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inspection report

INSPECTION OF MENTAL HEALTH SERVICES

LONDON BOROUGH OF HARINGEY

February 2006

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- Host the Children's Rights Director role.

INSPECTION OF MENTAL HEALTH SERVICES

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February 2006

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Inspectors would like to thank all those involved in the inspection.

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Summary

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Introduction

1.1 The fieldwork for this inspection of mental health services took place between 7 and 17 February 2006**.** The inspection was carried out by three service inspectors, Jan Clark, Alison Rix and Ian Whitehead, and an expert by experience, Jean Haldane**.**

1.2 The objective of the inspection was to evaluate how far the London Borough of Haringey had implemented national and local objectives relating to adults with mental health difficulties and the quality of services the Council is responsible for.

1.3 We were particularly interested to see how well Haringey had responded to the national agenda for adult mental health about promoting independence and social inclusion, fairness, racial equality and consistency and how far they were progressing:

- The National Service Framework (NSF) for Mental Health (and associated guidance); and
- The National Priorities and Planning Framework (2003-06).

1.4 The inspection used standards and criteria drawn from legislation, service users' and other stakeholders' perspectives, guidance, research and understanding of good practice. These are reproduced at Appendix A.

1.5 During the course of this inspection we:

- carried out a number of interviews with service staff, managers, service users and their carers;
- conducted surveys by questionnaire of service staff, service users and carers;
- examined a number of case files; and
- analysed statistical data concerning the Council's performance.

1.6 Further details of the background to this inspection and the methodology used can be found at Appendix B.

1.7 The inspection aimed to support local change and development. Inspection findings are also integral to the assessment of the overall performance of social services and the Council as a whole.

Conclusion

1.8 Haringey was demonstrating a new commitment to partnership working and was developing some good arrangements through the Haringey Strategic Partnership, the planning infrastructure provided by Theme Boards and the development of a Compact with the voluntary sector. At a strategic level, the mental health strategy and joint commissioning plan, once fully comprehensive, refined and in place, would act as drivers to modernise and improve the mental health service across the joint well-being agenda. Mental health services were coming from an underdeveloped base, where structures, systems and processes had not been progressed in line with national developments. There was significant work to do to ensure that front-line practice and procedures were in line with those expected and generally being delivered nationally.

1.9 Key inhibitors to mental health service development and the provision of consistently good outcomes for service users were:

- the partial integration of the service;
- the lack of robust performance management and quality assurance;
- the lack of capacity within the joint commissioning function;
- separate commissioning budgets; and
- the distance between where budgetary commitment decisions were made and front-line care planning and service delivery.

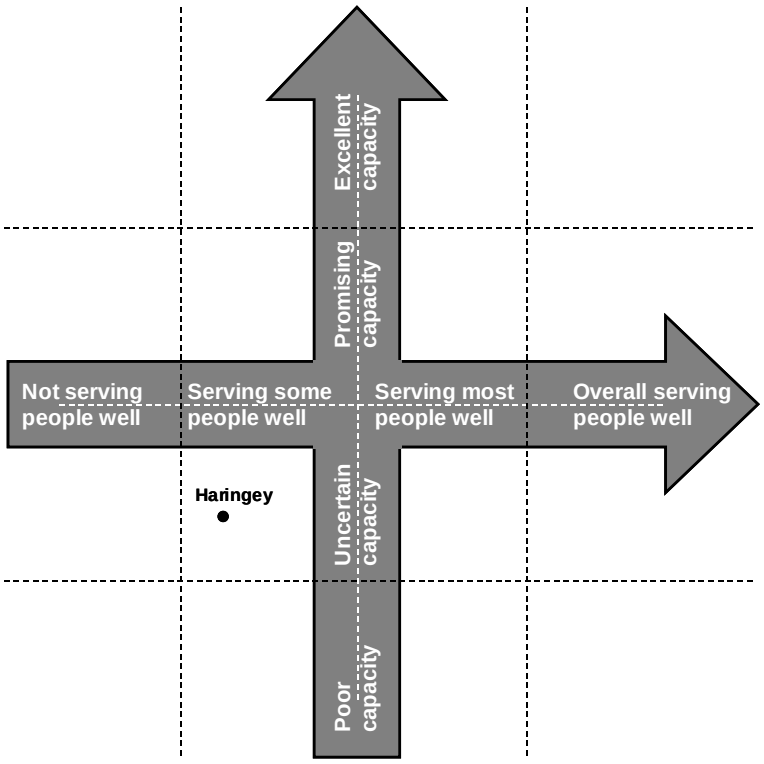
1.10 Senior management lacked stability and there were a number of new management posts within the re-structured integrated service. Management stability and strong leadership would be essential to provide momentum and drive the direction and vision for service improvement.

1.11 Service provision lacked cohesion and some key service areas were very underdeveloped, such as Direct Payments and early intervention. Care co-ordination was not working consistently and effectively. Assessment, care planning and reviewing systems and practice were weak overall and staff confusion over roles and responsibilities was impeding the effectiveness of interventions. The lack of awareness of adult protection policy and procedures within the mental health service was a concern, particularly given that it was a priority area of focus for the Council.

1.12 Overall, services had a considerable distance to travel to achieve the vision and strategic aims of the partner agencies and to ensure that high-level objectives were leading to operational improvements, better quality services and better outcomes for service users. The Council must ensure that it retains close links with the integrated service, promotes the social care profile and establishes robust governance arrangements.

1.13 We judged that Haringey was serving some people well and that capacity for improvement was uncertain. These two judgements are illustrated in the following matrix:

The Assessment Matrix



National Priorities and Strategic Objectives

1.14 Haringey's Community Strategy was effective in setting out Haringey Strategic Partnership's (HSP) priority areas for the improvement of local services. Beneath the HSP was a clear planning framework for the local implementation of national priorities, guiding and oversight of the more detailed work taken forward by multi-agency Theme Boards. The Well-Being Theme Board planned, organised and delivered the community strategy and priorities for social care and linked explicitly with the Mental Health Executive.

1.15 There was a shared vision for adult services and a growing culture of multi-agency partnership as the means of delivering improved and integrated mental health services. A joint mental health strategy had recently been developed with the participation of all stakeholders, setting out the service's high level aims for the next three years. This document was overly long and somewhat repetitive. Some key managers had not read the strategy and further work was needed to improve its accessibility to stakeholders. A day service strategy was in development and had yet to impact on service configuration and delivery. Day services had been slow to modernise and still operated on a largely buildings-based model.

1.16 There was a strong emphasis on business planning corporately. The guidance was clear and promoted a consistent performance management approach down to service area level. There was less consistency in team and provider service plans at the front-line however, which did not routinely include targets and performance measures and therefore made measuring service development and effectiveness difficult. Overall, performance management was being strengthened and analysis of performance information improved.

1.17 Partnership structures generally worked well but some areas, such as the Community Mental Health Teams (CMHTs), needed improvement to ensure priorities were focused on and milestones put in place. Independent sector Local Implementation Team (LIT) members felt they had become disempowered by recent reorganisation. Mental health services and key processes such as the Care Programme Approach (CPA) and care management were not fully integrated. Together with separate health and social care budget arrangements this had inhibited the achievement of the best outcomes for service users.

Cost and Efficiency

1.18 The joint mental health commissioning strategy being developed was seen by partner agencies as the key driver of future developments, although it needed significant refinement before it could be ratified and implemented. The Primary Care Trust (PCT) plan to create GP clusters and establish lead GPs for mental health would contribute positively to more effective commissioning and promote consistent practice.

1.19 The partnership recognised that there was insufficient commissioning capacity in regard to mental health within the partnership. There were some delays in providing support packages and agreeing placements, and financial decision making was too far removed from the operational front-line. The key strands of good commissioning were not all in place. Contract monitoring arrangements were variable, with an over-emphasis on spot purchase contracts with providers which constituted the majority of individual care packages. There was insufficient emphasis on quality outcomes and consistency across in-house and external provision.

1.20 The Supporting People programme was being developed to provide a range of supported accommodation with a strong focus on mental health services as the programme's top priority.

1.21 The Council was actively engaging with the high numbers of black and minority ethnic groups within the population to identify need and develop culturally sensitive and appropriate services.

Effectiveness of Service Delivery and Outcomes for Service Users

1.22 There were some good in-house mental health day services which generally were valued by service users, although the opportunities for gender specific services were limited and waiting lists for some therapeutic services were long. Some service users were facilitating sessions in their day service and finding this very beneficial in building their confidence and self-esteem.

1.23 Few service users were in paid employment. However, a Welfare to Work plan was in place and there was a local drive to improve the prospects of employment for people with mental health problems. The Council could do more to encourage other local employers.

1.24 Some key services were very underdeveloped such as early intervention and Direct Payments or they were difficult to access, such as benefits advice and the crisis service. Service users and carers who had engaged with the crisis team had found its support to be very helpful. Generally, carers' services could be further strengthened. Plans were being developed to achieve this with a new carers' centre due to open shortly.

1.25 Haringey was committed to protecting vulnerable adults and this area of work had notable prominence on the Council's very accessible website. It was of concern therefore, that key front-line staff in the mental health service were largely unaware of the adult protection policy and procedures and their responsibilities in this regard. The lack of awareness within the service suggested a potential for under-reporting of alerts so that the Council could not be confident of effective adult protection in this service area.

Quality of Services for Users and Carers

1.26 Assessment, care planning, service provision and review were not strong processes as care management and the CPA were not integrated. Staff were confused about roles and responsibilities and care co-ordination was not working effectively. This was not assisted by separate case file recording systems where it was often difficult to track a service user's pathway through services and key documents were not always shared.

Difficulties for managers and staff in accessing the separate health and social care information systems exacerbated some of the problems.

1.27 There were examples of good practice with individual service users, many of whom had very complex needs. Risk assessments and identified indicators of relapse were not of a consistent quality, however. Many were incomplete or information within them was unclear or contradictory. Contingency planning was poor in some cases.

1.28 There was a wide range of public information and the Council's website carried good information about available services and key policies. Links to the main community languages were also helpful. *The Directory* contained comprehensive and straightforward information about the mental health services available, but was not available in all public access sites around the borough.

Fair Access

1.29 A multi-agency Race Equality Task Group operated across health and social care including the Police to consider partners' Race Equality Schemes and identify core priorities for improvement through joint or co-operative working. This was a positive initiative. Impact assessments had been carried out on all major Council policies including the joint mental health strategy. The Council had assessed that it was achieving Level 2 of the local government equality standard and aimed to achieve Level 4 by 2007.

1.30 Work across service interfaces could be stronger. Protocols were in place to guide staff working across some service interfaces and staff experience of engagement with other services such as children and families and learning disability varied considerably.

Capacity for Improvement

1.31 Councillors were clear about their responsibilities, were well informed about mental health and engaged in planning and scrutiny arrangements. There was a range of methods of communication with staff and service users in the mental health services and the Director of Social Services was accessible and met with new and front-line staff regularly.

1.32 There had been a hiatus however, in the development and modernisation of the mental health service, due in part to a lack of continuity at senior management level and political caution about partnership working. Whereas there was good recent development of strategic plans to develop and modernise services, these lagged behind national developments and were slow to translate into front-line service delivery. The failure to integrate CPA and care management and the lack of full ownership and clarity of the care co-ordinator role among staff were key deficits. Overall,

the mental health service had a considerable distance to travel to achieve the vision and strategic aims of the partner agencies.

1.33 Performance management and quality assurance systems were being developed but there was more to do, particularly in relation to commissioned services. A performance strategy sub-group of the Well-Being Partnership Board monitored objectives based on a number of joint indicators across health and social care, including mental health. Not all managers in the service were aware of how performance measures might be applied to their service and how to build this into business and team plans.

1.34 Management arrangements across the Community Mental Health Teams (CMHT) were still being developed. Not all teams were co-located. Arrangements for Approved Social Worker (ASW) re-approval had been recently revised following failures in the system.

1.35 The Council had developed strong partnership arrangements. It was strengthening its relationship with the voluntary sector through a new compact and was actively seeking to engage diverse groups within the community.

What Happens Next

1.36 Haringey Council will prepare an action plan to address the recommendations of this report. This should connect with the Council's own improvement planning and issues which it is addressing from any other external support and examination.

Reading the Remainder of This Report

1.37 This Chapter has given an overall summary. Chapter two brings together the recommendations. Chapter three outlines the Council profile and the context in which the Council is operating. Chapters four to nine give more details of the evidence used in our analysis and judgements.

1.38 In addition, there is a series of appendices giving other detailed information as follows:

- Appendix A sets out the standards and criteria used as a basis for this inspection;
- Appendix B sets out the background and methodology for the inspection;
- Appendix C lists the people that we interviewed; and

- Appendices D to F set out the results of the questionnaires to service users, carers and fieldworkers.

1.39 To maximise our contribution to the agenda for modernisation, our aim has been to produce a report that will be accessible to front-line staff and managers throughout the service in addition to members of the public.

Recommendations

2

National Priorities and Strategic Objectives

2.1 Social services and partners should ensure that front-line team plans reflect service strategies and incorporate measurable targets and objectives through which staff and front-line managers can measure continuous improvement.

2.2 The Council should work with partners to ensure that the configuration, terms of reference and operation of the Local Implementation Team (LIT) are acceptable to all stakeholders and that it continues to contribute positively to the inclusive development of mental health services.

Cost and Efficiency

2.3 Social services and HTPCT should review the Section 28 Agreement and the Commissioning Arrangement Agreement for the mental health service ensuring that these agreements are current, reflect current service structures and are reviewed regularly.

2.4 Social services, partners and stakeholders should review the multi-agency panel process to ensure efficient, effective and consistent operation.

2.5 Social services and health should ensure that commissioning budget responsibility is closely aligned with operations and that appropriate training and support is in place.

Effectiveness of Service Delivery and Outcomes for Service Users

2.6 Processes should be put in place to ensure that front-line mental health staff are operating effectively in protecting adults from abuse within the multi-agency policy and procedures.

2.7 Social services should take action to increase the use of Direct Payments by people experiencing mental health difficulties and ensure their participation in future scheme developments and monitoring.

2.8 The Council should ensure that it is demonstrably acting as a positive role model in promoting the employment of disabled people, including those with mental health issues.

2.9 An early intervention service should be established.

2.10 The needs of carers within the mental health service should be identified, recorded and appropriate services developed within a stronger performance management framework.

Quality of Services for Service Users and Carers

2.11 The Council and partners should undertake a comprehensive review of the CPA process and the review should:

- involve service users, carers, staff and other stakeholders;
- seek to understand the shortcomings in the existing CPA and learn from best practice; and
- result in improved documentation, effective care co-ordination, relapse identification and contingency planning, quality assessment, care planning and review.

2.12 The Council and partners should review the quality and effectiveness of case file recording and auditing.

2.13 The Council and partners should strengthen quality assurance processes.

2.14 Social services should ensure that risk alerts relating to individual cases are given prominence on the electronic case records system.

2.15 The Mental Health Service Directory should be more widely distributed across public access points in the borough.

Fair Access

2.16 Partners should ensure that eligibility criteria and access to the Crisis, Assessment and Treatment Team and Alexandra Road Crisis Unit are clearly understood by service users and all staff involved in mental health services and are consistently applied.

2.17 The Council should work with partner agencies to ensure that opportunities for single gender services are developed and that all services take demonstrable steps to ensure that environments and services are fully inclusive.

2.18 Partners should ensure that the availability and choice of advocacy support for service users and carers is increased.

2.19 Partners should ensure that service users and carers are aware of their rights to access interpreting services and the complaints procedure.

Capacity for Improvement

2.20 The Council and partners should ensure that performance management, monitoring and measurement systems are robust and operating effectively at all levels within integrated services.

2.21 The Council should work with its partners to:

- ensure that the profile of social care is well promoted;
- demonstrate that social care is valued within the integrated service; and
- consult widely to gain a good understanding of stakeholder perceptions regarding social care profile, the reasons for them and how to address these.

2.22 The Council and partners should continue to develop a fully integrated service, underpinned by co-located teams, integrated practices and infrastructural support.

2.23 An operational protocol to guide staff and managers through working across the interface between mental health and learning disability services should be developed, implemented and regularly evaluated to ensure effectiveness.

Council Profile

3

3.1 The outer London Borough of Haringey covers 11.5 square miles from Tottenham in the east to Highgate and Muswell Hill to the west, with Wood Green at its centre. The borough's highly diverse population is approximately 225,000 in 92,200 households with 66 per cent of the population coming from black and minority ethnic backgrounds. The Council estimates that there are at least 183 community languages.

3.2 The population is relatively young with a degree of turnover of about six per cent; newer communities include travellers and high numbers of asylum seekers and refugees, significant numbers of whom have mental health needs contributing to the complex demographic and socio-economic profile of Haringey. Over 70 per cent of refugees and asylum seekers are men and nearly 80 per cent of them are under 40. Generally, the age structure of Haringey is significantly different to the national picture, with a larger proportion of young adults and relatively fewer older people.

3.3 Overall, the Council is characterised by an east-west divide, with marked deprivation in the east of the borough. Forty per cent of residents live in wards that are among the 10 per cent most deprived in England. Haringey is now ranked as the 15th most deprived borough nationally. On its own, Tottenham would constitute the fourth most deprived area in the country and the most deprived area in London. Housing need outstrips supply with approximately 5,400 households currently in temporary accommodation.

3.4 Unemployment stands at 5.8 per cent compared with the London average of 3.6 per cent and 23 per cent of economically active people aged between 16 and 74 years have no educational qualifications. Since the decline locally of manufacturing industry, the borough is predominantly residential with the service sector being the main source of employment. Haringey Council itself has 9,000 employees.

3.5 Just under a third of Haringey households have no earned income and nearly 40 per cent of children were eligible for free school meals in 2003 – nearly twice the national average. In recent years, the Council has been successful in securing significant investment in the area through government initiatives including New Deal for Communities, City Growth, Sure-Start and other funding streams with the aim of regenerating the area, improving life and employment opportunities for local people and attracting business into the borough.

3

Administrative and Political Context

3.6 The Council comprises 57 councillors with overall control lying with Labour with 41 seats. Liberal Democrats held 16 seats at the time of the inspection with local elections due in May 2006.

3.7 The Council Leader and executive committee govern the business of the Council through a cabinet model of decision-making. The executive committee, consisting of the leader and nine executive members, makes decisions with input from the lead councillor for housing. A single overview and scrutiny committee supports the Council in its business.

Health and Social Care Arrangements

3.8 Haringey mental health services are provided through a partnership between Haringey Council, Barnet, Enfield and Haringey Mental Health NHS Trust and Haringey Teaching Primary Care Trust. The PCT and social services areas are co-terminous. There are four CMHTs, assertive outreach and crisis team comprising health and social care staff.

3.9 There is a high number of single-handed GPs, a significant number of whom are due for retirement shortly.

3.10 A higher than average number of adults in Haringey require mental health services with a higher proportion having severe and enduring needs. Thirty-three per cent of admissions are for schizophrenia, schizotypal and delusional disorders (the London average stands at 23 per cent with the England average at 14 per cent.). Haringey admissions for substance misuse and mood affective disorders are also above average and refugees are likely to be over-represented in in-patient services. This is significant given the high proportion of refugee and asylum seekers within the local population.

Council Vision

3.11 The Council has developed five corporate priorities to improve the quality of life of its residents. They are:

- **Better Haringey** - creating a cleaner, greener, safer borough. Supported by £5 million environmental improvement programme, launched in September 2003;

- **Raising educational achievement** to improve life chances of all members of the community;

- **Building safer and stronger communities** is a high priority for the Council and its partners. The Council has also been awarded Beacon Status for its work with communities;

- **Achieving excellent services** - the Council is committed to improving all its services; and

- **Putting People First** - the Council aims to provide the individual support people need to fulfil their potential, through targeted investment aimed at ensuring no one is disadvantaged because of where they live or their personal circumstances.

Financial Information

3.12 Haringey is a reasonably high spending council compared to the Institute of Public Finance (IPF) comparator group, spending £575.35 of the Personal Social Services (PSS) budget per capita. This puts them as the third highest spending council in the group. The Council's gross budget for mental health in 2005-06 is £8.8 million, of which £4.5 million is for externally commissioned services and £4.3 million is allocated to residential care. For mental health services the budget per head of population aged between 18 and 64 years is £19.35 above the IPF average of £49.18, placing Haringey as the second highest council in the IPF family.

3.13 Expenditure on residential care for people with mental health problems is relatively high in relation to the comparator group, with expenditure on day services being relatively low.

Performance Assessment

3.14 Star ratings for councils were introduced in 2002. The Commission for Social Care Inspection (CSCI) rated Haringey as a two star council in November 2005 for its social services performance. The judgement for adults' services remained the same as 2004, being judged to be serving most people well, with promising capacity for improvement.

3.15 The Audit Commission currently rated Haringey as a three star council in its Comprehensive Performance Assessment (CPA) process.

National Priorities and Strategic Objectives

4

STANDARD 1: NATIONAL PRIORITIES AND STRATEGIC OBJECTIVES

The council is working corporately and with partners to deliver national priorities and objectives for social care in mental health services, and their own local strategic objectives to meet the needs of their diverse local communities.

This standard looks at how far social services:

- acted strategically using national guidance and objectives and were achieving milestones;
- were achieving continuous improvement in services;
- planned services in partnership with health and other agencies, using a range of planning mechanisms and involving service users and carers properly in those arrangements; and
- were delivering and managing services in an integrated way.

4

STANDARD 1: National Priorities and Strategic Objectives

STRENGTHS	AREAS FOR DEVELOPMENT
• Haringey's Community Strategy provided an overall planning framework for national priorities and strategic objectives. • The vision for adult social care services was clear and reflected national priorities and strategic objectives. • There was a current Welfare to Work Strategy. • There was a strong emphasis on business planning corporately. The guidance was clear and promoted a consistent approach to service area level. • A Best Value Review of mental health services in 2003 facilitated a review of performance and activity and led to some positive outcomes. • In 2005 Haringey was a Beacon council for engaging and involving local people. Service users and carers were consulted on mental health service developments, with training available to help participation. • The approach to performance management was improving, supported by a dedicated performance team. • Quarterly meetings with voluntary sector providers had recently been established. A Compact was about to be signed. • A mental health sub-group of the Safer Communities Partnership was now in place. • The Council was working closely with Police to tackle social problems such as misuse of drink and drugs.	• The joint mental health strategy was repetitive and not easily accessible to all stakeholders. • Partners had only recently developed a draft strategy to modernise day services. • Front-line services' team plans did not include performance measurements or targets. • There was no service users' network to represent service user views. • Service users and carers were unsure of their influence on service development as a result of consultation, which they felt was not always meaningful. • The Council and partners had not yet developed a fully integrated mental health service using Health Act flexibilities and pooled budgets. • Partnership structures generally worked well but some areas needed improvement to focus on priorities and establish milestones. • Some LIT participants expressed a lack of clarity as to its current purpose and role following recent reorganisations.

RECOMMENDATIONS

- **Social services and partners should ensure that front-line team plans reflect service strategies and incorporate measurable targets and objectives through which staff and front-line managers can measure continuous improvement.**
- **The Council should work with partners to ensure that the configuration, terms of reference and operation of the Local Implementation Team are acceptable to all stakeholders and that it continues to contribute positively to the inclusive development of mental health services.**

4

Strategic Planning and Policy Implementation

4.1 The Haringey Strategic Partnership (HSP) was the chief high-level multi-agency planning forum in the borough. The HSP had agreed the Community Strategy for 2003-07 which constituted the overall planning framework for the local implementation of national social care priorities and all local partners were signed up. There were five priority areas, set out in Chapter Three of this report.

4.2 A number of Theme Boards had been established to manage this agenda and report to the HSP:

- well-being;
- children and young people;
- enterprise;
- safer communities; and
- better places.

4.3 The Well-Being Theme Board worked in conjunction with the Choosing Health agenda and was responsible for planning and delivering the overall strategy for social care in accordance with *Independence, Well-Being and Choice*. Local Area Agreements had been agreed as the means of delivering the shared strategic objectives and were subject to detailed discussions at the time of the inspection. The Well-Being Board had seven strategic objectives:

- to promote healthy living and reduce health inequalities;
- to protect all adults;
- to encourage opportunities for active living;
- to facilitate a minimum standard of living;
- to provide opportunities for socialising and life-long learning;
- to enable people to stay in their own home; and
- to meet current and future housing need.

4.4 The vision for adult social care was clearly set out in the strategic objectives and work of the Well-Being Board and reflected national priorities. The work of the Theme Boards and local objectives had a strong presence on both the Council's website and on the streets of the borough

where large banners were displayed detailing improving outcomes under the key service areas.

4.5 The *Haringey Health Report 2004* had focused on mental health issues and provided the basis for the development of the joint mental health strategy. This strategy had four key aims:

- to make explicit the values and principles of a proposed model of care for primary and secondary mental health services;
- to clarify the priorities for mental health services to achieve the vision in Haringey;
- to provide outline strategic frameworks for mental health services for older people, children and adolescents as a basis for further partnership work; to foster increased links across Theme Boards with developed crossover work at strategic and front-line levels; and
- to redress inequalities contributing to poor mental health, in particular for high-risk groups.

4.6 The development of a joint mental health strategy was a positive development. However, the document ran to some 51 pages and the content was somewhat repetitive. A number of key managers had not read it and it was not easily accessible to all stakeholders, particularly service users, carers and some other agencies. There would be clear benefits in refining and streamlining the strategy to be a more engaging and accessible document that could be more widely understood and owned.

4.7 We were pleased to note that there was a current Welfare to Work Strategy aiming to challenge employers and facilitate access to employment opportunities for people with poor mental health. The strategy had been revised in October 2005, despite this no longer being a national requirement.

4.8 Day services still operated on a buildings-based model and modernisation had been slow. A draft strategy for the modernisation of day services, *One Step Beyond*, had recently been developed and was subject to consultation. This included a useful map of current services with commissioning information. It outlined a vision for future services to be more individual and community based, delivered through a whole systems approach to holistic assessment and service delivery. The proposed model put recovery, social inclusion and health promotion at the heart of services. More prominence should be given to the provision of Direct Payments within this model. The draft currently lacked details of timescales, costs and measurable outcomes as well as using somewhat outdated service user data from 2003-04.

4.9 Participants in the LIT, chaired by the Joint Mental Health Commissioning Manager, reported that it had become more effective over the recent years with a useful and inclusive sub-group infrastructure. However, recently, changes to the composition of the LIT by the key partner agencies had prompted uncertainties among the wider membership about its future and their role within it with some agencies expressing a sense that senior managers were becoming distanced from stakeholder views. A planning executive had been established but only statutory agencies were represented and voluntary sector members were unclear about their future relationship with this overarching executive. Many stakeholders felt disenfranchised due to this recent change.

4.10 The establishment of an Early Intervention Service as expected under the National Service Framework, was presenting an on-going challenge to Haringey, in common with a number of councils nationally, due to limited resources. As yet there was not a comprehensive service in place, although there were some early intervention service strands. The voluntary sector service, Open Door, worked with young people including those with first episodes of psychosis, and Antenna worked with young African-Caribbean adults. The proposed service would encompass crisis response to early detection and treatment, with a key role for primary care services in early detection. There was significant work to do to develop this service, which was the only area attracting a red light under the analysis of LITs by the Strategic Health Authority.

Continuous Improvement

4.11 Haringey was aiming to establish a culture of continuous improvement and to this end was improving performance management and analysis of performance information. The provision of a dedicated performance team and business improvement managers at senior levels in the Council was supporting this stronger approach.

4.12 There was a strong emphasis on business planning throughout the Council down to service manager level and this was set within clear guidance in the Business Planning Framework 2005-08. This set out the expected focus on measurable targets and objectives for service areas which had to link to the corporate objectives. Business planning was the responsibility of the assistant directors in services to monitor compliance within their area. In relation to mental health, the guidance could usefully be updated to reflect staff changes.

4.13 There was a clear strategy to link the business planning process throughout the department to individual staff appraisal in competency-based People Plans. However, we found that this approach did not cascade down to front-line service team plans. Where these were in place they did not all follow a consistent format and lacked performance targets and measures. Managers of these services were not clear how they monitored

performance or progress in service development. Their approach to business planning needed to be brought in line with the existing comprehensive framework and strengthened to bridge the gap between front-line operational activity and high level planning and corporate priorities.

4.14 The Council used a balanced scorecard performance measure. This set out past, current and comparative performance with identified difficulties and actions to rectify. The scorecard was monitored at the management team meetings for each service area and had a combination of qualitative and quantitative data.

4.15 The Best Value Review of mental health services in 2003 had demonstrated that the service was not on track to meet the targets for the NSF and had facilitated the focus on service performance review that had been undertaken subsequently. There had been some positive outcomes resulting in the current agenda moving the service forward to develop greater community-based opportunities. The review had identified the need for better co-ordination in the CMHTs and that there was not enough focus on Direct Payments. These areas still needed development.

4.16 Data collection, reporting and monitoring within the Council was being developed, although there was more to do within the mental health service. This was made more challenging by the use of different and incompatible information technology systems across health and social services and the lack of universal access to both systems by staff from both disciplines. Social services was introducing Framework*i* which in the longer term was expected to provide a more user friendly and flexible client recording system. There were initial teething problems associated with the introduction of a new IT system that staff and the project management team were working to resolve.

Involving Service Users and Carers in Planning

4.17 The Council had developed a consultation strategy with eight guiding principles to operate corporately and ensure a consistent approach to consultation. The Council had been awarded Beacon status for engaging and involving local people. The Council's main consultation exercises were published on the website as feedback.

4.18 The User Consultation Partnership Board operated as a sub-group of the Mental Health Partnership Board. It was now chaired by a service user and had discussed both the joint mental health strategy and the day services strategy. One hundred mental health service users had been consulted in the development of the draft joint mental health strategy and follow-up groups of service users had discussed the resulting draft paper. Members of the User Consultation Partnership Board had acted as facilitators at the workshops discussing the future of day services.

4.19 There were four service user representatives on the LIT and there was a standing item on the agenda to look at service user issues. This group was now a sub-group below the planning executive.

4.20 The Mental Health Executive involved the chief officers of social services, Haringey Teaching Primary Care Trust (HTPCT) and the Barnet, Enfield and Haringey Mental Health Trust (BEHMT). It operated as the key accountable body within the Mental Health Partnership. Similarly, the executive member for social services met regularly with the chair of the HTPCT and the BEHMT. Relationships were positive overall although there was mutual recognition that the partnership was going through very difficult times in light of the severe financial constraints placed on services, particularly in health. Historically, there had not been a strong ethos of partnership working but this had changed over the recent past. The mental health service was making progress towards integration, albeit from a low base in some areas particularly in relation to CMHTs and individual commissioning systems such as the CPA.

4.21 Stemming from the 2004 Haringey Health Report, there had been a clear increase in focus on mental health needs and service provision across key partner agencies. The report had been presented to the Well-Being Board and to the HSP as well as neighbourhood assemblies. Other strategic boards such as the Safer Communities Board had also discussed the report and shared their perspectives on how community improvements could be made through partnership working. The Safer Communities Board now had its own mental health sub-group.

4.22 Partner organisations demonstrated a good understanding of the context in which each was working. They saw the Council's move towards more localism through neighbourhood based approaches as positive, giving good opportunities to develop local solutions to often very focused local issues. There was some recognition that while the main planning structures were working well, there needed to be some further review to ensure that the focus was on the key priority areas and that clear delivery milestones were in place. There was a need to strengthen the operational integration in CMHTs and other front-line services such as crisis intervention and the development of early intervention services.

4.23 Community mental health services had been reorganised in April 2005 into the current CMHT arrangements with four teams under single line management through the BEHMT and social workers under secondment. Integration was therefore still at an early stage. Considerable work remained to be done to consolidate and develop more integrated systems and procedures, although there was evident commitment to build on these early foundations.

4.24 Currently in the CMHTs, social services' staff budgets, vacancy control and care management budgets were held separately from those in the BEHMT. Although there was an informal agreement to move to a Section

31 agreement and pooled budget using Health Act flexibilities in the future, no date had yet been fixed for this to be achieved.

4.25 The HTPCT and social services were planning to reconfigure the joint commissioning arrangements over the next few months to strengthen their joint approach and develop some much-needed capacity. Joint work was also underway with the Trust to review resources and future commissioning and decommissioning intentions. A strategic outline business case had been developed regarding the closure of St Ann's Hospital and to reprovide with community based provision.

4.26 Quarterly meetings with the voluntary sector had recently been established and a compact was due to be signed during the period of the inspection. Although these developments had been slow in coming to fruition, the expectations for Compact having been set out by government in 1999, they were positive partner initiatives.

4.27 There was close working with local Police to tackle social problems, particularly around the misuse of drink and drugs. The Police were active participants in some of the key strategic groups operating to drive local improvements. Supporting People initiatives demonstrated close partner working and relationships across housing, libraries and leisure and Welfare to Work were established. Local libraries often supported exhibitions of work related to mental health issues.

Cost and Efficiency

5

STANDARD 2: COST AND EFFICIENCY

Social Services commission and deliver mental health services to clear standards of both quality and cost, by the most effective, economic and efficient means available – they achieve value for money in mental health services.

This standard looks at how far social services:

- were commissioning services effectively and efficiently;
- were aligning budgets to national priorities and the needs of their diverse communities;
- were considering the use of joint financial arrangements; and
- had robust budget management.

5

STANDARD 2: Cost and Efficiency

STRENGTHS	AREAS FOR DEVELOPMENT
• Work was underway to improve mental health needs identification across the whole population and to develop aggregated health and social care data. • The Supporting People programme was being developed to provide a range of supported accommodation. • The Council was taking steps to engage with black and minority ethnic communities. • Unit cost information and ensuring value for money was being strengthened. • Mental health has had some claim on the Council's asset management strategy. • The Council was providing its social care services within budget.	• The joint commissioning plan for mental health services was still in early draft form. • There was insufficient commissioning capacity currently within the partnership. • Spot contract monitoring arrangements could be strengthened. • The non-integration of CPA and care management budgets was inhibiting the development of seamless services to facilitate beneficial outcomes for service users. • Separate funding arrangements with providers by the commissioning agencies did not always reflect the allocation of health and social care responsibilities. • Budgets were not yet being reshaped to meet needs of a modernised service. • Preventative services were underdeveloped.

RECOMMENDATIONS

- **Social services and HTPCT should review the Section 28 Agreement and the Commissioning Arrangement Agreement for the mental health service ensuring that these agreements are current, reflect current service structures and are reviewed regularly.**
- **Social services, partners and stakeholders should review the multi-agency panel process to ensure efficient, effective and consistent operation.**
- **Social services and health should ensure that commissioning budget responsibility is closely aligned with operations and that appropriate training and support is in place.**

5

Commissioning

5.1 Partner agencies recognised that more effective joint commissioning had to be developed to ensure best use of limited resources and value for money. Work was underway to achieve this although more had to be done. An overarching three-year joint commissioning strategy was in development deriving from the joint mental health strategy. This draft commissioning strategy was some way from being a finalised document that would take the mental health commissioning agenda forward. In addition to budget decisions being made by the commissioning partners and the resultant financial framework being included within the commissioning plan, the document was overly complex and lacked activity and other relevant qualitative data and measurable deliverables. The strategy would benefit from considerable revision and streamlining to ensure it would be accessible to as wide a range of stakeholders as possible, that the future commissioning intentions were clear and that progress on the plan could be monitored effectively. Recently completed research data on local needs in relation to housing and employment also was to be incorporated into the commissioning plan before the document could be finalised.

5.2 The HTPCT had developed a proposal to configure the local area into four similar sized clusters encompassing some 80,000 patients in each for the purposes of a stronger approach to health commissioning. A lead GP for mental health would be appointed in each cluster to lead on training and development. The CMHTs would link to each cluster. This positive proposal was reflected in the Mental Health Scrutiny Review report although no timeline for achieving this new primary care configuration had yet been put in place. There were also plans to increase the current six graduate mental health workers in primary care to seven in the next 12 months adding to the stronger focus on mental health that the PCT wanted to establish.

5.3 The research on needs that had been recently undertaken had highlighted some challenging issues. Some service users at the higher end of need wanted the most basic levels of need met. Managers would need to give further consideration to the future role of residential care although, as a general principle, this remained a model commissioners rightly wanted to move away from.

5.4 Overall, the partnership had recognised the need to develop more useful information about local mental health needs across the population to better inform future commissioning. Work was in progress to develop stronger information on social and health care needs in relation to mental health and to aggregate this data into the commissioning plan as it evolved.

5.5 There was a dedicated contracts service comprising two teams of staff, thirteen in all. One team worked on children and families' contracts and

the second team focused on community care contracts. There was a dedicated mental health contracts officer. For block contract providers a quarterly monitoring meeting was convened with the contracts officer for which the provider submitted a monitoring form as the basis for discussion alongside any recent CSCI regulatory inspection reports and other pertinent information. There were also six monthly and annual service review meetings which included examination of accounts and other financial and activity data. Most providers felt that this worked well and that communication and promptness of payment had improved. This was not a view shared by all providers however, and the occasional inconsistencies were still an issue to be addressed.

5.6 Most contracts with providers in mental health were spot purchases, mainly in the residential sector. Monitoring of these services was the responsibility of the commissioning social worker through the case reviewing process. This system could be strengthened. There was no evidence of this quality-monitoring role in care management documentation, nor how it linked with staff in the joint commissioner's team who had responsibility for overseeing placements. Providers reported that they experienced differing approaches to quality and service monitoring for different service users. As part of actions to achieve efficiency savings, commissioners were aiming to reduce the use of spot contracting and make greater use of block and framework contracts.

Reflecting National Priorities

5.7 The Council's level of expenditure on mental health was quite high for its comparator group with a significant proportion of the budget spent on residential care provision. The Council was committed to changing this profile, although there was work to do to change the culture at the front line of services to seek alternatives to residential care in care planning and to develop community based alternative provision. The Council planned to achieve this over a number of years to ensure that the infrastructure and culture change were well embedded.

5.8 The Council and other agencies were responding positively to national priorities and had embraced strongly the well-being agenda putting in place a multi-agency planning infrastructure to support its delivery. Embracing this concept had given new impetus to partnership working and there had been clear progress through partnership working in recent months.

5.9 The Community Strategy reflected national priorities and provided the local context for budget planning over the period covered by the strategy. This was about to be extended to 2008-09. The Council had been successful in delivering on the objectives of the strategy within resources, which had been recognised in the recent Comprehensive Performance Assessment.

5.10 New service developments such as the Therapeutic Network, the Crisis Resolution Team and Assertive Outreach reflected national priorities and there was a high priority for Supporting People with a £4 million mental health programme. However, there were some clear areas of challenge outstanding, notably the lack of an early intervention service and preventative services were underdeveloped. This was given prominence in the Scrutiny Review Report and was reflected in the report's recommendations.

5.11 The partnership's approach to decommissioning should be incorporated into the final commissioning plan.

5.12 The service was still operating a separate care management and CPA system with separate budgetary arrangements. There has been a long-standing requirement to integrate CPA and care management systems and it was very disappointing that Haringey Mental Health Services had not achieved this key stage of service integration. This was a key area for priority development.

Efficiency

5.13 Haringey had undertaken cost and activity comparisons across the London boroughs mainly using the personal social services expenditure (PSSEX1) Summary for Mental Health for 2004-05. It was clear from this that the Council was at the high end of costs for residential and nursing care. There was also a higher than average number of service users in residential care with the number of service users being helped to live at home dropping. This data contributed to the focus of the commissioning plan on increasing community-based services with a reduction in the use of high cost services.

5.14 The business planning framework was effective in ensuring that planning and realising efficiency savings, were informed by the Council's medium term financial strategy and, were embedded in commissioning managers' objectives. This was less clear in in-house provider managers' business planning. Target efficiency savings for the service had been set for the past three years and the service needed to save £255,000 in the current year with £221,000 being the target for 2006-07.

5.15 We concluded that plans to achieve efficiency targets in the service were pragmatic and achievable. These included:

- identifying people in residential care who could be supported in the community;
- using the Supporting People programme to develop intensive floating support teams for people with mental health difficulty;

- understanding the need to develop a variety of supported housing models;
- setting clear review and transfer of care targets for the CMHTs and monitoring these monthly;
- ensuring that block contracts address gaps in provision and providers operate on a rehabilitation and move-on model;
- block and framework contracting is increased with a reducing use of spot purchasing resulting in better value for money; and
- investment in Crisis Assessment and Assertive Outreach Teams.

5.16 Social services were introducing a new service user information system, Framework*i*. This was some way from operating fully effectively but senior managers were confident that it would provide improved management and performance monitoring information. A new finance system, SAP, was also being introduced.

Joint Financial Arrangements

5.17 At the current time, the Council did not have a pooled budget arrangement with health using Health Act flexibilities Section 31. A Section 28 Agreement was in operation between the Council and the HTPCT although the documentation for this agreement given to inspectors was not signed. Additionally, the documentation setting out commissioning arrangements between the two agencies was out of date and not reflective of the service's current joint commissioning or service infrastructure.

5.18 A Joint Commissioning Manager had been appointed and held delegated powers for the financial and managerial responsibilities associated with joint commissioning. The post holder chaired the multi-agency panel, which met monthly and at which all care package requests had to be presented for approval. Where cases needed urgent approval for service provision, social workers could make representation outside of panel directly to the Joint Commissioning Manager. Workers told us that they had great difficulty in accessing the Joint Commissioning Manager outside of panel in order to get approval in these situations. They also spoke of having to wait for several panel meetings to get their case presented.

5.19 Information about panel decisions indicated that 28 packages had been approved, mostly for residential provision, between April 2005 and February 2006 although there was no information of packages that had not been approved or how long it had taken to present cases to panel. We were told that requests were often turned down. There was no clear supporting evidence of service users suffering detriment due to delays in the system, although there was evidence of delays. In January 2006, a fortnightly

panel to address changing needs identified in reviews separately was introduced. It was too early to evaluate the impact of this panel but it was likely to improve the passage of care package requests through panel and reduce delay.

5.20 Some front-line staff found the panel process intimidating. While the process needed to be robust in ensuring the right outcomes for service users, this issue could usefully be explored by managers to ensure that staff are clear about panel expectations in relation to their presentation of evidence to facilitate the process. The regular attendance of one of the joint commissioning team members at CMHT meetings gave the opportunity for this to be addressed.

5.21 Haringey had identified the need to strengthen its mental health joint commissioning prior to the inspection and we would concur. We had a strong concern about capacity in the current arrangements with too much operational and financial responsibility being focused on the Joint Commissioning Manager role. This resulted in care package decisions being made at too high a level in the service and at too great a distance from the individual service user. Rather than focusing on the strategic development of joint commissioning, the Joint Commissioning Manager was too involved in operational details. Plans were in place to delegate some budget responsibility to the CMHT team managers from April 2006 and we welcomed this development as it should ensure a greater capacity for strategic development as well as facilitate more responsive care package decisions. A training package to support managers in taking on this new role had yet to be agreed.

5.22 The commissioning agencies' separate funding arrangements with providers did not always reflect the allocation of health and social care responsibilities. An example of this was that most of the funding for carers' support from the Mental Health Carers' Support Association came from the PCT whereas the service was mostly meeting social care needs rather than health. Moving to a pooled budget and more integrated arrangements would help to address these issues and ensure resources were targeted on agreed priorities.

Financial Strategies

5.23 The Council's Community Strategy set the strategic agenda which was reflected in the financial strategy. There was a pre-business planning review of both the Council's business and financial plans to take account of emerging issues likely to have an impact locally as well as ensuring existing local financial and service objectives were being addressed. The pre-business planning review also identified potential risks and strategies to manage these.

5.24 The Council had identified possible financial risks to the Supporting People Programme and had established a £250,000 contingency fund to address any such eventualities.

5.25 Haringey was in a strong financial position overall with good levels of reserves and was managing resources very tightly to maintain this position. CMHT team managers reported some frozen posts within the service and the difficulty they had in gaining agreement from senior managers for agency staff. There was no cover for staff on long-term sick leave.

5.26 The difficult financial position faced by health was likely to have some impact on service development in mental health. Discussions were underway at the time of the inspection about budget commitment within the partnership.

5.27 There was an asset management strategy covering 2005-08, which included mental health services. The aims of the strategy were explicitly to support the development of good services and promote partnership initiatives. Council capital funds had been used to develop the Alexandra Road Crisis Centre, refurbish the Crisis Team offices and to support the development of co-located CMHTs through the provision of some items of equipment. Not all the teams were co-located however and there was still development work to do to achieve this goal.

5.28 Significant investment in 2003-04 had also been made in both the Clarendon Centre and Six8Four, the main mental health day service providers.

Budget Management Arrangements

5.29 In-house provider budgets were delegated to unit manager level. Budget management information was produced and discussed in management meetings on a monthly basis and accountability was tightly managed. An interim financial management IT module was in place until the new Framework*i* module was ready.

5.30 Overall, budget management was effective in managing resources but budget responsibility was inconsistently applied and not uniformly close enough to operational activity and this should be addressed.

Effectiveness of Service Delivery and Outcomes for Service Users

6

STANDARD 3: EFFECTIVENESS OF SERVICE DELIVERY AND OUTCOMES FOR SERVICE USERS

Mental health services promote independence, protect people from harm and support them to make the most of their capacity and potential and achieve the best possible outcomes.

This standard looks at how far social services were:

- promoting the independence and social inclusion of service users safely;
- offering an effective Direct Payments scheme;
- offering the right services to meet people's needs and preferences; and
- supporting carers (including young carers) in their caring role.

6

STANDARD 3: Effectiveness of Service Delivery and Outcomes for Service Users

STRENGTHS	AREAS FOR DEVELOPMENT
• The Supporting People strategy was giving priority to mental health needs and had developed some beneficial services. • There were some good in-house mental health day services that were valued by service users. • Some service users were facilitating sessions in their day service. • The local libraries staged regular information displays on well-being and mental health. • The Council was working with HAVCO and Volunteer England to set up a volunteer bureau. • The Therapeutic Network was highly valued and producing effective outcomes. • Service users and carers valued the support of the crisis team. • Councillors were aware of the needs of carers and there was information for carers on the Council's website. • The Council gave a high profile to its commitment to adult protection on its website, which carried a link to the policy document.	• There was difficulty in transferring some mental health service users from in-patient services. • The strategy for day services was yet to be implemented. Financial pressures were causing delay in modernising services and services remained mainly buildings-based. • Early intervention services were underdeveloped. • Services to support carers were underdeveloped. • No mental health service users and very few carers were accessing Direct Payments. • No independent support agency was currently in place. • Direct Payments for service users and carers were not effectively promoted. • Front-line mental health staff were not sufficiently aware of the adult protection policy, procedures and their roles and responsibilities. • There was potential for greater promotion of independent living and social inclusion for some service users.

RECOMMENDATIONS

- **Processes should be put in place to ensure that front-line mental health staff are operating effectively in protecting adults from abuse within the multi-agency policy and procedures.**
- **Social services should take action to increase the use of Direct Payments by people experiencing mental health difficulties and ensure their participation in future scheme developments and monitoring.**
- **The Council should ensure that it is demonstrably acting as a positive role model in promoting the employment of disabled people, including those with mental health issues.**
- **An early intervention service should be established.**
- **The needs of carers within the mental health service should be identified, recorded and appropriate services developed within a stronger performance management framework.**

6

Promoting Independence and Social Inclusion

6.1 The independence of service users was promoted and supported through a number of service strands. The Supporting People programme was mainly focused on the needs of people experiencing problematic mental health in its first two years of operation and was prioritising the development of support services to reduce bed blocking and the use of residential services. The Supporting People team had worked jointly with mental health commissioners to achieve early successes in the programme. These included:

- twenty mental health service users moving from residential care into independent living accommodation in 2005;
- tenancy support through a housing worker in St Ann's Hospital working with transferring service users;
- a vulnerable adults team set up in housing to manage nominations to Supporting People providers; and
- a project officer working with CMHTs to facilitate step down from residential care.

6.2 Haringey's performance on PAF C31[1]: national performance indicator about helping adults with mental health problems live at home, showed a decreasing trend since 2002-03. In part this downward trend was due to the considerable data cleansing operation the Council had undertaken which had reduced the numbers significantly. In addition the increase in people being supported through the Supporting People programme had further reduced the numbers counted in the performance indicator, and it would be important to monitor future performance in this area given that the Council was more confident in the accuracy of the data being recorded.

6.3 At the time of the inspection, there was some difficulty in transferring some 25 mental health service users from in-patient to community services. This reflected an improved position from the 40 delayed transfers that had existed last year. Partners regarded this as a short-term problem as plans within the Supporting People programme were expected to provide a longer-term solution and facilitate transfers of care through the development of services better tailored to meet specific needs. Overall, there were high levels of homelessness, with 5,000 people currently waiting to be rehoused.

6.4 Day services were primarily provided through an in-house service based at Clarendon Day Centre (650 service users in a 12-month period) and

[1] PAF 31 is one of the CSCI Performance Assessment Framework performance indicators.

Six8Four Centre, which catered for approximately 30 people per week. In addition there was a range of smaller services mainly within the independent sector and in total, day services were being provided to approximately 1,000 people in mixed gender provision.

6.5 Inspectors visited both Clarendon and Six8Four centres and found that they were well used across a seven-day period and offered a variety of services, sessions and opportunities. The Six8Four service had operated on a drop-in basis for a number of years until the reprovided service had opened in its current location in the past three years. All attendees were now required to be on CPA and to have a current risk assessment. Service users mostly spoke highly of the support they had through the in-house services, particularly at Six8Four. The environment was lively and stimulating and the decoration reflected the community that it served which was mainly African-Caribbean and eastern-European. The catering was also of a good standard with considerable choice and the facility for service users to buy a meal to take home in the evening. The chef and catering staff in the service fully recognised the role they played in contributing to the well-being of service users and were to be commended on their efforts.

6.6 Some service users had received support in the past from community support workers linked to the day services but they had been unable to access this type of support recently and missed this service.

6.7 Independent sector agencies that wrote to us also praised the in-house day service in their promotion of social inclusion although they felt that this was not consistent across all mental health services. Other examples of a socially inclusive approach across the Council that we noted were:

- regular displays about mental health and well-being in local libraries;
- Studio 306 – a consortium of service users working together to sell their art work; and
- a competition in which a mental health service user had designed a stained glass window for a new older people's respite care home.

6.8 Following the closure of day hospital services and local campaigning, the Primary Care Trust had established the Therapeutic Network as a small pilot scheme based in one of the CMHT offices. This service was delivered by three occupational therapists on a part-time basis over four days per week mainly on a group work model. Twelve service users could participate for up to 12 weeks at a time focusing on leisure, education and accessing mainstream services. Participants did not have to be on a CPA but had to be motivated and committed to rehabilitation. This very popular and valued service had achieved some positive outcomes for service users, some of whom had continued to offer mutual support to each other after completing their programme. One self-supporting spin-off group met

regularly in the café of a local department store and had gone on a short-break to Paris with another trip in the planning stage.

6.9 There was some short-term evaluation of the effectiveness of the Therapeutic Network, although this could usefully be expanded to ascertain the longer-term impact on participants. There was a three-month waiting list strongly suggesting a need to develop and expand this service model. Funding had been for one year initially and at the time of the inspection, the future of the network was uncertain. We were pleased to note that shortly after fieldwork, funding was secured to enable the service to continue.

Direct Payments

6.10 A Direct Payments development officer had been in post since May 2004 focusing on promoting the scheme and delivering training to staff. There were about 150 people using Direct Payments, mostly from physical disability and older people services where most of the developmental work had been done. No learning disability service users or mental health service users were using Direct Payments and we considered that this was a significant deficit that needed to be given priority. There was no permanent independent agency support currently but a temporary arrangement was in place while a new tendering process was due to be completed in April.

6.11 A CMHT team manager was the champion for Direct Payments within the service but there were no triggers promoting Direct Payments on CPA documentation and managers were not confident that front-line staff were considering Direct Payments as a preferred or primary approach to meeting identified need. We were told that Direct Payments were routinely considered at panel wherever feasible. The leaflet setting out information about Direct Payments focused on the provision of care primarily and did not fully embrace or reflect the Council's focus on well-being or social inclusion. It was likely that service users and possibly staff in the mental health service would be put off by the focus on care, as they would not see Direct Payments as relevant to their situation. The development of mental health specific information to promote the scheme to this service user group or revision of the general public information and staff guidance to better reflect the well-being concept was needed.

6.12 The collection of information and activity analysis of the scheme was underdeveloped. There were no data fields on Direct Payments in the Framework*i* system and no information on the outcomes of the scheme or the length of time taken to process people's application. This made it difficult to performance manage the scheme or monitor progress. The draft strategy document read more as a position statement and background paper rather than a driving strategy. The associated action plan was not SMART.

6.13 There was a Direct Payments' steering group attended by officers but no service users. As no one we spoke to was sure who chaired the group since the previous assistant director had left, it was clear that the group had not met for some time and it was not evident what outcomes had been achieved.

6.14 Most service users and carers that we met had not heard about Direct Payments and were keen to learn more.

Range of Services

6.15 The Clarendon and Six8Four centres provided a joint training programme covering topics including catering, art, IT and audio engineering. The Six8Four A team (also known as The Grime Squad) was a low cost domestic cleaning service giving work experience to mental health service users and providing a wide range of cleaning services through a professional referral system. A number of service users were also actively involved in running or facilitating sessions in the centres. There was a successful and popular football team and coaching sessions operating from Six8Four which had received national recognition. Richmond Fellowship also ran employment advice sessions at the centres.

6.16 A pilot Personal Development Planning scheme had been established as a passport for mental health service users engaging in work and training initiatives. In 2004, a Mental Health Employment Team was started at Clarendon Centre and the two workers were managed by the centre manager. The scheme was based on a person-centred planning model and explored training, volunteering and work experience placements with participants. Support was available to service users on an on-going basis once training, education or work had been accessed. To date, 76 service users had expressed interest and 25 had used the job club. Nineteen people had found some form of work, or had gone onto further study or training.

6.17 The Welfare to Work Disabled People's Partnership had good multi-agency representation, with clear lines of reporting and accountability. It had recently developed a new joint strategy for 2005-15 based on local research commissioned by the partnership, *Barriers to Work for Disabled People.* Facilitating employment opportunities for people with mental health difficulties challenged the local partnership operating within the context of Haringey, which had the third highest rate of unemployment across London. The action plan for 2005-06 pragmatically prioritised raising awareness and mapping the range of existing provision to gain a more complete picture of need. The strategy had clear links to national and local initiatives and priorities and promoted the social model of disability. As one of the leading local employers, the Council should ensure that it acts as a positive role model in employing disabled people including those with mental health issues.

6.18 The Council was working closely with HAVCO and Volunteer England to establish a volunteer bureau.

6.19 The Haringey Equal Access to Training initiative (HEAT) was run by two disability consultants as part of the Welfare to Work programme and trained disabled people, including those with fragile mental health, to become disability consultants. Three people with mental health problems were among the ten people on the programme. This scheme was currently a pilot funded through the Local Development Agency (LDA) and Employ Upper Lea Valley which, if successful, would be rolled out to other areas.

6.20 The use of medium secure provision was growing across London and this was creating an issue of capacity. Councils and agencies in the North Central London Sector were working together to find ways to manage this growth. A pilot forensic nursing service scheme had been developed to ensure early treatment and diversion from hospital for people in Police custody where appropriate.

6.21 A Crisis Assessment and Treatment Team (CATT) and Assertive Outreach Team had been recently established and the Alexandra Road Crisis unit offered an emergency placement service. An Emergency Reception Centre operated at St Ann's Hospital.

6.22 Older people's mental health services were to operate on an integrated CMHT model from early 2006. There was a Trust-wide specialist service for people with early onset dementia and a developing psychiatric liaison service to support older people in acute settings.

6.23 The Vulnerable Adults Team (VAT) provided housing advice and support for people with mental health and housing problems as part of the homelessness service and included staff from both housing and mental health service backgrounds. The team provided support to people presenting mental health, drugs and alcohol needs and offenders. Currently the homelessness team was going through transition to become a prevention and housing options service. The VAT was experiencing significant operational difficulties due to long-term sickness of a key member of a small staff team. A working group had been convened to address the difficulties through consideration of a management secondment to run the team and explore ways of improving the service's performance.

6.24 Welfare benefits advice was provided through the three local Citizens Advice Bureaux. The Scrutiny Review reported that service users were waiting for up to a month for benefits advice and this was placing some people under financial pressure. We would support the recommendation made within the report to ensure sufficiency of access to benefits advice.

6.25 Some stakeholders felt that it was becoming increasingly difficult to access services, particularly where people had lower levels of need and

were mainly in need of preventative support. With limited resources statutory agencies had focused services on the higher levels of need, making it increasingly important that front-line staff were able to signpost people with lower levels of need to appropriate support services. There was only one day centre service for people not on enhanced CPA and not all service users felt comfortable about attending this.

6.26 There were long waiting times for some therapeutic services such as the Therapeutic Network and psychological counselling where people could wait for up to 12 months during which time their difficulties were likely to increase resulting in a need for greater levels of support.

6.27 A local early intervention service had not yet been developed, although there were some early intervention strands within two specialist services for young adults. This remained an on-going challenge to the partner agencies in delivering the expectations of the National Service Framework, which included the provision of such a service. The Scrutiny Review recognised the lack of this service and made recommendation for its development as part of the joint commissioning plan. We also considered this to be a key area for development.

Carers

6.28 There was useful information for carers on their rights and available services contained in the *Mental Health Directory*, although this was not widely available. Carers' leaflets had been developed in the six main community languages.

6.29 A current carer's strategy had been developed in 2005 with the participation of carer representatives and was intended to shape and direct carer service development over the next three years. The strategy document incorporated an eight objective action plan for the first year to be monitored by the Carers' Partnership Board as a sub-group of the Well-Being Board, membership of which included carers. The strategy included consideration of the needs of young carers, and also included generic activity data across all service user groups. With the introduction of a more sophisticated information system it may be possible in future years to develop the data relating to carers along specific service user group lines enabling a more targeted approach to service development and improved performance monitoring.

6.30 There was a dedicated carers' development manager whose main role was to focus on strategic development but who, as the only dedicated resource, inevitably became involved in individual situations. This manager attended team meetings and sent out briefings to teams across children's and adults' services and was responsible for managing the carer's grant.

6.31 Haringey recognised the need to improve its performance on carers' assessments and identified £15,000 for carers' assessments and support

services. Support services included some short-term break provision and various pampering sessions for carers such as tea at The Ritz. Two-day intensive gardening sessions could be arranged through the Council's care and repair team. A scheme to offer carers tuition on the use of computers was also being developed.

6.32 As a means of increasing the number of carers' assessments undertaken and services being offered, managers were considering the delegation of the carers' grant to team manager level. No targets to improve performance were currently being set in business plans and the level of attention to carer issues was largely dependent on the individual commitment of the CMHT team managers. One team was performing better than the other three.

6.33 We found little evidence of carers' assessments on the case files that we examined or that assessments resulted in support services being offered. The 20 carers who responded to our questionnaire presented a mixed picture of experience, with comments about frequent changes of worker and psychiatrist and the difficulty in accessing staff or getting a response to telephone calls or letters. Some carers spoke of dedicated but part-time staff, which again sometimes made it difficult to get a response when needed. Eight of these carers did not know that they were entitled to an assessment in their own right, but five had had an assessment in the past year. The carers that we met during the inspection described poor experiences of carers' assessments where either people had not been offered one or it had not been completed or did not lead to anything.

6.34 Most support services for carers engaged with the mental health service were operated by the Mental Health Carers Support Association (MHCSA) which ran carer support groups, provided respite and information and acted as an advocacy agency particularly for people involved in CPA process and supported housing. Carers who accessed services through the MHCSA found the support beneficial. The Black and Minority Ethnic Carers' Support Service and Asian Carers' Support Group were having new contracts to include the undertaking of carers' assessments.

6.35 A recently jointly appointed carers' assessor was identifying carers through out-patient services who had not previously come into contact with services or care co-ordinators but who needed support.

6.36 Plans were being developed to include carers in the Direct Payments scheme.

6.37 The Council was supporting a carers' assessment pilot by Sheffield University on acute wards as one of ten sites nationally. Carers had been trained as interviewers and would be paid £25 per interview to meet other carers and record their experiences of carers' assessments.

6.38 A room within a centre for people with physical disabilities had been earmarked as the new carers' centre to operate from April 2006 which, although small, was centrally located in the borough and offered equitable access to carers across Haringey.

6.39 We concluded that overall, carers' support services were underdeveloped in relation to mental health while showing some improvement across adult services generally, warranting greater developmental attention and a stronger performance management approach. The new strategy provided a good basis for the development work and performance management could be strengthened through the business planning process.

Vulnerable Adults

6.40 A multi-agency Policy and Procedures for Protecting Vulnerable Adults from Abuse in Haringey had been developed and launched in 2002 and updated in December 2005. The Adult Protection Training Programme for 2006 had been published in November 2005, during which month training specifically for ward and deputy ward managers had been run. Senior managers recognised that training on this aspect of service needed to be on-going and had developed a comprehensive nine module programme. Operational guidelines setting out staff responsibilities in relation to adult protection in a multi-agency context were updated and launched in October 2005.

6.41 The strong commitment of the Council to adult protection was demonstrated by the high profile given to the policy and commitment on the home page of the Council's website. This gave easy access to the policy for the public and was a good way of increasing local awareness. The Council had also worked hard to engage the local Police in adult protection strategic development and the strong relationship that had been forged with the Area Commander was resulting in good Police engagement with this agenda.

6.42 The post of Adult Protection Co-ordinator had been upgraded to Adult Protection Manager with a remit across all adult services. This manager was a member of the Multi-Agency Public Protection Panel and the Local Children Safeguarding Board as well as participating in the Safer Community planning groups. The Adult Protection Committee was chaired by the Assistant Director Older People, and had a wide membership across all sectors.

6.43 The Council expected partners and providers to comply with the policy and operate exacting standards in relation to the prevention of abuse. Monitoring and oversight of these standards lay with care co-ordinators who were responsible for commissioning and overseeing spot contracted care and support provision as discussed in Chapter 2 of this report. A joint handbook of the policies and procedures had been issued to all front-line

staff in the service. However, we were concerned that front-line staff lacked awareness of the policy and procedures and were not sufficiently aware of their responsibilities. Community psychiatric nurses and some social workers were not able to speak knowledgeably about this aspect of their work and stated that they had not had any training in this area. Local CSCI regulatory inspectors had also identified problems in adult protection situations where community psychiatric nurses in particular had not reported adult protection alerts, were unsure of how to deal with alerts and failed to call strategy meetings, demonstrating a lack of awareness of the local procedures. Some social work staff were also very unsure of the procedures and lacked confidence in their ability to identify potential abuse and take appropriate action, although both they and the Police spoke positively about joint working in relation to vulnerable adults.

6.44 There was some discrepancy then, between the sound high-level multi-disciplinary work, the policy and procedures that had been put in place and operational practice at the front-line that needed to be addressed. Managers needed to put in place monitoring processes to ensure they could evidence front-line effectiveness with regard to adult protection.

Quality of Services for Service Users and Carers

7

STANDARD 4: QUALITY OF SERVICES FOR SERVICE USERS AND CARERS

Service users, their families and other supporters, benefit from convenient and good quality services, which are responsive to individual needs and preferences.

This standard looks at how far:

- the Care Programme Approach was in place and effective in assessing and meeting needs;
- care practice was holistic, systematic and put the service user at its centre;
- risk assessment and management was robust and promoted independence;
- there was a robust and effective management of service quality;
- privacy and confidentiality were being appropriately assured; and
- good quality information was available to service users and the general public.

7

STANDARD 4: Quality of Services for Service Users and Carers

STRENGTHS	AREAS FOR DEVELOPMENT
• There was a wide range of public information. • The Mental Health Service Directory contained comprehensive and straightforward information about mental health services.	• There were separate health and social care files. • Key documents were not always shared across files. • It was difficult to trace a service user's pathway through services using case records. • Social care case file recording was of an unsatisfactory standard. • Some service users felt that public information was confusing and not widely available. • The revised CPA process was not effective as a means of 'shifting the culture', promoting integrated practices and social inclusion. • Care co-ordination was not working effectively. • Assessments did not fully promote social inclusion and cultural diversity. • Risk assessments were not of a consistent quality, many were incomplete or information was unclear or contradictory. Contingency planning was poor in some cases. • The migration of information on mental health service users to social care electronic records was not fully complete and there were some gaps and inaccuracies. • Service users and carers were critical of the meaningfulness of care plans and the quality of reviews. • Management oversight of case files needed to be extended and improved analysis was needed to raise standards.

RECOMMENDATIONS

- **The Council and partners should undertake a comprehensive review of the CPA process and the review should:**
  - **involve service users, carers, staff and other stakeholders;**
  - **seek to understand the shortcomings in the existing CPA and learn from best practice; and**
  - **result in improved documentation, effective care co-ordination, relapse identification and contingency planning, quality assessment, care planning and review.**
- **The Council and partners should review the quality and effectiveness of case file recording and auditing.**
- **The Council and partners should strengthen quality assurance processes.**
- **Social services should ensure that risk alerts relating to individual cases are given prominence on the electronic case records system.**
- **The Mental Health Service Directory should be more widely distributed across public access points in the borough.**

7

Care Programme Approach Arrangements

7.1 The CPA had recently been reviewed, however there was widespread acknowledgement that the CPA process was not working well and that it had not promoted integrated practice. Front-line staff reported a lack of involvement with the review and felt that they had little influence on the outcomes. Many stakeholders were critical of the CPA documentation and the way in which it was completed. Staff in community teams often had to return documentation to ward staff when forms were incomplete, lacked details or had not been signed. Not all staff had access to electronic CPA. Many staff and stakeholders had not yet fully embraced a culture promoting the concept of CPA. Care co-ordination was not working effectively and there were different practices across the borough, of variable quality. Roles and responsibilities were not clear to many staff and other stakeholders. Service users, carers and other stakeholders considered that the service user was not central to care co-ordination and that the medical model predominated. The new CPA process had not demonstrably resulted in a stronger focus on social inclusion and a culture shift towards holistic assessment and person focused planning. Front-line staff were unclear on aspects of the CPA policy and how to get clarification. Staff who had raised queries had not received feedback.

7.2 Clarity and confidence about undertaking the care co-ordinator role had yet to be developed and embedded. A number of community psychiatric nurses were anxious about undertaking care management and social care commissioning and in a few cases there was evidence that individuals were reluctant or unwilling to take on all appropriate tasks associated with the role. This had frustrated some carers when they had raised social care related concerns about their relative's support needs and experienced a negative or unco-operative response.

7.3 Case recording and case files for health and social care were not integrated and key documents were not consistently shared across files. As a result of fragmented case recording and information held in separate files it was difficult to follow a service user's care pathway through services. There was some evidence of management overview in case files, and case file auditing, however the outcomes from these needed wider monitoring to ensure that they informed learning and improved standards. Some managers and staff had difficulties in accessing the separate health and social care information systems and this exacerbated some of the problems.

7.4 Case recording was generally of an unsatisfactory standard. From case file reading we found information on the social services Framework*i* system to be scant and inaccurate in places. In some cases, household occupants or close family members were not included on the key information record even though they may have been service users themselves or were cited as next of kin in Mental Health Act assessment documentation. The

migration of information on mental health service users was not yet complete and a data checking and cleansing operation was underway. However, we were not confident that all the significant number of inaccurate entries would be identified and corrected.

7.5 Working relationships and co-operation between ward staff and community-based workers were not strong. Social workers and community psychiatric social workers cited examples of difficulties in engaging with hospital staff and inconsistencies in practice between male and female wards. CMHT staff also described difficulties in obtaining information about the named nurse when service users were in-patients.

Assessment

7.6 Many service users we met and heard from did not feel fully involved in their assessments. Assessment, care planning and review processes were not strong due to the lack of an integrated care management and CPA system. Assessments were not generally holistic in their identification and analysis of need. Neither were they inclusive of multi-agency perspectives but were more reflective of the professional background of the care co-ordinator. There were several examples of service users' housing and leisure needs not being included within the assessment and care planning process, even though these clearly had a potential impact on the service users' mental health and general well-being.

7.7 We saw a range of assessment documentation on case files that had been developed prior to the review of the CPA. The CPA pro forma currently in use did not promote comprehensive assessment of need or consistency of approach to assessments. As a consequence it was difficult to determine how assessments were informing the effective formulation of care plans.

7.8 Providers were in a position to closely monitor the mental health and well-being of service users as they often had most regular contact and knew service users well. Providers had experienced difficulties when they assessed service users as needing to re-engage with CPA processes and contacted the CMHTs to expedite this on the service users' behalf. Providers held the view that their assessments were not given credence and that the CMHTs would only re-engage with the service user if they needed a Mental Health Act assessment.

Care Planning

7.9 Service users were critical of their care plans. They considered that care plans lacked any real meaning and did not feel that they were sufficiently involved in determining what went into their care plan. Many service users had not received a care plan or were not aware of whether they had or not, and others reported that it 'just arrived' in the post without discussion or explanation.

7.10 The Haringey CPA care plan did not include any trigger to promote the consideration of Direct Payments to meet identified need as an alternative to the provision of mainstream services. Care plans largely consisted of lists of activities such as outpatients' appointments or tasks rather than intended outcomes or objectives and it was difficult to determine how the progress or success of a care plan would be monitored. The only measure of the effectiveness of care planning built into the documentation was the section for the service user's perspective.

7.11 Provider agencies were not routinely or consistently involved in care planning processes even though they often had the most frequent contact and strongest relationships with service users. Providers experienced inconsistency in the clarity of care plans in relation to expected outcomes and measurable objectives. Often, providers were unclear how they were to meet the needs of the service user beyond simply offering a service.

Review

7.12 Many service users we met and heard from had concerns regarding the quality of their reviews. There was inconsistent practice around who attended reviews and whether service users were asked who they would like to be there. Most service users responding to our questionnaire said that they were usually or always invited to meetings about their care although only just over half felt they received the services that they had agreed with their care co-ordinator.

7.13 No pro forma for the recording of a CPA review had been included in the current CPA documentation, only an agenda for the review meeting. This did not include any provision for the evaluation of the effectiveness of previous care plans or recognition of what changes may have occurred since the last review.

Risk Assessment and Management

7.14 We found some examples of good practice with individual service users, many of whom had very complex needs, however, the quality of risk assessments and identified indicators of relapse was inconsistent, and in some cases, poor. Not all case files contained a risk assessment, although this was a service expectation and it was unclear what the threshold was to trigger a more profound assessment. It was also unclear what information would be passed on to the service providers or other agencies. Contingency planning was not widely evident and needed to be strengthened. Many case files were incomplete or information within them was unclear or contradictory.

7.15 One case had a risk alert flagged against a key person within the service user's circle on the old hard copy file. This alert had not been transferred

to the electronic records. Priority had been given to ensure that financial assessment and resource commitment information relating to service users was migrated so that contracts continued to be paid for. Similar priority must be given to ensure that risk alerts are also transferred to the electronic system and that they are prominent when records are accessed. The non-transfer of risk alerts was of significant concern.

Quality Management

7.16 A robust quality assurance framework and system was lacking. Explicit quality standards were not evident across the integrated service.

7.17 The monitoring of performance and quality of the spot contracts with providers in relation to individual care packages was the responsibility of care co-ordinators in the CMHTs through the case reviewing process. This arrangement was not working effectively and there was little recognition among the staff that this was their responsibility. There was no evidence of this quality-monitoring role in care management documentation. There was reluctance from some health staff to take on this task as they did not see themselves as being responsible for meeting the social care needs of the service user as required by the care co-ordinator role. This lack of clarity of understanding and the absence of any performance and quality assurance monitoring triggers within the CPA documentation, led us to conclude that quality assurance and performance management systems and practice were not sufficiently developed.

7.18 The departmental contracts unit acknowledged that it had not got a clear picture of the position regarding spot purchases. Spot contract providers reported that they experienced differing approaches to quality and service monitoring for different service users.

7.19 The council reported that quality was assessed by user consultation, analysis of complaints**,** members' enquiries, and procurement and contract monitoring procedures. However the monitoring and publicising of learning and outcomes from these needed strengthening.

7.20 In-house providers had a system of evaluation forms for completion by service users and carers. These were evaluated and discussed by unit managers on a regular basis although we did not find any examples of how services had been improved as a result of this service user feedback.

Privacy and Confidentiality

7.21 There was an agreed information sharing protocol between the council and its partners. This was compliant with data protection legislation and aimed to reduce the replication of data collection.

7.22 Service users and carers with whom we met felt that confidentiality and privacy were respected.

Information for Service Users and the Public

7.23 There was a wide range of information and work was ongoing to further improve the range and availability of information. The council had a mental health communication strategy which set out the core communication objectives of the service and outlined how these would be communicated to various groups.

7.24 The Council published a monthly magazine, *Haringey People*, that was delivered to every home in the Borough. This magazine provided news and views about Haringey, highlighted council services, policies and achievements. There had also recently been two features on mental health services. A magazine called *Equilibrium* was produced by service users and published for everyone interested in mental health in Haringey.

7.25 The mental health service and Tulip Mental Health Group had produced a very useful *Haringey Mental Health Directory*. This set out information about mental health and the local services that were available, including benefits advice and Supporting People and how to access them. Access to interpretation of the directory into alternative languages was offered within the introductory text and inside the back cover and could easily be missed. Signposting to interpretation services could more usefully have been placed on the outside back cover in the same way as had been done for the Welfare to Work Strategy and research document. We also found access to this very useful directory to be fairly limited to buildings visited mostly by professionals rather than widely available across public access points around the borough.

Fair Access

8

STANDARD 5: FAIR ACCESS

Social Services act fairly and consistently in allocating services and applying charges.

This standard looks at how far:

- eligibility criteria promoted fair access;
- social services were attending to the patterns of over and under representation of their populations in different mental health services;
- there was good access to appropriate services at times when they were needed;
- services were able to meet the needs of all their communities; and
- the charging system was fair and the complaints service worked well for service users.

8

STANDARD 5: Fair Access

STRENGTHS	AREAS FOR DEVELOPMENT
• Impact assessments had been carried out on all major Council policies including the joint mental health strategy. • A multi-agency Race Equality Task Group operated across health and social care including Police to consider partners' Race Equality Schemes and identify core priorities for improvement through joint or co-operative working. • The Council had assessed it was at Level two of the local government equality standard and aimed to achieve Level four by 2007. • There were some examples of initiatives to meet specialist cultural needs, such as with the Turkish community. • Haringey was actively engaging with communities whose first language was not English. • The Council had a sound approach to undertaking financial assessments.	• Work across service interfaces could be significantly stronger particularly in some service areas. • Not all service users understood the criteria for the crisis and home treatment team. Some staff found it difficult to access the service. • The different strands of service lacked cohesion. • There were some geographic inequalities in services and support available particularly to young black and minority ethnic service users. • There was over-representation of young African-Caribbean men in acute mental health services, particularly forensics. • Gender-specific services were limited. This reduced the accessibility and effectiveness of services in some instances. • Advocacy services were limited and offered little choice. • Service users and carers were not consistently aware of the complaints procedure. • Carers were not routinely aware that they could have an interpreter present in meetings.

RECOMMENDATIONS

- **Partners should ensure that eligibility criteria and access to the Crisis, Assessment and Treatment Team and Alexandra Road Crisis Unit are clearly understood by service users and all staff involved in mental health services and are consistently applied.**
- **The Council should work with partner agencies to ensure that opportunities for single gender services are developed and that all services take demonstrable steps to ensure that environments and services are fully inclusive.**
- **Partners should ensure that the availability and choice of advocacy support for service users and carers is increased.**
- **Partners should ensure that service users and carers are aware of their rights to access interpreting services and the complaints procedure.**

8

Eligibility Criteria

8.1 The Council had revised its eligibility criteria in accordance with Fair Access to Care Services (FACS) and applied these consistently across adult services. Guidance for mental health staff on the application of eligibility criteria was included in the Community Care Services Guide to Policies and Procedures and staff were confident in its application. Some inappropriate referrals were still being made by local GPs to CMHTs highlighting the need to continue to raise awareness among primary care providers about eligibility for statutory services being set at 'critical' and 'substantial' and signposting to appropriate alternative support services for lower levels of need.

8.2 The eligibility criteria were published on the Council's website and being made increasingly accessible through the high level of commitment the Council demonstrated in providing good access to intranet services across the borough.

8.3 Not all service users understood the eligibility criteria for accessing the crisis services. Some service users had been turned down by these services for reasons they did not understand.

Patterns of Representation in Services

8.4 The partner agencies all had Race Equality Schemes and a multi-agency Race Equality and Partnership Task Group had been established to operate across health and social care, including the Police. The main role of the group was to consider partners' Race Equality Schemes and identify core priorities for improvement that could be achieved through joint or co-operative working and to develop an action plan to address these. The Council's own Race Equality Scheme had been revised in 2005 and impact assessments had been carried out on all major Council policies. The Council had found this process challenging and had amended and revised policies where necessary. Joint training on undertaking impact evaluation work had been put in place across partner agencies.

8.5 The Council's self-assessment indicated it had achieved Level two of the local government equality standard with a commitment and action plan to achieve Level four by March 2007.

8.6 A mental health and equalities event held for World Mental Health Day 2005 and the Race Equalities Joint Consultative Committee in November 2005 had been popular and positive in helping to raise awareness about services and equality issues in the borough and had been multi-agency events.

8.7 There was an over-representation of African-Caribbean people within the service, particularly young adult men in acute services, specifically in forensic services and a large cohort of Turkish and Kurdish young people coming up through the Children and Adolescent Mental Health Services (CAMHS) system. Plans were in place to undertake work with the Turkish/Kurdish community to better understand this community's needs. The need for move-on accommodation and services had also been identified as important to service users. The research was to inform the on-going Supporting People work which was mainly focused on meeting the needs of people with mental health difficulties, as well as the work of the LIT and its executive. There were plans to report the research findings to the Supporting People Provider Forum in April.

8.8 The *Haringey Health Report 2004* highlighted the high number of suicides of African-Caribbean men and the high incidence of mental health difficulties among the very significant numbers of asylum seekers and refugees in the borough. Partner agencies recognised the need to develop better data about local service uptake and use this in the ongoing development of joint commissioning.

Out of Hours Services

8.9 The primary route into the CMHTs was through NHS Direct and local GPs, other than from in-patient services. Haringey had a number of customer service centres at key access points around the borough that provided information about services, as did the website.

8.10 Outside office hours, emergencies were covered by the Emergency Duty Team (EDT), which could access Framework*i* and had additional responsibilities for emergency housing and civil emergency response. Front-line staff reported good relationships and communication with the EDT service. An emergency reception unit operated at St Ann's Hospital.

8.11 The Clarendon Centre opened at weekends and in the evenings throughout the year. A CATT had been established across Haringey, providing support over 24 hours, seven days per week. This worked closely with Alexandra Road Crisis Unit, which provided an alternative to hospital admission and respite placements for up to eight service users and took referrals from a range of agencies including the Police and Probation Service and service user self referral. Stays were typically from three days up to two weeks. A CSCI registration inspection visit of this unit had recently taken place with a subsequently positive inspection report overall.

8.12 Service users who had engaged with the crisis team were positive about their experiences and valued the support of this service, feeling that it reduced the likelihood of their readmission to hospital. A number of staff from different agencies and some service users talked about difficulties in accessing both the CATT team and the Alexandra Road Unit and there

was inconsistency in ease of access across the borough that required managerial attention.

Meeting the Needs of All Communities

8.13 The population of Haringey was highly diverse and subject to constant change as it was of a highly transient nature. This presented the Council and its partners with ongoing challenges particularly in relation to the provision of mental health services. An example of this was the difficulty in providing a women only residential unit and a Greek speaking carer for one service user whose case we examined. Equalities training was included in staff induction and there was ongoing training on diversity issues.

8.14 The Council was to be a pilot site for community development workers and was working to share information across partnerships about ethnic differences in service access, provision and outcomes, with a view to making improvements. Other good initiatives included working with the Turkish/Kurdish community to bid for project funding from the National Institute of Mental Health in England (NIMHE) for a project with the University of Lancashire.

8.15 The assertive outreach service provided a specialist service, Antenna, for younger African-Caribbean service users aged between 16 and 25 years, a group identified as being particularly at risk of suicide locally.

8.16 A black and minority ethnic network/forum had been established as a sub-group of the LIT. This was attended by a core group from a range of local service user and carer representative groups, the Race Equality Council, senior managers from BEHMHT and some service users. Together with the wider membership, this constituted a large network of agencies engaged with the planning framework for mental health services.

8.17 Social services were working with the Director of Equalities at BEHMHT on the Delivering Race Equality Programme based on developing more appropriate and responsive services, further community engagement and better information. In addition the BEHMHT had recently twinned with a hospital in Sierra Leone in the expectation that significant shared learning would result. These were positive developments.

8.18 The level of co-operative working across service interfaces was not consistently strong and was a significant area for development. Some protocols had been developed to guide staff but this was not the case across the interface between mental health and learning disability services and this deficit had created some operational difficulties. Operational guidance encompassing work across this interface would reduce the risk of a service user not receiving support and this gap should be addressed.

8.19 An agreement had recently been reached that a multiple needs panel of third tier managers, chaired by the service manager for older people, would be convened as required to resolve issues around co-working, complex cases and funding responsibilities.

8.20 Gender-specific services were limited and although both in-house day centres tried to offer women only sessions, male service users returning to the centres from other activities sometimes interrupted these. Female service users told us that they found some environments within externally commissioned day services intimidating, making them disinclined to attend. Some of this was about the attitudes of male attendees towards women and the manner in which women were addressed. Given the limitations of existing buildings and resources, continuous evaluation of the accessibility of services to women should be undertaken and steps taken to reduce any risk of intimidation or feelings of discomfort any attendees may experience across in-house and externally provided services. A women's therapy centre operated in Holloway at a small cost to attendees for both individual and group therapy.

8.21 Women only housing units were being discontinued due to a lack of referrals. There was however, a strong feeling among housing stakeholders that there was a need for women only provision, which would be worth the Council exploring further with its partners to ensure all needs are identified and included in future planning.

Advocacy

8.22 There was little choice available for service users who needed or wanted to access advocacy support and service users regarded this as a priority for improvement. As part of the joint mental health strategy there was a plan to increase the provision of advocacy within primary care settings during the current year. Increased provision of advocacy was also identified as a strong recommendation in the Scrutiny Review. Given the financial pressures within the joint service, we were concerned that this might prove difficult to achieve, but we were assured that the provision of additional advocacy services would remain as a key priority objective for this year.

Interpreting

8.23 Some voluntary sector and service user representative groups held the view that services did not respond well to people who did not have English as a first language. About a third of the carers responding to our survey did not know that they could access an interpreter when engaged with services. We would encourage further exploration of this issue by the partner agencies as most staff reported good access to interpreting services particularly in the community. Access to interpreting in in-patient services was reported as being less easy to access and we heard about particular

difficulties for an in-patient service user who used British Sign Language. With 193 identified local languages, this would remain an area of challenge to services, as would the need to ensure that interpreters had a basic understanding of mental health issues and terminology to facilitate the understanding of service users and carers.

Charging

8.24 The Council's charging policy was operating in accordance with Department of Health *Fairer Charging* Guidance. Service users who received income support and whose overall income matched the defined 'basic' levels, excluding severe disability premium, were exempt from charges. Residential services were assessed in line with *Charging for Residential Accommodation Guidance* (CRAG).

8.25 There was good access to information about the Council's approach to charging available through leaflets and the website. However 15 of the 20 carers who responded to our questionnaire did not know how charges were calculated. Of 41 service user respondents, 31 did not know how charges were arrived at and 16 felt the charges were unfair.

8.26 We identified no areas for development regarding the undertaking of financial assessments.

8.27 A Scrutiny Review of benefit take-up had been presented to Executive in June 2005 and recommendations taken up. An example was a campaign in 2006 to increase benefit awareness and take-up. An anti-poverty strategy was also in development.

Complaints Service

8.28 Information regarding the complaints and comments procedure was available in leaflet form and was included in an information pack given to service users at the point of accessing the service. Information about making a comment or complaint was also on the website. Work was underway to develop a joint procedure within the service, building on social services' commitment to use information from complaints as a quality improvement driver.

8.29 Services had some work to do to improve awareness among carers and service users. Sixteen service users surveyed stated that they did not know how to make a complaint about services, and carers were also not widely aware of how to make a complaint.

Capacity for Improvement

9

STANDARD 6: CAPACITY FOR IMPROVEMENT

The council has corporate arrangements and capacity to achieve consistent, sustainable and effective improvement in social services.

This standard looks at how far:

- there was a clear vision for mental health services;
- there was sustained progress in the service;
- performance management arrangements were effective;
- the structure of the service was assisting its modernisation;
- the workforce was well trained;
- working relationships with other services were ensuring a holistic approach to service delivery; and
- the needs of children were being met.

9

STANDARD 6: Capacity for Improvement

STRENGTHS	AREAS FOR DEVELOPMENT
• The five Council priorities were well publicised through the website. The public could easily access key policy documents and social services' annual report. Internet services were free and widely available through the libraries. • Councillors were clear about their responsibilities, were well informed about mental health and engaged in planning and scrutiny arrangements. • There was a range of methods of communication with staff and service users in the mental health services. • The Director of Social Services met regularly with new and front-line staff and operated an open e-mail address. • The Council had achieved the Investor in People Award in March 2005. • The Council had developed strong partnership arrangements: was strengthening its relationship with the voluntary sector and actively seeking to engage diverse groups. • There were opportunities for joint training and voluntary organisations had access to social services' training.	• A lack of continuity at senior management level for the service had created a hiatus in direction, leadership and service developments. • Whereas there was good recent development of strategic plans to develop and modernise services, these lagged behind national developments and were slow to translate into front-line service delivery. • Performance management and quality assurance systems had not been fully developed, particularly in relation to commissioned services. • Teams were not staffed and configured according to demand and demographic factors. • Operational managers did not have good access to both health and social care electronic databases. • The full development of an integrated service and practice was inhibited by the lack of co-location of some teams. • Service users were not involved in the ASW re-approval process. Communication of ASW specific issues and developments could be more efficient. • There was a lack of career progression and access to appropriate NVQs for some day service staff. • The joint commissioning function lacked sufficient capacity. • Work across interfaces between primary care, provider agencies and specialist mental health services could be improved.

RECOMMENDATIONS

- **The Council and partners should ensure that performance management, monitoring and measurement systems are robust and operating effectively at all levels within integrated services.**
- **The Council should work with its partners to:**
  - **ensure that the profile of social care is well promoted;**
  - **demonstrate that social care is valued within the integrated service; and**
  - **consult widely to gain a good understanding of stakeholder perceptions regarding social care profile, the reasons for them and how to address these.**
- **The Council and partners should continue to develop a fully integrated service, underpinned by co-located teams, integrated practices and infrastructural support.**
- **An operational protocol to guide staff and managers through working across the interface between mental health and learning disability services should be developed, implemented and regularly evaluated to ensure effectiveness.**

9

Vision and Progress

9.1 Haringey Council had developed a strong community vision rooted in co-operative working with partner agencies and set out in the Community Strategy. The five Council priorities were well publicised through the Council website which the Council viewed as its chief method of communication with the wider public. Access to internet services was promoted and assisted through public libraries across the borough and there was evidence that public use of the website was increasing particularly among young people. Social services' annual report was also available on the website. In addition to the website, the Council relied on local area assemblies, staff team briefings, newsletters and special events to convey its vision and service strategies. The Council was developing a 'localism' approach with new neighbourhood structures. These were being developed through Local Area Agreements.

9.2 Councillors were clear about their responsibilities and we found them to be well informed about mental health services and actively engaged in the planning and service scrutiny arrangements. Their commitment to the local development of the well being agenda had marked a positive embracing of the partnership working approach which, historically, the Council had been cautious about and slow to adopt. This new approach to partnerships was being warmly received by other key agencies and the agenda was moving forward. One very committed councillor had driven the recent Scrutiny Review of the service. This review had been extensive and comprehensive and had resulted in a number of recommendations which were being taken forward positively to Executive Board.

9.3 Resources had been invested in the development of the following services:

- crisis assessment and treatment teams and assertive outreach team;
- strengthened management infrastructure of the CMHTs;
- the establishment of the Therapeutic Network;
- access to extensive interpreting services;
- IT hardware, systems and staff training; and
- expansion and improvement of day services through Neighbourhood Renewal Funds.

9.4 Planned target areas for resources were:

- development of early intervention in psychosis service;
- establish more carers' worker posts; and

- establish community development worker posts in conjunction with London Development Centre for mental health.

9.5 These were positive developments, however the outcomes from many of these investments had yet to be evidenced and many areas had yet to be fully implemented.

9.6 Partnership agencies had agreed to move to a section 31 agreement between the Council, the BEHMHT and the PCT over the next 18 months to better establish and reflect the joint commissioning approach and facilitate the establishment of a fully integrated service. The development of a joint mental health strategy and joint commissioning plan was a positive development although significant work was needed to refine both of these documents into clear, concise and accessible documents that could be owned, delivered and monitored by stakeholders.

9.7 Partnership working within the LIT was not operating effectively and this needed to be addressed to ensure shared ownership of the vision for mental health services. There was a need for improved clarity and transparency as to the purpose, role and membership of different partnership groups and sub-groups, with decision-making, reporting and accountability lines made clear. Many stakeholders did not feel that consultation mechanisms were operating meaningfully and reported that their views were not valued by senior managers.

9.8 The Director of Social Services encouraged members of the public to contact her through an open e-mail address and made efforts to attend service events in order to meet service users directly and follow up any issues they raised with her. She also met regularly with the mental health carers association and other voluntary organisations.

9.9 Although there were strategic plans to develop and modernise services these were not well advanced and lagged behind the developments in these areas nationally. The outcomes from service reviews and planning had been slow to translate into front-line service delivery and provision. There were concerns that there was limited capacity in commissioning.

Performance Management

9.10 A number of joint performance indicators had been developed, including some for mental health, although managers acknowledged that there was scope to develop a more extensive suite. Performance was being monitored through the performance strategy sub-group of the Well-Being Board by means of a traffic light system. Partners recognised the need to develop a joint performance framework to incorporate the strategic and management needs of the service and the different performance targets of each partner. There were difficulties in collecting data and management information to support the development of an improved performance

management system. The different management information systems in place in each agency contributed to this as the systems did not interface and not all managers had access to the different systems. Social services was introducing Framework*i* as its client record and management information system and the BEHMHT was developing RIO (an information software system) as part of the *Connecting for Health* framework.

9.11 The use of the balanced scorecard was positive, however, there was scope to develop joint performance management information further. The performance indicators were monitored monthly down to fourth tier managers. In mental health, performance indicators were discussed at team meetings.

9.12 Performance management and quality assurance systems needed strengthening. Not all operational managers and staff within the service were aware of how performance measures might be applied to their service and no targets or quality assurance measures were currently incorporated into the business plans of the in-house provider units. The inconsistent access to both health and social care electronic databases for operational managers did not help to promote effective performance management. Although overall the Council had developed a good business planning framework and guidance, this needed to be applied throughout all levels of the department. The CMHTs were beginning to look at the development of measurable outcomes to include in-team plans.

9.13 The in-house provider units were only being asked for occupancy figures by commissioners and were not required to provide evidence of outcomes or quality. Some in-house services had developed service user evaluation sheets but these were not of consistent format or used across all units.

9.14 The Council's own staff survey in 2004 showed that 78 per cent of staff understood how their work helped the Council achieve its aims. Seventy per cent thought the Council was committed to support the development of its people and 75 per cent thought the Council was getting better at doing this. Eighty-five per cent said they understood the Council's aims and objectives.

9.15 Historically, the Council had not had a strong approach to the management of staff performance and this was still an issue for some services including mental health. This previous reluctance to address poor staff performance was something that the Council was trying to change, in part through a corporate leadership programme being rolled out to third and fourth tier managers. This shift in management culture was at an early stage and would take time to consolidate and impact positively on practice quality.

9

Organisational Structure

9.16 Much work remained to consolidate and build on the restructured CMHTs and many operational details needed to be resolved. The degree of operational integration in the service varied across teams. The infrastructure supporting managers and staff within the integrated service needed strengthening. Front-line social work staff were generally positive about the prospects of moving into an integrated service with single line management arrangements which would mean transferring to the BEHMHT.

9.17 The lack of co-location inhibited the successful integration of some teams and prevented development of fully integrated practices. The different CMHTs were virtually identical in terms of size and staff establishment, and had not been reconfigured to match identified demographic needs or pressures in particular localities. There was some variation in how closely staff and clinicians were working together across the different localities of the CMHT and work was needed to produce equally cohesive practice across the service.

9.18 There had been a number of new managers in post over the last year. Whilst these developments were largely positive the impact of so much change had been unsettling and there was a significant amount of work to instil confidence and stability into the workforce. Strong leadership skills would be required and this needed demonstrating over time. Managers came from a mix of health and social care backgrounds and were able to support one another and share learning to develop the skills and knowledge required for effective management of both health and social care professionals. Some stakeholders considered that social care had a low profile and there was insufficient senior level leadership and promotion of social care.

9.19 Staff at the front-line felt that the number of changes of post holder at second tier level had led to a sense of lack of direction within the service. They felt detached from the senior management level. Independent sector agencies also expressed a view that the lack of progress in some service areas, particularly around the development of support services for carers, was attributable to the changes in senior management and resultant lack of leadership in addition to resource constraints. We concluded that these changes at second tier had created instability and a hiatus in strategic leadership to some extent, which had impacted on service development. The current interim post holder was moving the agenda forward and had the confidence of agencies within the partnership. Further changes were anticipated in managerial arrangements once the new chief executive came into post and the future departmental configuration had not yet been determined.

9

Workforce

9.20 There had been a recent launch of Haringey Way of Working (Haringey WOW) to all Council staff. This was to promote the concept of one council vision and the idea of being part of a corporate whole and part of the partnership approach rather than isolated council departments. The Council had achieved the Investor in People Award in 2005 and all managers had been given the retention of this award as an objective in their personal development plan.

9.21 A joint workforce strategy would help to address recruitment and retention difficulties experienced in parts of the mental health service. This strategy should link to the mental health commissioning strategy.

9.22 Although line management arrangements within the mental health service were clearly defined, front-line staff expressed some lack of clarity about where their professional development and supervision would come from given that they were not necessarily line managed by someone from the same professional background. A joint supervision policy was in place to address this, but some social workers and community psychiatric nurses had not received professional supervision for some time. A range of staff and managers spoke of the need for a professional social work lead within the service.

9.23 There were opportunities for joint training and voluntary organisations had access to social services' training. However, there was a lack of career progression and inconsistent access to appropriate NVQ levels and categories for some day service staff.

9.24 Haringey had a centralised organisational development and learning (ODL) function operating across all service areas until last year when a separate social services' training team was established. The team had a head of practice learning post and had 32 trainee social workers undertaking professional qualifications. A part-time mental health services learning and development post was being recruited to, which should strengthen the links between ODL and the mental health service which had weakened over the past year.

9.25 Joint training on CPA had been put in place for staff in the CMHTs but this had not included ward staff. This would be beneficial in improving the co-operative working between hospital and community based mental health professionals where relationships needed significant strengthening. The training programme delivered on the introduction of the new CPA process had not however, been as effective in achieving the required change in culture and practice necessary among front-line staff in the CMHTs as managers had expected.

9.26 A people planning process had been established across services to ensure that individual staff had annual performance and development reviews and had their own personal development plan with four objectives linked to service plans. Managers acknowledged that mental health services had not yet developed as robust an approach to this process as other service areas where it was working more effectively. Not all managers within the mental health service were aware of the People Plan. A monthly meeting chaired by the Assistant Director for Older People and attended by the Director of Social Services had been established in January 2006 to monitor the managing people and people-planning programme.

9.27 In-house providers did not feel that the training on offer met the specific needs of the services that they provided. There was no group work training on offer although this was the main model of their service intervention.

Approved Social Work

9.28 In 2005, there had been a significant problem with ASW arrangements when a number of practitioners had not had their warrants renewed by the Council due to a systems failure. Action to rectify this difficulty had been taken promptly once the situation had been recognised and the Council had notified CSCI. The ASW re-approval process had been scrutinised to identify how the situation had arisen and a new process and monitoring system put in place to prevent recurrence. Given the Council's commitment to service users in service development, an opportunity had been missed to involve service users in the re-approval process and this should be considered as an issue of best practice.

9.29 ASWs reported the refresher training to be of good quality and tailored to meet identified needs. The refresher training consisted of an annual three-day programme and was led by a barrister.

9.30 An independent consultant had been brought in to take forward the development agenda around ASW practice and some positive achievements had been made in co-operation with other agencies such as the Police and health services. Confidence in the system was being restored. A six-weekly meeting between the ASWs and the consultant took place where information was shared and issues discussed, which ASWs found useful. As developments were progressing fairly quickly in this aspect of work, it would have been helpful to the ASW group if they were able to communicate with the consultant through the Harinet e-mail system. The system also provided an opportunity to develop an electronic news or bulletin board for ASW issues where information and practice issues could be shared.

9

Interface Issues

9.31 There had been difficulties in agreeing funding to meet the needs of service users with a complex multiple diagnosis but this had recently been tackled through the creation of a panel represented by a manager from each service user group. This was chaired by the older people's service manager. Each case was reviewed individually. The success of the panel had yet to be evidenced, however it demonstrated some positive joint working and an intention to meet the needs of service users with multiple needs as effectively and efficiently as possible.

9.32 Interface arrangements needed strengthening, with robust monitoring systems to measure their effectiveness. Protocols were in place for age transitions but protocols also needed to be developed jointly between mental health and learning disability services.

9.33 The main local provider of statutory services was the BEHMHT with in-patient services comprising acute beds, continuing care and day hospital for older people. There was also a specialist personality disorder service as well as other specialist therapeutic services in primary care. Health managers recognised that work across the interfaces between primary care and specialist mental health services should be improved and had developed plans for a Local Enhanced Service for Primary Care to be implanted from April 2006. Following a serious incident in the borough, some GPs had been reluctant to accept service users back into their practices on a shared care or total discharge basis from CMHTs.

9.34 There were six graduate workers in primary care services, funded by the HTPCT, and the development of the link worker role was progressing better in the east of the borough than in the west.

9.35 Services for people with dual diagnosis were an issue for local agencies given the high numbers of people misusing drugs and alcohol and presenting mental health needs. The current dual diagnosis service was being reorganised to integrate into the CMHTs and the crisis team from April 2006. Agencies were engaged in exploring ways to expand the access into the DAAT service from the voluntary sector, specialist local providers and the medium secure in-patient service.

The Needs of Children

9.36 The mental health trust provided CAMHS tier 4 in-patient services, an adolescent outreach team and community team. Managers in both the adult and children and families service had been working to strengthen cross-interface and transitions working. The child protection advisor had led this work, resulting in improved understanding and working relationships. Protocols had been put in place but were being updated to

reflect the separation of children's and adults' services. The CAMHS protocol was finalised and launched following the inspection fieldwork.

9.37 Although there was some varied experience of working with staff in the children's service, most social workers and community psychiatric nurses found the policies and procedures governing working with children were satisfactory. All front-line staff in the mental health services had received child protection training.

Standards and Criteria

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STANDARD 1: National Priorities and Strategic Objectives

The council is working corporately and with partners to deliver national priorities and objectives for social care in mental health services, and their own local strategic objectives to meet the needs of their diverse local communities.

Criteria and Evidence

1.1 The council has a coherent overall **strategy for responding to national priorities** for social care generally and for mental health services in particular.
• A strategic partnership connects the variety of planning requirements effectively at each level. It monitors performance and acts promptly to address deviation. • There is a coherent, up-to-date strategy for meeting national priorities for mental health which integrates current and future national targets. • All national targets and milestones are being met and performance indicators are good.

1.2 Social Services have developed **local strategic objectives**, priorities and targets for mental health services which complement the national ones and serve the whole community.
• Plans set specific, measurable, achievable objectives; and there is a timetable for delivery. • Local objectives are being met. • The diversity of the community has been specifically addressed.

1.3 The council is consistent in implementing a strategy of **continuous improvement** and can demonstrate Best Value principles in social care mental health services.
• Strategies for improvement have been operationalised through resourced business plans which cascade down through divisions and teams to performance plans for individual staff. • Strategies are supported by sufficient data to allow every level regularly to compare actual performance with desired performance. • Strategies take account of relevant inspections and reviews, service user and carer views, provider views and complaints and representations. • Service reviews are systematically programmed, planned and implemented. They involve service users and have an impact on plans.

1.4 All mental health services reflect the active **involvement of service users and carers** including those from diverse groups within the community.
• The Council has effective arrangements to inform and consult adults with mental health difficulties and their carers about future direction and design of services. • The diversity of the community is fully recognised in the approach to consultation. • The planning system for mental health services is linked effectively to planning systems for other service areas which have an impact on mental health services. • Plans contribute to the Council's duty to promote race equality.

1.5 The Council has well-developed **joint working** arrangements that operate effectively.
• Agencies co-operate in providing services for adults with mental health difficulties. • Opportunities for joint work, co-location and joint management of appropriately integrated services are exploited. • Planning and working relationships between the mental health service, the wider council, the NHS, and other agencies are collaborative and ensure that services are comprehensive and seamless, particularly for: - service users with multiple needs; and - children and young people. • Leisure and employment opportunities are ensured through these arrangements.

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STANDARD 2: Cost and Efficiency

Social services commission and deliver mental health services to clear standards of both quality and cost, by the most effective, economic and efficient means available – they achieve value for money in mental health services.

Criteria and Evidence

2.1 Commissioning of mental health services is based on sound analysis of local population needs, including minority groups and is successful in **balancing cost and quality requirements**.
• A multi-agency commissioning plan informs the council's providing/purchasing plans. • The plan is based on: - needs-analysis which includes an understanding of demography and the needs of black and minority ethnic communities; - contract setting and market management that ensures access to a stable and sustainable provision; and - contract monitoring that ensures compliance while promoting quality and partnership. • Services take account of research into what works and good practice elsewhere.

2.2 Expenditure on mental health social care services reflects **national priorities** and is fairly allocated to meet the needs of diverse communities.
• Acting corporately, the Council ensures that national priorities for mental health services are fully reflected in the budget(s) for services. • The budget is prepared on the basis of need and is not based on incremental increases. • The budget recognises the need of diverse communities for diverse services.

2.3 The Council demonstrates **improved efficiency** in mental health services.
• Unit costs suggest value for money, good performance and are used in commissioning decisions. • Services promote prevention and community support rather than reactive crisis management and institutionalisation. • Technology is used comprehensively and effectively to support communication, management, service delivery and monitoring.

2.4 The Council has implemented **joint financial arrangements** with health and other partners for the delivery of mental health social care services.
• Agencies maximise choice and/or efficiency by co-operating to purchase services. • Complex arrangements for funding individual cases are agreed promptly between agencies. • Systematic consideration is being given, with partners, to optimise arrangements for service funding including the use of Health Act flexibilities.

2.5 The Council's **strategy for resource allocation** for social care supports improvement priorities, with effective risk management of the mental health services budget.
• Year on year, the Council's resource allocation is becoming more closely aligned with improvement priorities. • The strategy identifies risks to the plan and says what is to be done to manage them. • Threats such as unplanned contingencies are identified quickly; the council reacts to keep things on track. • Maximum use is made of funds from outside the main programme budget; the Council has a strategy for time limited funds.

2.6 The Council's **asset management** strategy is helping to deliver social care improvement priorities in mental health services.
• The Council's asset management strategy supports the service strategy; social services has the facilities needed to do the job. • The asset management strategy includes a considered balance between the Council's own facilities and those externally provided. • The capital programme supports social services' improvement plans. • Development, procurement and disposal arrangements are flexible and responsive; they take account of the impact on service users; there is proper consultation.

2.7 The Council demonstrates **probity** in managing resources. **Budget management** is effective and appropriately devolved to trained staff; accountability for budgets and expenditure is clear.
• It is clear who makes expenditure decisions against delegated budgets. • Financial and managerial responsibilities are closely aligned. • Accounting practice and up-to-date management information enables budget holders to monitor commitment and actual spend and take prompt corrective action. • Arrangements can cope with pooled budgets, joint finance and grants to voluntary organisations. • Audit letters confirm that spend is properly accounted for; auditor's recommendations are implemented. • Audit certifies that government grants are spent on the purposes for which they are intended.

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STANDARD 3: Effectiveness of Service Delivery and Outcomes for Service Users.

Mental health services promote independence, protect people from harm and support them to make the most of their capacity and potential and achieve the best possible outcomes.

Criteria and Evidence

3.1 The independence of service users and carers is promoted actively and consistently to minimise the impact of any disabilities, and to avoid family stress and breakdown.
• Direct payments are promoted; take-up is increasing. • Service users are increasingly benefiting from the service by becoming more independent, and personally fulfilled. • Service users have socially inclusive and valued lifestyles and the practicalities of their lives are attended to. • Leisure and employment opportunities are actively promoted and appropriately supported.

3.2 The **range of services** available is broad and varied to meet needs, offer choices to many and take account of individual preferences. This includes sensitivity to the needs and preferences of diverse groups.
• The range of services available is sufficiently broad and varied to meet service users needs and includes: • the full range of services specified in policy guidance; and • relevant specialist focus including multiple disability[2]. • Service planning responds flexibly to changing needs, aggregated demand and demographic and socio-economic factors. • There are services suitable for people from diverse racial and cultural backgrounds.

3.3 The council provides a good range of services to **support and encourage all carers** in their caring role.
• Carers' needs are routinely and separately assessed and reviewed. • The Council has identified older carers, and others whose potential change of circumstance may affect their future capacity, and put plans in place. • Carers say they are treated as partners in caring; they get plenty of information about services and the condition of the person being looked after. • The needs of young carers are identified and met.

[2] Multiple disability in this context includes needs stemming from learning disability, physical and sensory disability (particularly sight and hearing).

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3.4 Service users are effectively **safeguarded against abuse**, neglect or poor treatment when using services. Incidents of this kind are rare.
• Protection policies promote an informed, professional culture in the mental health service. • Commissioning and contracting arrangements specify required safeguards and are regularly reviewed; complaints systems in external providers link up with the services and council's procedures. • Service users and carers are not abused, neglected or treated poorly while using mental health services whether they are directly provided or are commissioned elsewhere.

STANDARD 4: Quality of Services for Users and Carers

Service users, their families and other supporters, benefit from convenient and good quality services, which are responsive to individual needs and preferences.

Criteria and Evidence

4.1 All **referral, assessment, care planning and review** processes are convenient, timely and tailored to individual needs and preferences, including diverse groups.

- Potential service users and their carers receive a prompt assessment appropriate to their presenting circumstances.
- Care Programme Approach arrangements:
  - comply with national guidance;
  - are systematic, holistic and needs based;
  - are focused on outcomes for service users;
  - incorporate a robust approach to the assessment and management of risks posed to and by the service user;
  - address leisure and employment needs;
  - address the needs of children – including young carers;
  - address issues of race, ethnicity, gender, sexuality and early life abuse; and
  - are audited, reviewed and revised against good quality standards.
- There are GP protocols for the identification and management of common mental health difficulties.
- Service users are effectively supported in care pathways and are at the centre of the care programme approach.
- Service responses are prompt; the assessed service of choice is provided without undue delay or resort to temporary measures.

4.2 The service has effective **quality assurance** systems in place and service quality is consistent across all sectors, services and communities.

- The service has a specified approach to quality assurance, possibly using established standardised systems (e.g. EFQM).
- Service users are satisfied that they are approached with courtesy and respect by staff who they regard as being well informed and reliable.
- Quality standards are defined for all services; provided by the service or purchased; they are consistently applied and monitored for compliance.
- The service responds to the CSCI, and other reviews and inspections, by taking corrective action as necessary.

4.3 Privacy and confidentiality are assured in all contacts supported by appropriate policies and procedures.
• Personal information on service users and carers held by the Council is only shared with consent, unless it becomes necessary to safeguard their welfare or prevent offending; service users and carers understand that. • There are specific rules for people whose competence is impaired by virtue of age or mental condition. Everyone understands those rules. • Interpretation for deaf people and people who don't speak English takes account of confidentiality and does not rely on family members. • All service providers are committed to the same rules and protect service user and carer privacy; compliance is monitored.

4.4 Good quality **information about services** and standards is readily accessible to all, including diverse groups in the community.
• Service users and their carers have accessible information which they understand which explains: - the psychiatric, psychological and social nature of mental ill health; - professional language and service terms; - local care management/care programme approach arrangements, their rights and responsibilities within it; and - how confidentiality is managed in the service. • Up to date information on services and service standards is freely available to the general public on request, through information points and libraries, using paper and electronic systems. • Information on standards is specifically given to service users and carers at the point at which choices are being made and, subsequently, as circumstances and needs change.

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STANDARD 5: Fair Access

Social Services act fairly and consistently in allocating services and applying charges.

Criteria and Evidence

5.1 Clear eligibility criteria for mental health services are published, easy to understand and fair to all.

- Eligibility criteria:
  - inform existing and potential service users and carers about what sorts of people, with what kinds of needs, qualify for what types of care processes and services;
  - help fieldworkers carry out effective assessments and then match them to assessed needs;
  - result in everyone being treated fairly and avoids discrimination or favour; and
  - are published in accessible formats.

5.2 Social Services are effective in monitoring the social care needs of the local population and the take-up of mental health services. **Fair access** can be demonstrated in all areas and action is taken to increase the services from under-represented groups.

- The service has published a race equality scheme which clarifies how it is promoting racial equality.
- Policies have been checked for compliance with the Race Relations (Amendment) Act.
- Profiles of referrals, assessments, care pathways and outcomes are routinely collected and examined to ensure that patterns of over or under representation in the service, or between services, are identified and dealt with.

5.3 There are clear routes to access all **key social services 24 hours a day, 7 days a week**, as needed.

- There is a specialist mental health crisis resolution team in operation 24 hours a day and seven days a week.
- Information on how to access services out of hours is widely available.
- General out of hours services are provided by appropriately skilled staff who are able to deal with requests from service users and referrals (or requests for advice or consultation) from other agencies.
- Out of hours staff can access case, service information and reference material (e.g. registers) promptly.
- Key workers alert out of hours staff to possible problems.

5.4 The range of services available reflects the needs of the community, promotes equality to comply with all relevant legislation and demonstrates that **diversity and social inclusion** are valued.
• The service is implementing a policy of equality of opportunity and anti-discriminatory practice in the mental health services it provides and commissions. • Staff have the knowledge and skills to work effectively with diverse communities. • Services respect and respond appropriately to needs which are associated with service users cultures and lifestyles.

5.5 Access to services is culturally appropriate, and inclusive. Advocacy services are promoted and used appropriately.
• Potential service users can access services in non-stigmatising ways that are welcoming and recognise cultural difference. • Service users have ready access to an independent advocacy service. • The staff profile in the service matches the diversity of the population it serves. • Service users have ready access to a specifically trained interpreting service; they do not rely on family members. • Service users who are parents who have been identified as being in need or at risk are supported appropriately in their parenting role – including support through children's care planning systems.

5.6 A fair and transparent **charging policy** has been agreed with stakeholders and approved by the Council, and income is collected efficiently.
• A policy, which sets out charges is readily available to users, potential and actual, to carers and to providers and referrers. • Financial assessments are completed quickly and explained to service users and carers. • Collection systems are easy for service users to understand and use.

5.7 Complaints are handled promptly and courteously. The complaints/comments procedure is well-publicised and user-friendly and effective in improving services.
• Information on how to complain/comment is readily given both at the commencement of service and, continuously, throughout. • The procedure is publicised in a range of formats and is accessible to all service users. • Staff understand the value of complaints and facilitate their use.

STANDARD 6: Capacity for Improvement

The council has corporate arrangements and capacity to achieve consistent, sustainable and effective improvement in social services.

Criteria and Evidence

6.1 The council's leaders have a **clear vision and strategic direction** for social services, communicate this effectively, and organise the necessary resources required to deliver it.

• National and local priorities for social services are clearly expressed within the strategic priorities for the whole council.
• The council's vision for social services relates to identified local community needs.
• The vision and the strategy are understood by:
  - staff and managers throughout the service;
  - service users and carers;
  - partner agencies; and
  - the general public.
• The service has a recent track record of delivering its vision.

6.2 The council's improvement strategy for social services has resulted in **sustained recent progress** in mental health services. It is supported by relevant policies, plans, objectives, targets and risk assessments.

• The strategy is translated into practical plans, with timescales, responsibilities, targets and objectives.
• These plans:
  - demonstrate how improvements will be achieved;
  - cover at least a three year period;
  - are realistic; and
  - are monitored effectively.
• The council has determined its specific responsibilities and those of its partners in delivering improvements. The plans include partners' contributions and are clearly linked with those partners' plans.
• Plans are informed and supported by best practice and the work of the local Regional Development Centre.
• The resources required to deliver the plans are identified and committed.
• All stakeholders are committed and actively involved.
• Potential risks and contingencies have been identified, and risk strategies are:
  - based on thorough risk analysis;
  - comprehensive; and
  - robust.
• Social services has a track record of successfully implementing its plans.

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6.3 Performance management, quality assurance and scrutiny arrangements are in place and effective: performance improvement can be demonstrably linked to management action.
Performance management, quality assurance, and scrutiny systems are in operation, and they are effective. Management action has resulted in service quality improvements. Performance data are used systematically and regularly (at least quarterly) to monitor performance issues. Plans and targets are adjusted in response to performance information. Service user and carer views are included in performance and quality management processes Improvement plans agreed with auditors and inspectorates are implemented and improvements achieved. Staff understand the relationship between their performance and the council's performance. They are motivated to contribute towards improvement. The council is a learning organisation. It develops the knowledge and skills of its staff and encourages teamwork, flexibility, innovation and initiative. Staff morale is good. Political arrangements support full scrutiny of mental health services functions. Councillors have particular roles and responsibilities in improving social services. Councillors with knowledge and interest in social services are actively involved in decision-making forums.

6.4 The council's **organisational structure** and management arrangements promote improvements for social services and the wider modernisation agenda.

• The structure of the organisation:
  • is clear and unambiguous;
  • supports delivery of its vision and strategies;
  • supports effective operations, including service delivery and cross- cutting issues; and
  • relates to management responsibilities and decision-making.
• The responsibilities and accountability of all managers are clear in the structure.
• Decision-making routes are clear and consistent and all councillors and staff understand and use them.
• Social services functions which require corporate working are supported by effective working arrangements and clear accountabilities.
• Political structures effectively support social services in achieving its targets for improvement and modernisation.

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6.5 The social care **workforce is well trained** and reflects local diversity. Local partnerships across all sectors have produced a human resources strategy that effectively trains, recruits and retains staff.

• The social care workforce reflects local diversity, including in commissioned services.
• Arrangements for training are undertaken through local partnerships.
• Staff are sufficiently trained and supported by policies to identify the needs of children (including their need for protection) and manage them effectively.
• Human resources strategies support good recruitment and retention procedures, and effective staff care.
• The workforce is sufficient to deliver the social care agenda.
• There are sufficient numbers of Approved Social Workers who are supported by appropriate:
  • supervisory arrangements;
  • continuous professional development; and
  • approval and re-approval processes.
• There is clear definition of roles and deployment of staff.
• The objectives of individual members of staff relate to service objectives.

6.6 The council works effectively with external and corporate **partners** to improve the range, quality and co-ordination of services.
• Working relationships are good with other social services and council departments, e.g. housing, leisure, education, etc. • The needs of children and service users with multiple needs are met. • Local forums bring stakeholders together. • Partnerships operate in an inclusive and accessible manner. • Partnerships contribute to a collaborative approach and seamless services. • There is widespread and relevant consultation about service need and about service design, both with partners and amongst the community. • The council has taken opportunities to make partnerships via Health Act Flexibilities and Children's Trusts. • The council actively participates in partnerships which support social inclusion, e.g. community safety. • Local partnerships have a track record of effective joint working to improve local social care services.

Inspection Background and Methodology

B

National Policy

B.1 The Mental Health Act of 1983 and the National Health Service and Community Care Act of 1990 had been the main focus of councils in the discharge of their statutory duties in respect of adults who experienced difficulties with their mental health.

B.2 The White Paper *Modernising Social Services* published in 1998 set out the present Government's expectations of social services and the Health Act (1999) placed a duty of collaboration on health and social services.

B.3 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 and 2003);
- Mental Health National Service Framework (1999); and
- The Policy Implementation Handbook (2001 and onwards).

B.4 This policy framework places the responsibility on social services (either as lead or as partner) to provide or commission services, which are:

- safe – to protect the public and provide effective care;
- sound – to ensure that service users have access to the full range of services they need; and
- supportive – working with service users, their families and carers to build healthier communities.

Inspection Background

B.5 The purpose of this inspection 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.6 This inspection builds on a programme of inspection work in recent years carried out by the former Social Service Inspectorate (SSI). There was a

national overview report of inspections *Still Building Bridges* published in 1999 and a further overview *Modernising Mental Health Services* in 2002. In 2004, SSI published *Treated as People*, an overview derived from both inspection and performance evidence.

B.7 The current inspection programme builds on the national objectives for social services including the performance management framework, the National Service Framework for Mental Health, and the Best Value and continuous improvement objectives for local councils.

B.8 An inspection design team created the inspection methodology. The standards and criteria were developed and refined following consultation through reference groups, which included service users and a wide range of other stakeholders.

Inspection Method

B.9 Before the inspection fieldwork, we asked Haringey Council to write their own evaluation based upon our standards and criteria. We also asked for relevant documents to explain and support this evaluation.

B.10 We conducted three pre-fieldwork questionnaire surveys to gain further information. We sent a questionnaire to mental health fieldworkers in Haringey, a second questionnaire to up to 100 service users and carers from lists of active cases prepared for us by Haringey.

B.11 From the list of cases prepared for us, we selected 10 for a detailed analysis of case records. For these cases we asked fieldworkers to complete a case profile and we interviewed service users and their carers.

B.12 During the inspection fieldwork we met a wide range of staff working in mental health services in Haringey, and also service users in groups, individually and at some of the services visited.

Inspection Activity

C

C.1 During the course of the inspection we held meetings and interviews with:

- Individual service users;
- Groups of service users and carers;
- Councillors;
- the Director of Social Services;
- the Director of the Mental Health Trust;
- the Director of Haringey Teaching Primary Care Trust;
- the Interim Assistant Director for Adults, social services;
- senior Primary Care Trust and NHS trust managers;
- senior managers in social services;
- the Joint Mental Health Commissioning Manager;
- contracts and Best Value officers;
- lead officers for planning, strategy and performance;
- managers of interface services;
- community mental health team managers and deputies;
- the Director of Nursing;
- finance managers;
- provider services managers;
- fieldworkers;
- approved social workers;
- community psychiatric nurses;

- psychiatrists;
- independent sector agencies;
- advocacy groups;
- equalities leads for health and social care;
- Police liaison officer;
- lead officers for Direct Payments;
- lead officers for adult protection;
- lead officer for carers;
- lead officers for personnel and training and development; and
- housing managers and representatives.

Results of Survey of Service Users

D

D.1 We asked 100 people who had received or were receiving services, a range of questions about their experience of services in Haringey. We received 41 replies. The numbers shown are actual returns.

Making contact	Always	Usually	Sometimes	Never	Not Stated
Are the staff easy to contact?	19	9	9	3	1
Are the staff easy to talk to?	19	13	5	2	2

Involvement	Always	Usually	Sometimes	Never	Not Stated
Are you asked what you think about the service(s) you receive?	11	8	11	11	0
Are you invited to meetings about your care?	20	10	6	4	1

Involvement (Continued)	Yes	No	Not Applicable	Don't Know	Not Stated
Do social services staff take note of any important matters relating to your race, culture or religion?	16	9	9	6	1

Informing You	Always	Usually	Sometimes	Never	Not Stated
Are you given written information about the service(s) you receive?	11	9	10	9	2

Informing You (continued) Does this information cover:	Yes	No	Don't Know	Not Stated
The Care Programme Approach?	25	5	7	4
Confidentiality?	20	8	9	4
How to get hold of services?	27	5	5	4
The nature of mental illness?	17	12	9	3
Professional terms and jargon?	12	16	9	4
Local strategies and plans for mental health services?	10	19	9	3

Informing You (continued)	Always	Usually	Sometimes	Never	Not Stated
Are you informed about what is happening at each stage?	13	10	9	6	3

Informing You (continued)	Yes	No	Not Stated
Do you know how to make a complaint?	24	16	1
Do you know that you can see your records if you wish?	32	8	1
Do you know that, if you wanted, you could have a friend/advisor/advocate to support you?	28	11	2

Informing You (continued)	Yes	No	Not Applicable	Not Stated
Do you know that, if you wanted, you could have an interpreter/translator?	20	6	14	1
Do you know how social services work out the charges for the service(s) you receive?	4	31	5	1
Do you think the charges are fair for the service(s) you get?	8	16	13	4

Quality of Service	Yes	No	Don't Know	Not Stated
Did you get the help quickly after a decision was made for services to be provided?	22	13	6	0

Quality of Service (continued)	Always	Usually	Sometimes	Never	Not Stated
Were you involved in deciding the service(s) you receive?	7	12	9	11	2
Are changes made to fit in with your needs?	10	11	9	9	2
Are you satisfied with the quality of the service(s) you receive?	15	11	8	7	0
Have you had the service(s) that you agreed with your care manager?	16	9	9	5	2
Have the services helped you?	18	10	6	5	2

Source: CSCI Survey of Service Users

Results of Survey of Carers

E

E.1 We asked 50 carers of people who had received or were receiving services, a range of questions about their experience of services in Haringey. We received 20 replies. The numbers shown are the actual returns.

Making contact	Always	Usually	Sometimes	Never	Not Stated
Are the staff easy to contact?	5	6	7	1	1
Are the staff easy to talk to?	6	8	4	1	1

Involvement	Always	Usually	Sometimes	Never	Not Stated
Are you asked what you think about the service(s) the person you support receives?	1	5	4	8	2
Are you invited to meetings about the care of the person you support?	4	5	5	5	1

Involvement (continued)	Yes	No	Not applicable	Don't Know	Not Stated
Do social services staff take note of any important matters relating to the race, culture or religion of the person you support?	6	5	4	4	1

Informing You	Always	Usually	Sometimes	Never	Not Stated
Are you given written information about the service(s) that the person you support receives?	3	4	5	8	0

Informing You (continued) Does this information cover:	Yes	No	Don't Know	Not Stated
The Care Programme Approach?	10	2	2	6
Confidentiality?	8	4	3	5
How to get hold of services?	6	6	2	6
The nature of mental illness?	7	7	1	5
Professional terms and jargon?	3	6	5	6
Local strategies and plans for mental health services?	4	8	4	4

Informing You (continued)	Always	Usually	Sometimes	Never	Not Stated
Are you told what is happening at each stage?	3	6	5	3	3

Informing You (continued)	Yes	No	Not Stated
Do you know how to make a complaint?	8	12	0
Do you know that you can see your records if you wish?	10	10	0
Do you know that, if you or the person you support wants, they can have a friend/advisor/advocate to support them?	13	7	0
Do you know about your right to an assessment of your own needs as a carer?	10	9	1

Informing you (Continued)	Yes	No	Don't Know	Not Stated
Have social services carried out an assessment of your needs as a carer in the past 12 months?	7	12	1	0

Informing you (Continued)	Yes	No	Don't Know	Not Stated
Do you know that, if you or the person you support wants, they can have an interpreter/translator?	8	5	5	2
Do you know how social services work out the charges for the services that the person you support receives?	1	15	3	1
Do you think that the charges are fair for the services that the person you support receives?	0	8	9	3

Quality of Service	Yes	No	Not Stated
Did the person you support get help quickly after a decision was made to provide the service(s)?	12	6	2

Quality of Service (continued)	Always	Usually	Sometimes	Never	Not Stated
Were you involved in determining the service(s) that the person you support receives?	6	2	4	8	0
Are changes made to fit in with the needs of the person you support?	3	5	5	6	1
Are you satisfied with the quality of the service(s) that the person you support receives?	5	2	12	1	0
Has the person you support had the service(s) that you agreed with their care manager?	4	5	4	4	3
Have the service(s) helped the person you support?	7	6	5	2	0
Have you as a carer received services to support you in your role?	5	3	4	7	1

Source: CSCI Survey of Carers

Results of Survey of Fieldworkers

F

F.1 Questionnaires were sent to all the mental health fieldworkers, asking a range of questions about their experiences of working with people in Haringey. All the questions referred to working with adults with mental ill health. We received 15 responses. The numbers shown are actual returns.

Background	Yes	No	Not Stated
Do you have a professional social work qualification?	12	2	1
Are you currently an Approved Social Worker?	5	9	1

Training Received	In past year	1-3 years	3+ years	None	Not Stated
Basic Approved Social Worker	4	0	6	2	3
Approved Social Worker Refresher	6	2	1	2	4
Care Programme Approach	5	5	3	0	2
Child protection	2	7	3	1	2
Children in need	0	1	3	5	6
Human Rights Act	5	5	0	4	1
Work with mentally disordered offenders	4	0	3	3	5
Mental health risk assessment	3	6	3	2	1
Mental health risk management	2	7	3	2	1
Equal opportunities in mental health services	0	4	6	1	4
Anti-discriminatory practice in mental health services	0	5	6	1	3
Disability Discrimination Act	0	3	2	6	4
Race Relations (Amendment) Act	0	2	0	8	5

F

Your overall opinion of the following:	Very good	Good	Average	Poor	Very poor	Not Stated
Arrangements with specialist health services for work with people with mental health problems.	1	7	6	0	0	1
Arrangements with housing for work with people with mental health problems.	0	4	3	8	0	0
Arrangements for assessment and care planning.	0	7	6	1	0	1
Arrangements with primary care for people with mental health problems	0	3	7	5	0	0
Arrangements with the Police for people with mental health problems.	0	5	7	1	1	1
Emergency out-of-hours arrangements.	1	4	8	2	0	0
Mental health services available generally in locality.	0	4	9	2	0	0
Available public information on mental health services in accessible formats.	0	4	6	3	0	2

Are the following policies and procedures adequate?	Yes	No	None available	Not stated
Care Programme Approach	13	1	0	1
Risk assessment (mental health)	13	1	0	1
Risk management (mental health)	11	1	1	2
Vulnerable adults	10	2	0	3
Arrangements with children's services	8	4	1	2
Violence to staff	12	0	0	3
Section 117 aftercare	10	3	0	2
Arrangements with medium secure units	5	4	1	5
Dual diagnosis – substance misuse	9	2	0	4
Dual diagnosis – learning disability	2	5	2	6
Child and adolescent mental health	9	3	0	3
Confidentiality	12	0	0	3

Source: CSCI Survey of Fieldworkers