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BY EMAIL and POST

Care Quality Commission
Re: Inquest into the death of Mr Ozan Atasoy

Dear Mr Thomas

Thank you for your letter dated 9 April 2014 in which you wrote to us under the provisions of Regulation 28 of the Coroners (Investigations) Regulations 2013 in relation to the inquest into the death of Mr Ozan Atasoy.

We are extremely saddened to hear of Mr Atasoy's death and of the circumstances surrounding his death. We are also grateful for your report in highlighting concerns and issues that which can now be fed into the intelligence monitoring systems to improve our regulation of health care providers, and in particular those involved in mental health care.

We confirm that the contents of your report, and the issues identified therein, will be disseminated within the CQC and in particular in relation to inspections of hospitals built in a similar way to Queen Elizabeth II Hospital. The issues will be fed into the intelligent monitoring systems that allow us to monitor services and also to plan and carry out future inspections. It is intended that the contents of your report in this case will form evidence that will be fed into the key lines of enquiry that form the core of our revised approach to the monitoring and regulation of mental health services.

We also confirm our satisfaction with the improvements that have been implemented by the trust in this case following the death of Mr Atasoy in order to address the issues that were highlighted during the course of the inquest, and in your report. The implementation of those actions would be considered during the course of our next inspection of the provider.

We have now published our 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. We are confident that they will provide a more robust approach to monitoring and inspection which would not only improve the identification of the sorts of issues identified in your report leading to the death of Mr Atasoy, but also enhance the resolution of those issues by providers. We set out an overview of the main changes proposed:

- 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; and
- 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 also hoped that the changes will help improve our identification of poor mental health care and point to interventions when things need to be put right. We have been testing out our new methodology with "Wave 1" inspections of NHS mental health trusts occurring during this and the last financial year. We have learnt lessons from those inspections which are now being fed into "Wave 2" 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 which we are confident will improve the identification and resolution of the sorts of issues that arose in this case. Those areas of action 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 rest of 2014 with the intention of publishing a national report in shortly in the autumn.

As part of the new inspection methodology for specialist mental health services a set of standard key lines of enquiry ('KLOEs') have been developed for use in inspections of mental health trusts. It is intended that a standard set will also ensure consistency of what we look at under each domain, which is vital for reaching a credible comparative rating. By way of background the standard KLOEs are underpinned by a series of prompts. Those prompts will be considered to be a guide as to what to inspect in order to answer the KLOE. The main prompts addressing the sorts of issues raised in your report would be as follows:

1. In relation to the height of the fence, security door opening mechanisms, the door release and the provision of CCTV, the following proposed prompts in particular would be considered within the context of assessing Safety:

   S2.1: Does the design, layout and maintenance of services enable safe clinical practice?

   S2.2: How does the provider ensure that people who use services are protected from harm, neglect or abuse? What safeguarding arrangements are in place? How are people using services encouraged to report abuse and involved in safeguarding decisions about themselves?

   S2.5: How does the provider manage positive risk-management? Is the provider risk averse? How proactive are staff in implementing positive risk-management? Are restrictive practices which have an impact on the freedom of people who use services minimised?

S3.3 Are there individually tailored care plans in place that help the person who uses services to minimise any risks to them?

2. In relation to observations, proposed prompts have been designed within the context of the evaluating how services understand and manage risk to persons using the service. We intend for the following prompts in particular to assist in assessing whether an observation policy for service users would be sufficiently robust, up-to-date and specific to service users:

   S3.1 Are people who use services supported with comprehensive risk management and offered a multi-disciplinary assessment at an early opportunity?

   S3.2 Does the assessment include:

   - *the person's physical health*
   - *risks to self or others*
   - *side effects of medication*
   - *individual biography*
   - *involvement of the person themselves in assessing risks*

   S3.3 Are there individually tailored care plans in place that help the person who uses services to minimise any risks to them?

3. In relation to staffing levels, we do not prescribe the particular number of staff members that are being employed to meet patients' needs, or particular staff-patient ratios. Rather, our assessment of whether essential standards of care are being met in this respect is based on considering the sufficiency of properly skilled staff to meet patients' particular needs. The following proposed prompts would be most relevant to under the new methodology in assessing whether the provider ensures that staffing levels and quality of staffing enables safe practice:

   S4.1 How does the provider ensure that staffing levels are sufficient to meet dependency needs at any given time? How does the provider ensure that no restrictive practice takes place?

   S4.2 How often are agency staff used? How does the provider monitor the quality of services and number of incidents in services which use agency staff?

   S4.3 How does the provider ensure that staff are skilled and trained to provide safe services? How does the provider ensure safe recruitment?

   S4.4 What are staff sickness levels and how does the provider monitor impact on other staff members and the service provided to people who use services? How does the provider monitor staff sickness levels as an indicator of staff stress?

4. In relation to the issues relating to the provision of occupational therapy and the named nurse system. The following proposed prompts in particular would be considered within the context of assessing effectiveness:

Evidence-based, assessment, care and treatment in line with recognised guidance, legislation, standards and best practice, for example:

- *NICE/SCIE quality standards and guidelines*
- *Mental Health Act 1983*
- *Mental Capacity Act 2005*
- *guidance published by professional and expert bodies*
- *national strategies and programmes*
- *Ensuring informed consent*
- *Assessment of Gillick competency of children and young people*
- *Assessment and care planning*
- *Assessment and recording of capacity and consent*
- *Supporting people to make choices and informed consent*
- *Review of care and treatment, through:*
- *Local audits*
- *National audits*
- *Monthly performance dashboards.*

Appropriately qualified, inducted and competent permanent, temporary and night staff.

- *Training and professional development including:*
- *Induction*
- *One-to-one meetings*
- *Appraisals*
- *Identifying learning needs*
- *Coaching and mentoring*
- *Clinical supervision.*

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 Trust 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 faithfully

Care Quality Commission