Inspecting Informing Improving

Healthcare Commission

Adult specialist community mental health services

Report of the follow-up to the 2005/06 review

Follow-up review

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The Healthcare Commission

The Healthcare Commission works to promote improvements in the quality of healthcare and public health in England and Wales.

In England, we assess and report on the performance of healthcare organisations in the NHS and independent sector, to ensure that they are providing a high standard of care. We also encourage them to continually improve their services and the way they work.

In Wales, the Healthcare Commission's role is more limited. It relates mainly to national reviews that include Wales and to our yearly report on the state of healthcare.

The Healthcare Commission aims to:

- Safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public.
- Promote the rights of everyone to have access to healthcare services and the opportunity to improve their health.
- Be independent, fair and open in our decision making, and consultative about our processes.

On 1 April 2009, the Care Quality Commission, the new independent regulator of health, mental health and adult social care, will take over the Healthcare Commission's work in England. Healthcare Inspectorate Wales will become responsible for carrying out our activities relating to Wales.

Summary

The aim of our programme of service reviews is to help NHS trusts improve their services. Our review of NHS adult community mental health services in England was carried out jointly with the Commission for Social Care Inspection (CSCI) in 2005/06, with the national report published in July 2007. The review highlighted a number of areas that needed to improve and we made recommendations to help this happen. This follow-up review enables us to measure what improvements have been made in these areas and what needs to be considered to help services to move forward.

This report sets out the overall results of our follow-up review. The findings provide useful information for consideration in the planning, monitoring and development of adult specialist community mental health services, particularly in light of the current and emerging policy context. For example, Lord Darzi's *Next Stage Review* provides a strong focus on clinical care pathways, quality accounts, commissioning for quality and innovation and a standard contract for mental health (a legally binding agreement between the commissioner and the provider of services).

Additionally, the recent revised guidance from the Department of Health, *Refocusing the Care Programme Approach* and the advent of the Department of Health-led New Horizons strategy for mental health services in England (the successor to the existing National Service Framework for mental health, which expires in 2009) is likely to see services focusing more heavily on issues such as: the physical wellbeing of people with mental health needs; the problems of stigma and social exclusion associated with mental ill-health; reducing inequalities for people with mental health needs from black and minority ethnic groups; and improving the care and outcomes for people with mental health needs in prison and for people who misuse drugs and alcohol. Specialist community mental health services will have a key role in each of these areas.

This report is aimed primarily at the boards of trusts, commissioners of health and social care, local implementation teams and frontline staff working in specialist community mental health services, and managers in the NHS, to ensure that they work in partnership to take action to address these important issues within their local communities.

The original review, carried out 2005/06, assessed the performance of key community services in 174 local implementation team (LIT) areas in England that contributed to mental health and social care for adults between the age of 18 and 65. The review gathered information from mental health trusts, health and social care trusts, primary care trusts and local councils with responsibility for social services. Using an assessment framework to measure the performance of services, the information was scored to assess three main themes:

1. Access to appropriate care and treatment (such as psychological or 'talking therapies').
2. Involving people who use services.
3. Focus on recovery and social inclusion.

The findings of the assessment showed that some services had responded well to the introduction of the National Service Framework for Mental Health, by providing a good range and quality of services for those who needed them. However, performance was very variable, leaving some people with little or no access to aspects of specialist care and treatment. Each LIT was given an overall score for the services within its area. The overall results were:

- 9% were scored as "excellent"
- 45% were scored as "good"
- 43% were scored as "fair"
- 3% were scored as "weak".

As a result of the assessment, we visited 11 LIT areas that had low overall scores to explore further the issues raised, and to provide an incentive for improving services where it was needed.

Based on the findings of the review, we made recommendations for each theme that were aimed at both providers and commissioners of services, summarised as:

Access to appropriate care and treatment: improve timely access to safe and effective specialist community mental health services.

Involving people who use services: improve people's experiences of using community mental health services by involving them more directly in decisions about their care, treatment and management of their medicines.

Focus on recovery and social inclusion: services must be designed in a way that improves people's outcomes for recovery and social inclusion in areas such as reviewing physical health, education, employment, housing and other community activities.

These recommendations provided the basis for the follow-up review. We selected 15 indicators for the follow-up review that focus on the areas of most relevance and importance in the original review. Ten indicators were from the Healthcare Commission's national survey of community mental health services, carried out in 2008, and five indicators were based on the national audit data collection relating to NICE guidelines for schizophrenia (2002) carried out by the Healthcare Commission during 2008. Detailed descriptions of the indicators can be found in the appendix.

The recent re-configuration of LITs meant that it was not practical to reproduce matching data sets for these organisations. The follow-up review was therefore carried out only at specialist community mental health provider level (trust level) rather than at the level of local implementation teams as in the original review. It does not provide an overall score for each LIT. Instead, it aims to measure the improvement or deterioration in performance of a specialist community mental health trust against each of the 15 indicators. The performance of a trust is compared against a fixed threshold based on the 2005/06 national average, for both the original and follow-up reviews, for each indicator. (It is important to note that the fixed threshold is a way of measuring progress only and is not necessarily acceptable in policy terms.) The focus is on assessing change, whether trusts have improved or not.

Key findings

The overall findings across all 15 indicators in the follow-up review show an improvement for 11 indicators. Two indicators showed no significant change and two showed a net deterioration. We also found that 21% of trusts performed at or above the 2005/06 national average for all indicators in the 2007/08 follow-up, and a further 60% of trusts performed at or above these averages for 12 to 14 of the indicators. However, 19% of trusts performed below these averages in four or more indicators.

It is important to note that the improvement of trusts for some indicators is measured against the relatively low baseline of the national averages for 2005/06, rather than being measured directly against specific set standards, and that many indicators still show room for considerable improvement. The national averages for most indicators (11 out of the 15) were between 50% and 74%. Trusts should be seeking to work towards achieving the objectives of the indicators for all of their service users.

Theme 1: Access to appropriate care and treatment

For people with mental health problems, access to effective support and treatment is vital to their recovery and to their inclusion in society. In the original review, we found that despite the increased availability of services, many people with mental health problems did not have information on how to access local support out-of-hours, and that greater access to psychological therapies was needed in line with guideline recommendations.*

Access to out-of-hours support: It is encouraging that 33% of trusts have improved against this indicator, while only 8% of trusts have deteriorated. However, it is concerning to note that, despite their low level of performance in 2005/06, the performance of 17% of trusts is significantly lower than the national average of 50%. There is clearly an urgent need for them to improve so that many more service users will know how to contact out-of-hours support when it is needed.

Access to evidence-based intervention: The National Institute for Health and Clinical Excellence (NICE) recommends that 100% of people with schizophrenia who experience persisting psychotic symptoms should be offered cognitive behavioural therapy (CBT).* While the 2005/06 national average of people being offered or receiving this therapy was 46%, we found that the performance of 34% of trusts was significantly lower than this level, including 21% of trusts whose performance had deteriorated below this level, despite greater emphasis on improving access to such therapies in the recent years. Results from this review suggest that the capacity of the mental healthcare system to deliver psychological therapies to the large number of people with psychosis remains a concern.

Theme 2: Involving people who use services

It is important that people with mental health problems are offered a choice of treatment

* The NICE Guidelines for Schizophrenia (2002) are currently under review and the recommendations measured in the follow-up review are expected to remain in place when the reviewed guidelines are published in March 2009.

that suits them. In the original review, we found that despite the need to involve service users in decisions about their healthcare, there was still considerable under-performance. We followed up these four key areas within this theme.

Involvement in the care programme approach (CPA) process: To assess how specialist community mental health services involved people in the CPA process, we included three indicators based on the views and experiences of service users. We found substantial improvements in all three areas against the national averages for 2005/06:

- "Service users have received a copy of their care plan": 41% of trusts had improved and 12% were significantly below the national average for 2005/06 (53%).
- "Service users have had a care review in the last 12 months": 35% of trusts had improved and 11% were significantly below the national average for 2005/06 (51%).
- "Service users know who their care co-ordinator is": 24% of trusts had improved and 20% were significantly below the national average for 2005/06 (70%).

These results suggest a steady improvement nationally on the indicators that relate to the involvement of service users in the CPA process. However, marked variations between trusts remain and the national averages against which they are compared are relatively low, suggesting that some trusts have been far more successful than others in ensuring that the infrastructure for the CPA is embedded within routine practice.

Involving people in decisions about their care and treatment: We included three indicators to assess the extent to which community mental health services take account of service users' views and involve them in decisions about their care and treatment:

- "Service users are involved in deciding what is in their care plan": 26% of trusts had improved and 15% were significantly below the national average for 2005/06 (58%).
- "Diagnosis was discussed with service users": 20% of trusts had improved and only 3% were significantly below the national average for 2005/06 (63%).
- "Service users 'have enough say in their care and treatment'": 24% of trusts had improved and only 6% were below the national average for 2005/06 (64%).

The results are again positive, but with further scope for improvement.

Care planning with advance directive for crisis and contingency plan: To assess whether people's choices about treatment were being documented in their care plan, we included two inter-related indicators in the follow-up review. The NICE guidelines for schizophrenia (2002) recommend that all service users with a diagnosis of schizophrenia should have an agreed advance directive or crisis and contingency plan in their care records, and that, in case of acute illness, this should "contain reference to the agreed choice of anti-psychotic medication".

We found mixed results overall:

- 29% of trusts had deteriorated from their 2005/06 performance in relation to the indicator "care record contains advance directive or crisis and contingency plan", and 21% had improved. The national average remains high, and currently, 80% of the audited records of people with schizophrenia have an advance directive or crisis and contingency plan in place.
- In relation to advanced directives that contained reference to the agreed choice of anti-psychotic medication in case of acute illness, 16% of trusts had improved, but there are still 29% of trusts performing significantly below the national average for 2005/06 (which was only 21%).

The overall results raise questions about how fully service users are being engaged in this process and the extent to which they are given opportunities to record their preferences for treatment.

Involving people in decisions and management of their medicines: The vast majority of mental health service users take medication for their condition. National policy emphasises the importance of providing good information and involving people in decisions about the medications they take. Two indicators were used here:

- The first relates to whether service users "had a say in decisions about the medicine they take". The results are positive, with 24% of trusts showing improvement and only 8% of trusts remaining below the national average for 2005/06 (62%).
- The second indicator concerns whether people were "told about possible side-effects of medication". Again, the results are positive, with 18% of trusts showing improvement and only 3% of trusts remaining below the national average for 2005/06 (52%).

The results overall for this theme are therefore positive, but with considerable scope to improve further.

Theme 3: Focus on recovery and social inclusion

Compared with the rest of the population, people with severe and enduring mental health problems are at a much higher risk of developing major physical health problems. Despite having had the lowest employment rate of all the main groups of people with disabilities, the original review found that only half of those who needed help with finding work reported getting it. We followed up these two areas:

Good physical health: We reviewed whether service users who had a diagnosis of schizophrenia "received a physical health review in the last 12 months in line with recommended good practice" and found that the good results from the national average of 81% in the original review had been maintained. While the performance of 18% of trusts had improved, 15% of trusts were significantly below the national average for 2005/06. Results suggest that there are still a number of people that are not receiving physical health checks or that this information is not recorded by secondary services.

Assistance with employment: The NICE guidelines on schizophrenia (2002) recommend that all people with schizophrenia should have a comprehensive assessment of their occupational status and and vocational aspirations. In our audit of the NICE guidelines, we followed up the care records of service users with schizophrenia to see if they recorded whether this assessment had been carried out or had been offered. We found that 59% of trusts had improved their performance, and only 4% had deteriorated against the 2005/06 national average of 64%. We also assessed service users' views, through the 2008 national survey of community mental health services, on whether those that wanted it had received help with finding work in the last 12 months. We found very little change, with 9% of trusts improving, and 9% of trusts remaining below the national average for 2005/06 (which was only 50%).

Overall, the results suggest that while there is a significant improvement in the area of assessing occupational status (at least for people with a diagnosis of schizophrenia), there was very little improvement in helping people to find work. This raises the question of the effectiveness of the support for helping service users back into the work place once their needs have been identified.

Conclusions

The findings of the follow-up review show that the overall progress made by many trusts is encouraging. However, they also point to only modest improvements in a number of aspects of services. It is important to note that the improvements for some indicators are measured against the relatively low base of the national averages for 2005/06, rather than being measured against specific set standards.

While the implementation of the national service framework has generally seen positive change, the pace of this change remains variable. In some areas, progress towards delivering key outcomes for service users around choice, personalised care and social inclusion has been relatively slow and incremental.

Two years on, the main areas of continuing concern are:

- The need for effective support for service users to help them get back to work.
- Better access to out-of-hours services for all service users.
- Provision of cognitive behavioural therapy for all service users who require it.
- The need to ensure that care plans have advance directive and contingency plans, and that they refer to the agreed choice of anti-psychotic medication in case of acute illness.
- The need for physical health reviews to be routinely and systematically carried out for all services users for whom they are appropriate.

Recommendations

We encourage all mental health providers to reflect on their performance in this follow-up review and to identify those indicators where their performance has deteriorated or shows potential for greater improvement based on their results in 2005/06.

We also recognise that, with the advent of the New Horizons Strategy, the role of local implementation teams may change. However, while they still exist, we urge them to continue to steer the direction of specialist community mental health services and to inform the focus of any successor forum to take on similar responsibilities.

Based on the findings of this follow-up review, we recommend that priority attention is given to the following areas.

Commissioners of health and social care should:

- Jointly assess and review the employment status and need for support of all people in contact with specialist mental health services.
- Monitor the experience of service users in accessing out-of-hours support, to inform commissioning decisions about whether the level of provision and the routes to get support are sufficient to meet local need and are well known to the people that may need them. Commissioners need to consider these findings and ensure that they are addressed within their standard contract agreements with providers.
- Ensure that primary care services carry out their responsibility to undertake physical health checks under the Quality and Outcomes Framework (QOF) payment system and the recommendations of the NICE guidelines for schizophrenia.

Providers and commissioners of specialist mental health services and their partner organisations should:

- Use the benchmarking information from this review to identify problem areas and improve services.
- Use the CPA self assessment tool (www.cpaselfassessment.org.uk) to provide a measure of assurance around implementing the refocused CPA.
- Agree local monitoring arrangements around the implementation of the refocused CPA to ensure that the framework is further embedded within routine practice.
- On an ongoing basis, review the range and provision of psychological therapies to people in contact with specialist community mental health services, to ensure that there is sufficient capacity and skills within the workforce to meet identified need.
- Sustain and further improve the assessment of the physical health needs of service users, ensuring that the contractual responsibility for the conduct of assessments and checks is made clear, and that the frequency and content of checks are recorded in care records.

CPA care coordinators and frontline support staff should:

- Work purposely to improve the experience of all service users and their carers in their involvement in the care planning process, to promote the choice and personalisation of care.

Introduction

Purpose of this report

This report sets out the overall results of our follow-up of the review of NHS adult specialist community mental health services in England. The report explores the extent to which services have improved since the original review in 2005/06. It is aimed primarily at the boards of trusts, commissioners, local implementation teams and frontline staff working in specialist community mental health services, and managers in the NHS. Separate reports for each individual trust are available on our website www.healthcarecommission.org.uk (www.cqc.org.uk after 1 April 2009).

This report should be read alongside the individual reports for each trust and the report of the original review, *No voice, no choice*, published in 2007[1], which sets out the context for the follow-up work and provides detailed recommendations to improve services.

What is a follow-up review?

The Healthcare Commission aims to promote ongoing improvements in healthcare. We provide assurance to service users and the public that improvements are taking place by following up the reviews of services that we have carried out previously. Service reviews are detailed investigations of particular services or aspects of healthcare that include an assessment of the performance of each NHS trust and other NHS organisations involved. We ask NHS trusts that have participated in a service review to make use of their results and implement the published recommendations to improve their services where necessary.

Follow-up reviews specifically aim to:

- Monitor change in a local organisation's performance since the original review.
- Provide a national summary of progress as well as individual reports on the performance of trusts.
- Develop improvement action plans with selected trusts whose services have failed to improve or have deteriorated.

The results of the review also feed into the Healthcare Commission's assessment of risk of underperformance in trusts and provide information to the public on the performance of local services.

What were the findings of the original review?

In 2005/06, the Healthcare Commission and the Commission for Social Care Inspection (CSCI) conducted a joint review of adult specialist community mental health services. The review assessed the performance of key community services in local implementation team areas that contributed to mental health and social care for adults aged between 18 and 65. Local implementation teams (LITs) are made up of representatives of the local mental health community, including people who use services, their carers, providers of mental health services (for example local mental health trusts and social services) and commissioners of health and social care. LITs are responsible for planning, commissioning services, and ensuring that there is a plan to deliver community mental health that meets the needs of people who use services locally.

The review gathered information from mental health trusts, health and social care trusts, primary care trusts and councils with responsibility for social services. The information was then arranged in a framework and was awarded scores to assess the following three main themes:

1. Access to appropriate care and treatment (such as talking therapies).
2. Involving people who use services (in the planning and delivery of their care).
3. Focus on recovery and social inclusion.

The findings of the assessment showed that some services had responded to the introduction of the National Service Framework for Mental Health[2] by providing a good range and quality of services for those who need them. However, performance was very variable, leaving some people with little or no access to aspects of specialist care and treatment. The overall results for 174 LITs were as follows:

- 9% were scored as "excellent"
- 45% were scored as "good"
- 43% were scored as "fair"
- 3% were scored as "weak".

In each of the three themes, the key findings showed where improvements were most needed, and which applied to many services at a national level:

- Access to services was limited in certain areas. Less than half of the people who responded to the survey of community mental health services said they had the relevant out-of-hours phone number, and access to effective psychological treatments, such as cognitive behavioural therapy (CBT), was patchy.
- The care programme approach (CPA)* was not being implemented in a way that put people first, with the majority not reporting that they were routinely involved in decisions about their medication and care.
- Some areas of recovery and social inclusion needed more focus. Only 50% of those who needed help to find employment received it; very few services were fully ensuring that physical health reviews were being carried out and health needs taken seriously; the take-up of direct payments** was low, with take-up by people using mental health services lagging behind other groups.

As a result of the assessment, we visited 11 LIT communities with low overall scores to explore further the issues raised and to provide an incentive for improving services where it was needed.

* The care programme approach (CPA) introduced in 1991, is a collaborative approach to care based around the needs of people using mental health services and their carers. Its principles include assessing the service user's needs and developing a plan with them; sharing responsibility with service users and carers to put the plan into action; reviewing the plan with service users and others to see that it is meeting their needs and to agree any changes. The Department of Health published revised guidance on the application of CPA in March 2008: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083650

** Direct payments are cash payments made to people who have been assessed as needing services, in lieu of social care services. They aim to give more flexibility in how services are provided so that people have greater choice and control over their lives, and are able to make their own decisions about how their care is delivered.

In addition, we produced recommendations based on the key findings for all LITs and their constituent services, aimed at both providers and commissioners:

Access to care: improve timely access to safe and effective specialist community mental health services.

Involving people who use services: improve people's experiences of using community mental health services by involving them more directly in decisions about their care, treatment and management of their medicines.

Recovery and social inclusion: services must be designed in a way that improves recovery and social inclusion outcomes for the people who use them in areas such as physical health review, education, employment, housing and other community activities.

These recommendations were used as the basis for the follow-up review.

The full performance scores and national report for the original review, *No voice, no choice*, published in 2007, can be found on the Healthcare Commission's website: www.healthcarecommission.org.uk (www.cqc.org.uk after 1 April 2009).

Measuring the performance of specialist community mental health trusts

Selection of indicators for follow-up

The follow-up review is not a repeat of the original review, but is a more focused approach based on a small set of indicators selected from the framework of assessment used in the original review, which reflect the recommended areas for improvement. The results focus on the change that has taken place in each indicator. The follow-up review took place two years after the results of the original review were published, so that trusts had sufficient time to respond to the recommendations.

To select the indicators for the follow-up, we consulted with people involved in adult specialist community mental health services at a national and local level, to ensure that the indicators were still relevant. However, the recent re-configuration of LITs has meant that it was not practical to reproduce matching data sets for these organisations. The follow-up therefore focused on indicators reported at provider (NHS specialist community mental health trust) level, where there was much less re-configuration. This enables us to summarise the changes in performance relating to key aspects of care, but it does not cover commissioning of services directly.

Even though the indicators are reported at NHS trust level, the results of the follow-up review are useful to all specialist mental health trusts, commissioners and relevant organisations in a locality that are concerned with improving the experience and care of people who use services. The findings of this review should be used to inform the commissioning and planning of community mental health services across health and social care.

We selected 15 indicators to follow up. The indicators were organised under three themes to align with the key themes in the report of the original review *No voice, no choice*, (pages 19-26). These themes and indicators are:

Theme 1: Access to appropriate care and treatment

- Out-of-hours support: people who use services should have the telephone number of someone to call out of normal hours, to ensure round-the-clock support and help in a crisis.
- Evidence-based interventions: people should be provided with, or be offered access to, effective therapies relevant to their needs – all people with schizophrenia should have access to cognitive behavioural therapy (CBT).

Theme 2: Involving people who use services

- Delivering components of the care programme approach, such as care reviews and care plans and involvement in decision-making, that takes account of personal preferences.
- People should have a designated care coordinator to help ensure that suitable care is provided efficiently to support often complex needs.
- Involving people in decisions and management of their medicines: people using services should be involved in managing their own medicines, advised of the choices available to them, and be given information about possible side-effects.

Theme 3: Recovery and social inclusion

- Good physical health: whether it takes place in primary or secondary care, the monitoring and delivery of regular physical health checks is a key component of effective care.
- Assistance with employment: the employment, educational or vocational status of people should be assessed and active support provided where it is needed.

A full list of all the indicators is provided in the appendix.

Categories of performance

The method developed for the follow-up review aims to measure the improvement or deterioration in performance of a trust against each of the 15 indicators. The performance of a trust is compared against a fixed threshold based on the 2005/06 national average, for both the original and follow-up reviews, for each indicator. The fixed threshold is a way of measuring progress and change in performance and does not necessarily mean that scores above the threshold are acceptable in policy terms.

The scoring rules for the indicators from the original review used the confidence intervals of each indicator to provide three categories:

1 = low (significantly lower than the national average).

2 = average (similar to the national average).

3 = high (significantly higher than the national average).

We applied the same scoring rules to the follow-up data from 2007/08 against the 2005/06 national average that we used in both the follow-up and original reviews, and we used the same three categories. Further information about the assessment framework and scoring rules of the original review can be found on our website: www.healthcarecommission.org.uk (www.cqc.org.uk after 1 April 2009).

For each indicator in the follow-up review, a trust's performance was allocated to one of nine categories, which focus on its performance in the follow-up review against the national average for 2005/06 and the direction of change as defined in table 1.

Table 1: The nine categories of performance	
Performance categories: current performance and (direction of change)	**What the categories mean for trusts**
High (consistent)	Performance in the 2008/09 review has remained significantly higher than the national average for 2005/06.
High (markedly improved)	Performance in the 2008/09 review has improved from being significantly below average to being significantly higher than the national average for 2005/06.
High (improved)	Performance in the 2008/09 review has improved from being similar to the average, to being significantly higher than the national average for 2005/06.
Average (improved)	Performance in the 2008/09 review has improved from being significantly below average to being similar to the national average for 2005/06.
Average (consistent)	Performance in the 2008/09 review has remained similar to the national average for 2005/06.
Average (deteriorated)	Performance in the 2008/09 review has deteriorated from being significantly above the average to being similar to the national average for 2005/06.
Low (deteriorated)	Performance in the 2008/09 review has deteriorated from being similar to the average to being significantly lower than the national average for 2005/06.
Low (markedly deteriorated)	Performance in the 2008/09 review has deteriorated from being significantly above average to being significantly lower than the national average for 2005/06.
Low (consistent)	Performance in the 2008/09 review has remained significantly lower than the national average for 2005/06.

Data sources

The data used in this review was taken from two sources:

The Healthcare Commission's national survey of community mental health services, 2008* (10 indicators): For the original review, data was collected during 2005/06, covering the period between 1 September 2005 to 30 November 2006. Data for the follow-up was collected during 2007/08, covering the period between 1 September 2007 to 30 November 2008.

The Healthcare Commission's audit relating to NICE guidelines for schizophrenia 2002,** (5 indicators): For the original review, data was collected covering the period 1 April 2005 to 31 March 2006. Data for the follow-up review was collected covering the period 1 April 2007 to 31 March 2008.

For some indicators, there may be no information available for a trust, through no fault of the trust. This was the case for some of the indicators based on the 2008 survey of community mental health services. For example, the number of service users surveyed may be too small for a reliable assessment and, where appropriate, this is indicated.

Trust mergers

In the period between the original and the follow-up reviews, restructuring and re-organisation of NHS organisations has caused a number to either merge to become new organisations with new names, or to change their names. Since 2005/06, the number of NHS providers of adult specialist community mental health services has reduced from 82 to 68. Where necessary, we have mapped the data from 2005/06 for the follow-up review from the old to the new organisations.

For organisations that have merged, we have aggregated the data from the old organisations from which the new organisation was formed, so that the 2005/06 data can be compared with that for 2007/08.

* Indicator coverage: people aged 18 to 65 on standard and enhanced CPA (prior to the revised CPA guidance of March 2008) using specialist mental health trust services in the community (including combined mental health and social care trusts and those foundation trusts and primary care trusts that provide mental health services). Trusts were asked to send survey questionnaires to 850 randomly selected service users. The national response rate was 35% for the survey in 2008.

** Coverage of audit: people aged 18 to 64 on enhanced CPA using specialist mental health trust services in the community (including combined mental health and social care trusts and those foundation trusts and primary care trusts that provide mental health services), with a diagnosis of schizophrenia or suspected schizophrenia. Each trust was asked to return (anonymous) information on at least 100 randomly-selected service user records.

Summary of the national findings

We use two main tables to present the national findings for the 15 indicators. Table 2 shows the percentage of trusts in each of the nine categories described in the previous section and table 3 summarises the changes in trusts' performance (improvement or deterioration).

The codes used in the tables, such as AC1 and AC2, are included for easy reference between the tables and figures, and to identify indicators in the definitive list in the appendix.

It is reassuring that the results are generally positive and show improvement – markedly so in some cases. The overall findings across all 15 indicators in the follow-up review show an improvement for 11 indicators. Two indicators showed no significant change and two showed a net deterioration. We also found that 21% of trusts performed at or above the 2005/06 national average for all indicators in the 2007/08 follow-up, and a further 60% of trusts performed at or above these averages for 12 to 14 of the indicators. However, 19% of trusts performed below these averages in four or more indicators.

However, it is important to note that improvements for some indicators are measured against the relatively low baseline of the national averages for 2005/06, rather than being measured directly against specific set standards. Many indicators also still show room for considerable improvement. The 2005/06 national averages (national average for each indicator, see table 3) for the 15 indicators can be grouped as follows:

Less than 50% of trusts (2 indicators).

50% to 74% of trusts (11 indicators).

75% of trusts and above (2 indicators).

We expect that each trust should be working towards achieving the objectives of the indicators for all, or almost all, of their service users. Indeed, the NICE guidelines for schizophrenia specifically recommend that all of the five audit indicators should be achieved at the level of 100%.

Figure 1 on page 22 shows the distribution of the indicator scores across the trusts in each of the review years and, in most cases, this has either not changed much or has increased. The apparent narrowing of the range in the indicator CPH "mental health patients that had at least one physical health review in the last 12 months" from 9% to 98% in 2005/06 to 55% to 99% in 2007/08 is due to one low performing trust in 2005/06, that has now improved.

Table 2: Percentage of trusts in each of the nine performance categories

Indicator code	Brief description of indicator	Low (consistent)	Low (markedly deteriorated)	Low (deteriorated)	Average (deteriorated)	Average (consistent)	Average (improved)	High (improved)	High (markedly improved)	High (consistent)
AC1	Access to out-of-hours support	14	0	3	5	17	18	8	8	29
AC2	Access to evidence-based intervention	13	3	18	6	31	6	15	1	7
PC1	Received a copy of care plan	9	2	2	14	8	21	14	6	26
PC2	Involved in decision on content of their care plan	8	0	8	8	45	11	15	0	6
PC3	Diagnosis was discussed	2	0	2	2	73	5	15	0	3
PC4	Care plan contains advanced directive	10	7	12	10	29	9	12	0	10
PC5	Reference to agreed choice of antipsychotic drug	3	3	10	4	46	10	15	1	7
PC6	Enough say in their care and treatment	3	0	3	2	64	8	15	2	5

Table 2 (continued): Percentage of trusts in each of the nine performance categories										
Indicator code	**Brief description of indicator**	**Low (consistent)**	**Low (markedly deteriorated)**	**Low (deteriorated)**	**Average (deteriorated)**	**Average (consistent)**	**Average (improved)**	**High (improved)**	**High (markedly improved)**	**High (consistent)**
PC7	Had a care review in the last 12 months	5	2	5	9	29	20	14	2	17
CC1	Know who their care coordinator is	17	0	3	12	21	5	14	6	23
MM1	Had a say in decisions about their medication	3	0	5	3	62	9	15	0	3
MM2	Told about the possible side-effects of medication	0	0	3	3	74	6	11	2	2
CPH	Physical health review	3	1	10	6	54	3	13	1	7
AE1	Received an assessment of their occupational status	1	0	0	4	18	12	35	12	18
AE2	Received help with finding work	0	0	9	0	81	4	6	0	0

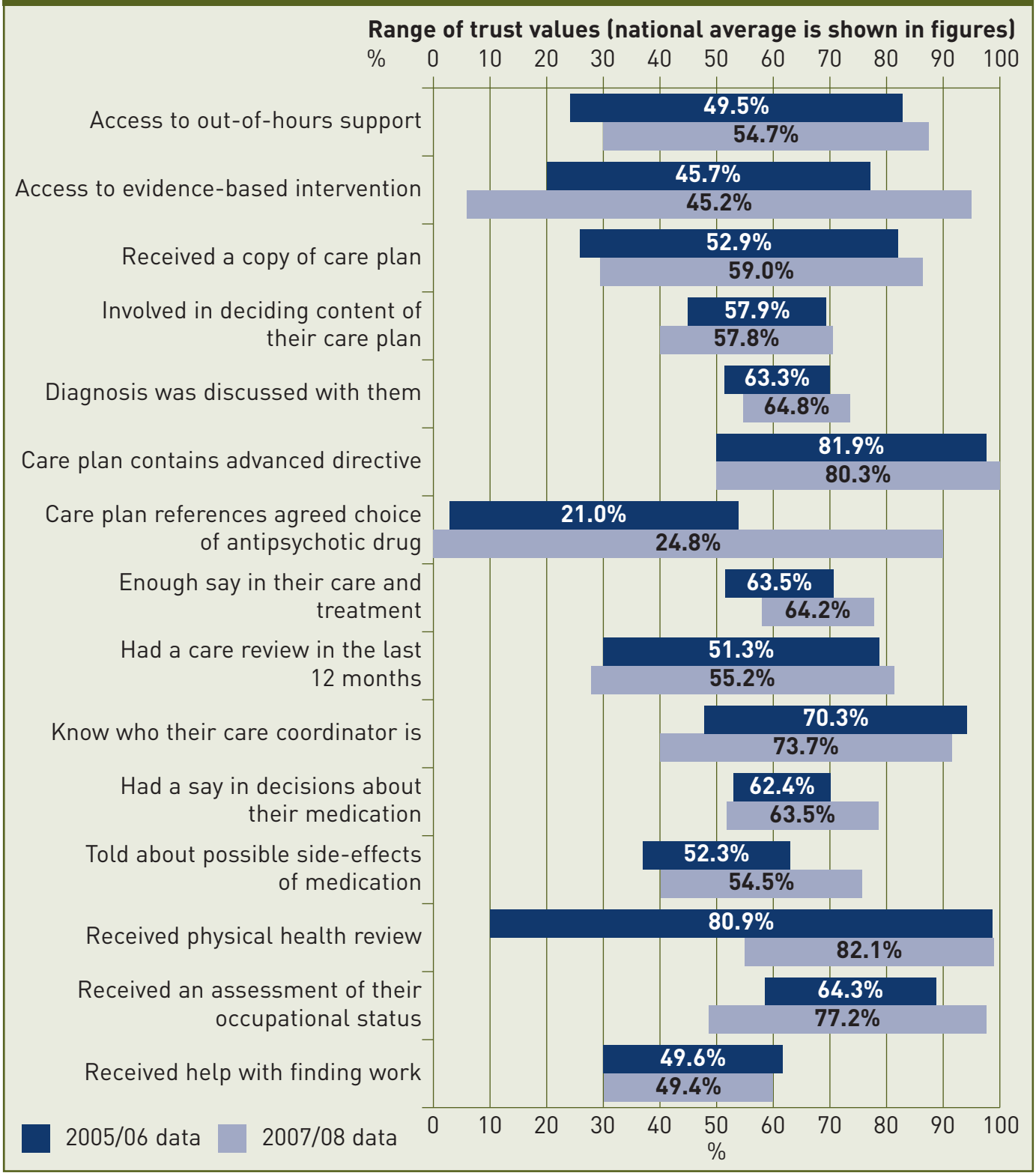
Note: Percentages are rounded to the nearest whole number therefore the total for each row may not add up to 100%. See page 15 for explanation of performance categories.

Table 3: Change in performance from the 2005/06 national average (threshold)

Indicator code	Brief description of indicator	2005/06 national average threshold (%)	Deteriorated and markedly deteriorated (%)	Improved and markedly improved (%)	Net change (%)
AC1	Access to out-of-hours support	50	8	33	26
AC2	Access to evidence-based intervention	46	26	22	-4
PC1	Received a copy of care plan	53	17	41	24
PC2	Involved in deciding content of their care plan	58	15	26	11
PC3	Diagnosis was discussed	63	3	20	17
PC4	Care plan contains advanced directive	82	29	21	-9
PC5	Reference to agreed choice of antipsychotic drug	21	18	26	9
PC6	Enough say in their care and treatment	64	5	24	20

Table 3 (continued): Change in performance from the 2005/06 national average (threshold)					
Indicator code	**Brief description of indicator**	**2005/06 national average threshold (%)**	**Deteriorated and markedly deteriorated (%)**	**Improved and markedly improved (%)**	**Net change (%)**
PC7	Had a care review in the last 12 months	51	15	35	20
CC1	Know who their care coordinator is	70	15	24	9
MM1	Had a say in decisions about their medication	62	8	24	17
MM2	Told about the possible side-effects of medication	52	6	18	12
CPH	Physical health review	81	18	18	0
AE1	Received an assessment of their occupational status	64	4	59	54
AE2	Received help with finding work	50	9	9	0
Note: Percentages are rounded to the nearest whole number					

Figure 1: Range of trust values 2005/06 and 2007/08



Findings for the 15 follow-up indicators are discussed below grouped into their respective themes (see appendix for related indicators for the three themes).

Theme 1: Access to appropriate care and treatment

For people with mental health problems, timely access to effective support and treatment is vital to their recovery and to their inclusion in society. In the original review, we found that despite the increased availability of services, many people with mental health problems did not have information on how to access local support out of normal hours, and that greater access to psychological therapies was needed in line with guideline recommendations[3].

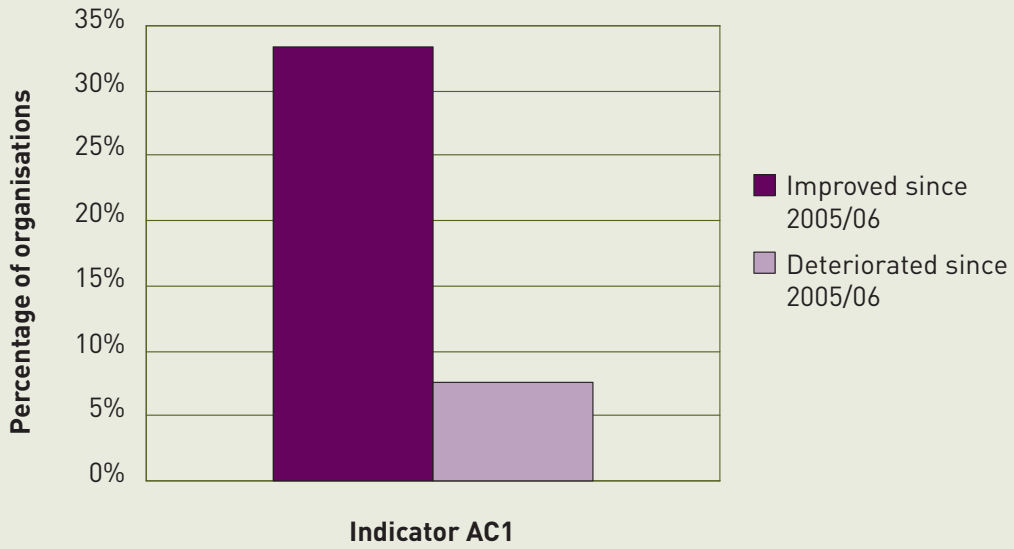
We followed up two distinct key areas within this theme: access to out-of-hours support, and access to evidence-based intervention.

Access to out-of-hours support

One of the priorities of the National Service Framework for Mental Health (1999) was that all people, particularly those with complex care needs, should be able to contact services and obtain support for 24 hours a day. The original review found that although three-quarters of LITs reported that their specialist mental health services were accessible to people at all times, only 50% of service users in the Healthcare Commission's national survey of community mental health services of 2005/06 reported that they had the telephone number of somebody to contact out of normal hours.

The percentage of people in the 2007/08 national survey of community mental health services who "have the number of someone from local NHS mental health services that they can phone out of office hours" (indicator AC1) shows that 33% of trusts had improved when measured against the national average of 2005/06, and only 8% of trusts had deteriorated (see figure 2). The result of these

Figure 2: Access to out-of-hours support



changes is a net improvement in performance of 26%.

It is important to note that nationally, 17% of trusts are still significantly below the national average for 2005/06 of 50% (table 2). There is clearly an urgent need for them to improve so that many more service users can be made aware of how they can contact out-of-hours support when it is needed.

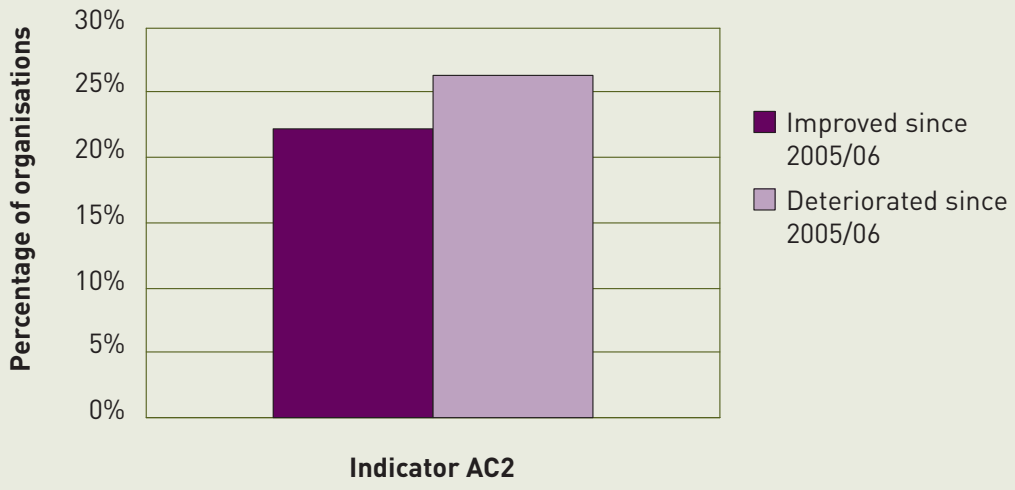
Access to evidence-based intervention

There is good evidence to show the effectiveness of psychological therapies in treating a range of mental health problems, including problems that can be more severe and enduring. For instance, NICE recommends that 100% of people with schizophrenia who experience persisting psychotic symptoms should be offered cognitive behavioural therapy (CBT)*. However, in our original review, only 46% of the sample of service users diagnosed with schizophrenia had been offered or had received at least one session of CBT in the previous year.

For the follow-up review, we revisited the indicator AC2 "percentage of service users (diagnosed with schizophrenia) who have received at least one session of cognitive behavioural therapy in the last 12 months". We found that although 22% of trusts had improved, 26% of trusts had deteriorated, resulting in an overall net deterioration of 4% (see figure 3). Overall, 34% of trusts are still significantly lower than the 2005/06 national average of 46%, having made no improvement against this indicator.

Despite greater emphasis on improving access to CBT in recent years, results from this review suggest that concerns remain in the capacity of the mental healthcare system to deliver psychological therapies to the large number of people with psychosis who would benefit from them.

Figure 3: Access to evidence-based intervention



* These recommendations are expected to remain in place in the reviewed NICE guidelines for schizophrenia, which are due to be published in March 2009.

Theme 2: Involving people who use services

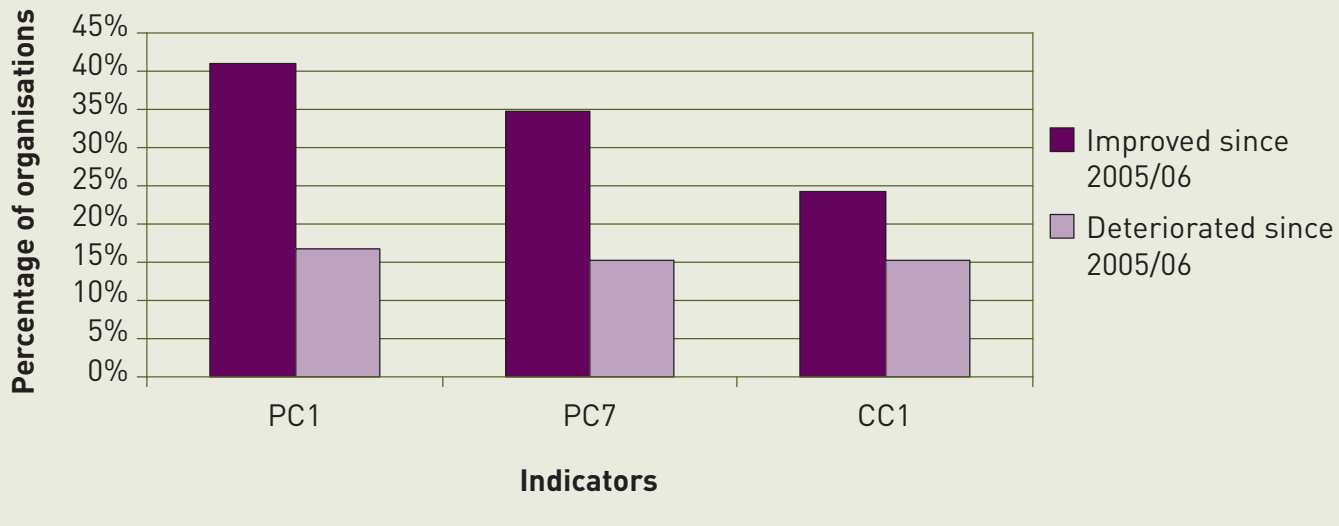
Since 1990, the care programme approach (CPA) has been the framework for assessing and planning care for adults with mental health problems who are in contact with specialist mental health services. Our original review identified problems with the implementation of certain aspects of the CPA, including whether service users knew who their care coordinator was, if they had received written copies of their care plan and whether a review of their care had been carried out within the previous year. It also highlighted concerns that many people were not fully involved in decisions about their own care, a key principle of the CPA.

For people with a diagnosis of schizophrenia, the NICE guidelines* recommend that care plans for all individuals with schizophrenia should contain an advance directive that outlines their choices of treatment if they were to have an acute episode that might require rapid tranquillisation. In the original review, a sample of the care plans of people with schizophrenia found that 82% contained either an advance directive or a contingency plan, but there was wide variation in results between trusts, and only 21% of the care plans containing this information actually made reference to the person's preferred choice of treatment.

We followed up this theme of involving service users with 10 indicators that are sub-divided into the following four groups:

Involvement in the CPA process
Three indicators are included here. We found substantial improvements in all these areas against the national average for 2005/06. This ranged from 24% to 41% of trusts improving performance across these indicators (see figure 4):

Figure 4: Involvement in the CPA process



* These recommendations are expected to remain in place in the reviewed NICE guidelines for schizophrenia, which are due to be published in March 2009.

- "Received a copy of their care plan" (indicator PC1): 41% of trusts had improved and 17% of trusts had deteriorated, giving a net improvement of 24%. Overall, 12% of trusts remained significantly below the national average for 2005/06 of 53%.
- "Have had a care review in the last 12 months" (indicator PC7): 35% of trusts had improved and 15% of trusts had deteriorated, giving a net improvement of 20%. Overall, 11% of trusts remained below the national average for 2005/06 of 51%.
- "Know who their care co-ordinator is" (indicator CC1): 24% of trusts had improved and 15% of trusts had deteriorated, giving a net improvement of 9%. However, it is important to note that overall, 20% of trusts remained below the national average for 2005/06 of 70%.

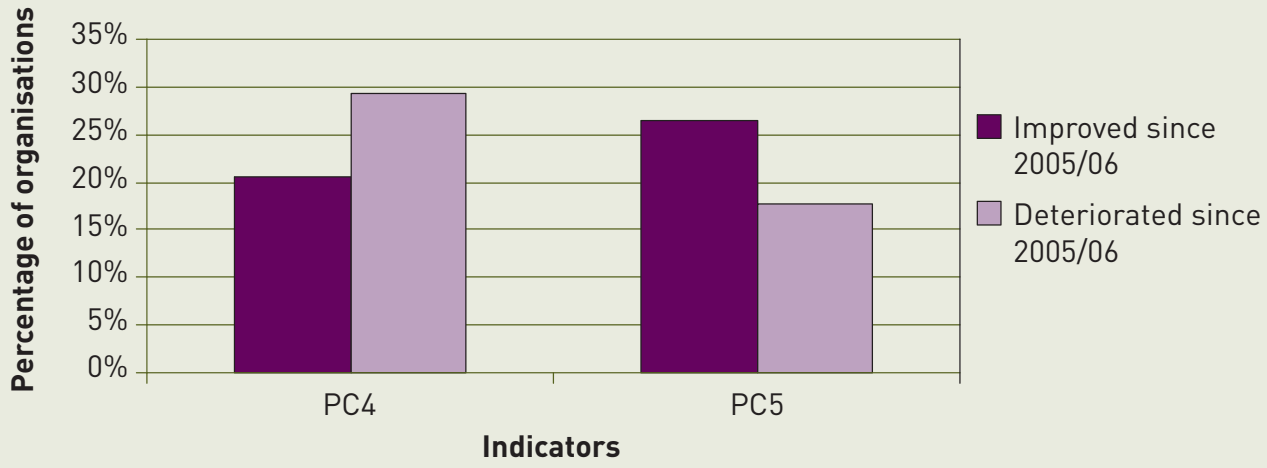
These results suggest that there has been a steady improvement nationally on the indicators that relate to involving service users in the CPA process. However, there are marked variations between trusts and the national averages against which they are compared are relatively low, suggesting that some trusts have been far more successful than others in ensuring that the infrastructure for the CPA is embedded within routine practice.

Care planning with advance directive or crisis and contingency plan

The NICE guidelines recommend that care plans for all people with a diagnosis of schizophrenia should contain an advance directive that outlines their treatment choices if they have an acute episode which might require rapid tranquillisation. We asked how many of the sampled care records of people who use the services contained an "advanced directive or crisis and contingency plan" (indicator PC4) and of those, how many "contained a reference to the agreed choice of anti-psychotic medication in case of acute illness" (indicator PC5).

For care records that contained an advance directive or crisis and contingency plan, the results show that while 21% of organisations had improved, 29% of organisations had deteriorated from their previous performance in 2005/06, giving a net deterioration of 9% (see figure 5).

Figure 5: Care planning with advance directive or crisis and contingency plan



However, it should be noted that the national average remains high, with currently 80% of the audited records of people with schizophrenia having an advance directive or crisis and contingency plan in place.

Of the advanced directives that contained a reference to the agreed choice of anti-psychotic medication in case of acute illness, 26% of trusts had improved and 18% of trusts had deteriorated, giving a net improvement of 9% (see figure 5). However, there were still 16% of trusts performing significantly below the national average for 2005/06, which in any case was only 21% of audited records that contained this information.

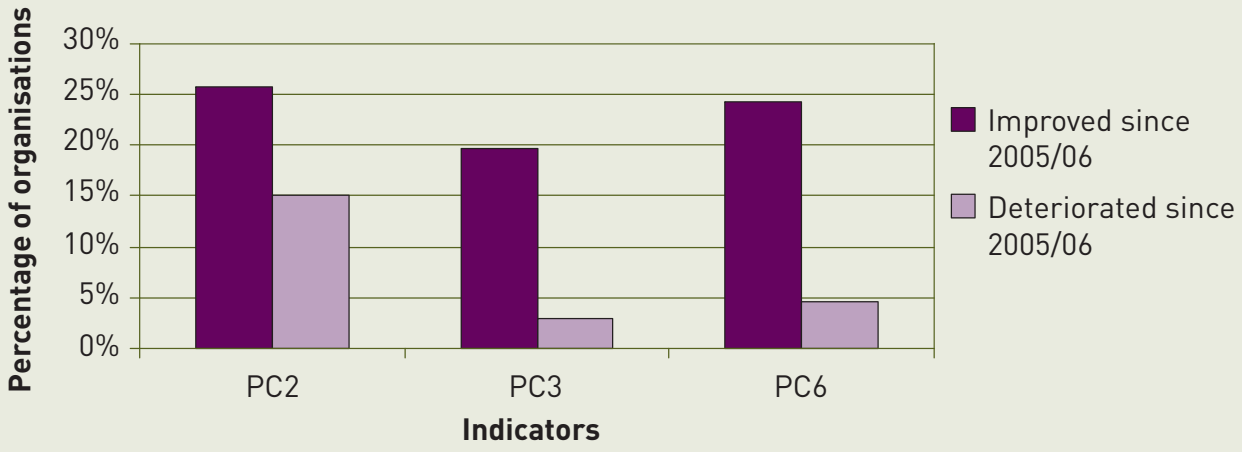
The overall results of these two indicators raise questions about how fully service users are being engaged in this process, and the extent to which they are given opportunities to record their preferences for treatment.

Involving people in decisions about their care and treatment

We included three indicators covering key issues to assess the extent to which community mental health services take account of service users' views and involve them in decisions about their care and treatment. Figure 6 shows that there were some improvements, ranging from 20% to 26% of trusts in all these areas against the national averages for 2005/06. Performance for each indicator was as follows:

- "Involvement in deciding what is in their care plan" (indicator PC2): 26% of trusts had improved and 15% of trusts had deteriorated, giving a net improvement of 11%. Overall, 15% of trusts remained significantly below the national average for 2005/06 of 58%.
- "Diagnosis was discussed with them" (indicator PC3): 20% of trusts had improved and only 3% of trusts had deteriorated, giving a net improvement of 17%. Overall, only 3% of trusts remained significantly below the national average for 2005/06 of 63%.

Figure 6: Involving people in decisions about their care and treatment



- "Have enough say in their care and treatment" (indicator PC6): 24% of trusts had improved and only 5% of trusts had deteriorated, giving a net improvement of 20%. Overall, only 6% of trusts remained below the national average for 2005/06 of 64%.

The overall results raise questions about how fully service users are being engaged in this process, and the extent to which they are given opportunities to record their preferences for treatment.

Involving people in decisions and management of their medicines

The vast majority of people who use mental health services take medication for their condition. National policy emphasises that the choice of medication should be made by the individual and their clinician together, based on an informed discussion of the pros and cons of drugs, including possible side-effects, and that this discussion and the outcome of treatment should be recorded.

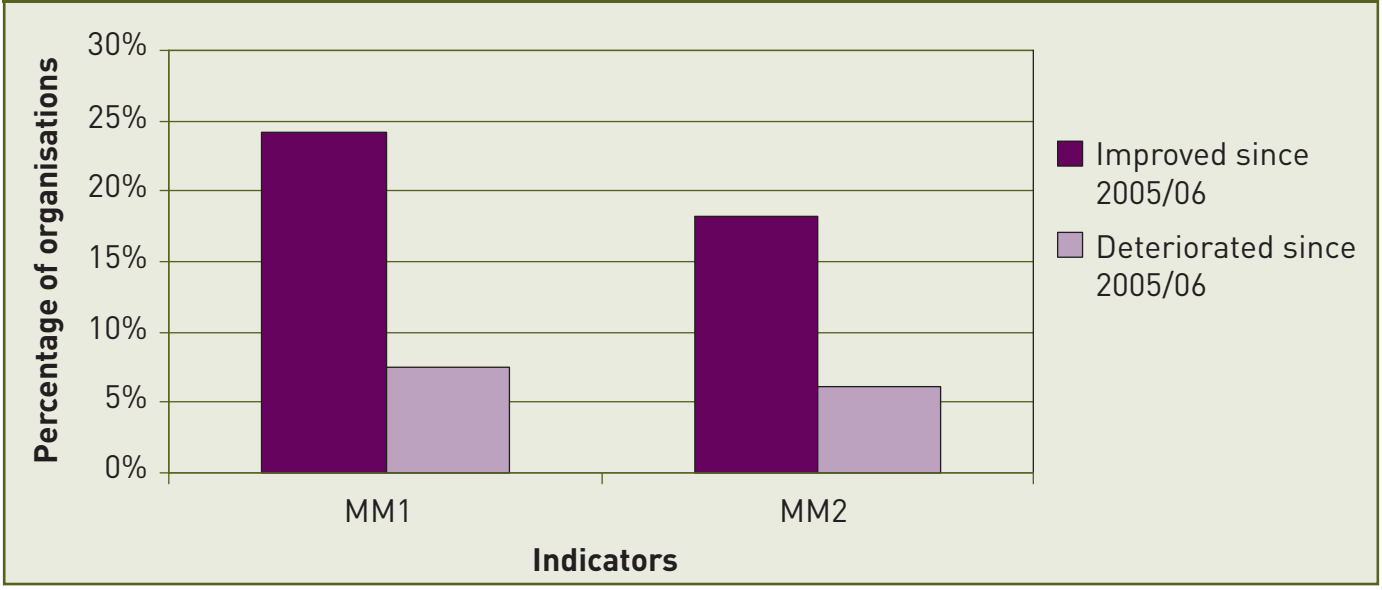
We used two indicators here:

- "Service users had a say in decisions about their medicine" (indicator MM1): the results were positive, with 24% of trusts showing improvement and only 8% of trusts remaining below the national average for 2005/06 of 62%.

- "Service users were told about possible side-effects of medication" (indicator MM2): again the results are positive, with 18% of trusts showing improvement and only 3% of trusts remaining below the national average for 2005/06 of 52%.

Figure 7 shows the performance for these two indicators.

Figure 7: Involving people in decisions and management of their medicines



Theme 3: Focus on recovery and social inclusion

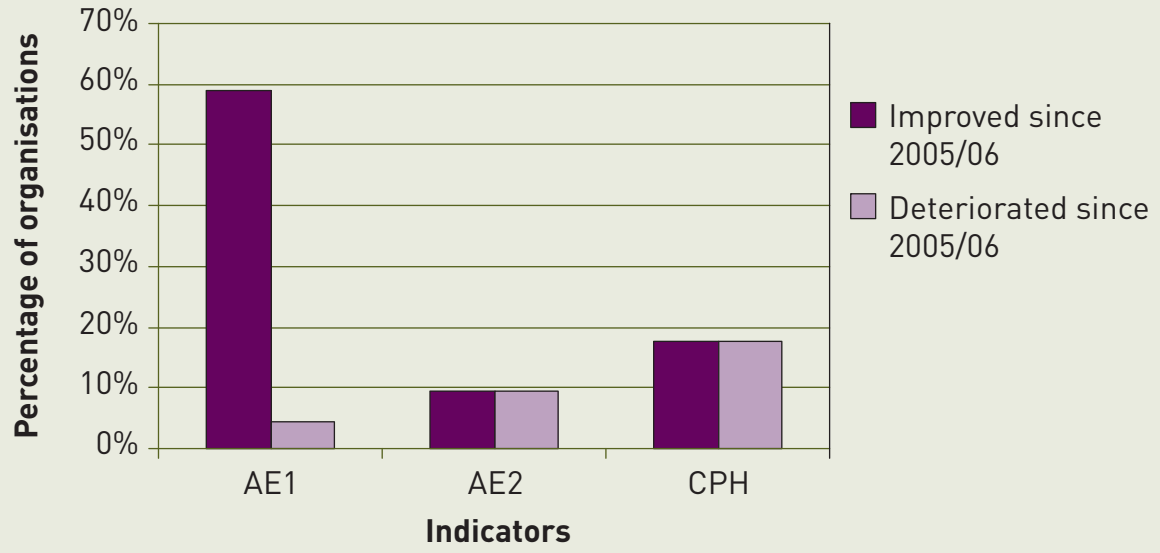
Compared with the rest of the population, people with mental health problems are at much higher risk of developing major physical health problems including obesity, smoking-related diseases, heart disease, high blood pressure, respiratory disease, diabetes and strokes[4]. In view of the extremely low employment rate among people with mental health problems, there has been growing attention nationally on supporting them to get or keep a job, especially those with more severe and enduring mental health problems. We followed up these two important areas:

Physical health checks

A physical health check is an important way to make an early identification of any major physical health problems for service users. Primary care providers have a responsibility to carry out a physical health check on an annual basis of anyone who is identified as having a severe and enduring mental health problem. For people with schizophrenia, the NICE guidelines recommend that they are offered a physical health screen at regular intervals within primary care or, for those that refuse this, that they can receive this check from secondary services*. Although our original review identified that 81% of service users with schizophrenia had had a physical health review in the previous year, it highlighted poor recording, in CPA care records, as to whether physical health checks had been carried out (indicator CPH).

When we followed this up, we found that although the national average of 81% was maintained (now 82%), there has been no clear overall improvement at trust level. Results showed that while 18% of trusts improved, an identical number of trusts (18%) showed a deterioration (see figure 8). In addition, 15% of trusts were significantly

Figure 8: Focus on recovery and social inclusion



* These recommendations are expected to remain in place in the reviewed NICE guidelines for schizophrenia, which are due to be published in March 2009.

below the 81% national average for 2005/06, suggesting that there are still a significant number of people who are not receiving physical health checks or that this information is not recorded by secondary services.

Secondary services need to play an active role in monitoring and helping people get access to physical healthcare and, where necessary, ensuring that physical health checks are carried out as recommended by the NICE guidelines for schizophrenia. Primary care services and commissioners of services should ensure that they carry out their responsibility to provide regular checks, and that they report the outcomes to relevant local specialist mental health teams, to help to monitor and encourage service users to attend them.

Assistance with employment

People with mental health problems have the lowest employment rate of all the main groups of people with limiting health problems and disabilities, and there is a wide gap between the work rate of people with mental health problems and that of the general population[5]. Health and social care services play a critical role in enabling people in contact with specialist mental health services to return to work, to get to work, and to retain work[6]. The NICE guidelines (2002) recommend that all people with schizophrenia should have a comprehensive assessment of their occupational status and vocational aspirations.

We reviewed and followed up two areas of assistance with employment. In the original review, 64% of care records for the sample of service users with schizophrenia recorded that this assessment had been carried out or offered (indicator AE1). In the follow-up review, we found that a significant 59% of trusts had improved in this area. The original review also identified that people in contact with mental health services were not getting enough help to find work (indicator AE2). Only half of the people surveyed in our 2007/08 patient survey who wanted this help reported getting it (the national average), and there were no examples of high performance in this area. In the follow-up, we found that while only 9% of trusts had improved, 9% of trusts were below the national average of 50% (see figure 8).

Overall, the results suggest that although there is a significant improvement in assessments of occupational status (at least for people with a diagnosis of schizophrenia), there was very little improvement in the area of getting help with finding work. This raises into question the effectiveness of the support to help service users back into the workplace once their needs have been identified.

Conclusions and recommendations

It is encouraging that, overall, the results are very positive and show that notable improvements have been made since the original review in 2005/06. However, it is important to note that the improvements for some indicators are measured against the relatively low base of the national averages for 2005/06, rather than being measured against specific set standards.

While change has generally been positive around implementing the national service framework, the pace of this change remains variable. In some areas, progress towards delivering key outcomes for service users around choice, personalised care and social inclusion has been relatively slow and incremental.

The main areas of continuing concern are:

- The need for effective support for service users to get back to work.
- Better access to out-of-hours services for all service users.
- Provision of cognitive behavioural therapy for all service users who require it.
- The need to ensure that care plans have advance directives and contingency plans, and that they refer to the agreed choice of anti-psychotic medication in case of acute illness.
- The need for physical health reviews to be routinely and systematically carried out for all services users for whom they are appropriate.

Recommendations

The follow-up review was carried out only at specialist community mental health provider level (trust level) rather than at the level of local implementation teams as in the original review. However, the findings provide useful information as a basis for planning and developing the future specialist community mental health services. Joint strategic needs assessment should be developed by PCTs and local authorities in consultation with the people who use the services.

We recommend that all specialist community mental health trusts should reflect on their performance in this follow-up review and identify those indicators where their performance has deteriorated against their levels in 2005/2006, and on those indicators where their performance has remained low or shows potential for greater improvement. This follow-up review should be used as a basis for trusts, in collaboration with partner organisations and commissioners, to develop action plans to meet local needs and to support further improvements in meeting the outcomes for those people who use adult specialist community mental health services.

We also recognise that with the advent of the Department of Health's New Horizons strategy to replace the National Service Framework for Mental Health, which expires in 2009, the role of local implementation teams may change. However, while they still exist, we urge them to continue to steer the direction of specialist community mental health services and to inform the focus of any successor forum to take on similar responsibilities.

Based on the findings of the follow-up review, we recommend that priority is given to the following areas:

Commissioners of health and social care should:

- Jointly profile and review the employment status and need for support of all people in contact with specialist mental health services. They should also assess whether current commissioning and provision of vocational advice and support services are sufficient to meet identified need, including a review of whether the underpinning partnership agreements and arrangements are robust and effective and that services are providing interventions based on the evidence of what works.[8,9]
- Monitor the experience of service users in accessing out-of-hours support to inform commissioning decisions about whether the level of provision and the routes to get support are sufficient to meet local need and are well known to the people that may need them.
- Consider the above findings and ensure that they are addressed within their standard contract agreements with providers. We recommend that the review's questions and indicators from the review could be used to inform local contracts, supported by robust local review mechanisms, so that they are able to directly address services that are not being delivered to desired outcomes, as demonstrated in the review, and to ensure that they shape and influence the market to provide what is needed to support people with mental health needs.
- Ensure that primary care services carry out their responsibility to undertake physical health checks under the Quality and Outcomes Framework (QOF) payment system[10] and the recommendations of the NICE guidelines for schizophrenia, and ensure that the outcomes of these physical health checks are reported to relevant local specialist mental health teams to support monitoring and encourage service users to attend them.

Providers and commissioners of specialist mental health services and their partner organisations should:

- Use the benchmarking information available from this review to identify problem areas and improve services.
- Use the CPA self assessment tool (www.cpaselfassessment.org.uk) to provide a measure of assurance around implementing the new CPA.
- Agree local monitoring arrangements around the implementation of the refocused CPA to ensure that evidence-based assessment and care planning including CPA are further embedded within routine practice. This should not only include attention to the infrastructure that underpins the CPA process, but should include monitoring and acting on the experience of the CPA from the perspective of service users and their carers, especially in relation to their involvement throughout the process.

- On an ongoing basis, review the range and provision of psychological therapies to people in contact with primary care and specialist mental health services, to ensure that there is sufficient capacity and skills within the workforce to meet identified need.
- Sustain and further improve the assessment of the physical health needs of service users, ensuring that the contractual responsibility for the conduct of assessments and checks is made clear, and that the frequency and content of checks are recorded in care records.

CPA care coordinators and frontline support staff should:

- Work purposely to improve the experience of service users and their carers in their involvement in the CPA process, to promote choice and personalisation of care.

Appendix: Summary of the 15 indicators

Theme	Indicator code	Data source	Description of indicator (for % of service users sampled)
Access to appropriate care and treatment	AC1	2008 survey of community mental health services	Percentage of service users who have the telephone number of someone from local NHS mental health services that they can contact out of normal office hours.
	AC2	Audit of NICE guidelines for schizophrenia	Percentage of service users who have received at least one session of cognitive behavioural therapy in the last 12 months, who were offered cognitive behavioural therapy in the same period or for whom cognitive behavioural therapy was not applicable.
Involving people who use services	PC1	2008 survey of community mental health services	Percentage of service users who have been given or offered a written copy of their care plan.
	PC2	2008 survey of community mental health services	Percentage of service users who were involved in deciding the content of their care plan.
	PC3	2008 survey of community mental health services	Percentage of service users whose diagnosis was discussed with them.
	PC4	Audit of NICE guidelines for schizophrenia	Percentage of service users sampled whose care plan contains an advance directive or crisis and contingency plan.
	PC5	Audit of NICE guidelines for schizophrenia	Percentage of service users whose care plan contains an advance directive or crisis and contingency plan that refers to the agreed choice of antipsychotic in case of acute illness.
	PC6	2008 survey of community mental health services	Percentage of service users who had enough say in decisions about their care and treatment.

Theme	Indicator code	Data source	Description of indicator (for % of service users sampled)
Involving people who use services (continued)	PC7	2008 survey of community mental health services	Percentage of service users who had a care review in the last 12 months.
	CC1	2008 survey of community mental health services	Percentage of service users who have been told who their care coordinator is.
	MM1	2008 survey of community mental health services	Percentage of service users who had a say in decisions about their medication.
	MM2	2008 survey of community mental health services	Percentage of service users who were told about possible side-effects of medication.
Focus on recovery and social inclusion	CPH	Audit of NICE guidelines for schizophrenia	Percentage of service users who have had a physical health review in line with recommended good practice in the last 12 months, or for whom this was not applicable.
	AE1	Audit of NICE guidelines for schizophrenia	Percentage of service users who received an assessment of their occupational/vocational status in the last 12 months, or for whom this was not applicable.
	AE2	2008 survey of community mental health services	Percentage of service users who have received help with finding work in the last 12 months that wanted it.

Method based on scoring rules from the 2005/06 review:

1. 2008 survey of community mental health services – relative measure, constructed using confidence intervals around a weighted mean standardised for age and sex.
2. Audit of NICE guidelines for schizophrenia – relative measure, constructed using confidence intervals around the proportion of service users sampled.

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