

# Mental Healthwatch handbook

Improving mental health with your community

'User voice is very important and should be listened to.'

together we  
are stronger

National Survivor User Network

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## Improving mental health with your community

The Mental Health Provider Forum leads a strategic collaboration of 'not for profit mental health organisations' including: The Centre for Mental Health; The Mental Health Foundation; National Mind; Rethink Mental Illness, NSUN and The Afya Trust.



Centre for  
Mental Health



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## Terminology

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### **Service users and survivors**

People who have experienced mental distress or have used/received mental health services use several words to refer to themselves. The phrase 'service users/survivors' is used to reflect the two terms that are most often used currently.

### **Enter and view**

Is the phrase used to describe the power Healthwatch has to visit health and social care services.

### **Healthwatch**

Under the Health and Social Care Act 2012 which came into force in April 2013 local Healthwatch took over from Local Involvement Networks (LiNs) as the statutory community, patient and service user champion. Each Healthwatch is commissioned by its borough or county council.

Healthwatch England is the national consumer champion in health and care. It has been given significant statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services. Healthwatch England is available to advise and support local Healthwatch but does not have powers to direct it. ●

## Acknowledgements

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With Patrick Vernon, Andy Bell, Emma Perry, Nigel Moyes, Annie Topping, Jacqui Dyer, Morgan Daley, Pauline Markowits and Catherine Pearson.

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## Foreword



For many years, people suffering from a mental health condition were often left undiagnosed and unsupported, significantly undermining not only their quality of life but also their family and carers.

Positively, change is happening and there is now a much wider recognition of the seriousness of mental health issues due to the tireless work of voluntary and community sector organisations.

The government's mental health strategy, No Health Without Mental Health, sets objectives to improve people's mental health and wellbeing and improve services for people with mental health problems. While this has helped to put mental health on the political agenda, there still remains much work to do to ensure there is parity of esteem and greater inclusion and equality in the delivery of mental health services.

As the consumer champion for health and care, Healthwatch England is committed to bringing the voice of people who use health and care services to the forefront to ensure their views are heard and reflected in how services are planned and delivered.

Mental health is a key priority area for Healthwatch and in the coming months we will be bringing people together to build and develop communities of interest, one of which will be themed around mental health. We are also undertaking our first Special Inquiry which will include a focus on people with mental health conditions who have experienced unsafe discharge from a hospital, nursing or care home, or secure setting in England.

I would like to congratulate the National Survivor User Network for producing this important and valuable resource. The handbook provides local Healthwatch with a useful tool to share and engage with partners across their local health and care community to bring about meaningful improvements for people using mental health services.

I wish the National Survivor User Network every success.

Patrick Vernon OBE

Committee Member,  
Healthwatch England

## Introduction

When people with experience of mental health conditions are properly involved in shaping the services they use and the communities they live in, their own health and the support available usually improves. As Healthwatch exists to champion the needs of local people it is in a unique position to support this kind of involvement and improve mental health in the community it serves.

Knowing this the National Survivor User Network (NSUN), a national mental health service user-led charity, designed the Mental Healthwatch scheme. The aim of the scheme is to support people with experience of mental health conditions to get involved in their local Healthwatch and to advise Healthwatch on the best means of involving service users and improving services in their area. It was launched in March 2013 with the support of the Department of Health and Healthwatch England and has grown into a network of over 150 volunteers and 50 Healthwatch.

Having worked with a number of Healthwatch up and down the country it became clear to NSUN that there was real enthusiasm for improving mental health but also a desire for more information about doing this effectively. Hoping to provide that guidance, NSUN secured funding to produce this handbook from the Department of Health through the Mental Health Strategic Partnership.

This handbook provides information on how Healthwatch can help improve mental health with a range of partners including central government, service users, commissioners, providers, the voluntary sector and councils. In the following chapters we have condensed the most relevant information relating to improving mental health with the groups listed above. This includes the government's mental health strategy, NSUN's 4PI involvement standards, the joint commissioning panel's values-based commissioning guidance, advice on visiting mental health services and information about the local authority mental health challenge.

There are also case-studies describing how three different Healthwatch have approached improving mental health and the results of our exclusive surveys of Healthwatch and service user attitudes to how the new system is developing.

We hope that both Healthwatch and people with mental health conditions wishing to get involved will find this information useful and that everyone will sign up to join us using our contact details on inside front cover because together we can improve mental health.

# Improving mental health with central government

In February 2011 the government published the No Health Without Mental Health strategy with objectives for everyone involved in promoting mental health and wellbeing. This briefing explains what the strategy is and how community organisations like Healthwatch can contribute to achieving better mental health for all.

## Facts and figures

- The Centre for Mental Health estimates the economic costs of mental illness in England at £105 billion each year. This includes the direct costs of services, lost productivity and reduced quality of life.
- Half of all lifetime mental health conditions emerge before the age of 14;
- One new mother in 10 will experience postnatal depression;
- Only a quarter of people with mental health conditions will receive any treatment;
- Nine out of 10 prisoners in England and Wales have a mental health condition.

## Aims of the government strategy

It sets out six key objectives for better mental health and care.

These are:

### 1. More people will have good mental health

More people of all ages and backgrounds will have better wellbeing and good mental health. Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.

### 2. More people with mental health problems will recover

More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment.

### 3. More people with mental health problems will have good physical health

Fewer people with mental health problems will die prematurely, and more people with physical ill health will have better mental health.

### 4. More people will have a positive experience of care and support

Care and support, wherever it takes place, should offer access to timely, evidence based interventions and approaches that give people the greatest choice and control over their own lives, in the least restrictive environment, and should ensure that people's human rights are protected.

### 5. Fewer people will suffer avoidable harm

People receiving care and support should have confidence that the services they use are of the highest quality and are at least as safe as any other public service.

### 6. Fewer people will experience stigma and discrimination

Public understanding of mental health will improve and, as a result, negative attitudes and behaviours towards people with mental health problems will decrease.

## Responsibility for achieving the strategy's objectives

With such a wide-ranging set of objectives, mental health now needs to be seen as everybody's business.

The NHS has a big role to play in improving the quality of care it offers to everyone with a mental health condition. This includes, for example, extending the Improving Access to Psychological Therapy (IAPT) programme to make talking therapies available to people of all ages, all ethnicities and in all parts of the country. It also includes changing the way mental health services support people to make better lives for themselves. Local authorities also have a lot to do. Councils already have to make plans to improve the overall wellbeing of their communities and these plans are likely to be extended by the government as councils now have responsibility for public health. They

also have responsibility for many of the biggest influences on our mental health for example: housing, the local environment and, of course, social care for both children and adults.

The need for action goes wider still. Schools can make a huge difference to children's mental health. The police and employment services all work with people who have mental health conditions and they too have roles to play.

Healthwatch, community and voluntary organisations can link up several of these agencies and can provide them with invaluable information, insights and examples of effective support, for example, of working with ex-offenders, older people, families and young children.

## Barriers to success

Public services, particularly those provided by local councils, are being cut by unprecedented amounts at present.

People with mental health conditions often lose out when services are cutting budgets. Benefit changes have meant that people with mental health conditions and their families have lost income and face stressful additional tests for eligibility.

Within the sphere of mental health itself, there are also significant inequalities that stand in the way of achieving the strategy's objectives. There is significant evidence to suggest that the experience of discrimination and marginalisation within society is connected to poorer mental health. Mental health care for children and older people often lags behind that offered to working age adults. People from some black and minority ethnic communities are still less likely to get talking therapies and much more likely to be diagnosed with severe mental health conditions and to be detained in hospital under the Mental Health Act. Homeless people, prisoners, lesbian, gay, bisexual and transgendered people, children in care, and care home residents have high levels of mental ill health that is too often not properly treated.

## The role of Healthwatch

Community organisations like Healthwatch will be fundamental to the success of the mental health strategy.

### Healthwatch could:

- Ensure that local authorities, health service commissioners, work programme providers, schools and others, take up the challenge to deliver the strategy's objectives;
- Encourage services to work together to offer individuals the support they need to make their own lives better;
- Provide a brokerage role, especially within the context of the growth in personalisation and personal budgets for health, as well as social care;
- See when progress is being made or when problems are emerging in the services they work with. They can provide early warnings when things go wrong and can monitor service users' and carers' views of the support they are offered.
- Support service users and carers to feed in to the structures that exist to have their voices heard. Healthwatch is key to getting the views and experiences of people using mental health services into local NHS decision-making.

If the strategy is to work for everyone, these inequalities will need to be tackled. It is often community and voluntary groups that are most keenly aware of these issues, by working directly with or emerging from within the very groups who are most disadvantaged. ●

# Improving mental health with service users and carers

Key to improving services is the insight of those who use, or who care for someone who uses, the services themselves. Service users, survivors and carers can find details about their local Healthwatch here: [www.healthwatch.co.uk/find-local-healthwatch](http://www.healthwatch.co.uk/find-local-healthwatch) or by phoning the Healthwatch England helpline on 03000 683 000.

In our survey of local Healthwatch (see appendix one), 72 per cent said they had done particular work to involve people with mental health conditions in their work. To build on this good start we recommend that Healthwatch adopts the 4PI involvement standards below.

## 4PI

NSUN has worked with partners to develop service user and carer led standards for involvement.

We call these new standards '4PI' which refers to the following aspects of involvement: Principles, Purpose, Presence, Process and Impact. This chapter explains these standards in order for Healthwatch to apply them to their own involvement work and to encourage commissioners and providers to do the same.

## Principles

Meaningful involvement starts with a commitment to shared principles and values. Our work suggests that involvement needs to begin with the following shared principles and values:

- To bear in mind at all times that our ultimate goal is to improve services and to improve the mental health, wellbeing and recovery of individuals;
- The need to embrace inclusivity, equality of opportunity and fairness;
- A commitment to listen to service users and carers with respect and openness;
- A commitment to change in response to the views of service users and carers;
- Clarity and transparency from the start in all communications;

- Acknowledgement of the power differentials that exist between professionals and service users, and a commitment to minimise them where possible;
- A commitment to support race equality and to challenge discriminatory organisational practices;
- An open-minded approach towards cultural differences and diversity in ways of working;
- Sensitivity about language and actions: to acknowledge that there are different ways of expressing and doing things.

## Purpose

The purpose of involvement needs to be both clear and shared with all of the people who are engaged in the involvement activity. The core purpose of any involvement activity should be to improve services and the experience of services for service users and carers.

- Everyone connected with the involvement activity or organisation should be clear about why service users and carers are being involved;
- Clarity about the purpose of involvement should be extended to individual roles and potential activities for service users and carers;
- Clarity and transparency needs to be shared about the potential for involvement and influencing, as well as the limits of influence;
- The intended outcomes for involvement should be agreed and recorded at the start in order that they can be monitored and evaluated.

## Presence

- A diversity of service users and carers should be involved at all levels and stages of an activity, organisation or project;
- Service users and carers should be involved at all levels within the organisation, project or activity including at decision-making levels;
- Service users and carers involved in an activity should include people from diverse

backgrounds and communities. This is particularly significant for communities who are over-represented within mental health services as a whole;

- At an early stage, an analysis of the population under consideration should be undertaken in order to ensure that the involvement activity reflects that population – and to ensure that people particularly affected by the service or issues under consideration are actively approached for inclusion;
- Procedures should be put in place to monitor the presence of service users and carers, and the diversity of those involved, throughout these levels;
- Care should be taken to ensure that service users and carers can be involved separately or give their views in separate ways as their views and priorities are likely to be different.
- There should be a minimum of two and ideally three service users/carers in any meeting.

## Process

The involvement process needs to be carefully planned and thought through, in order to ensure that service users and carers can make the best possible contribution.

- Information should be made widely available through a number of channels to ensure that service users and carers are informed of the opportunities for involvement;
- There should be a fair and transparent recruitment process;
- Role or job descriptions should be drawn up for involvement positions, whether they are paid or unpaid, employed or voluntary;
- Jargon should be avoided and acronyms explained;
- Feedback about the results or outcomes of an involvement activity should be given;
- Decision-making processes need to be open;
- Administrative and emotional support should be available;

- Opportunities for peer support or mentoring should be encouraged;
- Training should be given to enable equitable involvement and skills development;
- Training should be given to professionals/ members of staff to raise awareness about involvement;
- Where possible, training should be shared by and with service users, carers and professionals taking part in an involvement process, as this can help to build a sense of team work.

## Impact

People are not interested in involvement for its own sake; for involvement to be meaningful, it must make a difference and it should lead to the improvement of services and the mental health and wellbeing of service users and carers. Becoming involved can bring people out of isolation and help develop skills and confidence. The purpose of involvement should always remain at the centre of any attempt to assess impact.

In order to assess the impact of involvement, the following questions need to be asked:

- What were the intended outcomes of the involvement activity?
- What actual difference(s) have service users and carers made to the project, activity or organisation? (This can be monitored by continuous recording throughout a project as well as assessment at the end)
- How did everyone feel about the process of involvement? (e.g. using 'end of involvement' questionnaires)
- Did the involvement of service users and carers make a difference beyond the activity itself – to the delivery of services or the understanding of mental health, to the recovery or wellbeing of individuals? ●

*For more information contact NSUN using the details on back page of this handbook.*

## Case study: Healthwatch Suffolk involving service users

Right from the start Healthwatch Suffolk were keen to involve people with experience of mental health conditions and have worked hard to support service users to play a full part in their activities.

Nigel Moyes, pictured, has a long history of using services and of working to improve them. In August 2012 Nigel was recruited as a volunteer on to the Suffolk Healthwatch implementation board along with 11 other people.

Over five days Nigel and the other board members took part in an induction and he was also paid to attend a three-day patient leadership course. Nigel had previously had training on inspecting mental health services when he was part of the LINK<sup>1</sup> and said: 'I think it is really important to have proper training, recognition and respect for service users in order for them to make a full contribution.'

In his role Nigel has attended the Healthwatch 'people's launch' event in London, a children and young people's regional conference in Cambridge and other events.

He is now a member of Healthwatch Suffolk's mental health focus group and an 'enter and view' officer, able to inspect mental health services.

'It's been great to have my views as a mental health service user valued and used to promote mental health and direct involvement. NSUN have called me a "champion of mental health" in my county and I'm proud to have played some part,' Nigel said.

Healthwatch Suffolk chief executive Annie Topping said of Nigel's contribution: 'The Healthwatch Implementation Committee (HWIE) was instrumental in setting up Healthwatch Suffolk. As a member of HWIE, Nigel had made a significant contribution to this very important journey. Nigel used his experience as an ex-service user to help develop the operating model for public and service user engagement. Healthwatch is about promoting better outcomes in health and social care, and to do this, it is important to listen to users' feedback and use it to inform decision making.'



More widely Annie is enthusiastic about the contribution people with experience of using mental health services bring to Healthwatch.

'We have a mental health subgroup and membership includes local mental health user organisations as well as individual users. This forum provides an opportunity for service users like Nigel to share their experience with us, and in turn, we ensure their feedback is fed into the right place and heard by the right people.'

'Service users brings along valuable lived experience which is crucial in underpinning our daily work. Mental health is one of the key priorities in our work programme, and we look forward to working with Nigel and other people with similar experience to make a positive difference to current services,' she said. ●

<sup>1</sup> Under the Health and Social Care Act 2012 which came into force in April 2013 local Healthwatch took over from Local Involvement Networks (LINKs) as the statutory community, patient and service user champion. Each Healthwatch is commissioned by its borough or county council.

## Improving mental health with commissioners

NSUN is part of the joint commissioning panel (JCP) for mental health led by the Royal Colleges of Psychiatrists and GPs. The best commissioning involves the community, service users and carers underpinned by a values based ethos. The JCP has developed a values based commissioning (VbC) model outlined in 10 points below to enable this to happen.

By being aware of this approach and seeking to convince commissioners of its value, Healthwatch can support best practice and increase the input of the people it serves.

**1** VbC is an approach in which the commissioning process rests on three equal pillars:

- patient and carer perspective or values
- clinical expertise
- knowledge derived from scientific or other systematic approaches (evidence).

**2** VbC is based on the principles of co-production, collaboration and shared decision-making, moving away from services delivered 'to' people, clinician-based decision-making and consultation.

**3** VbC builds on existing commissioning models, by ensuring that patients, service users, and carers are involved at every stage of the commissioning process, and at all levels of decision-making.

**4** VbC is the practice of recognising the value of all those involved in the commissioning process. However, it makes explicit that commissioners need to reflect and incorporate the values of the people with, and for whom, they commission services. VbC promotes the principle that people who use services and carers are the first point of call for information about decisions relating to health care and treatment.

**5** Clinical commissioning groups (CCGs) can implement VbC by:

(a) Developing leadership – appointing stable, sustainable and visible mental health leaders at a senior level who oversee mental health commissioning supported by high calibre

managers; developing patient, service- user and carer leadership to actively engage people in understanding their own health and who are actively involved in decision-making about their own care.

(b) Developing strong links with peer networks and expertise – VbC advocates the use of outreach mechanisms to engage with the local population. CCGs can tap into local networks such as patient or service user-led peer support groups, voluntary sector services and other community settings such as faith groups or children's centres. Increasingly, use of online forums and social media will allow CCGs to reach people who do not engage with face-to-face or paper consultation techniques.

(c) Providing formal support and capacity-building, including training for patients, service users and carers involved in the commissioning process to support their general personal development and equip them with appropriate skills.

(d) Fostering organisational commitment – using values-based criteria in awarding contracts or funds and in the assessment of performance.

**6** To achieve the actions outlined in points a to d above VbC supports balanced decision-making within a framework of shared or negotiated values based on the premise of mutual respect and discussion. VbC recognises that it is not always possible to satisfy everyone's expectations. However, it encourages all individuals to actively engage in the commissioning process and service development.

**7** VbC supports outcomes based commissioning being underpinned by the principle that only the person using services or experiencing illness can truly attach value to health status. VbC is an approach which delivers patient and user-focused services, improves cost effectiveness, and supports current mental health policy and guidance on achieving key outcome measures.

**8** VbC supports the development of new

relationships, more choice and control for service users in public services, innovation through patient and care carer collaboration and engagement with the commissioning process, which in turn supports the government's personalisation agenda.

9 VbC supports the development of payment by results (PbR) through building on strengths, self-management, the equality of relationships, recovery and social inclusion. In this way, PbR then has far wider impacts than just financial reward.

10 VbC can help achieve the six shared objectives aimed at improving mental health outcomes in the mental health strategy

(a) More people will have good mental health – by capturing individual and community views and priorities, services are commissioned for public mental health and wellbeing.

(b) More people with mental health problems will recover – VbC gives equal status to patient, service user and carer input, clinical expertise and formal evidence leading to services that better reflect people's needs and therefore are more likely to help them recover.

(c) More people with mental health problems will have good physical health – VbC encourages an integrated whole-person approach and supports the commissioning of services that focus on an individual's physical, psychological, spiritual and social wellbeing.

(d) More people will have a positive experience of care and support – services commissioned using VbC, reflect all aspects of an individual's physical, psychological, spiritual and social wellbeing as important to their mental health.

(e) Fewer people will suffer avoidable harm – greater ownership and collaboration in service development and commissioning using a VbC approach throughout the whole commissioning cycle will result in increased

engagement of service users and carers, particularly in the areas of monitoring and feedback on service performance.

(f) Fewer people will experience stigma and discrimination – the long-term benefits of commissioning services which address patient, service user, and carer priorities and needs, is a greater focus on outcomes such as increased access to employment, education, training and recovery. This in turn can reduce social isolation and increase community engagement and participation reducing negative attitudes and stigma.

Mind and NSUN have produced a service user guide to values-based commissioning, to help people get involved in making decisions about mental health services. It provides information about how values-based commissioning works, how to get involved and how to make a case to commissioners. The aim of the guide is to make sure that everyone who is interested has the information and support to get involved in commissioning. ●

# Improving mental health with service providers

## About the chapter author Stephanie De La Haye

Stephanie is currently a Care Quality Commission (CQC) expert by experience who conducts inspections of mental health units across the north of England. Her role includes working with fellow CQC inspectors and commissioners in observing services, talking to service users, telephone interviews, and more, to create a robust inspection and to report any findings to the CQC. Stephanie was also a member of the national CQC mental health improvement board before it was replaced by other involvement structures.

One of the key powers given to local Healthwatch in relation to improving health care provision, is the ability to carry out an 'enter and view' visit of mental health services. The following chapter sets the context for this, and gives 'enter and view' guidance specially focused on mental health services.

## Context

In order to see and hear for themselves how these services are provided authorised local Healthwatch representatives have a legal right to 'enter and view' health and social care services.

This power includes premises where health and care is funded from the public purse, such as general acute NHS trusts, foundation trusts also local authority services, The power also covers private and voluntary sector establishments funded by the public purse, as well as specialist centres for people with mental health conditions, dementia and learning difficulties.

## Who runs provides mental health services?

Mental health services are run by NHS organisations, voluntary sector organisations,

including charities like Rethink Mental Illness, and some private companies. In the language of the NHS, all organisations that run services are called 'providers'.

There are 58 specialist NHS mental health trusts in England and most of them are already, or soon to be, established as 'Foundation Trusts' (the government has stated that all NHS trusts must become Foundation Trusts as soon as possible). This means they can take slightly more independent (of government) decisions about how local services are run and how budgets are spent.

## Community-based services

Most mental health services are based within the community, rather than in hospitals.

Community-based mental health services provide the care or support for people to live and manage with a mental health condition outside hospital.

Community-based services for people with mental health conditions are divided into health care and social care.

## Health care includes:

- Treatments, such as medication or talking treatments, for example cognitive behaviour therapy;

- Support from a specialist mental health worker or team, such as a psychiatrist, community mental health nurse (CMHN) or community mental health team (CMHT)

- Preventative, or public health services, that aim to help people look after their mental health and prevent mental health conditions.

Social care is support to manage day-to-day life and can include:

- Managing money, such as budgeting or paying the bills;

- Housework, such as cleaning, cooking or shopping;

- Using local services, such as peer support



groups, employment services, or day centres;

- Transport, such as using a taxi, minibus or bus pass to attend appointments or services;
- Managing relationships, such as relationships with friends, family or neighbours;
- Aids and adaptations to your home or help with mobility issues;
- Personal care, such as washing or dressing;
- Benefits and housing, such as help with applications, attending appointments or getting advice or information;
- Accessing or staying in training, education or employment;
- Support from a specialist social worker or support worker.

## Hospitals

Health professionals can advise a person experiencing a mental health condition to voluntarily admit themselves to a psychiatric hospital. Under the Mental Health Act (1983) approved mental health professionals can also order the compulsory detention of an individual if they believe it is in the interests of that individual's health, their safety, or the safety of other people.

## Types of mental health wards

- Acute admissions ward: This is usually the first ward a person is admitted to if this is the first time they are receiving hospital care. They will be assessed and given treatment. There may be little pressure to be active on this ward, as they or other patients may not be well enough at this point.
- Psychiatric Intensive Care Unit (PICU): This is a ward for people in acute distress; a person may be admitted to a PICU if there is a concern that they may harm themselves or others. They may be transferred here from an acute ward, or admitted directly. There are higher levels of staff on this ward, allowing for increased care and observation.

- Rehabilitation or Recovery ward: If the person is currently in hospital, they may be transferred to this ward as a step towards helping them become more independent. It aims to prepare them for returning to live at home. It can offer talking treatments and also occupational therapy to help with training in daily living skills. There will be more activity and less supervision here than on an acute ward.

- Specialist wards: individuals may be admitted to a specialist ward. These may include:

- Personality disorder unit
- Eating disorder unit
- A forensic unit (for offenders with mental illness)
- Mother and baby unit

There can be many different health professionals and advocates involved with someone's care while they are detained or in recovery.

### Working with others

Prior to deciding on carrying out visits Healthwatch should make contacts with local groups who support service users and people with lived experience. There may be local 'expert' run groups, groups run by voluntary groups organisations such as Mind or, Rethink, advocacy groups and/or the local mental health NHS trust's service user groups. There may also be individuals who are part of the CQC experts by experience scheme who inspect mental health units with the commission.

There are also national organisations which have a great deal of knowledge and resources that local Healthwatch can tap into, such as: NSUN, national Mind, the Royal College of Psychiatrists, Rethink, the Centre for Mental Health, and the Mental Health Foundation, amongst others.

### Training for volunteers

While a robust training programme for volunteers is essential, some key elements are needed for mental health visits, which should include:

- Dementia awareness;
- Deprivation of Liberty Safeguards awareness (DoLS);
- Mental Capacity Act awareness;
- Mental Health Act;
- Independent Mental Health Advocacy (IMHA);
- Effective report writing.

### Conducting an 'enter and view' visit

In addition to standard 'enter and view' best practice guidance available from Healthwatch England an individual local Healthwatch may develop local protocols to ensure that all of the correct procedures are in place and that the nature and purpose of the visit has robust outcomes with evidence recorded and monitored.

As for any visit the following protocol should be used for any visit, including a visit to a mental health service:

#### 1 Decide to make a visit:

- Agree the need to visit, under a defined remit.

#### 2 Define the strategy for the visit:

- Define the purpose of the visit;
- Think through the desired outcome of the visit;
- Decide whether the visit is to be announced, unannounced or within a defined time period shared with the provider;
- Agree the shape and format of the visit, to achieve its aims, including:
  - Types and numbers of staff and service users that it would be desirable to meet with / interview (with their agreement);
  - Any user forums that it would be desirable to meet;
  - Types of activities and service areas that it would be desirable to access / observe, for example to observe general interaction between staff, service users, to note environmental aspects of the care setting;
  - Ideally have an authorised representative with experience of using mental health services to be part of the visiting team.

### 3 Plan and schedule the visit:

- Agree the authorised representatives to undertake the visit, its proposed date, time and duration. Typically visits involve two to four representatives for at least two and up to four hours

#### Ensure that:

- Number of representatives is proportionate to the size of the establishment or service and appropriate to the purpose of the visit;
- A reserve person is in place in case one representative is unable to take part in the visit as planned;
- A lead team member is agreed, if appropriate;
- Ideally a mix of representatives appropriate to the setting to be visited (in terms of gender and ethnicity) and the skills / experience required (e.g. of client group / service).
- Communicate and gather information for the visit

#### Organise for the visit:

- Define specific questions to be asked and points to check (the visit toolkit), involving a wider group of people and any additional local groups as appropriate, to enable the visiting team to get the required information from the visit;
- Agree how responses and outcomes will be recorded.

#### Conduct the visit:

- Ensure all representatives are free of infection which could be passed to vulnerable service users;
- Cancel the visit if only one representative is available;
- Representatives wear identification badges throughout the visit and carry Healthwatch leaflets to explain what local Healthwatch is;
- Representatives present themselves to the provider's named contact for the visit or a senior member of staff, showing their identification badges and visit agreement/ authorisation documents.

While visiting any acute unit can be challenging, mental health services do have particular challenges for individuals who are visiting on behalf of Healthwatch. Team members may have never been to a mental health unit before; understanding the potential issues can put them at ease and so create the best conditions for the 'enter and view' visit.

Many mental health units will have locked entry as people will be detained under the Mental Health Act. This may be the first difference the Healthwatch team member may find.

From experience it helps if one of the people who is visiting has had personal experience of mental health services themselves. This can help develop trust and a degree of openness between the visitor and the service users and can contribute to a more robust visit.

Sitting and talking with patients is a valuable way to gain an understanding of how the patient feels about their stay, treatment and environment. If the visit is at lunchtime, then having lunch with the patients and staff gives a good picture of interaction, nutrition and other general aspect of care.

One aspect of care specific for to people who have been detained under the Mental Health Act is that of independent mental health advocacy (IMHA). Every detained patient has the legal right to this service. It is useful to find out if the patient has been told about the service and if they have used it. There may also be opportunity to talk to an IMHA if they are on the ward or are based within the hospital.

#### **End the visit:**

- Thank provider/staff members;
- Collate staff, resident and visitor surveys if appropriate;
- Report any possible safeguarding issues to the council's safeguarding team - and to the police in extreme circumstances;
- Collate feedback forms and assess the learning from these;
- Meet as a visiting team to discuss information collected and to consider recommendations, pulling together evidence-based findings.

#### **Report the visit:**

- Write up the findings which will include:
  - The reason for the visit;
  - How the evidence collected meets the visit's objectives;
  - Constructive observations and comments;
  - A final team report with a view to making this public;
  - Identified or anonymous sources of information including:
    - Discussions with staff;
    - Discussions with users;
    - Comments from carers and/or relatives;
    - Structured interviews;
    - Documentation provided by staff / the provider.

#### **Distribute the report:**

Make the report available to the provider, so they have the opportunity to make immediate changes if issues are identified. Those service users, carers and public involved in the 'enter & view' visit, so they have feedback on the visit. The report should also go to commissioners of the service, to ensure that the intelligence gathered on the needs and preferences of the local community can be appropriately considered as part of the commissioning process.

#### **Diversity and cultural issues**

The David Bennett Inquiry report made the crisis in black and minority ethnic (BME) mental health a national issue. It brought to light the discrimination in mental health services that has led to black people being excessively diagnosed as 'schizophrenic', over-represented among people who are 'sectioned' (involuntary committed to hospital) and apprehended in excessive numbers by the police as 'mentally ill', despite having similar rates of mental ill health as other ethnic groups.

The statistics show that people from some black and ethnic minorities (particularly young black African Caribbean men) are more often:

- 1 Diagnosed as schizophrenic**
- 2 Compulsorily detained under the Mental Health Act**
- 3 Admitted as 'offender patients'**
- 4 Held by police under Section 136 of the Mental Health Act**
- 5 Transferred to locked wards from open wards**
- 6 Not referred for psychotherapy**
- 7 Given high doses of medication**
- 8 Sent to psychiatrists by courts**
- 9 Have unmet needs**

Attention to these issues is vital when planning and visiting a mental health ward. Depending on the nature of the local community, it may be helpful for local Healthwatch to recruit volunteer visitors from these sections of the community. This should help make the visits more meaningful and robust, in terms of understanding the needs of and issues raised by some of the individuals who are detained there. ●

## Case study: Expert by experience CQC inspector

### Visit to a mental health unit, with detained and voluntary patients who are adults, some with dementia.

The unit is run by a private organisation. On entry to the unit my identity was checked and I was escorted to see the deputy manager of the unit. A 30 minute outline of what the unit does was given and a better idea of any issues, and the protocol to adhere to, was discussed. At this stage I was interested in finding out about de-escalation training (techniques to calm potentially violent situations), IMHA provision, and the general services provided. Using a template to record all information is key to writing up later and also having agreed outcomes of the visit.

One of the key objectives was to have a chat with as many patients as possible during the visit. It was vital that they knew I was an expert by experience inspector as this made a huge difference to people trusting me. By the time I had spoken to eight people the MHA inspector had only managed one person. I made sure I engaged with staff on the wards and also student nurses, who give another perspective to the visit. Most were keen to give their experience once I had sat next to people and said who I was. Some people of course may not have capacity, that is they may not be in a condition to speak lucidly, but you can observe staff interaction and care.

Then a key part of the visit was to just observe patients and staff and the interaction they have. As it was Christmas time when I made

this visit there was a lot going on and staff were giving opportunities for patients to get involved if they wanted. I observed staff dealing with a patient who was a little angry about something and how they dealt with it in the best way possible. Then lunch was served and I had lunch with them and discussed how the food was. For this particular visit a theme of football was apparent as many of the patients liked it and were given the chance to go to the football matches with staff to accompany them.

I was also collecting information leaflets and menus that the organisation uses, such as the advocacy service. I learnt that some of the qualifying patients had not been told about the advocacy service, which was highlighted in my final report. Of course some patients may respond better to either a male or a female visitor, and this needs to be taken into account when planning a visit to a single sex ward. Overall this was a good visit and the organisation fulfilled the care outcomes with only a few minor points for improvement.

So a post-visit de-brief with colleagues was an important part of the day. Then a final report was created and sent to the relevant agencies. ●

#### More information:

*Rethink: going into hospital Information for patients: [www.rethink.org/diagnosis-treatment/treatment-and-support/going-into-hospital-for-patients](http://www.rethink.org/diagnosis-treatment/treatment-and-support/going-into-hospital-for-patients)*

“It was vital that they knew I was an expert by experience inspector as this made a huge difference to people trusting me.”

## Case study: Healthwatch Bristol involving the voluntary sector



In order to ‘build on existing intelligence and networks’ and decide priorities, Bristol Healthwatch developed a ‘mental health champion’ scheme involving the local voluntary sector.

Project co-ordinator Morgan Daly said: ‘When we were setting up we were very conscious that it would not have been sensible to start from scratch and try and survey everyone in the area about their experiences regarding mental health services. We decided to map existing mental health groups and ask them to nominate a champion to liaise with us about their experiences and that has been really useful.’

Having talked to existing groups of service users and voluntary sector providers Healthwatch were able to put together a well-informed ‘where are we now?’ assessment and work-plan based on the priorities of those who knew the issues best. ‘It was obvious that mental health was a key priority for Bristol and we aimed to make sure Healthwatch was in a position to support a wide variety of people from a full spectrum of wellness,’ Morgan said.

Healthwatch Bristol then trained these champions over five sessions in areas including safeguarding, equal opportunities and ‘enter and view’ inspections.

Champion Pauline Markowits of the Bristol Survivors Network said: ‘I was sceptical at first but the training was really useful and sent a strong message that mental health was important and those with experience would be listened to.’

The Healthwatch has also produced and distributed thousands of freepost ‘tell us

your story’ leaflets inviting people to describe their health and social care experiences and priorities. ‘Face-to-face conversations are important but we wanted to give people the chance to be able to go back to the safety of their living room, marshal their thoughts and send us their views,’ Morgan said.

Healthwatch Bristol intend to use the intelligence they are gathering and the mental health champions they have trained to carry out ‘enter and view’ inspections of psychiatric services.

Pauline said: ‘With community mental health services out for tender there is a lot of change in the city and it’s really important that Healthwatch and other groups work together.’ ●

“...the training was really useful and sent a strong message that mental health was important and those with experience would be listened to.”

# Improving mental health with local government

When it comes to mental health, local government has a big, and recently increased, role.

Borough and county councils (as opposed to smaller district councils) are responsible for:

- Commissioning local Healthwatch;
- Hosting the strategy-setting and integrating health and wellbeing board;
- Having a scrutiny function to check on health and social care services;
- Running social services;
- Being in charge of public health, that is (i.e. prevention of ill health);
- Controlling or influencing most 'pre-determinants' of good health like social housing.

Healthwatch should have a place on the health and wellbeing board and will have relationships with officers and councillors in the relevant departments and scrutiny committees. Healthwatch can use the intelligence it gathers from the community to influence decision-making, direct attention to problems or successes and bring mental health up the local authority's agenda. One way of doing this is for Healthwatch to encourage the council to take up the 'local authority mental health challenge' if it is not among the 20 that have already done so.

The Mental Health Strategic Partnership, which includes the Mental Healthwatch sponsor, NSUN, established the 'local authority mental health challenge' to help councils improve the mental health of their communities. The challenge sets out 10 actions:

- 1 **Appoint an elected member as 'mental health champion' across the council;**
- 2 **Identify a lead officer for mental health to link colleagues across the council;**
- 3 **Follow the implementation framework for the mental health strategy where it is relevant to the council's work and local needs;**
- 4 **Work to reduce inequalities in mental health in our community;**
- 5 **Work with the NHS to integrate health and social care support;**

- 6 **Promote wellbeing and initiate and support action on public mental health, for example, through the joint health and wellbeing strategy;**
- 7 **Tackle discrimination on the grounds of mental health in the community;**
- 8 **Encourage positive mental health in our schools, colleges and workplaces;**
- 9 **Proactively engage and listen to people of all ages and backgrounds about what they need for better mental health;**
- 10 **Sign up to the Time to Change anti-mental health stigma pledge.**

Where Healthwatch are not already doing so we call on them to link up with their council mental health champion and encourage councils where they have not yet accepted the challenge to do so. ●

*So far over 20 councils have appointed mental health champions; and you can find a list of them and more information about the challenge here:*  
[www.mentalhealthchallenge.org.uk](http://www.mentalhealthchallenge.org.uk)

# Case study: Healthwatch Lambeth working with council and community



Having surveyed members and talked to hundreds of local people Healthwatch Lambeth has prioritised mental health.

Chief executive Catherine Pearson said: 'Our feedback was clear that mental health really needs to be our focus and now we are just working through how we can best do this and make the most impact with limited resources.'

As well as formally diagnosed conditions and services local members really want to address the issues around mental health like loneliness, isolation and undiagnosed illness. 'Obviously we are not a service provider but perhaps there is something about how we can connect people and involve them. That can fulfil a useful role in tackling these issues and ensuring they get the support and services they need,' Catherine said.

“...we can connect people and involve them. That can fulfil a useful role in tackling these issues and ensuring they get the support and services they need.”

As part of developing this thinking Healthwatch Lambeth is making links with partners such as the Samaritans and the Mosaic Clubhouse, a mental health community centre.

Catherine said: 'To be honest I am not always convinced of the usefulness of trying to "represent" diverse groups of people around various board tables. What we need to do is to get the commissioners and providers to hear the voices of the people they service directly in a way that people other than the "usual suspects" can take part in.'

To that end Healthwatch Lambeth and Mosaic are now arranging a 'flash-mob' where they intend to bring together councillors, commissioners, providers, service users, carers and members of the public in a local square for informal chats.

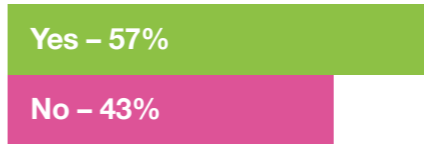
More formally Catherine has found that the council's health scrutiny committee has been one of the more useful forums for discussing mental health and other services.

'Healthwatch reports to the health scrutiny committee as a standing item and is able to feed into the agenda so that the concerns of our members are addressed. The committee has also co-opted a Healthwatch representative as a non-voting member so we get to really cross-examine commissioners and providers.' ●

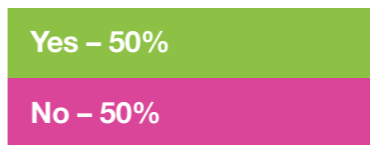
**Q&A**

In late 2013 and early 2014 we asked NSUN members to complete a short survey about their experiences of their local Healthwatch – 73 people responded.

**Q1 – Were you involved in the Local Involvement Networks (LINKs) that came before Healthwatch?**



**Q2 – Have you managed to get involved in your local Healthwatch?**



**Q3 – If yes briefly describe your involvement?**

‘Developing a partnership agreement and joint working project to seek the views of the people of the County about mental health issues in primary care.’

**‘I have joined the mental health focus group and taken part in the enter and view programme.’**

‘I emailed about getting involved in relation to mental health and pointed out the failure to comply with Mental Health Act Code of Practice at local unit but have not received a response.’

‘Only very marginally. I have raised issues relating to disability in general but mental health problems particularly, and they said they were unable to comment or be interested in anything deemed ‘political’. That seems to be everything.’

**Q4 – If no please describe what has stopped you from getting involved in Healthwatch:**

‘My priority is mental health services, and that’s what I most want to develop. That’s not really a priority for local Healthwatch because they have to respond to what the local people want, and local priorities lie more elsewhere.’

**‘They are struggling to engage with mental health users and users groups.’**

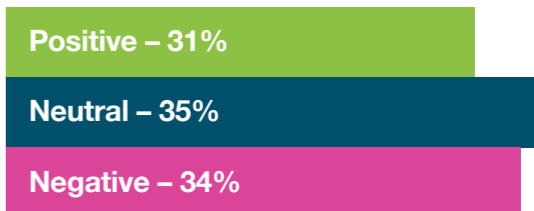
‘Healthwatch has a very different structure [from the LINK] and wanted to break away from the LINK members so we were not invited and our advances were not accepted.’

‘I gave details to local Healthwatch but have heard nothing. Possibility is that they have not contacted me because events are being held in places I cannot access as a wheelchair user.’

‘They claim to want service user involvement yet whenever I asked for an item to be put on agenda it didn’t happen.’

‘Local Healthwatch only want people representing groups.’

**Q5 – overall have you found the experience of involvement with Healthwatch positive, negative or neutral?**



## Q6 – Please describe briefly has been the most positive thing about being involved in your local Healthwatch?

‘Influencing the voice of service users at grass roots level.’

‘Being part of a mutually supportive team.’

‘I like getting updates on what is going on in my area and being asked to contribute.’

‘Felt listened to.’

‘The willingness to engage.’

‘Their local launch was excellent; I met people I’d not seen for years and new people too. It brought me up to date with some local issues.’

‘Being able to raise profile of mental health issues.’

‘A keen, well informed bunch of volunteers, many of whom have been involved with LINKs.’

**‘A keen, well informed bunch of volunteers, many of whom have been involved with LINKs.’**

‘Meeting local people who care about chronic illness, mental health and Wellbeing who like me want to help make positive changes for everyone.’

## Q7 – Please briefly describe what could have been improved in terms of involving people with mental health experience in Healthwatch

‘Better communication.’

**‘They are struggling to engage with mental health users and users groups.’**

‘Engagement from black and minority ethnic (BME) service providers with track records of engagement.’

‘To have a mental health policy or subgroup as my Healthwatch run by local council staff exclude mental health service users and put barriers up.’

‘Healthwatch is a more top-down organisation [than LINK] with many more full-time employees and a chief executive - it is not, so far, very good at fostering the involvement of volunteers.’

‘I think sometimes the groups are dominated by who turns up and speaks the loudest. I would like them to not just to rely on those who are already engaged and reach out more to different groups, both in responding to consultations but also highlighting the areas that need focusing on.’

‘A robust, visible and transparent expenses policy and support or ‘reasonable adjustments’ to enable people with complex problems, dual diagnosis and learning disabilities more involvement.’

‘Better welcome and inclusivity rather than corporate speak and attitudes.’

‘A time-out room or area where we can go if we get anxious or just need a break to recharge.’

‘Locality groups are ideal as less threatening than the county groups. Healthwatch needs to ensure that mental health is high on its list of priorities.’

‘A dedicated champion working with people on mental health agenda in local Healthwatch.’

## Q8 – Has your Healthwatch done anything in relation to mental health services in your area?

Yes – 43%

No – 57%

## Q 9 – If yes please briefly describe what this activity has been

‘Working with the Kings Fund around the poor crisis service.’

‘The mental health group has facilitated dialogue between senior NHS managers and service users - highlighting key service user issues.’

‘The implementation of a group designed to listen to and take appropriate action about the concerns of people with mental health experience in the County.’

‘Looked into the buildings that mental health services operate from, as there have been concerns for years that these buildings are unfit for purpose - both for staff and patients.’

‘Visited mental health hospital wards and residential and recovery homes.’

‘Set up sub-group for mental health and have patient reps as well as organisation from voluntary sector. Have had commissioners as well as our local mental health service providers at our meeting to answer questions around services.’

**‘Service providers have been giving details of plans and current provision at HW meetings.’**

## Q10 – Please briefly describe what more would you like to see your Healthwatch doing in relation to mental health

‘Better communications – regular email and printed newsletters for example.’

‘Unannounced visits to mental health wards.’

‘Helping to fight for more user-focused services.’

‘Healthwatch needs to champion ‘No Health without mental health’ especially at health and wellbeing board and at clinical commissioning group meetings.’

**‘Is in process of setting up a mental health project to assess mental health community services.’**

‘Separate group needed not just part of general health watch. Mental health champions needed.’

‘Better team working between the Healthwatch ‘professionals’ and the mental health service users and volunteers.’

‘Engaging those using the services, not just those involved in activism/committees. Be a voice for service users.’

‘Campaigning for better services and canvassing opinions of service users.’

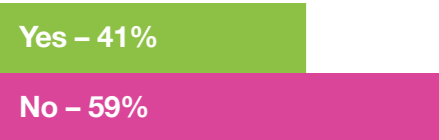
‘To bring to fruition the partnership proposal and support with resources the project to explore with the people of the County in primary care their needs and experience of mental health support.’

‘Have an influence with commissioning group to press for more funding for mental health.’

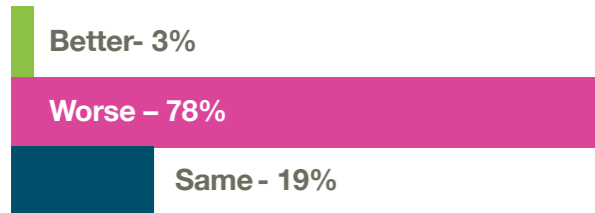
‘Ensuring standards and safety for inpatients; listen to people’s experiences; look in to

crisis care; look at how people with mental health conditions are treated in emergency departments; facilitate discussions between the clinical commissioning group and service users.'

**Q11 – Do you think your Healthwatch has the resources it needs to do a good job?**



**Q12 – Do you think services for people with mental health conditions in your area are getting:**



In late 2013 and early 2014 we asked all local Healthwatch groups to complete a short survey about their work – 44, nearly one third responded.

## Q1 Do you have the resources you need to do the job that is expected of you?

Yes – 51%

No – 49%

‘We have a mental health subgroup led by a governor of our local mental health trust.’

‘We have had a mental health working group and are now trying to forge a partnership with our local Service user organisation.’

‘Working with a small group of users and carers to develop a structure/strategy for ensuring mental health is embedded in all the work undertaken by Healthwatch.’

‘Connecting with support groups in this area and working in partnership to develop a mental health forum.’

‘We have a mental health consumer action group that brings together service providers and users so that they can collate issues and present them to local Healthwatch as a collective voice.’

‘We’ve recruited a community champion for mental health who is a service user. We have also worked with this person previously to help them raise concerns over lack of consultation about changes to services, and supported the establishment of a mental health service user forum in the area.’

‘We have a set up a task and finish group to look at service provision on mental health and plan to gather feedback from service users.’

‘Working with the local authority public health team we held two mental health service user and carer focus groups and several one to one interviews across the borough.’

## Q5 Can you describe what would help you improve your work with people who have experienced mental health conditions?

‘More volunteers who have used mental health services.’

‘More engagement from ‘professionals’ to tell people about us.’

‘Greater resources/specialised staffing.’

‘The resources to do more outreach work with hard to reach groups.’

‘Support from my health and wellbeing board.’

## Q2 If ‘no’ who do you attach most blame to?

Yes – 79%

No – 31%

## Q3 Have you done any work to particularly involve people with mental health conditions in your Healthwatch?

Yes – 72%

No – 31%

## Q4 If ‘yes’ to the previous question please briefly describe this work

‘Commissioned children and adolescents mental health services research project.’

‘We have service users and carers sitting on our task and finish groups.’

‘Be Involved Devon is commissioned as the mental health engagement strand for Healthwatch Devon. We have a monthly newsletter and hold local meetings quarterly.’

‘Working with CCG who are procuring new mental health services. Working with public health regarding the mental health strategy No Health without Mental Health.’

‘Set up a mental health sub-group for mental health and we have a number of voluntary sector representatives who work with people who have mental health issues.’

‘A greater understanding of the issues faced by those with mental health on a daily basis.’

‘Development of a Healthwatch mental health network to share ideas, best practice etc.’

‘Examples from elsewhere of what has made a difference will be useful.’

‘Information relating to best practice for the delivery of mental health services and a simple guide to psychiatric conditions and treatments (mental health is not my specialist area).’

‘Monthly updates of what other local Healthwatch’s are doing. Help to develop a focus group to gain insight in to people’s views and experiences who are directly affected by mental health services.’

## Q6 Please describe anything useful you have learnt from working with your local council

‘Nobody wants to know.’

‘Public health is not integrated into the local authority and both want voluntary and community groups to make pledges for No Health without Mental Health.’

‘They are out of date and touch of real people.’

‘There are some who are really supportive and others who just shut the door.’

‘The council’s mental health commissioner is an extremely positive advocate and enabler of co-production when commissioning services, developing and evaluating them. He is passionate about the people who use services using their experience and knowledge to support others.’

‘They were great partners for setting out legal frameworks, protocols and so on.’

‘Publication of benchmarked contract monitoring tools should be provided by Local Government Association for new services, to reduce variation and ensure an even handed approach is being taken.’

‘You must maintain a continuous dialogue but remember Healthwatch is meant to be “independent”’.

‘They are supportive of efforts and take mental health seriously and do what they can with the resources they have. They encourage partnership working to achieve results.’

‘Their approach to engagement and consultation seems to be to adopt the bear minimum. Huge funding shortfall for public health particularly makes it difficult. Not joined up with CCG mental health agenda.’

‘Vital to identify key relevant officers. Ensuring they take on board user and carer involvement from the beginning.’

‘Council has regular mental health forum; we are currently looking at how influential the user forums are - they are well supported but the outcomes of their work do not always translate into service plans. The council has some good communication tools.’

‘They have a very tough job ahead to reduce their budgets and they are constrained through their internal processes and the political element that local democracy brings.’

‘The council are supporting us to make good links into a wide range of networks. They are keen to support us and have involved us in a lot of partnership working.’

‘Learning where their priorities will be focused



in austere times, keeping abreast of their organisational structure and the change in focus looking for community focused support.'

'We have learnt together that it is best to have all the relevant people around the table in the first instance and that partnership working and working with patients and carers really adds value and creates better outcomes.'

## Q7 - Please describe anything useful you have learnt from working with your local clinical commissioning groups

'To date the local CCG seems very supportive of the patient voice.'

**'Good relationship with public and patient rep but CCG expectations of what Healthwatch can deliver is too high.'**

'We work across two CCG areas which are developing at different rates. One of the CCGs is more advanced in terms of their approach to mental health engagement. So we can see the value in words being turned into action.'

'Nobody wants to know.'

'Joint working, the sharing of information, regularly updated on service changes, consultations etc.'

'Commissioners attending our meetings now and it helps us to both understand the financial constraints from government and we are working together to get the best for our mental health services within those constraints.'

'We have a close working relationship with our local CCG, with one of our members sitting as a representative on the board. We are able to bring issues directly to the CCG board this way.'

'That expedient solutions to consultation/engagement are being sought and this is not necessarily aligned to meaningful community participation.'

'Continuous dialogue is crucial to maintain those communication pathways, allowing greater and more meaningful interaction when needed.'

'They are understaffed and the recent re-structuring of the NHS has resulted in a loss of skills, knowledge and experience.'

'They speak a different language that takes some time to learn and often operate in a different culture.'

'The CCG are still establishing themselves, but we have found they are also keen to make sure we are involved in things. We have learnt what influences them in terms of setting priorities, and they are keen to work with us to increase public participation in decision making.'

'Health, social and voluntary services need to work better together.'

'Public engagement initiatives can be held up by CCG internal systems and protocols so be careful when committing to any collaborative work and always ensure Healthwatch's role is made very clear.'

## Q8 Please describe anything useful you have learnt from working with your local mental health providers

'Services are still very much in need of modernisation. For example, not everyone with a mental health problem wants to make a basket or paint.'

'They tend to try to do engagement in house and don't appear to see the need to proactively engage with Healthwatch.'

'Nobody wants to know.'

'The current provider has recently set up locally within the city. We are looking at a protocol for working with them and any newly commissioned provider.'

'They want to hear from us and involve us but

can't always action what we recommend.'

'We have a clearer picture from providers of where gaps in services are which will help us to determine our work plan for the coming year.'

'The importance of having people who have used services develop and being integral to new and existing services. Some work we have previously carried out includes co-producing a leaflet outlining the complaints process with the main local service providers, developing our relationship with the complaints manager at our mental health trust.'

'They are hopelessly overstretched and still required to make further cuts and savings which clearly impacts on the most vulnerable of service users.'

'That with the right help, support, people with mental health issues can live happy lives.'

'The local provider trust is trying to engender good involvement practice but the feedback from users is that they still do not feel fully listened to. A quite big programme of service change led to a reduction on some services people valued, particularly community based provision.'

'They are very in tune with service user needs and experiences and do try to involve the people who use their services in how they are delivered.'

'Good feedback about service user experiences.'

## Q9 Have you carried out an 'enter and view' inspection of a mental health service?

Yes – 16%

No – 84%

## Q10 If 'yes' please describe what you learnt from this and any advice for other Healthwatch groups

'We visited a couple of day centres. These showed us what fantastic work these groups

**'That they start to see how things should be done by working together from a person in real need.'**

did and how much service users relied on them. It also highlighted the constant struggle these groups had for funding.'

'Difficulties arise when the staff, within settings used by mental health service users, do not have a mental health background.'

'The facility was very anxious about what we'd say and do so there was a lot of reassurance and persuasion needed but once we did it, it went well.'

'There is a gap between the commitment to involvement work - lots of it happens in our borough - and the actual changes that happen as a result. We would like to see more done to promote true co-production of the solutions people need. The goodwill exists, but the bureaucratic aspects of service planning can get in the way of good intentions. We aim to work with all our commissioners and providers to improve this situation.'

'We follow the quality and safety checks and reports carried out by the trust and county council.'

'We inspected a small acute unit - due to sensitive nature patients we talked to were hand-picked by staff therefore not totally independent.'

'User voice is very important and should be listened to.' ●

## Further reading and useful links

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### Healthwatch England

<http://www.healthwatch.co.uk/>

### Local Healthwatch and Human Rights:

what you need to know. This guide is a short leaflet to help Local Healthwatch organisations understand their role in ensuring people's human rights are respected, protected and fulfilled.”

<http://www.bih.org.uk/news/new-resource-local-healthwatch-and-human-rights>

### The National Involvement Partnership

**(NIP)** 4PI framework aims to promote good practice and to measure, monitor and evaluate the involvement of service users and carers in mental health services.

<http://www.nsun.org.uk/assets/downloadableFiles/4pi.-ni-standards-for-web.pdf>

### A review of values-based commissioning in mental health – Emma Perry, Jo Barber and Elizabeth England, 2013.


This is a review of values-based commissioning in the West Midlands. It reports an evaluation of the West Midlands mental health commissioning modelling group and consultations with service users and carers.

<http://www.nsun.org.uk/assets/downloadableFiles/values-based-commissioning-report--20132.pdf>

### No decision about us without us – Department of Health, 2012.

This guide explains the commissioning structures and suggests how you can get involved as an individual or a group.

[http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/mentalhealthfoundation/1537502012\\_No\\_decision\\_about\\_us\\_without\\_us.pdf](http://socialwelfare.bl.uk/subject-areas/services-client-groups/adults-mental-health/mentalhealthfoundation/1537502012_No_decision_about_us_without_us.pdf)



‘User voice is very important and should be listened to.’

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