Advancing practice through regulation

Paul Lelliott
Deputy Chief Inspector of Hospitals
(lead for mental health)
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Overview

• CQCs role and purpose
• Our new approach to mental health inspection
• What we have found so far
• Our work on crisis care
• Intelligent monitoring in mental health
Our purpose and role

Our purpose

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 role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.
We ask these questions of all services:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well led?
### CQC’s 5 key questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe?</td>
<td>Are people protected from abuse and avoidable harm?</td>
</tr>
<tr>
<td>Effective?</td>
<td>Does people’s care and treatment achieve good outcomes and promote a good quality of life, and is it evidence-based where possible?</td>
</tr>
<tr>
<td>Caring?</td>
<td>Do staff involve and treat people with compassion, kindness, dignity and respect?</td>
</tr>
<tr>
<td>Responsive?</td>
<td>Are services organised so that they meet people’s needs?</td>
</tr>
<tr>
<td>Well-led?</td>
<td>Does the leadership, management and governance of the organisation assure the delivery of high-quality patient-centred care, support learning and innovation and promote an open and fair culture?</td>
</tr>
</tbody>
</table>
A new approach: Why?

• Previous CQC inspections
  o Missed important problems
  o Focused on compliance vs non-compliance
  o Did not give a picture of overall quality of care
  o Were undertaken largely by ‘generic’ inspectors without expert clinical input
  o Did not command confidence (e.g. from providers)

  o But … had good elements (e.g. evidence gathering)
Our new approach: Mental health

Three Phases

1. Pre-inspection:  
   - selection of trusts  
   - planning  
   - datapack  
   - recruitment of teams

2. Inspection:  
   - 11 core services  
   - 5 key questions  
   - large team (50-100+ people)  
   - visits to clinical areas  
   - listening events  
   - focus groups  
   - interviews

3. Post-inspection:  
   - report writing  
   - confirmation of ratings and enforcement  
   - quality Summit
11 core services will always be inspected:
1. Acute wards for adults of working age and psychiatric intensive care units
2. Long stay/rehabilitation mental health wards for working age adults
3. Forensic inpatient/secure wards
4. Child and adolescent mental health wards
5. Wards for older people with mental health problems
6. Wards for people with learning disabilities or autism
7. Community-based mental health services for adults of working age
8. Mental health crisis services and health-based places of safety
9. Specialist community mental health services for children and young people
10. Community-based mental health services for older people
11. Community mental health services for people with learning disabilities/autism

We will also assess other services if there are concerns (e.g. from complaints or from focus groups)
• We rate each service on each of the five key questions: (Safe? Effective? Caring? Responsive? Well led?)

• Four-point scale: Outstanding ★★★★ Good ★★★ Requires Improvement ★ Inadequate ★★
What have we done so far?

• 66 acute trusts inspected (around 40%)
• 12 mental health trusts and one large independent MH provider
• 8 stand alone community health services, and several which are managed by acute or MH trusts
• 2 ambulance trusts
Mental health programme

- **Jan-Mar 2014**: 5 ‘Wave 1’ inspections of trusts/FTs
  - selected to represent a range of size and location

- **Apr-Sep 2014**: 8 ‘wave 2’ trusts; 1 independent location
  - range of size and location (including combined MH/CHS)
  - not explicitly selected on the basis of risk
  - some FT aspirants
  - shadow ratings (some published with reports)

- **Oct 2014-Mar 2015**: 12 trusts; 12 IH locations; 12 SMS services
  - selected on the basis of risk
  - ratings published with reports
What have we found about quality and safety?

• Variation

• Common themes

• Individual services and domains
Variation

• The degree of variation between the best and the worst is large and unacceptable

• There is variation
  o between trusts
  o between services within a trust
  o within individual services (e.g. one ward may be inadequate, while others are functioning well)
## Trust 1 ratings grid

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic</td>
<td>Inadequate</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Inadequate</td>
<td>Inadequate</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Specialist services</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Adult Community</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Crisis</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Older People</td>
<td>Inadequate</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Psychiatric Intensive care &amp; s136</td>
<td>Inadequate</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Acute Admissions</td>
<td>Inadequate</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Rehab</td>
<td>Inadequate</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Provider</td>
<td>Inadequate</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Inadequate</td>
</tr>
</tbody>
</table>

**Overall provider rating:** Inadequate
## Trust 2 ratings grid

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Community Services</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Community Health Inpatient Services</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Children and Families</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of Life</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Older People</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Perinatal</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Adult Community MH Services</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Rapid Response Liaison Psychiatry</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Crisis</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Longstay</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Adult Inpatient</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>PICU</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Forensic</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

**Overall provider rating**

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires Improvement</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>
Key Findings: Compassionate care

- Compassionate care is alive and well in the NHS in all trusts inspected
Key Findings: Ward environments

We have visited mental health wards that:

• are in old buildings whose layout does not allow safe observation
• are dirty and poorly maintained
• are unsafe with blind spots and ligature points in rooms to which patients have unsupervised access
• do not comply with the requirement to provide same-sex accommodation
• have seclusion rooms that do not conform with best practice
Key Findings: Crisis response and the acute pathway

• Not every service can provide a specialist emergency assessment in the community 24/7
• Some A&E departments have inadequate liaison mental health input
• In some areas a high proportion of people detained under Section 136 are taken to a police station
• In some trusts, people may be admitted to a bed far from their home (this affects people of all ages)
• The unavailability of local PICU beds can result in admissions to an intensive care bed >100 miles from home
• Bed management practices can result in people being moved from ward to ward repeatedly during an admission episode
Reflections after one year

• The CQC’s new approach is more robust and credible than that previously used

• Providers tell us so
  • an independent evaluation of the acute hospital inspections (Prof K. Walshe) has confirmed this

• We are still on a learning curve.

• Consistency is the greatest challenge, particularly as judgement is required to synthesise all the evidence
How do we ensure consistency?

- Recruiting good teams (clinicians, managers, inspectors, experts by experience)
- Training
- Consistent methodology: KLOEs and subheadings
- National quality assurance group
- Factual accuracy checks
Launched in November 2014, with a focus on the experiences and outcomes of people at a time of mental health crisis.

- A key aim is to develop our approach to monitoring, inspecting and regulating the quality, safety and responsiveness of crisis care.
- We are taking a care pathway approach to look at how different organisations and agencies work together for three groups of people:
  - Key Group 1: People who present to accident and emergency (including a focus on those who self-harm)
  - Key Group 2: People who requires access to and support from specialist mental health services
  - Key Group 3: People who are detained under Section 136 of the Mental Health Act
Elements of our thematic work

Phase 1: building our evidence base

- Survey to map health-based places of safety
- Public call for evidence
- Review of national data

Phase 2: local area inspections

We are currently developing our tools and methods to carry out 15 local area inspections:

- November 2014 to January 2015
- Evidence-led and will explore where we think there may be issues with the care pathways
- Areas of good and poor practice
Map of health-based places of safety

- Published April 2014 on CQC website
- Survey of all 58 providers
- Shows all health-based places of safety in England
- Allows people to find out about provision in their local area:
  - Where it is and how to contact?
  - When is it open?
  - What is the capacity?
  - Who does it accept?
- We will shortly publish a full report of our findings
• A prioritised set of indicators relating to the five questions
• Focuses on raising questions about risks rather than full spectrum of performance
• Overall weighted ‘priority banding’ for each NHS Trust to help prioritise our inspection activity
• Banding based on proportion of indicators flagged as risk
• Available to the public
Organisation of indicators

- Indicators we have prioritised for routine monitoring
- Prompt action which can include a request for further information, an inspection of a site
- Aggregate summary will inform how we prioritise trusts for comprehensive inspection
- Wider set of indicators that are examined along with tier 1 to inform “key lines of enquiry” for inspection
- Do not cause regulatory action if a single indicator or a combination of several indicators breach thresholds
- “Horizon scanning” to identify future indicators
- Devised/updated through engagement with Providers, Royal Colleges, Specialist Societies and academic institutions and international best practice
**Development Approach**

**Redesign and rethink - COMPLETE**
- Determine ‘ideal model’ for each sector, identify focus areas for each of the 5 questions (safe, effective, caring, responsive, well led)
- Undertake activity analysis to understand types and rates in each sector
- Identify a long list of potential indicators for inclusion from national and international research
- Initial engagement with MH expert reference group and data owners

**Engagement and testing COMPLETE**
- 2 draft prototypes created indicators used for high level scheduling and in data packs for new comprehensive inspections
- Online forum - testing of proposed indicators (for providers, Experts by Experience and voluntary organisations)
- Internal and MH expert reference group – to test draft outputs

**Launch Q3 2014/5**
- Finalise indicator set and share outputs internally
- MH NHS Trust provider testing – end of September
- Draft reports will be shared with trusts for review during October
- Publish first version – November
What we plan to publish

• A trust level report, presenting the analysis for all indicators within the model and the related priority banding

• A listing of trusts grouped by priority bands

• A data file containing all the analysed indicators for each trust

• Explanatory text about the analysis tool and how we will use it, and what it does not represent (i.e. not a judgement)
• Publication of KLOEs, prompts and what good looks like
• Involvement of providers in work to define what good looks like
• Identify, recognise and publicise outstanding services
• Encourage sharing and ‘buddying’ by outstanding services
• Engage large numbers of clinical and managerial staff as members of inspection teams
Summary

• The new inspection programme has come a long way in the past 9 months
• It is undoubtedly better than the model it has replaced
• We can and must continue to improve
• Mental health has parity within the CQC
• Advice and comments are always welcome – and do please consider offering your services!