Care Quality Commission

A fresh start for the regulation and inspection of mental health services

Working together to change how we regulate, inspect, and monitor specialist mental health services

The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work
- We are independent, rigorous, fair and consistent
- We have an open and accessible culture
- We work in partnership across the health and social care system
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others
- We promote equality, diversity and human rights

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Foreword from the Chief Executive

During the past six months we have set out a new vision and direction for the Care Quality Commission in our strategy for 2013-2016, *Raising standards, putting people first* and in our consultation, *A new start*, which proposed radical changes to the way we regulate health and social care services.

We developed these changes with extensive engagement with the public, our staff, providers and key organisations. Stakeholders in the care sectors have welcomed our proposals, which include the introduction of chief inspectors; expert inspection teams; ratings to help people choose care; a focus on highlighting good practice; a more tailored approach for the sectors; and a commitment to listen better to the views and experiences of people who use services.

In May 2013, we established an expert advisory group to help us develop the detail of our approach for specialist mental health services. This group has been significant in helping us shape the proposals we outline below. Our mental health programme will continue to engage with members of this group, people who use services, and with other interested individuals and organisations to develop, test and evaluate our plans to make sure these work for the sector.

This document sets out the conversations we want to have with all our stakeholders in the mental health sector and signals our commitment to develop changes with them. It sets out our priorities for improving how CQC monitors, inspects and regulates specialist mental health services. We describe how CQC will work with people who use services their families and carers, providers, and other organisations to deliver these priorities.

The responses to *A new start* demonstrate that there is strong support for the new framework, principles and operating model that we will use, including the five key questions that we will ask of services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive?
- Are they well-led?

We are clear, however, that we will recognise differences within sectors and will develop our model for each of them accordingly – especially considering the diversity and complexity of this sector.

For mental health services, we are giving particular thought to how we bring together our specific responsibilities in monitoring the operation of the Mental Health Act with our wider regulatory responsibilities. This is particularly important given that people who are detained under the Act are the only group of people who can be treated

against their will – so it is critical that we use both our regulatory and Mental Health Act monitoring powers to protect their rights and interests. And as with other sectors, we will promote equality, diversity and human rights and ensure that our new approach is underpinned by these principles. This is particularly in view of the known health, social and economic inequalities experienced by people with mental health problems and people with a learning disability or autism.

The programme of work set out in this document is hugely important. It will help us to make sure that we deliver our purpose for people who use specialist mental health services – to make sure these services provide people with safe, effective, compassionate, high-quality care and to encourage them to improve. If we can achieve that it will improve the lives and experiences of people who use mental health services, their carers and families.

David Behan
Chief Executive

Introduction from the Chief Inspector of Hospitals

We have started to put in place the changes in our strategy, *Raising standards, putting people first*, and our consultation, *A new start*. They will enable us to deliver our purpose – making sure health and social care services provide people with safe, effective, compassionate, high-quality care and encouraging services to improve.

In our strategy we said we would strengthen our focus around the Mental Health Act, the Mental Capacity Act, and Deprivation of Liberty Safeguards to protect some of the most vulnerable people in society and those in vulnerable circumstances, particularly those who have had their freedom restricted by being detained and treated against their will. We said we would improve the links between our work under the Mental Health Act and how we regulate mental health services. Our aim is to make sure that our regulation of services and Mental Health Act monitoring work together effectively for people.

In *A new start* we said that we will inspect and regulate different services in different ways, based on what has the most impact on the quality of people's care. However, there are some general principles that guide our future 'operating model.' They apply to:

- The way we register those that apply to CQC to provide health and care services.
- The standards that those services have to meet.
- How we use data, evidence and information to monitor services.
- How we work with and hear from people who use services, their carers and families in our work.
- The expert inspections we carry out.
- The information we provide to the public on our judgements about care quality, including a rating to help people compare services.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

These principles will guide our regulation and inspection of the mental health sector but the detail will be specific to the sector. We will ask our five key questions of all services – are they safe, effective, caring, responsive to people's needs and well-led. As Chief Inspector of Hospitals, and with my Deputy Chief Inspector of Mental Health, when appointed, we will lead expert inspection teams. These teams will spend more time listening to people who use services, carers, advocates and staff. They will use professional judgement supported by objective measures to assess the quality and safety of care to help improve the experiences of those who use specialist mental health services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

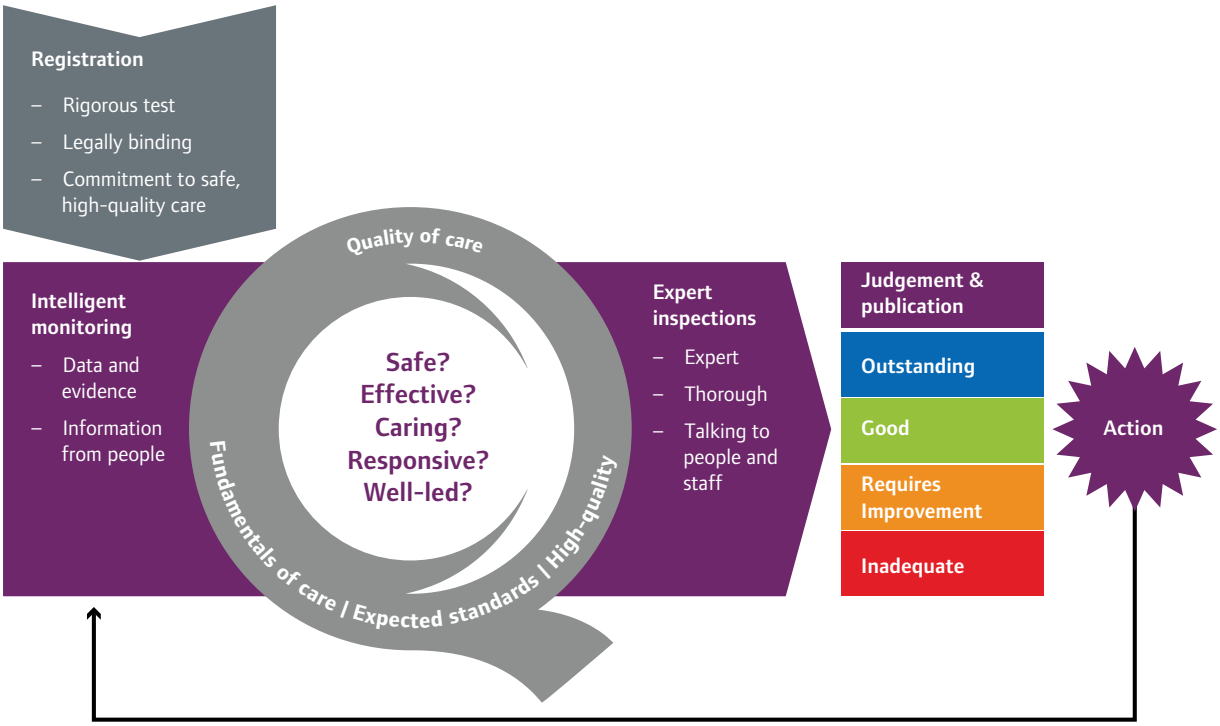
Developing our new approach for specialist mental health services

Monitoring, regulating and inspecting mental health services

Our consultation, *A new start* set out the principles that guide how CQC will inspect and regulate all care services. It described our future 'operating model' which includes:

- Registering those that apply to CQC to provide care services.
- Intelligent use of data, evidence and information to monitor services.
- Expert inspections.
- Information for the public on our judgements about care quality, including a rating to help people choose services.
- Publishing information about our ongoing monitoring of the Mental Health Act.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

FIGURE 1: OVERVIEW OF OUR FUTURE OPERATING MODEL



These principles guide our regulation of the mental health sector, but the detail of how we will do this will be specific to the sector and to the services within it.

Mental health services that the Chief Inspector of Hospitals will be responsible for

1. **Hospital services for people with mental health needs, learning disabilities and problems with substance misuse**

   These services are for people with mental health needs, learning disabilities or autism, who are admitted to hospital to stay for assessment or treatment. This might include providing care, treatment and support for people detained under the Mental Health Act 1983 (MHA) or by an authorisation under the Mental Capacity Act Deprivation of Liberty Safeguards.

   These services may also include inpatient treatment for people with problems with substance misuse.

2. **Community-based services for people with mental health needs**

   These services provide care, treatment and support in the community for people with mental health needs, through a wide range of services. They employ a broad range of health and social care professionals mainly in multi-disciplinary teams.

   Community services may also have certain responsibilities to people subject to the Mental Health Act.

Our mental health programme will also develop our new approach to residential treatment for people who misuse substances and/or rehabilitation services and community-based services for people who misuse substances. We will publish a separate document like this about these services early next year. We will also consider the needs of people with problems with substance misuse and mental health needs within the development of our model for mental health services.

The Chief Inspector of Hospitals will oversee the regulation of services for people with a learning disability or autism who are receiving specialist inpatient care and community-based health services for people with a learning disability or autism. However, our Chief Inspector of Adult Social Care will oversee community-based social care services, which cover most of the care provision for people with a learning disability. We will be looking at the experiences of people with a learning disability across the sectors we regulate, by working with people with a learning disability, their families and the groups that represent them.

We recognise that mental health treatment and support is an important component of services in other sectors. This is particularly the case in primary care where the vast majority of people who have mental health needs are supported but also, for example, in services provided by A&E departments and as part of prison health care. We are also aware that people with learning disabilities, dementia, acquired brain injuries or neurological conditions also require treatment for conditions that are not related to their primary mental health needs in acute hospitals and other health settings. They may also lack capacity to consent to interventions that are offered. For people in these circumstances, we will look at how to balance respect for their independence with the need to find the least restrictive way to protect someone within the framework of mental health legislation.

Our new approach will develop mental health 'modules' to support our inspections of services that our two Chief Inspectors of Adult Social Care and Primary Care are responsible for. This will include where we carry out joint inspections with other inspectorates. For example, our Chief Inspector of Primary Care will oversee prison health care services; our mental health programme will develop the modules for mental health and substance misuse services in prisons to support our joint inspection work with Her Majesty's Inspectorate of Prisons. We will also support

the wider incorporation of the Mental Capacity Act into community and inpatient settings. For example, we will ensure that providers know when they must instruct an independent mental capacity advocate for people lacking capacity to make specific decisions at the time they need to be made.

Developing our new model in partnership

We are committed to developing changes to how we monitor, inspect and regulate in partnership. We have been discussing our ideas for change with a range of stakeholders including people who use services, providers, voluntary sector organisations, our staff and other interested individuals and groups to help develop our thinking.

We have established an expert advisory group to work with us to develop our proposals. This group has given us a helpful steer on the overall model, the key themes and data sources we should consider for our intelligent monitoring model of mental health services, and how inspection might work in mental health. They have also raised some useful challenges about how our approach will work for providers of complex services. We have engaged members of this group and other colleagues in more detailed discussions on quality in mental health, which services to always inspect, how to involve people who use services in our new inspections, indicators for our intelligent monitoring for mental health and ratings for mental health services.

Our next phase of partnership working to develop the new approach will involve working with small groups on time-limited projects. These groups will develop:

- The questions that will underpin our regulatory judgement about mental health services.
- Definitions of 'what good looks like' in mental health.
- The methods we will use when we inspect.
- The indicators that will trigger follow-up as part of our intelligent monitoring of specialist mental health services.
- The guidance we will share with providers about the new model.

People who use services are represented on our expert advisory group, as well as in the smaller group projects, but we are also working with specific groups to discuss aspects of our new approach. These include our Service User Reference Panel of people with experience of detention, local Healthwatch groups, foundation trust governors from NHS trusts that provide specialist mental health services, and representatives from local and national advocacy organisations.

We will build on the work we have already done to involve people who use mental health services and their carers to advise us on what to look at during inspection, how to gather and use information, and what methods will work best to secure people's views. They will also continue to take part directly in inspections and advisory groups.

Focusing on the issues that matter

At the heart of our new approach is our commitment to tailor our inspections on the issues that matter in each sector, while setting it within our overall framework of whether services are safe, effective, caring, responsive and well-led. Protecting the rights of detained patients is particularly significant for CQC, not only because of our dual responsibilities under the Mental Health Act and Health and Social Care Act, but also because this is the only group of people who are treated against their will. Therefore, focusing on the rights and the experience of people subject to detention is critical.

Our new model for specialist mental health services will also reflect national policy priorities for mental health. In particular, it will reflect a key aim of the Government's mental health outcomes strategy to improve outcomes for people with mental health problems through access to high-quality services and by achieving parity of esteem for mental health as for physical health and other care services. We know there are a number of areas of concern that we should focus on through our monitoring, inspecting and regulation of specialist mental health services, for example:

- Deaths under mental health care – people in the care of specialist mental health services are a high-risk group for suicide; unidentified, poorly treated or preventable physical illness contribute to premature mortality; and there are specific concerns, such as deaths caused by restraint.
- The experience of people who have a mental health crisis or who are admitted to hospital – the availability and responsiveness of services to supporting people through crisis and preventing admission to hospital; and growing numbers of people being admitted to hospital far away from their home area because of severe pressures on their local acute or admission wards.
- Transitions and interfaces between services – including the transitions between child and adolescent mental health and adult mental health services; between services for adults and older adults; and interfaces between services for people in contact with the criminal justice system who have mental health needs.

We will also consider the lessons from other key reports and findings, such as the lessons of Robert Francis' Report for mental health on safety, transparency and responding to people who use their services and their families and carers, the implications of Don Berwick's report on patient safety and continue our ongoing involvement in the delivery of the Winterbourne View Concordat.

We will develop our new approach to take account of these issues as we inspect and rate services (as safe, effective, caring, responsive and well-led). We know that within the current climate there are significant challenges for providers of specialist mental health services but we will keep a focus on the impact of care, identifying where improvement is needed. We recognise that some factors that contribute to poorer care are outside a provider's control and we will take this into account where this is the case.

How we are developing the new regulatory approach

People responding to our consultation helped us to work out the most important changes we need to make to improve the way we regulate mental health services. We set out our early thinking on this below and would welcome comments on our proposals for change

- **Full integration of regulation and Mental Health Act (MHA) monitoring.** People told us that they supported our proposal to integrate our Mental Health Act (MHA) monitoring with our wider regulatory model for mental health. As well as increasing our access to expertise, skills and knowledge, we anticipate a number of other benefits including:
  - Improving our ability to assess the quality and safety of services and to take regulatory action when we find care that is inadequate or requires improvement, including a failure to comply with the MHA or where appropriate the Mental Capacity Act to safeguard people's rights and interests.
  - Improving collaboration and action across the system in response to the combined findings of our inspections and MHA monitoring.
  - Building confidence among providers and people who use services by combining our findings in a single report. This will also help to promote public understanding and awareness of the experiences of people who are detained and influence wider policy debates locally and nationally.
  - Strengthening our 'intelligent monitoring' of providers by sharing information and data collected through our monitoring and inspection approaches (see 'Better use of data and intelligence' later in this document).
  - Producing more consistent information on the operation of the MHA. This is important to the wider mental health sector because the restrictive nature of the MHA often shines a spotlight on the most difficult or pressurised areas of the system including admission, assessment, community support, transfers and discharges.
  - Ensuring that safeguards to protect people whose rights are restricted under the MHA are upheld and that our assessment of whether a provider is 'well-led' reflects the focus of the leadership within an organisation on promoting effective operation of the MHA.

We will take more time to listen to the experiences of people who are subject to the Mental Health Act by carrying out extra visits and will publish information about our ongoing monitoring of the MHA. We will also involve those with experience of care – Experts by Experience, to talk to people who are detained and to meet with their families. The information we gather through these visits will inform the questions our wider inspection teams ask providers. These teams will always have expertise on the operation of the Mental Health Act.

- **People's views and experiences of care** – we will make greater use of information from people who use services, employing new methods to do so and learning from best practice. We have had consistent feedback about the importance of giving particular weight to information we receive about people's experiences in the judgements we make about the effectiveness and responsiveness of mental health services. We will gather this information through a range of sources including:
  - Increased time spent talking with people who are subject to the MHA.
  - Increased involvement of Experts by Experience in our inspections and visits to people subject to the MHA.
  - Using external sources of information from other organisations – for example, advocacy services (including independent mental health advocacy and independent mental capacity advocacy), Healthwatch, local community groups – as well as providers' own reviews and national surveys.
  - Greater focus on engaging with people who use community mental health services, including services for older people with dementia and for people with learning disabilities or autism.
  - Greater focus on gathering the views of carers.
  - Social media, including Twitter, Facebook, and relevant discussion forums. We will use these platforms proactively to share information, interact and engage with individuals, user groups and organisations.

- **Complaints made by people who use services** will form a key source of information within our new model. We already consider the formal complaints made by people whose rights are restricted under the MHA (or their representatives) about the way staff have used their powers under the Act. Although we are not able to follow up formal complaints on behalf of other individuals, we will place more emphasis on the content and trends in complaints made and will also consider how complaints are handled and responded to by providers. We will trial a new approach to look at complaints in our pilot inspections of mental health providers.

- **Expert inspectors, with specialists and Experts by Experience as part of inspection teams.** We are moving our approach away from our inspectors being responsible for a wide range of providers to a model where inspectors specialise in particular sectors. This means that inspectors will have specialist knowledge of mental health services to inform their regulatory judgement. We will also ensure that we have expertise in the Mental Capacity Act, in particular the Deprivation of Liberty Safeguards, as well as ensuring that CQC teams include experts in the operation of the MHA.

  We will also include professional experts from the field in our inspection teams, drawing from the range of disciplines that work in this sector (including nurses, social workers, doctors, occupational therapists, psychologists, pharmacists and other therapists) who will bring current practice knowledge and expertise to the inspection process. We will include more Experts by Experience in our inspection teams, including people with experience of detention under the MHA and people with a learning

disability, to ensure that the voice of people who use services is heard and has a key impact on our assessments and judgements about services and practices in the sector.

- **Consistent focus on core services across all providers where there are known inequalities, or where people are in especially vulnerable circumstances.** Feedback from our consultation has emphasised that inspection should always cover both inpatient and community-based services where these are provided. We have had some suggestions for what these core services should be and will use our first pilot inspections to test and refine the list of these, which are:
  - Acute admission wards (all units across all age groups).
  - Psychiatric intensive care units and health-based places of safety (all units/ health-based places of safety).
  - Long stay/forensic/secure services (all units).
  - Child and adolescent mental health services (inpatient and community).
  - Services for older people (all inpatient services that are not acute admission wards and a sample of community services).
  - Inpatient services for people with learning disabilities or autism (all units) and community learning disability and autism services provided by a mental health provider (sampling approach to be applied).
  - Adult community-based services (sampling approach to be applied).
  - Community-based crisis services (all services).
  - Specialist eating disorder services (all services).

  Where other specialist mental health services (such as services for people who are deaf) are provided, we will ensure that these are considered for inspection. Also, we will inspect other services that are not on the core list where our intelligent monitoring or other information has alerted us to concerns.

  We are proposing to inspect a minimum of a third of all services where we have indicated that a sampling approach will be applied. Through our ongoing engagement and piloting, we will test whether this is the right level of services to sample and whether this approach could be applied for other core services.

  We are also continuing to explore other ideas and options for core services, including whether the pathways of care developed for mental health Payment by Results could offer an alternative framework for selecting services to inspect. We are also considering whether to focus on the experience of certain groups, depending on the population served by the provider and how services are organised to meet their needs. This might include, for example, people who have complex needs such as a learning disability, substance misuse problems or physical health problems, as well as mental health needs, or people who self-harm or those who services find hard to engage.

- **Focus on transitions, care pathways and joint working,** including where people move between services and where care is provided in an integrated way. Transitions between services will include moving between services within the provider – such as between children and young people's and adult services or between adult and older adult services – as well as between providers – such as the transition between primary and secondary care or between independent sector and NHS services.
- For the providers we regulate, this will mean looking at the timeliness of responses and the way they work with other providers to achieve positive outcomes for people who use services. This includes integrated working to address physical as well as mental health needs; to promote recovery, health and wellbeing; to prevent or respond appropriately to crisis; and to achieve quality of life, including in relation to housing, employment and social participation.

- In the first year, this will include themed work on the experience and outcomes for people experiencing a mental health crisis. This will help us to build tools and develop methods to incorporate in our new inspection approach to ensure that consideration is given to the quality, safety and responsiveness of care provided to people experiencing a mental health crisis in the future.

- **Clarify how national standards and guidance relate to the five key questions we ask of services** – are they safe, effective, caring, responsive and well-led – with people's experience of services at the core. In consultation with experts, including people who use services, we will describe standards based on 'what good looks like' for each service type or service segment (for example an acute admission ward in a mental health hospital). We will also develop lines of enquiry that reflect the key issues and priorities for the sector including:
  - Promoting recovery, good mental and physical health.
  - Preventing suicides and deaths in care that could be avoided.
  - Ensuring that people have a positive experience of care.

  We will also scrutinise care that leads to isolation and dislocation for people, such as out of area placements, which should encourage services to have strong links to local communities.

- **Ratings.** There was support in our consultation for a rating using the following principles:
  - Ratings will follow an inspection.
  - Ratings will be made on a four-point scale (outstanding, good, requires improvement and inadequate).
  - Ratings will be given at a level where it is most meaningful to the public (for example whether at corporate, location or service level).
  - Ratings will also be given for each of the five key questions we will ask of all care providers.
  - Ratings will benefit a wide audience including people who use services and their carers, the public, providers, commissioners and other stakeholders.
  - Providers can appeal their ratings on the basis that CQC has not followed due process.

  Our approach to rating healthcare providers needs to recognise the complexity of both the NHS and independent healthcare sector and the similarities and differences between services. We will be testing how best we can rate these complex providers of multiple services as we carry out these inspections. We will be engaging with providers and people who use services to help us with our approach during this period.

  For NHS trusts that combine a diverse range of services, we will look to come to a rating for a set of core services within each sector (such as mental health or community health). We will then use this information to help us come to a judgement on what this means for the quality of service provision for a provider overall.

- **Frequency of inspections based on ratings.** The frequency of our inspections will be based on our ratings of a service. However, we will be able to bring forward an inspection of a provider rated 'good' or 'outstanding' if we receive concerns from people who use the services, staff or others, or if we are alerted to a potential decline in quality through from our intelligent monitoring analysis.

  We will continue with additional specific visits to talk with people subject to the Mental Health Act. These visits remain important for safeguarding individual patients whose rights are restricted, and reviewing how legal powers of compulsion are being used. The frequency with which these visits take place will not be dictated by a provider's rating.

- **Greater focus on community-based services – especially the experience of those on community treatment orders.** Our inspections so far have tended to focus on hospitals. Until recently, there has been a lack of clear guidance on our approach to inspecting community mental health and learning disability services (although we carried out a pilot of inspection methods for community-based services earlier this year). We recognise the importance of community services to people's experience of care and will increase our focus on these services through our inspections.

  We have made relatively few MHA visits focusing on people receiving supervised community treatment. We will increase the number of these visits and expect that such visits will routinely involve Experts by Experience.

  We will look more closely at how services work with other organisations that are important in supporting recovery in mental health, such as housing and criminal justice.

- **Better use of data and intelligence** – including information from whistleblowers and the findings of others, such as Healthwatch and third sector organisations, and national surveys. In our operating model, we refer to all of the key information we will bring together as 'intelligent monitoring'. This will be continually updated and reviewed on an ongoing basis.

  We are developing sets of indicators under each of the five key questions, and will be testing them with experts, including people who use services, to ensure that we are collecting information about aspects of services that matter most to people's experience of care. We recognise the importance of positive risk management in mental health when making assessments about safety and risk. Qualitative data will be a strong component in our regulatory model for mental health and learning disability to ensure that appropriate weight is given to people's views and experiences.

  The data we use to inform our lines of enquiry and judgements of service providers will include information and indicators based on national data sets such as the Mental Health Minimum Data Set and the statistics collected by the Information Centre for Health and Social Care on Mental Capacity Act Deprivation of Liberty Safeguards.

  We will also do more work in the four to six weeks before inspections to gather information, particularly where there are identified gaps, to inform which services to inspect and the focus of our inspection. This may include gathering information about the safety culture, quality governance, the views and concerns of people who use services, their carers and representatives and staff and the support provided to people who have complex needs.

What these changes will mean for people using services

We anticipate that the changes we are making to our regulation of mental health services will mean:

- Making it easier for people who use services, their families, carers and advocates more to share their experiences of care.
- A greater focus on the voices of people who use services in our new inspection process – particularly through better involvement of Experts by Experience in reviewing the information and intelligence from people who use services, shaping the lines of enquiry, gathering feedback from people who use services and carers and providing a user-focused perspective throughout the inspection.
- Better engagement with organisations representing local groups of people who use services and the voluntary sector to share their perspectives on the quality of care.
- Improved assessments of specialist mental health services by inspection teams, focusing more on the issues that matter to people who use the service and how people's rights are protected.

- Greater clarity about how services compare, where possible to inform choice among people who use services and carers.
- In the longer term, improved quality of service provision where problems are identified and improvement action required.

Second Opinion Appointed Doctors

CQC is responsible for the provision and management of the Second Opinion Appointed Doctor (SOAD) Service, a statutory function within the Mental Health Act. The SOAD service safeguards the rights of detained patients who either refuse the treatment prescribed to them or who are assessed as lacking mental capacity to consent to the proposed treatment plan.

CQC appoints SOADs who are totally independent of the treatment team. SOADs decide whether due consideration has been given to the views and rights of the patient, and whether the proposed treatment is appropriate and should be given. The service receives around 15,000 requests for second opinions every year. Around a fifth of visits by SOADs result in a change to the patient's treatment plan.

While we are changing our inspection model, the SOAD service will continue. However, to support the changes, we are developing the means by which intelligence received through the service will contribute to our new inspection model. We are currently carrying out an audit of prescribing practices for detained patients with a learning disability, using data from SOAD visits. We will use this learning to assess how we can capture the data arising from such visits to inform our future monitoring.

What will happen next?

We will engage with people who use services, families and carers, Experts by Experience, provider representative groups and stakeholders. This engagement will help us develop the thinking and co-produce the content for our assessment framework for specialist mental health and learning disability services.

To support that engagement:

- We have established an external mental health expert reference group to help us with our thinking. The membership of that group includes representatives of provider networks, professional bodies, academics, Experts by Experience and some of our key partners in mental health. We will also establish a reference group to help develop our approach to inspecting and regulating specialist health services for people with a learning disability or autism and a separate reference group to support the development of our approach to specialist substance misuse treatment services.
- We will establish time-limited groups to help us to develop particular aspects of work, for example the five key question areas, the methods we use on inspection and the intelligent monitoring indicators. These groups will include our own staff, Experts by Experience and external stakeholders.
- We will also engage the public through focus groups, through local Healthwatch, and through our networks of groups representing people whose voices are seldom heard.
- We will keep people updated on what the engagement is telling us.
- We will begin to pilot our new inspection approach, starting with the NHS, but will expand this to other specialist mental health providers, including independent sector services. In our first wave of pilot inspections, we have selected five trusts that provide some or all of the identified cores services, including one trust that also provides community health services where we will carry out a joint inspection. These inspections will run in parallel to the first wave of community health service inspections. We have given priority to selecting trusts that are aspiring to be foundation trusts for this first wave unlike the first wave of inspections of acute hospitals where the sample was selected on the basis of known risks. The five trusts we have selected that provide specialist mental health services are:
  - Coventry & Warwickshire Partnership NHS Trust
  - Devon Partnership NHS Trust
  - Dudley & Walsall Mental Health Partnership NHS Trust
  - South West London & St George's Mental Health NHS Trust
  - Solent NHS Trust.

  We appreciate how important it is for NHS providers that are seeking to attain foundation trust status and will endeavour to balance this with risk-based considerations during our pilot inspections.

Current proposed timeline for changes to the mental health sector

We want to make the improvements we have identified quickly, but without compromising the time available for co-production and quality. Our proposed timeline and activities are set out below:

November 2013 – March 2014:

- Engagement with internal and external stakeholders on the five key question areas, the intelligent monitoring indicators and methods
- Meetings with the external advisory group and other working groups
- Development of pilot inspection methodology
- Wave 1 pilot inspections of NHS trusts providing specialist mental health services – starting in January 2014 – with ongoing evaluation of the new approach and methods
- Formal consultation on guidance for the new regulations and CQC's enforcement policy; information on the Single Failure Protocol published for information (may be subject to change)

April – June 2014:

- Wave 2 pilot inspections begin
- Draft handbook for providers of specialist mental health services published for information
- Final versions of the regulations guidance and CQC enforcement policy published

July – September 2014:

- Initial shadow ratings of some services shared with pilot providers
- Publication of intelligent monitoring information for mental health providers
- Final handbook for providers of specialist mental health services published for information

October 2014:

- New model rolled out to all providers, including the use of ratings

Although this is not a consultation, we would like to hear your views on any of the proposals and changes that we have set out in this document. If you would like to get in touch, please contact us at at **cqcinspectionchangesMH@cqc.org.uk**

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