Clinical governance review

Leeds Mental Health Teaching NHS Trust

AUGUST 2003

Introduction

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Leeds Mental Health Teaching NHS Trust (the trust) provides mental health services to around 740,000 people across the Leeds metropolitan area. The trust provides a wide range of mental health services including inpatient, outpatient and day services; specialist mental health services; clinical psychology, psychotherapy and counselling. The trust also provides learning disability services. The trust provides its services from seven major sites with a total of 708 beds. There are 17 adult mental health community teams, eight older adult community mental health teams and a number of additional specialist community services. In all, the trust's 2,189 staff operate across 78 sites.

In February 2000, the trust signed a major contract to build and provide a new mental health service for Leeds. The £47 million public private partnership is currently the biggest of its kind for modernising mental health services.

This report by the Commission for Health Improvement (CHI) gives an independent assessment of how well the trust ensures high standards of care and what it is doing to continuously improve the quality of services.

For this report, CHI looked at clinical governance in the trust and spoke to staff who cared for patients in adult, older people and addiction services. Other services provided by the trust, including learning disabilities and forensic services, were not included in this review. CHI also reviewed how the trust responds to the diverse population it serves as part of its clinical governance arrangements. The review is part of a rolling programme of reviews of clinical governance in every NHS organisation in England and Wales.

Clinical governance is the system of steps and procedures adopted by the NHS to ensure that patients receive the highest possible quality of care, ensuring high standards, safety and improvement in patient services.

What is the purpose of the review?

CHI's clinical governance reviews set out to answer three questions:

1. What is it like to be a service user here?
2. How good are the trust's systems for safeguarding and improving the quality of care?
3. What is the capacity in the organisation for improving the service user's experience?

What is covered by a CHI review?

CHI's review assesses seven areas of clinical governance. The areas are:

1. patient, service user, carer and public involvement
2. risk management
3. clinical audit
4. staffing and management
5. education and training
6. clinical effectiveness
7. use of information

CHI's review also describes two further areas:

1. the service user experience
2. the trust's strategic capacity for developing and implementing clinical governance

An explanation of CHI's assessments

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

i Little or no progress at strategic and planning levels or at operational level.

ii a) Worthwhile progress and development at strategic and planning level but not at operational level, OR

b) Worthwhile progress and development at operational level but not at strategic and planning level, OR

c) Worthwhile progress and development at strategic and planning and at operational level, but not across the whole organisation.

iii Good strategic grasp and substantial implementation. Alignment of activity and development across the strategic and planning levels and operational level of the trust.

iv Excellence – coordinated activity and development across the organisation and with partner organisations in the local health economy that is demonstrably leading to improvement. Clarity about the next stage of clinical governance development.

What are CHI's conclusions about Leeds Mental Health Teaching NHS Trust?

What was the overall impression of the trust?

The trust is taking positive steps towards introducing clinical governance. It used the CHI clinical governance review process to embed clinical governance in the organisation. The trust began to shift the culture of the organisation following an external review of the trust's mental health services in 1999 by the Department of Health. This external review arose as the result of a series of untoward incidents which received adverse publicity in the local press.

CHI is impressed by the strong commitment of staff to delivering care in a busy, multicultural environment. CHI found that staff are keen to serve the needs of the diverse population that the trust serves. However, most black and ethnic minority service users who spoke to CHI found that services were not culturally sensitive.

There are some good systems in place to ensure that the needs of service users are considered. They now need to flow through into improved performance in some key areas of service user and carer experience. While the trust has structures in place for clinical governance, the links between the different clinical governance components need strengthening.

The trust needs to engage more effectively with all its partners by involving them and agreeing with them a model of care built upon the existing partnership work done so far. Planned developments need to be recorded in a cohesive framework which includes vision and purpose for the organisation.

The trust needs to focus on ensuring that the care programme approach is consistently implemented across the trust and that performance in relation to admissions, emergency readmissions, waiting times, and service user experience on acute inpatient wards improves.

What are CHI's conclusions based on its review of Leeds Mental Health Teaching NHS Trust?

The trust has worked hard to address the issues raised in the 1999 external review and has managed a significant level of strategic and organisational change successfully. Many of the strategies and systems to support clinical governance are still very new.

The trust engages service users and carers and is working to support them from various communities. The trust needs to continue to develop this work to enable all service users and carers to fully participate in the clinical governance structures.

The trust needs to improve communication and consultation within the organisation and with its partners, especially with the voluntary sector. Through this process, it needs to engage and support staff at all levels.

What areas of notable practice were identified?

The trust has robust structures and the necessary financial commitment for facilitating patient and public involvement.

The trust has a comprehensive performance reporting system which includes trends in quality indicators and national service framework requirements.

The human resources department has fostered good relationships with both staff and trade unions.

The trust received a communications award for its annual report.

The parent and child unit has won national recognition for the work it has done in being client centred.

The trust has made good investment in developing and supporting black and ethnic minority managers as part of a positive action programme.

What, if anything, did CHI find that the rest of the NHS can learn from?

Each clinical area has a storyboard on display that outlines who manages the service and gives a description of the services provided by that team or area. Also on display is the service philosophy and plans for the future. Carers and staff welcome these storyboards as a useful way to understand the service structure.

A public involvement department coordinates all service user and carer developments and activities.

There is excellent multidisciplinary team care with a good model of service delivery for early onset dementia service users.

The trust has introduced a personal responsibility framework which is an innovative approach for dealing with performance issues.

The trust's public and private finance scheme won a national award.

What are the key areas of action that the trust needs to address to improve its clinical governance systems?

CHI expects the trust to review all aspects of this report. Here we highlight areas where action is particularly important or urgent.

- Building on existing relationships, the trust should make sure its partners in social services, primary care, voluntary services, other agencies and senior clinical staff are involved in developing and agreeing models of care.
- The trust should work with its statutory and voluntary partners to develop a clear service strategy and vision for the trust. This should be communicated effectively to all staff.
- The trust needs to ensure that senior medical staff and other senior healthcare staff are effectively working with the executive team to improve the patient experience.
- The trust needs to continue to develop trust wide systems and processes that link all clinical governance components in order to improve patient outcomes and the patient experience.
- The trust needs to develop a systematic organisational development programme to support change and embed clinical governance.
- The trust should ensure that the care programme approach is systematically implemented across the trust.
- The trust needs to give priority to developing its information systems and ensuring that its information strategy is developed in partnership with its partners and incorporates their needs.
- The trust needs to strengthen and develop existing methods of communication to ensure engagement with a wider internal and external audience and audit the results.

What is it like to be a service user in Leeds Mental Health Teaching NHS Trust?

In this section we report what we observed and what service users said about their experiences, through surveys or directly to CHI. We also look at what the trust's figures can tell service users about access to services, how they are involved in their own care and the outcomes of their care.

Many things can impact on a service user's experience of their local NHS service. These may include the outcome of their treatment, whether they and their relatives or carers were treated with respect, the information they were given about their care and the choices they had in the care they received.

Are service users treated with dignity and respect?

Throughout our visit, we saw staff treating service users with dignity and respect. The new modern buildings are welcomed and service users told CHI that they are a tremendous improvement over previous accommodation.

Service users welcomed the private rooms with ensuites available in some areas. Service users have keys to their own rooms and the observation windows are used sensitively. The electro convulsive therapy (ECT) suite is well arranged for privacy. There are a range of rooms available for visitors, who are not allowed in patient lounges to ensure privacy. There are separate sleeping areas for men and women, non smoking areas and, in some units, there is a separate sitting room for women.

Some service users told CHI that the level of noise on some wards was disturbing, particularly loud music played until 11 pm in the lounge area. Patients felt that complaints about this were inadequately dealt with.

The culture of care within the trust strives to be respectful. Some service users feel that staff perceive inpatients who are compliant, undemanding and fairly independent as good whilst service users who have complex needs, or are more demanding and/or more assertive about their rights, are treated by staff as a problem patients.

The facilities for service users taken to hospital under section 136 of the Mental Health Act are not funded. These service users are removed by police and transferred into the care of the trust. They are kept in police cells and carers feel this denies service users dignity and respect. The Mental Health Act code of practice states that as a general rule, it is preferable for a person thought to be suffering from a mental disorder to be detained in a hospital rather than a police station.

Can service users access the services they need?

The trust provides a range of services, which can be accessed through the community mental health teams. The trust does not have a crisis resolution service for service users experiencing a mental health episode. There is variability in the provision of out of hours services across the trust which includes intensive home treatment in some areas and day hospitals in others. The accident and emergency (A&E) department of the local acute trust is one of the routes used to access services out of hours. This has caused considerable problems both for service users and carers who experience long waits in A&E while beds are found. There are, however, no long waits for beds for older people.

Service users often experience a lack of continuity in medical care. Some service users that spoke to CHI had up to five consultants treating them for the same condition in the past year. Carers have highlighted the changeover of senior house officers and specialist registrars as an issue that can be distressing. The trust has acknowledged this problem and has plans to address it.

The transitional protocols for service users making the transition between adolescent and adult services (that is, between the ages of 16-18) are currently under review.

Many service users and carers told CHI that there is a lack of respite care for all service users and bookings sometimes have to be made six months in advance. Some service users told CHI that advocacy services are inadequate.

There are information leaflets at reception and most of these are in English. Service users and carers who don't speak English find it difficult to access necessary information. Information leaflets about services and various clinical conditions are not available in some areas.

Some service users, both inpatient and community based, felt they are not fully informed about services and treatment on offer, and have to seek out information themselves. The women's ward in the Becklin Centre has well organised, accessible information and resources for inpatients, an example of which other service areas could learn from.

Legal representatives acting on behalf of clients told CHI that access to medical and nursing records as part of the mental health review tribunal proceedings takes a long time. In a number of instances, the deadline for receiving independent reports was missed because the trust had not released the necessary information. This can result in the service user being unnecessarily detained.

On wards, most areas have phones that can be wheeled around. There are some payphones but these are not always in working order.

Each clinical area has a storyboard on display that gives a description of the services provided by that team or area, the service highlights, the individual who manages the service, the service philosophy and the plans for the future.

How good are the standards of cleanliness, food and facilities?

The new wards are very clean. There are open plan receptions and paintings on the walls which make the wards welcoming.

The toilets and bathrooms are clean. There is ample and varied space for visitors and facilities for children in some units. In some areas, the lounge is small and there is not enough room for chairs for the number of service users in that area.

Inpatient areas have a facility for service users to make hot drinks as well as access to drinking water. Some service users found the dining areas small. Food at one of the trust's sites, The Mount, was considered to be of sub standard quality by service users while at the Becklin Centre, food was described as good with plenty of choice. However, it should be noted that food is produced by the same supplier. Service users told CHI that information on catering for special needs for ethnic minority service users was not always available and in many instances, the same ethnic food was offered over a long period.

The trust provides facilities for pastoral care for both staff and service users with the multifaith room accessible all the time. There is also a gym and a computer training room. However, there is a lack of skilled instructors to enable service users to make use of these facilities.

What do the figures show about outcomes at the trust?

The April 1998 / March 2001 data shows that overall mental health readmissions are high. In the period April to September 2002, a total of 223 discharged service users were readmitted to hospital within 90 days of discharge. This represents 22.1% of the total discharges for that period, which was above the target of 12.3% set by the trust. The readmission figures are high because the trust has included planned readmissions in the figures where an admission is seen as part of the care programme approach and any contingency plans. The trust has audited these readmissions and is taking action to reduce these in future. The trust is looking at access to a crisis resolution service as part of this process.

The trust is not meeting the *NHS Plan* targets in the following areas: reducing to zero the number of people waiting over 21 weeks for a first outpatient appointment and the number of patients missing appointments. The number of follow up visits made within seven days of discharge for people on the enhanced care programme approach (CPA) are significantly lower than the national service framework (NSF) target. The level of compliance may be underreported. CPA is a national programme designed to ensure that people with mental health problems are systematically assessed and treated and are involved in developing their own care plans. Systems within the trust to collect this information have only been recently introduced and will require time to get embedded. The trust is implementing electronic systems to collate discharge follow up data.

What did CHI find out about how care is organised at the trust?

Many service users, carers and stakeholders told CHI that care in the trust is managed using a traditional medical model, although most teams include different professional groups. The involvement of other professionals such as psychotherapists is at the doctor's request. Many service users and carers feel that the needs of service users are not always met and that there is a greater dependency on drug treatment and less on the talking therapies, such as counselling.

On a number of sites, the trust has adult acute wards with multiple consultants admitting patients. There is no single consultant overseeing the process. Much staff time is taken up with bed allocations, communicating with agencies and attending ward rounds and CPA meetings. At times, service users are sent home on leave and their beds are then allocated to others. Service users have sometimes returned from leave early to find that they do not have a bed. Nurses then have to make a decision about whether to ask patients to stay out on leave as the on call duty doctor often does not know the patient.

On the whole, staff contact with patients is good, but some service users felt that some staff spent more time on administrative tasks compared to supporting service users towards recovery.

A shortage of occupational therapists reduces the opportunities for meaningful therapeutic outcomes for users.

The trust's parent and child unit is an example patient centred service at the trust. Parents can remain with their child while they are experiencing a mental health episode. The support given to parents is welcomed by stakeholders and carers.

Staff and stakeholders told CHI that implementation of CPA throughout the trust is variable. There are pockets where is well implemented while in other areas implementation is inconsistent. The trust does have protocols to ensure service users have continuity of care through the CPA. However, service users told CHI that the commitment to CPA from medical staff was variable. In a recent audit undertaken by the trust, it was found that 59% of service users were involved in their care planning, 23% were not involved and 18% were not sure.

What areas of the service users experience should the trust consider?

- The trust needs to urgently consider how the needs of service users can be improved out of hours.
- The trust needs to urgently ensure there is a lead consultant for admission wards in adult services in accordance with the Department of Health guidance.
- The trust needs to urgently agree and implement the transitional protocol for service users aged 16 to 18.
- Service users' access to talking therapies needs to be enhanced.
- The trust needs to work with partners to ensure that the suite for service users taken into care under section 136 is funded so that service users are not held in police cells.
- Information leaflets about services and various conditions need to be available in all areas.
- The trust needs to ensure service users have continuity in medical care.
- The trust needs to work with partners to develop access to respite care.
- The trust needs to work with partners to promote access to advocacy services.
- The trust needs to ensure there is consistent implementation of the care programme approach throughout the trust. This could be done by reviewing the process and ensuring the commitment of medical staff.
- A directory for service users on services and facilities provided by the trust, including a map of where these services are located, would be beneficial to service users.
- The trust needs to ensure reports are provided in a timely manner for mental health tribunals and managers' hearings.
- Recreational, educational and pastoral facilities need to be promoted and an appropriate level of support for such services provided.

What is CHI's assessment of the trust's systems for patient, service user, carer and public involvement?

This section describes how people can have a say in their own treatment and how they and service user organisations can have a say in the way that services are provided.

What is CHI's main assessment?

A culture of service user involvement is embedded in the trust. It is well understood and supported by staff.

CHI's assessment = ii (c)

What are CHI's key findings?

The trust is committed to involving service users and carers and has dedicated resources for this. It has a strategy in place with action plans, objectives and timescales. The strategy sets out the trust's objectives and areas of good practice. The executive team is committed to the strategy and gives it a high priority. In 2003/2004, the budget for patient and public involvement is £532,600.

The trust has a public involvement department to take forward the public involvement agenda. The trust has structures which are continuing to develop. The board lead for patient and public involvement is the director of mental health services. The operational arm of this work is carried out by the head of public involvement who is supported by a team of staff. Staff interviewed by CHI showed great commitment in this area.

A carer involvement strategy is under development. To make a difference for service users and carers, the trust has recently appointed eight service user development workers who are each working in adult acute inpatient wards. These workers are current or former service users who are part of the health care team.

The trust encourages a culture of patient and public involvement. However, those from the black and ethnic minority communities have not been as involved as possible. The trust recently commissioned a report on diversity which identified a gap in the services it provides to the black and ethnic minority communities. In response to this report, the trust has decided to appoint a diversity project manager to take forward the diversity issues within the organisation. It has also appointed a service user involvement facilitator for black and ethnic minority communities to ensure that a real difference is made to service users from these communities. Some staff have attended training on diversity.

There are leaflets available in most areas on how to make a complaint. There are also leaflets in different languages but the availability of these is inconsistent. Leaflets on how to complain are available in Braille, in large print and on audio tape. There is evidence that learning from complaints is taking place. Complaints are analysed and reported to the board and there were several examples of changes happening as a result of complaints.

There is variation in the frequency and awareness of the community involvement meetings held between service users and staff on inpatient wards. On some wards, regular meetings are happening with minutes and action points displayed on the notice boards. On other wards, service users are unaware that meetings take place.

Customer care training is available for ward staff but only some staff interviewed were aware of this.

The trust can access interpreters of locally spoken languages via the telephone interpreting service Language Line. There are inconsistencies in access to and use of interpreters. Stakeholders reported that some community mental health teams are unable to access translation and interpreting services.

What areas of patient, service user, carer and public involvement should the trust consider?

- All staff need to attend diversity training.
- Systematic ways to collect and analyse service user and carer feedback, including complaints, need to be developed in order that good practice and learning can be shared across all clinical teams and areas.
- All frontline staff need to have customer care training.
- There needs to be good access to and use of interpreters by inpatient and community mental health teams.
- Service users from the various communities in Leeds need to be supported to participate in the clinical governance agenda.

What is CHI's assessment of the trust's systems for risk management?

This section describes the trust's systems to understand, monitor and minimise the risks to patients and staff and to learn from mistakes.

What is CHI's main assessment?

The trust has a clear risk assessment and risk management policy and has developed systems to undertake risk assessment plans. Consistent access to training programmes for staff on risk needs to be implemented.

CHI's assessment = ii (c)

What are CHI's key findings?

The trust has implemented a system which allows staff to assess risks in their work areas. The trust also has a risk management system that allows incidents, complaints and claims to be monitored and reported on. It has developed structures for risk management and reporting. It also has good systems and procedures for learning from risk analysis and management. There are lists of potential risks, known as hot lists, and a risk register is used to identify improvements. Staff that CHI interviewed are aware of these structures, systems and procedures. Most staff are aware of the serious untoward incident reporting system.

The controls assurance and the clinical governance committee has responsibility for managing risks.

The trust has good training programmes for staff on risk, violence and aggression prevention and other related areas. Access to such programmes is variable with some staff unable to attend them. Cardio pulmonary resuscitation (CPR) training is not mandatory for staff working in inpatient areas.

The trust is beginning to develop strategies for engaging other voluntary agencies in risk analysis and management. There are service level agreements with partner organisations that outline how risk is managed and they are developing links with social services on care planning.

Staff and stakeholders told CHI that there were at least four different risk assessment tools used by the community mental health teams with different layout, content and depth of information required. The trust is relying on analysis of the care environment risk profile and aims to have a standardised tool in use across the trust.

Staff told CHI that there is lack of clarity around the consent process. There is a consent policy in place but few staff are aware of it. The trust has made very little progress on establishing advance directives where service users inform carers and the trust in advance how they would like to be treated when their mental health significantly deteriorates.

There is variable implementation of the procedure to deal with drug and alcohol use on the adult admission ward. The trust recognises this.

At one of the trust's sites, the Becklin Centre, the reception desk is located some distance from the entrance and there is some concern that anyone could access the inpatient area without being seen by staff who are working in reception.

The trust is developing ways to increase service user and carer involvement in risk assessment.

The trust employs a number of locum doctors. Induction programmes for these staff are inconsistent.

What areas of risk management should the trust consider?

- All staff should have appropriate risk management training.
- A review of mandatory training programmes for clinical staff should be undertaken.
- The trust needs to ensure that there is clarity around the consent process and appropriate health care staff are aware of the consent policy.
- Assessment tools should be standardised across the trust and community mental health teams.
- Systems and processes for establishing advance directives should be in place.
- Application of the drug and alcohol misuse policy should be consistent on adult inpatient wards.
- There needs to be consistent induction programmes for locum doctors.

What is CHI's assessment of the trust's systems for clinical audit?

This section describes how the trust ensures the continual evaluation, measurement and improvement by health professionals of their work and the standards they are achieving.

What is CHI's main assessment?

The trust has a clinical audit strategy and dedicated resources to support this. Some staff have accessed the resources and are aware of it.

CHI's assessment = ii (b)

What are CHI's key findings?

The trust gives high priority to clinical audit. There is an audit strategy and a department that provides good support for staff who undertake audit. The trust is developing effective committee structures to support clinical audit and there are plans to ensure accountability throughout the trust. In some areas, there are good links between the directorates and clinical teams through the clinical audit forum.

There is a timetable for implementing various components of the audit strategy to ensure that clinical audit is linked with other components of clinical governance. Audit links with partner organisations, such as primary care trusts, social services and others, are being established. There are no links with the voluntary sector in dissemination of audit results.

The trust supports staff to get involved in national audit and the results of these national audits are shared widely within the organisation. There is good support for multidisciplinary audit and CHI found some examples of patient and public involvement at a local level.

There are some good systems at a directorate level to ensure clinical audit results are widely shared. However, these are not consistent across the organisation. Implementation and monitoring of actions as a result of audit is carried out, usually by staff who have taken an enthusiastic interest in the area. The systems to enable the trust executive to monitor whether directorates are implementing audit recommendations are not as well embedded. There are many examples of audits and re audits that are helping to implement beneficial change for service users and carers.

The trust supports clinical audit in service areas through the clinical audit support team and provides education and training to enable staff to carry out audit. However, not all staff interviewed are aware this support is available.

Results of audit are discussed locally in audit meetings, journal clubs and other such meetings. There is no formal mechanism for sharing audit findings across different clinical areas.

What areas of clinical audit should the trust consider?

- Implementation of the clinical audit strategy needs to be performance managed.
- Clinical audit training needs to be provided to all appropriate staff.
- Learning from clinical audit needs to be systematically shared throughout the organisation and with partners.
- Links between clinical audit and other clinical governance components need to be developed.
- The trust needs to develop robust monitoring systems to ensure audit recommendations are implemented.

What is CHI's assessment of the trust's systems for clinical effectiveness?

This section is about the way the trust ensures that the approaches and treatments it uses are based on the best available evidence, for example from research, literature or national or local guidance.

What is CHI's main assessment?

The trust committee structure for clinical effectiveness is new and will take time to become embedded. The clinical effectiveness strategy needs coordination and its implementation needs to be effectively evaluated.

CHI's assessment = i

What are CHI's key findings?

The trust has structures in place for organising and prioritising work on research and effectiveness. Staff told CHI that the newly established clinical effectiveness forum will help make these processes more clear.

The trust has a strategy for clinical effectiveness. The strategy is not coordinated across the organisation and staff awareness of it is variable. There are no mechanisms to performance manage the clinical effectiveness strategy. The priorities have been agreed and there are some links with clinical audit, but these are embryonic. Links with risk management are yet to be established. However, the research and development programme is well established.

National Institute for Clinical Excellence (NICE) guidance is disseminated widely throughout the organisation. CHI found some evidence of implementation of the guidelines at a local level and staff told CHI that they have been involved in learning and using new guidelines. However, the application of these guidelines is not consistent across all areas. There is no central monitoring of compliance with NICE guidance.

Research and development is well established in the trust. The trust participates in the west Yorkshire network of NHS trusts which coordinates patient and public involvement in research and development. The trust has a research and development strategy and the budget for its research in 2002/2003 was £570,400.

There is variable working with partner agencies in clinical effectiveness. There are good links with other trusts and academia, but links with the voluntary sector are not yet established.

Evidence based practice has been implemented in some areas. Staff told CHI of some improvements made as the result of evidence based practice. However, staff and stakeholders told CHI that evidence based practice from other areas such as social services and the voluntary sector is not systematically disseminated, implemented and monitored. Outcome evaluation has taken place in some areas and not in others.

Some ward based staff appear to have easier access to the internet and research journals. It is less easy for community staff to access computers. The majority of staff appear to receive guidelines and also know where to access guidelines and policies.

Training for staff in critical appraisal is limited. In some areas, the teams arrange to share and review evidence. This does not appear to be consistent across the trust. There is central commitment to ensuring service user involvement in critical appraisal, though it is developing slowly.

What areas of clinical effectiveness should the trust consider?

- Implementation of the clinical effectiveness strategy needs to be effectively evaluated.
- Robust structures to support clinical effectiveness need to be put in place across the trust.
- There needs to be trust wide, consistent coordination of clinical effectiveness.
- Clinical effectiveness needs to be linked to other clinical governance components at all levels.
- The trust needs to ensure there is central monitoring of departments' implementation of NICE guidance.
- The trust needs to ensure evidence based practice from other partner organisations areas, such as social services and the voluntary sector, is systematically disseminated, implemented and monitored.

What is CHI's assessment of the trust's systems for staffing and staff management?

This section covers the recruitment, management, and development of staff. It also includes the promotion of good working conditions and effective methods of working.

What is CHI's main assessment?

The trust has newly developed structures, policies and procedures for staffing and staff management. These are helping the trust deliver national priorities. The trust needs to now promote diversity within its workforce at all levels.

CHI's assessment = ii (c)

What are CHI's key findings?

The trust gives high importance to human resources (HR) structures. The appointment of a director of human resources was viewed positively by staff. The trust has a good HR strategy which is delivering the national priorities. The strategy does not explicitly mention clinical governance. The trust gives great importance to HR because it recognises the important role staff play in delivering the *NHS Plan* and modernising services.

The trust has developed a number of important staff support services and has won both regional and national modernisation awards for its staff support. In the staff survey and during interviews with CHI, there were concerns raised around support for staff and heavy workloads. The trust has responded to these issues through local care group action plans and staff told CHI that some progress has been made.

Over the past 12 months, the trust, working closely with trade unions, has revised all of its HR policies and procedures and has produced a staff handbook. Staff report that the HR department is fostering good relationships with both staff and the trade unions.

Service user involvement in recruitment is now being actively promoted. The people count project, which is about giving employment opportunities to people with mental health conditions, is also valued by staff and service users.

There is a significant lack of staff from black and ethnic minority communities at senior management level within the trust. The trust recognises that it needs to take actions to ensure greater diversity in its senior management and clinical workforce.

Most staff that CHI spoke to had an induction and appraisal, and had a personal development plan. Sixty five percent of medical staff have had an appraisal and all consultants in older people services have had an appraisal. The trust has introduced a personal responsibility framework which is an innovative approach to dealing with performance issues. Staff told CHI they valued this approach.

There are good systems in place for ensuring that the registration and qualifications of clinical staff, including locums and agency staff, are checked on appointment. There are good systems in place to check reregistration of nursing staff.

There are examples of good multidisciplinary team working, although arrangements for this are variable across the trust. There is no systematic approach to ensuring effective multidisciplinary team working.

The trust is facing considerable problems in recruiting psychiatrists, occupational therapists and others staff groups. It is examining ways it can address these problems. Until these issues are adequately addressed, the trust recognises that staff will continue to face a high work load and that service users will experience discontinuity of care. However, the trust is committed to minimising this discontinuity through effective care planning.

The trust has no psychiatric recruitment difficulties in older people's services.

Communications have been improved by the introduction of a uniform, top down team briefing note. Some staff said the briefing note was insufficiently differentiated for their needs and caused information overload. There is no recognised system for communication upwards and across the trust.

Staff and stakeholders said that security is an issue. Examples of cars being broken into whilst parked on trust premises were highlighted.

What areas of staffing and staff management should the trust consider?

- The trust needs to ensure that there is an organisational development strategy that supports the delivery of the human resource strategy and clinical governance.
- Systems need to be put in place to improve communication within the organisation.
- Security throughout the organisation needs to be improved.
- Initiatives to recruit from black and ethnic minority communities need to continue to be developed, particulary to senior management roles.

What is CHI's assessment of the trust's systems for education and training?

This section covers the support available to enable staff to be competent in doing their jobs, whilst developing their skills and the degree to which staff are up to date with developments in their field.

What is CHI's main assessment?

The trust has demonstrated its commitment to education and training. The education and training strategy is in draft. The trust recognises that it needs to have systems in place to performance manage the implementation of this strategy.

CHI's assessment = ii (c)

What are CHI's key findings?

The trust's education and training strategy is in draft, pending further consultation with staff and stakeholders. It has a number of effective processes and structures in place to support education and training. The trust is in the process of appointing someone to lead on education and training across the trust. Staff reported that training is linked with personal development plans. There is a policy in place to support continuing professional development. Some staff are given time off to undertake training and their absence from work is filled with appropriate staff. The trust has undertaken a training needs analysis and the results have influenced the courses provided by the training centre.

The trust's Andrew Sims centre provides a significant education and training resource for medical staff and there are plans to make it multidisciplinary. Some staff groups don't have access to the centre. Overall, clinical staff told CHI that training in the trust has improved since the Andrew Sims centre was set up.

The trust recognises the importance of ensuring that all staff attend mandatory training and have personal development plans (PDPs). Staff told CHI that PDPs are valued and in a recent staff survey, seventy three percent of staff have agreed a PDP with their manager. Forty four percent said having a PDP was useful.

The trust is working with partners in numerous areas. It is working with another mental health trust in a joint project which facilitates the two organisations sharing good practice and developing common solutions to problems. It also works closely with local universities in the provision of education and training for staff.

Staff are able to access leadership programmes such as the Leading an Empowered Organisation (LEO) course. The trust has also invested in developing and supporting black and ethnic minority managers as part of a positive action programme. Both these programmes have been positively received by staff.

The trust has equality and diversity training although few staff have had it. The uptake of this training is not monitored across the organisation and awareness of this training is low amongst staff.

There is a clinical supervision policy and general managers are responsible for ensuring implementation and monitoring of clinical supervision. Staff told CHI that clinical supervision is working well in some areas and needs to improve in others.

The uptake of training and development for individual staff is variable. Some staff have more opportunities to access courses than others. Staff told CHI that there are few opportunities for health care support workers to access nurse training. There is no clear career pathway for non medical staff.

The systems for monitoring mandatory training are not robust and there are few opportunities for training on the many new policies that have emerged over the past few months. There are very few opportunities for staff to train jointly with other providers such as social services and the voluntary sector.

Staff told CHI that the trust puts most of its focus on medical training. It does not provide consistent support for staff to pursue national vocational qualifications across the trust. The trust plans to address this issue by ensuring that there is access for staff through individual learning accounts funded by the local workforce development confederation.

What areas of education, training and continuing personal and professional development should the trust consider?

- The trust needs to ensure that its education and training strategy is formally approved by the board and centrally monitored.
- The trust needs to identify what training is mandatory and ensure that there are systems in place to monitor the uptake of mandatory training across all staff groups.
- Customer care and diversity training courses should be part of mandatory training programmes.
- The trust needs to ensure staff are trained in new policies.
- Opportunities to access education and training need to be consistent across the organisation.
- Opportunities to plan and deliver education and training jointly with social services, primary care trusts and the voluntary sector should be considered.
- The trust needs to develop career pathways for non medical staff.
- The trust needs to develop opportunities for healthcare support workers to access nurse training.

What is CHI's assessment of the trust's systems for using information?

This section describes the systems the trust has in place to collect and interpret clinical information and to use it to monitor, plan and improve the quality of service user care.

What is CHI's main assessment?

The trust has developed structures to improve performance reporting and performance information is viewed at a corporate level. However, systems to support the use of information to improve the quality of care and monitor the patient experience across the organisation need further development.

CHI's assessment = ii (a)

What are CHI's key findings?

The trust has developed structures and processes to improve the use of information. The information management and technology (IM&T) strategy sets out the trust's agenda for improving both its technology and its information provision. The trust has begun work in developing the range of information it needs on national targets, however it recognises that it still has some gaps.

The trust has developed structures to improve performance reporting on clinical governance. Some staff see the performance reports, but others are not aware of them. The trust produces performance reports every two months. These performance reports, which include quality indicators, are received and discussed by the board. This process facilitates monitoring of the patient experience.

The board has made good progress identifying the information it expects from senior managers. It has not yet made clear what it expects from directorates and teams. Front line staff are involved in collecting activity information but are unaware of what use is made of the information they collect. They do not routinely receive feedback on clinical outcomes.

The trust recently appointed a head of performance management who will be developing the performance reporting mechanisms to the trust board. A strategy on what information the trust will use for service planning and performance management purposes has recently been approved by the board.

The trust does not have a centralised system for service users' notes. Service users' inpatient notes are separate from their notes in community mental health teams. This can affect the quality of care and staff reported concerns about it.

There are several areas within the IM&T agenda that are still under development, particularly with regard to access and use of IT. Around 60% of staff currently have access to a personal computer (PC). Some staff reported good access to PCs, however, others told CHI that up to eight staff sometimes share one PC.

The District Audit report in 2001 highlighted a number of data quality issues to be addressed and a suggested action plan to resolve this. In response, the trust appointed two data quality trainers whose posts have now become permanent. Currently, data is still paper based and in a number of areas collected and checked manually. Data collection methods vary in practice across departments. Staff told CHI that they do not have the systems to produce data reliable enough to know what is happening in patient care. However, work is underway to implement a networked information system to support care coordination and the care programme approach.

The trust has developed systems to collect information relating to service user ethnicity. The use of this information to improve services for people from the black and ethnic minority communities is variable.

The trust has dedicated resources for IT training. Because not all staff have had this training, email and other technology cannot be used as a reliable tool for information sharing across the trust.

The trust lacks the necessary communication systems to meet the challenges of working across so many sites. The trust recognises this and plans to address this through investment in 2003/2004.

Communication with GPs is either by fax, telephone or letter. Electronic links are not yet available. The trust has made progress on information sharing with social services through the development of joint information sharing protocols.

The sharing of PCs by staff is a risk to service user confidentiality. Not all front line staff are routinely receiving training on handling confidentiality and only a few staff were aware of the confidentiality requirements placed upon them by the Caldicott guidelines.

What areas of using information should the trust consider?

- The trust should urgently ensure front line staff can contribute to the development of clinical indicators to improve staff understanding of what is happening in patient care.
- Staff access to personal computers needs to be improved.
- Staff need to be trained in the use of IT as a tool to underpin their work.
- Communication links and supporting technology need to be improved across the organisation via effective team working and linking this to an organisational development strategy.
- Staff awareness of Caldicott guidelines needs to be raised.
- The trust needs to ensure that there is an integration of service users records at an operational level.

What is the trust's strategic capacity for improvement?

This section describes the ability within the trust to monitor and improve the quality of service user care.

What is CHI's main assessment?

The trust has developed structures to take forward the clinical governance agenda. These are new and will require time to get embedded in the organisation. Improved communication of these structures to front line staff will help the trust take clinical governance forward. The trust needs to ensure its core purpose and values are shared widely within the organisation and new services are jointly developed with partners in order to improve the quality of the patient experience.

What are CHI's key findings?

The trust has come a long way since the external review of 1999. It has made good progress in ensuring that services are provided in modern buildings. It has ensured that the patient and public involvement agenda has been embraced throughout the organisation. It has linked up with social services to ensure a level of cohesion in joint working. Leadership within the trust ensured all this was accomplished against a background of new emerging NHS organisations, such as primary care trusts, and new commissioners for mental health services.

The medical director and director of nursing and workforce development drive the clinical governance agenda within the trust. The CHI clinical governance review has been used by the trust to develop and embed clinical governance. CHI found that staff were aware of clinical governance and how they can contribute to it in their area. However an overarching understanding of clinical governance processes was not as evident. For example, staff were not aware of the structures, albeit new, for clinical effectiveness and clinical audit and how these are linked to other clinical governance components.

There is variable coordination across the seven technical components of clinical governance. Links between clinical audit, clinical effectiveness, and risk programmes are only beginning to develop.

The trust has a huge change agenda but contributions to this process from front line staff are ad hoc. Staff have not been sold the benefit of the monitoring and evaluation systems that the trust has launched. CHI found front line staff enthusiastic, willing to change and motivated to do so. However, staff told CHI that there are high sickness levels in some services due to stress.

There has been significant improvement in team working at board level since 1999 when the trust had its external review. There is still some additional work that the trust needs to undertake to ensure that there is cohesive team work throughout the trust including at strategic level. The executive team needs to continue building better relationships with senior healthcare staff and the culture of involving this staff group in management decision making processes needs to be implemented. Both staff and stakeholders consider the recent appointment of a new medical director, new human resources director and new associate medical directors to be positive appointments. The trust has also appointed a professional head of psychology and a professional head of occupational therapy to support clinical governance.

The trust board is committed to serving its diverse population appropriately. This level of commitment needs to now be replicated at all levels within the organisation.

Both staff and stakeholders told CHI that there is a lack of clarity around the trust's vision for its services and its core purpose. The real challenge for the trust is fragmentation of information. Development of future services needs to be compliant with the national agenda and explicit

links need to be made between all the trust's internal strategies such as human resources, estates, workforce plans and others.

At the moment, information on service development is fragmented across a number of documents such as the local implementation plan, the local delivery plan, the human resource strategy and others. This fragmentation causes confusion for staff and stakeholders. Planned service developments need to be recorded in a cohesive framework in order to enable all stakeholders and staff to have a clear understanding of the vision and strategic direction of the organisation. This framework would outline time scales for the trust to achieve its goals and how developments would be funded. The trust is strengthening its local development plan and plans to communicate this to staff.

The recently approved human resources strategy is a positive step forward. In it, the board has identified its core purpose and values. These need to be shared widely within the organisation and with stakeholders. Development programmes to ensure these are embedded within the organisation need to be implemented.

Since the external review of 1999, the trust has made progress in its working relationships with partners. Social services and primary care trusts recognise the progress the trust has made in partnership working. However, relationships with the voluntary sector need to be urgently built upon and the contribution that this sector can make in helping the trust to realise its core purpose needs to be acknowledged, valued, supported and enhanced.

Further information

The CHI clinical governance review took place between January 2002 and August 2003.

This report sets out the main findings and areas for action from the review. The trust has been given a detailed summary of the evidence on which these findings are based.

The trust will produce an action plan that will be available from:

Leeds Mental Health Teaching NHS Trust
Trust Headquarters
Meanwood Park
Tongue Lane
Leeds
LS6 4QB

or from the CHI web site. The trust's implementation of the action plan will be monitored.

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Further details of CHI's work are available from:

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Mike Atkin, Chief Executive

Dr David Newby, Medical Director

Peter McGinnis, Director of Nursing and Workforce Development

Kirsty Speight, Assistant Director of Nursing and Workforce Development (trust coordinator)

CHI would like to make clear that responsibility for the content of the report and its conclusions is CHI's alone.

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