INSPECTION OF MENTAL HEALTH SERVICES

LONDON BOROUGH OF BARKING AND DAGENHAM

February 2006

COMMISSION FOR SOCIAL CARE INSPECTION

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London Borough of Barking and Dagenham

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We would like to thank all staff, service users and carers who took part in the inspection.

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Summary

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Introduction

1.1 The fieldwork for this inspection of social care mental health services took place between 28th February and 2nd March. The inspection was carried out by four inspectors, Laura Middleton, Alison deMetz, Lynn Hampton, Edi O'Farrell and an expert by experience, Wendy Kennerley.

1.2 The objectives of the inspection were to evaluate how far Barking and Dagenham 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 Barking and Dagenham 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 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 understandings of good practice. These are reproduced at Appendix A to this report.

1.5 During the course of this inspection we:

- carried out a number of interviews with service staff, managers, users and their carers;
- conducted a survey by questionnaire of service staff and 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.

Overall Conclusion

1.8 Mental health services in Barking and Dagenham had developed incrementally as the National Service Framework had been implemented, but faced significant challenges. The fieldwork for this inspection took place at a time of imminent structural change for the Council and within a period of development for mental health services.

1.9 The mental health service was presented to inspectors as integrated and working well together, but also recognised further work was required to formalise joint decision-making, effective user involvement, co-ordination and shared understanding.

1.10 User satisfaction with existing services was high, although they reported difficulties in access, especially out of hours, and delays when more than one team was involved.

1.11 Most services for carers were of a high standard, appreciated by carers and there were plans for further development. There was a good young carers project.

1.12 While there was a wide range of services, and a clear drive to maintain people at home where possible, services were not always well co-ordinated and there were some gaps.

1.13 People from black and minority ethnic communities were not well served, and staff lacked the skills, knowledge and confidence necessary.

1.14 Case recording was poor, and although recognised as an issue had not been addressed.

1.15 The Council and its partners have to make improvements both by developing new services, and by taking remedial action in areas where they are not performing well

1.16 Some factors hinder the Council's ability to make further improvements:

- anticipated rapid demographic change which will create uncertainty about future demand for services;

- the compulsory top-slicing of all Primary Care Trust allocations resulting in planned increases in expenditure on mental health services by Barking and Dagenham Primary Care Trust (the Primary Care Trust) being deferred, which will slow developmental work;

- lack of clarity about who is responsible for professional standards; and
- lack of user involvement.

1.17 There were other factors, which we judged made the Council's prospects more encouraging:

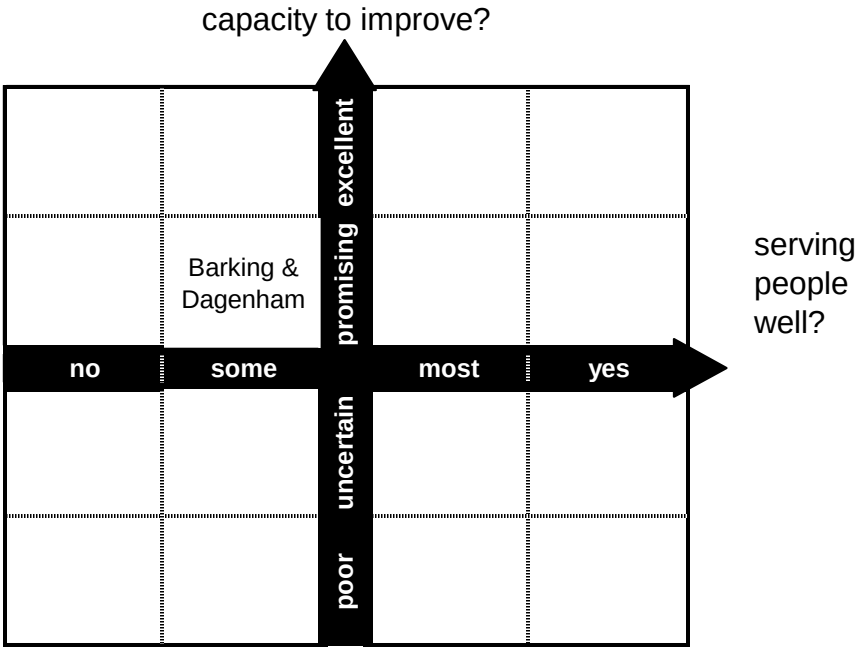
- commitment of the Council as a whole to social inclusion;
- good co-operative working within the Council;
- successful regeneration bids;
- the appointment of the new Borough Director for mental health services;
- good multi agency co-operation between Barking and Dagenham Council, the Primary Care Trust and the North East London Mental Health Trust (NELMHT); and
- well thought out restructuring within the Council.

1.18 There was drive and commitment at senior level in the Council and the key partner organisations of NELMHT and the Primary Care Trust. At grass roots level, service users and carers valued those working directly with them, and satisfaction among existing users and carers was high. However the dynamism at senior level will only deliver the improvements needed if there is a wider acceptance that change is both necessary and must be co-ordinated, and if both new developments and remedial actions can be adequately financed.

1.19 We judged that some people in Barking and Dagenham were being served well and that their capacity for improvement was promising. These two judgments are illustrated in the following matrix.

1

The Assessment Matrix



National Priorities and Strategic Objectives

1.20 The framework for community mental health services had developed on the lines of national policy and the National Service Framework. There was an up to date strategy for mental health commissioning, which linked to the Local Implementation Team Plan, the latter being the mechanism for setting out annual plans for meeting local and national targets.

1.21 Some key documents were still in the process of being developed, namely an overarching Adult Social Care Commissioning Strategy (expected May) and a Local Area Agreement (expected June).

1.22 Service user groups consulted as part of the inspection reported poor responses to consultation, and a tendency for the Council to be defensive when its views were challenged although the Council has re-commissioned the advocacy service provided by HUBB and provided additional funding. Organisations representing the black and minority ethnic communities reported the Council had not been good at heeding their recommendations, nor fed back to them.

1.23 Service users were not on the Local Implementation Team, although this was planned for July and work had started on establishing a user committee.

1

Cost and Efficiency

1.24 Commissioning and budget setting were based on historical patterns and incremental change.

1.25 Proposals set out in the Local Implementation Team were costed, but budgets had yet to be committed by each organisation. The Primary Care Trust had indicated it was unable to fund new developments in mental health services, given these were not a national priority for the NHS next year.

1.26 Services were delivered within tightly managed budgets, but there was no overspend and councillors were committed to maintaining support.

1.27 The PCT appeared to be spending about £500,000 on out of Borough placements, which had not been properly evaluated. This will be addressed as part of the Council's Adult Commissioning Strategy.

Effectiveness of Service Delivery and Outcomes for Service Users

1.28 In line with national requirements under the Policy Implementation Guidance, there were two Community Mental Health teams (CMHTs), a crisis resolution team and assertive outreach, although the latter had different names in Barking and Dagenham (Home Treatment Team and Intensive Case Management respectively).

1.29 Service users and carers were largely satisfied with services received, although there were issues around access and information, particularly for non-English speakers.

1.30 There were shortfalls in provision for some groups of people, while others were provided for out of Borough.

Quality of Services for Users and Carers

1.31 All three organisations demonstrated commitment at senior level to delivering good mental health services, but there was a lack of clear lines of accountability to achieve operational improvements, even where the needs were recognised.

1.32 Adult protection was an area for concern, as whilst protocols and procedures were in place team managers were not sufficiently aware of them.

1

Fair Access

1.33 The website was easy to use and informative, but links to mental health services beyond the Council were not consistently listed. The website could be a valuable information resource but service users seen by inspectors were not aware of its existence.

1.34 Eligibility criteria were not consistently understood or applied between teams.

1.35 The Council and partners had recognized difficulties with referrals to mental health services, large numbers of which come through primary care. These were being addressed through a new team, the Assessment and Brief Intervention Team (A&BIT) staffed from existing resources. This was in the process of being evaluated, with the Primary Care Trust still to agree the clinical referral pathways for the team.

1.36 Out of hours services reported difficulties accessing resources and poor co-ordination with other services as a result of which some users were left without appropriate, timely help.

Capacity for Improvement

1.37 The self-assessment as presented to inspectors tended to minimise the operational difficulties in the service and was short of critical analysis. The situation reported by people during the inspection, and the evidence gathered during the case tracking exercise, indicated shortcomings in practice on the ground. Senior staff were open to suggestions and keen to make changes and responded to concerns highlighted by the inspectors.

1.38 Those providing services could be better supported in terms of a wider resource base, better information, consistent professional support to maintain standards and training in key areas, such as adult protection.

1.39 Previous inspections have highlighted similar issues to this inspection: for example weaknesses in involving service users and in services for black and minority ethnic communities. The Council had taken steps to address these issues, but the evidence suggested there was still much work to be done in mental health services.

1.40 The Primary Care Trust is required to remain in financial balance and respond to wider financial issues in the NHS. At the time of the inspection it was unable to commit additional investment in 2006-07 to mental health, which would delay the delivery of the Local Implementation Team plan.

1.41 NELMHT had been a failing Trust until two years ago, and was in the continuing process of regenerating itself under a new management and Board.

1.42 Both of these partnership issues impacted significantly on the Council's ability to drive improvement, in that, despite commitment in principle from both the Primary Care Trust and NELMHT, progress in developing mental health services was held back.

1.43 Some management issues should be eased by the new Borough Directorship, a recently created post with tripartite accountability to the Head of Adult Services in the local authority for social care functions, the Chief Operating Officer (NELMHT) for health service functions, and the Chief Executive of the Primary Care Trust.

What Happens Next

1.44 Barking and Dagenham will prepare an action plan to address this report's recommendations. This should connect with the council's own improvement planning, and issues which it is addressing from other external support and examination.

Reading the Remainder of This Report

1.45 This chapter has given an overall summary. Chapter two brings together the recommendations and chapters four to nine give more detail of the evidence used in our analysis and judgements. The focus of these chapters is on areas and issues where we have made recommendations and which are of particular significance.

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

1

Recommendations

2

National Priorities and Strategic Objectives

2.1 The Council and its partners should formalise its joint management, at all levels, in order to turn high-level vision more effectively into agreed actions. This exercise should include addressing the structures within the mental health teams in order to clarify management and professional accountability across the joint services.

2.2 The Council and its partners should improve their involvement with service users in order that they become more meaningful, paying particular attention to ensuring the contributions from black and minority ethnic communities are included.

2.3 The Council should ensure that the corporate developments to improve partnership working with community groups and voluntary agencies include those working with the mental health services.

Cost and Efficiency

2.4 The Council and its partners should produce a realistic Local Implementation Team Plan, which is prioritised in relation to available budgets.

2.5 The Council should audit the effectiveness of the accommodation panel in order to ascertain whether it is achieving its objectives. This review should be underpinned by improvements to recording standards so that a realistic analysis of referral, assessment and provision data can be made.

2.6 The Council should produce a detailed report on those users who are accommodated outside the Borough, based on whether or not they and their carers needs could be met as effectively by local services.

Effectiveness of Service Delivery and Outcomes for Service Users

2.7 The Council and its partners should urgently and jointly address adult protection services in order to ensure people using services are adequately protected. This includes:

- mandatory up to date training on adult protection for all staff who work directly with service users;
- training on evidence based investigation for social workers and others conducting investigations; and
- joint agreements on how records are kept, including collating information from different sources.

2.8 The Council should undertake a review of the function day centres to ensure they are actively promoting independence and are resourced to do so.

2.9 The Council should explore service improvements for carers. This should include:

- the feasibility of establishing a night phone-in line to provide emotional support, possibly staffed by volunteers; and
- how best to meet the needs of people with mental health problems who also have caring responsibilities.

2.10 The Council and its partners should institute training and development to improve understanding of the dual needs of parents and children. This should include training for both mental health and childcare workers, in assessing and balancing risks for both children and parents with mental health problems.

Quality of Services for Users and Carers

2.11 The Council and its partners should work together to address the known operational deficiencies:

- in Care Programme Approach;
- ASW Practice;
- standards of recording; and
- care plan reviews, including those for people in residential care.

2.12 The Council and its partners should develop a charter of service standards specific to mental health services for use by service users and carers; ideally this should be developed in partnership with service users and carers.

2.13 The Council and its partners should look at their information for service users, to improve the explanations of conditions or illnesses.

2

Fair Access

2.14 The Council and its partners should work together to improve fair access to services.

- agree and disseminate common eligibility criteria and ensure team managers and care coordinators understand them;
- give much higher priority to improving the range and quality of its services for black and minority ethnic groups; and
- address the concerns of users and front line staff about access out of hours.

2.15 The mental health service should establish a single complaints process for users, so that the onus is on the organisations to establish accountability, rather than the complainant. The Council and its partners should jointly collate information from complaints and act on it to improve mental health services.

Capacity for Improvement

2.16 The Council and its partners should develop a project to improve technical resources for staff, and provide training to make use of them.

2.17 The Council and its partners should improve their joint quality assurance systems in order to:

- recognise and acknowledge where problems are raised by providers, partners or staff;
- evaluate new or re-structured services against criteria agreed in advance; and
- involve users and carers in service evaluation.

2

Council Profile

3

Demography

3.1 Barking and Dagenham is an outer London Borough with a population of 164,346 at the 2001 census, estimated to be about 173,000 at the time of the inspection. At the last census 15 per cent of the population classified themselves as non-white, which is lower than for London as a whole. However, refugee populations, who are likely to have a high need for mental health services, are relatively high. The London Asylum Consortium reported in the week ending 5th March 2004, that there were 2,050 asylum seekers in Barking and Dagenham, the largest number among all four outer NE London boroughs. Estimates for the numbers of black and minority ethnic people now living in the Borough varied between 20 and 25 per cent (according to the Local Implementation Team black and minority ethnic Mental Health Forum).

3.2 It is the sixth most deprived borough in London (Index of Multiple deprivation 2004). Forty per cent of the population have no qualifications, which is the highest in London. Health is also poor compared with the general picture in London, and mental health needs are above the national average (Primary Care Trust local services assessment). The expansion of Thames Gateway is expected to result in the population of Barking and Dagenham increasing by an estimated 60 per cent over the next 10 years. There was acknowledgment from a range of sources that racism is an issue in the Borough which is being addressed through the Council's Community Cohesion Strategy and the social regeneration of the Borough.

Political context

3.3 Barking and Dagenham is organised on a cabinet model and with a permanent scrutiny board and an elected mayor. It is divided into 17 wards, each electing three councillors. The Council had been Labour controlled since its inception in 1965. The Assembly, the Council's senior body, comprises 51 Members, 43 of whom are Labour, three Conservative, two Chadwell Heath Residents Association, one Liberal Democrat and two vacancies.

3

Funding

3.4 The Council spends £3.64 million, or four per cent of its annual budget on mental health services. There is no Section 31 agreement in place in mental health, although a number of posts were joint funded with the Primary Care Trust and NELMHT. It was the intention of the Council to enter into a Section 31 agreement with the NELMHT in 2006-07, a move agreed in principle by the Chief Officer Group. The Executive endorsed the Council's Strategy for Resource Allocation in Social Services in 2004. This three-year plan allocated additional resources to Social Services, of which mental health services received an extra £750,000. The Council has needed to monitor its budget closely but has delivered services within it.

Management and Organisation

3.5 At the time of the inspection the Council was about to restructure along children and adult services lines. An interim director was in place, whose contract was to be extended to cover adult and community services, pending the appointment of a permanent director in the Autumn of 2006. This overlap was designed to ensure a smooth handover to the new team.

3.6 Barking and Dagenham is covered by one coterminous Primary Care Trust and for the delivery of mental health services is covered by North East London Mental Health Trust (NELMHT).

3.7 Mental Health services were delivered in partnership with the Primary Care Trust and NELMHT. There were a number of joint posts, but no formal governance agreements or pooled budgets.

3.8 It was the intention of the Council and NELMHT to codify these arrangements through developing a partnership agreement in 2006, with the new Borough Director joining the Adult and Community Services Departmental Management Team. After several months with an interim Borough Director, this newly created post was filled on a permanent basis just prior to the inspection.

3.9 Community mental health services are delivered through a range of teams mainly based at the Hedgecock Centre. The two Community Mental Health Teams (CMHTs), the Intensive Case Management, and Home Treatment teams, the Supported Accommodation Team the Assessment and Brief Intervention Team (A&BIT), and outpatient appointments are all located at the Hedgecock Centre.

3.10 Psychology and psychotherapy services are provided at the Becontree Psychotherapy Centre, and day opportunities provided from Porters Avenue Resource Centre.

3.11 A range of alternative day care, education, employment and support services are provided by voluntary sector partner agencies across the Borough.

Performance assessment

3.12 The Commission for Social Care Inspection (CSCI) assesses the performance of social services and produces an annual star rating of performance. At the time of the inspection Barking and Dagenham was rated as a one star council. The Council has a Comprehensive Performance Assessment rating of fair from the Audit Commission. However there was evidence of improvement in overall performance in adult services and the recent adult performance assessment (2005) was most and promising.

3

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 properly in those arrangements; and
- were delivering and managing services in an integrated way.

4

National Priorities and Strategic Objectives

STRENGTHS	AREAS FOR DEVELOPMENT
• There was good multi-agency co-operation in mental health, between Barking and Dagenham Council, and Primary Care Trust and the North East London Mental Health Trust (NELMHT) and some senior posts were jointly financed. • The Council and its partners have established a strategic direction in relation to the National Service Framework. This was translated into action plans through the Local Implementation Team and there have been a range of developments consistent with the broad direction. • Explicit links have been established between national and local objectives, corporate and mental health objectives and between the Council and Primary Care Trust. • The Council had an over arching regeneration agenda which should benefit most citizens, including those with mental health problems, by improving the environment. • Planning and working relationships within the Council are collaborative.	• While Chief officers met regularly to agree on the general direction, many implementation decisions remained unilateral. • Many of the developments in the self-assessment were still aspirational and lacked clear implementation plans. • There were inadequate arrangements for informing and consulting with service users in recent and forthcoming developments. • Voluntary organisations and providers of community based educational, vocation training and employment schemes described varying levels of involvement and information sharing, and felt that partnership working needed to be strengthened. • The Council had adopted the social model of disability but not all staff and partners understood what the concept meant in practice. • It was difficult to ascertain how joint decision making occurred as no formal mechanisms were in place.

RECOMMENDATIONS

- **The Council and its partners should formalise its joint management, at all levels, in order to turn high-level vision more effectively into agreed actions. This exercise should include addressing the structures within the mental health teams in order to clarify management and professional accountability across the joint services.**
- **The Council and its partners should improve their involvement with service users in order that they become more meaningful, paying particular attention to ensuring the contributions from black and minority ethnic communities are included.**
- **The Council should ensure that the corporate developments to improve partnership working with community groups and voluntary agencies include those working with the mental health services.**

4

Strategic Planning and Policy Implementation

4.1 The Council and its partners had a range of strategic plans, which related to national objectives, but their successful implementation was reliant on continuing financial support from all the agencies.

4.2 The framework for community mental health services had developed on the lines of national policy and the National Service Framework. There was an up to date strategy for mental health commissioning, which linked to the Local Implementation Team Plan, the latter being the mechanism for setting out annual plans for meeting local and national targets.

4.3 Some related plans were still being developed at the time of the inspection, namely an overarching Adult Social Care Commissioning Strategy (expected May 2006) and a Local Area Agreement (to be approved in June).

4.4 Within the Council collaborative working was strong, under the leadership of a relatively new chief executive (12 months). There was a strong regeneration agenda, bearing fruit in bringing external finance into the area.

Continuous Improvement

4.5 The Council and its partners have made improvements in the last few years, but started from a low base in mental health services and still have a long way to go. Although the Council acknowledged it faced significant challenges, not all the operational problems identified in the inspection or by the mental health service itself were being actively addressed. Changes made as a result of inspections in other areas of service had yet to translate consistently into the joint mental health service.

Involving Service Users and Carers in Planning

4.6 The Council believed it was improving in involving service users and carers, but further work is required before this is embedded in practice.

4.7 During the inspection, the Council demonstrated a lack of basic awareness in how to involve users: for example by inviting people (by letter) to attend meetings but without offering refreshment or transport costs.

4.8 A local voluntary organisation, HUBB User Advocacy Group, had been commissioned by the Council to consult with users, including those from minority communities, but did not think they were given sufficient time to do so, given the nature of the user group.

4.9 Groups representing users, and users themselves, told inspectors that the Council consulted, but did not always feed back nor heed their recommendations. The Council were described as being "defensive and dismissive" if user consultation failed to support their own strategy, and practical suggestions became lost in official speak.

4.10 The Local Implementation Team, whilst having a plan for user involvement/representation, did not yet have user representation or a sub group, and inspectors were concerned that some managers thought such a group would be "tokenistic". This demonstrated a lack of awareness of how the expertise of service users can assist in the planning and monitoring of mental health services. However the Council's position is that they accept the benefits of user involvement in the planning and delivery of services.

4.11 A voluntary organisation, TULIP had been commissioned to develop a user committee for the Local Implementation Team, including members from minority communities, which would support user representation on the Local Implementation Team.

Joint Working

4.12 There were good relationships at some levels between the key organisations delivering mental health services, but these had yet to be formalised. This meant services were not well co-ordinated and responsibilities unclear. The new structures should help address this.

4.13 After a period of serious financial and management problems, the new management at NELMHT had recognised the need to strengthen locality management in each of the four boroughs it provided service for, and had created four new Board level Borough Director posts to address this. The post in Barking and Dagenham was the last of the four to be filled, in February 2006, meaning the new post holder had yet to make a significant impact. His brief was to address operational issues, many of which are identified in this report. In so doing, he has strong backing from all three organisations to which he will report, but will have to achieve improvement within a framework of increasing financial constraints.

4.14 The Primary Care Trust had recently reported to the Local Implementation Team that mental health was not identified by the NHS as one of the top six priorities in 2006-07. This had implications for delivering the Local Implementation Team plan. One of the major elements of the planned growth was to develop a full Early Intervention Service, currently a service gap. NELMHT have reported to the Local Implementation Team their intention to deliver the service during the latter part of 2006-07 probably through a shared service with the neighbouring Borough of Havering. Good working relationships between NELMHT, the PCT and

the Council should enable the parties to offset the effect of these financial difficulties.

4.15 Joint quality management was underdeveloped. There was clearly motivation and intent from all three bodies to improve, but decision-making was not formalised. This meant implementation was not well planned nor were new developments properly evaluated, with criteria for success being agreed in advance.

4.16 A number of voluntary organisations and providers of community based educational, vocation training and employment schemes reported they were not well involved and information was not systematically shared with them. This was described to inspectors as partnership "being relational, not structural". The Council attributed this negativity to some organisations not being successful in getting grant monies, which may have some bearing, but the evidence suggested it was more complex and widespread than that. Organisations who were key partners such as HUBB User Advocacy Group and TULIP talked of recent "seismic change" as a result of pressure from central government which had meant that, while relationships had been satisfactory in the past, they could now take their place "at the top table" and engage more confidently with the Council. Groups representing the black and minority ethnic communities were typically smaller and newer and yet to establish strong infrastructures or develop the same quality of working relationship with the Council.

4

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 arrangements.

5

Cost and Efficiency

STRENGTHS	AREAS FOR DEVELOPMENT
• Although finances were tight, services were delivered within budget, and good use was made of external sources. • Councillors maintained oversight of the budget on a monthly basis, and were alert to forthcoming pressures. • PAF C31 (2005) indicated the number of adults with mental health problems helped to live at home declined slightly from 2.1 to 1.9 per 1,000 of the population aged 18-64, but it remained good. • There were clear council rules about procurement and contract setting which ensured access to stable and sustainable provision. • A number of posts were currently jointly funded.	• There were no pooled budgets; although the Council intended to enter into a Section 31 agreements with NELMHT. • The Local Implementation plan was costed, but monies were not committed by the various parties • The Council recognised that services which were provided outside the Borough were needlessly expensive as well as constituting poor practice for people having to travel. • Providers reported varying experiences of the contracting and monitoring process. A lack of consistency left the authority open to challenges of inequality. • Commissioning arrangements were not well connected to processes to identify and monitor unmet need. • The poor quality of case files meant information on which to base planning or commissioning decisions was unreliable.

RECOMMENDATIONS

- **The Council and its partners should produce a realistic Local Implementation Team Plan, which is prioritised in relation to available budgets.**
- **The Council should audit the effectiveness of the accommodation panel in order to ascertain whether it is achieving its objectives. This review should be underpinned by improvements to recording standards so that a realistic analysis of referral, assessment and provision data can be made.**
- **The Council should produce a detailed report on those users who are accommodated outside the Borough, based on whether or not they and their carers needs could be met as effectively by local services.**

5

Commissioning

5.1 The overall funding position in the NHS has meant that mental health is not seen as one of the six key priorities for 2006-07, and the lack of significant new investment this year has necessitated the Council and its partners exploring ways National Service Framework priorities could be delivered within the existing budget.

5.2 Joint commissioning was underdeveloped, meaning best use may not be made of joint resources. The Chief Officers of the Council, Primary Care Trust and NELMHT met regularly to agree on general direction, but implementation decisions were delegated to the various organisations, and it was not always clear where decisions were actually made.

5.3 The Local Implementation Team Plan was costed, but the relevant agencies had yet to commit expenditure, and it was doubtful if the plan could be implemented without revision. The Primary Care Trust, whose priorities were driven by the NHS nationally, were unable to commit monies to growth in mental health services in 2006-07. This had implications for delivering the existing plan, which had yet to be fully worked out at the time of the inspection.

5.4 Within the Council, a culture of commissioning, as opposed to rolling over previous arrangements, was just developing at the time of the inspection. It was not well linked to information from assessments, or based on intelligence about unmet need. The inadequate quality of recording meant that information from assessment and review would, in any case, be a poor basis for planning decisions. There was a mental health commissioning plan, but implementation details, through the Local Implementation Team, were unclear and joint finance was not agreed. It was planned to sit within a larger commissioning plan for adult services, which was still in the process of being developed at the time of the inspection.

Efficiency

5.5 In 2004, PAF B15 suggested unit costs for residential care were competitive, and within the top PAF banding. Information for this indicator is no longer collected. The high cost of out of Borough placements suggested the Council may not have been making most efficient use of resources, and it had yet to complete an evaluation of how well such placements were serving peoples needs.

5.6 PAF C31 (2005) indicated the number of adults with mental health problems helped to live at home declined slightly from 2.1 to 1.9 per 1,000 of the population aged 18-64, but it remained in the top band.

5.7 The mental health service has made use of an accommodation panel for five years to ensure fair and consistent access to services according to need, challenge poor practice and tease out alternatives. There has been no formal audit of the panel and the perception of its effectiveness was very different between its chair and reports by practitioners.

Joint Financial Arrangements

5.8 While there were no Section 31 agreements in place, a number of posts were jointly funded with NELMHT and the Primary Care Trust. It was the intention of the Council to enter into a Section 31 Agreement with NELMHT in the future, a move agreed in principle by the chief officers.

Budget Management Arrangements

5.9 The Council's major decisions on expenditure were driven by national priorities. Last year joint funding was made available by the PCTs and Council to employ a community development worker to improve services for black and minority ethnic groups.

5.10 The Council spent £3.64 million, or four per cent of its annual budget on mental health services in 2005-06. Councillors maintained oversight of the budget on a monthly basis, and were alert to forthcoming pressures. The Executive endorsed the Council's Strategy for Resource Allocation in Social Services in 2004. This three-year plan allocated additional resources to Social Services of which mental health services received an extra £750,000. The Council has needed to monitor its budget closely but has delivered services within it.

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 preferences and needs; and
- supporting carers (including young carers) in their caring role.

6

Effectiveness of Service Delivery and Outcomes for Service Users

STRENGTHS	AREAS FOR DEVELOPMENT
• Services contributed to social inclusion. • Service users felt supported by social workers, with effective and practical intervention. • The quality of local residential provision was good. • Services were being developed to include people with a diagnosis of personality disorder, who previously may not have had access to an appropriate service in the Borough. • Many services for carers were imaginative, responsive and appreciated by those using them. • Training on carers' assessments was related to actual assessments, providing an effective link between theory and practice. • There was a good Young Carers project which recognised that both children and parents have needs. • Those using the Home Treatment Team saw it as a positive resource. • The mental health crisis house received positive feedback from both users and staff. • The Council was a pilot for Individual Budgets and was within the project timeframes identified by CSIP to deliver the individual budgets by June 2006. • Service users at the William Bellamy Centre were satisfied.	• Service users felt that there could be more leisure and employment opportunities to promote independence, and better information about what was available. • Safeguarding and Adult Protection policies were not consistently understood by managers nor embedded in practice. • The range of services was inadequate and insufficiently broad and varied to meet service users' needs in relation to accommodation options. • There were problems in making appropriate arrangements for service users with high risk or challenging behaviour. • Take up of direct payments was low and it was not effectively and consistently promoted. • The Borough did not meet the needs of those mental health service users who needed forensic services. • Commissioning arrangements were not connected to processes to identify and monitor unmet need. • The range of services was inadequate and insufficiently varied to meet the needs of black and minority ethnic service users. • Inspectors saw no activities at the William Bellamy centre which were actively promoting independence. Resources were limited: there was only one computer for delivery of IT training for example. • Carers would appreciate a 24 hour listening service, to provide emotional support by phone especially during the night. • There was a shortfall in help for people with mental health problems who were also carers, or parents. The dual needs of parents and children were not well understood.

6

RECOMMENDATIONS

- **The Council and its partners should urgently and jointly address adult protection services in order to ensure people using services are adequately protected. This includes:**
  - **mandatory up to date training on adult protection for all staff who work directly with service users;**
  - **training on evidence based investigation for social workers and others conducting investigations; and**
  - **joint agreements on how records are kept, including collating information from different sources.**
- **The Council should undertake a review of the function day centres to ensure they are actively promoting independence and are resourced to do so.**
- **The Council should explore service improvements for carers. This should include:**
  - **the feasibility of establishing a night phone-in line to provide emotional support, possibly staffed by volunteers; and**
  - **how best to meet the needs of people with mental health problems who also have caring responsibilities.**
- **The Council and its partners should institute training and development to improve understanding of the dual needs of parents and children. This should include training for both mental health and childcare workers, in assessing and balancing risks for both children and parents with mental health problems.**

6

Promoting Independence and Social Inclusion

6.1 It was the Council's stated aim to deliver modern services and promote independence. Conceptually, this fitted under their regeneration agenda. There was a range of community based educational, vocational training and employment opportunities, although users thought more could be done to ensure such opportunities were advertised.

6.2 The Council had secured funding to support this work. Capital Volunteering was helping existing organisations to increase the number and range of supported volunteering opportunities for people with long-term mental health problems. The Borough had been allocated £450,000 over two and a half years with service delivery through four voluntary organisations starting in March 2006.

6.3 There were a range of services to support people living independently in the community. This included specialist benefit, housing and employment advice as well as social work support. Rethink offered a practical support team linked to employment and befriending. Service users reported being well supported by social workers and other front line staff.

Direct Payments

6.4 Take up of direct payments was low in mental health compared to a high take up across other client groups. The Council as a whole had 234 people in receipt of direct payments, five of whom were identified as users of mental health services, although four of these were people with physical disability who had their direct payments arranged via physical disability services. While senior staff were aware of the need to take action to improve take up of direct payments in mental health, the Council was also in the process of preparing for the introduction of a pilot Individual Budget scheme, which has specific targets for mental health. The Council was monitored by CSIP and expected to deliver the first individual budgets by June 2006. The Council anticipated that this scheme will be better geared to the needs of people with mental health problems than direct payments.

Range of Services

6.5 The Council and its partners offered a range of services, from residential, day care, support at home, and access to employment and leisure. Care management was offered through the A&BIT, CMHTs, Home Treatment, and Intensive Care Management Teams. These were not always working well together and there were some shortfalls.

6.6 Some services were only available out of the area, necessitating people traveling to services, and carers having to make journeys to visit those in residential services.

6.7 Senior managers and staff reported shortfalls in availability for people needing forensic services, and for people whose behaviour was challenging. There were problems accessing secure accommodation out of hours. Services were described as insufficient to meet the needs of the black and minority ethnic communities, a difficulty exacerbated by the high numbers of asylum seekers and a changing ethnic mix.

6.8 While in-house accommodation services were of good quality, they were all mixed gender group living, leaving little choice of provision type.

6.9 There was a good range of services for people who had accepted they needed to address their drug and alcohol problems.

6.10 There was a shortfall in help for people with mental health problems who were also carers, or parents. The dual needs of parents and children were not well understood.

Carers

6.11 Many services for carers were imaginative, responsive and appreciated by those using them. Those responding to the carers' questionnaire were largely positive about the help they received. The carers' workers were enthusiastic and good at listening and responding to carers.

6.12 Training on carers' assessments was related to actual assessments, providing an effective link between theory and practice.

6.13 There was a good Young Carers project, which recognised that both children and parents have needs. It offered joint services, such as theatre tickets, to enable families to enjoy things together.

6.14 While there was support in the daytime, carers would have appreciated a phone line at night and weekends, not to report emergencies but to offer emotional support and someone to talk to.

Vulnerable Adults

6.15 Safeguarding and Adult Protection policies were in place but not consistently understood by managers nor embedded in practice. It was unclear from files how those cases where there was potential risk of abuse were identified. Some files had sticky red dots attached, but managers were unable to give consistent explanations about their meaning. An inter agency agreement about how abuse should be recorded on files was not yet in place. Whilst interagency protocols are in place these were not understood in practice by managers.

6.16 It was difficult to get information about training on adult protection, as responsibility between team managers, the adult protection service and the

professional lead was unclear. Adult abuse awareness training was not mandatory for all relevant staff, including for social workers. The last training was over two years ago. Some staff reported a lack of confidence in the area of adult protection.

6.17 Front line managers, who were all employed by the mental health trust, were unclear about adult protection procedures, which were Council led.

Quality of Services for Users and Carers

7

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.

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 assured appropriately; and
- good quality information was available to service users and the general public.

7

Quality of Services for Users and Carers

STRENGTHS	AREAS FOR DEVELOPMENT
• The Home Treatment Team had a robust approach to the assessment and management of risks. Service users were effectively supported in care pathways. • Most service users found staff easy to talk to, and were included in their own care planning. • Information for young carers was good with leaflets, a website and chat room. • The website was easy to find and easy to navigate. It contained basic information on services available and terms used e.g. care plan, assessment. • Service users had been supported to set up a Women's Group at Porters Avenue. • Barking and Dagenham Disablement Association had UKBSL signers who were used by mental health service users. • Most service users responding to the questionnaire said they were given written information about services.	• Case records were not well organised, accurate, up-to-date, or reflective of practice. • Although the unacceptable standard of record keeping had been recognised by the Council the problem had not been addressed. • Continuity, quality and consistency were not assured when cases were worked between teams/professionals. • Team Managers were unaware of systems in place to record user requests for access to files, and information relating to this was difficult to secure. • Significant deficits in practice had been identified over a number of years, and previous intervention had failed to bring about improvement. • There appeared to be no formal liaison between Health leads who were charged with monitoring and auditing aspects of performance, and SSD leads who may be responsible for addressing the issues raised. • Half the respondents to the service user questionnaire said the written information about services did not cover the nature of their illness or explain jargon. • Care management was not being provided to people placed with Outlook Care. There was a discrepancy between the service offered to community based service users and those in residential care. • Inspectors saw no explicit standards written for service users.

7

RECOMMENDATIONS

- **The Council and its partners should work together to address the known operational deficiencies:**
  - **in Care Programme Approach;**
  - **ASW Practice ;**
  - **standards of recording; and**
  - **care plan reviews, including those for people in residential care.**
- **The Council and its partners should develop a charter of service standards specific to mental health services for use by service users and carers; ideally this should be developed in partnership with service users and carers.**
- **The Council and its partners should look at their information for service users, to improve the explanations of conditions or illnesses.**

7

Assessment and Care Planning

7.1 Significant deficits in practice had been identified over a number of years, and previous intervention had failed to bring about improvement. Assessments were not always systematic, holistic or needs based and did not work effectively across all parts of the service. Care plans were not being systematically reviewed.

7.2 Inspectors found no evidence on files of audit by management, nor were decisions made in supervision recorded. Case records were poor. Inspectors had only limited access, but the Council's own pre-inspection audit of 36 files in December 2005 revealed that:

- only two out of 36 had full assessments;
- some had no in-date care plans, others were of a "very poor standard", and not signed by care co-ordinators or clients;
- no evidence that clients or carers had copies of plans;
- carers were not identified;
- many care plans did not indicate assessment of needs; and
- some files lacked risk assessment.

These problems had not been rectified.

7.3 There could be up to four different files open at any one time: CMHT/ A&BIT/OP/HTT. Staff reported lack of consistency in filing protocols. This lack of integrated files and problems in recording undermined both the care planning process and the ability to collate useful information for commissioning.

7.4 Team managers were unaware of systems to record user access to files, and it was difficult to get information about this. Inspectors were told that eight users had seen their files in the last year, but no details of how and where were available.

7.5 Inspectors saw evidence in some files that care managers were seeking to promote independence.

7.6 Some users reported they did not agree with their plans, which was not recorded on the files.

7.7 Most users reported they were treated with respect and had good relationships with staff.

7

Review

7.8 Reviewing of care plans was not happening consistently, meaning service users may not be getting the best service nor an up to date care plan. Outlook Care reported that no reviews were being carried out, denying residents care management. Senior management were unaware of this until the inspection, but took immediate action at senior level to address this with the provider.

7.9 Given the poor condition of files, and the absence of care plans on many, the mental health service lacked a good foundation on which to base reviews.

Risk Assessment and Management

7.10 The Council's own audit of case files noted that risk assessments were not consistently recorded: many files had none at all, others were up to six years old. Users with known risks were highlighted by the case tracking exercise as inappropriately accommodated, for which the Council provided no satisfactory explanation.

7.11 Adult protection was an area for concern, which has been detailed in the previous chapter.

Quality Management

7.12 Quality management was not operating effectively to ensure good practice.

7.13 The Council's pre-inspection audit of 36 files in December 2005 revealed a very "worrying picture" which they noted needed to be "addressed immediately as there was an inspection coming up". (Barking and Dagenham Council internal audit) Despite this recognition of a serious problem, no remedial action had been taken by the time of the inspection. This highlighted the lack of accountability and confused roles within front line and middle management. There appeared to be no formal liaison between Health leads who were charged with monitoring and auditing aspects of performance, and SSD leads about who may be responsible for addressing the issues raised.

7.14 Inspectors saw no specific standards written for service users. These would be useful as a baseline in order for users and carers to understand what quality of service and behaviour from staff they have a right to expect.

7.15 The service sought to make improvements by consulting staff and users about the quality of existing services. Inspectors were shown the results of

a survey of staff and users undertaken last year about mental health services in the Borough, which identified some key themes.

7.16 Staff noted the need to improve communication between teams, with greater clarity needed about their respective roles. They also noted, confusion about eligibility and referral routes and the lack of appropriate services to discharge to, including accommodation.

7.17 Users noted the need to repeat information during assessments, delays caused by lack of communication between services; long waits for assessment; slow response when returning calls. The Council had accepted these areas were problematical and was working on an action plan to address them.

Privacy and Confidentiality

7.18 Inspectors had no evidence to suggest there were any difficulties maintaining the privacy and confidentiality of service user records. Both the Council and NELMHT had written protocols on meeting the requirements of the Data Protection Act and Freedom of Information Act, and staff training about this.

Information for Service Users and the Public (4)

7.19 The Council website was easy to find and navigate. It contained basic information on services available and terms used such as care plan and assessment.

7.20 It would have been improved by better internet links to other services and information. The website could be a valuable information resource but service users seen by inspectors were not aware of its existence.

7.21 Information for young carers was good with leaflets, a website and chat room.

7.22 Most respondents to the CSCI surveys of users and carers said information was given to them about services, but it was harder to get information about specific conditions. Service users were confused about access to services, especially after hours.

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 the times 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

Fair Access

STRENGTHS	AREAS FOR DEVELOPMENT
• FACS guidelines had been published in the form of a leaflet, Crystal marked for plain English. • The SSD complaints procedure was robust, although the numbers of complaints from mental health appeared low. • Advocacy services were praised, and were available through a range of voluntary organisations. • Inspectors received no complaints about charging for services. Many people received free services and others saw charges as fair.	• Services for black and minority ethnic groups were in need of improvement. • There was not a single point of access and CMHTs felt referrals to them from primary care were sometimes inappropriate. • The new Assessment and Brief Intervention service had provided an alternative route for referrals from primary care, but its eligibility criteria for service had yet to be ratified by the Primary Care Trust. • There was a lack of clarity among team managers about the function and eligibility criteria of different services, meaning that inappropriate referrals could be made or services underused. • There was currently no jointly agreed protocol for complaints that spanned both health and social services. • No evidence was available about information from complaints or compliments translated into day to day practice in mental health services. • There was a range of reported difficulties in practice with out of hours services.

RECOMMENDATIONS

- **The Council and its partners should work together to improve fair access to services.**
  - **agree and disseminate common eligibility criteria and ensure team managers and care coordinators understand them;**
  - **give much higher priority to improving the range and quality of its services for black and minority ethnic groups; and**
  - **address the concerns of users and front line staff about access out of hours.**
- **The mental health service should establish a single complaints process for users, so that the onus is on the organisations to establish accountability, rather than the complainant. The Council and its partners should jointly collate information from complaints and act on it to improve mental health services.**

8

Eligibility Criteria

8.1 Eligibility criteria were published by the Council both in leaflets for users and charts for staff. In practice, most users accessed services through their GPs, and CMHTs reported that many referrals from primary care were inappropriate, suggesting a lack of shared understanding. The new A&BIT team had been established to make this simpler but at the time of the inspection the Primary Care Trust had yet to ratify the eligibility criteria nor GPs to use the system consistently.

8.2 There was a lack of clarity among team managers about the function and eligibility criteria of different services, meaning that inappropriate referrals could be made or services underused.

Out of Hours Services

8.3 Out of hours services were uncoordinated and unclear to users. Senior staff were unaware of many of the problems faced by staff out of hours, and reporting lines from the EDT to mental health services were unclear.

8.4 Users reported being unclear about how to get help out of hours, and some thought there was no after hours service. The Council website referred variously to the "out of hours team"; "the emergency duty team" and the "emergency social worker service", although these were the same service. This team dealt with mental health assessments. The Home Treatment and Intensive Case Management teams also operated out of hours, but co-ordination between these services was poor.

8.5 The intensive case management team only offered a service to its own existing service users.

8.6 The Council reported that the Home Treatment Team offered an all-hours rapid response services for people, aged 16-65, in acute psychiatric crisis and at risk of hospital admission. The team was multi-disciplinary and community based and was set up to assess, treat and provide support in the initial stages of a crisis through to resolution. Referral was via the Community Mental Health Teams, Assessment and Brief Intervention Team, GP or accident and emergency services. However, the Emergency Duty team reported operational problems with the HTT describing it as understaffed and not functioning in the way they would have preferred, that is: working extended hours, and offering joint assessment with the emergency duty team.

8.7 Additonal problems out of hours included a perceived lack of timely availability of police support. Although senior managers reported positive relationships with the police, the latter was also a problem reported by approved social workers. On one of the cases tracked, police were

unavailable to attend a mental health assessment for over 48 hours. The emergency duty team, which covered all user groups, was managed by older people's services and staff seemed unaware of a clear route to report mental health issues.

Meeting the Needs of All Communities

8.8 Action was being taken to improve black and minority ethnic monitoring and consultation with representatives was taking place through the Black and Minority Ethnic sub-group of the Local Implementation Team, facilitated by the Community Development Worker. However, this was from a low base, and the Council had not established a culture of routine monitoring and black and minority ethnic engagement. Work had been recently undertaken on ethnic monitoring for all services, with the next stage being planned to map staff. This did not include monitoring of faith or language.

8.9 The Council was alert to the need to provide better services for minority communities, but had been slow in bringing about change. Not all staff had the knowledge and skills necessary to work with diverse communities, and acknowledged this. First line managers, as well as voluntary sector partners such as HUBB User Advocacy Group and Barking and Dagenham carers, recognised the shortfalls in meeting the needs of the diverse, and changing minority communities. There was a lack of culturally sensitive services: language line was available but was thought by staff to be too expensive for prolonged use. The bilingual advocacy service provided through the translation and interpreting service was small and funding was limited.

8.10 Referrals from the CHMT to RETHINK were low for people from black and minority ethnic backgrounds and the Council were not clear why.

Advocacy

8.11 Advocacy services were available and supported financially by the Council, through HUBB User Advocacy Group and the Translation and Interpreting Service (TIS) (for bi-lingual services). The contract with HUBB had been re-specified in 2005 to provide a borough specific service (it had previously been shared with Havering) and additional funding provided by the Council. Barking and Dagenham are one of the few areas to offer bi-lingual advocacy. Both thought their services were not well promoted, and reported low referral rates from the Council. All of HUBB User Advocacy Group's referrals were self-referrals.

8

Interpreting

8.12 For Deaf people, Barking and Dagenham disablement association had UKBSL signers who were used by mental health service users.

8.13 Interpreting for other non-English speaking people was available through the Translation and Interpreting Service (TIS) which covered three London boroughs. This was commissioned by the Primary Care Trust, and provided translation and interpreting in 25 different languages, including services for recent arrivals from Albania and Eastern Europe. There was positive feedback from users about the translation services. TIS reported they did not receive sufficient financial support from the mental health services and as such thought that mental health service users who were not English speaking were not receiving appropriate support either to access or use services.

Charging

8.14 Many mental health service users received free services. This included free day care. Inspectors heard no complaints about unfair charging, where these did apply.

Complaints Service

8.15 The Council complaints procedure was robust, although the numbers of complaints from mental health (three for 2004-05) appeared low. Service users interviewed as part of the case tracking exercise told inspectors they did not know how to complain, and there were no written standards for users on which they might base a complaint. There was currently no jointly agreed protocol for complaints that spanned both health and social services, meaning people had to make a decision whether it was a health or social care complaint, and accountability for resolving problems was split.

8.16 While the Council and members demonstrated a high level of commitment to the use of complaints, compliments and comments to improve services, no evidence was available about how this translated into day-to-day practice in mental health services.

8

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

Capacity for Improvement

STRENGTHS	AREAS FOR DEVELOPMENT

• There was commitment from partner agencies to drive improvements.
• Councillors demonstrated both knowledge of mental health services and commitment to improvement.
• The regeneration strategy was council wide and should mainstream social aspects of mental health services.
• There were good working relationships with other council departments.
• The Council was managing the imminent restructuring well, extending the contract of the interim director to overlap with the new appointment to ensure continuity.
• Effective performance management was a priority for the Council.
• Performance standards were monitored and have been maintained or improved.
• Links from the balanced scorecard to individual performance were being established and will be monitored.
• Contract monitoring ensured compliance while promoting better quality.
• The Council had a dedicated lead member to address issues from inspection.
	• Not all partners understood the strategic process and structure to drive improvement, meaning some felt excluded.
	• The mental health service was presented to inspectors as integrated and working well together, but inspectors found lack of clarity in joint decision-making, patchy user involvement and a lack of co-ordination and shared understanding.
	• Staff and managers throughout the service did not consistently understand the Council's vision and strategic direction.
	• The council's self-assessment was short of critical analysis and as such failed to present a realistic picture. Operational difficulties were minimised or not mentioned.
	• Staff morale was not consistently good.
	• Staff were not all provided with appropriate technical and office support to enable them to do their jobs effectively:
	  • Health and Council IT systems were incompatible, meaning duplication of effort to communicate.
	  • Approved social worker reports were handwritten
	• Quality assurance was not sufficiently robust to drive necessary change where services were provided on an inter agency basis:
	  • Lines of accountability were unclear which meant changes, which should occur at operational level, were not happening.
	  • There was limited shared understanding of the roles of different teams and their relationship with one another.
	• The emergency duty team was line managed by the older people's division, and lacked a clear route for reporting of operational difficulties into mental health services.

9

RECOMMENDATIONS

Some recommendations from other standards are relevant to ensuring improvement. In addition:

- **The Council and its partners should develop a project to improve technical resources for staff, and provide training to make use of them.**
- **The Council and its partners should improve their joint quality assurance systems in order to:**
  - **recognise and acknowledge where problems are raised by providers, partners or staff;**
  - **evaluate new or re-structured services against criteria agreed in advance, and**
  - **involve users and carers in service evaluation.**

9

Vision and Progress

9.1 All the key organisations demonstrated both vision and commitment to make improvements. These were outlined in the Local Implementation Team Plan. However, real progress is dependent not only on commitment but on realistic implementation plans and committed financial backing. In the absence of formal agreements, these ingredients were not consistently present. There was a clear understanding from the new Borough Director that plans had to be based on better evidence, clear lines of accountability, budgets matched with activity, integrated plans and agreed evaluation. Putting this understanding into action lay in the future at the time of the inspection.

9.2 There were some positive indications that the Council could drive improvement: working relationships with other Council departments were good; the regeneration strategy was pulling additional monies into the Borough; a Local Area Agreement was imminent and inspectors were impressed by the knowledge and commitment of Council members to the mental health services.

Performance Management

9.3 Effective performance management was a priority for the Council but this had yet to fully embrace all those services which were provided jointly.

9.4 Performance standards were monitored and had been maintained or improved. Links from corporate aims to individual performance were being established and will be monitored. However, these systems had yet to translate into sound quality management in the mental health service, where agreement on standards and monitoring needed agreement with partners.

9.5 The Council's self-assessment was short of critical analysis and as such failed to present a realistic picture. Some operational difficulties were minimised or not mentioned. The case file audit, for example, which had revealed very serious problems in recording practice, was underplayed as "variation from best practice". No mention was made of reported problems with the police; resource shortages in day centres or difficulties accessing services after hours.

9.6 The mental health service was presented to inspectors as integrated and working well together, but also recognised further work was required to formalise joint decision making, effective user involvement, co-ordination and shared understanding. While there was clear commitment from senior managers and councillors, the roles and responsibilities of middle mangers had not been made clear. As a result, operational problems were not dealt with appropriately. Inspectors were told of a range of operational

difficulties by front line staff and first line managers of which senior managers appeared unaware. Many could have been addressed at operational level, had lines of accountability been clearer. These included access to resources; staff training; recording and working relationships with other teams and agencies, all of which have been detailed in the previous chapters. The emergency duty team was managed through older people's services, and appeared confused about the route into mental health to discuss operational issues.

9.7 Even where problems were known, remedial action was not taken. For example, while the Council and NELMHT were aware that recording was a problem, the recognition of which had generated meetings and memoranda, no plan to address the issue had been drawn up or acted on.

9.8 The Council had a poor Supporting People inspection in 2004 (reported April 2005), and is to be re-inspected in August 2006. There was a critical children's Inspection in January 2005. These inspections highlighted some similar issues to this one. The Supporting People inspection noted weaknesses in involving service users and in services for black and minority ethnic communities. The children's inspection noted the voluntary sector felt excluded from decision-making; and that the quality of recording was "not high". The Council had taken steps to address these issues, notably by revised management arrangements to improve community and voluntary sector engagement and equalities and diversity, but the evidence suggested there was still work to be done in mental health services, where responsibility for quality assurance and operational improvement was less clear.

Organisational Structure

9.9 The organisational structure for delivering mental health services was changing as the Council restructured. Changes which related to the NELMHT review have been described earlier and were being put into place at the time of the inspection. More formal arrangements between NELMHT and the Council had been agreed in principle, and will be progressed with the new Borough Director in post.

9.10 The Council was handling the major restructuring well, despite some delays in filling key posts. The Borough Director for NELMHT/Barking and Dagenham came into post during the inspection fieldwork, and he had yet to decide on the structure beneath him. This was contributing to some problems in staff morale. The new post of Director for Adult and Community Service was not to be advertised until summer, although the extension of the Interim Director's contract until December 2006 seemed a sensible way to achieve a smooth transition.

9

Workforce

9.11 The mental health teams, including NELMHT posts, had an establishment of 80 posts, with a 14 per cent vacancy rate at the time of the inspection. Six new posts had been added to the establishment since 2004, with a further two funded through capital volunteering to follow.

9.12 Staff and middle managers did not consistently understand the Council's vision, or what it meant for them in practice. One of the CMHTs reported low morale, unfair workload allocation in comparison with the other team and uncertainty about future direction. The ICM (the assertive outreach team), was running with a 42 per cent vacancy rate and the supported accommodation team had 25 per cent vacancies. Agency staff covered posts in the latter teams, which was an expensive resource. A recruitment drive was due the month after the inspection.

9.13 Training and development were undertaking positive work for social services staff generally. They were building effective partnerships within the council and identifying and meeting training needs of staff. Some specific training and development needs of approved social workers needed more attention.

9.14 Most staff reported positively on their experiences of supervision, being regular and developmental.

Approved Social Work

9.15 The approved social workers were not managed efficiently.

9.16 Approved social workers were deployed in several different teams – the two CMHTs, ICM, Home Treatment, and the Learning Disability team. Communication between approved social workers was good – co-ordinated by senior approved social workers. However approved social workers experienced problems in caseload management, and balancing their regular work load with approved social worker responsibilities.

9.17 The lines of reporting for specific approved social worker issues were unclear between the lead for professional development, the team managers, and the CPA co-ordinator. The training and development section did not keep details of approved social worker professional development. The approved social workers did not feel well connected to the social services department.

Interface Issues

9.18 A range of teams were delivering mental health services, which front line staff reported as not working well together. Criteria were not commonly

understood across teams. This also applied to out of hours services, described in the previous chapter.

9.19 Both the emergency duty team and approved social workers reported that working relationships with the police needed to be addressed, especially with regard to response times where emergency duty team or approved social workers were dealing with people who posed a risk.

The Needs of Children

9.20 Case file data and reports from users and carers suggested that the mental health services could do more to support mental health users who were also parents. Some staff had difficulty in understanding that both parents and children had needs, and the challenge was to meet both, not to argue about which took priority.

9.21 The young carers project, for those children and young people who were recognised as having a supportive role for parents with mental health problems, was an example of good practice, demonstrating that meeting needs of both children and parents can be achieved. This was described under Standard 4.

9

Standards for Inspection

A

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 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.

A

1.4 Overall mental health services reflect the active **involvement of services users** and carers including those from minority ethnic communities.
• 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 cooperate 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.

A

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 ethnic 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 good performance, value for money and are used in commissioning decisions. • Services favour prevention and the community as against crisis and institutionalisation. • Technology is used comprehensively and effectively to support communication, management, delivery and monitoring.

2.4 The Council is implementing **joint financial arrangements** with health and other partners for the delivery of mental health social care services.

- Agencies maximise choice and/or efficiency by cooperating to purchase services.
- Complex arrangements for funding individual cases are agreed promptly between agencies.
- Systematic consideration is being given, with partners, to optimal 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.

A

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 the needs, offer choices to many and take account of individual preferences. This includes sensitivity to the needs and preferences of minority ethnic 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[1].
• Service planning responds flexibly to changing needs, aggregated demand and demographic and socio-economic factors.
• There are services suitable for people with different racial and cultural backgrounds.

3.3 The council provides a good range of services to support and encourage **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.

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

A

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.

A

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 Referral, assessment, care planning; and review processes are convenient, timely and tailored to individual needs and preferences including ethnic diversity.

- 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 **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 standard 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 CSCI, MHAC and other reviews and inspections by taking corrective action as necessary.

A

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 them.
- 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 minority ethnic groups.

- 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 **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 day 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 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.

A

5.4 The range of services available reflects the needs of the community, promotes equality to comply with the Race Relations Amendment Act 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 populations it serves.
- Service users have ready access to a specifically trained interpreting service; they do not rely on family member.
- 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 service 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.

A

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; 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.

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.

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 coordination 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.

A

Inspection Background and Method

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 upon 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 Barking and Dagenham 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 every mental health fieldworker in Barking and Dagenham, a second questionnaire to up to 100 service users and 50 separate questionnaires to carers. We selected service users and carers from lists of active cases prepared for us by Barking and Dagenham social services.

B.11 From the list of cases prepared for us we selected 10 for detailed analysis of case records. For these cases we asked fieldworkers to complete a case profile and we visited some of these service users at home.

9.22 During the inspection fieldwork we met a wide range of staff working in mental health services in Barking and Dagenham, 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:

- Service users (individually and in groups);
- carers;
- advocacy agencies;
- the Chief Executive, Deputy Chief Executive;
- the Interim Director of Social Services;
- the Director of Public Health;
- the Chief Operating Officer and Chief Executive of the Mental Health Trust;
- four councillors;
- the Head of Adult Services;
- the interim Borough Director and the incoming Borough Director;
- the Emergency Duty Team Manager;
- the Professional Social Work lead;
- second tier managers in social services;
- a group of approved social workers;
- representatives of the Local Implementation Team;
- the Mental Health Planning and Policy Manager;
- the Head of Procurement and Business Support;
- the Head of Performance Strategy;
- the Complaints Manager;
- the Joint Commissioning Manager ;

- performance management staff;
- commissioning staff from health and social care;
- CMHT managers;
- Council HR and training staff;
- independent service providers;
- health service managers;
- fieldworkers;
- the CPA Coordinator;
- the Adult Protection lead; and
- the Direct Payments coordinator.

Results of Survey of Service Users

D

E.1 We asked 100 people who had received or were receiving services, a range of questions about their experience of services in Barking and Dagenham. We received 28 replies. The numbers given are actual returns.

Making contact	Always	Usually	Sometimes	Never	Not Stated
Are the staff easy to contact?	14	10	4	0	0
Are the staff easy to talk to?	14	12	2	0	0

Involvement	Always	Usually	Sometimes	Never	Not Stated
Are you asked what you think about the service(s) you receive?	5	7	9	6	1
Are you invited to meetings about your care?	5	6	11	6	0

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?	8	4	11	3	2

Informing You	Always	Usually	Sometimes	Never	Not Stated
Are you given written information about the service(s) you receive?	6	11	7	3	1

Informing You (continued) Does this information cover:	Yes	No	Don't Know	Not Stated
The Care Programme Approach?	16	4	6	2
Confidentiality?	16	4	6	2
How to get hold of services?	17	3	6	2
The nature of mental illness?	14	6	6	2
Professional terms and jargon?	13	6	7	2
Local strategies and plans for mental health services?	10	6	10	2

D

Informing You (continued)	Always	Usually	Sometimes	Never	Not Stated
Are you told what is happening at each stage?	9	11	1	5	2

Informing You (continued)	Yes	No	Not Applicable	Not Stated
Do you know how to make a complaint?	14	13	-	1
Do you know that you can see your records if you wish?	15	12	-	1
Do you know that you could have an interpreter/translator?	9	3	12	4
Do you know that you could have a friend/advisor/advocate to support you?	20	6	-	2
Do you know how social services work out the charges for the service(s) you receive?	5	13	7	3
Do you think that the charges are fair for the service(s) you get?	7	5	10	6

Quality of Service	Yes	No	Don't Know	Not Stated
Did you get the help quickly after a decision was made to provide the service(s)?	18	4	6	0

Quality of Service (continued)	Always	Usually	Sometimes	Never	Not Stated
Were you involved in determining the service(s) you receive?	7	11	6	4	0
Are changes made to fit in with your needs?	5	13	5	3	2
Are you satisfied with the quality of the service(s) you receive?	15	8	2	3	0
Have you had the service(s) that you agreed with your care manager?	14	5	5	2	2
Have the services helped you?	16	5	3	3	1

Source: CSCI Survey of Service Users

Results of Survey of Carers ditto

F

F.1 We asked 50 carers of people who had received or were receiving services, a range of questions about their experience of services in Barking and Dagenham. We received 12 replies. The numbers given are actual returns.

Making contact	Always	Usually	Sometimes	Never	Not Stated
Are the staff easy to contact?	5	3	2	1	1
Are the staff easy to talk to?	5	4	2	0	1

Involvement	Always	Usually	Sometimes	Never	Not Stated
Are you asked what you think about the service(s) the person you support receives?	5	0	2	4	1
Are you invited to meetings about the care of the person you support?	3	2	2	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 the race, culture or religion of the person you support?	3	1	4	3	1

Informing You	Always	Usually	Sometimes	Never	Not Stated
Are you given written information about the service(s) that the person you support receives?	6	1	0	5	0

F

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

Informing You (continued)	Always	Usually	Sometimes	Never	Not Stated
Are you told what is happening at each stage?	4	2	2	4	0

Informing You (continued)	Yes	No	Not Applicable	Don't Know	Not Stated
Do you know how to make a complaint?	5	7	-	-	0
Do you know that you can see your records if you wish?	6	6	-	-	0
Do you know that you could have an interpreter/translator?	4	3	5	-	0
Do you know that you could have a friend/advisor/advocate to support you?	7	4	-	-	1
Do you know about your right to an assessment of your own needs as a carer?	5	7	-	-	0
Have Social Services carried out an assessment of your needs as a carer in the past 12 months?	3	7	-	1	1
Do you know how social services work out the charges for the services that the person you support receives?	1	7	3	-	1
Do you think that the charges are fair for the service that the person you support receives?	2	0	9	-	1

F

Quality of Service	Yes	No	Don't Know	Not Stated
Did the person you support get the help quickly after a decision was made to provide the service(s)?	7	4	-	1

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

Source: CSCI Survey of Carers

F

Results of Survey of Fieldworkers

1

G.1 We asked fieldworkers a range of questions about their experiences of services in Barking and Dagenham. We received 20 replies. The numbers given are actual returns.

Background	Yes	No	Not Stated
Do you have a professional social work qualification?	9	10	1
Are you currently an Approved Social Worker?	6	13	1

Training Received	In past year	1-3 years	3+ years	None	Not Stated
Basic Approved Social Worker	2	0	4	9	5
Approved Social Worker Refresher	5	2	0	9	4
Care Programme Approach	5	9	1	3	2
Child protection	7	8	1	2	2
Children in need	2	3	0	11	4
Human Rights Act	5	6	2	5	2
Work with mentally disordered offenders	2	5	3	8	2
Mental health risk assessment	8	6	3	2	1
Mental health risk management	6	6	1	5	2
Equal opportunities in mental health services	2	2	3	11	2
Anti-discriminatory practice in mental health services	3	3	4	8	2
Disability Discrimination Act	0	3	3	12	2
Race Relations (Amendment) Act	1	0	3	12	4

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Your 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.	2	9	8	0	0	1
Arrangements with housing for work with people with mental health problems.	1	5	7	7	0	0
Arrangements for assessment and care planning.	4	9	5	2	0	0
Arrangements with primary care for people with mental health problems	1	9	6	2	1	1
Arrangements with the Police for people with mental health problems.	3	12	4	1	0	0
Emergency out of hours arrangements.	1	7	6	3	2	1
Mental health services available generally in locality.	1	6	10	3	0	0
Available public information on mental health services in accessible formats.	2	7	8	2	0	1

Are the following policies and procedures adequate?	Yes	No	None available	Not stated
Care Programme Approach	19	1	0	0
Risk assessment (mental health)	18	1	0	1
Risk management (mental health)	18	1	0	1
Vulnerable adults	17	0	0	3
Arrangements with children's services	15	2	0	3
Violence to staff	14	1	1	4
Section 117 aftercare	17	1	1	1
Arrangements with medium secure units	14	0	1	5
Dual diagnosis – substance misuse	12	1	1	6
Dual diagnosis – learning disability	9	4	2	5
Child and adolescent mental health	13	1	1	5
Confidentiality	16	0	0	4

Source: : CSCI Survey of Fieldworkers