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RESPONSE OF: THE ROYAL COLLEGE OF PSYCHIATRISTS

RESPONSE TO: CQC Mental Health Strategy consultation

The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by Dr Michele Hampson, Rowena Daw and Richard Meier.

The Consultation was approved by Dr Ola Junaid, Associate Registrar.

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1. Where does the Care Quality Commission need to focus its efforts in the next three to five years to really make a difference in mental health?

In particular, it would be helpful to have your views on:

**What are the priority areas for improvement in mental health?**

- Availability of psychological therapies
- Care for elderly people
- Improvement in standards of inpatient care
- Protection, safety and care of detained patients and proper use of the MHA/MCA including CTOs
- In-reach NHS services in prisons
- Integration of physical and mental health services
- Reducing inequalities in care provision
- Joined up care
- Introduction of care pathways for mental health which reflect local arrangements and service configuration
- Standards and appropriateness of care in transition services
- Improving the care of those at all stages of the criminal justice pathway
- Commissioning
- Quality standards that measure outcomes

**How can CQC best make an impact in relation to these areas? What should we do?**

- **Availability of psychological therapies**
  - The College would like to see the NHS Information Centre’s IAPT data set included in the Mental Health Minimum Data Set as soon as it is feasible, in order that the CQC can review the availability of psychological therapies for service users in secondary care, for older people, people with severe and enduring mental illnesses, those with
dual diagnoses, learning disabilities or in custody, and people from Black and minority ethnic communities

- The CQC should work to ensure that people with personality disorder are no longer routinely excluded from services

**Care for elderly people**

- Elderly people suffer from age discrimination in access to mental health and social care services. While the neglect of elderly people with mental health problems should be a priority, there are particular areas requiring focused attention where concern has already been documented, such as older people with mental illness in care homes, older people with mental illness in general hospitals, and older people with mental illness admitted to general mental health wards which are often more disturbed and have higher levels of violence than specialist wards for the elderly.

- **Improvement in standards of inpatient care**

  - The CQC should investigate the negative link noted by the Healthcare Commission inpatient survey between size of organisation and the quality of in-patient care

  - The CQC should review and publish figures on bed-blocking of in-patient beds, given the detrimental effect on patients’ mental health which may ensue from remaining in hospital for months after their need for hospitalisation has ended while they await transfer to local authority accommodation

  - The CQC should consider introducing a new concept of organisational capability to ensure high quality clinical care, looking not only at inpatient environments but also the general ethos in clinical environments. For example, there may be administrative shortfalls, staff burnout, chaotic arrangements for covering absence and a series of organisational changes that undermine systems set up by clinicians in order to deliver high quality care.

  - The CQC should work to ensure sufficient availability of suitable beds for patients to be admitted to the nearest hospital for their general
adult in-patient care. Local accessibility should not be defined as “in area” or “out of area” since trusts cover considerable geographical areas. The CQC should monitor in-patient provision to ensure that what constitutes “suitable” includes an appropriate ward environment to protect all those who are vulnerable, regardless of gender and where there is adequate therapeutic activity.

- In cases where there is no other option but to place a young person on an adult psychiatric ward, the CQC should ensure that such a placement is carried out in accordance with the standards contained in the College’s document *Safe and Appropriate Care for Young People on Adult Mental Health Wards* ([http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/safecareforypaudittool.aspx](http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement/safecareforypaudittool.aspx))

- Regarding mixed sex/single sex accommodation, the CQC should ensure that accommodation in psychiatric settings conforms to guidance laid out in the Mental Health Act Code of Practice (16.9)

- The CQC should ensure that ethnic composition data is collected re DOLs/CTOs

**Protection, safety and care of detained patients and proper use of the MHA/MCA including CTOs**

- The CQC should ensure that the hospital visits carried out by the former MHAC continue as a mechanism to monitor in-patient care and highlight shortcomings; hospital visits play an important role in identifying local issues that require remedy and ensuring that those detained in hospital have an independent review of the care provided to ensure that their human rights are adequately protected.

- These visits, which should include out-of-hours visits, and interviews with patients and staff, in addition to inspection of premises, should concentrate on what is essential to patients, for example: what is the atmosphere like on the wards (how intimidating are they); what therapy/activities are really available for patients (as opposed to
what the trust says is available); what is the state of the bedding and how clean are the toilets and wards; how hot is the food, how varied the diet and are required ‘special’ diets available and varied; what is the access to fresh air etc.

- There are clinical areas, e.g. learning disability and old age services, where use of the provisions of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards should be a focus for the CQC.
- The CQC should ensure that CTOs are used only where clinically necessary
- The CQC should monitor how many patients in hospitals are detained under the MHA (s3) and how many under the MCA DOLs provisions (and the ethnic data on each group)

- **In-reach NHS services in prisons**
  - In line with recommendations from the Bradley report, the College feels that CQC should monitor the provision of mental health services in prisons in order to ensure that the standard of in-reach NHS services is equivalent to that in the community; also, the CQC should make the 14 day transfer target (for transfer to hospital from prison) a priority

- **Integration of physical and mental health services**
  - The CQC should work to improve the quality of services in A&E for people with mental health problems, especially for those that self harm or are suicidal, through ensuring the adequate availability of liaison psychiatrists
  - There needs to be a greater focus on the need for liaison psychiatry to treat those with chronic long-term conditions
  - The CQC should ensure that those providing physical healthcare in secondary services assess, treat and refer those with mental health problems and that there are mental health quality indicators in their care pathways.

- **Reducing inequalities in care provision**
The CQC should ensure that care is delivered in line with NICE and other evidence based guidance regardless of age, gender, ethnicity or geographical location.

- **Joined up care**
  - The CQC should monitor the development of joint working in order to ensure the availability of need-appropriate services both within mental health services working across directorates e.g. re learning disabilities following mainstreaming, and with external agencies, e.g. around employment, training and meaningful activity.
  - The CQC should ensure adequate liaison between primary care mental health provision, including IAPT, and secondary care. This should be demonstrated in terms of development, service delivery and monitoring.

- **Introduction of care pathways for mental health which reflect local arrangements and service configuration**
  - The CQC should investigate ways to resolve the tension between national benchmarking and locally relevant benchmarking to ensure that CQC reviews are able to identify and understand what local needs are, and what a local care pathway might look like, even if it deviates from a national benchmark.
  - Performance frameworks for commissioning can be used for evaluating performance against standards. The CQC continues not to use that methodology but to rely on quality indicators and a panel of them which highlight risk areas which they then investigate. Arguably this is not systematic nor reliable, and near misses and oversights can still take place while extreme outliers might be overlooked.
  - The CQC should consider carrying out an in-depth assessment of the impact of specialisation on the care pathway, in order to investigate whether or not a return to more aggregated teams but with specialised functions within team would be beneficial, since very little
is known about the impact increasing specialisation has in terms of cost effectiveness, choice, and patient and carer satisfaction.

- **Standard and appropriateness of care in transition services**
  - The CQC should monitor to what extent care is based on need rather than age, in order to highlight the impact which the rigid age criteria employed by some services has on care

- **Improving the care of those at all stages of the criminal justice pathway**
  - The CQC should monitor the implementation of the Bradley Review, including the transfer rates from prison to hospital, and between medium secure units and low secure units
  - The CQC should monitor the use of section 136 of the mental health act and the introduction of s136 suites in hospitals or clinics

- **Commissioning**
  - The College believes that the improvement of quality in mental health services would be facilitated by increasing the engagement of clinicians in the planning of future services and the quality standards that these services must deliver. The CQC should consider comparing organisations and commissioning processes in order to study the impact of direct involvement of frontline clinicians with commissioners.
  - Given the wide disparity of funding locally for mental health services, the CQC should consider the impact this has on care by comparing high and low spending PCTs and linking this to work on commissioning.
  - The CQC should monitor Trusts to ensure that efficiency savings are made in ways that least prejudice care and patient experience, and that levels of funding for mental health care are not detrimentally affected compared to other services

- **Quality standards that measure outcomes**
  - The CQC should place greater emphasis on measures of patient outcome rather than measures relating to organisational process.
CQC should monitor more intensively new specialists’ services, especially where these are not evidence-based, to ensure safety.

CQC should review quality of care across socially stratified groups who appear to show different outcomes and benefits from service use.

CQC should collect data on service users’ feeling of safety in order that patients who seek safe environments actually experience them.

CQC quality indicators need to demonstrate that they are predictive of quality and of outcomes rather than simply being process measures that are already collected and, therefore, convenient to look at. These need to make sense to service users, carers as well as clinicians. Existing outcome measures, such as HoONOS, provide a usable set of measures.

In order to encourage staff ‘buy-in’ to the culture of quality indicators, the CQC should require trusts to feed back information that is already collected at team level. The HealthCare Commission in-patient survey was a useful development as this is an area of care which is known to be highly variable in quality. However, as that variation can also occur across an organisation it is important that in future there is sufficient data for reliable findings to be reported for each ward, so that staff feel that the findings are relevant to them.

Both the College and the College’s Research and Training Unit (CRTU) have produced a series of reports and statements that highlight quality standards in a range of areas (http://www.rcpsych.ac.uk/publications/collegereports/councilreports.aspx ). This wealth of professional expertise should be tapped by the CQC and the CQC would benefit from increasing the partnerships with key mental health professional bodies, including the RCPsych. The CQC may wish to consider the development of a mental health advisory group consisting of key professional bodies and increasing the number of professionals engaged in work, perhaps as secondments, in the CQC.
Given the problems in applying PbR to mental health, the impact of this process on quality should be monitored both in terms of accessibility of care and the quality achieved.

CQC should employ measurable standards for care and practice and require evidence that standards which have been developed are being met. Audit standards for national accreditation of dementia care in general hospitals, commissioned by the Healthcare Commission, are an example. CQC might consider adopting other national accreditation standards as indicators of good practice and encourage their development, for example, those developed for older people’s mental health inpatient wards and memory services developed by the Centre for Quality Improvement, Royal College of Psychiatrists (CCQI – see: http://www.rcpsych.ac.uk/clinicalservicestandards/centreforqualityimprovement.aspx)

The Department of Health will make a statement on the use of antipsychotic drugs for people with dementia imminently following the inquiry by the All-Party Parliamentary Group on Dementia who are also expected to report on the training needs of the social care workforce. These reports may produce recommendations to create standards that can be measured and audited.

The National Dementia Strategy suggests expected improvements in care which could be subject to audit.

When should CQC tackle these issues?
What would success look like?

2. How should we involve people who use services and their families and carers in developing, implementing and monitoring the strategy?
In particular, it would be helpful to have your views on:

• **How should we feature this in the mental health strategy?**
  • Most trusts have user and carer forums and they could be asked to review the strategy over the next year and send representatives to a national Forum. Part of trusts’ strategies should be to involve users and carers in similar processes locally, and users and carers should receive the necessary support to do so, which will then also assist them participating with the national CQC agenda. The Royal College of Psychiatrists has an extensive user and carer email network, which may be able to provide the CQC with a reasonably rapid initial response; in addition, the College’s Centre for Quality Improvement strives to place service users and carers at the heart of all quality improvement.

• **What approaches should we use to make sure involvement is effective throughout this process?**
  • In addition to considering the development of a mental health advisory group consisting of key professional bodies, the CQC might give similar consideration to the development of a service users (and carers) advisory group, separate or in conjunction with the professional group.
  • A series of focus groups of service users, carers and their families could be organised in different parts of the country and different settings with, where appropriate, advocacy and support to ensure that all groups are met.
  • Questions could be added to the national in-patient survey to ask users and carers what other topics they wish to see included.
  • The CQC should make clear in its annual report how user and carer feedback has influenced the process.
  • The College feels that it is vital that the CQC fully embrace their commitment, outlined on page 3, section 2 of the background to the consultation, to work with others; we would therefore urge the CQC to coordinate its work with the College’s Centre for Quality Improvement
reviews and to use the data we produce annually to keep itself informed of current activity and progress.

**September 2009**