Care Quality Commission

Providing the best care, with appropriate support, in the right place

Dr Kevin Cleary
Deputy Chief Inspector for Hospitals, Mental Health and Community Services
Learning Disabilities and Autism 2020
12 March 2020

The Care Quality Commission is the independent regulator of health and adult social care in England.

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

Our core services

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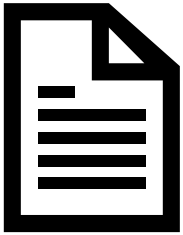
- Mental health
- Learning disabilities and autism
- Urgent and emergency services (A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care

CQC's MHA responsibilities

MHA monitoring



NPM responsibilities

Providing the Second Opinion Doctor (SOAD) Service

Reporting to Parliament

In 2018/19 we:

- carried out 1,190 visits, met with 4,436 detained patients, and required 4,477 actions from providers
- Our Second Opinion Appointed Doctor service carried out 14,354 - 29% of treatment plans were changed

Monitoring the Mental Health Act 2018/19

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- More people given information about their rights, but…
- …more focus on human rights needed by healthcare services when using the MHA
- People not always receiving care and treatment they need, in both community and hospital
- Those in long-term segregation more restrictions and delays in receiving independent reviews – particularly those with learning disabilities and/or autism
- Published 6 February 2020

Some areas of concern about the MHA

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1. The use of human rights principles and frameworks
2. Involvement in care
3. People in long-term segregation
4. Access to care and treatment
5. The interface between the MHA, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards is complex and difficult to navigate

Access to care and treatment

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- People are not always receiving the care and treatment they need, with services struggling to offer appropriate options, both in the community and in hospital, close to home
- There has been a 14% fall in the number of mental health beds from 2014/15 to 2018/19
- Between June 2018 and March 2019, coroners made us aware of at least seven deaths of people who were assessed as requiring admission, but for whom no mental health bed was available
- Too many people with a learning disability and autistic people are in hospital because of a lack of local, intensive community services

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Focus on specialist inpatient mental health care, learning disability and autism

Overall core services

69% rated good

10% outstanding

19% requires improvement

3% inadequate

- Access remains a problem
- Mixed picture of quality
- Safety is a continued concern: more than a third of NHS and independent services rated requires improvement and inadequate for safety
- Lowering quality for learning disability and autism wards

#StateOfCare

State of Care 2018/19

Download the report by holding your phone camera to this QR code

#StateOfCare

Current ratings for **NHS mental health services** for people with learning disabilities

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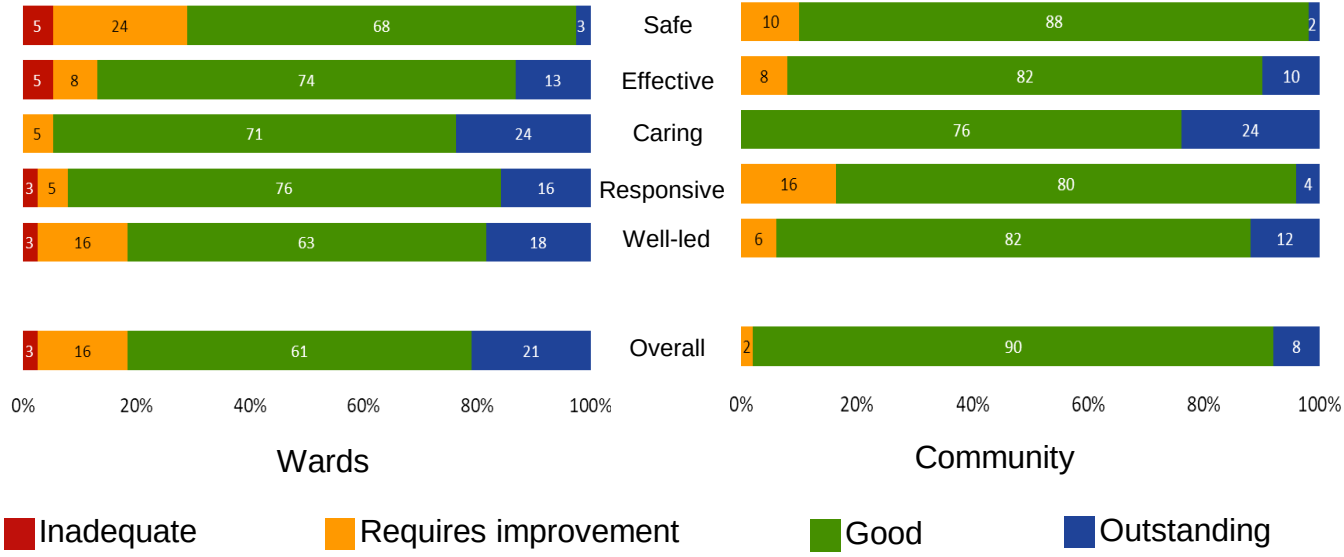
Ward-based learning disability services are performing worse (with a lower percentage of organisations rated good or outstanding) than community-based learning disability services in all key questions except 'Responsive'.



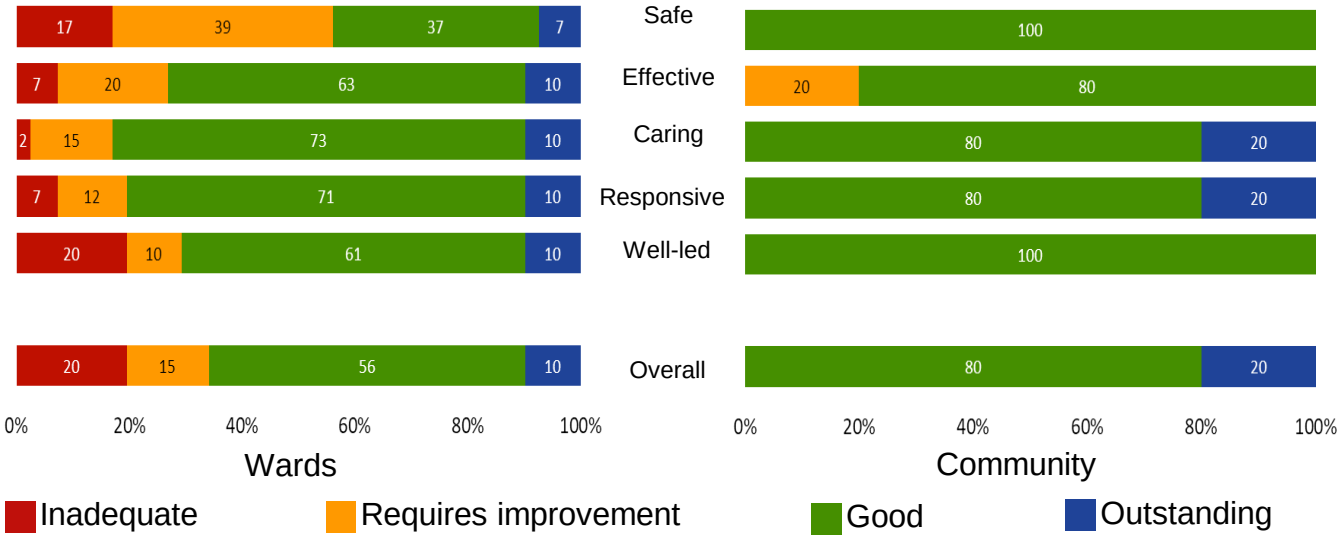
Note: Figures in charts are in percentages

Source: CQC ratings data, data extracted 24/02/2020

Current ratings for **independent mental health** services for people with learning disabilities

Ward-based learning disability services are performing worse (with a lower percentage of organisations rated good or outstanding) than those in the NHS, for all key questions.

Please be aware there are only 5 independent community learning disability services and therefore a reliable direct comparison with NHS services cannot be made.



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Children's Commissioner's third annual report

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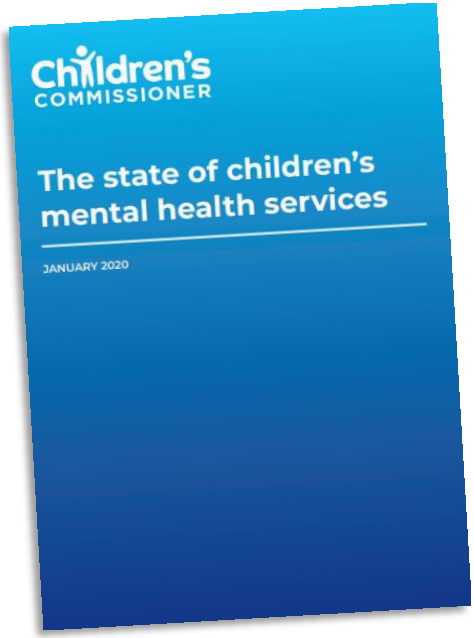
- 'The state of children's mental health services' reviews the state of children and young people's mental health services (CYPMHS) in England
- The current system is still far away from adequately meeting the needs of all children with mental health problems

Key findings include:

- On average, children are waiting just under 8 weeks to enter treatment
- Treatment varies hugely across the country



Source: Children's Commissioner Children's mental health report warns 'chasm' remains between what services are available and what children need (30/01/2020) *https://www.childrenscommissioner.gov.uk/2020/01/30/childrens-mental-health-report-warns-chasm-remains-between-what-services-are-available-and-what-children-need/*

Picture source: https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/01/cco-the-state-of-childrens-mental-health-services.pdf

Our overall concerns with the mental health sector

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- Poor physical environment of mental health wards
- Sexual safety on mental health wards
- Use of physical restraint
- High number of rehabilitation wards out of area
- Mental healthcare for people with physical health problems
- High secure hospitals
- Physical health of people with mental health problems
- Clinical information systems
- Staffing

CQC and restrictive interventions: Overview

CQC are concerned about the **high** and **widely varying** use of restraint and inconsistent reporting

- CQC's State of Care in Mental Health Services report in 2017 raised concerns about restrictive interventions
- Mental health safety improvement programme set up in 2017
- In November 2018 The Secretary of State asked the Care Quality Commission (CQC) conduct a thematic review
- We reported interim findings in May 2019, with a full report due Spring 2020.

#CQCrestraintreview

The mental health safety improvement programme

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- Commissioned by the Secretary of State for Health and Social Care
- Involves every mental health trust in England, built around CQC's inspection cycle
- CQC, NHS Improvement and trust agree the priorities for improvement and sign off a plan
- Agreement on improvement support from NHSI
- Universal safety improvement offer accessible by all providers on issues of common concern - restraint and sexual safety
- Logistical support from the Royal College of Psychiatrists

How will the review work in practice?

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Stage 1	Stage 2
In-depth review of restraint, prolonged seclusion and segregation in: • Child and adolescent mental health wards • Wards for people with learning disabilities and/or autism (all ages)	**In-depth review of prolonged seclusion and segregation in:** • Mental health ‘rehabilitation’ and ‘low secure’ wards **Exploratory review of use of restrictive in interventions in:** • Care homes for people with learning disabilities and/or autism • 14 secure children’s homes

What key things are we looking at throughout the review?

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Number of people subject to restrictive interventions in these settings

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

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

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

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

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

Quality of leadership and the culture

The role of the **wider system**

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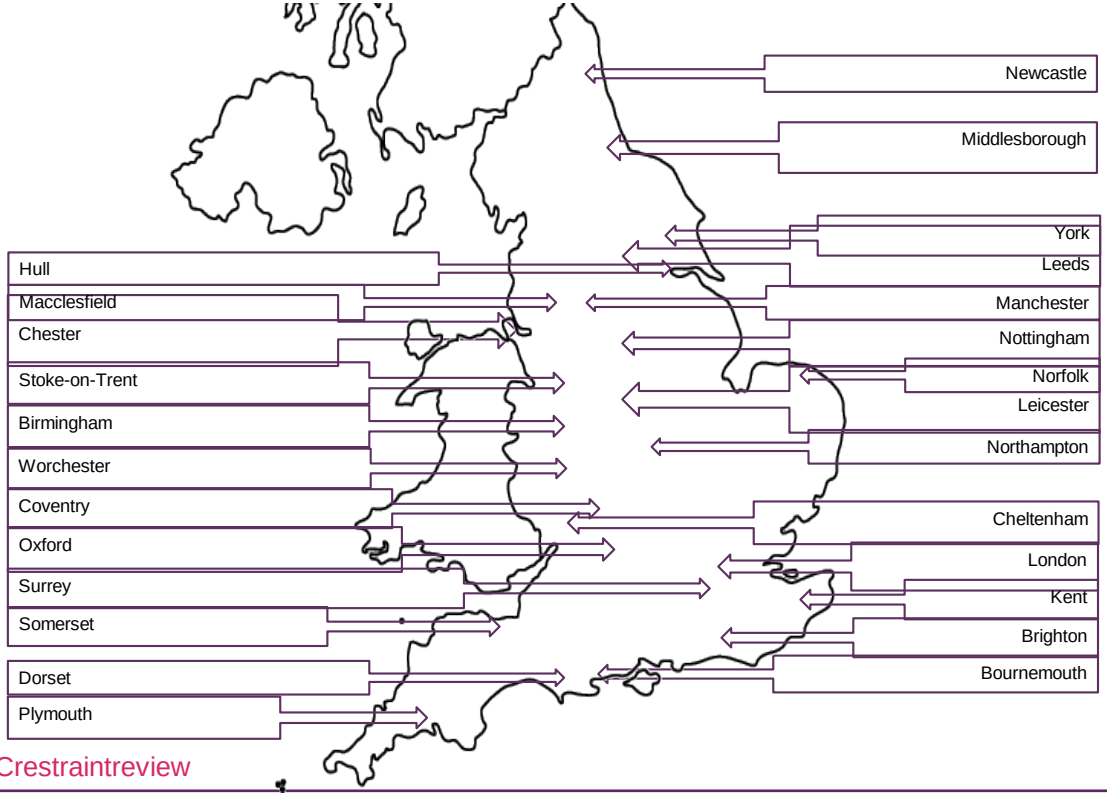
Where have we been?
Hospital visits



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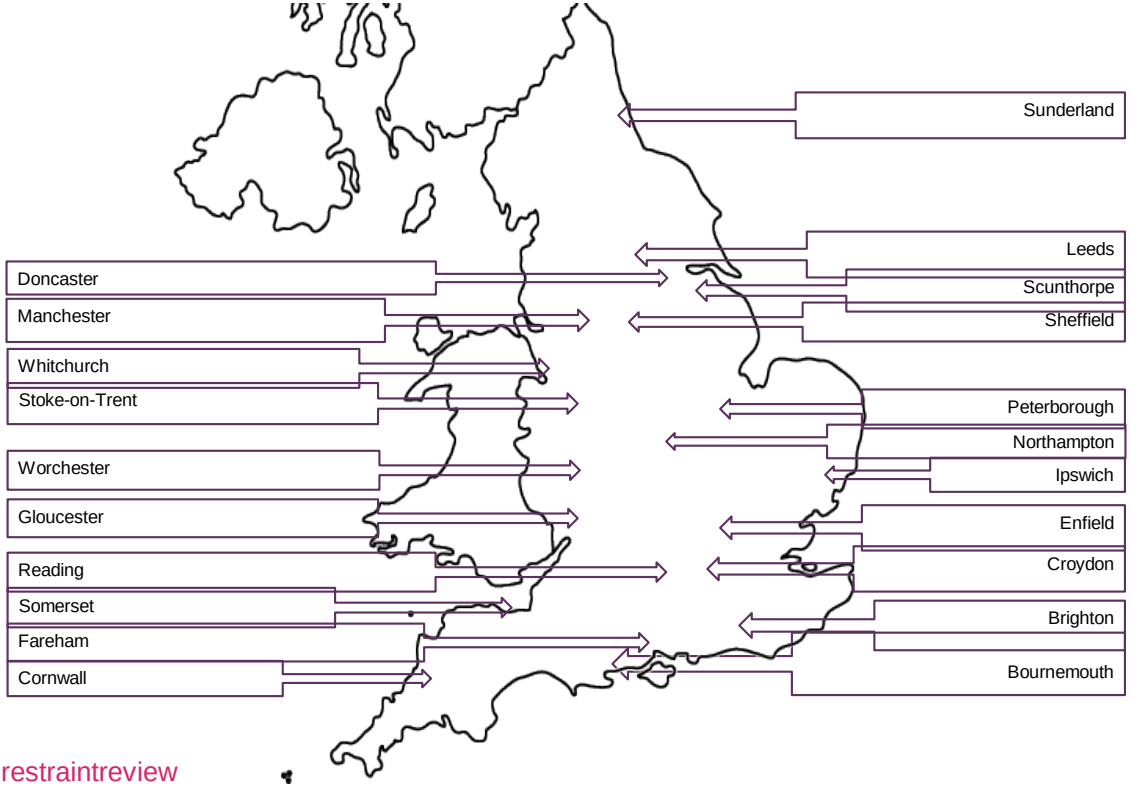
Where have we been?
Social care visits



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The final report: Spring 2020

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The final report will:

- Take a view of restrictive practice in health and care including the wider quality of care
- Take a human rights approach
- Put the voices of people who use services at the centre

Out of scope:

- Deaths in ATU's
- Special educational needs and disabilities
- Education system
- Justice system
- Adult eating disorder units
- High and medium secure

RSSthematic@cqc.org.uk
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CQC Connect: podcasts

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- CQC now podcasts: listen on your usual platform
- The first series of *CQC Connect* launched in January:
  - Giving feedback on care
  - The state of care
  - Innovation and technology
  - Maintaining outstanding in GP services
- More episodes in the pipeline
- Do feedback on the series so far and suggest future episode topics

Published and forthcoming reports

Coming soon:

- Driving improvement in community health services
- Assessment of mental health services in acute trusts (AMSAT)
- Final report on restraint, seclusion and segregation

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