Commission for
Health Improvement

What CHI has found in:
mental health trusts

sector report
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Mental health problems are common and diverse. One in four people will experience a mental health problem at some time in their lives, most commonly anxiety or depression. It is also estimated that one person in every 250 will have a psychotic illness such as schizophrenia or bipolar affective disorder (manic depression). Not everyone with a mental health problem has a severe illness or will experience severe symptoms all of the time and 90% of mental health problems are treated in primary care. Nevertheless, people with severe mental health problems are among the most excluded in society.

The Commission for Health Improvement (CHI) is committed to promoting improvement in the quality of patient care. One way we hope to achieve this is by sharing what we have learnt. This report, the third in a series reporting on our findings within different sectors of the NHS, has been produced to share what we have learnt about secondary mental health services. It gives our view of how well mental health services are meeting the needs of service users and the public and responding to the challenges they face. It is based on four sources of evidence: 35 clinical governance reviews, in England and Wales, published by the CHI between July 2001 and October 2003, representing about half of the specialist mental health trusts; two investigations into serious service failures; a report on safeguarding arrangements for children in England and a self audit of child protection arrangements in England.

Mental health services are different to other parts of the NHS, partly because people can be compelled to use those services, sadly because of the stigma attached to mental health problems, but also because the experience of using services is critical to people's recovery. One of the key sources of information in our reviews has been obtained by asking service users to tell us about their experiences, good and bad, of the services they use. Users' perceptions of the care they receive are often very different from those of people providing the care.

Service users often have a longer term relationship with mental health services than is common in other sectors. CHI's survey of users of secondary mental health services found that over 50% had been in contact with services for over five years. Of course the services people receive are often low in their list of priorities relative to employment, housing, social networks, education and a decent income. A recent survey of people using secondary mental health services found that only 9.5% of those who responded were in full time paid work. We highlight in this report those organisations that have most actively assisted users in finding employment, either within their own organisations or elsewhere.
So what does our work tell us? Mental health services have historically been given a low priority within the NHS and CHI’s reviews show that mental health services, despite the progress evident over the period of our reviews, still lag some way behind the acute sector in developing clinical governance arrangements – those systems and processes that promote high quality care and continuous improvement. At the same time, other parts of the NHS can learn from the user centred culture of mental health services and the common good practice in mental health around, for example, user involvement in staff training and recruitment.

A great deal of good practice was evident during the reviews, some of which is illustrated by examples throughout the report. One important lesson from this work is the need to ensure that examples of good and innovative practice are spread within individual trusts and across the service as a whole.

We recognise that we are not alone in identifying the issues and concerns that are detailed in this report, nor in highlighting the achievements that have been made. The Modernisation Agency, the Department of Health, the National Institute for Mental Health, the Mental Health Act Commission, the Mental Health Partnership, user, carer and voluntary organisations, and users and carers across the country are deeply involved in the development of modern, user focused services.

Dame Deirdre Hine
Changes in mental health services

Mental health services have undergone unprecedented change in recent years. The movement away from institutional care, which began in the 1950s, resulted in a rapid decline in the number of people with mental health problems being cared for in hospital, and a parallel movement towards community based services.

A series of policy initiatives in the 1990s have attempted to consolidate community based services around an appropriate balance between care and control, support and public safety. The white paper Modernising mental health services: safe, sound and supportive (1998) set out to identify and fill the gaps in service provision.

The National Service Framework for Mental Health, published in 1999, sets out the policy context, values, standards and implementation programme for mental health services, articulated through a broad set of standards that must be achieved in local services. The NHS Plan (2000) extended the agenda described by the national service framework by detailing new services, including assertive outreach, crisis resolution (sometimes called home treatment) and early intervention in psychosis services. The plan introduced graduate primary care mental health workers, gateway workers and carer support workers and endorsed structural changes such as the creation of care trusts. It also considered the mental health workforce requirements and issues relating to recruitment and retention, leadership and training.

The National Service Framework for Older People (2001) includes a specific standard around mental health in older people with the aim that older people with mental health problems have access to integrated mental health services. However, the focus of policy, local priorities and the national performance indicators remain centred around adult mental health services.

In Wales, the National Service Framework for Adult Mental Health was published in 2002. Policy is less evolved in Wales. The evidence from CHI’s reviews is that services are less developed in Wales and that an older, more institutional model of care is found.

Alongside the development of new service models, the Government has developed proposals to reform the Mental Health Act (1983) to bring it in line with the way in which contemporary mental health services are provided.
Organisation of mental health services

The organisational provision of mental health services has also changed rapidly with the creation in England of specialist mental health trusts and the increasing integration of health and social care provision. There are now 85 providers of secondary mental health services in England, including 18 primary care trust (PCT) providers. Mental health services in Wales are provided by trusts that also provide acute and community health services.

Mental health trusts are typically large organisations, with a range of local authority and PCT partners, operating from a multiplicity of sites. This makes the challenge for trust boards of communicating effectively with users, carers and staff and assuring the quality of services more difficult.

The integration of mental health and social care was given added momentum by the 1999 Health Act, which enabled the integrated provision of health and social care in single organisations through the delegation of mental health social care to NHS trusts. Five mental health care trusts have been established, while other NHS trusts and local authorities have used the flexibilities allowed by the Health Act to develop integrated provision.
CHI's findings

Capacity in mental health services

CHI's clinical governance reviews have taken place at a critical time in the evolution of mental health services in England and Wales. This has given CHI an important opportunity to assess the sector, the way services are developing and the prospects for its future.

Mental health services are four years into the 10 year programme outlined in the national service framework to develop modern, community based mental health services. Initiatives such as the development of outcome measures and the mental health minimum dataset offer the possibility of measuring the quality of care service users receive and improvements in the quality of their lives.

Mental health trusts have also experienced major organisational change, through mergers, the separating out of general community services and the development of social care partnerships. The consequences of these changes are reflected in CHI's findings. Trusts and services are at very different stages of development. On the basis of work we have done so far, a number of trusts are performing well, but a larger number face significant challenges. While mental health trusts are moving in the right direction, their ability to develop further the quality of their services is inhibited by serious capacity problems in management, staffing and the infrastructure and the scale of change needed. The ability of providers to meet the challenges set out in the national service framework are dependent on these capacity issues being resolved.

Despite a broad consensus about mental health policy, wide engagement with that agenda and evidence of innovation and change, there is considerable dissatisfaction and frustration in the mental health sector that the priority accorded to mental health is is not always reflected in practice. Commissioning and performance priorities remain focused on the acute healthcare sector. In addition, recent research by the Royal College of Psychiatrists and the Sainsbury Centre for Mental Health shows that despite its stated priority and the funds associated with the national service framework, mental health trusts have significant financial problems. The resources allocated for service developments have also not always found their way into services.
The historical legacy of the neglect of mental health services is still regrettably evident in the findings of CHI’s investigations. CHI has found that factors such as the isolation of services, institutional environments, low staffing levels and high use of bank and agency staff, closed cultures and poor clinical leadership and supervision have caused the neglect of patients. While these instances are rare, CHI cannot be confident that other examples of poor quality care do not exist.

Shortages of skilled staff, problems in recruiting experienced managers and years of under investment in information systems inhibit progress. Similarly, staff and service users work too often in environments which are unacceptable. Within the sector itself, the focus on adult mental health services has been at the expense of, for example, services for older people and child and adolescent mental health services. Similar attention to performance and resources are required by providers and commissioners to bring improvements to those services.
Characteristics of stronger and weaker trusts

CHI’s reviews have identified common factors among trusts that are performing well and among those that have made less progress. This relates in part to capacity. Trusts that CHI found to be making progress in implementing clinical governance generally have also made good progress in implementing the national service framework, developing integrated provision with their social care partners and implementing the care programme approach.

<table>
<thead>
<tr>
<th>Characteristics shared by trusts performing well in clinical governance reviews</th>
<th>Characteristics shared by trusts performing poorly in clinical governance reviews</th>
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<tbody>
<tr>
<td>Lower vacancy rates, particularly in psychiatry, or active attempts to resolve vacancy problems; high staff morale; good progress with Improving Working Lives</td>
<td>Serious problems with recruitment generally in psychiatry and inpatient nursing; low morale; cultural and operational divide with social care staff</td>
</tr>
<tr>
<td>Good progress with developing national service framework/NHS Plan services and the care programme approach</td>
<td>Limited or partial developments of new services and limited implementation of the care programme approach</td>
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<tr>
<td>Leadership is cohesive, visible and well regarded by staff and partners</td>
<td>Staff perceive leadership as remote; weaknesses in executive or non executive leadership</td>
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<tr>
<td>Strong relationships between clinicians and managers</td>
<td>Lack of engagement of clinicians in management</td>
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<tr>
<td>Cohesive structures between different parts of the trust</td>
<td>Disconnection between different parts of the trust</td>
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<tr>
<td>Strong structures to support clinical governance in directorates and sectors/localities; understanding of relationships between the board and directorates, sectors and services</td>
<td>Limited structures below corporate level to support implementation and performance management of clinical governance, or structures to support clinical governance components</td>
</tr>
<tr>
<td>Well developed clinical information systems and progress with performance management</td>
<td>Fragmented information systems and little development in performance management</td>
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<tr>
<td>Good progress on organisational and operational integration with social care</td>
<td>Limited progress with organisational and operational integration with social care</td>
</tr>
<tr>
<td>Effective communication systems in place</td>
<td>Poor communication systems</td>
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</table>
CHI's investigations have found the same problems and characteristics in the organisations subject to investigation.

**Staffing**

There are serious problems nationally with the recruitment and retention of mental health staff. The local experience varies, depending on working conditions, recruitment strategies and the attraction of particular organisations and localities. Significant staffing shortages, primarily of psychiatrists and inpatient nurses, have a major impact on clinical leadership and the quality of care. In inpatient areas there are particular concerns about staffing levels, skill mix, the use of locum, bank and agency staff and the impact of low staffing levels on staff safety. New community based services are also attracting inpatient nursing staff from the challenging environments in which they currently work.

Some trusts have worked hard and developed local initiatives to tackle these problems. In nursing these include nurse rotation schemes, nursing cadet schemes, flexible working, subsidised accommodation and childcare facilities and outreach work with local communities to promote working opportunities.

However, some trusts are in places operating a locum psychiatry service, which is expensive and has a significant impact on the quality and continuity of care. Clearly if trusts are struggling to maintain a service, then it is unlikely that the systems for improving the quality of care that CHI assesses in its reviews will be a priority. Some trusts have managed to address their consultant recruitment problems by attracting overseas consultants, increasing the national training numbers for specialist registrars, and the development of more flexible roles.

**Good practice example:**

At the time of the CHI review, North Cumbria Mental Health and Learning Disabilities NHS Trust had reduced its consultant vacancies from seven to one and was pioneering a new associate psychologist grade to enable more flexible roles as part of the national Changing Workforce initiative.
**Good practice examples:**

Oxleas NHS Trust actively seeks to employ service users, including their recruitment as patient advice and liaison service (PALS) telephone liaison officers to provide advice and information to service users and carers.

At South West London and St George’s Mental Health NHS Trust 33% of the staff employed in deaf services are deaf and 74% of staff have achieved stage 1 in British Sign Language. Schemes to increase access to employment within the trust for people who have experienced mental health problems have also been successfully implemented with approximately 20% of staff recruited last year having personal experience of mental health problems. The chief executive chairs an ethnic minority action group and a race equality group has been established. The trust is a beacon site for cultural awareness training and is taking the lead in promoting diversity training in the local health community.

Leeds Mental Health Teaching NHS Trust has made significant investment in developing and supporting black and ethnic minority managers as part of a positive action programme.
Staff morale
In each of its clinical governance reviews, CHI carries out a staff survey which enables us to benchmark staff opinion across organisations. The picture varies from trust to trust. While many staff work under considerable pressure in difficult environments, CHI has found only a handful of trusts where morale is generally poor. CHI has also been impressed by the commitment and dedication of clinical, non-clinical and care staff to providing high quality care to service users across the sector. Evidence of institutional models of care persist but are relatively rare. Where morale is low, staffing levels, stress, high workloads and poor communication between staff and management are generally responsible. However, CHI has found many mental health organisations with high morale, effective communication and strong relationships between clinicians and managers.

Good practice example:
CHI found a very high level of staff morale throughout Tees and North East Yorkshire NHS Trust. Staff enjoy their work and feel well supported even in remote areas of the trust. The trust has successfully achieved both pledge and practice accreditation in Improving Working Lives standards and was also regional employer of the year.

Education, training and continuing professional development
Trusts have shown a strong commitment to developing their staff. Attendance at training, particularly for inpatient staff, can be limited by service pressures and the need to maintain acceptable staffing levels. There are issues of access to training for staff on night shifts. Monitoring of mandatory training, particularly around control and restraint and cardiopulmonary resuscitation, needs to be more systematic. Most trusts have good partnership arrangements with educational institutions and some are developing good links between service needs, staff appraisal, personal development and training.

Good practice example:
West Kent NHS & Social Care Trust has four levels of training to ensure staff perform their role effectively: induction; learning and capacity building; work based assessment and competence; and qualifications linked to job roles and lifelong learning. All staff groups can progress through this framework.
**Appraisal and clinical supervision**

The implementation of appraisal and clinical supervision is inconsistent. CHI found several trusts with out of date or unimplemented appraisal procedures and a number of staff who have never received an annual appraisal. Where schemes exist, appraisal rates amongst clinical and non clinical departments varied considerably. This is also the case for clinical supervision, which is often informally arranged between line managers and peer groups due to high workloads and low staffing levels.

**Good practice example:**

In West Kent NHS & Social Care Trust the clinical practice supervision programme for nursing staff is notable for the range of choices it gives to nursing staff and for its evaluation tool, which assesses whether the supervision framework has led to service improvement.

**Information**

Information capacity in mental health trusts is severely under resourced. Progress towards implementing the national mental health minimum dataset and developing electronic systems to support the care programme approach is inconsistent. Some trusts have made good progress towards achieving some of these objectives. The picture of IT management for most trusts, however, is poor and information systems to support the delivery of care and the use of information to monitor the quality of care are under developed. While performance management is evolving, trust boards and care teams often receive limited information to enable them to monitor the quality of care. In a minority of trusts more sophisticated performance indicators have been developed and are used routinely. Outcome measures are not routinely used although there are isolated examples where outcome measures are incorporated in the care programme approach.

Trusts that have undergone major reorganisation often have a multiplicity of systems for recording information; some are networked, some are on stand alone machines and others are paper based. This creates problems in using information effectively. Despite increased investment in IT equipment and improved staff access to desktop computers, the current IT systems of several trusts are inadequate to support clinical governance and service delivery needs. Most are incompatible with the systems used in other local health organisations and social services, hindering access to up to date clinical information.

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*Screening, care, advice, next steps.*

What CHI has found in: mental health trusts
Record management

Many trusts experience difficulties developing unified and accessible clinical records. Service users have multiple case notes based at different sites, which are difficult for staff to obtain. In some trusts this situation is exacerbated by services based across large geographical areas and the poor quality of clinical notes.

Service user records are often paper based and are not shared across health and social care teams, resulting in further duplication and a lack of information. Manual tracking systems such as tracer cards are poorly maintained or non-existent, which adds to the difficulties accessing information and developing effective record management systems.

In many trusts access to clinical records out of hours or in an emergency is difficult. Some, however, have developed systems to enable staff to access care programme approach information at any time, while others use electronic patient summary screens and procedures to ensure that up to date service user information is available when needed.

Partnership working

The areas covered by mental health trusts generally contain a number of local authorities and primary care trusts. There are good examples of structural approaches to partnership working with primary care trusts, such as jointly funded posts with responsibilities across primary and secondary mental health care. Many trusts also have senior staff with social care responsibilities on their executive teams and trust boards.

Health and social services partnerships

There is a range of partnership development between trusts and local authorities. Five mental health and social care trusts are now in place while other trusts have taken advantage of Health Act flexibilities to integrate the provision of mental health and social care services. However, there is evidence from one of CHI’s investigations to suggest that in some cases, local partnerships have not been sufficiently developed to put these arrangements successfully in place.
While many staff in integrated teams reported that different professional groups work well together, CHI found that sometimes differences in cultures, values and approaches of health and social care organisations were creating tensions at team level with some staff unsure about their lines of managerial accountability and professional leadership. In some organisations health staff are being managed by a health professional and social care staff by a social care professional, devaluing the partnership approach.

North Essex Mental Health Partnership NHS Trust has developed robust arrangements for working with Essex Social Services. The process of developing the partnership agreement was undertaken in an open and consultative manner with the involvement of other local health organisations and service users.

Local trainee police officers spend time within mental health services at Leicestershire Partnership NHS Trust to gain a better understanding of mental health issues.

Safety

CHI is disappointed with how trusts manage risk despite the importance attached to issues of safety and risk in mental health. CHI found problems with the quality of hospital environments, staffing levels and skills and systems for preventing and managing risk. On several occasions CHI has instructed that trusts take immediate action to secure the safety of staff and service users. Situations where this has been necessary include failure to carry out timely investigations into serious untoward incidents, inadequate clinical safety policies and unsafe environments for staff and service users.

Trusts generally have good systems for incident reporting and reviewing serious untoward incidents, including suicides, but CHI found little evidence of feedback to staff, dissemination of learning or trend analysis. A few trusts do not have a risk management strategy and structure and have an inconsistent approach to risk assessment.

CHI has found an inconsistent approach to the prevention and management of violence and aggression in a number of trusts. In some areas staff accept violent behaviour as the norm, in others zero tolerance approaches are used. Staff sometimes lack confidence in the systems for managing violence and aggression because of access to training or shortages of the required skills.
To improve the uptake of mandatory training at Northamptonshire Healthcare NHS Trust a process known as ‘walk though’ is used once a month at St Mary’s Hospital to update the skills of staff in control and restraint.

CHI also has concerns about policy and practice around drug administration and lone working, safety of environments and staff and the quality of workplace risk assessments. We have found key clinical and safety policies are sometimes out of date and unreviewed.

Risk assessment processes are often inconsistent. Most trusts carry out environmental risk assessments at clinical or departmental level with a focus on preventing violence and aggression and identifying environmental risks. Other trusts have risk registers and assessment tools for corporate and clinical risk enabling them to improve and prioritise routine assessments and monitor high risk areas. However, during the course of the reviews CHI has identified serious risks to patients that the trusts had not acted upon, such as ligature points in a number of wards and units and risks associated with limited medical cover on some wards.

Risk assessment and partnership working

Many trusts are working in partnership with social services, the police and other organisations, but this tends to be at an individual risk assessment level rather than part of a broader risk strategy. CHI did, however, find some examples of good practice between trusts and partner organisations, such as interagency agreements on risk assessment and management, the involvement of GPs via video link and the development of working relationships with the police to tackle specific issues on some inpatient wards.

North Staffordshire Combined Healthcare NHS Trust and South Staffordshire Healthcare NHS Trust have jointly developed a clinical risk management training initiative with social services which has been endorsed by the National Institute for Mental Health and the Zito Trust. Service users are involved in planning, providing and evaluating this training.

CHI found that although most staff are familiar with incident reporting processes there are limited mechanisms for staff to discuss concerns with senior managers and clinicians. Systematic reporting of incidents is patchy and there is often a lack of clarity about when to report near misses.
Lone working
Many trusts have lone worker policies but the systems to monitor the whereabouts of staff in the community or to provide help if required could be strengthened. Some reviews highlighted examples of serious incidents such as staff being threatened with firearms. Staff awareness of lone worker schemes is patchy and some schemes operate using local practices that are not widely known throughout the trust. There is also a variable level of compliance with lone worker policy procedures, such as recording movements, and increasing risk assessments to wider staff groups. Only a few trusts have identified the need to strengthen lone worker schemes through further staff training and resources.

Child protection
Following the Victoria Climbié inquiry, CHI, Her Majesty's Inspectorate of Constabulary (HMIC) and the Social Services Inspectorate (SSI), carried out an audit of the implementation of the relevant practice recommendations made by the report. The audit included all 625 NHS organisations, 150 councils with social services responsibilities in England and all 43 police forces in England and Wales.

The audit found that while NHS organisations were taking action on the inquiry recommendations, they were not all protecting children and young people as well as they could. In particular it found that child protection policies and procedures do not apply throughout all organisations; not all boards have sufficient awareness of child protection issues; working arrangements between agencies vary; record keeping by health professionals and record keeping systems need improvement and child protection training is patchy.

Two thirds of mental health trusts needed to update their child protection policies and procedures. A third of mental health trusts were unable to provide 24 hour access to people knowledgeable about child protection. A fifth of mental health trusts could not supply 24 hour access to case notes or access the child protection register. There was no named doctor for child protection in 21% of trusts and 16% did not have a named nurse.

Other areas where trusts recognised their need for improvement were in developing policies for child visitors and improving communication and information sharing.

At Berkshire Healthcare NHS Trust, staff can access the child protection registers through the duty team. When contacted, the team rings back to verify the caller's identity before passing on any information.

South London and Maudsley NHS Trust has policies for children visiting patients on adult wards. Evaluation of this policy is planned.

What CHI has found in: mental health trusts
User perspective

CHI has a contract with MIND to recruit, select, train and support service user reviewers. In each review, two service user reviewers interview up to 32 service users from the trust being reviewed, using a structured interview. A service user reviewer is also part of the review team. This has enabled CHI routinely to capture service user experiences and ensured a user focus in the visiting team.

Accessing services

CHI’s reviews took place at a time when trusts were introducing new service models associated with the national service framework and The NHS Plan. The aims of the Plan are to establish 220 assertive outreach teams for people with complex needs who traditionally have not maintained contact with services, 50 early intervention teams to provide support to young people with psychosis and 335 crisis resolution teams to support people who are in crisis at home and, therefore, prevent admissions to hospital.

Assertive outreach services are being implemented across the country. However, crisis resolution services are limited and service users commonly report problems in accessing out of hours services or the ability to contact someone out of hours. In some areas crisis resolution services are in place, working effectively and preventing unnecessary admissions to hospital. CHI commonly found major inconsistencies in the model and availability of provision within the same organisation.

Other services for service users in crisis are under developed. For example, in too many areas police cells are still the only place of safety for service users who are taken by the police from public areas. This is contrary to recognised good practice.

Providing mental health services in geographically dispersed rural areas presents particular problems, requiring long journeys to access services or visit relatives. This can present particular problems when services such as electro convulsive therapy (ECT) or psychiatric intensive care units (PICU) are provided on only one site. Access can be even more difficult for specialist services such as inpatient child and adolescent services or early onset dementia services.

Child and adolescent mental health services have the longest waiting times from referral by GPs. Service users also report long waits for psychological therapies.

Good practice example:

Leicestershire Partnership NHS Trust had developed a fast track access system, which enables rapid admission for service users in crisis.
Acute inpatient care: access to inpatient care
The problems around the quality of adult acute inpatient care have been well documented, by the Sainsbury Centre for Mental Health and in the Department of Health's guidance on adult acute inpatient care provision published in 2002, and were confirmed by CHI's findings.

CHI found bed capacity in many trusts under severe pressure. While new community based services will reduce admissions to hospitals over time, in some wards bed occupancy rates still exceed 150%. Service users sleep on different wards to where they are receiving care, or return from visits home to find their bed has been allocated to another user. In some areas users and carers have told CHI of their difficulties in arranging admission to hospital, feeling that they have to wait until their situation reaches crisis point until they can be admitted.

**Good practice example:**
South West London and St George's Mental Health NHS Trust has a gold standard, monitored by the trust board, that every service user who requires admission is admitted to a bed near where they live. Effective management of admissions occurs because clinicians are actively involved in decision making about bed management.

Problems accessing services are mirrored by problems discharging users, most commonly because of a lack of supported accommodation.

**Inpatient environments**
CHI found a variety of inpatient environments during its reviews. In some trusts, inpatient provision has been recently renewed.

**Good practice example:**
Leeds Mental Health Teaching NHS Trust has reorganised the whole of its hospital facilities over the past three years. Service users who require admission to hospital are now cared for in purpose built modern facilities with single rooms.

However, other trusts still deliver care in buildings with Victorian fabric and infrastructure that compromises the quality of care and the privacy and dignity of service users.
Some of the new accommodation provides excellent facilities with single sex sleeping and bathroom facilities, gyms, multisensory rooms, libraries, gardens, music and computer rooms. In some trusts, particularly those providing care in old Victorian buildings, mixed sex wards with shared bathroom facilities and poor security between dormitories remains a concern. The structure and design of some wards also inhibit patient privacy. Service users reported a lack of privacy when wishing to make phone calls or when receiving guests. Child friendly visitor environments are rare. While uncommon, CHI has found examples where service users do not have access to fresh air either because of insufficient staff escorts or because of unsafe external environments.

Service users also report concerns about their personal safety and exposure to violent incidents. Violence on wards is often linked to poor staffing levels, high bed occupancy and an inappropriate mix of service users with different needs. Staff are also struggling to manage the use of illicit drugs and alcohol. Some trusts routinely lock the doors to wards in order to protect service users from the external environments in which trusts work. While some trusts have procedures to ensure the rights of informal patients are not infringed, in practice those procedures are not always followed. Ensuring an appropriate balance between the liberty of patients and their safety is a recurring dilemma. Female service users in particular reported feeling vulnerable and unsafe.

Inpatient activities
Service users commonly report feeling bored on inpatient wards. The availability of therapeutic programmes varies from trust to trust. Low staffing levels and the use of agency staff affects the range of activities available. Staff shortages in, for example, occupational therapy reduces therapeutic activity on wards. Some trusts have created special activity coordinator roles to work with service users on projects developing their self esteem and confidence. However, service users commonly report that the range and quality of activities are limited, with few activities to keep them occupied in the evening and at weekends. Users also report limited treatment options and complementary therapies.

Seclusion
CHI has particular concerns about the use of seclusion facilities. In some trusts a lack of psychiatric intensive care provision has led to service users being secluded inappropriately on acute wards. In others seclusion facilities were in a poor condition when CHI visited, lacking basic toilet and washing facilities. Some did not meet the code of practice standards required under the Mental Health Act.
**Older people**

CHI has found excellent, innovative, user focused services for older people. However, it has also conducted two investigations into allegations of abuse of older people with dementia. In September 2003, CHI published its investigation into matters arising from care on Rowan ward, Manchester Mental Health & Social Care Trust. The service on this ward had many of the known risk factors for abuse: a poor and institutionalised environment, low staffing levels, high use of bank and agency staff, little staff development, poor supervision, a lack of knowledge of incident reporting, closed inward looking culture and weak management at ward and locality level.

At a strategic level the organisations that were the subject of CHI investigations had poor overall leadership with a lack of strategic direction and poor communication with staff. They had both experienced major organisational change, had serious financial problems and had weak clinical governance systems. In addition, internal performance monitoring and information systems were inadequate. Problems within the organisations were mirrored by confused accountability in the wider health and social care communities.

CHI’s clinical governance reviews have found other examples of poor quality care in this area. There is a lack of priority given to services for older people. Users and carers report that staffing levels are often inadequate and staffing shortages common. There remain wards where older people with mental illness and dementia are mixed. There is a lack of capacity in nursing and residential homes and a lack of intermediate care. The performance management of older people’s services is immature and trusts have limited information to satisfy themselves that they are providing high quality care.

**Good practice example:**

West Kent NHS & Social Care Trust’s Admiral Nurse scheme provides holistic support to carers of people with dementia. The scheme also provides training and education on the needs of people with dementia for healthcare professionals.

**Black and ethnic minority service users**

The disadvantage experienced by black and ethnic minority service users is well documented. The Department of Health published its strategy *Inside Outside* (2003) with the aim of reducing discrimination and social exclusion in mental health services.
Some trusts have made considerable efforts to develop culturally appropriate services, while others have barely begun to address this agenda. Some trusts have developed specific services in partnership with local black and ethnic minority communities, such as the assertive outreach teams in South London and Maudsley NHS Trust and Barnet, Enfield and Haringey Mental Health NHS Trust. Other trusts have made considerable investment in cultural awareness training for staff, dealing with bullying and harassment and developing strategies to recruit a diverse workforce and develop their black and ethnic minority staff. However, even in those trusts that have made most progress, the experience of working with communities in different ways is seldom shared across mainstream services. These examples of innovative practice are generally isolated initiatives and not widely adopted, but they provide excellent support to local communities and are good examples of what can be achieved.

Tavistock and Portman NHS Trust works with local groups to provide services in the community, where they are needed. The trust provides an outreach counselling service for refugee children in a local school. It is also involved in a joint project with the CarAf (Caribbean/African) Centre, Black Parents and Teachers Association and Haverstock School to improve access to early intervention therapeutic mental health services for young black people and their families, and to improve support for those who are failing at school.

The trust has also worked with the Bangladeshi and Somali communities to develop mental health services that are accessible and adaptable to their needs.

Other trusts have produced spiritual care strategies to improve resources and facilities for service users with specific religious needs. They have built relationships with religious leaders to provide pastoral and spiritual care to service users from different faiths.

Barnet, Enfield and Haringey Mental Health NHS Trust’s antenna outreach service in Tottenham provides mental health services to African/Caribbean service users aged between 16 and 25 years. The team offers support, advice and practical help to service users, parents, guardians and carers using a social model of care. It uses innovative ways of working with local communities to promote greater awareness of mental health.
While there are excellent examples of community liaison and effective mental health promotion campaigns, reducing the stigma associated with mental illness, trusts have been slow to develop links with local groups and support capacity building within black and ethnic minority communities. Even where trusts are working successfully to engage service users in their work, the involvement of black and ethnic minority service users is limited.

Most trusts are still struggling to meet the needs of black and ethnic minority communities, even when they are the majority population. Dietary requirements are often not met and access to appropriate interpreting services is difficult, despite many trusts having interpreting units. The use of children or other family members as interpreters is not unusual. Where interpreters are provided, they are often not trained to deal with psychiatric consultations and have no knowledge or experience of psychiatric terminology or medication. Few trusts provide information on Mental Health Act issues in languages other than English.

People from ethnic minorities are still facing inequalities in mental healthcare. Poor links between trusts and local communities and a lack of self assessment on diversity issues, in relation to policies and practice, are barriers for many trusts. Most importantly, there is little evidence that trusts have the information that would enable them to assess the services they provide for black and ethnic minority service users. Basic ethnic monitoring data is still limited.

**User involvement**

Systems for involving service users are better developed in mental health than in other healthcare sectors. Users are often involved in service planning and development, and staff recruitment and training. CHI has found examples where user involvement is embedded in the principles and practice of trusts at every level. There are also trusts where this is exemplified in their own recruitment practices and support for staff at work; for example at South West London and St George's Mental Health NHS Trust, where approximately 20% of staff recruited in the year prior to the CHI review had experience of mental health problems.
<table>
<thead>
<tr>
<th>Good practice examples:</th>
<th>In Leeds Mental Health Teaching NHS Trust and Newcastle, North Tyneside and Northumberland Mental Health NHS Trust service users are employed as members of the care teams on acute wards and in the community. Some mental health trusts have invested heavily to make services more user focused. Other trusts have appointed dedicated staff to coordinate user involvement activities and employ paid service user and carer consultants. While user involvement is still inconsistent in many areas CHI has found many examples of good practice across the country:</th>
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<td>Good practice examples:</td>
<td>At Norfolk Mental Health Care NHS Trust service users set up the Choices Café in partnership with the trust several years ago. The trust provides the café's food but it is run by the service users for service users. East Kent Community NHS Trust has a number of groups and projects to involve and gain feedback from service users. These include the patients' council, user involvement and an empowerment project for older people, which has improved older people's involvement in the trust. Service users on the medium secure unit's patient's council review service delivery at Oxfordshire Mental Healthcare NHS Trust. Service users chair the council and there are numerous examples of change made as a result of their suggestions. Several trusts have good links with voluntary and service user organisations and provide designated offices and equipment for them. Through partnership working some voluntary organisations coordinate trust user involvement and provide independent advocacy, although users report that the availability of advocacy services is patchy.</td>
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Good practice examples:

The former South Birmingham Mental Health NHS Trust works with an independent user led organisation called User Voice, which coordinates user involvement and provides group advocacy for users through a number of mechanisms.

County Durham and Darlington Priority Services NHS Trust works in partnership with service users, carers and other agencies on the Bridge project, which provides activities and support into employment for female service users at County Hospital.

CHI review teams spoke to several service users who feel that their contributions are valued and that they are facilitating change. However, many professionals and local stakeholders expressed concerns that many trusts rely on the most articulate and active users who are not always representative of the diverse user population. In most trusts the participation of black and ethnic minority service users is particularly limited.

The involvement of carers is, in contrast with the involvement of users, less developed both in planning and service development and in the implementation of the assessment of carers’ own needs.

Choice

Service users report a lack of choice in treatment options, particularly on inpatient wards. Users also report concerns about not being told of the possible side effects of medication or having a say in decisions about the medication they take; not having had any talking therapy; not being aware of their rights to see their medical records and their rights under the Mental Health Act.
**User information**

Accessible information is essential for meaningful involvement and for users to understand their rights if they are detained under the Mental Health Act. In some trusts user information is well coordinated and can be accessed via websites, newsletters and prospectuses. Other trusts are less consistent and produce information on an ad hoc basis. In order to ensure consistency and corporate ownership a few trusts have developed a set of standards for the production of service user information. They have also encouraged user involvement by incorporating their artwork and suggestions into the production process. Information in different formats or media, such as Braille or community languages, is particularly limited.

The quality of information available for service users does not always prepare them for meaningful involvement in individual care planning or in the planning and delivery of services more generally. Many service users are not aware of complaints procedures or are dissatisfied with the outcome of their complaints.

**User involvement and care planning**

There is a gulf between user and trust perceptions of user involvement in care planning. Service users commonly report that they are not involved in their own care planning, do not have care plans and do not have their care plans reviewed, whereas trusts report that users are involved. This difference may be attributed in part to the way in which questions about user involvement are asked. However, it also reflects the reality that mechanisms for involving service users in their own care are ineffective. The reasons for this include poorly implemented systems for the care programme approach and limited information and support for service users. The review teams found that many service users and their carers have little or no input into care plans and some are not even aware that they have one.
Care programme approach
The care programme approach (CPA) was introduced in 1991. It has four main elements: the assessment of a service user’s needs, the development of a care plan to meet those needs, the allocation of a care coordinator to ensure that those needs are addressed and the regular review of the care plan. It was revised in 1999, from when service users have been placed on the standard or enhanced care programme approach according to the complexity of their needs and the range of support required to meet them. Despite being introduced 12 years ago, its implementation is still problematic. Large numbers of users are not being placed on the care programme approach or allocated a care plan and coordinator. In some trusts there is still considerable clinical resistance to it and the burden of associated documentation. Although some trusts have reviewed care programme approach procedures, redesigned documentation and piloted electronic systems, practice in many trusts remains inconsistent.
Good practice examples:

Community Health Sheffield NHS Trust organises its care programme approach efficiently. Procedures and documentation have been redesigned, staff training delivered and the compliance of care programmes against the standards is continuously monitored.

Tees and North East Yorkshire NHS Trust has an electronic version of the care programme approach in place.

Central North West London Mental Health NHS Trust has developed a code of practice, designed by a local user group, for managing care programme approach meetings.

South London and Maudsley NHS Trust has developed a video for use by carers and service users which explains the process.

South West London and St George’s Mental Health NHS Trust carried out systematic care programme approach audits to monitor its implementation.
Appendix 1

Clinical governance reviews

CHI began undertaking clinical governance reviews of mental health services in 2001. This is part of the rolling programme to assess clinical governance arrangements in NHS organisations in England and Wales, which has completed in excess of 300 reviews. To date CHI has published 35 reports on mental health services. This report draws on findings from the completed clinical governance reviews.

CHI defines clinical governance as:

"The framework through which NHS organisations and their staff are accountable for the quality of patient care."

Clinical governance reviews describe and assess the seven components of clinical governance on a one to four scale:

- patient, service user, carer and public involvement
- risk management
- staffing and staff management
- clinical effectiveness
- clinical audit
- education and training
- use of information

In addition, reviews describe the patient experience and the organisations’ strategic capacity to deliver clinical governance, but these are not given numerical assessments. The assessment system and a summary of the attainments by mental health trusts are included in appendix 2.

During the reviews, evidence is gathered through documents, stakeholder interviews, and further interviews and observations during a site visit. This involves a peer review process, for which CHI seconds a team of people most of whom work in the NHS. A review team typically has six to eight members depending on the size and complexity of the organisation and will include a doctor, a nurse, an NHS manager, a representative of the professions allied to medicine a lay reviewer and a service user reviewer. The team is managed by a review manager, who is a CHI employee.
What CHI has found in: mental health trusts
Assessing components of clinical governance

On the basis of the evidence collected, CHI’s reviewers assess each component of clinical governance against a four point scale:

I little or no progress at strategic and planning levels or at operational level

II worthwhile progress and developments at strategic and planning levels but not at operational level
or:
worthwhile progress and development at operational level but not at strategic and planning levels
or:
worthwhile progress and development at strategic and planning levels and at operational level but not across the whole organisation

III good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the organisation

IV excellence – coordinated activity and development across the organisation and with partner organisations in the local health economy that is demonstrably leading to improvement. Clarity about the next stage of clinical governance
Attainments by mental health trusts

The table below illustrates the spread of development in each of the elements of clinical governance. Each indicates one trust attaining that level for the component.

<table>
<thead>
<tr>
<th>Patient &amp; Public Involvement</th>
<th>I</th>
<th>II</th>
<th>III</th>
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<tr>
<td>Risk Management</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<tr>
<td>Clinical Audit</td>
<td>I</td>
<td>II</td>
<td>III</td>
</tr>
<tr>
<td>Staffing and Staff Management</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<tr>
<td>Education, Training and Continuous Personal and Professional Development</td>
<td>I</td>
<td>II</td>
<td>III</td>
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<td>Clinical Effectiveness</td>
<td>I</td>
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<tr>
<td>Use of Information</td>
<td>I</td>
<td>II</td>
<td>III</td>
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Appendix 2

Investigations

CHI investigations are in depth examinations of organisations where there has been a serious service failure. Trusts are not given assessment scores for their progress in clinical governance during investigations.

CHI has undertaken investigations in the following mental health trusts:
- North Lakeland Healthcare NHS Trust (now North Cumbria Mental Health and Learning Disabilities NHS Trust)
- Manchester Mental Health & Social Care NHS Trust
- Pembrokeshire and Derwen NHS Trust
  (investigation still underway at time of writing)
What CHI has found in: mental health trusts