



Jane Ray
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The Quality of Mental Healthcare in England and CQC priorities
September 2019

Our purpose and role



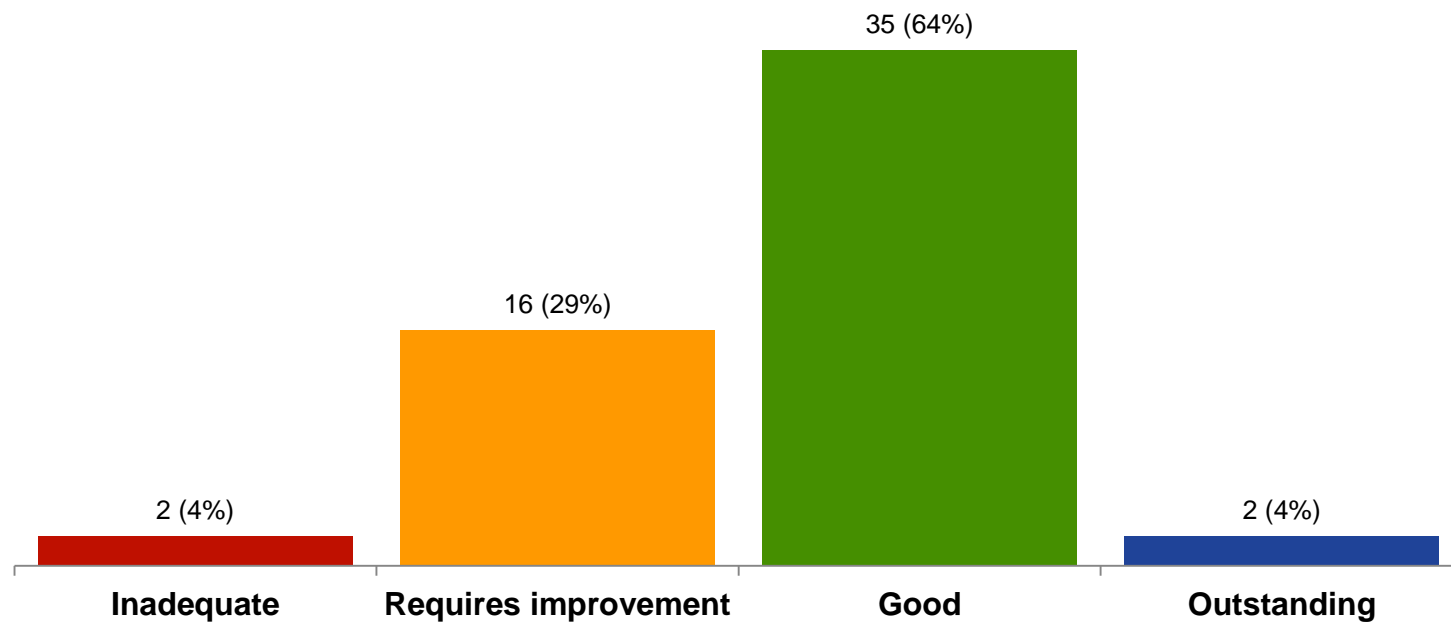
- We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve



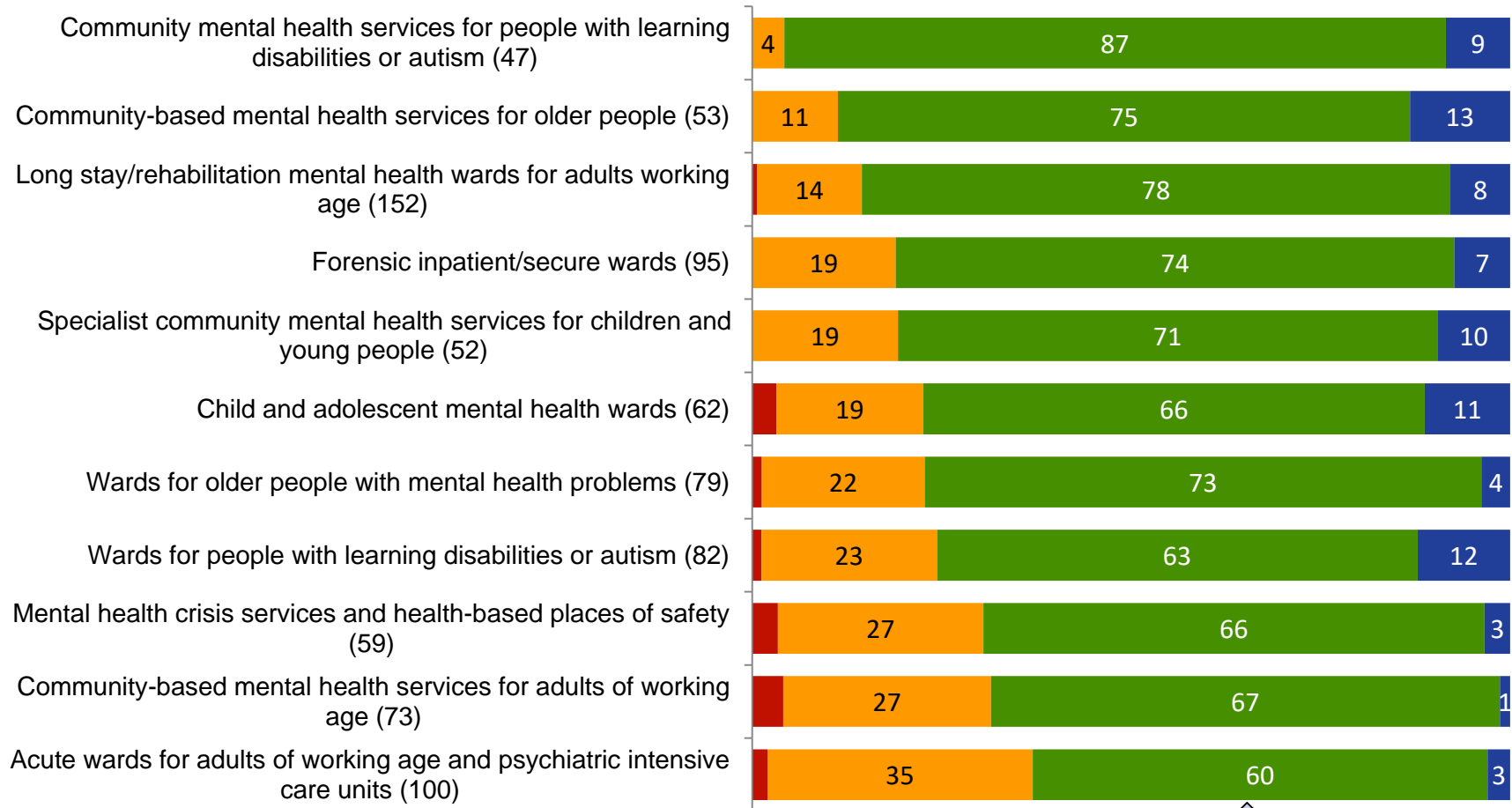
- Register
 - Monitor and inspect
 - Use legal powers
 - Speak independently
 - Encourage improvement
-
- People have a right to expect safe, good care from their health and social care services

- **CQC's view of the current quality of services**
- **Key concerns identified by our programme of inspection**
- **Current priorities and programmes of work**
- **The direction for regulation in the future**

The overall picture in mental health trusts in England

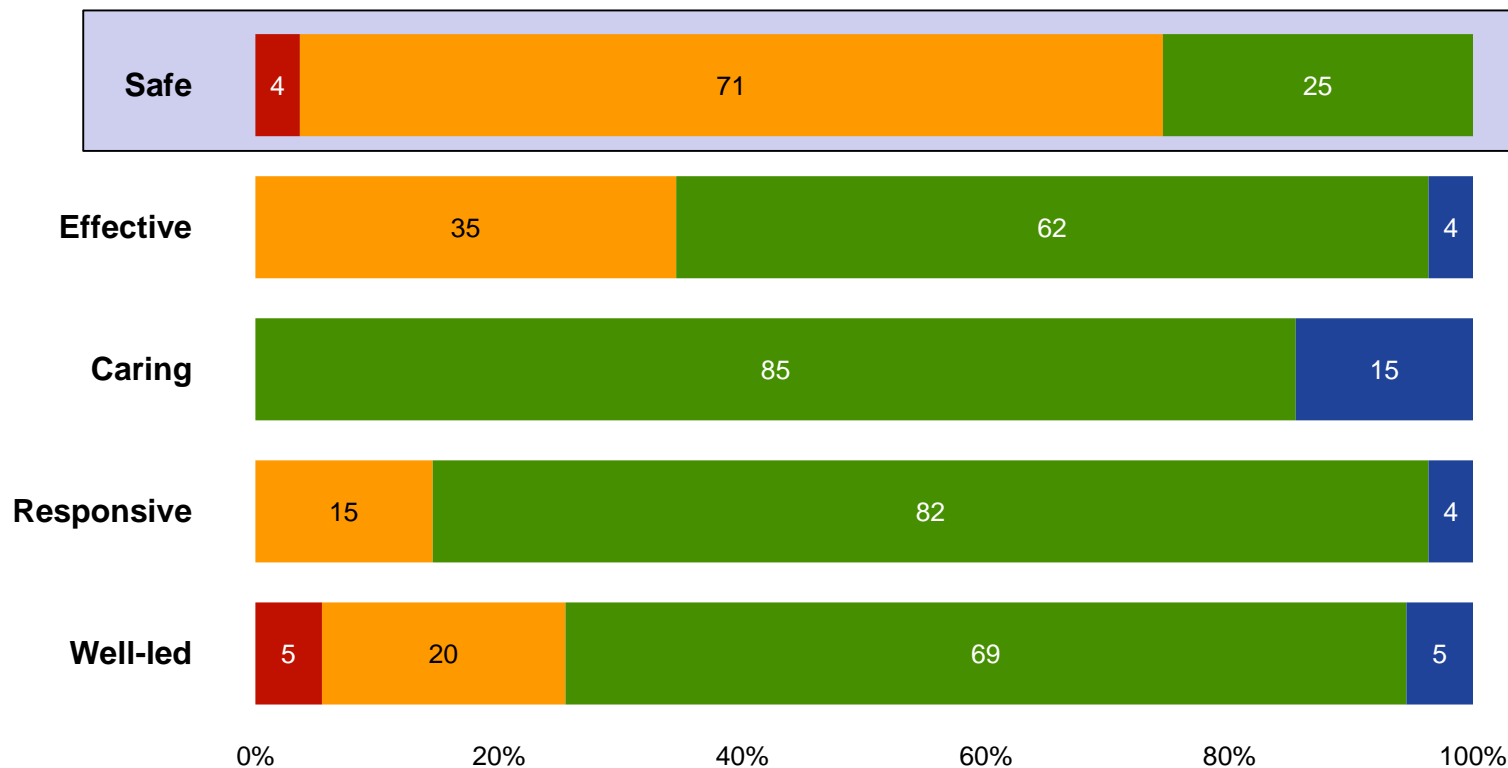


Current ratings for mental health core services



NHS and Independent

Safety is our biggest concern



Reminder of CQC's overall concerns in the mental health sector



Poor physical environment of mental health wards



Sexual safety on mental health wards



Use of physical restraint

High number of rehabilitation wards out of area



Mental healthcare for people with physical health problems

Physical health of people with mental health problems



Clinical information systems



High secure hospitals



Staffing

Poor physical environment of mental health wards

- Facilities not designed to meet need of today's patients
- Fixtures and fittings a hazard
- Blind spots and too few staff to observe all areas easily
- Dormitories

Sexual safety on mental health wards

- Incidents of sexual harassment and assault
- Breaches of guidance on eliminating mixed sex accommodation

Locked rehabilitation wards

- High number of people in these wards, often situated a long way from the patient's home

Specific Concerns: 2



Closed communities

- Considering the culture
- Hearing people's experiences

Physical restraint

- Great variation between wards in frequency of use
- Continued use of prone restraint
- Lack of consistency in reporting use of restraint
- Quality and consistency of training

Staffing

- Some providers are struggling to staff services safely
- Use of bank and agency staff may affect safety, patient experience and continuity of care

How we're addressing our concerns



Care Quality Commission

The state of care in mental health services 2014 to 2017

Findings from CQC's programme of comprehensive inspections of specialist mental health services

STATE OF CARE

Care Quality Commission

Briefing

Substance misuse services

The quality and safety of residential detoxification

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and encourage services to improve. We exercise our independent voice by publishing our views on quality issues in health and social care.

Care Quality Commission

Monitoring the Mental Health Act in 2016/17

Care Quality Commission

Keeping people safe from harm

SEXUAL SAFETY ON MENTAL HEALTH WARDS

Care Quality Commission

Are we listening?

REVIEW OF CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH SERVICES

MARCH 2018

Care Quality Commission

Driving improvement

Case studies from seven mental health trusts

MARCH 2018

Care Quality Commission

Mental Health Act

The rise in the use of the MHA in England

Mental health rehabilitation inpatient

Ward types, bed numbers and use by clinical commissioning groups and NHS trusts

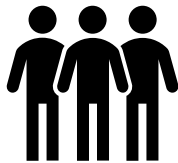
Interim report on CQC restraint review end May 2019

Key questions

For people with a mental health problem, a learning disability or autism:

1. How can hospital and residential care providers, and the wider system, protect the welfare and rights of those who are subject to prolonged seclusion or segregation and minimise the likelihood of this being the outcome of care?
2. What changes do hospital and residential care providers need to make to create an environment that minimises the use of restraint?

What key things will we be looking at throughout the review?



Number of people subject to restrictive interventions in these settings

Pathway that the person has followed to end up in segregation and/or prolonged seclusion

Quality of care and of the **physical environment**

Safeguards in place to protect the person's rights and to protect the person from abuse



Impact of segregation and/or prolonged seclusion on **people who are subject to it and on their families**

Impact on other **patients/residents** and staff

Quality of leadership and the culture

The role of the **wider system**

The work is in two phases

Phase 1 (from January 2019) 	Phase 2 (from June 2019) 
<ul style="list-style-type: none">• Specialist NHS and independent sector wards for people of all ages with learning disabilities and/or autism.• These include assessment and treatment units and low and medium secure wards for people with learning disabilities and/or autism.• Child and adolescent mental health wards	<ul style="list-style-type: none">• NHS and Independent sector mental health ‘rehabilitation’ and ‘low secure’ wards• Residential care homes for people with learning disabilities and/or autism• Children’s residential services (in partnership with Ofsted)• 14 secure children’s homes in England (in partnership with Ofsted).

The methods we will use



Literature review to develop our understanding



Information request to Providers



Site visits to providers where people are subject to segregation, prolonged seclusion and restraint



Co-production and engagement with people with lived experience and system partners



External Advisory Group made up of the public, providers, clinicians, commissioners and voluntary sector

- Pathway into segregation
- Suitability of the built environment for autistic people and the conditions in which people are segregated
- Training and skills of staff who work with those with the most complex problems and challenging behaviours
- The challenge of discharge
- Is the system part of the problem?
- Is this a human rights issue?

'Getting it right' for mental health wards: Why?



'Our greatest concern is about the quality and safety of care provided on mental health wards' (*last year's State of Care*)

'We must acknowledge that the environment in which we look after those detained under the Act is now often anything but therapeutic' (*Simon Wessely's foreword to the MHA review report*)

There is 'wide variation in the quality and capability of these acute mental health units across the country'.... 'capital investment from the forthcoming Spending Review will be needed to upgrade the physical environment for inpatient psychiatric care' (*NHS long term plan*).

'CQC should develop new criteria for monitoring the social environments of wards. These criteria should be the yardstick against which wards are registered and inspected and this should be reflected in ratings and enforcement decisions' (*Report of the MHA review*)

We need to improve:

- **The physical fabric.** Many wards are not designed for today's patients, poor lines of sight, fixtures and fittings that endanger people at risk of suicide, dormitories, challenge of eliminating mixed sex accommodation.
- **Access to the full range of treatment and care interventions** recommended by NICE.
- **Staffing** - enough who know the ward and the patients to maintain safety, and staff with the skills required to minimise restrictive interventions.
- **The quality of leadership** and the extent to which this fosters a culture of engagement, co-production and 'no force first'.
- **The interface with community services**

Safety and quality of inpatient care: 'Getting it right'



CQC will:

- **Review, and where necessary, revise the guidance** that directs our inspectors; to set an appropriate level of expectation for quality and safety.
- **Strengthen our assessment of actions to minimise the use of restrictive interventions** (drawing on learning from the thematic review).
- **Assess steps taken to mitigate impact of shared sleeping arrangements** and the credibility of plans to eliminate them.
- **Give greater weight to patients' access to a wider range of treatment and care interventions**
- **Implement the actions in our recent report on sexual safety**
- **Continue with the mental health safety improvement programme**
- **Assess Boards' awareness of the quality of the inpatient estate** and how active are the steps taken to obtain capital investment – if that is required.

Any questions?



Thank you