training was not mandatory and, as Figure 2 shows, fieldworkers reported low levels of uptake.
Furthermore, it appeared that when training had been received, then this had been part of a professional qualification or Approved Social Work (ASW) course rather than within a service-wide approach to workforce planning and staff development.

**Key Messages**

4.34 There were serious deficiencies in common, service-wide approaches to diversity issues. There was a danger that culturally competent approaches developed by councils might not be replicated in the development of joint services.

4.35 Many services needed significantly to develop:
- their understanding of the needs of black and minority ethnic communities in mental health services; and
- their response to those needs.

4.36 Services were best where they:
- knew the nature of the communities they served;
- understood the issues associated with culture and mental ill health, and had the skills to act on that understanding;
- engaged their black and minority ethnic communities; and
- used nationally recognised benchmarks and guidance.

4.37 Urgent attention was required to ensure that all staff, managers and care pathways were culturally competent.
Co-ordinated Care

5

Context

5.1 The Care Programme Approach (CPA) was introduced in 1990-91 as a systematic approach to care for mental health services across health and social services. Care management was introduced shortly afterwards as a social services system for meeting wider community care needs.

5.2 Further guidance on the CPA was issued to health and social services throughout the 1990s, but implementation was patchy and inconsistent. The CPA and care management were together the focus of specific guidance in 1999 and this was reinforced in both the NSF and NHS Plan. An audit pack for the CPA was also issued in 2001 to assist local services in their modernisation programmes.

5.3 The CPA is the key mechanism through which councils discharge their community care and other relevant responsibilities for people with mental health difficulties.

5.4 We hoped to find robust integrated practice supported by good training, management and policy. We also hoped to find service users at the hub of CPA policy and practice.

The National Picture

5.5 The CPA was integrated with care management in few of the inspected councils although most reported that they would achieve this in the short or medium term future. There were few written standards for the CPA and joint audit arrangements were considerably underdeveloped. CPA policies tended not to promote holistic practice or needs-based care planning and most did not require attention to equality issues.

5.6 Different services approached the CPA in different ways and there was little evidence of services approaching developments in an evidence-based way. There was little evidence of services seeking out and learning from good practice outside their NSF Implementation Team areas.

5.7 Information systems to support the CPA were also underdeveloped and failed generally to meet NSF requirements. The position in many areas was disordered although most councils were actively addressing joint CPA information systems as a matter of high priority.
5.8 Service users appreciated support in CPA processes and valued having copies of their assessment and care plans where this was happening.

5.9 The needs of families were not adequately addressed. In particular, the needs of carers and children were not being approached systematically. (Issues around children’s needs are discussed in the next chapter.)

5.10 There was wide variation in how services approached risk assessment, risk management and contingency planning. The recording of risk assessments and contingency plans was very poor and there was evidence of risk management planning in only half of the case files we examined.

5.11 Over three-quarters of the fieldworkers who responded to our survey had received training in risk assessment but less than half had received training in risk management.

5.12 Policy and practice was better in councils that:
   • related to fewer and more stable NHS mental health service providers;
   • had consolidated their mental health services under a single manager who was then regarded as the social services mental health ‘champion’ within the council and the ‘social care’ champion between agencies;
   • had good relationships with health partners at middle and strategic levels;
   • had agreed the nomination of a single manager to develop the CPA across agencies, and had provided that manager with effective administrative and other support;
   • had adapted care management information systems for use as CPA systems in the mental health service;
   • had adopted a project management approach to the development or amendment of CPA policies to meet national guidelines; and
   • had involved service users, carers, and operational staff and managers in the development and oversight of CPA arrangements.

5.13 The poorest performance was found in councils that:
   • had inherited poor quality CPA arrangements and not revised them;
   • had most recently gone through boundary changes;
   • related to a large number of mental health service providers;
   • had the shortest history of joint working with current partners; and
   • had not ensured that social care issues or community care responsibilities were properly reflected in policy and procedure.

5.14 Some councils related to multiple health service providers; here, success also depended upon the willingness of those providers to collaborate in developing common and shared approaches to the CPA. Conversely, some
health service providers related to multiple councils; here success depended upon councils’ willingness to collaborate in developing shared and common approaches to the CPA. Performance was better where councils needed to collaborate.

5.15 Care practice was highly valued by service users when it:
- recognised and addressed their needs as ‘whole people’;
- acted as a passport to a range of services; and
- was a lifeline at times of difficulty or crisis.

5.16 There was evidence in all councils of some skilled and sensitive work involving holistic assessments and sound and imaginative goal-orientated care planning and review. These examples were however, in the minority and what was lacking was a consistent approach across all disciplines, driven and supported by robust sets of policies and procedures. In some areas fieldworkers were struggling with inappropriate systems as best they could to promote the interests of their service users and good care practice.

Leadership for Co-ordinated Care

5.17 Many councils had agreed the appointment or nomination of a lead manager who was responsible for the implementation and development of CPA arrangements. There was little consistency in the level of management or agency this manager was placed in. Performance was variable in councils with no nominated lead across agencies, but tended to be poorer when compared to councils where there was one. Performance was better where the appointment or other arrangement was more stable and long-standing.

5.18 Performance was best where arrangements for implementation and development:
- reported directly to the local joint senior management structure;
- were supported administratively;
- contained good levels of championing of social care and social services issues; and
- involved front-line staff, operational managers, service users and carers.

Policies

5.19 Most policies applied to all adults of working age but there were exceptions in either policy or practice in some areas, particularly for:
- hospital in-patients where the CPA was ‘suspended’ pending discharge to the community; and
- users of specialist community services who did not have a fieldworker.
5.20 The compliance of local policies with national guidelines varied greatly and no policy met them completely either ‘to the letter’ or to ‘the spirit’. Common broad failings included:

- viewing the CPA as a review mechanism rather than as a systematic approach to identification and meeting of need;
- not placing the service user at the centre of arrangements for their care;
- lack of attention to diversity issues; and
- failing to address the needs of children and carers.

Integration of CPA and Care Management

5.21 The CPA should, in effect, have been care management for adults with mental health difficulties and this had been achieved in some mental health services.

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<tr>
<td>Integration of CPA and Care Management Policies</td>
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In Leicester, local policies had been revised following the 1999 guidelines and a new integrated CPA piloted in 2000. Over 300 staff from all agencies had attended training which had included the introduction of the new documentation.

In Hounslow, Bedfordshire and Haringey, the CPA was the single system for assessment, care planning and review. It integrated social services care management processes.

Assessment

5.22 Approaches to assessment varied greatly between and within councils. There were no ‘common assessment’ arrangements although some ‘core assessments’ were being developed. The quality of assessments tended to depend upon:

- individuals’ professional preferences;
- whether community care budgets were being accessed; and
- practice in a specific team (usually in small specialist areas).
Good Practice

Unified Assessments

In Harrogate (North Yorkshire) there was an initial assessment tool which provided a good representation of psychiatric and other specialist views while, at the same time, retaining a good holistic picture.

5.23 Generally, guidance on assessments in CPA policies was poor and some assessment forms had been reduced to single tick lists. Assessments were generally not holistic and did not address service users’ strengths. Assessments were best in the following areas:

• where fieldworkers were using (now obsolete) community care assessment forms and guidance; and

• in specialist areas – particularly in community forensic, care management and assertive outreach services.

5.24 This did not mean that fieldworkers were not capable of undertaking good quality assessments. There were good assessments when they were required for purposes other than the CPA (for example by Mental Health Act Review Tribunals and submissions for community care funding). Rather, local policy and management did not require good quality assessments as the foundation of care planning.

5.25 The best assessments were those which were most holistic and which properly addressed social care and social services issues. These included attention to both the standard of living and the quality of life experienced by service users.

Elements of Good Quality Assessments

- Community living skills
- Personal & interpersonal skills
- Diversity and cultural issues
- Personal & social development
- Budgeting & wider domestic skills
- Education
- Employment
- Links with general practice
- Community integration
- The needs of children
- Housing & accommodation

5.26 Mental health services were a long way from being able to demonstrate that assessments systematically addressed these areas.
Care Planning and Review

5.27 Approaches to care planning and review again varied greatly, both between and within councils. Our examination of case records highlighted a general medical orientation, a focus on medication and compliance with medication regimes. What was missing were:

- objectives and goals;
- attention to changes in needs and the development of strengths; and
- attention to how services might change to accommodate changes in needs and circumstances.

Figure 3: Quality of practice – care planning

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Total Respondents= 335
Source: Social Services Inspectorate Survey of Fieldworkers – 2000-01

5.28 We also found poor performance in achieving compliance with set review dates in all but one council, and there were also many instances reported of reviews being held without the presence of the service user.

Figure 4: Quality of practice – reviews

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Total Respondents= 335
Source: Social Services Inspectorate Survey of Fieldworkers – 2000-01
5.29 Practice did however vary, and in some councils the position was much better.

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<th>Good Practice</th>
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<tr>
<td>Setting Goals in Care Planning</td>
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<tr>
<td>In Lewisham, 19 of the 20 care plans examined contained aims and objectives and all plans reflected assessed needs.</td>
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5.30 Mental health services were a long way from being able to demonstrate that care planning and review was effective.

Risk Assessment and Management

5.31 A similar position was found in respect of risk assessment and risk management. Policy guidance was poor as was the recording of assessments. A single form was used to record risk assessments and management plans in only two councils, and in one the arrangements were insufficient to promote, support or demonstrate good practice.

5.32 Guidance tended to neglect diversity issues, children's issues and risks posed to service users, as well as risks presented by them.

5.33 Good approaches were found in some specialist services, particularly in forensic, case management and assertive outreach services, but what was lacking was a robust approach across all services.

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<tr>
<td>Risk Assessment and Risk Management</td>
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<tr>
<td>In Bedfordshire there was specific and good quality guidance on the assessment and management of risk. This guidance was based on sound evidence and was signposted in the core CPA guidance.</td>
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Cornwall was working with the County Forensic Service to develop a common approach to risk assessment and management. New documentation had been piloted and initial training had been delivered to all community-based staff.

In Leicester, a draft ‘Risk Assessment Framework’ had been produced providing useful guidance on risk assessment and management. This included risk to the service user and to children, and gave useful attention to issues of race, disability and gender in relation to risk.

In Hounslow, a new risk assessment form had been implemented. Fieldworkers found it useful in supporting good practice.
Information Systems

5.34 Information systems did not comply with most NSF requirements and most councils were actively addressing this to achieve total or partial compliance in the short to medium term.

5.35 Most services had at least two separate systems (one for CPA and one for care management), and in most services there were also casework/patient files and patient record systems. Some of these elements were integrated in some services but in no services were they totally integrated. While social services generally operated a single system to support community care responsibilities, health services typically had multiple systems developed in different specialist areas.

5.36 In some services, fieldworkers were inputting the same information into multiple systems and this was clearly inefficient.

5.37 There were wide variations between and within mental health services as to how far progress had been made. Performance was worst where:

- there was inadequate agreement about which staff had access to what information;
- IT development in health and social services had been separate; and
- different parts of the service had different and incompatible systems.

5.38 There were, however, a number of good developments.

Good Practice

Integrated Information Systems

In the Isle of Wight, health services had agreed to use the social services client information system. This system was to be linked to health settings through the NHS Net and records would be integrated.

The Harrow social services client information system was robust and able to support the CPA. Index entries reliably signposted key events in care pathways. Health and social services were developing a project to use the internet to draw on data from existing separate IT systems. This would create an internet-based shared system.

In Southend, a system developed by the mental health services trust was to be implemented. This was a ‘care pathways’ based system and the council was confident that it would meet NSF requirements.
Standard Setting and Audit

5.39 Some CPA policies contained or were accompanied by sets of values and objectives. Those that did were of better quality.

Good Practice

Clarifying the Purpose of the CPA
The Bedfordshire CPA Policy, shared with a neighbouring council, contained clear statements of:

• the values underpinning the Care Programme Approach;
• its aims and objectives; and
• the expected short, and long-term outcomes of the CPA.

These statements were well evidenced by policy.

5.40 Similarly, there was little setting of performance standards for the CPA although standards had been set in some councils and in one this had been a result of a Best Value Review.

5.41 There had been joint approaches to audits of the CPA in few mental health services and some of these were descriptive rather than evaluative.

5.42 There were, however, examples of good practice.

Good Practice

Audit

In Leicester, the application of the CPA had been the subject of external audit. This had been followed by an internal audit of compliance with documentation completion requirements.

Southend had evaluated the performance of its Locality Community Health Teams – this had included a sophisticated audit of care arrangements and practice, including some elements of the CPA.

There was a regular audit of the application of the CPA in North Tyneside.

5.43 What was missing was a robust structure of audit activity, which covered as a minimum:
• implementation;
• the quality of care practice;
• the experience of service users;
• outcomes for key stakeholders; and
• regular reporting of audit findings to senior joint management forums.

The Needs of Carers

5.44 Councils have specific responsibilities for carers (including young carers). These include a lead responsibility within the NSF for ensuring that all individuals who provide regular and substantive care for people on the CPA have an annual assessment of their needs.

5.45 Where assessments of carers’ needs were undertaken then carers reported that they felt recognised, valued and supported in their role.

5.46 There were some triggers to initiate carers’ assessments in some CPA policies and assessment arrangements, and some guidance and assessments seen were of high quality. Generally, however, even where policy existed, councils tended to take a ‘defensive’ approach, preferring to undertake assessments only where carers were assertive or relying on carers to initiate assessments. In our survey only 34 per cent of carers identified by fieldworkers said that they had been informed of their right to an assessment and only 27 per cent had received such an assessment in the previous year.

5.47 CPA arrangements needed to demonstrate:
• a systematic joint approach to identifying carers and the role they undertook in the overall care of service users;
• arrangements for assessing and reviewing carers’ needs;
• an understanding that service users may have needs also as carers; and
• an understanding that there were additional responsibilities for young carers and that there were arrangements to ensure that those responsibilities were discharged.

Key Messages

5.48 The CPA was care management for people with mental health problems to some extent in some areas.

5.49 Further work was required to ensure that CPA arrangements:
• were care management for people with mental health problems in all services;
• constituted a systematic approach to care as a whole rather than focused on reviews;
• placed service users at their centre;
• effectively addressed standard setting and audit; and
• incorporated consistent, evidence-based and robust approaches to the assessment and management of risk.

5.50 Most services were working hard to ensure that information systems were rationalised and modernised.

5.51 Most services were working towards ensuring a systematic approach to the identification of carers and the assessment of their needs.
6

Context

6.1 The modernisation of mental health services is a complex and demanding task. It requires strong leadership and a clarity of vision which encompasses both long, and short-term goals. It also requires effective and inclusive management and planning structures.

6.2 This inspection was undertaken within two years of the publication of the Mental Health National Service Framework (NSF) and at a time when further guidance was being issued on service types and approaches to health promotion. It was therefore conducted early in the modernisation process. None the less, we hoped to see councils having established strong foundations and to be planning effectively with partner agencies and others to achieve modern services.

6.3 We also hoped to see councils ensuring that they continued to discharge their wider responsibilities (particularly those regarding children) in services as they were modernised.

The National Picture

6.4 All councils were committed to the modernisation of mental health services and were actively engaged in appropriate structures for the local development and implementation of the NSF. The level of that commitment and engagement varied considerably.

6.5 Councils were also at very different stages in their modernisation of mental health services. Most had achieved a degree of joint working (for example by the co-location of some fieldwork services), and some had joint management structures in place. Most, however, fell between these two positions.

6.6 Most councils also had a long-standing collaborative approach to commissioning and some were actively considering use of Health Act flexibilities to consolidate joint arrangements.

6.7 Progress and performance were best where there was full commitment to developing and maintaining partnerships between health and social services at all levels, and where mental health leads were supported appropriately by more senior managers and by councillors. Performance was also best where
6 health and social services had effectively engaged proper representation of other key stakeholder communities (most importantly housing services, service users, carers, the independent sector and local business communities) at appropriate levels in planning and management structures.

6.8 Good performance was also clearly associated with councils’ ability to keep their focus on initiatives associated with the wider Modernising Social Services policies in the development of mental health services. These included performance management and attention to promoting independence. Many councils, however, were focused on the NSF and had lost sight of the wider policy context.

6.9 There was little evidence of strategic commissioning in mental health services and services not covered by the National Service Framework tended to be excluded from service strategies. As a result there was fragmentation in the independent sector, a lack of attention to costs (particularly of residential care), and little effective market management.

6.10 Other areas of poor performance were:
- inability of some relevant services to establish their base budgets;
- poor performance management arrangements;
- obscure or confused line management and supervisory arrangements; and
- poor relationships between mental health and wider social services functions.

6.11 Performance was worst where joint management arrangements had been implemented without clarity of roles and responsibilities and without clear lines of accountability and responsibility, and where staff conditions of service, policies and protocols and other issues had not been modified in the light of the change of circumstances.

6.12 Good performance was associated with:
- visible and credible leadership at senior management level;
- strong performance management;
- effective change management;
- clear lines of accountability and responsibility;
- good operational policies for services; and
- strategic commissioning.

6.13 Few councils were able to demonstrate that they were discharging their wider responsibilities (particularly those for children) in mental health services, whether those services were joint or not.
6.14 The position was better, however, in services where fieldworkers were managed by social services managers but this did not guarantee that children's issues were managed safely. Care Programme Approach arrangements were poor in this respect and there were few operational policies concerning the interface between mental health and children's issues and services.

6.15 Area Child Protection Committee (ACPC) procedures generally failed to address mental health issues in families or the support of parents so that they were able to act as partners in child care arrangements.

**Vision**

6.16 All councils were committed to implementation of the NSF. Some councils were also considering use of the financial flexibilities outlined in the Health Act to develop and/or consolidate joint financial arrangement. Most councils were taking a more cautious and tentative approach. One council had taken the innovative step of engaging a national mental health research institution to work with senior managers across health and social services to establish a joint vision for the future.

6.17 The approach to establishing joint services varied but in most cases progress was influenced by difficulties in establishing base budgets and costs.

**Leadership**

6.18 There were nominated leaders for mental health in social services in most councils. There were agreed leads for services across agencies in few and the effectiveness of the lead was inhibited in some councils by either being at junior levels or by their taking a reactive or defensive position. Leads were rarely mandated to develop services across council functions.

6.19 Leads tended to be at middle management levels, usually at third tier, and these officers tended to be operationally responsible for all mental health services in the council. This had a direct impact upon their ability to effect change and develop services across agencies and other council services effectively. They were able to do so only when they received the active support of more senior management. Levels of this support varied considerably.

6.20 Leads also tended to be poorly supported by planning, personnel and staff development functions. Levels of accountancy support were better in some councils, especially in those which had experienced difficulties with budgets in the past and those where performance management was more firmly embedded.

6.21 Leads were most effective where they:
- were more senior;
were more skilled, assertive and proactive in inter-agency negotiation;
were operational managers responsible for all council mental health services;
had established managerial credibility with key stakeholders;
were properly supported and clearly mandated by senior managers; and
had effective structures for problem solving with health partners in addition to joint planning arrangements.

6.22 Councils and their mental health leads could not afford to take a passive stance in service planning, development and problem solving.

Partnerships, Planning and Implementation

6.23 Strong and effective leadership needs to be supported by robust and inclusive planning, implementation and governance structures. The commitment of councils to modernising mental health services was reflected in their engagement in joint planning and overarching joint governance structures. In all councils, this engagement and commitment to joint development was high.

6.24 All councils were represented on NSF Local Implementation Teams (LITs) (or their equivalent) which reported to wider partnership boards which included, for example, senior social services officers, senior health commissioners and providers, councillors, the independent sector and local business communities.

6.25 The introduction of the NSF and the performance management framework surrounding it had resulted in better and more productive relationships between partners, some of whom had historically felt that they shared little in common and whose relationships had been difficult and distant. Progress had been made even in areas where relationships had been particularly poor.

Good Practice

<table>
<thead>
<tr>
<th>Strategic Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Wiltshire, all mental health planning, policy implementation and service development was done jointly with the full participation of the council and health agencies through a joint commissioning board. This board contained user and carer representation.</td>
</tr>
</tbody>
</table>

6.26 Local arrangements had ensured that all councils had:
• identified and engaged most key individuals, groups and agencies;
• gained commitment to achieving national standards and service models;
• agreed arrangements for implementation of the NSF; and
• met some early milestones specified in the NSF and NHS Plan.

6.27 In order to plan effectively councils need to ensure effective representation of all key stakeholders. This includes service users, carers, the independent sector and black and minority ethnic communities (representation of black and minority ethnic communities is discussed in Chapter 4). The level and nature of representation of service users varied greatly between councils. Performance was better in councils which ensured representation was effective and that service users were properly supported in planning processes.

Good Practice

Service User and Carer Representation in Planning

In Dudley, the key planning and implementation group (the Mental Health Board) had two service user and two carer representatives. Service users were supported in this role by a local advocacy agency, and carers by the local Carers Development Worker. Briefings were held prior to Board Meetings.

In Cornwall, Mental Health User Forums had been in place for some years. They were supported by a user forum co-ordinator employed by the local rural community council. Similar arrangements existed for carers who were supported by the County Carers’ Co-ordinator. Both were members of the local NSF Implementation Team.

6.28 In some areas, service users, carers and the independent sector regarded their engagement as shallow, reactive and tokenistic. Most councils were far from being able to show that they were aware of service user and other key stakeholder’s views and were effectively responding to them.

6.29 All LITs had successfully developed Local Implementation Plans (LIPs) and some had taken advantage of this process to incorporate or develop wider strategies for mental health services beyond those specified in the NSF. What was generally lacking were plans which covered all relevant services, particularly those in the independent sector, and which demonstrated a commissioning approach. Plans also tended not to be underpinned by robust population needs assessments based on demographic indicators or information from care activity. This made performance management difficult.
There were good and innovative services and developments in all council areas, particularly in day care, employment and supported accommodation. These tended to be opportunistic and outside the context of a coherent overall strategy. This was compounded by mismatches in many areas between supply and demand. In many areas, some services maintained waiting lists while others were operating under-capacity.

Similarly, some of the better-performing councils had reviewed some services and mapped them against indicators of need, but where these were services which were not specified in the NSF it was difficult to see how they had influenced overall strategy.

Market management was generally underdeveloped in mental health services. This included councils whose general approach to market management was better. This was compounded by a general lack of attention to costs, even in some areas where costs were high.

While concentrating appropriately on the NSF, what was missing was a whole systems approach and an understanding of the complex nature of the mental health services arena.

The better-performing councils had more of the elements necessary for effective commissioning and strategy formulation:
• population needs assessment which included demand indicators from service activity;
• strategic planning on a whole system basis;
• contract setting; and
• market management.

Performance Management

To achieve the modernisation of services safely and effectively, robust approaches must be taken to performance management to ensure:
• the delivery of the best possible service within available resources;
• the setting and achieving of objectives within an integrated approach to planning, service delivery, monitoring and evaluation; and
• that progress can be measured and demonstrated.
This requires a performance management approach at strategic, manager and practitioner levels.

The strategic commitment to the Care Programme Approach has already been noted in the preceding chapter, as has the general inability of services to demonstrate that this commitment has been effected at service and
operational levels. Performance on the CPA was better in services which had begun to adopt a performance management approach.

6.37 Performance management in mental health services was poor in most councils.

6.38 All councils had high-level indicators, usually in their Best Value Performance Plans. Most councils’ social services also had sets of indicators and objectives at a whole service level which related to corporate objectives.

6.39 Some individual services (usually day and employment services) had developed objectives and indicators as part of their overall management approach but these seldom related to corporate or whole service plans.

6.40 Some councils had developed performance management plans for their own or joint mental health services as a whole, and one had developed a good set of objectives and performance indicators. Where such plans existed they tended not to be known to staff at operational levels, existed in draft form or contained indicators which related to only one of the modernisation agendas – that is, either the social services or the mental health services agenda.

6.41 There was a higher level of awareness of performance management techniques than there was of actual performance management practice and managers keen to implement initiatives did not feel supported by more senior managers.

6.42 Performance was better in services that had:
- understood the benefits of adopting a performance management approach;
- adopted a performance management approach in mental health services;
- ensured that objectives were set and monitored which related to the national and local modernisation agendas for both social services and mental health services; and
- ensured that staff were aware of the objectives and the part they played in achieving them.

6.43 As working arrangements become modernised, councils will need to develop better approaches to the management of performance to ensure that services are safe and that they meet requirements.

Joint Working Arrangements

6.44 All councils had achieved the integration of services to some degree. In some cases this involved the co-location of workers in some community fieldwork teams and in some there were co-located services in jointly
managed services. Most councils fell between these two extremes but were planning greater levels of joint working in the future.

6.45 The structures of managerial and professional accountability varied considerably between and sometimes within councils, even within those which related to a single NHS trust.

6.46 In most joint services, supervisory arrangements were confused or inadequate. Arrangements were better where social workers were co-located but supervised by social services managers, but there were costs under these arrangements for effective service delivery. Few joint services had supervision policies, and the understanding of supervision and its practice varied considerably.

6.47 In creating organisational structures, services need to be clear about the functions of supervision, that is:

- managerial control;
- support; and
- professional development

and to ensure that all these functions are effectively discharged.

6.48 Services also need to be clear that separate arrangements may be necessary for the supervision of Approved Social Workers (ASWs).

6.49 Conditions of service issues had also not been attended to as services became more joint. We found many fieldworkers who said that they were seconded to mental health services and who were managed by jointly appointed managers but whose contracts had not been changed to formalise this.

6.50 Few teams possessed operational policies to clarify and support staff roles, responsibilities and teamworking practices.

6.51 Many policies and protocols concerning, for example, complaints and access to records, had not been revised and updated to ensure that they fitted with new organisational arrangements. In many areas staff were confused about which policies and procedures existed and applied.

6.52 We found that, in pursuing modernised and joint services, insufficient attention had been paid to:

- conditions of service;
- organisational and cultural issues;
- working practices;
- supervision; and
- relationships with wider social services functions – particularly child care.
Children’s Needs

6.53 One corollary of the increasing specialisation of mental health services in councils, accompanied by their greater integration with specialist health services, has been the distancing of those services from mainstream social services. As mental health services are modernised councils need to ensure that they continue to discharge their relevant wider responsibilities effectively in developing services. This involves developing robust management approaches to children’s issues in mental health services so that staff and managers are able to identify and manage these issues effectively.

6.54 Conversely children’s services staff need to be aware of mental health issues and should have effective mechanisms to secure the support of specialist mental health services staff to contribute to assessment and other work.

6.55 The performance of mental health services in addressing the needs of children was poor. Performance was better in councils which had recognised the potential for a lacuna to develop between mainstream approaches to children and specialist or integrated mental health services, and had begun to address it.

6.56 The needs of children were poorly addressed in CPA policy. Most councils recorded the presence of children in the household but few specifically required initial consideration of child protection or children in need issues. Fewer still gave guidance to staff on the identification and local management arrangements for children’s issues.

6.57 Many staff reported that they were versed in children’s issues but these tended to be staff who had received professional qualification training and who had practiced in the past as generic social workers. Confidence and awareness were lower amongst staff who were more recently qualified. Only 43 per cent of staff reported that they had received training in child protection issues and only 15 per cent reported receiving training in children in need issues.

6.58 There was, however, some good performance in this area.

**Good Practice**

**Addressing Children’s Needs in the CPA**

The Leicester CPA assessment documentation carried a specific trigger to ensure that staff considered child protection issues within the assessment.

The Bedfordshire assessment documentation carried a similar trigger and the CPA policy contained specific good quality guidance to staff on the identification and management of risk to children. It determined that where there were children in a service user’s household then their needs must always be considered, and emphasised the primacy of children’s needs.
6.59 What was lacking was:

- an awareness of responsibility for the identification of child care issues in mental health services; and
- the discharge of that responsibility through mental health care practice.

Links with Children’s Services

6.60 Strong links supported by robust protocols and shared understandings of roles, responsibilities and working practices are required if children’s needs are to be met effectively.

6.61 Few mental health services had written guidance on the relationships between children’s and mental health services although some were aware of the importance of this and had developed draft guidance.

**Good Practice**

**Relationships with Children’s Services**

The Southend Area Child Protection Committee procedures required that all children of families with a parent who experienced difficulties with their mental health should be considered under the children’s assessment framework.

In Oxfordshire mental health and children’s services staff had trained together to develop good understandings of each other’s roles, responsibilities and working practices.

6.62 Overall, however, only 43 per cent of fieldworkers reported that they had access to policies concerning arrangements with children’s services. Of that group only half regarded policy to be adequate to promote safe practice. Policies did exist in some areas but staff were not aware of them.

6.63 In general, relationships between mental health and children’s services were reported to be good in some parts of some councils. It was found to be poor in most parts of most councils. The quality of relationships depended upon:

- the proximity of the location of mental health and children’s services staff and managers; and
- goodwill.

6.64 Councils are mistaken if they rely on these factors to ensure safe practice.

6.65 Conversely, if parents who experience difficulties with their mental health are to act as partners with the statutory agencies in child care processes
then local policy should determine that they receive appropriate support. This was absent in almost all Area Child Protection Committee (ACPC) documentation examined.

6.66 What was missing was:

- advice to mental health services staff on the identification and management of children’s needs;
- advice to children’s services staff about the identification and management of mental health needs of parents; and
- guidance on the roles and responsibilities of all staff in families where there were both mental health and children’s issues.

Key Messages

6.67 All councils were committed to implementing the National Service Framework and most were active partners in planning and implementation structures; there was evidence of progress towards modernisation in all services.

6.68 There was a need to ensure effective representation in planning mechanisms of service users, carers, the independent sector and black and minority ethnic communities.

6.69 The quality and scope of plans and strategies varied; all covered services specified in the NSF but few covered services beyond this; approaches to commissioning, particularly attention to costs and market management needed developing.

6.70 Joint working and joint management were developing in all areas. Greater attention was needed to:

- operational policies for teams and individual services;
- employment terms and conditions;
- policies on complaints; and
- line management and supervisory arrangements.

6.71 All services had histories of collaborative purchasing and service provision; some were actively considering use of Health Act flexibilities to further develop and consolidate arrangements.

6.72 Performance was best where services were attending to the modernisation agenda of both mental health and social services.

6.73 Greater attention was required to performance management.
6.74 Relationships between mental health services and other social services functions were becoming more distant; specific attention was required to arrangements for identifying and meeting the needs of children and supporting parents in child care processes.
Standards and Criteria

STANDARD 1: EFFECTIVENESS OF SERVICE DELIVERY AND OUTCOMES FOR SERVICE USERS

Service users and carers experience services which are effective in promoting mental health and inclusion in valued social activities.

Criteria

1. Service users and carers are satisfied that they are approached with courtesy and respect by staff whom they regard as being well informed and reliable.

2. Service users’ independence is promoted and they are safeguarded against abuse by adult social care mental health services.

3. The practicalities of service users’ lives are attended to by adult social care mental health services.

4. Service users have socially valued life styles.

5. Service users, including those with a dual diagnosis (mental illness and drug or alcohol misuse), have access to a range of social care services appropriate to their needs and preferences.

6. Service users have ready access to welfare rights support and advocacy independent of the statutory authorities.

7. Carers have access to a range of services which support them in their role.

8. Service users on the Care Programme Approach have access to appropriate services 24 hours a day and on all days of the year.
STANDARD 2: FAIR ACCESS

Social services acts fairly and with consistency about who gets what social care services, and how they charge for adult mental health services.

Criteria

1. Care Management/Care Programme Approach arrangements work to two tiers (standard and enhanced) that correspond clearly to social services’ wider care management eligibility criteria; these criteria are understood by service users and are applied consistently.

2. Service users and carers have equitable access to specialist adult social care mental health services through primary care.

3. The system for charging is transparent, fair, and consistent with Department of Health guidance.

4. Social services is implementing a policy to ensure equality of opportunity in staff recruitment, retention and relationships at work in the adult mental health services it provides and commissions; the staffing profiles of services match those of the populations they serve.

5. Social services is implementing a policy of equality of opportunity and anti-discriminatory practice in the adult mental health services it provides and commissions; in doing this it has implemented the Disability Discrimination Act (1995).

6. Social services ensures that adult mental health services it provides and commissions have policies to support their employees who may experience difficulties with their mental health.

7. Social services has assessed the needs of its populations and, with partner agencies where appropriate, monitors service use to identify and deal with patterns of over or under-representation in adult mental health services.

8. Users of adult social care mental health services have ready access to an appropriate interpreting service so that they are not dependent upon their relatives or others involved in their care to interpret for them.

9. Service users are clear about the reasons for decisions taken by social services which affect their lives.
STANDARD 3: INFORMATION AND COMMUNICATION

Service users and carers are well informed and are helped to communicate their needs and views to social services.

Criteria

1. The public, users of adult social care mental health services and their carers have ready access to information concerning:
   - adult mental health and other relevant services;
   - how to access those services, including whom to contact in an emergency;
   - the psychiatric, psychological and social nature of mental ill health;
   - professional language and service terms;
   - the strategy of social services and its partner agencies for adult mental health;

   and service users and their carers understand this information.

2. Service users and their carers have information which they understand and which explains local Care Management/Care Programme Approach arrangements, their rights and responsibilities within it, and how confidentiality is managed.

3. Service users and carers are aware of their rights of access to their records held by, or on behalf of, social services.

4. Service users and their carers are aware of their rights to complain and to make representations about services provided and commissioned for them by social services.

5. Service users and their carers are supported through and involved in the Care Management/Care Programme Approach process; they have been involved in building their plans, have agreed to them, and have copies of their care plans which they understand.

6. Service users and carers are involved meaningfully in service design and review.
STANDARD 4: CARE MANAGEMENT/CARE PROGRAMME APPROACH – PRACTICE AND POLICY DEVELOPMENT

Social services and partner agencies have robust mechanisms in place to oversee and develop Care Management/Care Programme Approach policy and care practice.

Criteria

1. Social services care management arrangements are integrated operationally and procedurally with local Care Programme Approach arrangements to form a single approach for all adults aged 18 to 64 years with mental health problems.

2. Social services has agreed the appointment or nomination of a lead officer for the strategic oversight and development of care co-ordination across health and social care.

3. Adult mental health services have engaged with primary care to ensure that mental health needs are identified and managed effectively.

4. Care Management/Care Programme Approach arrangements set standards for both the process and outcomes of assessment, care planning and review.

5. Care Management/Care Programme Approach arrangements are audited regularly to evaluate their implementation and the quality of performance against set standards, the results of these audits are reported to senior management of both health and social services.

6. Local joint health and social services policy and guidance determines:
   - a consistent approach to the assessment and management of risk which promotes independence safely;
   - the allocation of care co-ordinators and their role;
   - processes and procedures for care planning and review;
   - the nature and management of confidentiality.

   This guidance includes mechanisms for the resolution of problems, effectively incorporates issues of equality of opportunity and is reviewed regularly in the light of developments.

7. Information systems to support the Care programme Approach:
• assist staff in managing their case loads;
• ensure that key facts are available to professionals who need them;
• support a framework of audits;
• assist in service planning and development; and
• contain a subset of information concerning people eligible to receive services under Section 117 of the Mental Health Act.

8. Social services ensures that adult social care mental health services are evidence-based in their approach to both individual service interventions and general service styles.

9. There is a joint policy and process concerning the investigation and consideration of serious incidents.
STANDARD 5: CARE MANAGEMENT/CARE PROGRAMME APPROACH PROCESS

Care Management/Care Programme Approach systems ensure the effective co-ordination of adult mental health services and facilitate effective access to all relevant support services.

Criteria

1. In accordance with the Carers (Recognition and Services) Act 1995 and the Mental Health National Service Framework all individuals who provide regular and substantial care for a person on the Care Programme Approach have an assessment of their caring, physical and mental health needs; this assessment is repeated on at least an annual basis.

2. Care Management/Care Programme Approach arrangements are applied to all adults irrespective of the profession, agency or service providing the main support.

3. Care planning and service provision is systematic and is based on the assessment of needs and strengths and on risk taking.

4. Care co-ordinators ensure that a single assessment facilitates access to both health and social services and to a range of other relevant support services.

5. Assessments are holistic and are sensitive to issues of equality of opportunity.

6. A locally agreed pro forma is used for the recording of risk assessments and management plans.

7. Social services staff have the knowledge and skills to work effectively with diverse communities.

8. Care plans include contingency plans of action to be taken by the service user and others (including the service user’s GP) in the event of a change in needs or circumstances.

9. Care plans are reviewed at appropriate intervals and the review process accommodates a user or carer’s request for a review.
STANDARD 6: COST AND EFFICIENCY

Social services commissions and delivers adult mental health services to clear standards, covering both quality and costs, by the most effective, economic and efficient means available.

Criteria

1. Social services collaborates with health to consider the potential for joint financial arrangements, including pooled budgets, lead commissioning and integrated provision.

2. Where social services is commissioning adult mental health services it has ensured that it continues to discharge its statutory duties effectively.

3. There is clear accountability for budgets, with financial and managerial responsibility aligned as closely as practicable and supported by robust systems.

4. Social services, with partner agencies, has the key elements for the effective commissioning of adult mental health services in place – population needs analysis, strategic planning, contract setting and market management.

5. Social services knows the unit costs of all its adult mental health services (whether provided or commissioned) and uses this information to manage efficiently and to encourage competition in the provision of good quality responsive adult mental health services.

6. Social services has established local objectives and performance measures for adult mental health services.

7. The council has a programme of Best Value Reviews set out in a local performance plan and it includes social services for adults with mental health problems; the review of these services has a clear way of determining best value.

8. Reviews of adult social care mental health services have resulted in setting performance and efficiency targets for those services, the publication of information about those targets and how they are met and the use of this information to address any shortcomings.

9. Service users and carers benefit from the improvements that result from the council’s best value duties.
STANDARD 7: ORGANISATION AND MANAGEMENT ARRANGEMENTS

Adult mental health social care services policies are delivered through robust and integrated structures and procedures which ensure that the needs of service users and carers are met.

Criteria

1. Social services is actively engaged in all relevant local joint agency planning and policy implementation systems and ensures that local planning and service evaluation and development involves users, carers and representatives of the independent sector.

2. Social services has policies and procedures jointly agreed with housing authorities and providers for the provision of suitable accommodation for adults with mental health problems and for supporting housing staff in their contacts with adults with mental health problems.

3. Social services has a nominated lead senior manager responsible for the strategic oversight and development of mental health services across the local council and across agencies.

4. Adult social care mental health services staff are supported in their work by a range of joint policies and procedures covering the interface of adult mental health services with other social services responsibilities; these include:
   - child and adolescent mental health
   - dual diagnosis
   - mentally disordered offenders
   - relationships with High Security Hospitals, medium secure units and units provided by the independent sector and child protection/children in need (including young carers).

5. Managers routinely monitor the quality of work in individual cases based on a range of information including that from audit of case records, staff supervision and feedback from service users and carers.

6. Social services ensures effective systems for staff supervision through written guidance and skilled management.

7. Line management arrangements are robust and clear and allow for the effective discharge of responsibility and accountability.
8. Social services has implemented a strategy for ensuring that its workforce (and those of the adult mental health services it commissions) have the knowledge and skills required for the delivery of a high quality mental health service.

9. Social services has developed and implemented strategies to assure the quality of the adult mental health services it provides and commissions.
B.1 This overview report is based upon an analysis of the findings of 19 individual inspections carried out between June 2000 and September 2001. This was the first phase of a rolling programme of SSI inspections. The inspected councils with social services responsibilities are listed in Appendix D.

B.2 The purpose of this programme of inspections was to evaluate the implementation of Government policy relating to the social care needs of adults of working age (18 to 64 years) who experience difficulties with their mental health.

B.3 This inspection builds upon the Social Services Inspectorate’s (SSI’s) programme of work in recent years, which has focused on social work in Medium Secure Units, services for Mentally Disordered Offenders in the Community, and the Integration of CPA and Care Management. The latter was the subject of a national overview report, Still Building Bridges, published in March 1999.

B.4 It also builds upon other work the SSI is undertaking in respect of the wider Modernising Social Services policy and is the second ‘whole service’ inspection. It harmonises with the national objectives for social services, the performance management framework, Best Value and the Mental Health National Service Framework. The areas of performance of the performance management framework and national service framework are to be found in the standards and criteria.

Inspection Method

B.5 Each inspection had a team of two inspectors and (usually) a lay assessor. One inspection team was accompanied by a reviewer from the Commission for Health Improvement. They undertook, typically, nine days of fieldwork for each inspection. Each team used the same methods of gathering evidence and the same standards and criteria to evaluate services (see Appendix A).

B.6 Before the inspection fieldwork we asked councils with social services responsibilities to write their own evaluation based upon our standards and criteria. We also asked for relevant documents to explain and support this evaluation.

B.7 Before each local inspection we also conducted three questionnaire surveys to gain further information. We sent a questionnaire to every mental health
fieldworker employed in or responsible to the council with social services responsibilities (a total of 412 were returned). We sent a second questionnaire to 80 service users in each council (501 responded) and a separate questionnaire to all identified carers (264 responded).

B.8 We also used a range of other sources to gain more information before the fieldwork. These included Joint SSI/Audit Commission Review reports and the mid-year monitoring results for the performance assessment and national service framework. We were also briefed by SSI-Performance inspectors.

B.9 From the list of cases prepared for us we selected 20 in each council for detailed analysis of case records (a total of 335 case records were examined). For these cases we asked fieldworkers to complete a case profile.

B.10 The following interviews and meetings were typically held in each service:

- Service users (individually and in groups)
- Carers (individually and in groups)
- Elected Members
- The Director of Social Services and other relevant senior managers
- Specialists in planning and policy
- Business Support and Performance Management Managers
- Managers and practitioners involved in mental health services
- Senior Mental Health Services Trust Managers and commissioning managers
- The Personnel Officers
- Race Equality leads
- CPA leads and administrators
- Managers of independent sector services
- Staff Development Managers
- Housing Managers

B.11 The Inspection Design Team led the work on developing the inspection method. Appendix C gives some details about this team.

B.12 Phase two of this national inspection commenced with further inspections in 2002.
The Inspection Design Team created the inspection methodology. The standards and criteria were developed and refined following consultation through reference groups comprising representation from within and outside the Department of Health.

**External Reference Group Members**

- David Joannides: Association of Directors of Social Services
- Alan Beadsmoore: MIND
- Erica Lewis: National Schizophrenia Fellowship
- John McFadyean: Leicestershire Health Authority
- Peter Scott Blackman: Afiya Trust
- Richard Ford: Sainsbury Centre for Mental Health
- Kevin Stanley: NHS Executive
- Eve Thompson: National Schizophrenia Fellowship
- David Shaw: National Schizophrenia Fellowship
- Geraldine Neufville-Goldson: Mental After Care Association
- Steve Moss: National Schizophrenia Fellowship
Inspections took place in the councils listed below. Reports of individual inspections are available from the SSI, Department of Health, at the addresses below and from the Department of Health website, www.doh.gov.uk/publications/pointh.html

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Email: corrin.shepherd@doh.gsi.gov.uk

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**Southend-on-Sea**

**Blackpool**
North West Inspection Group
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501 Chester Road
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**Cornwall**

**Dudley**

**Wiltshire**
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40 Berkeley Square
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Email: susan.miller@doh.gsi.gov.uk
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