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BY EMAIL and POST

Care Quality Commission
Re: Inquest into the death of Mr Neil James Carter

Dear Dr Cummings

Thank you for your report dated 5 March 2014 in which you wrote to us under the provisions of Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 in relation to the inquest into the death of Mr Neil Carter.

We are extremely saddened to learn of the circumstances leading to Mr Carter's death on 20 November 2012. We are also very grateful for identifying particular concerns and for requiring the Commission to review what actions should be taken to prevent the occurrence or continuation of such circumstances in the future.

Please treat this letter as the formal response of the Care Quality Commission ('the Commission') to your report of 5 March 2014.

In your report and pursuant to the requirements of Regulation 29 of the Regulations you require the Commission to provide details of any action that has been taken or which is proposed to be taken in response to the concerns highlighted in your report, or an explanation as to why no action is proposed if appropriate.

In responding to your Report we endeavour to address the three specific concerns raised in the order that you set them out. We will also outline proposed developments in the Commission's regulatory functions across Mental Health Services more generally. Before doing so, however, we set out below an overview of the Commission's recent regulatory action in relation to The Priory Hospital Roehampton. We do so with the aim of providing some context and overview for our actions and to address some of the underlying concerns you raised in relation to The Priory Hospital Roehampton as follows:

- An introduction to the role of the Commission in the context of The Priory Hospital Roehampton;
- The Commission's recent regulatory involvement with The Priory Hospital Roehampton;
- The Commission's response to the specific concerns set out in your report arising from the death of Mr Neil James Carter; and
- The proposed future regulatory response across Mental Health Services.

The Commission: An introductory summary of our regulatory responsibilities

The Commission has the following fundamental statutory functions conferred on us by the Health and Social Care Act 2008 ('the Act'):

- Registration functions;
- Review and investigation functions;
- Monitoring, compliance and enforcement functions; and
- Functions under the Mental Health Act 1983.

Our main objective in performing our functions is to protect and promote the health, safety and welfare of people who use health and social care services.

We perform our functions for the general purpose of encouraging the following:

- The improvement of health and social care services;
- The provision of health and social care services in a way that focuses on the needs and experiences of people who use those services; and
- The efficient and effective use of resources in the provision of health and social care services.

In performing our functions, we must have regard to the following:

- Views expressed by or on behalf of members of the public about health and social care services;
- Experiences of people who use health and social care services and their families and friends;
- Views expressed by Local Healthwatch organisations about the provision of health and social care services;
- The need to protect and promote the rights of people who use health and social care services. Those right include in particular the rights of children, of persons detained under the Mental Health Act 1983, of persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005, and of other vulnerable adults;
- The need to ensure that action by the Commission in relation to health and social care services is proportionate to the risks against which it would afford safeguards and is targeted only where it is needed;
- Any developments in approaches to regulatory action, and best practice among persons performing functions comparable to those of the Commission

(including the principles under which regulatory action should be transparent, accountable and consistent); and
- Such aspects of government policy as the Secretary of State may direct.

The Act requires the Commission to publish guidance about compliance with the requirements of the regulations. The Commission has published "Guidance about compliance, Essential standards of Quality and Safety" ('the Guidance') which provides advice to providers about how and what they need to do to comply with the Regulations in the form of outcomes and prompts.

The Guidance sets out what people who use services have a right to expect about the quality and safety of care. There are 16 standards that compliance inspectors inspect as part of their role. Those standards deal with aspects of care such as treating people with dignity and respect, providing effective and appropriate care and treatment that meets their needs and protects their rights, protecting people from abuse, having clean environments and having enough qualified and supported staff to provide the care needed.

In addition we are the body corporate delegated to monitor the exercise of duties and powers of the Mental Health Act 1983 as set out in section 120 of the Mental Health Act 1983 ('the Mental Health Act') as well as associated directions and regulations. These state in particular that the Commission:

- Must keep under review and, where appropriate, investigate the exercise of the powers and the discharge of the duties conferred or imposed by the Mental Health Act so far as relating to the detention of patients or their reception into guardianship or to relevant patients. Relevant patients are patients liable to be detained under the Mental Health Act, community patients, and patients subject to guardianship.
- Must make arrangements for persons authorised by the Commission to visit and interview relevant patients in private.
- Must make arrangements for persons authorised by the Commission to investigate any complaint as to the exercise of the powers or the discharge of the duties conferred or imposed by the Mental Health Act in respect of a patient who is or has been detained under the Mental Health Act or who is or has been a relevant patient. These arrangements:
    - may exclude matters from investigation in specified circumstances, and
    - do not require any person exercising functions under the arrangements to undertake or continue with any investigation where the person does not consider it appropriate to do so.

For the purposes of a review or investigation, the Commission may at any reasonable time:

- Visit and interview in private any patient in a hospital or regulated establishment,
- If the authorised person is a registered medical practitioner or approved clinician, examine the patient in private there, and

- Require the production of and inspect any records relating to the detention or treatment of any person who is or has been detained under this Act or who is or has been a community patient or a patient subject to guardianship.

In monitoring the operation of the Mental Health Act, the Commission must also ensure that registered providers and wider statutory services work within the Mental Health Act Code of Practice unless there are cogent reasons for departure.

In addition, since the UK ratified the United Nations Optional Protocol to the Convention against Torture ('OPCAT') in 2009 we are required to prevent torture and other forms of inhuman or degrading treatment through regular visits to places of detention by bodies known as National Preventive Mechanisms ('NPM'). As the visiting body to places of psychiatric detention in England, the Commission is part of the UK's NPM and our work helps to fulfil the UK's legal obligations under the OPCAT.

The Commission's response and regulatory functions encompass first health and social care statutory functions under the Health and Social Care Act 2008, as well as the associated Care Quality Commission (Registration) Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; secondly, they comprise the role as the body monitoring the exercise of duties and powers of the Mental Health Act.

The Commission's recent regulatory involvement with The Priory Hospital Roehampton

As you are aware The Priory Hospital Roehampton is an independent hospital specialising in the management and treatment of mental health problems including addictions and eating disorders, and the treatment of people detained under the Mental Health Act.

Since June 2013 the Commission have carried out the following compliance inspections of The Priory Hospital Roehampton:

1. **25 June and 3 July 2013**: On those dates the Commission carried out an unannounced joint compliance inspection by a team that included compliance inspectors, a pharmacy inspector and a Mental Health Act Commissioner. The visit was carried out following concerns that the Commission had received about the care being provided. This visit was also the first inspection visit following the death of Mr Carter. The inspection focussed on 8 outcomes, and the service was found to be non-compliant with four outcomes. We set out a summary of the findings below:

(1) Outcome 1: Respecting and involving people who use services. This corresponds with Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
The Priory Hospital Roehampton was found to be non-compliant with this outcome and the provider was required to take appropriate action to achieve compliance with the regulations.

(2) Outcome 2: Consent to care and treatment. The Priory Hospital Roehampton was found to be meeting this standard.

(3) Outcome 4: Care and welfare of people using the service. The Priory Hospital Roehampton was found to be meeting this standard.

(4) Outcome 7: Safeguarding of people who use the service from abuse. The Priory Hospital Roehampton was found to be meeting this standard.

(5) Outcome 9: Management of medicines and corresponds. This corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
The Priory Hospital Roehampton was found to be non-compliant with this outcome and the provider was required to take appropriate action to achieve compliance with the regulations.

(6) Outcome 10: Safety and suitability of premises. This corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
The Priory Hospital Roehampton was found to be non-compliant with this outcome and the provider was required to take appropriate action to achieve compliance with the regulations.

(7) Outcome 13: Staffing. This corresponds to Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
The Priory Hospital Roehampton was found to be non-compliant with this outcome and the provider was required to take appropriate action to achieve compliance with the regulations.

(8) Outcome 17: Complaints: The Priory Hospital Roehampton was found compliant with this standard.

Where The Priory Hospital Roehampton was found non-compliant the Commission required that compliance actions be taken. The provider sent a report setting out the actions that were being taken, which were acceptable to the Commission.

2. **24 October 2013**: The Commission undertook a joint unannounced inspection in direct response to information that was received following a death of a patient at the hospital in September 2013. The inspection was conducted by compliance inspectors and a Mental Health Act Commissioner. The inspection focussed on outcome areas that related to some of the concerns raised including emergency procedures, observation policies and staff training and also assessed whether the actions required to achieve compliance with Outcomes 1 and 10, following the inspection on 25 June and 3 July 2013, had been completed. The Priory Hospital Roehampton was found to be compliant with all outcomes that were assessed. We set out a summary of those findings below:

(1) Outcome 1: Respecting and involving people who use services. The Priory Hospital Roehampton was found to have become compliant with this standard with compliance actions satisfactorily met.

(2) Outcome 4: Care and welfare of people using the service. The Priory Hospital Roehampton was found to be meeting this standard.

(3) Outcome 7: Safeguarding of people who use the service from abuse. The Priory Hospital Roehampton was found to be meeting this standard.

(4) Outcome 10: Safety and suitability of premises. The Priory Hospital Roehampton was found to have become compliant with this standard with compliance actions satisfactorily met.

(5) Outcome 14: Supporting workers. The Priory Hospital Roehampton was found to have become compliant with this standard with compliance actions satisfactorily met.

3. **12 March 2014:** The Commission carried out a joint unannounced inspection comprising a compliance inspector, a Mental Health Act Commissioner and a pharmacy inspector. The inspection focussed on assessment against outcomes 9 and 13 to consider whether the compliance actions that were required following the inspections on 25 June and 3 July 2013 had been satisfactory completed. We summarise the findings below:

(1) Outcome 9: Management of medicines. The Priory Hospital Roehampton was found to be meeting this standard.

(2) Outcome 13: Staffing. The Priory Hospital Roehampton was found to be meeting this standard.

The specific concerns set out in your report arising from the death of Mr Carter

Having provided the context in which the Commission currently operates we now set out our considered response to the specific concerns arising from the death of Mr Carter that were identified in your report of 5 March 2013.

1. **There were repeated failures to perform basic nursing observations**

One of the steps that the Commission has undertaken in response to this has been to consider observation training as part of the follow-up inspection of staffing standards on 12 March 2014. The inspection on 12 March comprised a joint unannounced inspection comprising a compliance inspector, a Mental Health Act Commissioner and a pharmacy inspector. The inspection of 12 March focussed on assessment against outcomes 9 (Medicines Management) and 13 (Staffing) to consider whether the compliance actions that were required following the inspections on 25 June and 3 July 2013 had been satisfactory completed. During the inspection of 14 March the Commission found training on how to carry out

observations formed a specific component of improved training that had been introduced by The Priory Hospital Roehampton for agency staff.

Observation training was also a specific component of improved training for new permanent staff. All new staff underwent an 'assessment of competence to carry out observation' when they began employment. This included assessment of their understanding of the observation policy, recording observations and responsibilities when carrying out observations. These competencies were signed off by the ward manager once completed before staff could work on the wards. In addition, all staff were given quick reference 'flash cards' which they were able to refer to if they needed reminding of certain procedures including the one on observations.

The provider's observation policy and the implementation of that policy were considered in detail at the inspection of October 2013, which was carried out by compliance inspectors and a Mental Health Act Commissioner. The policy and its implementation met appropriate standards and the provider was found to be compliant with the regulations in this respect. However, we will continue to monitor information we receive from and about the provider in this respect and will use the information highlighted in the Report to plan and focus the Commission's next inspection of The Priory Hospital Roehampton.

2. Inadequate numbers of staff with an inappropriate skill mix and with an inappropriate layout over two floors.

In relation to the concern about the inadequacy of staff numbers and skill mix at The Priory Hospital Roehampton, the Commission incorporated that concern into the inspection of The Priory Hospital Roehampton on 14 March 2014. The Commission found that there had been improvements in staffing at the location since the death of Mr Carter. In particular:

- Ward managers confirmed that there had been a recruitment drive since the death of Mr Carter.

- The Priory Hospital Roehampton's Human Resources (HR) department detailed the changes that had introduced since our previous inspection in October 2013. In particular, whereas all staff recruitment had previously been carried out centrally, away from the site which was having an impact on the amount of time it took to recruit staff, all assessment days and interviews are now taking place on site. They reported that this had reduced the average time that it took to recruit permanent staff and carry out all the necessary Disclosure and Barring Service (DBS formerly known as Criminal Records Bureau or CRB) checks and occupational health checks was approximately 20 working days, a reduction of 15 days. All staff interviews included a three point competency assessment which tested candidates on drug calculation, care planning and verbal reasoning. Successful candidates were interviewed by a panel which consisted of a clinical services manager, HR staff and a ward manager.

- The provider had carried out a needs analysis to calculate how many more staff were needed. We saw that although there were still some vacancies open at the hospital, the provider had taken steps to try and recruit into these positions. Since June 2013, 56 clinical staff had been recruited. We were shown evidence that since our previous inspection in October 2013 the use of agency staff across the whole hospital had reduced from 18% to 8%.

- A Mental Health Act Commissioner made a further visit to the ward, where Mr Carter was a patient, on 19 March 2014. They found safe staffing levels were in place on that occasion. However, the Commission intends that ward staffing levels and, in particular, the skill-mix of staff be incorporated within our monitoring of the provider, as well as in the planning and focus of our next inspection of The Priory Hospital Roehampton.

- The appropriateness of the ward layout over two floors and its impact on patient care has not been specifically looked at by the Commission to date in its inspections since the death of Mr Carter. Within the Commission's regulatory methodology this concern relates to outcome 10 dealing with the safety and suitability of premises. Outcome 10 corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We are grateful that this concern has been brought to our attention and we intend to incorporate the outcome specifically into the planning and execution of our next inspection of the hospital.

3. **There was deliberate falsification of a nursing record**

   The Commission has seen no evidence of deliberate falsification during the course of our inspections. It is extremely worrying that such evidence was presented. It is also a very difficult thing for the Commission to identify either in regular monitoring or at an inspection visit unless it had been brought to our attention by staff, patients or relatives. Nevertheless, this information will inform the planning and delivery of the next inspection visit of The Priory Hospital Roehampton.

   The Commission would also respectfully suggest that if it has not been done so already this may be a matter which would require referral to the relevant professional regulatory body, whether NMC, GMC or otherwise.

The Commission plans to undertake the next inspection visit of The Priory Hospital Roehampton within the next four months. The precise date of the inspection has not been set and it is to be unannounced. It is also intended that that visit would consider not only the specific areas of concern highlighted in this report but also those highlighted in a separate Regulation 28 report that was addressed to the Commission following the inquest into the death of another service user at The Priory Hospital Roehampton. That visit would also take account of any further intelligence that is gathered or brought to the Commission's attention before that inspection. The planning of that inspection is also being coordinated with the Mental Health Act Commissioners' monitoring of the provider for the same purposes.

The Commission's proposed future regulatory response across Mental Health Services

In more general terms the Commission has published its intentions for a more specialised approach to the inspection of mental health services in both the NHS and independent sector. The changes are set out in a fresh start for the regulation and inspection of mental health services. An overview of the main changes proposed include as follows:

- Full integration of regulation and Mental Health Act (MHA) monitoring;
- Including Mental Health Act specialists on all inspections of mental health services;
- Inspection teams of specialist inspectors, experts by experience and professional experts;
- Ratings for mental health services – services will be rated outstanding, good, requires improvement, or inadequate;
- New ways of engaging with people who use services, their careers and families, during inspections and at other times;
- Greater focus on community mental health services;
- Making sure we have better information about mental health services and developing our intelligent monitoring system for these services;
- Looking at how people are cared for as they move between services;
- Recognising that mental health treatment and support is part of services in all sectors;
- The appointment of new Chief and Deputy Chief Inspectors of Hospitals. This includes the appointment of [redacted] as Deputy Chief Inspector of Hospitals with a portfolio of mental health services. It is hoped that those appointments will provide important specialist leadership for our regulatory and MHA monitoring roles.

It is hoped that the proposed changes will help identify poor mental health care and point to interventions when things need to be put right. We are testing out our new methodology with "Wave 1" inspections of NHS mental health trusts occurring during this financial year. We hope to learn from these inspections to ensure our regulatory responses are robust, proportionate and sustainable.

In our most recent annual report on the use of the Mental Health Act, we have also stated our expectation that we hope to see improvements in certain key areas including an expectation that Commissioners and providers of mental health services being proactive in initiating and embedding learning from the deaths of people subject to the Mental Health Act. We expect to see alignment of local preventative and investigative work with the national findings on mental health related deaths. This includes emerging guidance from national bodies and the use of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness toolkit. We expect services to notify us of deaths of detained patients and patients who are on a community treatment order at the time of their death.

The Commission has also identified five key areas of action. These are in line with, and complement, our strategic intentions including recognising that people in the care of specialist mental health services are a high risk group for suicide and unidentified, poorly treated or preventable physical ill-health. We are concerned about how services respond to, review and report on deaths, so we are committing to include the information we hold on deaths in psychiatric detention in all future annual reports. We will work with partners, including NHS England and the National Confidential Inquiry into suicide and homicide by people with mental illness, to look at how we can do this in a way that offers better intelligence and opportunities for shared learning and preventative action. The Commission will also work with key partners in developing the Mental Health Crisis Care Concordat. This will focus attention on the issues that have been highlighted around emergency mental health care. The Commission has committed to delivering a thematic programme around the experiences and outcomes of people experiencing a mental health crisis, and will take this forward over the course of 2014 with the intention of publishing a national report in the autumn.

Conclusion

We greatly value the intelligence that you have provided us in your report. The information contained informs our intelligence mechanisms, which in turn directly influences the planning for future inspections, both in respect of The Priory Hospital Roehampton specifically as well as elsewhere. In broader terms it also informs broader policy discussions within the Commission in relation to considerations about improvements to our regulatory approach.

Please do not hesitate to contact us with any questions or concerns.

Yours sincerely

[redacted]

[redacted]
Interim Head of Hospital Inspections (Mental Health)
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