Commission for Social Care Inspection
Making Social Care Better for People

Healthcare Commission

JOINT COMMUNITY MENTAL HEALTH SERVICES REVIEW

Inspecting for improvement report

Halton LIT community

January 2007

Commissions' values and aims

The Healthcare Commission and Commission for Social Care Inspection are committed to:

- putting the people who use health and social care services first
- promoting continuous improvement in health and social care services
- promoting the rights of everyone to have equal access to health and social care services
- being independent, fair and transparent in the undertaking of the fieldwork

The Joint Community Mental Health Services Review's 'inspecting for improvement' aims to promote improvements in the quality of health and social care for the benefit of the people who use community mental health services.

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Introduction

The statutory service providers and commissioners that were members of the Halton LIT at the time of the fieldwork were

- Halton Borough Council
- 5 Boroughs Partnership NHS Trust
- Halton & St Helen's Primary Care Trust

The purpose of fieldwork was to:

- further explore findings from the data analysis;
- focus on identified areas of concern;
- gain a greater understanding of performance issues; and
- assist LIT members with improvement planning.

People who use mental health services and their carers were central to the fieldwork. It provided a stronger and more comprehensive evidence base on which to assess and understand:

- access arrangements to key community services
- interface between primary care & in-patient services
- provision for access out of hours
- service provision for carers
- service provision for diversity
- addressing physical health needs
- supporting social inclusion

Overall Findings

A review of data and local information indicated that Halton LIT had made relatively less progress in implementing parts of the National Service Framework (NSF) for Mental Health in comparison to other LIT areas. The seven areas, outlined above, are reflective of the limited range of services that have been available in Halton. Substantial work had recently been undertaken at local and regional levels to redress this, by developing and implementing an ambitious strategy for modernisation. The model for service redesign, which became known as *Change for the Better*, had been consulted upon in 2006 and was at the early stages of implementation at the time of this Improvement Review. The focus of this fieldwork was to explore the effectiveness of the strategy and assess improvements on outcomes for service users and carers.

Partner organisations in Halton were working to overcome historical challenges and difficulties in joint working that had contributed to the failure to meet some of the NSF targets. Some effective local services consistent with a modern mental health service had been established over the last two years following agreement on a joint commissioning strategy, although these were initially developed piecemeal. The drive for change had gathered pace because of NHS financial imperatives, and the 5 Boroughs Partnership NHS Trust led on developing the operational model *Change for the Better*. The consultation process for *Change for the Better* highlighted how the outcomes set out in the recovery model would be achieved. This led to significant changes including increased investment, reconfigured in-patient services and a plan for a phased introduction of the model. Further work was being done to formalise partnership arrangements, and the creation of a single PCT for Halton and St Helens had established an infrastructure to support an increasingly unified approach to *Change for the Better*. Members of the LIT were enthusiastic about the potential for improvement.

A Local Development Team (LDT) had been established to oversee the implementation process. We found that although there were reporting lines from the LDT up to Chief Executive level in all key partner organisations, there was a lack of clear accountability and leadership. There was also widespread concern amongst staff, service users and carers about the implementation of plans to change services. Insufficient attention had been given to the development of community based and preventative services, at a time when decommissioning arrangements were being made. This situation was compounded by the fact that responsibility for the development of primary care services was divorced from the LDT's remit. There were insufficiently robust systems in place for feedback to and quality assurance of the LDT, and the high levels of anxiety amongst community staff, users and carers were not being heard or addressed. Further, challenges to aspects of the model that were raised in relation to the inclusion of older people in adult mental health services required further consultation and final resolution.

We judged that because of these unresolved issues, the implementation stage of *Change for the Better* required urgent action to ensure that the change management process was refocused and properly managed, without which the success of the service redesign was at risk. Unless quality issues in areas of access, interface between services, and the range of services were speedily rectified, there was a high likelihood of there being a negative impact on outcomes for service users.

There was a mixed picture in relation to care planning and assessment. A training programme was being implemented to improve practice, and plans were in hand to address the lack of integration of case files and underperformance of IT systems. Improvements in care planning, risk assessment and recording needed to be supported by more robust management oversight and quality audit.

Improvement Planning

Prior to the review the LIT had developed an action plan to address areas where performance was below national averages. It is the intention of the improvement planning that it will dovetail with existing improvement work rather than add to it.

The commissions will therefore work jointly with the LIT community to facilitate planned improvements in response to the findings of this report.

The most pressing issues for improvement planning are:

- Clear lines of leadership and accountability to be established for *Change for the Better*, with urgent action taken to ensure that primary care and community service developments are co-ordinated and implemented as a priority. This needs to ensure that a range of services are developed that will deliver an effective recovery model and improved outcomes for service users.

- The need to develop whole systems thinking and approach to strategic planning, service planning and commissioning. This will need to take account of the effectiveness of current integrated working arrangements - joint finance, management and IT systems.

- Taking charge of the agenda for services for older people within adult mental health services. This will include determining that the needs analysis is robust, that this is used to drive a needs-led service which is developed in consultation with older people's service leads, and addresses the concerns and issues that have been raised by stakeholders.

- Improvements in assessment, care planning, risk assessment and review. This will be supported by a greater focus on the quality of practice and recording.

The desired outcomes for service users and carers are:

- Improved access to a range of services in the community that focus on prevention and social inclusion.

- To benefit from seamless service provision and continuity of care from primary and secondary care, which results in timely follow-up or support by the right service.

- To receive effective person-centred care co-ordination, from a named care co-ordinator.

SUMMARY OF FINDINGS

Strengths

- There was good consensus about and commitment to the modernisation of services along a recovery model.
- Work was being done to strengthen partnership working, and this would further benefit from the recent reorganisation of the PCT.
- There had been positive and effective developments in services that supported social inclusion.
- Recent improvements in support services for carers were highly valued.
- The understanding and use of Direct Payments was improving.
- Users and carers valued the service provided by the Assertive Outreach Team.
- A range of services had been developed by Halton Borough Council and voluntary sector providers, which were effective and highly regarded by users and carers. These included Making Space, MIND, TREDS and the Councils' community support outreach service.
- Commitment had been made to developing a women's service to further address social inclusion and well-being issues

Areas for Development

- There was a lack of leadership and quality assurance of the implementation of the service redesign, and the capacity to support the change management process was underdeveloped.
- Integration was limited in respect of joint management, joint finances and IT systems.
- Interface arrangements were variable and further work was needed in respect of young people and older adults services.
- There was a limited range of services, with insufficient psychological therapies available.
- Primary care and out of hours services were underdeveloped.
- The needs of minority groups were not fully understood or met.
- There were insufficient quality assurance and evaluation systems in place, which undermined engagement of key stakeholders.
- Case files and ICT systems were not integrated and management oversight of practice and recording needed strengthening.
- There were gaps in recognition of social care issues in assessments and care plans.
- Information about services and conditions was not systematically distributed to service users and carers.
- Users and carers experienced negative attitudes from some groups of staff.

Criteria 1: Access

Data analysis showed that Halton was under-performing in areas concerning access to services, effective interface between services, and out-of-hours arrangements.

As noted elsewhere in this report, Halton were aware of these deficits and had set out to radically redesign services with the intention of promoting seamless pathways of care, and a range of services that were accessible to people according to their need. *Change for the Better* set out a model that included enhanced primary care treatments, a single point of access into a full range of secondary care services through an Access and Advice Centre, and a clear pathway into in-patient and specialist care.

There had been some positive developments, including the recent establishment of an Early Intervention Team (EIT). The Crisis Resolution team (CRT) was imminently to be extended to provide a twenty-four hour service seven days a week, and it was intended to also extend as a Home Treatment service. Recruitment had begun to the Access and Advice Team, and one person was in post. Interpreting and translation services were working well, which promoted good access.

However, we found a lack of clear planning that would ensure effective transitional arrangements, and also significant gaps in progress toward the long-term vision. The most important of these was that planning for the development of primary care services was divorced from the implementation of *Change for the Better* – the Local Delivery Team (LDT) did not have the responsibility for this as part of its remit. This undermined joint planning and there was a lack of co-ordination in developing the primary care service. The LDT was overseeing closures of services that would result in functions such as those relating to administration and monitoring of medication transferring from day centres to primary care, without the appropriate training or staffing arrangements being put in place to support it. This was causing high levels of anxiety in staff, users, carers and GPs.

As well as potentially undermining the quality of outcomes for users, this was alienating key stakeholders from the commitment to the change process. This was further hampered by lack of clarity around the development of key elements of the pathway through care. For example, the development and role of the Access and Advice team was not well known or understood. Staff were unsure how the extended CRT and Home Treatment service would operate, including how it would manage the interface with in-patient services. There was a lack of information about or progress being made in relation to the development of access to services for people with mild to moderate mental health problems, or services such as psychological therapies, which were being reduced rather than expanded. Users, carers and staff were concerned that thresholds for access were already high, and that this would become more of an issue unless a broader range of support services were put in place.

Out of hours

There were very few out-of-hours services. The CRT operated until 9 pm, and was about to be launched as a 24-hour service seven days a week service. This was a key improvement, although greater clarity was needed regarding the management and function of the team.

MIND provided a social drop-in on a Sunday morning, and the Council's community support outreach team operated in the evenings and weekends. These were both identified as highly valued services, but were insufficient to meet people's needs.

Interface Arrangements

Key partners were able to demonstrate effective partnership working in learning disabilities services. There were also good working relationships with services for people with physical disability and sensory impairment. However, these would be strengthened by the development of formal protocols. Effective protocols across mental health services ensured the safe and timely transition of service users between teams.

There were some challenges in the interface between Children & Adolescent Mental Health Services (CAMHS) and adult services. The *Change for the Better* proposal would raise the age for entering into adult services to 18 years old, but further work was needed on transition arrangements, differences in eligibility criteria, and access to in-patient beds, particularly for young people aged 16 to 18 years of age.

There was a lack of clarity about what the *Change for the Better* plans would mean in terms of improving services for older people. A commitment had been made to ensure that services would be needs rather than age led, and arrangements were being made to continue to care for people with mental health problems within the adult services up to the age of 75 years. The details of this needed clarification, and insufficient work had been done to ensure that there were robust interface arrangements and protocols put in place to guarantee clear pathways to support and care. This would need careful monitoring and evaluation, and attention to the financial implications for the local authority.

Some service users and carers that we met reported poor experience of hospital discharge to the community, with discharges taking place without time for effective care planning. Pressure on in-patient beds led to difficulties in securing a bed or retaining it while on leave from hospital.

While we heard that individual practitioners had a good relationship with police colleagues, there had been problems in securing a good response when needed. This was felt to be an issue relating to changes in how the police received and responded to calls. Operational arrangements with the police needed to be strengthened to ensure the safety of Approved Social Workers and the public.

Criteria 2: Care Arrangements

Range of services

Historically Halton had offered a limited range of services. Lack of effective commissioning, partnership working, and financial management had impeded progress in service developments. Services had remained traditional and bed-based, with a lack of focus on primary care, community services and prevention. National targets for key services, such as Early Intervention Teams (EIT), and support, time and recovery (STaR) workers, had not been met. There were long waiting lists and lack of access to psychological therapies. There was only one Cognitive Behavioural Therapist in Halton, and progress had been slow on recruiting support time and recovery (STAR) and graduate workers. Day services were traditional and buildings-based.

There had been some developments in community services over the last two years to redress this position. Users and carers spoke highly of a number of services recently established in the voluntary and statutory sectors, particularly the Assertive Outreach Team, the Council's community support outreach team, and Making Spaces. Counselling services, provided by Mind and/or mental health resource centres, were widely used and able to prioritise service users with urgent need.

There was increasing investment in and awareness of social inclusion issues, particularly from the local authority who had developed creative solutions in partnership with other agencies and across council departments. Some valued recent developments included *Building Bridges*, (supporting people into mainstream activities), *TREDS* employment services, and an in-reach service to Registered Care Homes that aimed to support rehabilitation into mainstream housing (Imagine). The Council had reconfigured employment services to establish a clear pathway for service users from job preparation to full employment – *Steps 2 Work*. This had been effective in helping a small number of service users to gain employment. The council had also taken the opportunity to create robust links across other corporate areas: housing and accommodation needs were being planned for through this framework. Effective benefits advice and debt management services further promoted social inclusion, and there was good access to advocacy services.

As noted above, the stated intention of the redesign of services under *Change for the Better* was to co-ordinate partnership working to ensure that an improved range of effective services was in place. However, staff, users and carers were reporting service closures rather than developments as the implementation process had started. We heard that these closures were necessary to release funding before alternatives could be put in place. Transitional arrangements from existing services to new had not been agreed to or secured, and users anticipated the loss of valued services with either no replacement or unacceptable alternatives being offered. The planned reconfiguration of day services to one site in Runcorn may disadvantage some users and carers for a variety of reasons including economically. Users, carers and staff were concerned that the

implementation of the service redesign had weakened rather than strengthened their position in relation to choice and the quality of options available to them.

Retraining for staff in the new culture and an analysis of the impact of the changes on community teams' caseloads was being undertaken, but adequate arrangements had not yet been made to ensure that services were equipped to deal with the changing demands that would inherently follow the implementation of a recovery model and move away from bed-based services.

Carers

There had been significant improvements in services to carers. A Carers' strategy and action plan had been developed following a public conference, which was overseen a mental health carers' subgroup. A database had been established to help identify and contact carers, and a dedicated carers worker appointed to promote carers' assessments and take up of services. The majority of carers that we met had had assessments and practical support through Direct Payments and/or the carers' service, and they spoke highly of the benefits that included access to complementary therapies, trips out, and training and information through the carers' support group. A carers' pack of information had been developed, which included useful contact numbers.

Diversity

Partner organisations were at different stages in addressing diversity issues. There was a clear commitment from the 5 Boroughs Partnership NHS Trust (5BPT) in respect of social inclusion, and Halton council had a framework and policies in place to support social care services in addressing the needs of people from black and minority ethnic communities. The PCT had work to do to develop an approach to equalities and diversity that would underpin the development of culturally sensitive services. Greater synergy between partners in developing the agenda around equalities and diversity could be realised through the local strategic partnership providing leadership and co-ordination.

Although there was a lack of a unified approach by commissioners to developing services for people with diverse need, action was being taken to develop a women's centre. A Women's lead was in post, and the Council had committed capital funding to develop the project. This was at the consultation stage, and represented an important potential benefit to women of all ages in Halton.

Criteria 3: Decision Making And Choice

Information

Halton LIT had an information sub-group, and an information strategy had been developed. There was a well regarded website, and information was available to carers in a pack which contained key contact numbers. However, further work was required to ensure that service information was disseminated systematically. Information about services and conditions was not available in a co-ordinated, easy to access manner. Specific areas such as the patients or carers' charter, and complaints procedure needed a higher profile.

Assessment and Care Planning.

Halton did not have integrated case files or joint IT systems to support the Care Programme Approach (CPA). A bespoke IT system (OTTER) had been developed in the hope that this would be able to integrate care recording and produce performance management reports, but this had not been realised. Research was taking place to identify the best alternative system to replace it.

The consequent uncoordinated arrangements made case file reading challenging, which would undermine information sharing and continuity of care for practitioners. Case files lacked clear audit and management input to promote the quality and consistency of recording. There were plans to invest in two new posts in each locality, (a CPA co-ordinator and administrative support), and this would be of benefit to make much needed improvements in recording and quality assurance.

Following discussion with managers of concerns arising from our review of case files, the Trust decided to undertake a more detailed file review. This confirmed initial findings that there was scope for improvement in a number of areas of assessment and care planning. The key areas included:

- It was extremely difficult to track key information from the case files.
- Information sharing across teams and agencies did not routinely take place as and when required.
- There was no evidence of management overview on some files.
- Risk assessments did not always reflect pertinent issues identified elsewhere in the case notes.
- Assessments and care planning did not consistently consider wider social issues, such as history of drug use and child care arrangements, or have effective arrangements in place to address them.
- Adult and child protection issues were not satisfactorily and consistently identified and responded to in a timely and effective way.

Members of the CMHTs demonstrated an awareness of social inclusion issues, and how to address these in care planning. Also, training programmes were underway to effect a culture change that would help staff move away from a medical model of care towards a recovery model. However, users and carers were yet to feel the benefits of this. Many users and carers that we met felt disempowered by negative attitudes from staff, lack of individualised care and feeling that they were not listened to. Users and carers identified this as being a particular issue when they had contact with specific groups of staff – in-patient staff, psychiatrists, the CRT and GPs. This created feelings of being unable to get help when it was needed, and a lack of continuity of care that was compounded by high turnover in locum psychiatrists. Some users and carers felt that this was exacerbated by differences in gender and ethnicity between themselves and medical staff, which contributed to cultural and communication barriers. The Trust needed to evaluate the quality of communication between staff and users, and ensure that effective systems were in place to monitor and improve the experience of service users and carers.

How reviews were conducted, in terms of formality and size, was also creating high anxiety, and presented a barrier to service users and carers participating fully in planning for their care and support. The Trust needed to set standards for reviews and ensure that review processes were sensitive to service users and carers needs.

Adult Protection

An adult protection multi-agency committee had been established, chaired by the Council. We found that managers and staff at all levels in the council and Trust were clear about the procedure and their roles. There had been extensive training and review of procedures that had improved referral and response to Adult Protection issues. While there were quality assurance systems in place that included case file sampling by the Adult Protection lead, the systems for routine audit by practice managers needed to be strengthened. More robust monitoring was needed to ensure that all relevant issues in both adult and child protection were quickly identified and responded to.

Partnership Working

Halton were aware of deficits in partnership working that had contributed to ineffective commissioning, and stagnation of services in the area. In recognition of these deficits and the pressing need for modernisation, the Council led on the development of a joint Commissioning Strategy for the period 2005-8, which set out a whole systems approach to service redesign. The local authority and primary care trust (PCT) were to commission and performance manage the 5 Boroughs Partnership NHS Trust in the phased withdrawal from investment in in-patient services, and reinvestment in a spectrum of community based support, care and treatment.

Progress remained somewhat piecemeal and single-agency, until increasing pressure for the Trust to make financial savings became the key driver for implementing change. There was consensus that action was overdue and progress in taking forward modernisation was therefore welcomed. However, the consultation process identified serious concerns from partners about whether the model would deliver the vision and improved outcomes for service users. Significant extra funding and a phased introduction were agreed to promote an effective transition period.

Subsequent to the consultation for *Change for the Better*, a Local Development Team (LDT) was established, to oversee the implementation process. The view of the Trust was that the LDT would be responsible for making decisions about local implementation, although they chaired the meetings, and had appointed a project manager to oversee the process. We found that although there were reporting lines, there was a lack of accountability to and leadership from any of the key organisations.

There were insufficiently robust systems in place for feedback and quality assurance. Greater attention should be given to ensuring that effective feedback and evaluation processes are in place that includes promoting user, carer and independent sector involvement in consultation. This should not only include ensuring representation on planning groups, but also extend to reviewing infrastructure. We found that information was given to established forums for users and carers but insufficient consideration had been given to ensuring that the information reached a wider audience of users and carers who were not involved in formal groups and meetings.

Membership of the LIT had improved in terms of range of stakeholders and consistency of attendance, and action was being taken to review the infrastructure supporting user and carer attendance. Terms of reference were established and there were clear links to sub-groups and the Partnership Board. Members were clear about their role in relation to strategy and planning, but there was less clarity regarding the practicalities of overseeing the delivery of *Change for the Better* and how they linked to the LDT.

We found that integration was underdeveloped between Halton's key partners. A partnership agreement had been developed but was not yet in force. There were no Section 31 agreements in mental health, few joint management posts, and no integrated IT systems. Management arrangements for the future teams had been split between the Trust and the Council. Proposals for 'joint accountability' were not well developed or detailed, and there was potential for polarisation of services and teams rather than 'seamless services' unless this was mapped out more clearly. The extent of integration should be reviewed to determine whether improvements could be made to whole systems and partnership working.

There had been no joined-up commissioning of private and voluntary sector services, and opportunities to maximise their input into the reconfiguration plans had not been taken. Improvements were needed in the formal arrangements for developing and monitoring contracts, and co-ordinating the engagement of the independent sector in commissioning plans and *Change for the Better*.

There were good working relationships in integrated teams, although these were not fully multi-disciplinary. CMHTs did not have OT or psychology staff, and neither the CRT nor AOT had social workers although recruitment was underway. Staff turnover was low, and there had been recent developments in developing joint workforce planning and training strategies, which were at a very early stage. Staff valued the management that was available to them, but not all staff had access to appropriate professional development and supervision.

Social Care

Access

The Council's arrangements for accessing out of hours services had been reviewed with the provider Cheshire county council and a decision made that Halton and St Helen's Council's would combine their resources to establish a single EDT for both council's. An out-of-hours team was to be established with ASW capacity within the team. The current arrangements relied on a diminishing number of volunteers from the daytime ASW rota supported by a single ASW within the Cheshire service.

Access to key service user information out of hours is crucial to the safe operation of out-of-hours services. Currently ASWs were unable to access key information beyond 9.00 p.m. This would need to be addressed as a matter of urgency. The opportunity to make the necessary improvements could be taken when the CRT extends it hours of operation.

The council needed to ensure that legal advice and management support was available to ASWs out of hours. These matters should be addressed as a matter of urgency.

Care Arrangements

In general, we found that improvements in planning and services to address social care issues were not underpinned in CPA. Insufficient attention was given to identifying and addressing employment, housing and financial concerns; key areas in developing an effective recovery model approach. The co-ordination of care plans would be strengthened by all services, i.e. housing and voluntary sector providers, involved in the support and care of individuals being involved in CPA reviews.

Health Care

Care Arrangements

Physical health reviews were compliant with the NICE guidelines for schizophrenia. However the proposed shared care approach to medicines management had a number of significant barriers to successful implementation. There were professional tensions between the secondary and primary care medical staff, and also lack of training for GPs who felt unprepared and under resourced to adopt this practice.

Systems need to be strengthened to ensure that there are up-to-date documented audits against the NICE Guidelines in medication prescribing.

Decision-making and Choice

There was good access to voluntary and advocacy services and some specialist services had been commissioned to support the needs of specific groups. A wide range of information was available on conditions and medicine management. Prescribing of atypical anti-psychotics was above the average.

Conclusion

Halton was at a critical stage in managing a wide-ranging and ambitious programme of change. Despite past difficulties, partnerships were being strengthened and a consensus about the future vision for services was emerging. It was essential to establish clear leadership of the implementation stages to lead the change management process. Timely and assertive action was needed to redress some faltering in the initial stages of the implementation process, and increase capacity to support the change management process. The PCT commissioning role needs to link more clearly with this.

There was still the opportunity to begin to address the quality issues identified in this review and build upon some very positive developments that have been made in moving towards a recovery model. Some of the building blocks to support changes in service configuration have been put in place but these urgently need to be built upon to deliver an effective and comprehensive range of services.

The improvements needed to the commissioning and operational arrangements need to be supported by improvements in care planning, ensuring that the recovery model and social inclusion are fully embedded and promoted.