

Position statement and action plan for mental health 2010-2015

March 2010

About the Care Quality Commission

The Care Quality Commission is the independent regulator of health care and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act.

Whether services are provided by the NHS, local authorities or by private or voluntary organisations, we make sure that people get better care by:

- Driving improvement across health and adult social care.
- Putting people first and championing their rights.
- Acting swiftly to remedy bad practice.
- Gathering and using knowledge and expertise, and working with others.

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Background

As the independent regulator of health and adult social care, CQC has a unique ability to influence the quality and safety of care in England.

We are responsible for driving improvement and taking action if providers and commissioners of care do not meet essential standards of quality and safety. We will also ensure that people have the power to make informed choices about the care services they receive and access to services that offer a seamless experience of care.

We want to focus our activities to ensure that they make a real difference to people. We have therefore published a five year strategic plan setting out how we intend to approach our work.

We have identified **five** priorities where we believe our unique role as regulator will enable us to significantly enhance the quality of outcomes for people who use services:

- 1. Making sure that care is centred on people's needs and protects their rights**
- 2. Championing joined-up care**
- 3. Acting swiftly to help eliminate poor quality care**
- 4. Promoting high quality care**
- 5. Regulating effectively, in partnership.**

Our work to achieve improvement in these priority areas will always be underpinned by the principles of equalities and human rights. This will include a strong focus on differences in access to services, the safety and effectiveness of care, and people's rights to be treated with dignity and respect. We will pay particular attention to the needs of people in more vulnerable circumstances, including those with mental health needs; learning disabilities; physical disabilities or long-term conditions; older people; and children and young people.

This document sets out our early thinking on our approach to ensuring that services for people with mental ill-health not only reach basic standards of quality and safety, but also that they improve. It sets out some priority actions for CQC to ensure that, working with others, we can make a difference to services for people with mental health needs. It is supported by a briefing note in the appendix, which sets out some information on what we know about services for people with mental health needs and about the care that they and their families experience.

The action plan covers the provision and commissioning of health and adult social care services for all people with mental health needs, including people subject to mental health legislation. This includes the range of health care sectors (primary, secondary and specialist care) and settings

(provider trusts, local authorities, independent sector). The plan encompasses children and young people in contact with specialist child and adolescent mental health services (CAMHS) to services for adults and older adults with mental health needs. We recognise the importance of taking a whole systems view of the provision and commissioning of services for people with mental health needs, particularly in view of the extensive integration of health and social care within much of the sector. As the regulator of health and adult social care, we are in a prime position to focus on the outcomes of partnership working and joint commissioning.

How we developed this plan

As well as reviewing the information we hold about the performance of services and mapping the implications of national policy and reports about mental health care, we also worked with people who have mental health needs, their families or carers, other key stakeholders and internal staff at CQC. We have aimed to focus on what matters to the people who use the services we regulate, and to give a clear direction to our mental health work as we go forward.

What have people told us?

To gain the views of people with mental health needs, their carers, staff that work in mental health services and representatives of mental health organisations, we:

- held two events with external stakeholders that included people with experience of using mental health services and carers of people with mental health needs
- asked for the views of external stakeholders through a range of email networks and websites
- asked for views at various meetings, including the first meeting of a new mental health improvement board.

We asked for views on two key questions:

- 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?**
- 2. How should we involve people who use services and their families and carers in developing, implementing and monitoring the action plan?**

Once we had identified the key themes from the feedback and had begun developing our proposals, we also held two events to discuss our thinking with people who use mental health services (including people with experience of detention under the Mental Health Act) and carers. We used

these events to seek their views on whether our proposals would address issues of concern to service users and carers. We have amended our proposals as a result of these discussions.

General messages from stakeholders' feedback

The feedback included some general messages including the need for CQC to:

- Ensure that our mental health action plan is in line with the Department of Health's *New Horizons* vision, and takes account of other key national policy, guidance and findings.
- Make the most of joining up the three predecessor commissions, including the involvement of experts by experience and building on the commitment to equality and diversity issues.
- Challenge unjustifiable variations.
- Take a systematic, whole systems approach that looks at the whole person along their journey, or pathway of care, through services.
- focus on the integration of services and transitions between them.
- Place more emphasis on outcomes for people who use mental health services rather than focusing on organisational process. These include quality of life and social and economic outcomes, not just clinical ones – measures need to be meaningful in relation to service users' recovery.
- Think about different ways of motivating change, using both the 'carrot and the stick' – learning from the best performers is to be welcomed.
- Avoid duplication with other organisations.
- Recognise the responsibility of the board of mental health trusts – challenge and benchmarking are helpful to this.
- Ensure there is a more robust reporting and monitoring process and a greater speed in response to concerns outside of the normal inspection process.
- Use our enforcement powers, particularly when there are consistent failings, taking into account the size of organisation.
- Provide more clarity around our role and raise awareness about what we do.

Main areas of concern

We have analysed the main themes from this feedback that relate to the priorities for our work on mental health. These are summarised in Table 1.

Table 1: Concerns raised through consultation

Theme	Areas of concern
<p>Rights, values and equalities</p>	<ul style="list-style-type: none"> • Protect the interests of people whose rights are restricted under the Mental Health Act – with particular concerns about the use of Community Treatment Orders, access to advocacy, explanation of rights, consent to treatment, mental health review tribunals, potential abuse of patients, arrests and prosecutions of detained patients and use of places of safety (Sections 135 and 136), delays in Second Opinion Appointed Doctor (SOAD) visits. • Make service user involvement a priority issue to focus on within CQC’s assessments, including access to advocacy to enable involvement. • Personalisation of care, social inclusion and recovery – how staff enact the right values. • Tackle inequalities in the experience of services and outcomes – most often mentioned in relation to people from black and minority ethnic groups and older people, but also for people with a physical or learning disability, people living in a rural community and offenders in prison, with the need for a better picture of service provision for people who are lesbian, gay, bisexual and transgender. • Ongoing monitoring of the Mental Capacity Act Deprivation of Liberty Safeguards and the implementation of equalities legislation. <p><i>“If CQC was down to its last 50 pence, loss of liberty is the single issue it should spend it on – to safeguard that people’s rights are being respected.”</i></p> <p><i>“The role of CQC should be to champion recovery focussed practice and a positive approach to care, ensuring that recovery doesn’t become a conveyor belt approach and can respond to different needs.”</i></p>
<p>Focus on specific needs, including the interface and transition between services</p>	<ul style="list-style-type: none"> • Relatives and carers – improved support for carers and respect for their role. • Children and young people – improved transition between child and adolescent mental health and adult mental health services and interventions with young offenders. • Parents with mental health needs – improved interface between adult mental health and children’s services • People with dementia – ensuring local implementation of the National Dementia strategy. • Criminal justice – better interface between services, particularly in relation to diversion, improved access for prisoners to specialist mental health services, support for prisoners with mental health problems returning to the community and timely transfers of

	<p>prisoners to forensic mental health services.</p> <p><i>“Think carers, think family. The impact on carers is important - they are a crucial part of the system but are often marginalised and excluded. There is a long way to go before they become partners in care.”</i></p> <p><i>“Individual care pathways – service users having access to information on choices and care available to them... Care pathways across health and social care, criminal justice, housing and benefits, and need to ensure that it is managed in the best interests of the user rather than the organisation.”</i></p>
<p>Better services to meet needs</p>	<ul style="list-style-type: none"> • Access to services – in particular evidence-based psychological therapies, good physical health care, early intervention, out-of-hours support and easier access to consultants. • Quality of inpatient care and inpatient environments. • Safe care – in particular learning from serious untoward incidents, medicines management, use of restraint. • Access to direct payments and personal budgets as means for promoting personalisation of services, independence, choice and control. • Primary care, prevention and mental health promotion – including the need for better recognition and support of mental health problems in primary care and a greater emphasis on mental health promotion and prevention. <p><i>“Increased access to all services, therapies, employment support, primary care mental health services, support for carers and families with evidence of access.”</i></p> <p><i>“Prevention and intervention are key, the speed of diagnosis being crucial to recovery.”</i></p>
<p>Supporting service provision</p>	<ul style="list-style-type: none"> • Commissioning of mental health services – to ensure that mental health commissioning, including joint commissioning, is more robust, with a particular focus on commissioning services to meet local needs, purchase of evidence-based services, out-of-area placements and access to services. • Workforce capability and capacity – including staff access to training and learning, barriers to innovation, skill mix, better staffing levels and retention. <p><i>“Commissioning in mental health is poor. CQC should have a special focus on whether mental health commissioning is needs-led, outcome-focused, evidence-based, has incentivised contracts with agreed sensible measures”.</i></p> <p><i>“There needs to be explicit reference in assessments to workforce capability and capacity. CQC needs to understand that although it may sound less exciting, this is fundamental to everything else being achieved”.</i></p>

<p>Develop the approach to regulating mental health services</p>	<ul style="list-style-type: none"> • Anomalies and inconsistencies in relation to what is covered by registration because of the scope of the regulations. • Develop methods and the range of information we use to assess services – including the need to develop approaches that get to the experience of service users and to use information to tackle inequalities. • Work in partnership to develop the evidence base, reduce burden, avoid duplication and ensure coherence and consistency. <p><i>“There is a need for real communication between CQC and other regulators about priorities, to agree measures, prevent duplication and lack of clarity e.g. CQC and Monitor aligning their performance frameworks.”</i></p> <p><i>“We need to get to truth behind tick-boxes including a need to ensure that self-assessments are tested, that regulation & inspection are effective and ensuring the regulating body has direct experience of the services.”</i></p>
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Involving people who use services and carers in developing, implementing and monitoring the plan for our work on mental health

There were some key messages from the feedback about how people who use services and carers would like to be involved in developing, implementing and monitoring the plan for our work on mental health:

- Build on what was good before, use existing groups and networks and keep the user voice broad based and real.
- Include people from the start of the process and involve them in everything we do at all levels.
- Put involvement at the heart of any strategy – dedicated resources must be made available to enable meaningful engagement.
- Model best practice in a way that is recognised by providers.
- Employing people with mental health problems is fundamental – CQC to consider becoming a MINDFUL EMPLOYER®, an initiative aimed at increasing awareness of mental health at work and providing support for businesses in recruiting and retaining staff with mental health needs.
- Partnership working and co-production – including starting with an initial approach to our work on mental health for the next two to three years but co-produce the medium/longer term plan with service users and carers.

- Subject all products to service user and carer impact assessments and build in user focused evaluation of the action plan.
- Reflect views from the consultation process.
- Use a range of mechanisms for achieving involvement and identify separate mechanisms for considering different perspectives.
- Help improve contact with mental health service users and carers through LINKs.
- CQC should have sound standards and should check the quality of involvement.

What are the challenges for us?

Our work with people with mental health problems and their carers has given us information that has helped us to think about taking forward the five strategic priorities which will guide our work over the next five years, and what these priorities might look like for mental health services.

In taking forward these priorities, we will draw on the powers available to us. There are a number of activities that we will undertake in regulating health and adult social care. Our core statutory functions include:

- The registration of health and social care providers to a common set of quality and safety standards, and checking ongoing compliance with these registration requirements.
- Powers of escalation and enforcement where services fall below essential quality standards.
- Visiting patients whose rights are restricted under mental health legislation to ensure their rights are protected.
- Carrying out periodic reviews of the performance of providers and commissioners; and
- Undertaking special reviews and studies of particular aspects of care.
- Publishing information to drive choice, change and improvement.

For the first time, we will be able to use a common set of requirements when regulating the quality and safety of health and social care providers. We have ensured that the detail of our system for registration is focused on the outcomes for people using services, that it promotes their rights and ensures that care is delivered in a person-centred way.

Our strategic approach to regulation aligns with the general messages from the stakeholder feedback about the approach to our work on mental health. In particular, we have indicated our intention to:

- Secure fair access to appropriate care.
- Be driven by the outcomes that people who use services identify as being important to them and take a rights-based approach.
- Champion better coordination and integration of health and social care, so that the services people receive are joined up and their experience is good.
- Be flexible and timely in responding to issues of performance and poor quality services that we find, or that are brought to our attention, and ‘nip them in the bud’.
- Promote high-quality care and act swiftly to help eliminate poor quality care.

- Work with other organisations to improve the quality of life for communities and individuals within them.

There are also a number of concerns raised through the consultation which will be addressed through other specific action plans, including plans for our work with people with a learning disability, children and young people, older adults, safe and effective care and public health. We will ensure alignment between these and the action plan for our work on mental health. Separate workstreams will also address some of the concerns raised about carers, support for people with dementia, our work on criminal justice and on services for people who misuse substances. The Department of Health have indicated their intention to keep the coverage of the scope of our registration system under review, particularly as this relates to counselling, psychotherapy and community-based substance misuse services – we will contribute to this process on an ongoing basis through evidence from our work or from external partners.

This action plan has been developed within the context of existing national policy and in anticipation of the implications of the Government's *New Horizons* strategy. The twin aims of the strategy are to improve the mental health and wellbeing of the population and to improve the quality and accessibility of services for people with poor mental health (see appendix 1 for further information). However, as the *New Horizons* consultation document indicated, financial constraints mean that service improvements will need to be self-financing, soundly evidence-based, and clearly related to local commissioning intentions, as informed by Joint Strategic Needs Assessments (JSNAs). It sees effective multi-agency and specialist commissioning as the key to better quality services and better value for money. As identified in our response to the *New Horizons* consultation, we are concerned that current commissioning of services to meet the mental health needs of local populations is not sufficiently mature and sophisticated to drive this change.

As highlighted by the recent King's Fund report, there is strong evidence that the recession is likely to exacerbate mental ill-health over the next five years, and demographic effects such as ageing will increase levels of chronic mental illness and cognitive impairment (for example, dementia), resulting in increased pressure on primary, community and secondary mental health services. Increasing demand for mental health services in the context of funding constraints presents an enormous challenge for both commissioners and providers. It also has the potential to impinge on people's access to, and the quality of, primary, community and inpatient mental health services. Increased focus on community-based care in a tight fiscal environment could also put greater pressure on inpatient services for those with severe mental illness, including detained patients, which increases risks to access, quality and safety. As the regulator, we therefore have a key responsibility to monitor the quality and efficiency of services to make sure that essential standards of quality and safety in care are maintained and improved.

Since 2007, there has been a major drive to transform adult social care in England with the launch of the 'Putting People First' concordat in adult

social care. There has been a key focus on a system-wide reform of the social care system so that it can respond to the demographic challenges presented by an ageing society and the rising expectations of those who depend on social care for their quality of life and capacity to have full and purposeful lives. Key elements of the vision include: prevention, early intervention and re-ablement, personalised care (including person-centred planning, self directed support and personal budgets to become mainstream for people with long term conditions) and information, advice and advocacy.

To support the transformation process, the social work role is moving away from a practice model based on care management to one more focused on advocacy and brokerage, with an emphasis on positive risk taking. From a social care perspective, implementing the transformation of social care within mental health is seen as a challenge, particularly in view of a greater focus on risk management within the field as opposed to positive risk-taking and control. In some areas, mental health social workers have been withdrawn from integrated health and social care teams to enable refocusing of the social work role. We need to be aware of the evolving roles and responsibilities within health and social care services for people with mental health problems and the potential implications that this may have for joined-up working.

What we will do

In this section, we set out how we aim to use our powers to bring about changes and improvements in services for people with mental health needs, and how these relate to our strategic priorities. In doing so, we need to be realistic about what we have the capacity to deliver as we embed our new ways of working and we need to ensure that the actions we identify are capable of delivering the improvements we seek. The consultation and briefing note highlight a wide range of priorities that have been identified for mental health services and we need to focus on how we can use our core functions to drive improvement.

On the basis of this consultation, the national policy context and previous findings, we have identified three key areas for improvement where we plan to make a difference over the next five years:

- Prioritising a focus on rights, equalities and values within our regulation of mental health services, paying particular attention to access to, and experience of, services for people from black and minority ethnic groups, younger people, and older people with mental health problems.
- Ensuring that people with mental health problems receive care that is effective and safe.
- Improving the outcomes of the commissioning of services for people with mental health problems to meet individual needs, and promote social inclusion and recovery.

We have also identified two enablers that will help CQC and partners to bring about change in this field:

- Developing the focus and analysis of the information and intelligence we hold about the provision and commissioning of services for people with mental health needs, making best use of this information and ensuring that it is more widely available in the system.
- Building our capability as an organisation to understand the area of mental health and our capacity to engage with people who use services and their carers.

Tables 2 and 3 set out how we will use our system of registration and reviews to identify issues and concerns raised with us, and what additional actions we might take to increase the potential impact of this work. We have set these actions against our five strategic priorities. We have also suggested some measures that can help to evaluate the progress of this work. We have established an internal steering group, to further develop the action plan. The group will agree a framework for monitoring delivery in collaboration with service users and carers. They will review progress and report to CQC's Board in 12 months.

We have also established a mental health improvement board to advise us on the priority areas for mental health and how we can maximise our regulatory impact to improve outcomes for people who use mental health services and their carers within the system.

We are committed to involving people in our work and working with people who use services, as we believe this is fundamental to improving care. We want to involve people in many different ways such as surveys and consultations, and by working with voluntary bodies, and working directly with experts by experience and advisors. In 2009 we launched our *Voices into Action* statement, which sets out our plans for involving people. *Voices into Action* addresses most of the comments and suggestions in relation to our approach to involving people who use services in our work on mental health. However, we need to develop a specific plan on how to implement this general strategy within our work in this area.

Table 2: Actions to take forward enabling activities

Enabling activities	Specific actions	Measures
<p>Developing the focus and analysis of information and intelligence we hold about the provision and commissioning of services for people with mental health needs, making best use of this information and ensuring it is more widely available in the system.</p>	<p>Work with people who use services and carers, the Department of Health, the National Mental Health Development Unit, Social Care Institute for Excellence, the Health and Social Care Information Centre, regulatory bodies and other relevant organisations to make sure that we are measuring what matters, particularly to people who use services.</p>	<p>Performance assessments, including benchmarking that key stakeholders see as relevant to assessing the quality and safety of services for people with mental health needs.</p>
	<p>Enhance the analysis and use of the information and intelligence we already gather to develop our assessment of the provision and commissioning of services for people with mental health needs.</p>	<ul style="list-style-type: none"> • Sources of qualitative information scoped and methods for analysis developed with an initial focus on patient feedback from our Mental Health Act visits; national data sets (mental health, health, social care and primary care) and other intelligence reviewed for potential development of new indicators for use in our periodic reviews and/or Quality and Risk profiles; systematic analysis of qualitative and quantitative data completed. • Best use made of the evidence from Mental Health Act monitoring. • The potential for using social care information and intelligence to assess mental health services evaluated. • Potential for using acute and primary care data within our assessments evaluated. • Options scoped for including indicators from the Delivering Race Equality dashboard within our periodic review and other equalities-related information. • Contribution made to external work to develop patient recorded

		outcome measures (PROMs) within mental health.
	Developing our approach to using and communicating the findings from our work and assessments.	Communications plan for our work on mental health developed and evolved alongside our programme of work and within the context of promoting equality and human rights; consideration given for each publication how best to share and use the findings.
Building our capability as an organisation to understand the area of mental health and our capacity to engage with service users and their carers.	Develop training and policy briefing for staff across our fieldforce to enhance expertise in relation mental health.	Training and policy briefing delivered and evaluated.
	Support the work of the Mental Health Improvement Board and ensure that there are governance processes to support it.	Board meets regularly and reports an impact.
	Develop user focused monitoring of the mental health action plan.	User focused monitoring of the action plan identifies an impact.
	CQC commits to becoming a MINDFUL EMPLOYER®.	Actions taken to translate the principles of MINDFUL EMPLOYER® into practice.

Table 3 Actions on our top five priorities

CQC's five priorities	Specific actions	Measures
1. Making sure that care is centred on people's needs and protects their rights	<p>In assessing services' compliance with registration, for both mental health-specific services and mainstream services, the following regulations from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 will be particularly important:</p> <p>Regulation 9 (Outcome 4): care and welfare of people who use services</p> <p>Regulation 11 (Outcome 7): safeguarding people who use services from abuse</p> <p>Regulation 17 (Outcome 1): respecting</p>	

	<p>and involving people who use services</p> <p>Regulation 18 (Outcome 2): consent to care and treatment</p> <p>Regulation 23 (Outcome 14): supporting workers</p> <p>Thematic visits and analysis as part of annual reporting on the use of the Mental Health Act; development of indicators based on evidence from Mental Health Act visits incorporated into periodic review.</p> <p>Consult on special reviews on the implementation of the refocused Care Programme Approach, the dementia care pathway, the use of restraint and the health and social care needs of offenders as part of the 2010/11 programme of special reviews and studies.</p> <p>Contribute to the development of the annual survey of people who use mental health services to ensure it reflects changes in national policy; analyse variations in experience by age, gender, ethnicity particularly in relation to the equivalence of care.</p> <p>Contribute to monitoring of the provision of age-appropriate services for children and young people under the age of 18, including in whole life establishments.</p>	<p>Selection of focus for visits and/or analysis reflects the key priorities for our work on mental health and the concerns raised through the consultation.</p> <p>Mental health consultation concerns reflected.</p> <p>Findings of variations analysis used to inform national progress in relation to monitoring CQC's Single Equality and Human Rights Scheme; Analysis of the survey findings by ethnicity used to contribute to the PSA target on improving the experience of service users from black and minority ethnic groups</p>
<p>2. Championing joined-up care</p>	<p>Continue work on the special review of healthcare needs of people with learning disability and mental health needs, ensuring that there is robust follow-up to the findings of the review.</p>	<p>Review delivered with clear supporting action plan.</p>

	<p>Gather information to monitor and support the operation of Mental Health Act outside of hospital.</p> <p>Ensure that due profile is given to the assessment and treatment of mental health problems within the development of the registration process for primary care.</p> <p>Ensure that due profile is given to the care and treatment of people with mental health problems within the development of CQC's regulatory functions within criminal justice settings including within joint inspections with criminal justice inspectorates and with a focus on the interface between services.</p> <p>Work with the Audit Commission to contribute to the development of the Comprehensive Area Assessment to ensure a focus on mental health, including joint commissioning of services to meet the mental health needs of the local population.</p>	<p>Meetings with Approved Mental Health Practitioners to focus on effectiveness of assessment processes.</p>
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<p>3. Acting swiftly to help eliminate poor quality care</p>	<p>Building better intelligence and information into Quality and Risk Profiles, which reflect the concerns in the sector, including the use of information from third parties such as service user-led organisations, national voluntary sector organisations, those running accreditation schemes and clinical audits.</p> <p>In assessing services' compliance with registration for mental health-specific services, the following regulations from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 will be particularly important:</p> <p>Regulation 11 (Outcome 7): Safeguarding people who use services from abuse</p> <p>Regulation 13 (Outcome 9): Management of medicines.</p> <p>And from the Care Quality Commission (Registration) Regulations 2009:</p>	<p>Sector-relevant QRPs developed and delivered.</p> <p>Standardised approach developed for handling safeguarding concerns that include clarity around the escalation process; Safeguarding concerns from our monitoring of the Mental Health Act and Mental Capacity Act Deprivation of Liberty Safeguards are acted upon in an efficient and effective manner.</p>
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	<p>Regulations 16, 17 & 18 (Outcomes 18, 19 & 20): Notification of incidents.</p> <p>Contribute to the NPSA's work on developing national definitions of serious untoward incidents and the collaborative review of existing processes for investigating and learning from them.</p> <p>Identify indicators for NHS trusts that provide mental health services that can highlight where there may be problems in terms of safe and effective care.</p>	<p>Notifications used to assess compliance with registration regulations; swift action taken where non-compliance identified.</p> <p>Selection of indicators identified in consultation with senior clinical staff.</p>
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<p>4. Promoting high quality care</p>	<p>Review the information used within our assessment of PCTs and councils on the commissioning of services for people with mental health needs as part of our work to align and integrate our approach to assessing commissioning. This might need a more focused piece of work through a special review or study in the future.</p> <p>Publish examples of good practice by mental health providers, to help reduce the stigma associated with mental health services and to promote organisational learning that would lead to greater personalisation of care, independence, choice and control for people who use services.</p>	<p>Performance assessment of commissioning includes the commissioning of primary care and specialist mental health services to meet the mental health needs of the local population and provides access to services and interventions to promote recovery and social inclusion.</p> <p>Examples of good mental health practice promoted.</p>
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<p>5. Regulating effectively, in partnership</p>	<p>Partnership working with Department of Health, Monitor, regulatory bodies, the Association of Directors of Adult Social Services, and the Local Government Association to develop the assessment of mental health services and to ensure</p>	<p>Greater alignment of performance assessment frameworks and standards-based assessments.</p>
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	<p>alignment. Work in collaboration with the National Mental Health Development Unit, Social Care Institute for Excellence, professional bodies, other regulators and standard setting bodies to ensure alignment between registration requirements and areas identified for improvement.</p> <p>Work in collaboration with Her Majesty's Inspectorate of Prisons to encourage improvement in the safety and quality of mental health services in places of detention.</p> <p>Develop a whole systems approach to the assessment of CAMHS, working with the National Advisory Council and other relevant organisations to encourage improvement in the safety and quality of mental health services for children and young people.</p>	<p>CQC's registration of healthcare in prisons includes a sufficient focus on the provision of care for people with mental health and substance misuse problems.</p> <p>Agreements developed with partner organisations that allow for whole systems approach.</p>
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Additional considerations

Our analysis of feedback from the consultation indicates that there are a number of concerns that may be addressed through our registration and reviews, but that we should review these once these processes have been implemented to ensure that the concerns are sufficiently addressed. These include:

- Young people's transition to adult mental health services
- Access to evidence-based psychological therapies
- Access to advocacy
- Medicines management
- Compliance with relevant NICE guidelines
- Carers' issues
- Joint commissioning
- Identification and treatment of mental health problems within primary care
- Availability of services for people with medically unexplained symptoms

Appendix: Background and briefing paper

Mental health and mental health problems

Mental health and well-being are more than the absence of a mental health problem. Mental health is as important as physical health and means that people can make the most of their potential, can build positive relationships with others and can play a full part within society. Everyone's mental health can fluctuate – poor mental health can affect us all.

Mental health problems or 'disorders' can develop due to a complex interaction of biological, social and psychological factors. More common mental health problems (also referred to as 'neurotic' disorders), such as anxiety, depression, panic, phobias and obsessive compulsive disorder can cause appreciable emotional distress and can affect how people cope with their day-to-day life. Less common conditions, such as psychoses, can lead to people experiencing disturbances in thinking and perception that are severe enough to change someone's perceptions of reality. These include schizophrenia and affective psychosis, such as bipolar disorder.

Dementia and Alzheimer's disease are types of organic conditions involving progressive degeneration of the brain including impairment to memory. Personality disorders are longstanding conditions with certain characteristics and which can often interfere with the ability to make and sustain relationships. Eating disorders, such as anorexia or bulimia, often start in childhood or adolescence. The prevalence of behavioural disorders, such as attention deficit-hyperactivity disorders (ADHD) and conduct disorders decrease with age, but affect adults as well as children. Substance misuse includes both harmful drinking and dependence on alcohol and the use of drugs not consistent with legal or medical guidelines.

How many people have mental health problems?

One in four of the general population in England experiences at least one diagnosable mental health problem in any one year, and one in six people has a mental health problem at any given time – equivalent to 6 million people in the UK. More than half of those with a common mental health problem have both depression and anxiety.

It has also been estimated that:

- One in 100 people will have schizophrenia or bipolar disorder at some point in their lives – the prevalence of a psychotic disorder among the general population living in the community is around four in every 1,000 people, although rates are higher among those in other settings.

- Dementia presents a huge challenge to society, both now and increasingly in the future, particularly among older people. There are currently approximately 570,000 people with dementia in England, a figure that could double in the next 30 years; 25% of those with dementia are aged 85 or over.
- Nearly 850,000 children and young people aged between 5-16 years have a mental disorder –about 10% of the population.
- Among adults in the general population living in their own home, around 8% have signs of ADHD, 6% have an eating disorder, 6% are alcohol dependent and 3% are drug dependent, although the rates for hazardous drinking and general drug use are much higher (24% and 9% respectively).

Just under a quarter (23%) of respondents to the 2007 adult psychiatric morbidity survey met the criteria for at least one of the mental health disorders under study. Of these, around one in five (19%) met the criteria for two mental disorders with another 12% meeting the criteria for two or more conditions. Having co-morbid mental health problems is known to be associated with increased severity of symptoms, longer duration of problems, greater impact on day-to-day living and increased use of health services.

These estimates relate to the general population living in private households - the rates are much higher than this among people living in residential or institutional settings (such as prison) or among people who are homeless. For example, it is estimated that up to 90% of the prison population have a mental health problem, with much higher prevalence rates compared with the general population for all mental disorders. Common mental health problems and personality disorders are prevalent and 7% of male and 14% of female prisoners have a psychotic disorder.

There are notable differences in the prevalence of mental problems by age, gender, ethnicity and socio-economic status: women are more likely to have a common mental health problem than men, though men have higher rates of suicides and addictions; common mental health problems are least likely in those aged over 75 though organic mental health problems are far more common among older people; prevalence of a psychotic disorder is significantly higher among men from certain black and minority ethnic groups.

Certain factors are associated with higher risk of developing mental health problems including those who leave school early or who are unemployed. Chronic ill health or physical disability, adverse life events, poverty and deprivation also increase the risk. Such factors can also affect recovery from mental health problems. Support to address underlying social issues that contribute to mental ill health can be as important as interventions to treat mental health problems in aiding recovery.

There are particular groups of people at higher risk of having mental health problems including: prisoners, refugees, parents and carers, victims

of abuse and looked after children with high levels of co-morbid mental health problems among people who misuse drugs and alcohol, are homeless and who have a physical or learning disability.

Mental health problems can have major implications for outcomes and life chances. People with mental health problems are at higher risk of suicide, attempted suicide and self harm. Nationally there has been progress in reducing the rate of suicides, particularly among men and those in contact with inpatient mental health services. However, over time, there has been an increase in the proportion of women reporting suicidal thoughts and in the proportion of people reporting self-harm, especially among women aged 16-24.

Mental health problems are both the cause and consequence of social exclusion. Compared with the general population, people with mental health problems experience key inequalities in health and social outcomes. These include different outcomes in relation to physical health, employment, education, housing, social networks and community participation. People with mental health problems, especially more severe and enduring mental health problems like psychosis:

- Are at a greater risk than the general population of developing a range of serious physical health problems. For example, people with schizophrenia can expect to live 10 years less than someone without a mental health problem and have lower survival rates for a range of key conditions including stroke, diabetes and respiratory disease.
- Have had the lowest employment rate of all the main groups of disabled people with a wide gap between the work rate of people with mental health problems and that of the general population. People with mental health problems are at more than double the risk of losing their jobs than those without.
- Are more likely to be in debt, have serious rent arrears and are at greater risk of losing their home.
- Are more likely to have restricted social networks and more limited involvement in community activities.

Stigma and discrimination and low expectations amongst professionals can reinforce social exclusion.

In 2007, around a quarter (24%) of the general population with common mental health problems received treatment for their condition, mostly in the form of medication. The level and nature of treatment very much varied by mental health problem: over half of adults (57%) with a phobia were receiving treatment compared with only 15% of those with depression and anxiety. Half of those (48%) with two or more disorders were receiving treatment. For those with more enduring mental health problems, four in every five people were receiving some form of treatment (medication and/or counselling).

The service landscape

This section outlines the service landscape with particular reference to those services for which CQC has or will have regulatory responsibility.

Primary care and mental health promotion

Most of the people treated by the NHS for a mental health problem are treated by their GP and do not need referral on to more specialist services, although some may be offered additional treatment in the form of talking therapies such as cognitive-behavioural therapy. Nine out of 10 people with a mental health need have their condition managed entirely in primary care, including around a quarter of people with severe mental health problems. It is thought that a third of all consultations with GPs at least in part relate to a mental health issue.

‘Medically unexplained symptoms’, whereby people have persistent physical symptoms for which no medical explanation can be identified, account for as many as one in five new consultations in primary care. It is estimated that up to 70% of people with these symptoms will also have depression or anxiety that could be detected and treated. There are ongoing concerns about the recognition of mental health problems in primary care with calls for education, training and support to increase confidence in identifying and working to address mental health issues.

Mental health promotion involves any action to enhance the mental wellbeing of individuals, families, organisations and communities. This includes both targeted interventions to people who have been identified as having mental health problems and attention to mental health within wider public health promotion activities (such as activities to tackle obesity, smoking, alcohol misuse and teenage pregnancy).

Secondary mental health services

Secondary mental health services are provided by mental health NHS trusts (including foundation trusts) and primary care trusts (PCTs), local authority social services departments and a range of independent and voluntary sector providers. These include a wide range of services including inpatient, community based support and rehabilitation services, supported housing, residential care, crisis, outreach, day services and drop in centres.

In England, as at the end of March 2009, there were 57 specialist mental health trusts with 10 primary care trusts providing mental health services. In general, community-based secondary mental health services comprise multi-disciplinary teams with a range of health and social care professionals that integrate staff employed by health and local authorities. Whatever their professional or employment background, staff from these teams should all take account of a range of needs of the individuals with whom they work including health (both mental and physical health), social, cultural and spiritual needs. This often involves liaison with other organisations (for example housing, benefits and employment services) to address people’s needs.

Over the last decade, there has been a significant expansion in the provision of community-based services for adults including the establishment of over 700 new teams including:

- **Early intervention** services for young people at the onset of their illness.
- **Crisis resolution/home treatment teams** which provide a direct alternative to hospital admission for people with acute mental health problems and can facilitate early discharge for people whilst still in an acute phase of their illness.
- **Assertive outreach teams** provide treatment and support to people who mental health services have found hard to engage – usually people with severe mental health problems and often additional needs relating to substance misuse, offending and social relationships.
- **Community mental health teams** are the mainstay of community based provision, often providing long term support to people with enduring mental health problems.

In the year 2007-2008, national figures show:

- Nearly 1.2 million people (1,190,542) were in contact with NHS specialist mental health services for adults – this is equivalent to about one person in every 50 in England.
- Around one in 11 of people using secondary NHS mental health services (8.9%) spent time as an inpatient in a mental health hospital.
- The number of detentions under the Mental Health Act in 2007/08 was 47,600.
- Less than 5% of people had a hospital stay exceeding a year. Over half of people admitted to hospital had a stay of less than a month.

In 2007/2008, NHS community mental health teams in England had a total caseload of more than 300,000 people. For community mental health teams for older people, this figure is more than 150,000 each year. In 2007/08, 106,000 episodes of home treatment were delivered. At the end of the year, 20,000 people were receiving care from assertive outreach teams and 16,000 young people were on the caseload of early intervention in psychosis services.

The two tables overleaf show the level of service provided by local authorities for people with mental health problems.

Table A

Estimated number of clients receiving local authority services by service type 2007-2008				
	Total number (rounded figures)		Of which, number of people with dementia	
	18-64	65-74	18-64	65-74
Community-based services	178,000	88,000	5,200	39,000
Local authority residential care	200	4,600	-	29,000
Independent sector residential care	9,000	33,000	400	19,000
Nursing care	2,300	19,000	300	11,000
Total number of clients*	187,000	130,000	5,700	64,000

Table B

Estimated number of clients receiving community-based local authority services during the period, 2007-2008				
	Total number (rounded figures)		Of which, number of people with dementia	
	18-64	65-74	18-64	65-74
Home care	15,000	5,400	500	1,500
Day care	22,000	4,200	800	1,400
Meals	1,400	1,100	50	300
Short term residential care	1,500	400	-	200
Direct Payments	3,400	500	100	200
Professional support	109,000	9,800	3,400	1,400
Equipment and adaptations	2,400	1,200	100	300
Other	12,000	1,700	200	300
Total number of clients*	144,000	19,000	4,200	3,800

*Clients may be receiving more than one type of service.

Secure and specialist services

Mental health secure services provide treatment for people whose mental health problems may mean that they are at significant risk of harming themselves or others. These include medium and high secure services – the latter being provided in the three high secure hospitals at Ashworth, Broadmoor and Rampton. There has also been the development of mental health in-reach teams for prisons. By 2007, 80% of prisons had nurse-led mental health in-reach teams, consisting of a core team of psychiatric nurses with varying access to other professionals.

Depending on need, users of mental health services may be referred to specialist services such as those for people with eating disorders, substance misuse services, learning disability services or forensic psychiatry. For children and young people, specialist child and adolescent mental health services (CAMHS) provide both community and inpatient services. Approximately one third of inpatient CAMHS provision is in the independent sector, which provides a wide range of specialised services

ranging from secure and forensic mental health assessment and treatment, to day services.

All secondary and specialist mental health services provide a broad range of interventions to reflect the clinical, emotional, psychological, social and physical needs of the service user.

Funding

Commissioning of services for people with mental health needs is carried out by primary care trusts, specialist commissioning groups, mental health trusts, partnership trusts, some joint commissioning with local authorities and sometimes by local authorities themselves. The Department of Health have stated that this has led to a fragmented approach and inefficient use of capacity*.

The NHS spends 14% of its annual budget on mental health services – in 2007/08, the spend on adult mental health services totalled £5.53 billion*. In real terms, during the period 2000/03 and 2007/08, investment in mental health services has increased by 30%**.

For adults, the largest areas of investment have consistently been in clinical services (£881 million in 2007/2008), secure and high dependency provision (£859 million in 2007/2008) and in community mental health teams (£667 million). Investment in the three priority areas identified by the NSF MH has also increased over time:

- Assertive outreach – from £71.3 million in 2002/2003 to £124.9 million in 2007/2008.
- Crisis resolution/home treatment – from £35.2 million in 2002/2003 to £213.7 million in 2007/2008.
- Early intervention in psychosis – from £7.3 million in 2002/2003 to £69.2 million in 2007/2008.

The policy landscape

The National Service Framework for Mental Health (NSF MH) (1999), which has provided the central direction for the development of mental health service provision drew to an end in 2009. From 2010, building on the NSF MH the *New Horizons* cross-government programme provides the framework for the future of mental health service provision. This has heralded a new vision for mental health to reflect the themes from the

* Department of Health, *Roadmap for Commissioners for the Procurement of Mental Health Services in England: Mental Health Policy, Background and Context* (2008).

** NHS Confederation Mental Health Network, *Key facts and trends in mental health* (2009).

NHS next stage review *High quality care for all: NHS Next stage review*, particularly the emphasis on prevention, empowerment and quality.

New Horizons is a programme of action with two key aims to improve:

- the mental health and well-being of the population, and
- the quality and accessibility of services for people with poor mental health.

The programme takes a life course approach, from laying down the foundations of good mental health in childhood through to maintaining mental resilience into older age; from prevention of mental ill health, through effective treatment to recovery. The key themes in the vision are:

1. **Prevention and public mental health** – recognising the need to prevent as well as treat mental health problems and promote mental health and well-being.
2. **Early intervention** – expanding the principle of early intervention to improve long-term outcomes.
3. **Stigma** – strengthening our focus on social inclusion and tackling stigma and discrimination wherever they occur.
4. **Strengthening transitions** – improving the often difficult transition from child and adolescent mental health services to adult services, for those with continuing needs.
5. **Personalised care** – ensuring that care is based on individuals' needs and wishes, leading to recovery.
6. **Innovation** – seeking out new and dynamic ways to achieve our objectives based on research and new technologies.

With strategies to tackle these themes examined in the context of:

7. **Multi-agency commissioning/ collaboration** – working to achieve a joint approach between local authorities, the NHS and others, mirrored by cross-government collaboration.
8. **Value for money** – delivering cost-effective and innovative services in a period of recession.

New Horizons: a shared vision for mental health, outlines the next steps to improve mental health and wellbeing services, sets out cross government commitment to improve mental health and describes the system levers to achieve national and local progress.

Underpinning the vision is a set of guiding values that are seen as equally important in achieving mental health and wellbeing, which are:

- equality, justice and human rights
- reaching our full potential
- being in control of our lives
- valuing relationships.

These values and the key themes in the *New Horizons* vision align closely with values, and approaches outlined in the CQC strategic plan. We anticipate that CQC's key priorities and our work in mental health will help to support improvement in relation to most of the *New Horizon* programme themes. Although CQC does not have a specific remit in relation to the reduction of stigma, we hope that the focus on equality and human rights within our regulatory approach will contribute to this.

In recent years, the mental health care sector has been required to implement several key changes to policy and legislation, including:

a) Care Programme Approach (CPA)

Since 1990 the CPA has been the framework for assessment and care planning for adults with mental health problems in contact with specialist mental health services. In 2008, the Department of Health issued the *Refocusing the Care Programme Approach: Policy and positive practice guidance*. Key changes include replacing the previous system of two levels of CPA (standard and enhanced) with focusing the 'new' CPA just on people with more complex needs, making explicit the underlying principles and values to help services check that practice is more personalised within an ethos of recovery, a greater emphasis on access to evidence-based services and clarification of the competencies required for being a care coordinator. Services were required to implement changes from October 2008.

b) Supervised Community Treatment

In 2007, a number of amendments were made to the Mental Health Act 1983. The most significant change was the introduction of supervised community treatment (SCT) - aimed at people with a mental disorder who have been detained for treatment under the Mental Health Act but who are likely to disengage once they are discharged. The purpose of SCT is to allow people to be safely treated in the community rather than under detention in hospital. The community treatment order (CTO) has introduced the ability to recall the patient subject to certain conditions. Since their introduction in November 2008, there have been much higher numbers of applications made for CTOs than had been anticipated.

c) Independent Mental Health Advocacy

From April 2009 PCTs had responsibility for ensuring that independent Mental Health Advocates (IMHAs) are available to detained and CTO patients, and detaining authorities must ensure that such patients are aware that such help is available. CQC have responsibility for monitoring fulfilment of this legal duty.

d) Mental Capacity Act Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 aims to protect people who cannot make decisions for themselves through providing clear guidelines for carers and professionals about who can take decisions in which situations. The Mental Health Act 2007 introduced safeguards into the Mental Capacity Act which provide a framework for authorising the deprivation of liberty. As of 1 April 2009, responsibility for monitoring and reporting on the

Mental Capacity Act Deprivation of Liberty Safeguards was conferred on CQC including powers to:

- Visit and interview people accommodated in hospitals and care homes.
- Inspect records relating to the care of people whose liberty has been deprived or is at risk of being deprived.
- Require the disclosure of relevant information.

e) Requirements under the Optional Protocol of the United Nations' Convention Against Torture (OPCAT)

CQC is a part of the National Preventive Mechanism by which the UK government discharges its responsibilities as a signatory to the Optional Protocol of the United Nations' Convention Against Torture (OPCAT). This means that it is responsible for satisfying the requirement that the state facilitates regular and independent visiting of people detained in mental health hospitals.

There are also a number of existing policy initiatives that have key relevance for the focus of our work on mental health:

f) Delivering Race Equality (DRE) in mental health programme

Launched in 2005 as a five year programme, DRE is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status. The three building blocks of the programme are:

- more appropriate and responsive services
- community engagement in the development of services
- better information including improved monitoring of ethnicity.

Until 2010, CQC will continue to run the annual Count Me in Census, one of the main sources of information to monitor progress in achieving the objectives of the DRE programme. The previous reports have consistently highlighted the need for prevention, early intervention, and cross-sectoral collaborative working to reduce the risk of admission and detention where possible, without compromising the care given to patients. Mental health services have a key role to play, but partnership between all statutory agencies and organisations outside the healthcare sector, black and minority ethnic communities and service users themselves will be needed to achieve this.

The message about preventing mental ill-health, by addressing the upstream contributory factors and intervening early, is at the heart of *New Horizons*, the government's vision for the future of mental health care in England. An assessment of the DRE programme by the National Mental Health Development Unit will help to inform *New Horizons* which will identify future priority areas. An agreement has also been secured for a DRE dashboard that will continue to assess progress over time through mainstreaming consideration of ethnic differences within other data sets (including information on access/use of services).

g) Public sector agreement (PSA) target on social inclusion

In October 2007, the government announced a new public sector agreement target to support adults at risk of social exclusion. This included two targets for adults in contact with secondary mental health services (as one of four care groups), specifically to increase:

- the proportion of adults in contact with secondary mental health services in settled accommodation
- the proportion of adults in contact with secondary mental health services in employment

h) Improving access to psychological therapies (IAPT) programme

In 2007 the Department of Health announced £170 million over three years to support roll out of the 'improving access to psychological therapies' (IAPT) programme. The aim of the programme is to support the implementation of a stepped care psychological therapies service model in two thirds of all primary care trusts by 2011 with a measured target of improved well-being for at least 50% of all people who access services. The key aim of the IAPT programme is to support primary care trusts in implementing the National Institute for Health and Clinical Excellence (NICE) guidelines for people with depression and anxiety disorders.

i) National dementia strategy

Living Well with Dementia, published in June 2008, set out the Government's strategy for dementia for the next five years. The key priorities for this strategy are to improve awareness of dementia both in public as well as professionals, ensuring early diagnosis and intervention and finally delivering high quality care and support for people with dementia and their carers. An implementation plan is being published which will detail the national and regional arrangements to ensure successful delivery of the strategy.

j) The Bradley review

This independent review was commissioned to examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services and the barriers to such diversion. A key recommendation of the report was that inspectors and regulators involved in the criminal justice system, in partnership with CQC, should determine how they will ensure quality assurance for services provided to offenders with mental health problems and learning disabilities, with a particular focus on joint inspections.

k) Improving health, supporting justice

Improving Health, Supporting justice, published in November 2009 outlines the Department of Health's delivery plan in relation to improving the health and well being of offenders. It incorporates the Government's response to the Bradley report but has a wider remit that goes beyond the issues highlighted in relation to people with learning disabilities and mental health problems. The expectations made of CQC within the document are that by April 2011:

- all organisations providing health and adult social care will be expected to be registered with the CQC;
- the criminal justice inspectorates and CQC will, where possible, undertake joint inspections; and
- statutory inspectorates working in the criminal justice system will have an agreed understanding of health and adult social care standards and the quality of service provision, whether they are provided by the public, private or third sector.

I) The CAMHS review

The report, which contains 20 recommendations for Government, sets out a clear vision for promoting children's psychological well-being and mental health and how we can best achieve a step change in the quality and consistency of services at all levels.

In addition, there a number of wider policy developments that underpin mental health service development including:

- **Putting People First concordat in adult social care:** Published in 2007 and supported by a ring fenced grant of £520 million over three years, the concordat set out the principles by which local authorities, the NHS, voluntary agencies and private providers should work together to create a more personalised care service and to system-wide transformation of adult social care.
- **The National carers strategy:** which sets out the Government's agenda vision for the future care and support of carers
- **Safe. Sensible. Social: The Government's Alcohol Strategy:** which sets out to: minimise the health harms, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly.
- **The Expert patients programme:** a lay-led self management programme that has been specifically developed for people living with long term conditions. The aim of the programme is to support people to increase their confidence, improve their quality of life and better manage their condition.
- **World Class Commissioning:** intended to deliver a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. There are four key elements to the programme; a vision for world class commissioning, a set of world class commissioning competencies, an assurance system and a support and development framework.
- **Payment by results:** a new way of paying for NHS hospital and community health services that will replace the present system of block contracts and locally agreed prices. It is planned to apply in time to all services, including mental health. Under payment by results, hospitals and other providers will be paid according to the quantity of work done, as measured by the numbers and types of cases treated. The amount paid for each type of case, as determined mainly by diagnosis,

will be the same everywhere and fixed in advance through a national tariff.

- **Mental health standard contract:** The NHS standard contracts cover agreements between PCTs and providers for the delivery of NHS-funded services. In 2009/2010, the contract applied to agreements for: NHS trusts, new foundation trusts and foundation trusts whose existing contracts have expired; new agreements between PCTs and independent sector providers; new agreements between PCTs and third sector providers.
- **Adult social care green paper:** The adult social care green paper lays out a series of options for reforming the care and support system to ensure good quality and cost-effectiveness.

What do we know about the quality of services for people with mental health problems?

Primary care and mental health promotion

Information about the quality of care received by people with mental health problems treated solely in primary care is limited. In relation to our assessment of mental health within primary care, there are a few items in the Quality Outcomes Framework on people with an enduring mental health problem, particularly in relation to ensuring that annual physical health checks are carried out. However, there is an absence of key data including information about prescribing practices, characteristics of service users and access to a range of interventions. Information from the IAPT data set may offer new options around access to CBT for people with anxiety and depression that could be included in our assessments. It is therefore important that the development of our approach to the registration of primary care gives consideration to how we assess compliance in relation to the service provided to people with mental health problems.

Although standard one of the National Service Framework for mental health (NSF MH) focused on mental health promotion, this has been one of the elements identified as having received less attention, with concerns about under-investment to progress this area of work. The NSF MH identified improvements in the psychological health of the population and a reduction in the suicide rates as measures of progress for this standard. Good progress has been made towards the national target for reducing suicide although the 2007 adult psychiatric morbidity survey showed increasing levels of common mental health problems and no change in the overall prevalence of psychotic disorders.

Secondary mental health services

Compared with other trust types, NHS trusts that provide mental health services have tended to perform better in meeting core standards as part of the annual health check. However, it has been recognised that the national priorities and indicators for mental health trusts have been

extremely limited, linked to the limited profile of mental health within vital signs and the NHS operating framework. The national priorities performance assessment of mental health services was expanded to include eight new indicators for 2008/09. This has had an impact on the performance of these trusts. Overall for 2008/09: 30% of specialist mental health provider trusts scored “excellent”, 46% “good”, 16% “fair” and 9% “weak”.

More in-depth analysis through previous reviews, visits, inspections and assessments have identified significant variation in the quality and safety of secondary mental health services. For example:

- The joint review of community mental health services found that care reforms had not permeated all local implementation teams equally, with particular concerns about access to services, involving service users in their care, promoting social inclusion and recovery, and developing safe and effective information and governance systems. Although the follow-up review indicated that some progress had been made, the findings indicated that there was still considerable room for improvement of these services particularly in relation to the key outcomes for service users around choice, personalised care and social inclusion
- The acute inpatient mental health service review highlighted wide variations between trusts performance, and in some places, marked differences between wards within trusts in relation to quality of acute inpatient services with four key priority areas identified for improvement: putting greater focus on the individual and ensuring care that is personalised; ensuring the safety of service users, staff and visitors; providing appropriate and safe interventions; increasing the effectiveness of the acute care pathway
- The older persons’ mental health national review identified problems with the availability of data to assess the quality of specialist services for this group. However, variations were noted in access to the full range of mental health services that are available to younger adults (including out-of-hours and crisis services, psychological therapies and alcohol services), the quality of inpatient care (with particular concerns about the levels of violence and the quality of accommodation leading to safety related incidents), the extent of integration of health and social care staff within community mental health teams.

Regulated social care and independent healthcare

There has been a continuous process of assessing social care services throughout the year through service inspections, culminating in a quality rating of “excellent”, “good”, “adequate” or “poor”. However, of the regulated social care services, it is only possible to break down the ratings for care homes by care group. As Table C indicates there are a lower proportion of homes for people with mental health problems rated as “excellent” including a greater proportion of homes that provide dementia care as rated as “poor” or “adequate”.

Table C

Quality ratings for regulated adult social care homes as at October 2009			
Quality rating	Homes with provision for people with a mental disorder*	Homes with dementia care provision*	All care homes
0 Stars - Poor	2%	3%	2%
1 Star - Adequate	15%	17%	15%
2 Stars - Good	61%	61%	60%
3 Stars - Excellent	17%	16%	20%
Not Yet Rated	4%	3%	4%
Rating Suspended	0.07%	0.1%	0.07%
	100%	100%	100%
Total number of homes	2,971	5,910	18,492

* Homes with at least one place registered for specified care group

Compared with acute hospitals, independent sector hospitals' compliance with national minimum standards has not been so good. A significant minority of providers (1 in 10) have not met core standards in relation to: monitoring and ensuring the quality of treatment and service, recruitment and training of qualified staff, patients receiving treatment in premises that are safe and appropriate; and not meeting service specific standards in relation to: risk assessment and management, protection of patients from self-harm, the management and restraint of patients displaying aggressive and violent behaviour.

Experience of patients detained under the Mental Health Act

The Mental Health Act Commission's thirteenth biennial report^{**} acknowledged that there are some excellent inpatient services, that there had been a real increase in funding and that some progress had been made in developing inpatient services. However, in addition to reporting on the implementation of the Mental Health Act, the report reiterated ongoing concerns about key factors that directly impact on the experience of people who are compulsorily detained in hospital. These included problems with accessing transport and hospital beds, overcrowding on wards/ high bed occupancy, staffing capacity and expertise, access to activities and psychological therapies, service user involvement in planning their own care and treatment, physical interventions and working with people who are intoxicated by drugs or alcohol.

PCTs and local authorities as commissioners

CQC has a statutory duty to review and assess the performance of PCTs and councils as commissioners and publish the results. Our current assessment of PCTs as commissioners covers a wide range of important

^{**} The Mental Health Act Commission, *Coercion and consent; monitoring the Mental Health Act 2007-2009* (2009).

public and general health issues and has some specific indicators relevant to mental health on the commissioning of:

- crisis resolution home treatment services
- early intervention in psychosis services
- CAMHS

The Annual Performance Assessment of councils has included a broad assessment based on a wide range of quantitative and qualitative evidence, including the National Indicator Set. We hold councils to account for the quality of the services they are purchasing through using several data sets (CRL and LAMA). If social care provision is poorly rated, we will address this directly with councils.

Whilst there are relatively few measures in the National Indicator Set that directly relate to mental health, it is possible to disaggregate information by disability, including mental health. Currently the Annual Performance Assessment contains two specific indicators that are relevant to mental health services:

- NI 149 Adults with mental health problems in settled accommodation
- NI 150 Adults with mental health problems in employment

However, there are data quality problems with these two national indicators. The Annual Performance Assessment also includes a number of other measures that incorporate information on services for people with mental health problems which give a picture of services locally funded services.

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