

Written evidence submitted by The Care Quality Commission (CQC) (MHS0010)

1. The Care Quality Commission (CQC) is the independent quality regulator of health and adult social care in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage these services to improve. We do this by using our powers under the Health and Social Care Act 2008 and we can take regulatory action against providers where the quality and safety of care falls below acceptable levels.
2. CQC regulate, inspect and rate mental health services, including those for people with mental health needs, learning disabilities and autism. This includes the care, treatment and support provided in hospital and in the community. We also check that patients' basic human rights are maintained while they are being cared for or treated under the Mental Health Act.
3. Much of the information we hold has been published and is already in the public domain, and we hold limited information on the questions you have posed. We hope the information we can provide on your broader lines of inquiry is helpful. Our information particularly draws on our regulation of mental health services leading up to and during the covid-19 pandemic.

Introduction and publications

4. Mental health is a key area where we have previously raised concerns about the lack of community care and early diagnosis and support. It is likely that people who have been unable to access mental health services since the start of the pandemic will be looking for more help once services are re-established. Enhanced mental health support will be needed for people and communities.
5. We have previously highlighted the difficulties that some people have had in accessing the right mental health care and support at the time they need it. Alongside our State of Care report 2019-20ⁱ, we published three pieces of work that showed there was limited progress in improving access for people.
 - Mental health rehabilitation inpatient servicesⁱⁱ
 - Children and young people's mental health careⁱⁱⁱ
 - Mental health care in acute trusts^{iv}

CQC RATINGS DATA:

6. 01 September 2020: Overall ratings for locations and providers with a Primary Inspection Category of 'Mental health - community & hospital - independent' or 'Mental health - community & residential - NHS'

Rating	Number of MH NHS and IH Overall Ratings
Outstanding	30
Good	200
Requires improvement	53
Inadequate	15

7. 01 September 2021: Overall ratings for locations and providers with a Primary Inspection Category of 'Mental health - community & hospital - independent' or 'Mental health - community & residential - NHS'

Rating	Number of MH NHS and IH Overall Ratings
Outstanding	28
Good	193
Requires improvement	56
Inadequate	16

8. NHS England and Improvement have developed and publish a dashboard^v that monitors the progress in delivery against the 'NHS Mental Health Implementation Plan 2019/20 – 2022/23'^{vi} This includes the measures they have identified for tracking progress in relation various national ambitions.
9. NHS Digital also publish the 'Mental Health Services Monthly Statistics'^{vii} which provides a picture of people using NHS funded secondary mental health, learning disabilities and autism services.
10. The Royal College of Psychiatry also publishes the 'Early Intervention in Psychosis audit report and resources 2020/21'^{viii} which provides national and organisation-level findings on the treatment of people by Early Intervention Psychosis teams in England.

Workforce

11. In our 'State of Care,19-20' report, we said that “workforce issues and an ongoing decline in the number of inpatient mental health nurses continued to add to difficulties with people accessing acute services, for example leading to longer waiting lists”.
12. State of Care found that staffing issues in all regions had been a key factor affecting access to services. Inspectors and external stakeholders heard about services competing for staff, with smaller services and those in rural or deprived areas facing particular challenges filling vacancies.
13. In our publication, 'Inpatient experience during the pandemic, November 2020'^{ix}, we said that “workforce challenges in the NHS were a concern before the pandemic. During the pandemic there was enormous support for the NHS with retired health professionals volunteering to return to the frontline”.
14. In our thematic review into Restraint Segregation and Seclusion, 'Out of Sight – Who Cares?'^x workforce was an issue covered both in the hospital and community mental health space. Our reviewers found that staff were under pressure because of a high staff turnover, lack of appropriate training and high use of agency staff. In addition, we found poor staff cultures, and there was often a disconnect between the multidisciplinary team and frontline workers. The review found that many wards had a high number of vacancies. This led to the reliance on agency staff who are not part of the established staff team. This reliance on agency staff means that staff did not always know the needs of the people they are looking after.

15. In our recent report about best practice in the community – ‘Home for Good’^{xi} it is demonstrated that people can and do lead fulfilling lives in their own homes when they are given the right support. The report shows that inpatient care being viewed as the only answer for some people is a misconception. The report outlines how for services to be bespoke and truly person-centred; this involves recruiting and training specialist staff teams.
16. NHS Digital publish national and regional data on the Mental Health and Learning Disability Workforce^{xii} that will help give the panel an overview. The Power Bi dashboard, page 2, indicates an overall increase in the last three and half years and page 3 highlights the changes by key staff groups.

Children and young people’s mental health review: Update on local actions^{xiii}

17. In following up the 2018 recommendations for local action that we made about access to mental health care for children and young people, we found that these were being implemented in varying degrees in the health and wellbeing areas who responded to our self-assessment questionnaire. For example, while our findings indicated there was stronger prevalence of joint commissioning, almost one in five local health and wellbeing boards reported back that there was no joint commissioning of support for teenagers and young people as they move to adult services.
18. NHS England’s dashboard for ‘Children and Young People with an Eating Disorder (CYP ED) Waiting Times’^{xiv} highlights data containing information on the number of children and young people who have accessed or are waiting for treatment following a routine or urgent referral for a suspected eating disorder.

Improving access to psychological therapies (IAPT)

19. We regulate psychological therapies that are provided by or are under the direct supervision of a doctor, nurse or a social worker. In the IAPT services model, supervision is most likely led by senior therapists instead of medical staff or a social worker. Therefore, CQC is not able to regulate psychological therapies in IAPT services and we hold no data relevant to the inquiry. However, we are currently working with the Department for Health and Social Care, trade associations and other key stakeholders to identify and understand how we may inspect and rate psychological therapies going forward. Progress on this matter has been delayed due to the Covid-19 pandemic.

Adult severe mental illness

20. Our report, ‘Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus (COVID-19) pandemic’^{xv} demonstrates that inpatient mental health services were profoundly affected by the COVID-19 pandemic. This includes the initial wave of ward reconfigurations to reduce bed numbers and allow flexibility to isolate infected patients; significant reductions in community services that may have prevented some admissions; and the pressures on patients and staff. In some cases, service reconfigurations will have compromised patient environment quality and we would expect such steps backward to be reversed as soon as practicable. In all services, the periods of lockdown presented very challenging limitations on patients’ activities and ability to have leave from hospital. In many cases, reduced staff levels

throughout the pandemic period will have led to similar challenges. These factors have contributed to a delay in progress in actioning commitments to improve patient experience.

Upcoming CQC publications

21. Our State of Care 2020-21 report is due to be published on 22 October 2021, which will provide a more up to date picture of the trends in patient experience and the quality of care over the past year. We will share a copy of this report with the Panel once it has been published.
22. We expect to publish a new Provider Collaboration Review on Children and Young Peoples Mental Health in November 2021 reviewing the mental health care of children and young people during the COVID-19 pandemic.
23. If you have any queries please contact Mat Hughes, Senior Parliamentary and Stakeholder Engagement Adviser matthew.hughes@cqc.org.uk.

ⁱ https://www.cqc.org.uk/sites/default/files/20201016_stateofcare1920_fullreport.pdf

ⁱⁱ <https://www.cqc.org.uk/publications/themed-work/mental-health-rehabilitation-inpatient-services-%E2%80%93-2019-update>

ⁱⁱⁱ [Children and young people mental health review: Update on local actions | Care Quality Commission \(cqc.org.uk\)](#)

^{iv} [Assessment of mental health services in acute trusts | Care Quality Commission \(cqc.org.uk\)](#)

^v [NHS England » NHS Mental Health Dashboard](#)

^{vi} [NHS Mental Health Implementation Plan 2019/20 – 2022/23](#)

^{vii} <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics>

^{viii} [Audit reports \(rcpsych.ac.uk\)](#)

^{ix} [Inpatient experience during the coronavirus \(COVID-19\) pandemic | Care Quality Commission \(cqc.org.uk\)](#)

^x [Out of sight – who cares?: Restraint, segregation and seclusion review | Care Quality Commission \(cqc.org.uk\)](#)

^{xi} [Home For Good: Successful community support for people with a learning disability, a mental health need and autistic people | Care Quality Commission \(cqc.org.uk\)](#)

^{xii} [Mental health and learning disabilities workforce in the NHS - NHS Digital](#)

^{xiii} [Children and young people mental health review: Update on local actions | Care Quality Commission \(cqc.org.uk\)](#)

^{xiv} [Statistics » Children and Young People with an Eating Disorder Waiting Times \(england.nhs.uk\)](#)

^{xv} [Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus \(COVID-19\) pandemic | Care Quality Commission \(cqc.org.uk\)](#)