

# 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

## **Our purpose**

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

## **Our role**

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

## **Our values**

**Excellence** – being a high-performing organisation

**Caring** – treating everyone with dignity and respect

**Integrity** – doing the right thing

**Teamwork** – learning from each other to be the best we can

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# Foreword

Mental health has never had a higher profile. More than ever before, people are being encouraged to talk openly about their mental health and to share their experiences. More people than ever are receiving treatment and care for mental health conditions; in part due to a reduction in the stigma associated with mental ill-health.

But this vital work can only truly succeed if it is supported by mental health services that give people the help they need, when they need it, where they need it. The mental health sector in England is at a crossroads. The Five Year Forward View for Mental Health, published last year, points the way to a future where people have easy access to high-quality care close to home, and they are able to exercise choice.

To achieve this vision, and so meet the raised expectations from the public and government, the sector must overcome an unprecedented set of challenges – high demand, workforce shortages, unsuitable buildings and poor clinical information systems. Some services remain rooted in the past – providing care that is over-restrictive and that is not tailored to each person's individual needs. But the best services are looking to the future by working in partnership with the people whose care they deliver, empowering their staff and looking for opportunities to work with other parts of the health and care system.

These outstanding mental health services – like Northumberland, Tyne and Wear NHS Foundation Trust and East London NHS Foundation Trust – provide care in hospitals and round-the-clock care in the community that are world-class. They have leaders, both at a provider and ward level, who shape the care they deliver around the people who receive it.

The challenge is how to ensure that everyone, no matter where they live or who they are, has access to services of this quality. The good news is that mental health services in England have the raw material to achieve great things. We have rated almost every service as good or outstanding for having caring and compassionate staff – ratings that were informed by our own observations and with interviews with many thousands of staff and patients.

We have now completed comprehensive inspections of all specialist mental health services in England. Our inspectors have found many examples of excellent care – but we also found too much poor care, and far too much variation in both quality and access across different services.

At 31 May 2017, 68% of core services provided by NHS trusts and 72% of those provided by independent mental health locations were rated as good; a further 6% of NHS and 3% of independent core services were rated as outstanding. Since starting our inspection programme using the new approach we have re-inspected 22 mental health NHS trusts that we initially rated as inadequate or requires improvement. It is encouraging that 16 of these improved their rating (15 from requires improvement to good, and one from inadequate to requires improvement).

The pressure on services at least partly explains why, at 31 May 2017, 36% of NHS core services and 34% of independent mental health core services were rated as requires improvement for safe, with a further 4% of NHS and 5% of independent core services being rated as inadequate for safe. On too many wards, the combination of a concentration of detained patients with very serious mental health conditions, old and unsuitable buildings, staff shortages and lack of basic training, make it more likely that patients and staff are at risk of suffering harm.

More than 50 years after the movement to close asylums and large institutions, we were concerned to find examples of outdated and sometimes institutionalised care. We are particularly concerned about the high number of people in 'locked rehabilitation wards'. These wards are often situated a long way from the patient's home, meaning people are isolated from their friends and families. In the 21st century, a hospital should never be considered 'home' for people with a mental health condition. This principle underpins the drive to transform care for people with a learning disability. It applies equally to those with severe and enduring mental health conditions.

We concluded that, too often, these locked rehabilitation hospitals are in fact long stay wards that institutionalise patients, rather than a step on the road back to a more independent life in the person's home community. In a number of cases we found that these hospitals did not employ staff with the right skills to provide the high-quality, intensive rehabilitation care required to support recovery. This could result in people using these services feeling hopeless and powerless, and failing to fulfil their potential to regain control of how they live their lives.

These hospitals must more actively support patients to acquire the skills they need to live more independently and be more proactive in planning discharge. At the same time, health and social care commissioners must ensure that suitable accommodation and intensive community mental health support is available in the person's home area. This is right for the wellbeing of the people involved, and for their friends and families, and it also makes economic sense. Long-term out of area care in hospitals – whether this is people with a learning disability spending long periods in hospital or people in 'locked rehabilitation' wards – not only risks people's isolation and institutionalisation, but is also very expensive.

Three years after publication of the Department of Health's guidance 'Positive and Proactive Care: reducing the need for restrictive interventions', we are concerned about the great variation across the country in how often staff physically restrain patients whose behaviour they find challenging. This wide variation is present even between wards that admit the same patient group. In response to this, CQC is further strengthening its assessment of how and how often services use physical restraint; we wish to send a clear message to providers that we will be subjecting services where staff frequently resort to restrictive interventions to much tougher scrutiny.

Those who deliver and commission care must learn from the services that are getting it right. CQC will play our part – highlighting good practice, supporting improvement and acting on behalf of people to ensure that everyone gets the help they need when they need it. Our commitment to encourage improvement and act in the best interests of people will remain unchanged – but we will work more closely with experts in the field of mental health care to ensure that our inspectors understand the latest thinking on what is a rapidly evolving area of policy and practice.

**Dr Paul Lelliott**

Deputy Chief Inspector (Lead for Mental Health)

# Summary

We have completed our programme, which started in 2014, of comprehensive inspections of all specialist mental health services in England. The landscape of specialist mental health care in England is complex – care is provided by both mental health NHS trusts and independent mental health providers. As at 31 May 2017, we have rated services provided by 54 NHS trusts and 221 independent mental health locations.

The government and other political parties have made mental health care a national priority. The Five Year Forward View for Mental Health, published in 2016, is a cross-governmental blueprint that lays out a single programme of commitments for the whole mental health sector. It covers a number of areas for change: challenging stigma, introducing initiatives to promote mental health and prevent mental ill-health, reducing the suicide rate, improving access to high-quality services, tackling inequalities in mental health, especially for people from Black and minority ethnic groups, giving people a choice of interventions, ending out of area placements, and integrating physical and mental health care.

There are a number of significant pressures and challenges in providing specialist mental health services that must be overcome if we are to realise the vision set out in the Five Year Forward View. There is high demand: an estimated 1.8 million people were in contact with adult mental health and learning disability services at some point in 2015/16, and the total number of detentions each year under the Mental Health Act rose by 26% from 2012/13 to 2015/16. In many parts of the country, people with suspected dementia or with an eating disorder have to wait many weeks, and sometimes months, for specialist assessment, and children and young people with a mental health condition are facing longer waits for treatment. Meanwhile, the number of NHS mental health nurses has declined in recent years – a 12% fall between January 2010 and January 2017.

Through our inspections, we found many examples of good and outstanding care – but we also found too much poor care, and far too much variation in quality and access across different services.

As at 31 May 2017, we had rated 68% of NHS core services as good and 6% as outstanding. Among independent services, 72% of core services were rated as good and 3% as outstanding.

Some types of service performed particularly well, especially community mental health services for people with a learning disability or autism (80% rated as good and 9% as outstanding) and community-based mental health services for older people (76% rated as good and 10% as outstanding). In these services, we found with more consistency that staff were skilled and appropriately trained, patients were involved in planning their care, and there were systems in place to deal with urgent referrals.

And across all services, the vast majority of staff genuinely cared about the people who used their services. The overwhelming majority of NHS and independent services were rated as good or outstanding for having caring and compassionate staff (NHS: 88% good, 9% outstanding; independent: 93% good, 5% outstanding). With very few exceptions, staff

formed relationships with their patients that were respectful and compassionate and they treated patients with dignity and respect.

In addition, services that needed to improve have made real progress when they have taken on board our findings and committed to tackle problems proactively and learn from others. Sixteen of the 22 NHS trusts (73%) that we first rated as inadequate or requires improvement improved their rating when we re-inspected them. This is testament to the good leadership and strong determination to improve, at both board and ward level, the development of close links between leaders and front line staff, and those staff feeling part of a culture that delivers high-quality care.

However, a substantial minority of NHS trust and independent services must improve the quality of care they provide. Twenty-five per cent of NHS core services were rated as requires improvement as at 31 May 2017, as were 23% of independent core services. And a small number were rated as inadequate: seven core services (1%) in NHS trusts and three core services (1%) among independent services.

In this report, we have identified several areas of concern:

- **The safety of services:** for both NHS and independent mental health services, safe was the key question that we most often rated as requires improvement or inadequate. As at 31 May 2017, 36% of NHS and 34% of independent core services were rated as requires improvement for safe. A further 4% of NHS core services and 5% of independent services were rated as inadequate for safe. A number of factors contributed to these ratings: the physical environment of many mental health wards located in older buildings that are not being designed to meet the needs of today's acute patients; some services struggling to ensure wards were safely staffed at all times; and staff in both inpatient and community services not always managing medicines safely.
- **Persistence of restrictive practice:** more than 30 years after the introduction of mental health legislation that enshrined the principle of least restriction, some patients still receive care that is overly restrictive. We found that there are about 3,500 beds in locked mental health rehabilitation wards, with about two-thirds managed in the independent sector. These wards are often situated a long way from the patient's home, meaning that people are isolated from their friends and families. Our inspectors were concerned that some of these locked rehabilitation hospitals were in fact long stay wards that risk institutionalising patients, rather than a step on the road back to a more independent life in the person's home community. We do not consider that this model of care has a place in today's mental health care system.

Also, across all mental health services, we found great variation between wards in how frequently staff use restrictive practices and physical restraint to manage challenging behaviour. We noted that those wards where the level of restraint is low or where they have reduced it over time have staff trained in the specialised skills required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm.



- **Access and waiting times:** a number of people have difficulty in accessing the service that is best equipped to meet their needs. Sometimes our inspectors identify this unmet need directly on inspection: for example, long waiting times in a community child and adolescent mental health service, a mental health crisis team that did not provide 24-hour cover, or patients' discharge being delayed because of the unavailability of a community care package. It was harder for inspectors to gauge other instances of unmet need – for example, how many people had been admitted to a distant independent hospital because a bed was not available locally. Also, we could not always attribute responsibility for this unmet need to the providers that we regulate. These difficulties with access to local services were sometimes due to decisions of commissioners, rather than providers.
- **Poor clinical information systems:** many of the clinical staff we talked to voiced their frustration about the clinical record systems that they have to work with. They said they are often unable to locate or retrieve information that others have recorded, have to enter essential clinical information into a number of different systems because these systems 'do not talk to one another', or have to work with a confusing combination of electronic systems and paper. This problem consumes staff time that could be better spent in face-to-face contact with patients, increases the likelihood that essential information about risk is not communicated to staff who need to know, and can lead to care plans that do not reflect the contribution of all members of the multi-professional team or sometimes the voice of the patient.

# 1. Introduction

In 2014, we started our programme of comprehensive inspections of specialist mental health services in England. We have now inspected all 54 NHS mental health trusts in England and all 221 independent mental health services.

We know more about the quality of mental health care than ever before. The combination of evidence from our inspections, the findings from our monitoring of how providers apply the Mental Health Act 1983, and analysis of data from a range of other sources has given us an unparalleled resource of information. This detailed and unique picture of mental health care across the whole of England also provides us with a baseline against which we can continue to monitor and measure the quality of care.

The landscape of specialist mental health care in England is complex. Care is provided by mental health NHS trusts and independent mental health providers for people with a wide range of mental health needs in a variety of settings and locations – both in hospital and in the community. Many of the NHS trusts are very large and operate over a wide geographical area.

Due to the size and spread of many NHS providers, we have identified 11 core services that, if they are provided, we always include in an inspection (see box).

## **Core services for specialist mental health services**

In specialist mental health services, we always inspect the following 11 core services where they are provided.

### **Inpatient mental health**

- Child and adolescent mental health wards
- Acute wards for adults of working age and psychiatric intensive care units
- Long stay/rehabilitation mental health wards for working age adults
- Wards for older people with mental health problems
- Wards for people with a learning disability or autism
- Forensic inpatient/secure wards

### **Community mental health and crisis services**

- Specialist community mental health services for children and young people
- Community-based mental health services for adults of working age
- Community-based mental health services for older people
- Mental health crisis services and health-based places of safety
- Community mental health services for people with a learning disability or autism

Figure 1 shows how the services that we had rated as at 31 May 2017 were split between NHS trusts and independent providers. There were 54 NHS trusts overall, and 221 independent locations. (These independent locations were provided by 87 separate providers.)

**Figure 1: NHS and independent provision of rated core services, as at 31 May 2017**

<b>Core service</b>	<b>Number of NHS trusts (out of 54) providing each service</b>	<b>Number of independent locations (out of 221) providing each service</b>	<b>Total</b>
<b>Inpatient mental health</b>			
Child and adolescent mental health wards	30	24	54
Acute wards for adults of working age and psychiatric intensive care units	53	33	86
Long stay/rehabilitation mental health wards for working age adults	46	88	134
Wards for older people with mental health problems	53	12	65
Wards for people with a learning disability or autism	37	40	77
Forensic inpatient/secure wards	44	41	85
<b>Community-based mental health and crisis services</b>			
Specialist community mental health services for children and young people	43	4	47
Community-based mental health services for adults of working age	53	13	66
Community-based mental health services for older people	49	2	51
Mental health crisis services and health-based places of safety	54	1	55
Community mental health services for people with a learning disability or autism	42	2	44

Source: CQC registration data. Most trusts provide a range of the core services (many provide all 11) and many independent locations also provide a range of the core services. This table does not indicate the balance of the amount of provision between NHS and independent. For example, each NHS trust provides a higher number of acute wards than does any independent location.

As figure 1 shows, the independent sector provides a substantial proportion of children and young people's inpatient services, long stay and rehabilitation wards, wards for people with a learning disability or autism, and forensic inpatient/secure wards (especially medium and low secure services). The NHS funds much of the care provided by independent mental

health hospitals. Most of the NHS-funded independent care are inpatient services. Also, unlike other health sectors, most independent mental health hospitals provide the types of service that are also provided by the NHS. We have therefore combined our findings into a single report.

For the purposes of this report, we have combined the 11 core services into six groups:

- services for children and young people
- services for working age adults
- older people's services
- crisis care services
- services for people with a learning disability or autism
- forensic services.

Details of our findings for these groups are set out in chapter 3.

## 1.1 Context and challenges for specialist mental health services

Mental health services are still undergoing a transformation that began more than 50 years ago. England has a low number of admission beds per head of population compared with some other developed countries. This is achieved by virtue of universal coverage with community mental health teams, and well developed and specialised mental health services for older people that are successful at diverting many people from admission.

Mental health care has reached another crossroads in its journey of transformation. The government and other political parties have made mental health a national priority and the Five Year Forward View for Mental Health, published in 2016, points the way for the next stage of development. The Five Year Forward View is a cross-governmental blueprint that lays out a single programme of commitments for the whole mental health sector. It covers a number of areas for change: challenging stigma, introducing initiatives to promote mental health and prevent mental ill-health, reducing the suicide rate, improving access to high-quality services, tackling inequalities in mental health, especially for people from Black and minority ethnic groups, giving people a choice of interventions, ending out of area placements, and integrating physical and mental health care.

There are a number of significant pressures and challenges in providing specialist mental health services.

### High demand

At any one time, one in six adults will be experiencing a diagnosable mental health condition.<sup>1</sup> Three-quarters of adult mental ill-health starts in childhood and at least 10% of children aged five to 15 years have a diagnosable condition.

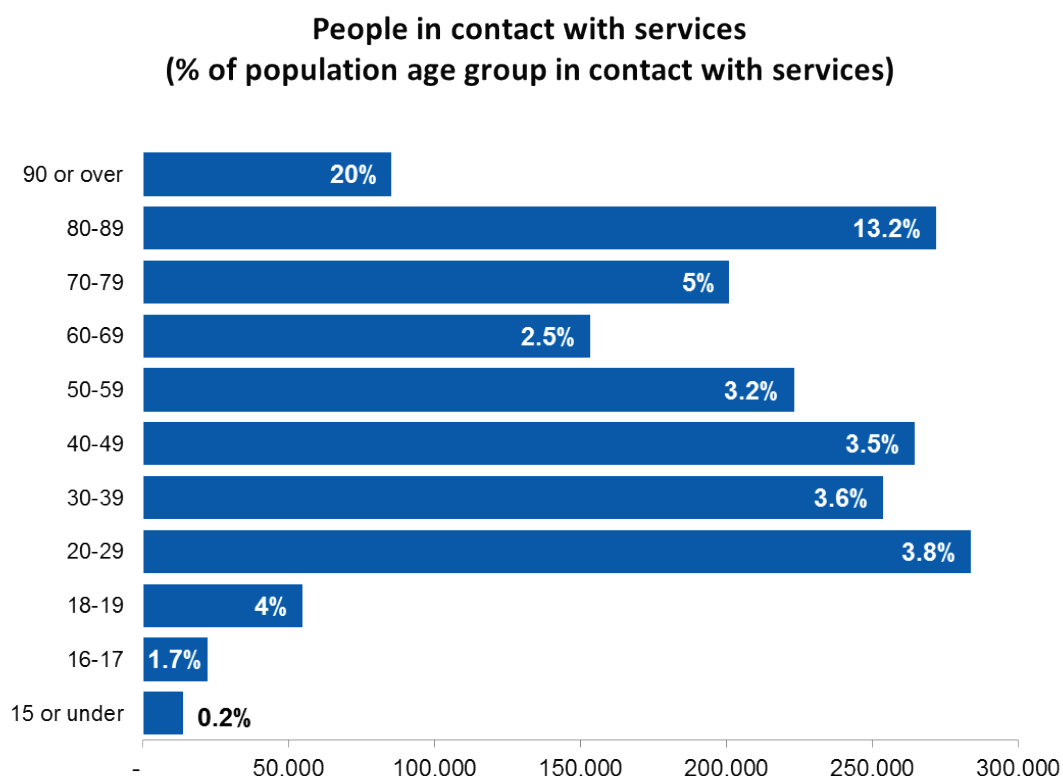
Although the majority of people with mental health conditions are supported and treated by primary care services or by IAPT (improving access to psychological therapies) services, an

<sup>1</sup> <http://content.digital.nhs.uk/catalogue/PUB21748/apms-2014-full-rpt.pdf>.

estimated 1.8 million people were in contact with adult mental health and learning disability services at some point in 2015/16. This equates to about 3.4% of the adult population in England. Of these people, 103,000 (6%) were admitted to inpatient facilities and 1.72 million (94%) were treated and cared for by community mental health services.<sup>2</sup>

As the population ages, so more people will need more mental health care – in 2015/16, 13% of those aged 80-89 and 20% of those aged 90 and over were in contact with mental health services (figure 2).

**Figure 2: Number of people in contact with services in 2015/16**



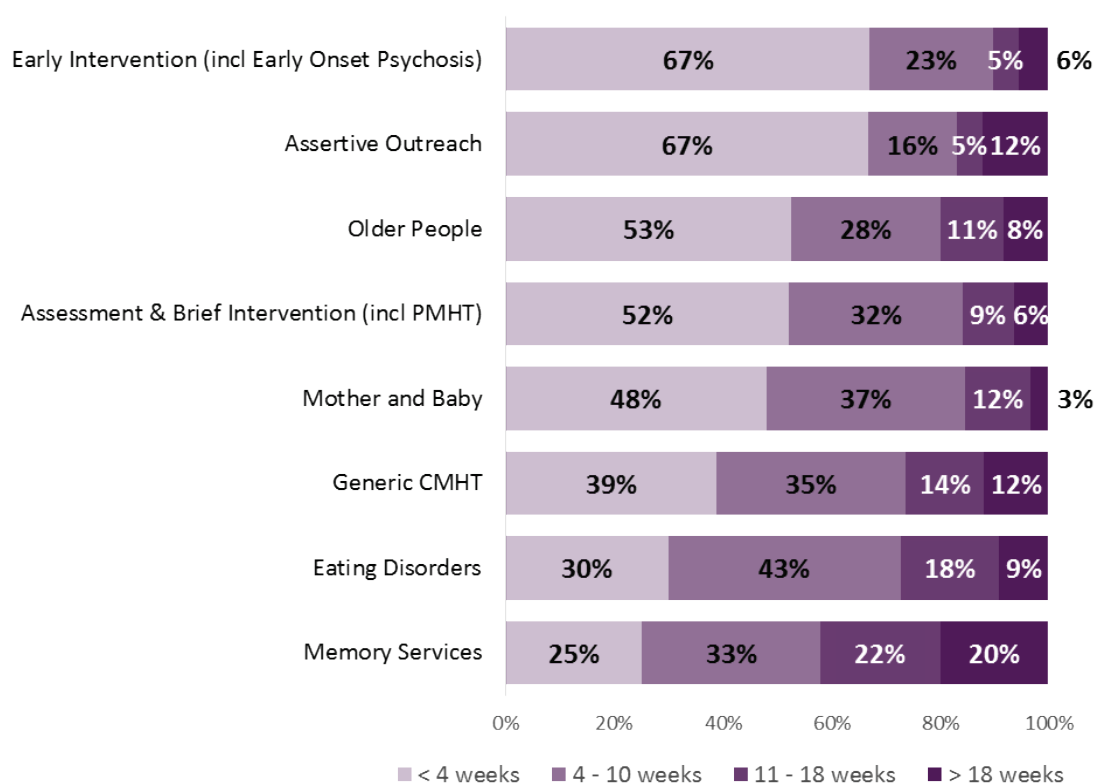
Source: NHS Digital, Mental Health Bulletin 2015-16 Annual Report

<sup>2</sup> NHS Digital, Mental Health Bulletin 2015/16 Annual Report.

There has been a steady rise in the number of people in contact with mental health services over the last few years. Although the number of patients admitted has remained stable, the total number of detentions each year under the Mental Health Act rose by 26% from 2012/13 to 2015/16.<sup>3</sup> Bed occupancy levels for acute admission wards remains high: occupancy in NHS services was 89% in the three months to 31 March 2017.<sup>4</sup>

Because of high demand, many people referred for specialised mental health treatment in community settings face long waits. Figure 3 shows that there are particularly long waiting times for NHS eating disorder services, with 27% of people waiting 11 weeks or more, and for NHS memory services, with 42% of people waiting for 11 weeks or more.

**Figure 3: Access and waiting times in NHS adult services: referral to treatment, second appointment waits for community mental health services, 2015/16**



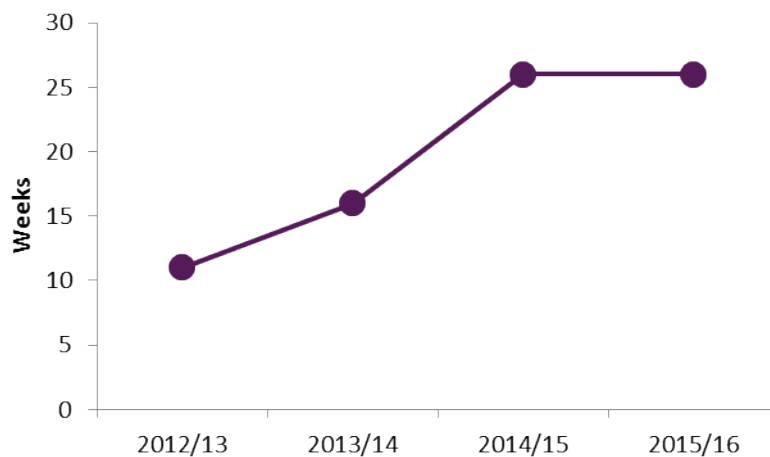
Source: NHS Benchmarking Network

<sup>3</sup> NHS Digital, *Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to Supervised Community Treatment: 2015/16, Annual figures, 2016*

<sup>4</sup> <https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

There has been a substantial increase in the maximum waiting times for routine appointments for children's and young people's community services in the NHS. The maximum wait for an appointment has risen from 11 weeks in 2012/13 to 26 weeks in 2015/16 (figure 4).

Figure 4: Maximum wait for a routine appointment in NHS children and young people's services



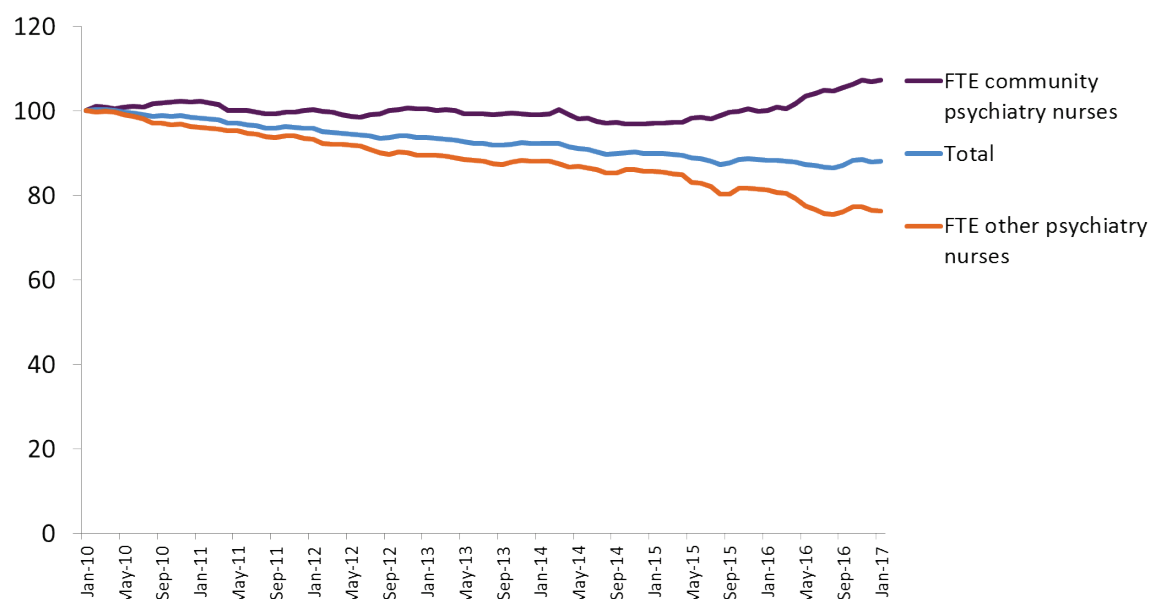
Source: NHS Benchmarking Network

NHS Providers highlighted rising demand in their July 2017 publication, *The State of the NHS provider sector*, which reported the views of NHS mental health chairs and chief executives about the challenges that their trusts are facing. More than 70% of the chairs and chief executives they surveyed expected demand for services overall to grow, recognising that increased focus on mental health and current societal pressures will generate more demand.

### Shortage of mental health nurses

The high and perhaps growing demand for mental health care has been accompanied by a steady decline in the number of NHS mental health nurses. From January 2010 to January 2017, the number of psychiatry nurses (full-time equivalent) fell by 12% (from 40,719 to 35,845 (figure 5, 'total' line)). During this period there has been an increase in the number of full-time equivalent community psychiatry nurses, but this has not been enough to prevent the total number declining.

**Figure 5: Indexed trends in full-time equivalent NHS psychiatry nurses, January 2010 to January 2017**



Source: NHS Digital, NHS Hospital and Community Health Service Monthly Workforce Statistics

Note: 'Other' psychiatry nurses includes nurses working in inpatient settings.

The King's Fund has reported a notable rise in the use of agency and bank staff since 2013, with requests for temporary mental health nursing staff increasing by two-thirds from April 2013 to December 2014.<sup>5</sup>

## Pressure on mental health acute wards

Because of the high threshold for admission, only those people who need intensive treatment and care are admitted to a mental health ward. A high and increasing proportion of inpatients are detained under the Mental Health Act. Also, despite the low number of beds, patients admitted to acute mental health wards in England have a long length of stay compared with those in a number of other developed countries.

Admission wards are a high risk environment. This is reflected in NHS Benchmarking Network<sup>6</sup> data for NHS services in 2015/16 that show the high number of incidences of violence towards staff (538 per 100,000 occupied bed days), and of violence towards other patients (286 per 100,000 occupied bed days).

To provide safe care, mental health admission wards need a well-staffed team of experienced mental health workers who know the patients and work together well. To provide effective care, the team must contain staff from a range of disciplines who can

<sup>5</sup> The King's Fund, *Workforce planning in the NHS*, 2015.

<sup>6</sup> The NHS Benchmarking Network ([www.nhsbenchmarking.nhs.uk](http://www.nhsbenchmarking.nhs.uk)) comprises more than 330 health and social care organisations across the UK. It collects, analyses and shares data from members in order to help them define their goals and strategy and identify areas for improvement, as well as enabling communication between members to share best practice.



provide the full range of treatments and interventions – physical, psychological and social. Future developments in community mental health services must not distract attention from the importance of improving the quality and safety of mental health wards.

## **Out of area placements**

We have become increasingly concerned about the placing of mental health patients some distance from their homes (known as ‘out of area placements’). NHS Digital have reported that, at the end of May 2017, there were 857 patients across the country counted as ‘out of area’, of which 96% (821) were deemed ‘inappropriate’, although this is likely to underestimate the true scale of the problem.<sup>7</sup> Alongside the snapshot figure, the data shows that more than 4,800 out of area placements started between 17 October 2016 and 31 May 2017, of which the majority (82%) also ended during that period.

In a separate piece of analysis the British Medical Association obtained data from clinical commissioning groups under the Freedom of Information Act relating to 41 mental health trusts. This found that 5,876 adults were subject to out of area placements for mental health treatment during 2016/17, which was a rise of 39% on 2014/15.<sup>8</sup>

The BMA analysed more than 1,100 patient journeys of people placed out of area. On average, visits involve a four-hour drive in a day or a six-hour trip by public transport. Apart from being potentially isolated from family or other visitors, this can also mean their care coordinator is unable to visit regularly, with a detrimental impact on continuity of care and effective discharge planning. There is a government ambition to end inappropriate out of area placements in acute inpatient services for adults by 2020/21.<sup>9</sup>

## **Wide variation in indicators relating to mental health acute wards**

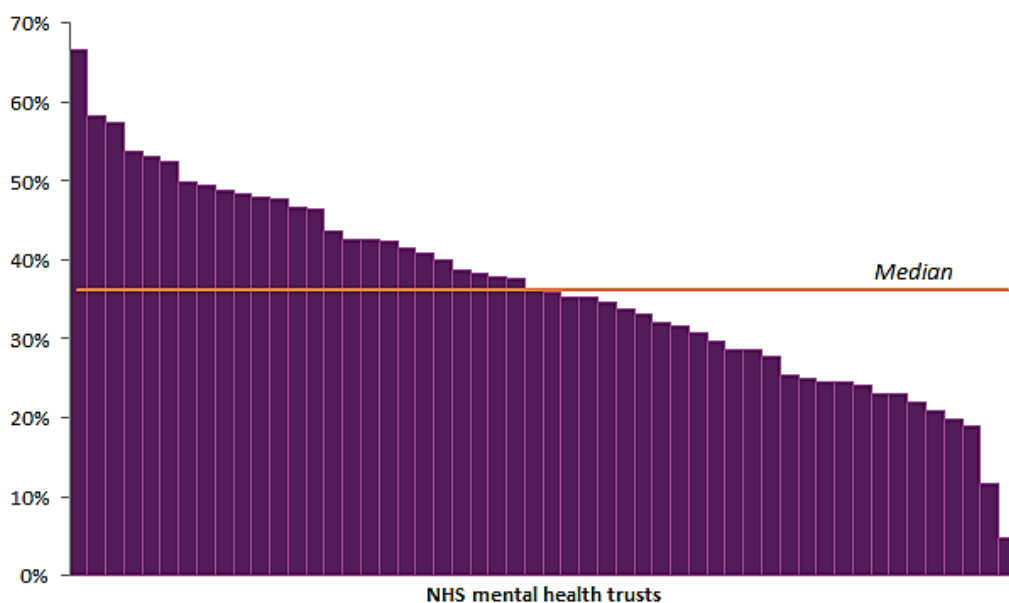
Information held by the NHS Benchmarking network for 2015/16 shows wide variation between NHS mental health services on a number of indicators that might reflect the extent of pressure on mental health wards. The percentage of adult acute mental health admissions that are involuntary ranges from 5% to 67% (figure 6). The number of readmissions as a percentage of all admissions ranges from less than 1% to 17% (figure 7).

7 NHS Digital, *Out of area placements in mental health services*, May 2017

8 <https://www.bma.org.uk/news/media-centre/press-releases/2017/june/bma-figures-show-starling-rise-in-mental-health-out-of-area-placements>

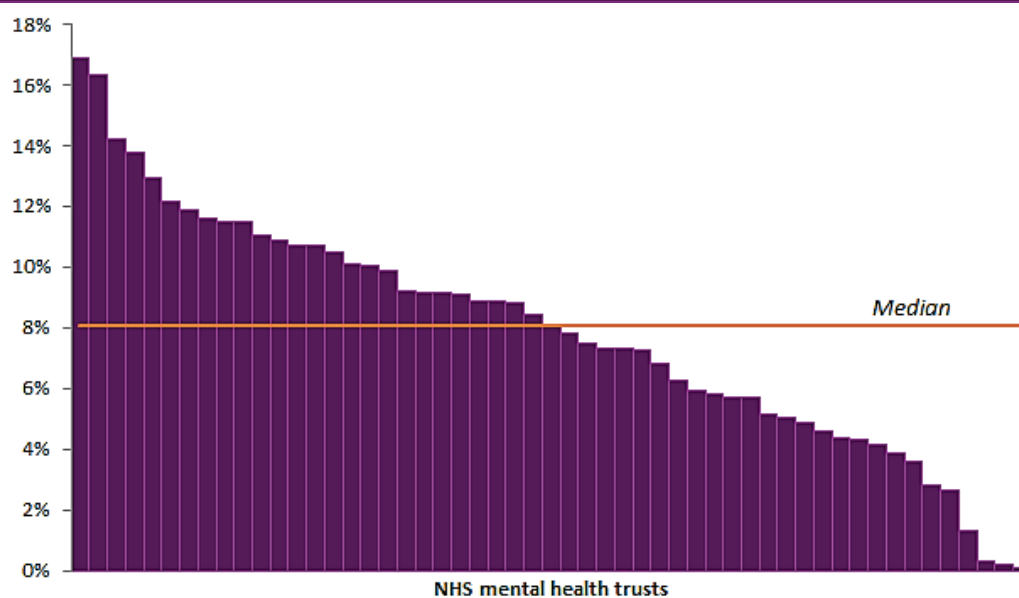
9 Independent Mental Health Taskforce to the NHS in England, *The Five Year Forward View for Mental Health*, 2016

Figure 6: Number of Mental Health Act admissions as a percentage of all admissions, 2015/16



Source: NHS Benchmarking Network

Figure 7: Number of emergency readmissions within 30 days as a percentage of all admissions, 2015/16



Source: NHS Benchmarking Network

## Use of restraint

There is an increasing interest in understanding the extent to which people using mental health services are at times restrained by staff. Data published by NHS Digital showed that during 2013/14 more than 6,000 people who spent time in hospital were subject to at least one incident of restraint. Collectively these people experienced more than 23,000 incidents of restraint, with 960 people having been restrained five or more times in the year.<sup>10</sup> Meanwhile the NHS Benchmarking Network and Department of Health carried out three bespoke data collections on the use of restraint between January 2015 and January 2016, during which the use of prone (face-down) restraint was reported to have fallen in most service areas but rose in high secure settings for people with a learning disability, high dependency rehabilitation wards, medium and high secure mental health wards, and children and young people's non-forensic services.

## 1.2 This report

This report looks at what we found about the quality of care across the whole range of specialist mental health services that we regulate.

Our report is based on our inspections of NHS and independent services published up to 31 May 2017. It is one of a series of reports across the sectors that CQC regulates, which aim to give an in-depth review of services based on our initial programme of comprehensive inspections.

For the report, we analysed the findings from our ratings, carried out interviews with senior CQC inspection staff and expert national professional advisors across the country, who have reviewed many inspection reports as part of our quality assurance process, and analysed a range of inspection reports from across the specialist mental health core services. Using the experiences and reflections from the expert interviews and the analysis of inspection reports, we present some of the common themes and characteristics underpinning the ratings we have given across the services.

The analysis of ratings covers services provided either by NHS mental health trusts or independent providers. A small number of specialist mental health services are provided by NHS acute or community trusts, and these are not included in the main data analysis.

<sup>10</sup> NHS Digital, February 2015: *Mental Health and Learning Disabilities Statistics Monthly Report: Final November and Provisional December*.

## 2. Overall findings

We have completed our full programme of inspections (with ratings) for all 54 mental health NHS trusts and for 221 independent mental health services.

Our inspection teams use their professional judgement, supported by objective measures and evidence, to assess each service against five key questions.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

Our judgements are informed by a range of detailed information that we gather from providers, partners, commissioners and, importantly, people's own experiences of care and the views of their families and carers. Our approach not only supports people to make informed decisions about care, but the detail of our inspection reports also highlights any shortcomings in the quality of care for providers and commissioners to respond to and act on. If providers do not respond well enough and fail to give people who use their services the standards they have a right to expect, we will take action to enforce improvement.

Following a thorough review process involving a number of checks to ensure quality and consistency, we publish our inspection reports on our website and award one of four ratings:

- outstanding
- good
- requires improvement
- inadequate.

### 2.1 Overall ratings

#### Core service ratings

We look at the whole picture of mental health care, and we provide ratings at core service level – where patients most directly experience the quality of care being delivered.

Overall, the performance at core service level of NHS trusts and independent providers was very similar. There were 68% of NHS core services rated as good as at 31 May 2017 (344 out of 506) and 6% were rated as outstanding (30 out of 506) (figure 8). Among independent services, 72% were rated as good (188 out of 260) and 3% as outstanding (nine out of 260).

However, this means that a substantial minority of core services need to improve: about a quarter of NHS and independent core services were rated as requires improvement (NHS 25%, independent 23%) and a very small number were rated as inadequate (seven NHS core services and three independent core services).

Where we find poor care, we take action to make sure it improves. From April 2015 to March 2017, we issued 21 Warning Notices to NHS mental health trusts and 91 to independent mental health providers. Across the entire sector, we also issued one urgent notice to impose a condition, one non-urgent notice to impose a condition and two non-urgent notices to cancel registration.

Figure 8: Overall ratings at core service level, as at 31 May 2017

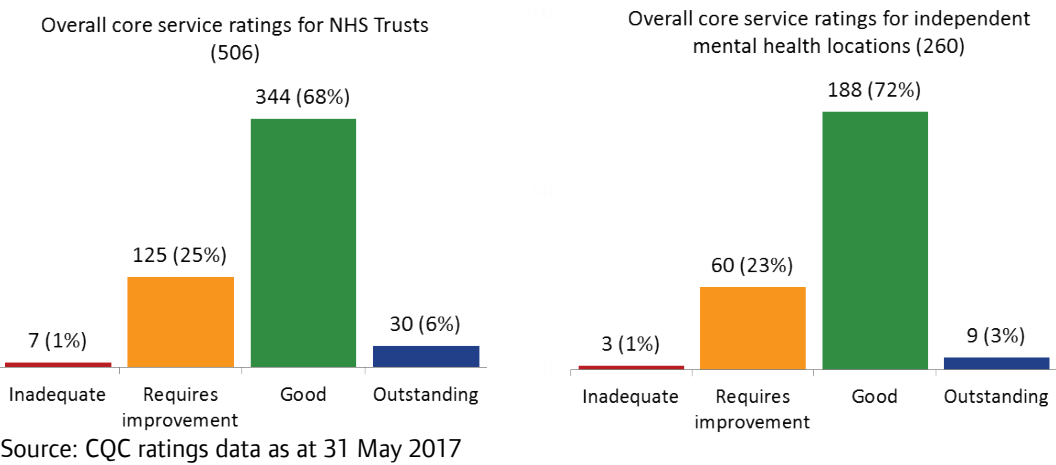
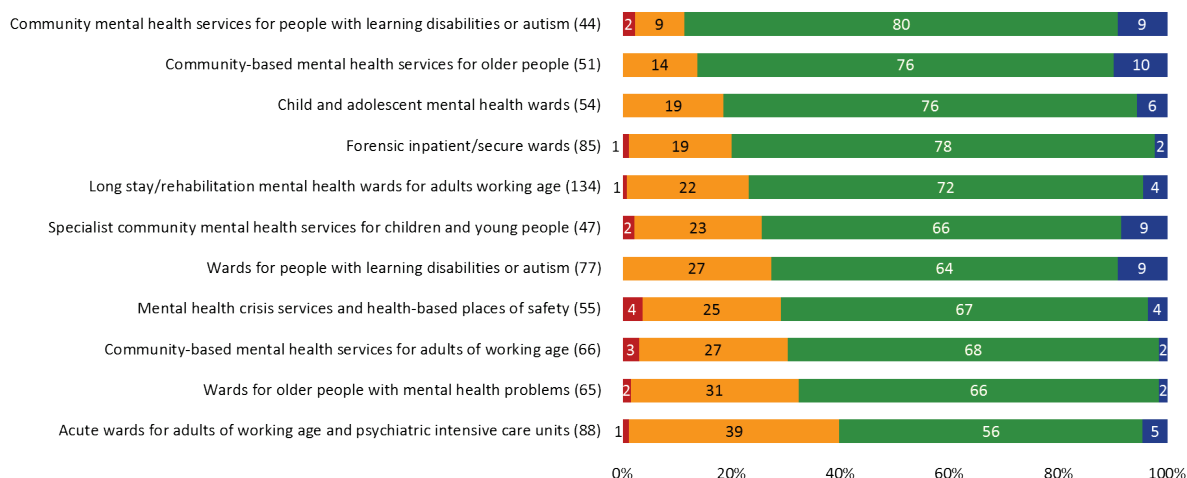


Figure 9 shows the overall core service rating for each core service, across both NHS and independent providers. We have found wide variation in the quality of care within and between the different services. It is difficult (and perhaps inadvisable) to make comparisons between the ratings for different types of services or between inpatient and community services for the same group of patients. The services are very different in nature and face very different challenges.

Having said that, it is striking that there is a 28 percentage point difference between community mental health services for people with a learning disability or autism and acute wards for adults of working age and psychiatric intensive care units, in terms of the proportion that we rated as good or outstanding (89% compared with 61%). This is further proof that the quality spectrum can look very wide indeed. We report on the core services in detail in chapter 3.

**Figure 9: Overall ratings for each core service (NHS and independent combined), as at 31 May 2017**



Source: CQC ratings data as at 31 May 2017. Figures on bars are percentages.

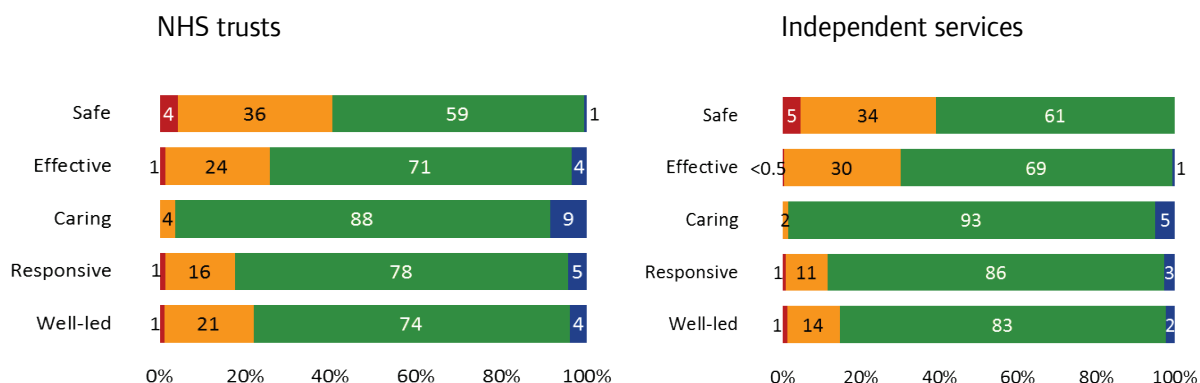
## Ratings by key question

As well as the overall rating, we give all services a rating for each of the five questions we ask of all care services. These allow us to look into greater detail at the issues that matter to people: are services safe, effective, caring, responsive to people's needs and well-led?

Figure 10 shows how NHS trusts and independent locations were rated against the five key questions across all their core services. There are close similarities among the ratings given at key question level to NHS and independent core services.

The safety of mental health services is our biggest concern, with 4% of NHS core services and 5% of independent core services rated as inadequate at 31 May 2017. A further 36% of NHS core services and 34% of independent core services were rated as requires improvement. We discuss the issues underpinning the key questions in 'Key findings from our inspections' on page 27.

**Figure 10: Key question ratings for NHS and independent mental health core services, as at 31 May 2017**



Source: CQC ratings data as at 31 May 2017. Figures on bars are percentages.

## Aggregated ratings

We also provide overall trust level ratings (in the NHS) or combined location level ratings (in the case of independent services) by aggregating the ratings of key questions awarded across all the core services provided by that trust or independent location. For example, if we have rated three out of the 11 core services as requires improvement for an individual key question (such as safe), then we would normally rate the NHS trust as requires improvement for safe.

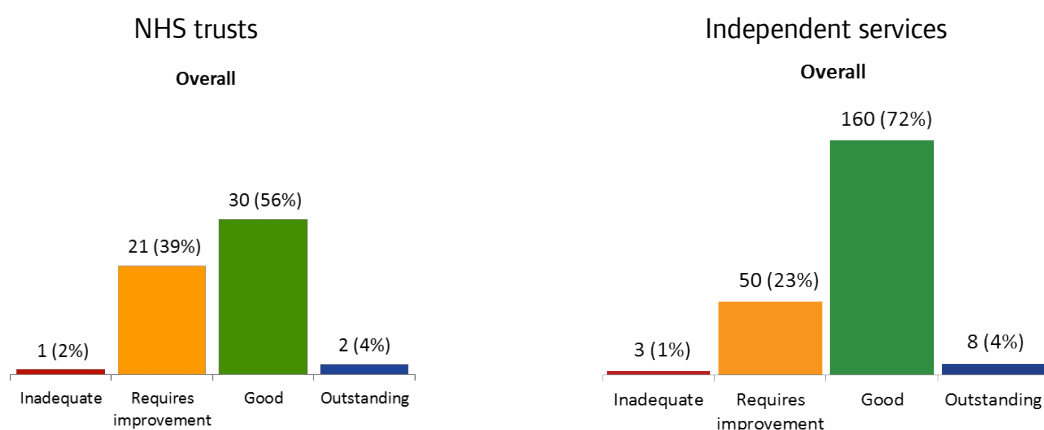
The size and complexity of NHS mental health trusts, and the variability between core services, means that it is possible that in some hospitals a few poorer performing core services may affect their overall rating.

Fifty-six per cent (30 out of 54) NHS trusts were rated as good overall as at 31 May 2017 (figure 11). We have rated two trusts as outstanding – Northumberland, Tyne and Wear NHS Foundation Trust and East London NHS Foundation Trust. Both trusts had a well-developed and structured approach to quality improvement.

However, 39% of NHS trusts (21) were rated as requires improvement overall. There was also one NHS trust (2%) rated as inadequate at 31 May 2017.

For the independent mental health locations, there were 72% (160) rated as good as at 31 May 2017, and 4% (eight) rated as outstanding. However, a substantial minority of locations need to improve: 23% (50) of independent locations were rated as requires improvement and 1% (three) as inadequate.

Figure 11: Aggregated trust/location level ratings as at 31 May 2017



Source: CQC ratings data as at 31 May 2017.

Note: The sole trust rated as inadequate, Isle of Wight NHS Trust, is a combined trust that delivers a wide range of acute, community, mental health and ambulance services.

### **Outstanding example – Northumberland, Tyne and Wear NHS Foundation Trust**

We rated Northumberland, Tyne and Wear NHS Foundation Trust as outstanding following our inspection in May and June 2016, due to a combination of innovation and high-quality care.

The trust is one of the largest mental health and disability trusts in England. It employs more than 6,000 staff and serves a population of approximately 1.4 million. The quality of the services provided by the trust was exceptional. The trust is well-led and has a clear vision and strategy for delivering the highest standards of patient care.

We were particularly impressed by the way the trust empowers frontline staff to contribute to the development of its services. As a result, staff are enthusiastic and keen to improve the quality of care that they provide. They place patients at the centre of everything that they do. This was confirmed by the highly positive feedback we received from people who use the trust's services.

The trust is prepared to innovate and work collaboratively with other NHS trusts. For example, they have worked with a neighbouring organisation to provide an eating disorders service.

Our inspectors found that staff were enthusiastic, had pride in the care and treatment they provided, and looked for opportunities to improve the experience of patients. The trust encouraged personal and professional development in all roles. Teams from a range of professional disciplines worked well together to support patients in their recovery and meet their goals.

The trust supported the physical health care of patients; for example, mental health nurses were trained in tissue viability to meet the needs of patients on the ward. A physical healthcare practitioner provided expert support to mental health nurses and acted as a liaison with acute hospitals, to ensure that patients' physical healthcare needs could be fully met before being transferred to a mental health hospital.

Discharge planning for patients started from the point of admission. Staff worked flexibly to adapt care and stretch existing boundaries to meet the needs of individual patients and their carers.

### **Outstanding example – Newbridge House**

Newbridge House is a small independent hospital near Birmingham providing a specialist eating disorder service for children and young people aged eight to 18 years. We rated it as outstanding following our inspection in January 2016.

Patients and parents were overwhelmingly positive about the care and treatment provided by Newbridge House. Patients felt safe there and knew how to complain if they were unhappy. They understood their care and treatment plans, and had been involved in



developing them. They told us they were actively involved in their weekly multidisciplinary meetings and they provided feedback in writing and in person at the meetings. They used the weekly 'community meeting' to provide feedback about the service and to request specific things like different trips out or new games to play. They knew there was an independent advocate they could talk to if they wanted to.

The company invested in, and was responsive to the needs of, its staff. As a result, staff morale was good. Managers listened to staff and provided them with additional resources when they asked for them. Managers routinely held supervision and annual performance reviews with staff. These were up-to-date. Managers supported staff to develop their skills and career by funding external and specialist training courses. For example, the company commissioned and hosted regular "Master Classes". These were open learning sessions where they engaged prominent speakers and leaders in the field to share knowledge and encourage debate.

Staff provided high-quality treatment and care. Different professionals worked well together to assess and plan for the needs of patients. Staff used specialist tools to assess the severity of the patients' eating disorder. To aid their recovery, patients had access to a wide range of specialist psychology and occupational therapy led therapies. These included drama therapy, psycho-education, yoga, mindfulness, relaxation, coping skills and creative art. Patients also had access to fun activities, which included shopping trips, film nights, crazy golf, trips to safari parks and swimming.

The service was well-led and managers had good systems in place so they could audit the quality of care. The senior management team were accessible to their staff. They had the skills and experience needed to drive forward the organisation. Managers and staff were continually looking for ways to improve outcomes for their patients. The service was committed to becoming accredited with the Royal College of Psychiatrists' Quality Network for Inpatient Child and Adolescent Mental Health Services.

## **Variation between and within services**

There is great variation in quality between mental health services. This is true both for mental health trusts and for independent mental health hospitals.

Also, there can be wide variation between core services within an NHS mental health trust. This is because they are large organisations that may provide care from many different hospitals and community bases spread over a wide geographical area. Figure 12 shows examples from two NHS trusts that have quite different ratings for their various core services, and illustrate the range of ratings possible. Furthermore, the pattern of ratings within trusts varies: one trust may be rated as good for one core service and requires improvement for another; in another trust, the position may well be reversed.

Figure 12: Solent NHS Trust ratings grid and East London ratings grid

Solent NHS Trust						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Community mental health services for people with learning disabilities or autism	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Requires improvement	Requires improvement	Not rated	Good	Requires improvement	Requires improvement
Long stay/rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Requires improvement	Good
Specialist community mental health services for children and young people	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Substance Misuse	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

East London NHS Foundation Trust						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Child and adolescent mental health wards	Good	Good	Outstanding	Good	Outstanding	Outstanding
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Good	Outstanding	Good
Community-based mental health services for older people	Good	Good	Outstanding	Requires improvement	Outstanding	Good
Forensic inpatient/secure wards	Requires improvement	Good	Outstanding	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Outstanding	Good	Good
Specialist community mental health services for children and young people	Good	Good	Outstanding	Outstanding	Good	Outstanding
Wards for older people with mental health problems	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding
Wards for people with learning disabilities or autism	Good	Requires improvement	Good	Good	Good	Good
Overall	Good	Good	Outstanding	Outstanding	Outstanding	Outstanding

Source: CQC ratings data as at 31 May 2017.

## 2.2 Key findings from our inspections

We present findings related to specific core services in chapter 3. In this section, we discuss a number of issues that are either more general themes, that affect all or a number of core services, or that we wish to highlight for further attention. Some are areas where we have identified a need to strengthen our approach to assessment.

### **Mental health services can be proud of their staff**

The vast majority of staff that we encountered in both NHS and independent mental health services genuinely cared about the people who used their services. We rated nearly all trust and independent core services as good or outstanding overall for the caring question (figure 10). With very few exceptions, staff formed relationships with their patients that were respectful and compassionate and treated patients with dignity and respect.

We have also seen many examples of staff involving carers and families, and of services providing specific support for carers. Families have complimented the attitudes of staff and the support that they have received, with staff making sure that families were involved with care planning and received regular updates.

The one area where mental health staff could do better as caring professionals is by engaging patients as true partners in their care. This issue has been flagged up by our Mental Health Act reviewers as well as by our inspectors. In too many services, care plans do not truly reflect the patient's voice. We will pay closer attention to this issue in future inspections.

### **Services need good leadership to become outstanding**

Our finding about the caring nature of their staff shows that mental health services have one of the key ingredients for outstanding care. The other ingredient required is excellent leadership. We concluded that 39% of NHS trusts and 15% of independent services needed to improve in terms of their leadership.

The influence of good leadership on staff cannot be overestimated. The NHS Staff Survey provides invaluable information on the views and experiences of people working in the NHS. Compared with the acute sector, those who work in mental health and learning disability trusts report poorer levels of overall satisfaction, and they are less likely to recommend the organisation as a place to work or receive treatment. On the other hand, they report better experiences of staff support, team working, line management and working practices. Worryingly, a higher proportion of mental health staff also reported experiencing harassment, bullying, abuse or physical violence from patients, relatives or the public in the 12 months prior to the survey.

When we analysed a number of inspection reports, we found six key themes that contributed to a rating of good or outstanding for well-led: leadership, a clear vision and set of values, a culture of learning and improvement, good governance, quality assurance, and engagement and involvement.

- **Leadership.** The senior managers of well-led providers were a visible presence. They spent a considerable proportion of their time in clinical areas interacting with patients and frontline staff. These leaders demonstrated the organisation's values in how they behaved and in how they treated staff. Also, well-led providers had a cohesive board or senior management team whose members asked the right questions, offered constructive challenge and debated difficult issues freely.
- **Clear vision and set of values.** Well-led providers knew what their purpose was and the manner in which they were going to achieve this. All staff and, in some cases, the patients had been involved in deciding the values. The values permeated the organisation from top to bottom and were reflected in how staff delivered care. In the best cases, the values translated into staff taking a recovery focused approach, working to reduce the stigma related to mental health conditions and adopting a truly holistic approach to care.
- **Culture of learning and improvement.** Providers that we rated as outstanding for well-led were learning organisations and were committed to continuous improvement. They had a culture of collective responsibility for improvement and staff at all levels were encouraged to develop the service and to innovate. Patients were partners in this enterprise and staff actively involved them both in identifying priorities for improvement, and in work to make improvement happen. In the best services, the frontline staff drove improvement; with managers seeing their role as being to enable this and to remove obstacles. Managers and staff in good services sought feedback from many sources and actively used this to inform improvement measures. Providers also recognised that learning from incidents and complaints was valuable and actively encouraged this among staff.

### **Outstanding leadership: East London NHS Foundation Trust**

The trust had inspiring and approachable leaders who shared a clear vision that was known and understood by staff working across the trust. They welcomed innovation and celebrated success.

The board was diverse and reflected the local communities. The non-executive directors brought with a wide range of professional skills and personal experience. Board members appropriately held executive staff to account to ensure the trust was meeting the needs of people using the services. There was no complacency; they set high standards and were always thinking about how the trust could improve.

The trust had robust governance structures in place. This meant that from ward to board there was a good understanding of the challenges facing the trust. Areas for improvement were recognised and work was done in a timely manner to make these changes. The trust had an extremely healthy culture. It was in the top five trusts in the country in the latest staff survey. Staff said how much they enjoyed working for the trust and felt valued and able to contribute. They also felt able to raise concerns. Staff felt very engaged in the work of the trust and it was recognised that the quality improvement programme contributed significantly to this. Staff also talked positively about their opportunities for learning and for career development.

- **Good governance.** While striving to learn and improve, well-led providers had not lost sight of the vital importance of getting the basics right. Well-led providers managed their beds well so that patients could be admitted when needed; for example by ensuring that home treatment teams and wards worked together to create a single pathway of care. They also monitored the waiting times of community mental health services and reacted quickly if these were lengthening.

Perhaps the most noticeable marker of the quality of basic governance was how the service deployed staff and ensured that staff had the necessary skills. Well-led providers devolved authority to ward managers and enabled them to act quickly to maintain staffing at a safe level as the case mix on the ward changed. Well-led providers also ensured that the staff had both the basic skills to provide safe care and the specialist skills to provide effective care. The stronger providers had a comprehensive programme of mandatory training in place and a system for monitoring this, that assured managers that staff could, for example, provide basic life support in an emergency or respond to a safeguarding concern about a child. They also ensured, for example, that all staff that might encounter older people were trained in working with those with dementia.

- **Quality assurance.** Well-led providers captured, stored and used information effectively. They had a range of meaningful indicators of the quality and safety of services and risk registers that provided staff at all levels with a record of current and emerging risks. These indicators and risk registers were derived from information captured by frontline staff during the course of their work and were used to monitor quality and safety by staff at all levels. Services with good quality assurance systems were rarely surprised at the findings of our inspections.

- **Engagement and involvement.** This theme cuts across the other five. Providers did best when they involved frontline staff and patients in decision making about the management of the organisation. Well-led providers trained, developed and sometimes employed those who used or had used their services so that they could work alongside mental health care professionals to assure and improve the quality of the service.

As well as involving their own staff and patients, well-led providers looked outwards and engaged with the range of groups and organisations that have an interest in the quality of care provided to the community that they served. For example, they forged strong and constructive relationships with local authorities and with primary care services – to ensure that patients with enduring mental health conditions and complex needs experienced seamless care. They were also willing to learn from other providers that had developed innovative services or that were performing well in some specific aspect of provision.

## Our biggest concern is about safety

For both NHS and independent mental health services overall, and for eight of the 11 core services, safe was the key question that we most often rated as requires improvement or inadequate. At 31 May 2017, 36% of NHS core services and 34% of independent core services were rated as requires improvement for safe; a further 4% of NHS core services and 5% of independent core services were rated as inadequate for safe.

We give more detail about our concerns about the safety of specific core services in chapter 3. The most common cross-cutting themes were:

- The poor physical environment of many mental health wards. Many inpatient facilities were not designed to meet the needs of the group of patients that are admitted to acute mental health wards today. Their design does not permit staff to observe all areas easily and many wards contained fixtures and fittings that people who are at risk of suicide could use as ligature anchor points. A substantial number of services admitted both men and women to the same wards. When this is the case, staff have a heightened responsibility to ensure that patients are safe from sexual harassment and sexual violence. We have taken action against services that did not follow NHS guidance on eliminating mixed sex accommodation.
- Some services struggled to ensure that mental health wards are staffed safely at all times. In chapter 1, we highlight the national shortage of mental health nurses. The shortage is greater in some parts of the country than others. The problem was worse in services that had high levels of sickness and high rates of staff turnover. The resulting negative effect on morale can create a cycle of increasing sickness and further staff turnover that can be difficult to break. Many providers used bank and agency staff to fill shifts. This can work well, provided the nurses who are filling in know the patients, their nursing colleagues and the ward routine. When this was not the case, it could affect patients' experience and continuity of care. In the worst cases, it could affect safety – particularly on wards where safety was already compromised by a poor physical environment.
- Staff in both inpatient and community services did not always manage medicines safely. We found examples where staff did not store or transport medicines securely or keep them at the correct temperature, did not keep accurate records when they administered medicines and did not monitor patients' physical health necessary to keep them safe.

## **Persistence of restrictive practices**

Three findings from our inspection programme indicate that, more than 30 years after the introduction of mental health legislation that enshrined the principle of least restriction, some patients still receive care that is overly restrictive.

### **Locked mental health rehabilitation wards**

The Royal College of Psychiatrists does not recognise locked mental health rehabilitation wards as a service model. The purpose of these wards is poorly defined. Many of the patients admitted to these wards do not live in the area where the ward is situated; meaning that they are in danger of losing touch with their home area. During the course of our programme of inspections, we became concerned that many of these services were de facto long stay wards. Also, we were surprised at how many beds there were in hospitals of this type.

Because these beds may be commissioned by any one of 209 clinical commissioning groups, or even by a local authority, there was no central register to show how many beds of this

type there were in England. Work carried out by the Centre for Mental Health informed an analysis of wards that might fall into this category.

In the absence of a central record, we had to gather this information from the written descriptions of services in the most recent inspection reports and/or from knowledge of the inspector who is the relationship owner for the provider. When necessary, we supplemented this information by phoning the provider.

From the available information, we identified 357 mental health rehabilitation wards. Of these, 248 were locked and 109 were unlocked. Figure 13 shows the distribution of beds in these wards between NHS and independent providers.

**Figure 13: The number of beds in mental health rehabilitation wards in England**

	<b>Locked ward</b>	<b>Unlocked ward</b>	<b>Total</b>
NHS	1,152	992	2,144
Independent	2,435	357	2,792
Total	3,587	1,349	4,936

Source: CQC.

Notes: Limitations of the data include that:

Inspection reports do not always contain detailed information about bed numbers.

Inspection reports do not always state clearly whether wards are locked or unlocked.

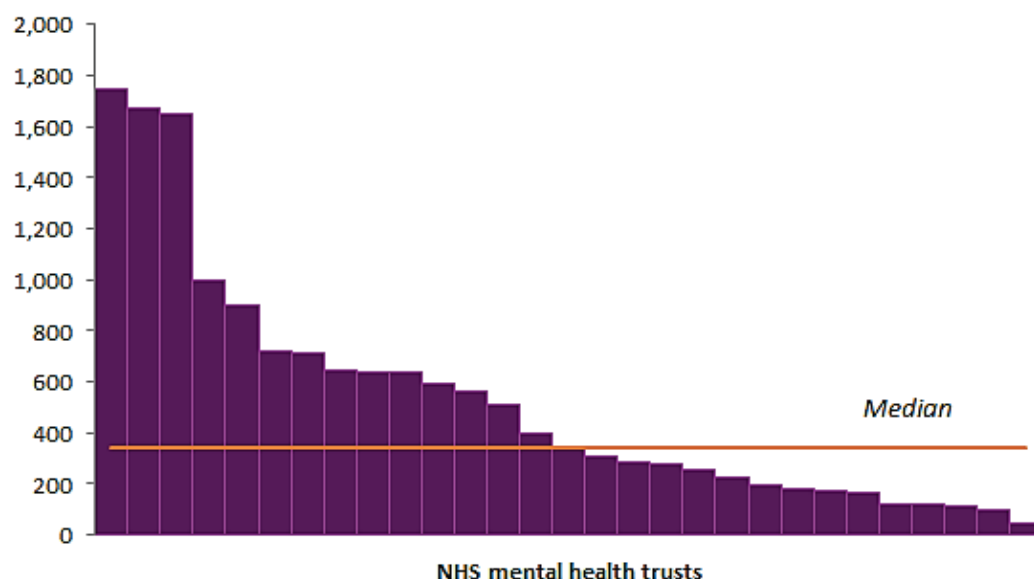
Some inspections were carried out two or more years ago. Some of the wards might have closed or their function changed.

Rehabilitation wards provided a total of 4,936 beds, of which 3,587 (73%) were in a locked ward. The independent sector provided more than two-thirds of the rehabilitation beds that were on a locked ward. A much higher percentage of rehabilitation beds in the independent sector were on a locked ward (87%) than was the case for those in the NHS (54%).

Our ratings of these services do not suggest that the general quality of these wards is any worse than other types of ward for working age adults (see chapter 3). As mentioned above, our concern is predominantly about whether they provide the right ‘model of care’ for our mental health service in the 21st century. We think it possible that a significant number of patients in locked rehabilitation wards have the capacity to live in a setting of lower dependency and with fewer restrictions – provided there was suitable accommodation and intensive community support available in their local area to meet their needs.

We are also concerned that some patients on rehabilitation wards appear to be spending far longer there than would be expected from a ‘rehabilitation’ service. Figures supplied by the NHS Benchmarking Network (figure 14) highlight the extreme variation in the length of stay on NHS high dependency rehabilitation wards, ranging from 45 to 1,744 days in 2015/16. The average length of stay was 341 days.

Figure 14: Mean length of stay in NHS high dependency rehabilitation wards, 2015/16



Source: NHS Benchmarking Network

### Use of restrictive interventions to de-escalate challenging behaviour

We have found examples, in all types of inpatient core service, of good practice in managing behaviour that might put patients or staff at risk of harm. Those wards where the level of restraint was low or where it was reducing over time had staff trained in the specialised skills required to anticipate and de-escalate behaviours or situations that might lead to aggression or self-harm. Staff on some wards made excellent use of positive behaviour support plans to anticipate and defuse situations that might have resulted in challenging behaviour. On many inspections, our inspectors have concluded confidently that staff used physical restraint or seclusion only as a genuine last resort.

However, we are concerned about the very wide variation between services in how frequently staff use physical restraint in response to challenging behaviour. We have also found a number of instances where staff were not recording all incidents of restraint and not documenting or recording seclusion or long-term segregation as required by the Mental Health Act Code of Practice.

We are committed to improving how we assess the use of restrictive interventions. In future, we will pay much closer attention to whether services have in place an active programme to reduce and minimise the use of restrictive interventions; and the extent to which they are able to demonstrate the impact of this programme.

### Night-time confinement in high secure hospitals

In 2016/17, our inspections of the three high secure hospitals in England found that all three had a shortage of nursing staff. At Broadmoor Hospital and Rampton Hospital, this restricted patients' access to therapies and activities. The low staffing levels at Rampton Hospital sometimes increased the risk to patients. One effect of the staffing shortage at Broadmoor Hospital and Rampton Hospital was that patients who were subject to night-



time confinement also had restricted access to day-time activities. We were also concerned that staff at Broadmoor Hospital and Rampton Hospital did not monitor and review patients in seclusion and long-term segregation in line with guidance in the Mental Health Act Code of Practice.

The combination of night-time confinement and restriction on day-time activities is unacceptable – the 2013 guidance to the security directions sets out arrangements for general night-time confinement that “should only be put in place where it is considered that this will maximise therapeutic benefit for patients, as a whole, in the hospital. For example, confining a group of patients at night may release staff to facilitate greater therapeutic input for patients during the day”.

We will monitor the response of the trusts that manage Broadmoor Hospital and Rampton Hospital closely. We have shared our concerns with the Secretary of State and shared and discussed our findings with NHS England Specialised Commissioning and the National Oversight Group for High Secure Services. We have recommended that all three high secure hospitals work more closely together to share best practice and to address the concerns that we have identified.

## **Access and waiting times**

A common theme across a number of core services was the difficulty that people have in accessing the service that is best equipped to meet their needs. Sometimes our inspectors identified this unmet need directly on inspection. Examples were when we found long waiting times in a community child and adolescent mental health service, when we encountered a mental health crisis team that did not provide 24-hour cover, or when providers told us of patients’ discharge being delayed because of the unavailability of suitable accommodation or a community care package. On other occasions, the need was less apparent to our inspectors. For example, the numbers of people waiting for transfer from prison to a particular medium secure unit, or the numbers admitted to a distant independent mental health hospital because a bed was not available locally, are not routinely available.

Furthermore, we could not always attribute responsibility for this unmet need to the providers that we regulate. These difficulties with access to local services were sometimes due to the decisions of commissioners.

## **Physical health care of people with mental health conditions**

One of the goals of the Five Year Forward View for Mental Health is that “by 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met”. Our inspectors found a mixed picture. We found some excellent examples, particularly in forensic wards, of staff enabling patients to access GPs, dentists and healthcare clinics, and promoting physical exercise and healthy eating in response to the growing numbers of patients at risk of obesity and associated conditions such as diabetes. However, we also found community mental health services where staff did not ensure that patients had their annual health checks, and where they failed to monitor the effects of medication and services for older people where there was lack of integration of physical and mental health care.

## **The problems caused by poor clinical information systems**

Our inspectors have talked to thousands of frontline clinical staff during the course of their work. Too many of these staff have voiced frustration about the clinical record systems that they have to work with. Staff sometimes have to work with a confusing combination of electronic systems and paper, or with a number of different electronic systems because these systems 'do not talk to one another'. Clinical staff often spent a high proportion of their working time entering information into electronic records. Because of the nature of the information entered, this problem often affected qualified nurses more than healthcare assistants. Despite this effort, too often staff were unable to locate or retrieve information that others had recorded.

We have seen examples of crisis teams not being able to access records for patients taken to a health-based place of safety. This problem had a real impact. It consumed staff time that could have been better spent in face-to-face contact with patients, increased the likelihood that essential information about risk was not communicated to staff who needed to know, and might have led to sub-optimal care plans that did not reflect the contribution of all members of the multi-professional team or sometimes the voice of the patient.

Regardless of whether they were recorded on paper or in an electronic system, our inspectors were often critical of the quality of care plans. We sometimes found that care plans were not personalised, did not cover all areas of need, did not fully take account of the patient's strengths and wishes, and were not being kept up-to-date.

# 3. What we have found in our inspections

## 3.1 Children and young people's services

### Key points

- 76% of child and young people's wards were rated as good, and 6% as outstanding; 66% of community services were rated as good, and 9% as outstanding.
- Getting access to services in the first place can be a significant problem – for both inpatient and community care.
- Many young people are admitted to a ward a long way from home – which can make it difficult for them to maintain close contact with their families and for families to participate in treatment.
- We have seen good examples of multidisciplinary working, with staff from diverse and different disciplines working well together, supported by a positive working culture.

Children and young people's mental health services provide assessment, care and treatment, both in hospital and in the community, for children and young people with mental health needs that range widely in terms of their complexity or severity. In the community, services usually consist of multidisciplinary teams of child and adolescent mental health professionals providing a range of interventions.

In 2015, NHS England and the Department of Health published *Future in Mind*, a report about how to improve children and young people's mental health services. There were a number of recommendations for change. These included the introduction of waiting time standards for services. There was also a requirement for areas to develop local plans that, in addition to improved access to help and support when it is needed, focus on better collaboration between agencies like the NHS, schools, local authorities, voluntary and community services to support better wellbeing in children and young people.

The Five Year Forward View for Mental Health, published in February 2016, recommended that at least 70,000 more children and young people should have access to high-quality mental health care and that services should move away from a tiered system and work towards a single point of access.

Early in 2017, we were asked by the Prime Minister to carry out a review of children and young people's mental health services. This will identify the strengths and weaknesses of the current system to support young people's mental health, and to help us better understand the pathways that children with mental health issues follow and the obstacles that they face.

The central question for our review is: How can we ensure that all partners make their unique contribution and work together so that children and young people, and their families and carers, have timely access to high-quality mental health care?

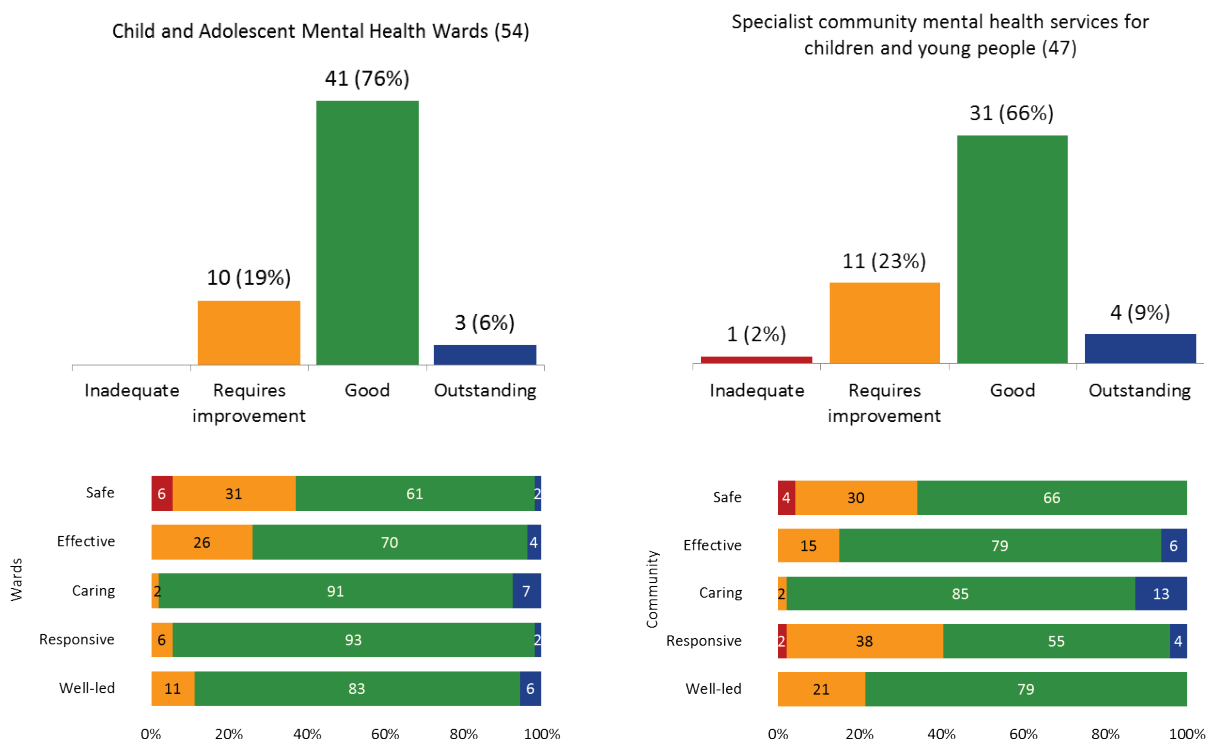
To carry out this work, we are listening to young people, their families or carers and inviting comments from members of the public. We are working with an expert advisory group consisting of a range of people and organisations, and with partners including NHS England, Ofsted and the National Audit Office. We are looking at evidence we have gathered from our inspection reports and external research into mental health provision for children and young people. The findings of the review will feed into a new government consultation on children and young people's mental health, expected in autumn 2017, and we plan to complete our review in March 2018.

## Ratings

We have inspected and rated 54 services that provide inpatient care for children and young people: 30 NHS and 24 independent services. As at 31 May 2017, there were 41 inpatient services (76%) rated as good and three (6%) as outstanding (figure 15).

We inspected 47 services that provide community mental health care for children and young people: 43 NHS and four independent. Overall, 31 (66%) were rated as good and four (9%) as outstanding.

Figure 15: Ratings for children and young people's services, as at 31 May 2017



Source: CQC ratings data as at 31 May 2017. Figures on horizontal bars are percentages.

Figure 16: Organisations rated as outstanding for children and young people's services, as at 31 May 2017

Children and young people's wards	Publication date
Central Manchester University Hospitals NHS Foundation Trust*	13/06/2016
East London NHS Foundation Trust	01/09/2016
Pennine Care NHS Foundation Trust	09/12/2016
Northamptonshire Healthcare NHS Foundation Trust	28/03/2017
Community services	
Weston Area Health NHS Trust*	26/08/2015
Lincolnshire Partnership NHS Foundation Trust	21/04/2016
Central Manchester University Hospitals NHS Foundation Trust*	13/06/2016
East London NHS Foundation Trust	01/09/2016
Northumberland, Tyne and Wear NHS Foundation Trust	01/09/2016
Derbyshire Healthcare NHS Foundation Trust	29/09/2016

\* These NHS trusts are not mental health trusts and as a result are not included in the ratings analysis.

## Access to services

On the whole, services are providing good quality care. However, getting access in the first place can often be a significant problem. This is true for both inpatient and community care. Many parents that we talked with in the course of our inspections praised the care that had been provided, but also described the struggle to get taken on by the service and the impact that the long wait had on their children and on them and their families.

This largely accounts for why we rated 38% of community services as requires improvement for responsive. A substantial number of services were not meeting their own or national targets for referral waiting times. There were even longer waiting times for some specialist assessments and treatment, for example for young people suspected of being autistic.

This problem of long waiting times was compounded by the fact that some community mental health services had no effective systems in place to monitor the risk for children and young people on these waiting lists. This meant that they would not know if a young person's condition had deteriorated and required urgent attention.

We did see some positive examples of access to crisis care in community services, including:

- patients and families being made aware of how to access services in a crisis and being able to contact staff easily and access services quickly in urgent situations
- staff able to respond to deteriorating mental health as well as supporting young people to recognise this themselves and know how to act
- out-of-hours provision, including availability of seven-day services and duty services for evenings.

There is national concern about the difficulty of finding a bed when a young person requires inpatient care. When a bed is found, it is often a long way from the young person's home. We do not always detect this unmet need because our assessment focuses on the quality of the care provided to patients who are already on the ward, and not to those that require or are awaiting admission. However, we have received reports of the impact of the unavailability of inpatient care. This includes a letter from an assistant chief constable about a 17-year old who was kept in a police cell for 78 hours because no bed was available. The assistant chief constable commented that "the majority of this time in police custody was unlawful and it amounts to a human rights violation, given that Article 5 of the European Convention on Human Rights prevents detention by the state except in accordance with processes outlined by domestic law".

## Staffing

Although in many cases staffing levels were sufficient and well managed, there were exceptions to this. We identified pressures on staffing including high sickness and absence rates, and the impact of increasing caseloads and referrals.

Some services struggled to respond to staffing shortfalls because of inadequacies in systems to support the management of staff. Some providers use bank staff in response to shortfalls in staffing levels – while this can work well in some cases, it can affect the continuity of care for children and young people. Services must also make sure that, in response to staffing pressures, they check the suitability of additional staff – at one service, staff brought in to help had started work before checks with the Disclosure and Barring Service had been completed, leading to possible risks to patients. Both inpatient and community services need to make sure that their staff complete their essential training.

We have seen good examples of multidisciplinary working, with access to a full range of relevant professionals and diverse therapies and specialities. In many services, staff from different disciplines worked well together, supported by a positive working culture, regular (often daily) meetings and good working relationships. A number of NHS services took a truly holistic approach to their patients' needs.

There were also examples of staff working well across multidisciplinary teams, for example inpatient and community teams working together to facilitate discharges, and of working with other organisations such as local authorities, acute hospitals, GP practices, schools, NHS England, commissioners and police. We also found examples of staff working with the third sector, for example work to support looked after children, vulnerable young mothers and people with specific psychological needs. However, some improvement is also needed – for example, ensuring staff know more about local advocacy services to advise young people where needed; fulfilling reporting requirements to the local authority; and supporting investigations by social workers.

We have seen good examples of engagement with staff, including daily incident reviews being carried out on wards, with multidisciplinary team involvement, and regular staff meetings to gather views and raise concerns without fear of victimisation. However, some services needed to better promote staff involvement and prevent staff feeling unsupported and intimidated.

## **Involving children and young people**

Many young people are admitted to a ward a long way from their home – which can make it difficult for them to maintain close contact with their families and for families to participate in treatment. Some inpatient services made provision for families to stay when visiting from long distances and some community and inpatient services offered formal participation opportunities for parents.

Some services excelled in involving the children and young people, so that the care provided took full account of their needs and preferences. This included involvement in planning for discharge and how best to manage risk, including what to do should they be in a crisis. However, staff did not always record the views of young people and their families fully, which meant that others involved in the patients' care might not know of their wishes.

Some inpatient services went further and involved young people in the running of the service, for example organising representation from a participation group at board level, and involving patients in staff recruitment and the development of the provider's websites.

There were good examples of participation in normal day-to-day activities being made available at inpatient units, including some off the ward – for example walks or theme park visits. In these services, staff actively supported and encouraged participation in a range of activities – gathering and acting on suggestions from patients and making activities available at a range of times, including evenings. These good examples showed a real focus on recovery focused care. We took action when we identified services where young people wanted more to do on weekends or where there were limited opportunities for activities due to poor facilities or staff shortages.

## **More focus needed on safety**

A number of providers need to improve their risk assessment and management, with particular difficulties with recording risk assessments on IT systems – especially in community services – where staff could not find risk assessments, either because they were not easily accessible or they were not routinely recorded.

There was broad awareness of safeguarding procedures, with protocols in place: staff knew how to make referrals to local authority safeguarding teams, and they were receiving appropriate training across community and inpatient services. But some services need to improve: some staff were not aware of how to escalate issues out of hours, and some did not always meet their duty to notify CQC after safeguarding concerns within the service had been raised.

We have seen some good practice in relation to restraint and restrictive practices, including the use of a sensory room to help the de-escalation of situations that would otherwise lead to restraint, and debriefing patients after the use of restraint. But appropriate, consistent and comprehensive recording of restraint and seclusion needs to improve in a number of inpatient services.

## **Getting the basics right**

In some services, staff did not complete care plans consistently. They were not holistic, not dated or were missing from care records. In some cases, managers did not provide regular supervision for staff or ensure that staff appraisals were completed.



## 3.2 Services for working age adults

### Key points

- 56% of acute wards for working age adults were rated as good, and 5% as outstanding. For long stay/rehabilitation wards, 72% were rated as good and 4% as outstanding. Among community services, 69% were rated as good and 2% as outstanding.
- We had concerns about the model of care provided by locked rehabilitation wards, especially in independent hospitals.
- The impact of the national shortage of mental health nurses was most apparent on acute mental health wards.
- Many acute wards and PICUs are located in old buildings that were not designed to meet the needs of these patients.
- We found many examples of commitment to continuous improvement among services for working age adults.

This chapter covers acute wards that provide care and treatment for people of working age who are acutely unwell and whose mental health conditions are such that they cannot be treated and supported safely or effectively at home.

Psychiatric intensive care units (PICUs) provide high intensity care and treatment for people whose illness means they cannot be safely or easily managed on an acute ward. People will normally stay in a PICU for a short period of time and will usually be transferred to an acute ward once their risk has reduced.

A rehabilitation ward should provide care and treatment for people whose complex needs are such that they require intensive and specialised rehabilitation over a longer period in hospital. Rehabilitation wards may also provide step-down for people moving on from secure mental health services.

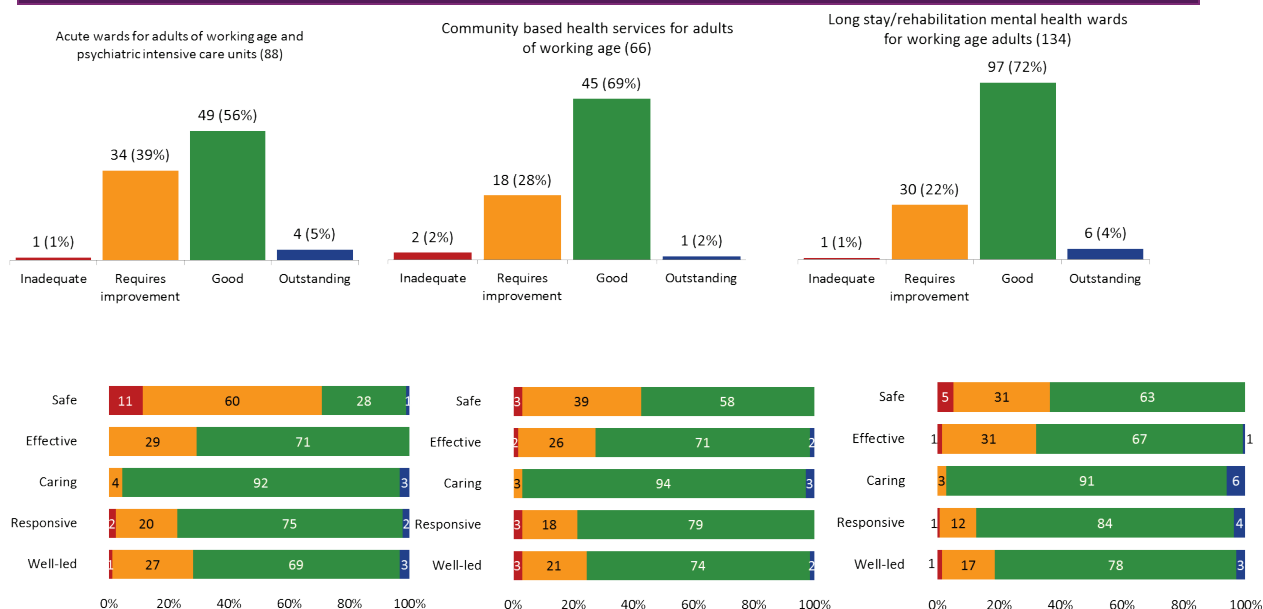
Community-based mental health services provide care and treatment for people who need care over and above what can be provided in primary care. Services are provided through a wide range of service models, and through a broad range of interventions. People using these services may receive support over a long period of time or for short-term interventions.

### Ratings

As at 31 May 2017, we had inspected and rated 86 services that provide acute wards for working age adults and PICUs (53 NHS and 33 independent), 134 services that provide long stay/rehabilitation wards (46 NHS and 88 independent) and 66 services that provide community mental health care (53 NHS and 13 independent).

There were 49 acute wards and PICUs (56%) rated as good and four (5%) as outstanding (figure 17). Of the long stay/rehabilitation wards, 97 (72%) were rated as good and six (4%) as outstanding. In community services, 45 (69%) were rated as good and one (2%) as outstanding.

Figure 17: Ratings for service for working age adults, as at 31 May 2017



Source: CQC ratings data as at 31 May 2017. Figures on horizontal bars are percentages.

Figure 18: Organisations rated as outstanding for services for working age adults, as at 31 May 2017

Acute wards and PICUs	Publication date
Dorset Healthcare University NHS Foundation Trust	16/10/2015
2gether NHS Foundation Trust, Gloucestershire	27/01/2016
East London NHS Foundation Trust	01/09/2016
Livewell Southwest Community Interest Company, Plymouth	19/10/2016
Long stay/rehabilitation wards	
Cornwall Partnership NHS Foundation Trust	09/09/2015
Kemple View, Blackburn	29/06/2016
Turning Point – Pendlebury House, Manchester	25/07/2016
Turning Point – Douglas House, Manchester	04/08/2016
Northumberland, Tyne and Wear NHS Foundation Trust	01/09/2016
Kent and Medway NHS and Social Care Partnership Trust	12/04/2017
Community services	
Northumberland, Tyne and Wear NHS Foundation Trust	01/09/2016

## **Safety of the ward environment**

Safety was the key question that we most often rated as requires improvement or inadequate. This was particularly the case for acute wards and PICUs: where we rated only 28% of services as good for safe and 1% as outstanding for safe. In many cases, this was due to concern about the safety of the ward environment, often compounded by deficiencies in staffing.

In chapter 1 we describe how, as bed numbers have reduced and the threshold for admission has increased, only those people who need intensive treatment and care are admitted to hospital. Increasingly, admission wards and PICUs are high risk environments. Many of acute wards and PICUs are located in old buildings that were not designed to meet the needs of such a patient group. They often have fixtures and fittings that are potential ligature anchor points for patients at risk of suicide, and their layout means that nurses cannot easily observe all areas. Some wards cannot be modified to eliminate these features. This makes it even more important that staff assess and actively manage and mitigate risks in the ward environment. This was sometimes not the case. An example is one independent acute service where senior staff had inadequate knowledge of ligature risks and were unable to identify them appropriately.

Seven years after the NHS issued guidance to eliminate mixed sex accommodation in all hospitals, we identified a number of acute and rehabilitation wards that still did not comply. This is a particular concern in mental health wards, where the patient group might include a mix of those who are disinhibited and those who are vulnerable to sexual abuse.

We identified a number of wards that had dormitory accommodation. In the 21st century, patients, many of whom have not agreed to admission, should not be expected to share sleeping accommodation with strangers – some of whom might be agitated. This arrangement does not support people's privacy or dignity.

## **Staffing**

Although in many cases staffing levels were sufficient with a good skill mix, our inspectors were told of patients not having enough one-to-one time with their named nurse or not seeing the psychiatrist responsible for their care frequently enough.

The impact of the national shortage of mental health nurses was most apparent on acute mental health wards. Some providers worked hard to fill staff vacancies through the use of bank or agency staff. Some used regular bank or agency nurses or gave such workers a full induction to try to ensure consistency and continuity of care for their patients. However, some services did not take steps to address high rates of agency and bank staff. Some agency staff were not sufficiently experienced or trained before starting work, patients on some wards told us that they had less confidence in agency staff, and the high turnover resulted in a lack of continuity of care.

## **Restrictive interventions and practices**

We concluded that staff in many services used physical restraint and other restrictive interventions appropriately. In these services, staff were skilled in de-escalation techniques and attempted to defuse situations and use low-level interventions before resorting to

physical restraint or seclusion. Unfortunately, this good practice was far from universal. Staff in some services did not keep good records of restrictive interventions by, for example, monitoring and recording the use of rapid tranquilisation and incidents of restraint in line with national guidance or the Mental Health Act Code of Practice.

We found wards where staff worked hard to minimise the use of ‘blanket restrictions’. Blanket restrictions are ward ‘rules’ that are applied to every patient on a ward and are not justified on the basis of an assessment of the risk posed to or by each individual patient. These might include blanket bans on the use of mobile phones or the practice of searching all patients on return from leave – including those who pose no realistic risk of bringing banned items onto the ward. Such bans can contravene the ‘least restriction’ principle required by the Mental Health Act Code of Practice and can cause frustration – and potentially result in a greater likelihood of aggressive behaviour. One ward addressed issues with illicit substances by providing an educational intervention rather than placing restrictions on leave.

However, some services need to improve in this area. Patients in some services did not have keys to their bedrooms and had restricted access to facilities (for example gardens and toilets), and drinks and snacks.

## **Access to and discharge from inpatient care**

People who need acute inpatient care should be admitted to a bed close to home. There are too many parts of the country where this is not always the case; patients might be admitted to a ward many miles from home. Also, in a few services, patients who take home leave might have to return to a bed on a different ward. This is not good for continuity of care. We saw some good examples of discharge planning in acute wards for working age adults. Some services had begun discharge planning when patients were first admitted, or well in advance of discharge, and others had continued support for patients post-discharge.

At some NHS rehabilitation services, trusts were working well with others to facilitate discharge. One service piloted an outreach service, which provided six weeks support to patients discharged in to the community, and at another, staff worked with other agencies to make sure patients were treated as close to home as possible to reduce out of area placements. However, in this and other services, the discharge of patients was sometimes delayed due to a shortage of suitable onward placements, social housing and a range of funding challenges. This indicates that there are wider systemic issues that the mental health sector cannot address alone.

We had particular concerns about the length of stay of patients in some rehabilitation wards, especially in independent hospitals (we describe our concerns about locked rehabilitation wards in chapter 2).

## **Access to non-crisis, community mental health care**

We found many positive examples of good access to community mental health care. Many services prioritised urgent referrals, undertaking assessments promptly and with staff following up patients who did not attend appointments. Staff also used a variety of techniques to engage patients who found it hard to engage with services. Many services had systems in place to respond to increased risks and changes in mental health; and provided out-of-hours contact and other out-of-hours support or services such as clinics.

## **Meeting patients' physical health needs**

Staff in some services failed to consistently ensure that patients were referred for physical health checks, or to record this. Some showed poor general monitoring of physical health (for example failure to act on early warning signs), including for patients with long-term conditions. On the other hand, we have seen good examples of staff being attentive to the physical health needs of patients, such as carrying out regular physical health checks – or ensuring that these had been carried out by the patient's GP. In some cases, staff also actively promoted a healthy lifestyle; for example by giving nutritional advice or help with stopping smoking. However, this was not always the case.

## **Pathways of care**

Some people with mental health conditions need ongoing care. Also, as their condition worsens and then improves, people often need input over time from a range of different services – both inpatient and community. In these cases, good care coordination and easy transitions from one part of the patient pathway to another are very important. Some providers had effective, detailed handovers between teams with periods of joint working to help patients become settled with a new care team. We also saw innovative practice, such as the use of tracking systems to assist working across different teams or organisations, and a city-wide bed management system.

## **Commitment to improvement**

We found examples of ward staff who were committed to continuous improvement, even in these challenging care environments. Many services were involved in quality improvement projects and clinical audits. Many wards for working age adults participate in the Accreditation for Inpatient Mental Health Services (AIMS) accreditation scheme and the Prescribing Observatory for Mental Health – both of which are managed by the Royal College of Psychiatrists.

Local leadership at the strongest services encouraged staff to be innovative and actively engage in improving the quality of care. The best services also showed that they had learned from complaints or serious incidents, and provided the opportunity for staff to collectively reflect on practice. One example of this is a ward manager from a psychiatric intensive care unit who had created a 'prevent management of violence and aggression' reflection group. This was a weekly meeting open to all staff on site. The meetings were an opportunity to discuss specific cases, incidents, and care plans for new patients. It was also an opportunity to reflect on practice and share lessons learned.

Although in many cases governance systems were robust and well-organised, there were exceptions to this. Above, we have described our concern about the failure of managers of some wards to identify and address environmental risks, such as ligature risks. In some wards and community services, we also found a lack of effective systems to monitor staff supervision and training, or to carry out clinical audits for the purpose of improving the quality of care.

### 3.3 Older people's services

#### Key points

- 66% of older people's wards were rated as good, and 2% as outstanding; 76% of community services were rated as good, and 10% as outstanding.
- A substantial number of services reported that some older people remained in hospital beyond the point at which they required that level of mental health care.
- We were concerned to find that, in some services, staff had not carried out a risk assessment or had recorded one that was formulaic or lacking in detail.
- We had concerns about the ward environment in some older people's services, such as potential ligature anchor points and failure to comply with the guidance on eliminating mixed sex accommodation.

Older adult services generally provide home-based assessment, care and treatment with multidisciplinary teams, with back-up from inpatient units that, preferably, specialise in the care of older people. The services must meet a combination of psychological, cognitive, functional, behavioural, physical and social needs, often related to ageing. Community services may be provided in a person's own home or in a care home.

There are almost 10 million people in England aged 65 and over.<sup>11</sup> Many older people require specialist mental health services because they have very different needs to adults of working age. These differences arise from:

- The far higher prevalence of organic mental health diagnoses in older people.
- The complex interplay between physical illness and mental illness in terms of causation, diagnosis and treatment. For example, older people are more likely to develop Parkinson's disease. People with Parkinson's disease are more likely to develop depression. Depression associated with Parkinson's disease is difficult to diagnose, and the treatment for the two conditions may interact with one another.
- Different and escalating social issues such as isolation, poverty and bereavement.
- The impact of physical frailty on engagement with services.

Older people treated in services that cater for adults of all ages have more unmet needs.<sup>12</sup> The Five Year Forward View for Mental Health states that "...bespoke older adult services

<sup>11</sup> Office for National Statistics, Mid-year population estimates 2016

<sup>12</sup> Abdul-Hamid WK and others, "Comparison of how old age psychiatry and general adult psychiatry services meet the needs of elderly people with functional mental illness: cross-sectional survey". *Br J Psychiatry* 2015; 207: 440–3

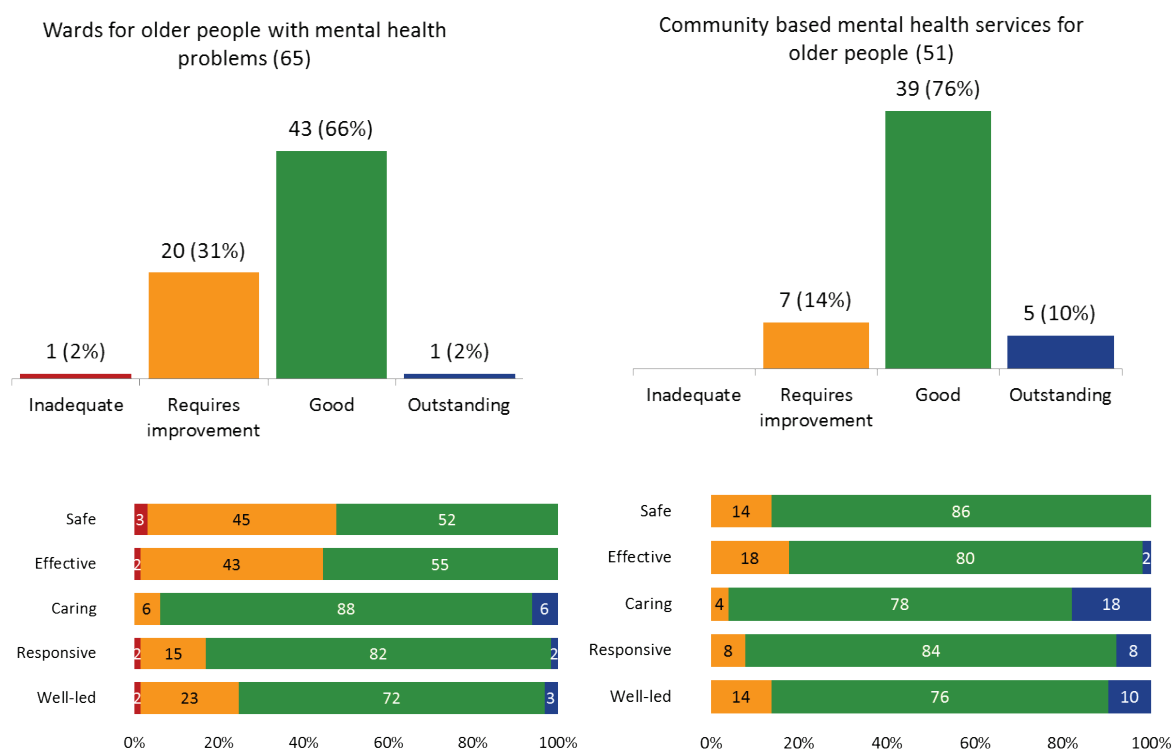
should be the preferred model until general adult mental health services can be shown to provide age appropriate care”.<sup>13</sup>

## Ratings

As at 31 May 2017, we had rated 65 inpatient services for older people: 53 NHS and 12 independent. Overall, 43 (66%) were rated as good, and one (2%) as outstanding (figure 19). However, 20 (31%) of these services were rated as requires improvement and one (2%) as inadequate. Our greatest concern was about the safety of inpatient services for older people, with 3% rated as inadequate and 45% rated as requires improvement, and the effectiveness of those inpatient services, with 2% rated as inadequate and 43% rated as requires improvement.

We have also rated 51 community services: 49 NHS and two independent. Of these, 39 (76%) were rated as good, and five (10%) were rated as outstanding. There were seven services (14%) that were rated as requires improvement. None was rated as inadequate. In terms of the profile of the ratings, this was one of the core services about which we had fewest concerns.

Figure 19: Ratings for older people’s services, as at 31 May 2017



Source: CQC ratings data as at 31 May 2017. Figures on horizontal bars are percentages.

<sup>13</sup> <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

Figure 20: Organisations rated as outstanding for older people's services, as at 31 May 2017

Older people's wards	Publication date
East London NHS Foundation Trust	01/09/2016
Community services	
Berkshire Healthcare NHS Foundation Trust	30/03/2016
Black Country Partnership NHS Foundation Trust	26/04/2016
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	12/07/2016
Northumberland, Tyne and Wear NHS Foundation Trust	01/09/2016
North Staffordshire Combined Healthcare NHS Trust	21/02/2017

## Safety on the wards

For some services, we had similar concerns about the ward environment as for wards for working age adults. These related to the layout of the wards, the presence of potential ligature anchor points, and failure to comply with the guidance on eliminating mixed sex accommodation.

It is particularly important that staff on old age mental health wards carry out thorough risk assessments. This is because many older people admitted to a mental health ward are at risk both from the consequences of their mental health condition and from the effects of physical ill-health and frailty. Some patients told our inspectors that other patients made them feel unsafe. We were therefore concerned to find that, in some services, staff had not carried out a risk assessment or had recorded one that was formulaic or lacking in detail. However, we also saw some good practice. One trust we visited used a board that was a 'quick visual guide' to risk for all patients on the ward, and this was discussed daily in a multidisciplinary meeting.

We were concerned about practices relating to physical restraint and the use of blanket restrictions in some independent inpatient services. Although we praised several for their use of least restrictive practices and specific de-escalation and safe restraint techniques, we found problems in others. These included: staff controlling patients' waking and sleeping hours; use of rapid tranquillisation without adequate staff training or legal authorisation; and patients subject to restrictions without deprivation of liberty assessments having been carried out.

Also, some NHS wards for older people could not ensure consistently safe staffing. For example, although recruitment was underway at one trust, the manager of one ward was carrying out a high number of nursing shifts. This affected their ability to supervise junior staff. Another trust was not able to staff ward rounds adequately due to its high vacancy rates. Some independent services also had staffing challenges. This sometimes included inadequate doctor cover out of hours.



## **Delayed discharges**

A substantial number of services reported that some older people remained in hospital beyond the point at which they required that level of mental health care. This is both not in the best interests of the people concerned and also means that people who need to be admitted may not be able to, or they may be sent to wards further away from their home, and from their friends and family.

Providers tell us that many of these delayed discharges are at least partly due to the pressures on the social care sector and the data shows that some of the sharpest increases in delays by cause have been waits for care packages in the person's own home.

## **Multidisciplinary teamwork and inter-agency working**

Given its importance for this group of patients, we were pleased to find that most older people's services, both inpatient and community, were staffed by multidisciplinary teams, with staff from a range of professional backgrounds working well together. Particular positive comments were made about regular multidisciplinary team meetings and the use of a 'wellbeing coordinator' in the independent sector. However, not all services ensured that older people had access to talking therapies that are recommended by the National Institute for Health and Care Excellence.

We did not always find that these teams were working well with, or coordinating care with, the wider health and care system that provides care to older people. We saw examples of close working with the Alzheimer's Society, and of good links with physical healthcare providers. But we also saw cases of separation between physical and mental health care. This resulted in a failure to treat patients holistically, a lack of discharge and pathway planning, and poor communication between inpatient and community services.

## **Focus on improvement**

Old age mental health services that did well had good consultant input and good local leadership (for example from matrons), and good links to primary care services. Good relationships with social services are also important, at local and strategic level.

The leaders of some old age mental health services were visible and credible to frontline staff. For example, one community interest company connected frontline staff to the wider organisation by allowing staff to become members of the company, and inviting staff representatives to board meetings. On the other hand, in some providers staff felt disconnected from senior management and lacked confidence about how managers would react if they raised concerns.

Some providers were focused on promoting a culture of innovation and improvement – for example, the creation of a 'brain food' group to improve nutrition (for which a research grant had been applied to continue the work) and an initiative to explore dementia among Black and minority ethnic people. However, in others there was a lack of learning – sometimes due to a lack of system or structure within which learning could take place and trends be identified. In some cases, learning could not take place effectively because investigations were of poor quality or incident reporting and auditing were poor.

We praised a number of providers for the ways in which managers and management structures made sure staff had the right skills and knowledge to make decisions, for example specialist training appropriate to their roles and allowing time for continuous professional development.

In terms of managing resources, we found examples of good practice in areas such as caseload audits and assessments, and management support for teams needing extra staff. However, there were cases where low staffing numbers were not being addressed, and inconsistencies in duty roster systems.

## 3.4 Mental health crisis care

### Key points

- 67% of crisis care services were rated as good, and 4% as outstanding.
- The use of police custody as a place of safety fell by 56% from 2014/15 to 2015/16. The roll-out of street triage schemes across the country has contributed to this.
- Not all parts of the country are yet commissioned to provide fully functioning crisis services 24 hours a day, seven days a week for all groups of patients who might benefit
- Crisis care staff often did not receive regular supervision – a concern because these staff are caring for the most at-risk patients in a context that lacks the structure of an inpatient setting.

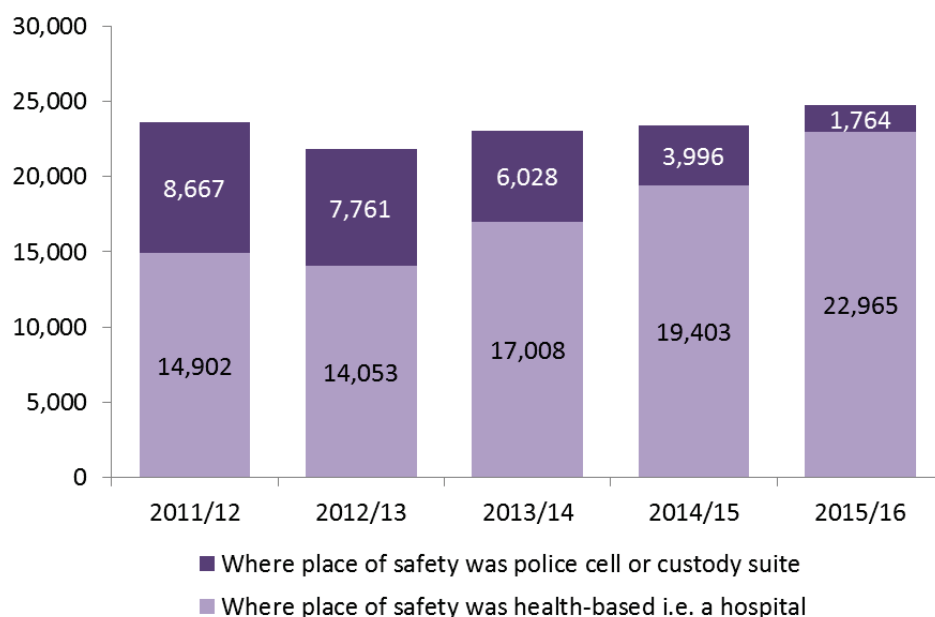
This chapter covers:

- Community-based mental health crisis services that provide care and treatment for people who are acutely unwell who would otherwise need to be admitted to hospital. These services include crisis resolution and home treatment teams that see people in their homes, and crisis houses for people who cannot be treated at home, but who do not need to be admitted to hospital.
- Health-based places of safety. These are rooms or suites where people who have been detained by the police under section 135 or 136 of the Mental Health Act are taken for assessment.

Our inspection programme builds on the work of our 2015 review of crisis care, [Right here right now](#), which highlighted the experiences of those accessing crisis care and the variation in the care they received. Under the auspices of the Crisis Care Concordat, significant efforts have been made nationally and locally to improve the provision of health-based places of safety and to divert people detained under section 136 away from police custody. Data from our survey of health-based places of safety has been crucial in identifying gaps in provision and informing the allocation of funding to improve provision. In March 2017, we updated our [map of health-based places of safety in England](#) which shows where each health-based place of safety is located and which trust it is provided by.

The overall use of section 136 has continued to rise, but use of police custody as a place of safety fell by 56% from 2014/15 to 2015/16, from 3,996 to 1,764 (figure 21). At the same time, use of health-based services as a place of safety rose by 18%, from 19,403 to 22,965. National Police Chiefs' Council data identified a 73% reduction in the use of police custody for under 18s as a place of safety from 2014/15 to 2015/16: from 161 down to 43.

Figure 21: Use of section 136 Mental Health Act, 2011/12 to 2015/16



Source: NHS Digital

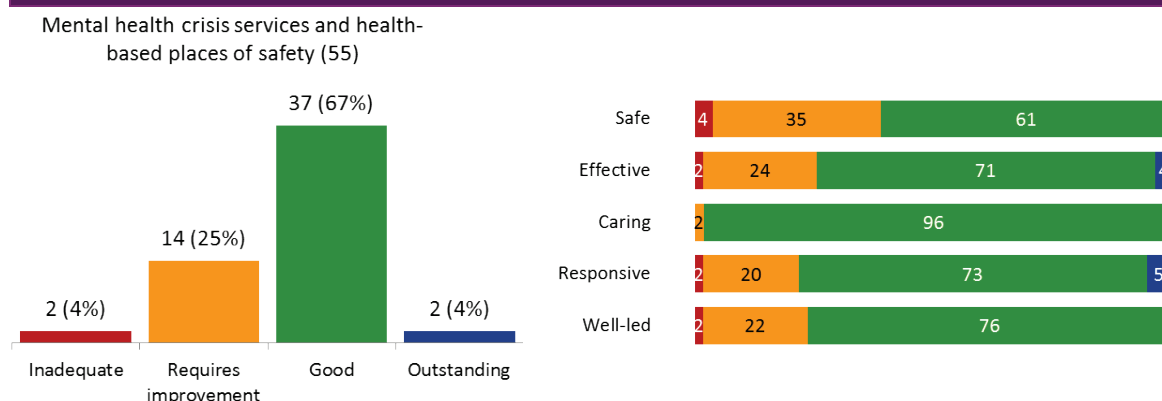
Proposed alterations to the Mental Health Act made through the introduction of the Policing and Crime Act 2017 will bring a number of changes that will affect the use of health-based places of safety. The length of time a person may be detained for the purpose of an assessment is set to be reduced to 24 hours, down from 72.

Police officers will also be required to consult with mental health practitioners, where practicable, before using section 136. The roll-out of street triage schemes across the country has widely seen a reduction in the number of people being detained in police cells under section 136. Finally, police cells will be prohibited as places of safety for people under the age of 18, and their use must be significantly restricted for adults. This is likely to put additional pressures on health-based places of safety, and also on A&E departments if that is the only alternative available to police officers.

## Ratings

As at 31 May 2017, we have rated 55 mental health crisis care services and health-based places of safety: 54 NHS and one independent. Of these, 37 (67%) were rated as good, and two (4%) as outstanding (figure 22). However, 14 (25%) services were rated as requires improvement and two (4%) as inadequate. There is considerable room for improvement in crisis care services, with nearly four in 10 services being rated as requires improvement (35%) or inadequate (4%) for safety. In addition, a fifth or more of ratings for effective, responsive and well-led were requires improvement.

**Figure 22: Ratings for crisis care services, as at 31 May 2017**



Source: CQC ratings data as at 31 May 2017. Figures on horizontal bars are percentages.

**Figure 23: Organisations rated as outstanding for crisis services and health-based places of safety, as at 31 May 2017**

Crisis services and health-based places of safety	Publication date
Rotherham Doncaster and South Humber NHS Foundation Trust	19/01/2016
2gether NHS Foundation Trust, Gloucestershire	27/01/2016

## Gaps in provision of crisis care

Where they were commissioned to provide full cover 24/7, most crisis teams that we inspected provided responsive care.

We found examples where contacting teams was straightforward and patients could get support when they needed it – 24 hours a day, seven days a week – and where people would be seen within four hours for a face-to-face assessment when referred into the service.

However, not all parts of the country are yet commissioned to provide fully functioning crisis services 24 hours a day, seven days a week for all groups of patients who might benefit. In one trust, the crisis care team did not operate 24 hours a day due to commissioning arrangements not funding this level of provision. After 9.30pm, teams relied on senior nurse practitioners to answer the team phone, or the mental health line, if people made contact. The senior nurse practitioners had other responsibilities, such as carrying out assessments, which affected their availability. Without access to this service, patients would have limited options other than to present at A&E where, in our thematic review into crisis care, we highlighted significant concerns in response to people experiencing a mental health crisis.

Street triage, where it was being used, was working well. In one service, street triage had been operating for three years and had significantly reduced the number of people with

mental health conditions being taken into police custody. The teams operated different working hours based on the need of the local population and they had also reduced overall use of health-based places of safety across the area. Street triage also allowed information sharing, for example with police services.

### **A focus is needed on safety**

Crisis teams work with people who would otherwise be in hospital. Many of these people are at risk of suicide or self-harm and some might pose a risk to others because of their distressed state. High-quality risk assessments are therefore important and these should be collaborative assessments – managed with the patients and with carers and family members.

While staff were generally assessing and managing individual risks to people using crisis care services well (including health-based places of safety), this was an area for improvement for some providers. For example, the crisis care teams of one provider had different approaches to engaging people who were not attending appointments. The provider had no clear criteria that guided teams in the measures they should take to ensure these people were safe before discharging them.

We concluded that for most services, staffing levels were sufficient to provide a safe service, with team members having manageable caseloads. However, managers had not always ensured that staff had undertaken training that is essential for this type of service, including in the prevention and management of violence. Also, staff in mental health crisis care services often did not receive regular supervision. This is a concern, because these staff are caring for the most at-risk patients in a context that lacks the structure of an inpatient setting.

Some services follow good practice in terms of lone working of staff, but others did not do all they could to ensure staff safety in this high risk area of practice. Both policy and practice varied, with a lack of consistency in how teams were managing risks to staff. For example, one service had good lone working policies in place that staff followed; in another, there was a lone worker policy but staff did not appear to be following it.

Although there were exceptions, the environments of most health-based places of safety were clean, safe and comfortable, and they promoted patients' dignity. Staff had assessed ligature risks and there were appropriate alarms systems that staff could use to summon help in an emergency.

### **The provision of the full range of interventions**

Good crisis service should offer social and psychological intervention and support patients by, for example, linking them in with community and recovery services, such as recovery colleges. However, this could be inconsistent. For example, one crisis and resolution home treatment team offered patients access to psychological therapies as part of their treatment (such as anxiety management, cognitive behavioural therapy and solution focused therapy), but staff did not always identify and document the need for such interventions at the assessment stage.

## Examples of good and innovative practice

We have seen a number of examples of good practice in delivering effective crisis care, including:

- Good multidisciplinary team working, with crisis care teams working effectively with other services to ensure patients received an effective crisis intervention service. One crisis care team had links with the outpatient and inpatient services across geographical areas, which enabled effective gatekeeping of all inpatient beds. One employed nurses to work in the local police control centre, and another formed a partnership with the local substance misuse services to secure early access for patients.
- One crisis service supported people to access planned short-term admissions to inpatient services for up to 72 hours where this met people's needs (for example, for people with borderline personality disorder and some crisis teams encouraging advance directives to help people determine their future crisis care needs).
- One service used the host family scheme (this example is the first of its kind in the UK) – this allowed people who were acutely unwell to stay with a local family for a few weeks, as an alternative to inpatient care.

## 3.5 Services for people with a learning disability or autism

### Key points

- 64% of wards for people with a learning disability or autism were rated as good, and 9% as outstanding; 80% of community services were rated as good, and 9% as outstanding
- We found examples where staff had achieved a marked reduction in the use of physical restraint and seclusion. However, we remain concerned about the high use of restrictive interventions in some inpatient services.
- Many services worked well with other health and social services to build partnerships to meet the needs of people using the service and carers.
- Contrary to the aims of the Transforming Care Programme, some patients have been in hospital for a long time and their care plans lacked evidence of active discharge planning.
- Staff in too many services were not applying the Mental Capacity Act appropriately.

This chapter covers wards and community services for people with a learning disability or autism. The Transforming Care programme is tasked with ensuring that people in England with a learning disability or autism are only admitted to a mental health hospital when that is the intervention most suited to their needs at that time. Hospital must never be considered 'home' for people with a learning disability; they have a right to live in settled accommodation of their choice in their local community. This requires robust multidisciplinary community services, including 24/7 access to crisis care services, improved access to mainstream health care and the embedding of positive behaviour support across the health and care sectors.

Once good community services are in place, hospital services for people with a learning disability or autism will be able to focus more on short-term assessment and treatment of people with mental health conditions, than on longer admissions for behaviour management.

Progress with Transforming Care has been patchy across England to date. Although we do not penalise providers for any lack of progress that is not within their control, we are increasingly checking that the Transforming Care 'building blocks' are in place. These include active participation by hospitals in care and treatment reviews, the implementation of positive behaviour support in both hospital and community services, and care in hospitals that is clearly discharge-oriented. We have also taken action to ensure that new providers who apply to register learning disability services are adhering to the model of care advocated by the Transforming Care programme. Our consultation on the next phase of inspection resulted in changes to registration of new specialist assessment and treatment units and hospital services for people with a learning disability or autism (as well as other types of learning disability or autism services), as well as to requests for variations to existing registrations. Our publication, *Registering the Right Support*, outlines our new approach.

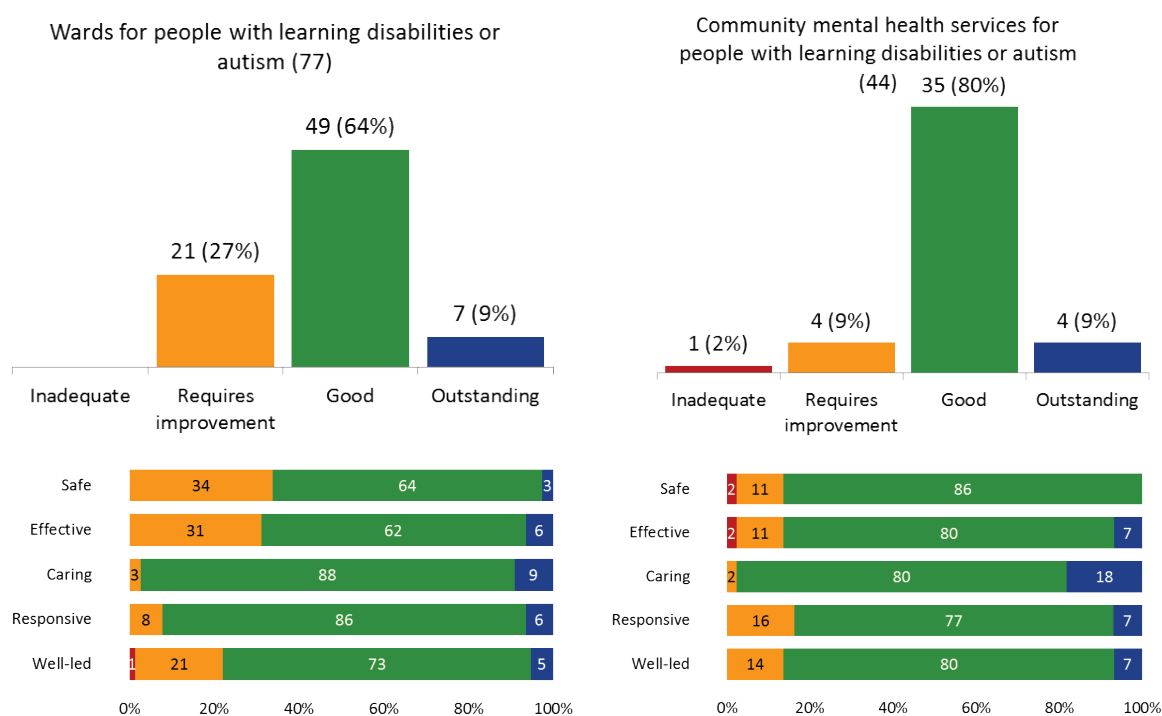


## Ratings

We have rated 77 services that provide wards for people with a learning disability or autism: 37 NHS and 40 independent. At 31 May 2017, 49 (64%) were rated as good, and seven (9%) as outstanding (figure 24). However, 21 of these services (27%) were rated as requires improvement. None was rated as inadequate. Our greatest concerns were about the safety of inpatient services, with 34% rated as requires improvement, and the effectiveness of inpatient services, with 31% rated as requires improvement.

We have inspected and rated 44 community services: 42 NHS and two independent. Overall, 35 (80%) were rated as good, and four (9%) were rated as outstanding. Only four services (9%) were rated as requires improvement and one service (2%) was rated as inadequate. The quality of care across all of our five key questions was generally good.

Figure 24: Ratings for services for people with a learning disability or autism, as at 31 May 2017



Source: CQC ratings data as at 31 May 2017. Figures on horizontal bars are percentages.

Figure 25: Organisations rated as outstanding for services for people with a learning disability or autism, as at 31 May 2017

Wards for people with a learning disability or autism	Publication date
Cheshire and Wirral Partnership NHS Foundation Trust	03/12/2015
South London and Maudsley NHS Foundation Trust	08/01/2016
Cambian – Sherwood Lodge, Mansfield	18/03/2016
Cambian – Cedars, Birmingham	09/06/2016
Northumberland, Tyne and Wear NHS Foundation Trust	01/09/2016
West Hills House	15/03/2017
Kent and Medway NHS and Social Care Partnership Trust	12/04/2017
<b>Community services</b>	
South London and Maudsley NHS Foundation Trust	08/01/2016
Northumberland, Tyne and Wear NHS Foundation Trust	01/09/2016
Livewell Southwest Community Interest Company, Plymouth	19/10/2016
Solent NHS Trust	15/11/2016

## Safety is our biggest concern

There is national concern about the use of restrictive interventions in inpatient services for people with a learning disability; including physical restraint and over-medication.

We found examples of where staff have taken action that has resulted in a marked reduction in the use of physical restraint and seclusion. However, we remain concerned about the high use of restrictive interventions in some inpatient services. As mentioned in chapter 2, we are committed to improving how we assess the use of restrictive interventions and will pay much closer attention to whether services have in place an active programme to reduce and minimise their use and the extent to which they are able to demonstrate the impact of such programmes.

Some NHS learning disability wards experienced the same problems with the safety of the physical environment and with staff shortages that affected other types of wards.

## Planning and coordination of care

Many learning disability and autism services that we inspected worked well with other health and social services to build partnerships to meet the needs of patients and carers. There was also evidence of services working with other agencies such as local authorities, police, schools and housing associations to support patients.

We have seen evidence of staff showing their commitment to supporting the physical health of people. Many services carried out comprehensive physical assessments and monitored patients with, or at risk of, cardio-metabolic disorders. Some inpatient services had on-site

medical staff and others liaised with external specialist healthcare professionals about the provision of care.

However, some services needed to improve the quality and consistency of care planning in both ward-based and community-based services. Although some plans were holistic and staff updated them according to changing needs, others were lacking detail or not personalised and, in some cases, not all staff had easy access to care plans.

## **Access to and discharge from care**

Some community learning disability services had long waiting lists. However, staff in some services carried out rapid assessments and reviews of waiting lists to identify those patients most at risk.

The aim of the Transforming Care programme is to ensure that people with a learning disability are only admitted to hospital when this is in their best interests and that hospital is never considered to be 'home'. When we inspected inpatient services, we frequently encountered patients who had been in hospital for a long time. In some cases, care plans had a lack of discharge planning information.

## **The use of the Mental Capacity Act**

We found too many services for people with a learning disability where staff were not following or applying the Mental Capacity Act appropriately. In some services, too few staff had received recent training in the Mental Capacity Act and there was no plan in place to address this. In some cases, because staff did not feel confident to make mental capacity assessments, staff routinely referred patients to a clinical psychologist or psychiatrist for these assessments.

## **Involving and respecting people**

The great majority of staff that we encountered in our inspections showed caring, considerate and compassionate interactions with people with a learning disability or autism using their services. One specific comment from a person using an NHS community service was that "the service had changed their life" – a comment that sums up a widely held view by people who used this service:

*"People who used the service all spoke very positively about it, saying that the quality of the support they received from staff was very high, that they felt listened to, cared for and respected. They described staff as very friendly and kind and that they took care to understand their individual needs, showing patience to fully involving them in the planning and delivery of their care and treatment. One person said that the service had changed their life. Another commented that the kindness and care that staff always showed to them made them very happy."*

Most services involved people in their own care planning – giving people time to voice their views and influence their care. Staff in some services encouraged patients to rate their own risk by using a red, amber or green rating scale. This showed that staff valued and respected

patients' self-assessment. The better services also involved people with a learning disability in reviewing and advising on improvements to the service and in the process for recruiting new staff.

Staff were frequently mentioned as “recognising (the) individual needs” of patients and ensuring other providers were aware of them. Most services were generally taking the communication needs of patients into account. For example, one service had developed a core team of staff trained in British Sign Language and Makaton to work with the patients. This appeared to have worked well, as incidents had reduced due to enabling patients’ communication with staff.

We have also seen positive examples of documents, leaflets and reports commonly being available in easy read format. In most cases, staff were providing information, support and encouragement for people, their families and carers on how to make complaints. However, one area of improvement for some services was to address the lack of information on wards about Independent Mental Health Act advocacy and supporting patients to make contact with an advocate.

## 3.6 Forensic services

### Key points

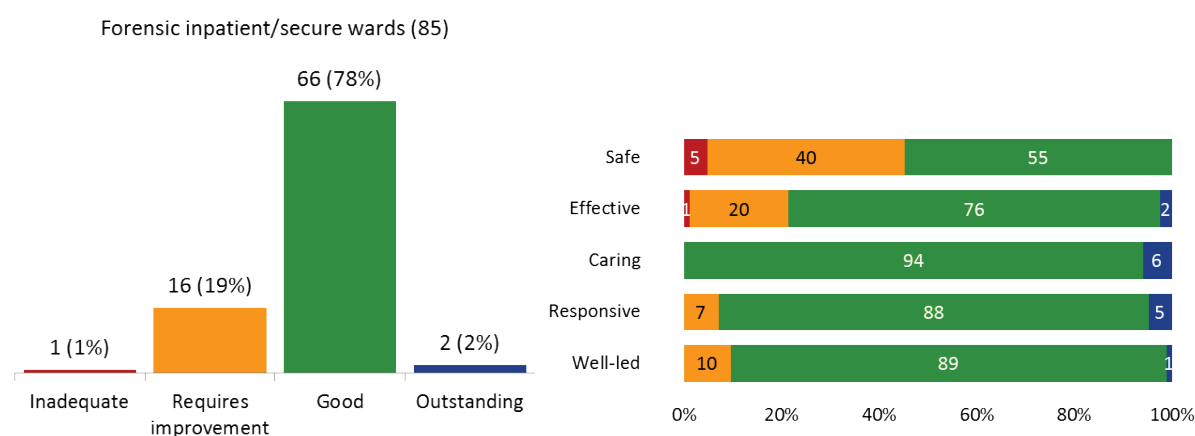
- 78% of forensic/secure wards were rated as good, and 2% as outstanding
- While some services had enough staff available to meet people's needs, some had multiple vacancies on wards. At the high secure Broadmoor Hospital and Rampton Hospital, a shortage of nursing staff had restricted patients' day-time access to therapies and activities.
- A number of forensic services have schemes that provide patients with employment opportunities within secure care – these make an important contribution to the patient's rehabilitation.
- We have seen a range of good practice in services attending to patients' physical health needs.

This chapter covers forensic inpatient and secure wards that provide care and treatment in hospital for people with mental health conditions who pose, or who have posed, risks to other people. People in secure services often have been in contact with the criminal justice system. These services may be low, medium or high secure, reflecting the different levels of risk that people are considered to present to themselves and/or to others.

### Ratings

As at 31 May 2017, we have inspected and rated 85 forensic services, 44 NHS and 41 independent. There were 66 services (78%) rated as good and two (2%) as outstanding (figure 26). In line with many of the other core services, our greatest concerns were around safety, with 34 (40%) rated as requires improvement and five (5%) as inadequate.

Figure 26: Ratings for forensic services, as at 31 May 2017



Source: CQC ratings data as at 31 May 2017. Figures on horizontal bars are percentages.

**Figure 27: Organisations rated as outstanding for forensic inpatient / secure wards, as at 31 May 2017**

<b>Forensic inpatient / secure wards</b>	<b>Publication date</b>
Barnet, Enfield and Haringey Mental Health NHS Trust	24/03/2016
Kemple View, Blackburn	29/06/2016

## **Safe staffing**

While many services had enough staff available to meet people's needs, some had a high number of vacant nursing posts. This resulted in high levels of use of bank staff. A few services had been unable to fill these vacant posts with bank staff. We saw examples of the effect on patients and staff of poor staffing levels. For example, there were wards where there were insufficient nurses to provide escorts for patients who were entitled to leave or to support other activities, and staff not always able to take their breaks. At one service, the night coordinator had to cover qualified staff on night shifts.

These shortages were not confined to nursing staff. Some services had vacancies for other members of the multidisciplinary team, including clinical psychologists and social workers. At two services, the shortage of administration support staff meant that qualified staff had to take time away from patient care on some occasions.

Forensic wards admit patients who pose the highest risk and who require specialised care. It is therefore concerning that we are found a number of services where a low proportion of staff had undertaken training essential to maintain safety and/or that did not provide staff with the specialist training required for patients with complex needs.

## **Concerns about the high secure hospitals**

We inspected all three high secure hospitals between November 2016 and March 2017, and found that all three had a shortage of nursing staff. At Broadmoor Hospital and Rampton Hospital, this had restricted patients' access to therapies and activities. The low staffing levels at Rampton Hospital sometimes increased the risk to patients. One effect of the staffing shortage at Broadmoor Hospital and Rampton Hospital was that patients who were locked in their rooms at night ('night-time confinement') also had restricted access to day-time activities. This was not in line with the high secure hospitals directions. At Rampton Hospital, a significant number of night shifts were covered by a single member of staff. We were also concerned that staff at Broadmoor Hospital and Rampton Hospital did not monitor and review patients in seclusion and long-term segregation in line with guidance in the Mental Health Act Code of Practice.

## **Adherence to mental health and mental capacity legislation**

As might be expected in these specialised settings, generally, there was good practice in the implementation and understanding of the Mental Health Act (MHA) and Mental Capacity Act (MCA). Staff assessed patients' mental capacity to make decisions when required and

most had policies, procedures, systems and ward environments that were in line with MCA and/or MHA codes of practice and associated guidance.

However, several providers had a number of areas for improvement:

- At one trust, staff were not following guidance in the MHA code of practice. They did not give patients an explanation of their rights under the MHA, did not make mental capacity assessments when required, did not give patients copies of their leave forms, and did not adhere to guidance on seclusion rooms.
- Staff in another trust did not understand best practice in use of seclusion and did not adhere to the trust's policy on this. This trust also had an over-restrictive policy on observing patients open their mail, which was not in line with MHA Code of Practice. It also needed to make improvements to MHA documentation and how staff recorded decisions relating to mental capacity. Underlying these problems was the finding that a low proportion of staff had received recent training in both the MHA and the MCA.
- The MCA policy of one independent provider did not comply with the Code of Practice and was not following the correct process around the Deprivation of Liberty Safeguards. The provider also needed to make changes to its seclusion policy to bring it into line with codes of practice, implement systems to monitor compliance with the MHA, give patients more timely information about their rights, and make improvements to the recording of mental capacity assessments. Once again, underlying these problems was a failure to provide staff with training in mental health legislation.

## **Restrictive practices**

We found a range of areas for improvement in relation to restraint and restrictive practices. These included staff imposing 'blanket restrictions' on all patients without paying regard to whether these were warranted for each individual, and staff not having a full understanding of seclusion. However, we also found some good practice and improvement, where restraint was used safely and as a last resort, and where initiatives were in place to reduce the use of restraint.

## **Involving people in their care and focusing on recovery**

The extent to which staff involve and engage with patients in secure services has improved in recent years. We found many examples of good practice in involving patients in developing their care plans and attendance at multidisciplinary team meetings. Specific examples included:

- a 'My shared pathway' approach – a recovery approach to care planning and daily ward briefings with all patients and staff
- 'advanced decisions' in place for patients, describing how they would like to be managed if they became distressed
- services that enabled patients moving from medium to low secure wards to familiarise themselves with the new environment before they moved, or that used a buddy system to support patients during admission.

This involvement of patients in decisions about their care resulted in personalised care and helped to ensure that care plans were holistic – incorporating physical, mental health and social care needs.

We also found a number of good examples of services enabling people to present their views and influence the service. These included staff ensuring that patients knew how to make a complaint and supporting them to do this. One service had developed a ‘fast track’ for both patients and visitors to make informal complaints. Patients in some services attended clinical governance meetings, and in one went on ‘away days’ with staff. In one service, patients reviewed complaints via a patients’ council, and in a number of services patients were actively involved in recruiting new staff.

The Quality Network for Forensic Mental Health Services is a standards-based peer-review system managed by the Royal College of Psychiatrists. Its aim is to enable quality improvement and change in forensic mental health settings through a supportive network and peer-review process. NHS England requires every medium and low secure forensic mental health service to participate. The Network has played an important role in finding where representation for people using services worked really well, and in sharing these ideas with other providers and units. The involvement of staff and patients in peer review of other units was helpful in this. Because they were geographically isolated, forensic units had tended to work in silos and had become stuck in particular ways of working. The Quality Network has brought units from all round the country into contact with one another and given them new insights into different ways of doing things.

A number of forensic services have schemes that provide patients with employment opportunities within secure care. These make an important contribution to the patient’s rehabilitation and eventual integration back into open society. We found good and outstanding examples of links with external partners, such as police, local colleges, faith leaders and a range of community organisations, to enhance opportunities for patients and support recovery:

- At one service, staff celebrated patients’ involvement in the Koestler awards, the UK’s best-known prison arts charity, and displayed patients’ art work in the service. Also, police officers and staff supported patients to attend a community judo club and staff were setting up a judo group at the service – which meant that staff and patients were able to learn judo together. The judo programme was a success and the service arranged ceremonies to present students with their certificates.
- At another service, staff supported patients to attend community and neighbourhood groups and to access learning, vocational and volunteer opportunities. Patients could attend vocational and academic courses, and improve basic skills such as numeracy and literacy. There were also a number of opportunities for paid ‘real work’. Patients applied and were interviewed for these posts, and they received reimbursement for the work they carried out.



## **Meeting patients' physical health needs**

Many people under the care of forensic services have co-morbid physical health conditions. They are also at risk from the adverse effects of some medications. We have seen a range of good practice in attending to patients' physical health needs, including access to GPs, dentists and healthcare clinics, access to a gym with a range of facilities and fitness trainer, and an embedded pan-service "food strategy" in response to growing numbers of patients at risk of obesity and associated conditions such as diabetes.

## 4. Improvement and re-inspection

As at 31 May 2017, we had re-inspected and reconsidered the overall rating of 25 NHS mental health trusts. We had re-inspected one or more core services for a further five trusts, but not reconsidered the overall rating.

We had initially rated 22 of the 25 trusts, that we re-inspected at the overall trust level, as inadequate or requires improvement. Sixteen of these improved their overall rating: 15 from requires improvement to good, and one from inadequate to requires improvement (Norfolk and Suffolk NHS Foundation Trust) (figure 28). The others remained the same except for Isle of Wight NHS Trust, which deteriorated from a rating of requires improvement to inadequate. However, only 10 of the 25 trusts were able to improve their overall safety rating.

We have seen a large number of trusts that are actively seeking to learn and improve, and many have approached the outstanding trusts and others in a spirit of collegiate learning and a willingness to work together to improve the quality of mental health care.

Figure 28: NHS mental health trusts re-inspected, as at 31 May 2017

Trust Name	First rating						Last rating							
		Safe	Effective	Caring	Responsive	Well-led		Overall	Safe	Effective	Caring	Responsive	Well-led	Overall
Northamptonshire Healthcare NHS Foundation Trust	26/08/2015							28/03/2017						
Kent and Medway NHS and Social Care Partnership Trust	30/07/2015							12/04/2017						
North Staffordshire Combined Healthcare NHS Trust	22/03/2016							21/02/2017						
South West Yorkshire Partnership NHS Foundation Trust	24/06/2016							13/04/2017						
Black Country Partnership NHS Foundation Trust	26/04/2016							17/02/2017						
Worcestershire Health and Care NHS Trust	18/06/2015							01/08/2016						
South West London and St George's Mental Health NHS Trust	16/06/2016							02/12/2016						
Lancashire Care NHS Foundation Trust	04/11/2015							11/01/2017						
Sheffield Health and Social Care NHS Foundation Trust	09/06/2015							30/03/2017						
Oxleas NHS Foundation Trust	13/09/2016							02/05/2017						
North West Boroughs Healthcare NHS Foundation Trust	01/02/2016							15/11/2016						
Devon Partnership NHS Trust	18/01/2016							15/03/2017						
Rotherham Doncaster and South Humber NHS Foundation Trust	19/01/2016							12/01/2017						
Leicestershire Partnership NHS Trust	10/07/2015							08/02/2017						
Leeds and York Partnership NHS Foundation Trust	16/01/2015							18/11/2016						
Oxford Health NHS Foundation Trust	15/01/2016							24/08/2016						
Sussex Partnership NHS Foundation Trust	28/05/2015							23/12/2016						
Dudley and Walsall Mental Health Partnership NHS Trust	19/05/2016							28/03/2017						
Norfolk and Suffolk NHS Foundation Trust	03/02/2015							14/10/2016						
Tavistock and Portman NHS Foundation Trust	27/05/2016							01/02/2017						
Bradford District Care NHS Foundation Trust	15/09/2014							08/06/2016						
Dorset Healthcare University NHS Foundation Trust	16/10/2015							07/09/2016						
Tees, Esk and Wear Valleys NHS Foundation Trust	11/05/2015							11/05/2017						
West London Mental Health NHS Trust	16/09/2015							09/02/2017						
Isle of Wight NHS Trust	09/09/2014							12/04/2017						

Source: CQC ratings data as at 31 May 2017.

The NHS core services with the most improvement were forensic inpatient/secure wards, long stay/rehabilitation mental health wards for working age adults and wards for people with a learning disability or autism (figure 29). In each case, 64% of those re-inspected improved their rating. The least improved service was community mental health services for people with a learning disability or autism – only one out of the 10 re-inspected had improved its rating.

Figure 29: Outcome of NHS re-inspected core services, as at 31 May 2017

Core Service	Deteriorated	Same	Improved	Grand Total
Acute wards for adults of working age and psychiatric intensive care units	0 (0%)	12 (50%)	12 (50%)	24
Child and adolescent mental health wards	1 (10%)	3 (30%)	6 (60%)	10
Community mental health services for people with learning disabilities or autism	1 (10%)	8 (80%)	1 (10%)	10
Community-based mental health services for adults of working age	2 (13%)	7 (47%)	6 (40%)	15
Community-based mental health services for older people	2 (13%)	8 (53%)	5 (33%)	15
Forensic inpatient/secure wards	3 (21%)	2 (14%)	9 (64%)	14
Long stay/rehabilitation mental health wards for working age adults	1 (7%)	4 (29%)	9 (64%)	14
Mental health crisis services and health-based places of safety	2 (11%)	11 (61%)	5 (28%)	18
Specialist community mental health services for children and young people	2 (14%)	4 (29%)	8 (57%)	14
Wards for older people with mental health problems	3 (14%)	12 (55%)	7 (32%)	22
Wards for people with learning disabilities or autism	1 (9%)	3 (27%)	7 (64%)	11
<b>Grand Total</b>	<b>18 (11%)</b>	<b>74 (44%)</b>	<b>75 (45%)</b>	<b>167</b>

Source: CQC ratings data as at 31 May 2017

We have re-inspected 83 independent mental health services overall. Of these, 36 (43%) improved; 37 (45%) stayed the same; and nine (11%) deteriorated. One service was rated as good overall on re-inspection, having not previously been rated at overall level.

The core services that improved the most were forensic inpatient/secure wards, child and adolescent wards, and community services for working age adults (figure 30). At the other end of the scale, a third of acute services for working age adults and PICUs and a third of wards for people with a learning disability or autism deteriorated and received a poorer rating on re-inspection.

Figure 30: Outcome of independent re-inspected core services, as at 31 May 2017

Core Service	Deteriorated	Same	Improved	Grand Total
Acute wards for adults of working age and psychiatric intensive care units	3 (33%)	4 (44%)	2 (22%)	9
Long stay/rehabilitation mental health wards for working age adults	0 (0%)	13 (62%)	8 (38%)	21
Forensic inpatient/secure wards	1 (7%)	5 (33%)	9 (60%)	15
Wards for people with learning disabilities or autism	5 (33%)	4 (27%)	6 (40%)	15
Wards for older people with mental health problems	1 (13%)	3 (38%)	4 (50%)	8
Child and adolescent mental health wards	1 (13%)	2 (25%)	5 (63%)	8
Community-based mental health services for adults of working age	0 (0%)	1 (33%)	2 (67%)	3
<b>Grand Total</b>	<b>11 (14%)</b>	<b>32 (41%)</b>	<b>36 (46%)</b>	<b>79</b>

Source: CQC ratings data as at 31 May 2017

## 4.1 Examples of improvements

### **Lincolnshire Partnership NHS Foundation Trust**

In December 2015, we inspected Lincolnshire Partnership Foundation Trust. We found that the provider needed to make improvements in safety, effectiveness and leadership, and as a result we rated the trust as requires improvement.

In response to the findings, the trust developed a robust action plan to address the issues. The trust was committed to making positive change across the core services. This included appointing members of staff as 'champions' to engage with staff and patients, drive positive change, and update the board on the trust's progress.

The executive team were keen to learn from other trusts that had been rated as outstanding. They visited the trusts to learn about the good practice and to discuss how to implement changes. The trust recognised the value of the connections they had with other trusts and continued to build on them, as well as implementing what they had learned across the organisation. There are now plans for the trust to share their improvement work with other trusts.

CQC now has quarterly engagement meetings with the trust. These meetings give the trust the opportunity to share actions plans and to update on progress. After an inspection in April 2017, we rated the trust as good overall in June 2017.

#### **Lincolnshire Partnership NHS Foundation Trust**

- Improved the external courtyards on the adult acute wards. For example, installing closed circuit television and two-way intercom systems and removing ligature risks.
- Fitted innovative observation panels in bedroom doors in the inpatient ward for children and young people. The panels had privacy frosting that was removed electronically when staff pressed a button.
- Reviewed its management of ligature risks within services.
- Supported healthcare support workers to carry out training to become registered nurses.
- Promoted clinical apprenticeship to encourage young people to seek employment in the trust.
- Had a culture where staff accepted change and positively embraced the opportunity it provided. Staff felt supported by the board to work with change and felt able to provide feedback about their experiences.

### **Oxford Health NHS Foundation Trust**

In September and October 2015, we inspected Oxford Health NHS Foundation Trust and rated it as requires improvement overall. We told the trust that it needed make improvements in the three core services for working age adults: acute wards and psychiatric intensive care units, long stay/rehabilitation wards, and community services.

A team of CQC inspectors returned in June 2016 and was encouraged by the significant improvements in the care and treatment of patients and in the care environments. We found there was better management of risks to patients from potential ligature anchor points, improved assessment and management of the physical health of patients, and the introduction of a fuller schedule of ward activities.

In community-based mental health services, staff had improved the quality of clinical assessments and care plans.

On the rehabilitation ward, changes had been made to bring it in line with guidance on the provision of same-sex accommodation, there were more personalised and holistic care plans, and there was the removal of unnecessary blanket restrictions and improvements in ward governance.

As a result of the inspection, we revised the trust's overall rating to good.

#### **Oxford Health NHS Foundation Trust**

- Developed a new estates dashboard. Any issues identified from daily environmental checks were passed to the facilities and estates management via the intranet system or telephone. The dashboard had resulted in real improvements in the speed and efficiency of response.
- Made changes to the rehabilitation ward for working age adults to bring it in line with the guidance on the provision of same-sex accommodation.
- Introduced more personalised and holistic care plans.
- Removed unnecessary blanket restrictions and made improvements in ward governance.
- Better management of risks to patients from potential ligature anchor points; improved assessment and management of the physical health of patients in the psychiatric intensive care units.

#### **Dartmouth House (formerly known as Harriet Tubman House)**

In August 2015, we inspected Harriett Tubman House, a long stay rehabilitation service for women of working age. We found serious failings in core service delivery, staff knowledge, governance and the care environment. As a result, the service went into special measures in December 2015.

The provider, Options for Care Ltd, closed the service to carry out a refurbishment of the building. They renamed the unit Dartmouth House and its statement of purpose changed to long stay rehabilitation for men of working age.

The service developed new governance structures to ensure patient safety and provide better quality care. The provider invited CQC's relationship holder and inspection manager for the region to monthly meetings to give updates on progress.

Within nine months, the service had a series of room types suitable for individuals at different stages of recovery. The provider staff records system was also updated so the provider could better monitor staff documentation. The service recruited an occupational

therapist, an assistant psychologist and therapy assistants to help deliver therapeutic sessions for patients.

Dartmouth House reopened in July 2016. We re-inspected the service and rated it as good overall. In March 2017, the service came out of special measures. CQC continue to have quarterly meetings with Options for Care to monitor quality improvements.

#### **Dartmouth House**

- Developed detailed, recovery focused care plans.
- Employed agency staff who had good knowledge of the service and could build relationships based on trust with patients.
- Encouraged patients to contribute to discussions about what activities should take place.
- Established a culture where open discussion was encouraged.
- Installed a strong administrative team to allow staff to spend more time with patients.
- Risk assessed ligature risks with the intention that the environment would reflect a patient's home.
- Developed a process that meant informal patients could leave at will. The front door was locked for security but patients could request that this be opened if there were no restrictions placed on them.
- Carried out adjustments for people who needed disabled access to the building.

# Conclusion

Mental health has never had a higher profile. More people than ever are receiving treatment and care for mental health conditions. As a result of our comprehensive inspection programme, we now know more than ever before about the quality of mental health care that people in England receive.

We will use this knowledge to target our future inspection activity and so achieve our strategic priority of delivering an intelligence-driven approach to regulation. We are also committed to encouraging improvement, innovation and sustainability in care. We do this by recognising and celebrating good and outstanding care when we see it. Going forward, through the next phase of our regulatory approach, we will work closely with national partners to contribute to work to address some of the widespread problems that we have flagged up in our report. These problems include the high number of people of all ages who are forced to accept care in wards many miles from their home, long waiting times for some specialist treatments, the great variation in use of physical restraint, and the poor and unsafe condition of many mental health wards.

As the regulator of health and social care, CQC is duty-bound to describe the problems that we have encountered on our inspections. We will continue to take action whenever we encounter poor care. However, it is important not to lose sight of the very many positive messages in our report. The mental health sector is at a crossroads and the staff, in both the NHS and the independent sector, are genuinely mental health services' greatest asset. They are the raw material with which the aspirations of the Five Year Forward View for Mental Health can be realised. We urgently need more staff of the same calibre, and services must provide the leadership and support to develop existing staff and the incentives to retain them.

There is cause for optimism. Mental health has never been a higher priority and there is a commitment to provide the resources required to implement the Five Year Forward View. The government has made separate commitments to improve mental health care for children and young people and to reform the Mental Health Act to better protect those most severely affected by mental ill-health. We will play an active role in both of these developments.

Finally, we have shown that mental health services can improve, despite the considerable pressures they face – almost three-quarters of NHS mental health trusts that were originally rated as inadequate or requires improvement improved their rating when we re-inspected.

We will continue to encourage leaders of mental health providers to develop the culture and introduce the technology that promote continuous improvement. We have been struck by the generous way in which the best NHS mental trusts have advised and supported those that have just started their improvement journey and by the general willingness of leaders of mental health providers to share ideas and to work together with their peers in other providers. This collegiate spirit puts mental health services in a strong position to meet the challenges ahead.

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