Royal Commission into
Victoria's Mental Health System

WITNESS STATEMENT OF DR KEVIN CLEARY

I, Dr Kevin Cleary, Deputy Chief Inspector of the Care Quality Commission (**CQC**), 151 Buckingham Palace Rd, Victoria, London SW1W 9SZ, United Kingdom, say as follows:

1 I make this statement on the basis of my own knowledge and experience, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true and correct.

2 I am making this statement on behalf of the Care Quality Commission and have been authorised to do so by the CEO Ian Trenholme.

Background

Qualifications and experience

3 In 1985, I graduated from the University of Otago Medical School M.B.Ch.B and was fully registered as a Medical Practitioner with the Medical Council of New Zealand in November 1986. I subsequently undertook training in psychiatry at St Bartholomew's Hospital and received my Membership of the Royal College of Psychiatrists in 1993. I undertook further higher training in Forensic Psychiatry and became a consultant in the NHS in 1997. In 2003-2006 I trained in Child and Adolescent Psychiatry to become a Consultant Child and Adolescent Forensic Psychiatrist.

4 Between 1997 and 2007, I held a number of clinical posts at the West London Mental Health NHS (National Health Service) Trust as a Consultant Child and Adolescent Forensic Psychiatrist.

5 I have held a number of senior medical roles in England, including:

(a) Chief Medical Officer at the East London Foundation NHS Trust;

(b) Deputy Chief Executive Officer and Medical Director at North Middlesex University Hospital; and

(c) Medical Director at the National Patient Safety Agency.

6 In my previous role, I was the Deputy to the Director of Mental Health and Quality Improvement Lead for Mental Health at New Zealand's largest District Health Board, Waitemata District Health Board.

Please note that the information presented in this witness statement responds to matters requested by the Royal Commission.

7 In my current role as Deputy Chief Inspector of the CQC, I am responsible for the regulatory oversight of all registered mental health providers in England. I manage 5 Heads of Inspection who are responsible for regional teams that undertake the inspections and report preparation for each provider organisation. I am responsible for the final quality checks on reports, relationship management with the wider system and the presentation of information to parliament either by written report e.g. Annual Mental Health Act report or oral evidence to a select committee. I report directly to the Chief Inspector of Hospitals who is the board executive responsible for acute care and mental health.

8 Attached to this statement and marked 'Attachment KC-1' is a copy of my CV.

The Care Quality Commission

The role of the Care Quality Commission in regulating the quality and safety of public mental health services in England

Overview of the mental health care system in England

9 The mental health care system comprises a complex community-based division that caters for both adults and children, and a smaller hospital-based division. Most patients who receive in-hospital treatment for mental health issues are detained under the *Mental Health Act 1983* (**Mental Health Act**).

10 The majority of mental health patients in England receive community-based treatment. That is, they receive treatment in a voluntary capacity, usually in their own private accommodation. A very small number of patients are subject to a Community Treatment Order, which means there is some legal control of their community-based treatment. The use of the order is 10 per 100,000 of the general population.

11 Mental health care services are provided by organisations known as NHS Trusts, which are typically responsible for providing services in a defined geographical area. NHS Trusts must be registered with the CQC in order to provide mental health services.

Overview of the CQC

12 Prior to the introduction of the CQC about a decade ago, there was experimentation in England with a number of different models of health care regulation. The first models were based on an assessment of various aspects of governance (i.e. financial and clinical). After repeated serious incidents involving the quality of the care being provided at an organisational level, there was a move to regular comprehensive inspections and intelligence monitoring as the primary method of regulation. The role of the CQC, as the national health care regulatory body, is to regulate the provision of health care and social

care services. Each of the four nations in the United Kingdom has its own independent health care system, so the role of the CQC is confined to regulation of the English system.

13 The CQC employs approximately 3,500 staff across various divisions, including an operational division responsible for hospital care (including mental health services), a division responsible for primary mental health services and a division responsible for social care.

Regulatory standards

14 The CQC's regulatory role is governed by the *Health and Social Care Act 2008* (**Act**), and the accompanying regulations set out in the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (**Regulations**).[1] The Regulations set out various requirements which must be met by registered service providers, which include but are not limited to:

(a) **Person-centred care**: the care and treatment of service users must be appropriate, meet their needs and reflect their preferences (Regulation 9);

(b) **Dignity and respect**: service users must be treated with dignity and respect (Regulation 10);

(c) **Need for consent**: care and treatment of service users must only be provided with the consent of the relevant person (Regulation 11);

(d) **Safe care and treatment**: care and treatment must be provided in a safe way for service users (Regulation 12);

(e) **Safeguarding service users from abuse and improper treatment**: service users must be protected from abuse and improper treatment (Regulation 13);

(f) **Meeting nutritional and hydration needs**: these needs must be met where care or treatment involves the provision of accommodation by the service provider, or an overnight stay for the service user on premises used by the service for the purposes of carrying out a regulated activity (Regulation 14);

(g) **Premises and equipment**: all premises and equipment used by the service provider must be clean, secure, fit for purpose, properly used and maintained, and appropriately located for the purpose for which they are being used (Regulation 15);

[1] Regulations 9 to 19 in Section 2 of Part 3 of the Regulations set out the "Fundamental Standards" with which registered service providers must comply in carrying on a regulated activity (being an activity carried on in England that is prescribed as a regulated activity in Schedule 1 of the Regulations).

(h) **Receiving and acting on complaints**: any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation (Regulation 16);

(i) **Good governance**: systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part (Regulation 17);

(j) **Staffing**: sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part (Regulation 18); and

(k) **Fit and proper persons employed**: persons employed for the purposes of carrying on a regulated activity must be of good character, have the necessary qualifications, competence and skill, and be of sufficiently good health to properly perform tasks intrinsic to their work (Regulation 19).

Monitoring

Data collection

15 The CQC receives a large amount of data as part of its monitoring and oversight function as a regulator. Various NHS bodies, including NHS Digital (the national information and technology partner to the health and social care system) and NHS England and NHS Improvement (a recently merged body that previously operated as two separate bodies) are responsible for collecting, processing and publishing data from the health records of individual children, young people and adults who are in contact with mental health services. This data feeds into a number of national data sets that are then provided to the CQC in the form of monthly reports. One such data set is the Mental Health and Learning Disabilities Data Set (**MHLDDS**).[2]

Inspections

16 The CQC has a large team of about 60 to 70 inspectors (in mental health) who are authorised to visit the premises of registered service providers to conduct inspections. Inspections may be announced (in that advance warning is given to the service provider) or unannounced.

17 The CQC maintains regular contact with registered service providers via its inspection managers, who are each responsible for managing the CQC's relationship with a particular service provider. The aim of the CQC is to inspect every registered service

[2] The Mental Health Minimum Data Set was renamed Mental Health and Learning Disabilities Data Set following an expansion in scope (in September 2014) to include people in contact with learning disability services.

provider at least once a year, if they have been rated as "inadequate" or "requires improvement". There are frequency rules which vary the requirements depending on previous ratings. However, an unannounced inspection of a provider can be carried out at any time on the basis of intelligence received about the provider, for example, through whistleblowing.

18 In conducting inspections, the CQC rates each service provider in respect of five key lines of inquiry. These lines of inquiry are safety, effectiveness, responsiveness, caring (in the way patients are treated) and leadership. The scale ranges from "inadequate", "requires improvement", "good" to "outstanding". The CQC rates each service provider in respect of each kind of service they provide (such as mental health services or children's services).

19 Internally, the CQC uses a complex series of conditions and criteria in assessing a service provider in relation to each key line of inquiry. These conditions and criteria are not publicly available. However, the CQC has published an assessment framework in which it details the key lines of inquiry, prompts (or questions) that inspection teams may use in assessing providers in relation to each key line of inquiry, and ratings characteristics, which comprise detailed explanations of each of the above ratings as they apply in respect of each key line of inquiry.[3]

20 The inspection process also involves the collection of feedback, which may be sought from patients and relatives on site, but may also be provided via the CQC's website.

Monitoring the welfare of detained patients

21 Until 2010, there was a separate entity named the Mental Health Act Commission responsible for monitoring the welfare of patients detained under the Mental Health Act. In 2010, the Commission was abolished and its role was taken over by the CQC. The CQC now has a separate team of people known as "Mental Health Act reviewers" who visit hospital wards to interview patients detained under the Mental Health Act. The CQC also deals with complaints from detained patients (but does not deal with complaints from patients not detained under the Mental Health Act).

[3] The assessment framework, titled 'Key lines of enquiry, prompts and ratings characteristics for adult social care services', was last updated in 2017 and is available at <https://www.cqc.org.uk/sites/default/files/20171020-adult-social-care-kloes-prompts-and-characteristics-final.pdf> [accessed 2 July 2020].

Actions open to the Care Quality Commission where it finds that a mental health service provider is not meeting the expected quality and safety standards

22 The CQC may take a number of different actions if it rates a registered service provider as "inadequate" or identifies some other concern in relation to one of its five key lines of inquiry.

23 These actions include:

(a) Issuing a requirement notice to the service provider which requests that the service provider address the issue identified by the CQC;

(b) Issuing a warning notice to the service provider which must be publicly displayed by the service provider (and which also requests that the issue identified by the CQC be addressed);

(c) Placing a condition on the registration of the service provider (restricting a particular aspect of the services provided by the service provider);

(d) Seeking to procure the issue of a fixed penalty notice to the service provider;

(e) Issuing a simple caution (a formal written record that an offence has been committed (either under the Act or the Regulations) that is typically issued instead of pursuing a criminal prosecution);

(f) Commencing criminal proceedings against the service provider; and

(g) Taking action to close down the service provider.

Receiving and responding to complaints about mental health service delivery

24 The CQC uses the complaints it receives to inform its approach to taking regulatory action.

25 The only patient complaints that the CQC formally investigates are those concerning the use of compulsory treatment under the Mental Health Act in relation to a particular patient in hospital. All other complaints are referred back to the provider for internal investigation or, if the complaint cannot be resolved internally, it may be referred to the Parliamentary and Health Service Ombudsman.

Improving the quality of care provided by mental health service providers

26 The CQC is not directly responsible for improving the quality of care provided by registered service providers. However, the CQC's ratings of service providers, which are made publicly available, do tend to motivate service providers to improve the quality of services they are providing. I have noticed that, over the last five to six years, the ratings given by the CQC to mental health service providers have improved. About three years

ago, there were only two mental health service providers rated as "outstanding" by the CQC, whereas now there are about five or six.[4]

27 NHS Improvement, which merged with NHS England on 1 April 2019 to operate as a single organisation, is the body primarily responsible for improving the quality of care provided by service providers.

Advantages and disadvantages of the English approach to the regulation of mental health services and other health and social services

Advantages of the existing system

28 Transparency is a major advantage of a publicly funded system. All of the CQC's ratings of registered service providers are made publicly available, which means there is a clear understanding of how the regulator regards service providers, particularly in relation to the quality of care they provide.

29 In my view, the current English system is more comprehensive than the New Zealand system, which does not publicly rate provider organisations. The New Zealand system is much more orientated towards quality improvement than regulatory intervention.

Disadvantages

30 One disadvantage of the current system is the bureaucratic nature of conducting regulatory activities as a publicly-funded body with a large workforce.

31 Maintaining the consistency of the CQC's ratings of service providers is a challenge when there are over a hundred people working in the mental health division alone. A common complaint made by service providers is that the CQC does not make consistent judgements and that the ratings given to service providers depend more on the particular individual who conducts the inspection (rather than being based on the quality of care provided). A lot of energy has been directed towards developing quality assurance measures designed to maintain consistency. Before a CQC report (setting out the CQC's ratings of a service provider) is made public, we hold a meeting and I make a final judgement as to whether the evidence supports the conclusions reached by the inspector.

32 This challenge in maintaining consistency of ratings, along with the transparency of the CQC's regulatory activities, leads to some service providers (particularly the less well rated ones) having an antagonistic attitude towards the regulator.

[4] The CQC publishes all of its inspection reports on its website <https://www.cqc.org.uk/publications#cqc-solr-search-theme-form> [accessed 2 July 2020].

Quality, safety regulation and oversight

The CQC's role in monitoring adherence to best practice standards of quality and safety in mental health services

33 While the CQC does not itself set best practice standards in mental health service delivery, it does assess service providers on whether they meet such standards.

34 There are a number of bodies that promulgate different forms of best practice standards and guidance. The National Institute for Care and Health Excellence (**NICE**) has developed a range of standards, guidance and advice directed to improving health and social care. NHS England and NHS Improvement is responsible for providing advice, guidance and standards in relation to patient safety.

35 In conducting inspections of registered service providers, the CQC does evaluate service providers in terms of how well they adhere to best practice guidance and advice (such as that promulgated by NICE). When reaching a judgement in relation to the "effectiveness" key line of inquiry, the CQC considers which forms of best practice guidance a service provider is using, whether that be guidance provided by NICE or by one of the royal colleges (professional bodies specialising in various areas of medical expertise). In the domain of mental health, the CQC examines best practice in connection with royal colleges such as the Royal College of Psychiatrists or the Royal College of Nurses.

36 This results in the CQC forming a judgement as to whether a given service provider is either completely adhering to the guidance, has only begun to adhere to the guidance or does not appear to be making any progress towards adhering to the guidance.

Evolution of the CQC's approach to regulation and enforcement

37 The CQC has recently been taking a stricter approach than it has in the past. Its enforcement action against service providers has increased over the past two to three years – for example, the CQC is now more likely to issue a warning notice to a service provider. Failure by a service provider to act upon a previously issued requirement notice will lead to a stronger regulatory response. The CQC has prosecuted provider organisations for health and safety breaches in the last couple of years and has removed the registration of mental health providers (in the private sector) for failure to maintain adequate standards.

38 About three to four years ago, the CQC became responsible for investigating health and safety breaches, which was previously undertaken by a separate body, the Health and Safety Executive.

39 Every five years, the CQC prepares a "five year strategy" that informs its overall approach to its regulatory role over the coming five years. The current five year strategy covers the period from 2016 to 2021.[5] The CQC is due to shortly begin planning its next five year strategy.

Workforce

The role of the Care Quality Commission in monitoring and overseeing health and mental health workforces

40 The CQC does not itself undertake any professional regulation of the health (or mental health) workforce. There are dedicated professional bodies that regulate each of the various professional groups. However, through its inspection and reporting activities, the CQC does play a role in assessing the workforce needs of service providers and considering whether they are meeting those needs in a way that enables them to provide the kind of services they are purporting to provide.

41 There are various standards set by national bodies such as the Nursing Council which concern staffing and training requirements. However, there are currently no prescriptive or formulaic standards specifically targeted to staffing requirements for mental health services.

42 When the CQC inspects registered service providers, it typically considers:

(a) whether there are enough staff to care for the number of patients admitted by the service provider, bearing in mind the number of patients who may require special observation or one-on-one care; and

(b) whether a service provider has appropriately skilled staff available on every shift.

43 The CQC can take regulatory action against service providers that do not meet the staff requirements for the kind of services they are providing. This is a common problem for small independent hospitals in particular, which often have difficulties with staffing.

44 Staffing issues are probably the most common reason for the CQC imposing conditions on the registration of a service provider; such a condition may, for example, limit the number of patients a service provider is allowed to admit on the basis that it does not have sufficient staff numbers to provide adequate care to additional patients.

45 The CQC has observed that there is often a correlation between the numbers of skilled staff employed by a service provider and the safety and quality of the services provided.

---

[5] The CQC's 2016-2021 five year strategy is available on its website <https://www.cqc.org.uk/sites/default/files/20160523_strategy_16-21_strategy_final_web_01.pdf> [accessed 2 July 2020].

For example, the CQC has rated more service providers as "outstanding", in areas such as East London, where there is generally a plentiful supply of trained staff. In other areas (such as the more remote areas of the country), where service providers typically have greater difficulties hiring skilled staff, the CQC has tended to give lower ratings to service providers (on the basis that inadequate staff numbers automatically lowers a service provider's rating).

46 The CQC does not play any direct role in building workforce capacity. Generally, service providers must forge their own relationships with local training institutions. For example, the better service providers based in London tend to have much stronger links with the London-based universities that produce trained nurses.

Changes to service delivery channels brought about by increasing digital opportunities

47 In general, the English health care industry has not seen a lot of innovation. However, the COVID-19 pandemic has certainly triggered or accelerated a number of changes; for example, most medical consultations are now conducted digitally and even some inpatient work has been conducted digitally.

48 Even before the COVID-19 pandemic however, there was an increasing move towards the digital distribution and provision of certain services. For example, there is a program called Improving Access to Psychological Therapies (**IAPT**), which is a structured program designed to cater for patients who have anxiety or depression but who would not normally meet the threshold requirements for a formal referral to a mental health service.[6] IAPT services have expanded to include both individual and group psychologist consultations which are arranged via Microsoft Teams or Zoom video conferencing software.

Other impacts of the COVID-19 pandemic on the English health system

Falling bed occupancy rates

49 Prior to the COVID-19 pandemic, bed occupancy rates in mental health were very high in London, where many hospitals were operating at full capacity and some patients had to be transferred to more remote hospitals. However, since the pandemic, bed occupancy rates have fallen significantly, with most hospitals in the country operating at around 80-85% capacity. This fall in demand could be partly due to the fact that community care

[6] The IAPT program began in 2008 and was directed to improving access to evidence based psychological therapies, such as cognitive behavioural therapy, for people with anxiety and depression.

teams are not able to be in contact as regularly with patients, so it is possible there is some hidden demand of which we are not yet aware.

Death rates

50 We know that the death rate for detained patients doubled across March and April, however this rise has tracked at about the same rate as shown by the data on death rates for the general population. Nevertheless, there is a current focus on people with learning disabilities, as there is a concern that that group may have experienced an increased death rate during the pandemic.[7]

Suicide rates

51 In terms of suicide rates, the picture is still unclear. It can take up to two or three years for the data on suicide rates to become available. Past experience tells us that, during times of crisis (such as financial crises and world wars), suicide rates often tend to fall. At present, there is no discernible increase in suicide rates for the general population. We do know that there has not been any discernible increase in suicide rates for detained patients.

52 Based on serious incidents data received by the CQC, there has been particular concern for people using the opioid known as methadone. Prior to the pandemic, these people were able to visit their local pharmacy on a daily basis and consume the drug at the pharmacy. Now, due to the restrictions imposed in response to the pandemic, these people may be acquiring two weeks' supply of the drug at once. Clearly, that poses a higher risk for these people, however at present we do not have any definitive data on this.

Innovation and improvement

Ways in which the Care Quality Commission evaluates service providers in terms of the development and implementation of new and innovative service models

53 One aspect of the CQC's five key lines of inquiry involves consideration of whether a registered service provider is using innovative models of service delivery that meet consumer needs. One of the requirements for obtaining an "outstanding" rating from the CQC is for service providers to show evidence of implemented innovation in their services. If the service provider can demonstrate that such innovation has been implemented in collaboration with patients, carers, service users and staff, that is all the

[7] This is based on data which has been progressively published by NHS England since 18 May 2020. The data was last updated on 2 July 2020 and is available on the NHS England website <https://www.england.nhs.uk/publication/covid-19-deaths-of-patients-with-a-learning-disability-notified-to-leder/> [accessed 2 July 2020].

better. The CQC does not use any prescribed model for this, but it does make an overall assessment of service providers' capacity to implement innovation and quality improvement on a practical level.

54 The CQC tests the practical aspects of this implementation in a number of ways. We assess service providers by reference to how they function at a board or executive level. We look for a strategic approach to quality improvement that has been adopted across all levels of the organisation. This may involve observing the board in action and interviewing key personnel, such as the chief executive officer, the medical director and the chief nursing officer. The assessment of how the board functions can then be tested against the input provided by the frontline staff responsible for service delivery.

55 CQC inspectors will also interview frontline staff to gauge their knowledge and understanding of the organisation's approach or methodology for practical implementation and improvement. When inspecting the best service providers, this knowledge is readily apparent; staff have been properly trained in relation to this methodology and are able to provide specific and practical examples of actions that have been taken within the organisation to improve service quality.

Compulsory treatment

The English approach to compulsory treatment

56 As noted above, most patients receiving treatment in hospital are detained under the Mental Health Act (they are not attending hospital on a voluntary basis). The Mental Health Act permits the detention of a person in hospital if, in the opinion of two medical practitioners, the person has a mental disorder of a nature that makes it appropriate for him or her to receive treatment in a hospital for at least a limited period (either because the treatment is necessary for the person's own health and safety or for the protection of the health and safety of others). Unlike the legal framework for compulsory treatment in New Zealand, the English legislation does not precisely define the concept of a "mental disorder", or which symptoms must be present in order for a person to have a "mental disorder". Although there are sound arguments both in favour of and against defining this term in the legislation, in my view there is no need for such a definition in the English legislation.

Patients' right of appeal

57 The Mental Health Act stipulates that patients must be detained using the least restrictive means possible. For most people, this means they are detained for a period of 28 days and may be assessed and administered compulsory treatment during that period.

58 Patients may appeal the decision to administer compulsory treatment to them in two ways. First, they have a right of appeal to the Mental Health Act Tribunal. Second, they may appeal to the hospital managers.[8] Patients seeking to appeal to the Tribunal are entitled to legal representation, but the same does not apply to patient appeals before the hospital managers.

The CQC's review function

59 In most cases, patients detained under the Mental Health Act are detained for no more than 28 days and the Compulsory Treatment Order is allowed to lapse. If a patient has not improved after receiving compulsory treatment and does not wish to receive further treatment, they can be detained for a longer period (of up to 6 months). However, if after 90 days of this longer period, the patient does not consent to continue receiving treatment, a doctor is appointed to review the patient's treatment. The CQC is now responsible for management of the appointment of doctors to carry out this review. This function was inherited by the CQC from the former Mental Health Act Commission.

60 The doctor appointed to conduct the review of the patient's treatment has a discussion with the patient about their treatment and then makes a decision as to whether the treatment should continue or the patient should either receive some other form of treatment, or does not need any further treatment.

Lessons to be learned from the English approach

Mental capacity must be taken into account

61 A person's mental capacity to make decisions about their own treatment and care is an important part of the assessment as to whether the person should receive compulsory treatment. Taking a person's mental capacity into account is also important to the long term health of the therapeutic relationship between the patient and the treatment provider. In my experience, if a provider does not listen to a patient and have regard to the patient's mental capacity to make decisions, the relationship between the patient and the provider will suffer.

62 This is an aspect of the compulsory treatment process that is scrutinised by CQC inspectors, who review the reports provided by the treating clinicians (setting out a patient's condition and the treatment they are administered) to check whether the person's capacity to make decisions has been considered, both upon admission and at regular intervals during treatment.

[8] The hospital managers are people specifically trained and appointed to hear appeals made by patients who are detained under the Mental Health Act, or who are subject to a Supervised Community Treatment Order.

Safeguards required in contemporary mental health legislation to minimise the use of compulsory treatment

Advance statements

63 Patients may prepare an advance statement that describes their preferred treatment options in relation to their future care. While staff should take a patient's advance statement into account in making decisions about the patient's treatment (and we would expect staff to do so where possible), there is currently no legal obligation under English law to follow the approach or preferences set out in the advance statement.

64 However, a report published in December 2018 following an independent review of the Mental Health Act, chaired by Professor Sir Simon Wessely, recommended the establishment of new statutory advance choice documents (ACDs) to ensure that people's wishes and preferences carry far greater legal weight.[9]

65 The report also contains a number of other recommendations:

(a) **Nominated Persons**: people should have a say in which relative has power to act for them, through the creation of a new role of "Nominated Person", to be chosen by the patient (rather than simply being allocated to the patient). The Nominated Person would have enhanced powers, including the right to be informed of the patient's detention in hospital and the right to be involved in decisions made about their care.

(b) **A right to advocacy**: people who are mentally ill need the services of someone who sees matters from their perspective and understands their rights. This right to advocacy should be based on an opt-out approach and should also extend to include people who are informally admitted to mitigate the risk of "de facto" detention.

(c) **Detailed care and treatment plans**: there should be a duty on the responsible clinician to formulate a detailed care and treatment plan for each patient. The wishes and preferences of the patient should be a key component of the plan and should be considered by the clinician and, if not followed, a record made providing reasons for the decision.

(d) **Rights to challenge**: patients should have strong rights of challenge that centre around the Mental Health Tribunal. The role of the Tribunal should be enhanced so that it is able to scrutinise statutory care and treatment plans and hear

[9] The Final Report of the Independent Review of the Mental Health Act 1983, titled 'Modernising the Mental Health Act: Increasing choice, reducing compulsion', is available on the UK Parliament's website <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion.pdf> [accessed 2 July 2020].

treatment challenges. In addition, patients should have a freestanding right to challenge (before the Tribunal) a specific course of compulsory treatment to which they object (the current system only allows this via the process of judicial review).

(e) **More stringent criteria for the use of Community Treatment Orders**: there should be a tightening of the criteria for the use of these orders and increased powers for the Tribunal to include dealing with the conditions of a Community Treatment Order.

Restrictive practices

Actions taken by the Care Quality Commission to reduce the use of restrictive interventions in mental health services

66 The CQC has been working with the Royal College of Psychiatrists to reduce the use of restrictive practices (such as long term segregation and seclusion) in hospitals. The Royal College of Psychiatrists has developed a suite of interventions to be used by service providers to reduce the use of restrictive practices.

67 The CQC monitors the types of restraints used by service providers. We expect service providers to have in place a policy improvement process that is aimed at actively reducing the number of restraints used on patients.

68 The CQC is also currently investigating the use of long term segregation, and in particular, how we might use our regulatory powers on organisations suspected of committing human rights abuses against patients who have been subjected to long term segregation. The Department of Health and NHS England and NHS Improvement have formed a panel to review the care and treatment of every person in long term segregation.

69 The ability of service providers to effectively reduce the use of restrictive practices will often be closely tied to their organisational culture; some organisations are much better than others at effecting changes of this kind.

An example of best practice in reducing or eliminating the use of restrictive practices

70 The East London Foundation NHS Trust provides a good example of best practice in this field. It is a large organisation which employs around 7,500 staff and provides services to a region covering East London and several nearby boroughs just outside London. As noted above, I previously worked at the Trust for about 10 years.

71 In 2013, the Trust introduced a quality improvement methodology known as QI ELFT (Quality Improvement at East London Foundation Trust), which was derived from a

scientifically based quality improvement approach that had previously been successfully applied in many other institutions. Part of this approach involves the institution allowing staff to work on aspects of quality improvement that interest them. When the Trust adopted this approach, it found that the top priority for its nurses was reducing violence and aggression. The Trust ultimately succeeded in reducing violence and aggression levels in its wards by up to 40% over the course of a year.[10]

72 Initially, the Trust's staff were trained by an external organisation until, eventually, the Trust became self-sufficient in developing and providing training to its own staff. A series of collaboratives were set up across the organisation so that staff could share what was happening in each area. They were encouraged to share and put up information on the walls of the wards so that patients, visitors and others could see what was being done. The staff came up with some very good ideas, including strategies for managing the day to day operation of the ward in a way that minimises patients' stress levels and ensuring staff are alerted sooner in the event that something goes wrong.

73 This approach was initially trialled in one ward, before it was gradually expanded to other wards and different parts of the institution. As a result, staff ratings of how much they enjoyed their work greatly improved. Patient feedback and ratings also improved. The Trust has continued to use the QI ELFT approach, which provided a solid foundation when the organisation later turned to develop a methodology specifically aimed at reducing the use of restraints.

Performance monitoring

The Care Quality Commission's approach to collecting, organising and analysing performance and feedback data

74 The CQC tracks and monitors the performance of registered service providers by analysing data collected from various sources. This data includes:

(a) **Performance data**: the data collected by bodies such as NHS England and NHS Improvement on the performance of service providers, which may include data on the number of serious incidents experienced by a service provider, how it has investigated those incidents, how many restraints it has used and how many suicides and deaths have occurred among its patients.

(b) **Patient feedback data**: the data collected directly from patients, carers and relatives who provide feedback via the CQC website.

[10] Jen Taylor-Watt, Andy Cruickshank, James Innes, Brian Brome, Amar Shah, 'Reducing physical violence and developing a safety culture across wards in East London', British Journal of Mental Health Nursing January/February 2017 Vol 6 No 1 <https://qi.elft.nhs.uk/wp-content/uploads/2017/02/Violence-reduction-at-ELFT.pdf> [accessed 2 July 2020].

(c) **Detained patients data**: the data collected specifically about detained patients, which may include the number of detained patients who have died in a given week.

(d) **Inspections data**: this comprises the data requested by the CQC from service providers prior to an inspection and the data collected by CQC inspectors during the inspection.

75 The role of the CQC's large team of data analysts is to synthesise and triangulate these different forms of data in order to form a view of how a given service provider is performing. This is not a simple task; proper data analysis is time-consuming and sometimes the data collected may not be reliable and may need to be verified against data collected from a different source.

76 The CQC has a statutory power, under section 65 of the *Health and Social Care Act 2012*, to demand the provision of data from service providers that are not cooperative or do not respond to requests for information.

Ways in which performance monitoring arrangements can capture the outcomes and experiences that are meaningful to consumers, families and carers

77 All hospitals are required to monitor patient experiences via a regular survey called the "Friends and Family Test". This survey data is reported directly to NHS England. The CQC also collects feedback directly via its website and there is an annual Community Mental Health Services survey conducted of all NHS mental health community providers which is based on patient feedback. The main difficulty is for organisations to know how to effectively use this feedback data to achieve change.

Commissioning

78 As the CQC does not play any role in the commissioning of services, I am not in a position to comment on the topic.

sign here ►

print name Kevin Cleary

date 6 July 2020

Royal Commission into
Victoria's Mental Health System

ATTACHMENT KC-1

This is the attachment marked 'KC-1' referred to in the witness statement of Kevin Cleary dated 6 July 2020.

Kevin Joseph Cleary MB ChB FRCPsych

Curriculum Vitae

PERSONAL DETAILS

Name	Kevin Joseph Cleary
Nationality	New Zealand/British/Irish
NZ Medical Registration	13995
GMC Registration	3374775; Specialist Register since 1997
Work Address	Care Quality Commission 151 Buckingham Palace Road London SW1W 9SZ
Work E-mail	Kevin.Cleary@cqc.org.uk
Current Post	Deputy Chief Inspector of Hospitals (Mental Health)

Profile

I am an experienced executive director who has worked as an Executive Medical Director at both a national and local trust level. I have extensive experience in patient safety, quality improvement and assurance, and organisational cultural change. I have led an innovative programme in improving the quality of care provided at East London Foundation NHS Trust, the trust received an outstanding rating from the regulator, CQC one of only two mental health and community services trusts in England to receive that rating and the only NHS Trust in London (including Mental Health and Acute).

EMPLOYMENT

Deputy Chief Inspector of Hospitals Care Quality Commission Sep 2019 ongoing

I am responsible for the regulation of all mental health providers in England, both NHS and private providers. I lead a large team of inspectors and provide oversight of the regulatory activity and production of assessments of the providers which are published on a regular basis. Enforcement activity is overseen by myself and includes civil and criminal prosecution. I also work with the mental health policy team and mental health act reviewers to maintain oversight of the use of the Mental Health Act in England and the development of relevant Mental Health Policy.

Assistant Director Mental Health and Clinical Lead for Quality Improvement Waitemata DHB April 2018-June 2019

This was a newly formed fixed term post at Waitemata DHB. It was based part time in I3 which is the Innovation and Improvement Hub which works with the whole of the provider healthcare system to improve the quality of care provided and to rapidly implement healthcare innovations. My role in I3 was to design an organisation wide approach to leadership development, particularly clinical leadership for quality improvement. The remainder of the time was in the Specialist Mental Health and Addictions Services division which provides mental health services for North and West Auckland. The role involved developing a service wide approach to QI in mental health including designing training, coaching senior leadership and implementing a single methodology.

Deputy Chief Executive and Medical Director (short term secondment) North Middlesex University Hospital NHS Trust October 2017- January 2018

The North Middlesex Hospital is a busy acute hospital in North London with the busiest Emergency Department in London, which receives about 550 patients a day. It employs 3000+ staff. I was seconded on a short term basis from East London Foundation Trust at the request of NHS Improvement (regulator) to help deal with several quality issues in relation to patient safety, patient experience and other regulatory concerns

Chief Medical Officer East London Foundation NHS Trust 2011-2018

East London Foundation NHS Trust is a community services (non-mental health) and mental health trust serving, City and Hackney, Tower Hamlets, Newham, Luton, and Bedfordshire. The trust provides non mental health community services in the London Boroughs of Newham and Tower Hamlets. ELFT employs 6500 staff and has an income of £360 million.

Portfolios

Quality and Safety

- Executive Lead for Quality Improvement including relationship with Institute for Health Improvement. Strategic and operational executive oversight of Quality Improvement programme.
- Created and implemented a Quality Strategy for organisation covering all three domains of quality: assurance, improvement and control
- Developed joint quality improvement programmes with external partners including Board of Governors and local primary care systems.
- Responsible for Serious Untoward Incident process, Chair of SUI Committee for liaison with related external bodies e.g. Coroners, Police, Healthcare Regulators.
- Development of coaching programme for quality improvement leads within East London Foundation NHS Trust.
- Trust representative at University College London Partnership medical director's Forum
- Communications of Clinical Information covering all aspects of clinical quality
- Chair of Quality, NICE Implementation and Medicines Committee.
- Development of care pathways in conjunction with clinicians and external providers of healthcare including primary care.
- Joy At Work-project to improve staff experience in daily work.
- Chair CQC Inspection 2017

Medical Management Responsibilities Included

- Recruitment of medical staff at Consultant grade
- Management of relationship with training bodies including Health Education England
- Ensuring compliance by medical staff with regulatory standards
- Relationship with relevant academic bodies

- Management of medical disciplinary processes and liaison with General Medical Council and NCAS

Corporate Responsibilities Included

- Director for infection control
- Senior Information Risk Officer for Trust 2014-2017
- Executive Director for Informatics and Information Technology 2014-2017
- Director for Performance 2014-2017
- STP Clinical Transformation Board member
- Commercial Bid Presentations
- CEO representative Local Authority Scrutiny Committee
- Chair LGBT trust network
- Implementation of new electronic records system
- Representation of Trust at External quality events including evidence to commissions of inquiry
- Caldicott Guardian
- Research and Development
- Member of Quality Faculty at NHS Improvement (regulator)

National Patient Safety Agency Medical Director 2007-2010

I was appointed as Medical Director of the NPSA in April 2007. The agency had been severely criticised in a National Audit Office report and most of the executive team were replaced.

The role of the Medical Director was to be the executive director managing The National Reporting and Learning Service (NRLS) and to be responsible for the three National Confidential Enquiries. Role included:

- Establishment of cooperative and engaged relationship with Welsh Assembly Government including supporting patient safety progamme in Wales.
- Member of NICE Interventional Procedures Committee 2007-2010
- Worked closely with WHO on roll out of WHO Safer Surgery Checklist in England and Wales. Including international launch event, media planning and implementation plan to ensure clinician engagement.
- Worked with other Arm's Length Bodies to ensure that the work of the agency was aligned appropriately with the work of other bodies. Closer working with NICE, NHS III and HPA.
- National TV and radio interviews on patient safety related issues
- Development of Never Events framework for commissioners in England
- Management of Commissioning of three Confidential Inquiries.
- Development of Clinical Board for Safer Surgery covering England and Wales. Chaired by President of Royal College of Surgeons (England). Clinically focussed on major safety issues in surgery

- Matching Michigan: two year project to reduce catheter related bloodstream infections in intensive care units in England. Darzi project carried out in association with Johns Hopkins University Baltimore.
- Agents for Change programme in collaboration with DH Medical Director's Office and BMJ. Initial event for 300 junior doctors from England and Wales. Identifying junior doctors as effective agents for change within the NHS. Development of network to support them.
- Relaunch of ***Clean Your Hands*** Alert including chairing expert reference group, development of advice and successful launch.

Clinical Director Posts West London NHS Trust 1997-2017

Child and Adolescent Forensic Directorate 2004-2007

Medium Secure Directorate 1997-2002

External Agencies

- Member of Quality Faculty at NHS Improvement. This is a national advisory panel, providing advice on developing quality improvement in the NHS in England including agreement of national strategy.
- Member of Faculty at IHI-ongoing

EDUCATION

Secondary School	Rosmini College Takapuna. 1974-1979
Undergraduate	University of Otago NZ 1980-1985 M.B.; Ch.B
Postgraduate	Membership Royal College of Psychiatrists 1993 Certificate of Completion of Specialist Training in Forensic Psychiatry 1997 Certificate of Eligibility in Child and Adolescent Psychiatry 2005 Fellowship Royal College of Psychiatrists 2008

ABSTRACTS AND PRESENTATIONS

NHS Improvement Annual Meeting. Quality Improvement and breaking the rules: Pecha Kucha Presentation 2017

Cleary K IHI 3rd Latin American Forum Multiple presentations on community care, mental health and quality improvement. Sao Paulo 2017

Cleary K , McCaughey H. Can Partnerships speed improvement in healthcare? http://www.ihi.org/communities/blogs/_layouts/15/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=414

Shah A, Binfield P, Warren J, Gabriel M and Cleary K. Engaging staff and service users to partner in quality improvement. IHI National Forum. Orlando December 2015

Shah A, Binfield P, Warren J, Cleary K Engaging staff and service users to partner in quality improvement. International Forum on Quality & Safety in Healthcare 2016 – Gothenburg

Panesar SS, Cleary K, Bhandari M and Sheikh A. Questioning the evidence? Bone cement implantation syndrome revisited through the eyes of a national database. 2nd North British Patient Safety Research Symposium, Aberdeen, 6th of November 2009. Oral presentation.

Panesar SS, Catchpole K, Russell J, Tang V and Cleary K. Surgical safety can be improved through better understanding of incidents reported to a national database. 3rd International Workshop on Behavioural Science Applied to Surgery will be hosted by Imperial College London on September 15th-16th 2009, London UK. Oral presentation.

NHS Wales Patient Safety Awards. Cardiff 2010

Cleary K, Dominici F, Goeschel CA, Johnson E, Hibbert P, Panesar SS, Scobie S, Shore A and Pronovost PJ. The Harm Susceptibilty Model: A method to prioritise risks identified in patient safety reporting systems. International Forum on Quality and Safety in Health Care, Berlin, Germany. 17th – 20th March 2009. Poster presentation

Cleary K. Annual Royal College of Psychiatrists Meeting . Patient Safety and Lithium Therapy 2010.

Cleary K. Academic Department of Psychiatry Cambridge. Patient Safety and Mental Health. 2010

Patient Safety in Acute Medicine. Harlow Hospital. 2010

International Conference Prescribing for Success. Key Note speaker. Manchester 2010

Expert Residential Panel. Haute Autorité de Santé Paris. Developments in Reporting Systems 2009

Medicines Reconciliation and Lithium Conference. Lithium Safety Alert development and release.RSM 2009

Health in Custody - Clinical and Legal Issues in Prisoners' Healthcare Conference. What goes wrong in prison healthcare and improvements needed. London 2009.

Broadmoor Quarterly Meeting .Root Cause Analysis and Investigations. 2009

Health Care Errors and Patient Safety. Chair. Kings College London. 2009.

Chair Mental Health and Patient Safety Conference NPSA Birmingham 2009.

WHO Annual Meeting on Reporting and Learning. Toronto. 2009

Cleary K. EU CMO meeting Prague. Patient Safety in the United Kingdom. 2009

Cleary K. Irish Risk Management Conference. Patient safety and reporting.2008 Dublin

Cleary K. Belgian Patient Safety Week. A national reporting and learning system. 2008

Cleary K. Annual Royal College of Psychiatrists Forensic Faculty Meeting. The role of the NPSA. 2009.

Cleary K. International Association Mental Health and the Law 2004. Healthcare provision in Young Offender's Institution.

RELEVANT PUBLICATIONS

To cement or not in hip fracture surgery.
Panesar SS, Cleary K, Bhandari M and Sheikh A
Lancet 2009; 374(9695): 1047 – 1049

Cementing the evidence to deliver safer patient care.
Panesar SS, Roberts P, Scarpello J, Cleary K, Bhandari M and Sheikh A.
Letter in response to Timperley AJ et al. JBJS online. Available online at http://www.jbjs.org.uk/cgi/eletters/91-B/7/851

Panesa Panesar SS, Cleary K, Sheikh A. Letter 2: Surgical training and working time restriction (Br J Surg 2009; 96: 329-330). Br J Surg. 2009 Jun 15;96(7):825-826

Panesar SS, Tang V, Cleary K and Sheikh A. Asthma patient safety incidents: national perspectives need to be informed by primary care reporting. Primary Care Respiratory Journal 2009; 18(1): 1-2

Catchpole K, Panesar SS, Russell J, Tang V, Hibbert P and Cleary K. Surgical safety can be improved through better understanding of incidents reported to a national database. 2009. Available online at http://www.nrls.npsa.nhs.uk/resources/clinical-specialty/surgery/?entryid45=63054

Can the surgical checklist reduce the risk of wrong site surgery in orthopaedics?--Can the checklist help? Supporting evidence from analysis of a national patient incident reporting system.
N oble DJ. Mirza SB. Patel B. Mann B. Emerton M. Cleary K. Sheikh A. Bhandari M.
Journal of Orthopaedic Surgery. 6:18, 2011.

Involving the patient to ask about hospital hand hygiene: a National Patient Safety Agency feasibility study.
Pittet D. Panesar SS. Wilson K. Longtin Y. Morris T. Allan V. Storr J. Cleary K. Donaldson L.
Journal of Hospital Infection. 77(4):299-303, 2011 Apr

Reflections on the National Patient Safety Agency's database of medical errors. Cleary K Sheikh A. Journal of the Royal Society of Medicine. 2009 102 (7):256-8

Cardiac surgery errors: results from the UK National Reporting and Learning System**.**
Martinez EA. Shore A. Colantuoni E. Herzer K. Thompson DA. Gurses AP. Marsteller JA. Bauer L. Goeschel CA. Cleary K. Pronovost PJ. Pham JC.
International Journal for Quality in Health Care. 23(2):151-8, 2011 Apr.

The harm susceptibility model: a method to prioritise risks identified in patient safety reporting systems**.**
Pham JC. Colantuoni E. Dominici F. Shore A. Macrae C. Scobie S. Fletcher M. **Cleary K**. Goeschel CA. Pronovost PJ.
Quality & Safety in Health Care. 19(5):440-5, 2010 Oct

Safer cut: revelations of surgical harm through a national database.
Bagley CH. Panesar SS. Patel B. Cleary K. Pickles J.
British Journal of Hospital Medicine. 71(9):484-5, 2010 Sep.

National Patient Safety Agency leads national implementation of measures to reduce the incidence of retained surgical materials.
Panesar SS. Cleary K. Sheikh A.
Surgeon Journal of the Royal Colleges of Surgeons of Edinburgh & Ireland. 8(1):54-5,

2010 Feb.

Reflections on the National Patient Safety Agency's database of medical errors.
Panesar SS. Cleary K. Sheikh A.
Journal of the Royal Society of Medicine. 102(7):256-8, 2009 June.

Is knowledge and practice safer in England after the release of national guidance on the resuscitation of patients in mental health and learning disabilities?
Flood C; Gull N; Thomas B; Gordon V; Cleary K.
Journal of Psychiatric & Mental Health Nursing. 21(9):806-13, 2014.

Comparison of intensive care unit medication errors reported to the United States' MedMarx and the United Kingdom's National Reporting and Learning System: a cross-sectional study. Wahr JA; Shore AD; Harris LH; Rogers P; Panesar S; Matthew L; Pronovost PJ; Cleary K; Pham JC. Am J Med Qual. 29(1):61-9, 2014 Jan-Feb