CYGNET/CAS MERGER INQUIRY

Summary of hearing with the Care Quality Commission on 26 July 2017

Background

1. The Care Quality Commission (CQC) said that the situation with locked rehabilitation (rehab) facilities was one of the issues flagged in the CQC report on the state of care in mental health care that was published recently.

2. The CQC had been surprised to find how many beds and patients there were in locked rehab wards. It said that there was no central register of these facilities because the places were mostly commissioned by one of the 209 clinical commissioning groups (CCGs). Hence the intelligence about the extent of commissioning these places was dispersed across the country.

3. It said NHS England commissioned certain services such as forensic and low secure and here all the information was in one place.

4. The CQC said that a much higher proportion of rehab beds in the independent sector were in locked wards than was the case in the NHS and it wanted to explore how many people in locked rehab wards really needed to be there, or whether it would be more appropriate to treat them further down the care pathway. It queried if all of the people in the wards needed such a high level of security and what the impact was of people being essentially locked up often far from their home setting. The number of patients at locations at significant distance from their homes raised issues of wellbeing due to lack of contact with family and friends and also regarding the quality of coordination with local services that needed to support their discharge into the community.

CQC ratings

5. An NHS provider may have four or five wards in different locations. In this case, the CQC report and rating would be about the four or five wards combined, not about individual wards. Independent sector providers often had only a single ward in a given location and so the CQC report would be a report on that one ward.

6. The CQC said that it hoped the ratings it gave facilities affected commissioning decisions, but in practice, the referral decision would often depend on where the bed availability was.

7. When inspecting, the CQC explained that as well as issuing a rating it would also take enforcement action if necessary. Ratings and enforcement happened in parallel. The CQC compared this to the previous regime where inspections had been purely about compliance with regulations and no ratings were involved.

8. A rating of 'requires improvement' rating usually meant that a facility was breaching one or more of the regulations and there would be a strong expectation that the provider would put it right in a timely manner. A rating of 'inadequate' would indicate immediate and pressing concerns and would be accompanied by enforcement action.

9. If a rating of 'inadequate' was given, a course of action would be taken against the service and this might require a service to suspend admissions. The CQC could even cancel the registration of a ward or facility, which would require the patients already there to move. More usually, it would work with NHS England and CCGs around the use of the beds and sometimes the provider would enter into a voluntary agreement to suspend admissions. The CQC said that there were only a very small proportion of locked rehab facilities that fell into this category, probably only around 1% of rehab services at present.

Inspections

10. The CQC said that its inspections using the new approach had been taking place for three and a half years and therefore providers were now used to its approach to regulation. It had a working relationship with every provider in the country and, following its recent review, it now had a view on the quality of care across all facilities in England. The CQC did not think that most other countries would be able to claim such a comprehensive oversight of provision.

11. The CQC said that when inspecting it would want to know about where the patients came from; what the relationship was like between the provider and the CCG; and how the provider promoted discharge. It would not usually ask about the nature of the contract between the CCG and the provider.

12. The speed and frequency at which the CQC would go back to see a facility rated as 'requires improvement' would depend on the extent and nature of its concern. Usually another visit would be done within two years. The CQC said that the new approach to inspecting had only been going for three to four

years, so it had not yet got around to re-inspecting some of the services rated as ‘requires improvement’.

Competition with the NHS

13. The CQC said that it did not have evidence around whether private providers and NHS providers competed for the same type of patients. It thought it was largely to do with whether the NHS had the type of provision needed in the local area. If there was local provision that was suitable for a person’s need, the CQC said there was no reason why the NHS would not be using it. Therefore, it suspected that the majority, if not all, of the placements in the independent sector were because the local clinicians had concluded that there was no suitable local NHS provision.

14. If an independent provider was looking at opening a facility in a particular area it would be because there was not sufficient NHS provision and so there was demand in the market. Hence the independent provider was looking to fill the gap. The CQC noted that the portfolio of independent providers was often different from one location to another as they provided what particular markets needed.

15. The CQC said that it was concerned that patients had continuity of care from their care team. Ideally, if someone were admitted to an NHS acute ward and they needed to move from that ward to anything other than their own home, there would be local provision to move them into. Whether it would be provided by the NHS or the independent sector was irrelevant, but it should be sufficiently local so that the person was able to maintain contact with the care team that would support them after they were discharged. The CQC said that one of the challenges with a care pathway that took someone out of area was the discontinuity in the care team that was working with the patient.

CQC report on the state of care in mental health services 2014 to 2017

16. The CQC’s report was based on an analysis of inspection reports, a review of other national evidence and the views of expert advisers. The concerns identified relating to rehabilitation wards related to: isolation and dislocation; patient mix; length of stay; lack of clarity over the service model of wards; over-restriction of patients; lack of meaningful rehabilitation; and a lack of sufficient focus on discharge. In addition, the CQC was concerned over the quality of some of the ward environments as some of them were located in quite old buildings.

17. The CQC wanted to understand how out-of-area placements affected people. It was concerned about people being dislocated from their local community teams. It was also troubled by the mix of patients it found in some wards: some units appeared to take people with a wide range of problems. For example, it had found instances where people with severe, enduring mental illnesses like schizophrenia were housed in the same unit as those with learning disabilities. It queried whether a single unit with a single group of staff could really cater for the needs of such a wide mix of patients and also whether the patient mix was appropriate.

18. The CQC said there was a physical difference between what it understood to be a locked rehab ward and an unlocked one. The former would often have an airlock, whilst the latter would not, as in many unlocked facilities the door would be open so patients could interact with the local community. Hence locked wards were more restrictive and inward looking, while unlocked wards encouraged interaction with the outside world in a way that supported recovery. It thought that some patients may be in a locked environment when they would benefit from a less restrictive environment.

19. The CQC also said that in some cases, wards were not being clear on what their service models were and which client group was being catered for. In several wards inspected, it was obvious that the provider had not defined the service model or the patient group being catered for and the risk was then that they admitted people who it was beyond their capability to care for.

20. The CQC stated that the majority of wards were single gender. However, some admitted both men and women. It was important that wards of this type complied with national guidance on providing bedrooms in separate parts of the ward, single-sex toilets and lounges that were only accessible to women etc. The CQC had found some rehab wards which admitted both genders and which were not compliant with the guidelines.

Trends in locked rehab

21. The CQC said it had been surprised to find how many people were in locked beds but, because it was unaware of how many people there had been in them ten years ago, it was uncertain if today's number was an increase on a previously low number, or a reduction from a high number.

22. It emphasised that hospitals should not become homes for those with mental health problems, but said that if someone had been in locked rehab ward for 10 to 15 years, it was difficult to think that they would not feel this to be the case and it would then be very difficult to discharge them.