Safety and care in specialist inpatient mental health services with Care Quality Commission (CQC)

Rethink Mental Illness Report

Contents

1. Background

Rethink Mental Illness was commissioned by the Care Quality Commission (CQC) to hold engagement sessions with people with experience of being in services to better understand their views of **safety and care in specialist inpatient mental health services**.

We proposed an engagement project from January to March 2023 to support CQC in finding out:

- What makes people feel safe and cared for as an inpatient?
- What makes people feel unsafe or at risk as an inpatient?
- What prevents people sharing their experiences of inpatient care?
- What can CQC do to make it easier for people that use these services and their families and carers, to share experiences of care?

We carried this out by engaging people with lived experience, current or recent, of specialist inpatient mental health services including:

- Children and adolescent mental health services (CAMHS) tier 4
- Learning disability and autism services
- Low and Medium Secure services
- Adult eating disorder (AED) services
- Families and carers of service users from any of these services

We engaged people from a range of different demographic backgrounds, ensuring as diverse as possible engagement with people. We focused on engaging people with or from different:

- Ages and gender identities,
- Religious, cultural, and ethnic backgrounds,
- Sexual orientations, and
- Geographical areas in England.

Whilst also trying to ensure we reached people with different communication and accessibility needs.

We gathered relevant insights from existing co-production, engagement, and consultation work we have done in the recent past with people from these services also, with consent, when drafting the areas for consideration.

We aimed to hold 6x engagement sessions for 1.5 hours, with 4-8 people, with the following groups:

1. People who have left secure services.
2. People in / who have left CAMHS tier 4 services.
3. People in / who have left LDA services.
4. People in / who have left AED services.
5. Families and carers of service users with any experience of specialist inpatient mental health services.
6. Families and carers of service users with any experience of secure services.

Given the short timeframe, we remained flexible in our approach for the running of these sessions.

All sessions were held remotely, via Microsoft Teams. We recruit experts by experience through a range of internal and external channels, including via Rethink Mental Illness services and groups nationwide, our communication channels reaching thousands of supporters, and our social media platforms reaching hundreds of thousands of people across the country.

The engagement sessions were written up by a note-taker during the session, who anonymised and coded the discussions.

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2. Methodology

Recruitment of experts by experience

The Rethink Mental Illness Programmes Team shared the opportunity to participate in the engagement project via numerous channels, from January 2023. These included:

- ✓ Existing mailing lists and supporter newsletters
- ✓ Internal channels including Workplace (access to all staff)
- ✓ External social media platforms (reaching 250,000+ people)
- ✓ Internal lived experience and carer's advisory boards
- ✓ Internal co-production networks through place-based areas
- ✓ Internal group coordinators (120+ groups across England)
- ✓ Internal Advocacy service team
- ✓ Internal Community Services teams
- ✓ Internal Mental Health Navigation team
- ✓ Directly with existing experts by experience
- ✓ Internal place-based Community Mental Health Unit

We built relationships with people via email ahead of sessions. Often engaging in multiple emails explaining the project, discussing eligibility and confidentiality, as well as safety, and also discussing the purpose and impact of the project. Building relationships with people took time. Sometimes, people were not well enough or in a stable enough situation to participate in the project at this time. Some people dropped out ahead of the sessions, after expressing interest.

Experts by Experience (EbE) within this report refers to all participants in the engagement sessions. We then differentiate between the different groups of people speaking by referring to people with lived experience of services, current or past, and families and carers.

A list of the materials utilised in the project can be found in the Annexes section of the report.

Co-production

We initiated the project with a small group co-production session. We identified 3x people with lived experience of services (adult eating disorder services, and secure services) who were interested in co-designing the engagement sessions with us.

We worked through the plan for the sessions, discussed safety and safeguarding, and reviewed the questions and how they were formulated. We then discussed how the sessions should be facilitated, run, and managed before, during, and after.

Engagement sessions

We were able to engage with to 16 people with lived experience of services (adult eating disorder (AED) services, children and adolescent mental health tier 4 services (CAMHS), low and medium secure services, Deaf secure services), including 8 carers of people with experience of low and medium secure services, Deaf secure services, AED services, and CAMHS.

All sessions were held as either of 1:1 (or 2:1, with a facilitator and note-taker) calls via Microsoft Teams with the expert by experience, small group discussions with 2-3 people, and a larger group session with 6 people. We also received feedback from 1 person via email.

As with all recruitment of experts by experience, there was attrition due to our screening process for suitability as well as timings and availability.

The engagement sessions were undertaken successfully. People involved in sessions were paid in accordance with our reward and recognition policy.

No safeguarding concerns were raised.

Note-taking

We have a note-taker during each session. Notes are written up with the person’s ‘code’ and their comments, as close to verbatim as possible. Any identifying information is deleted. Explicit consent is gathered for all special category data that people share e.g. diagnoses.

Notes are then cross-checked for confidentiality, and when inputting into the report, are anonymised so the people involved cannot be identified.

Feedback loop

After the sessions, we followed up with each person involved and shared a signposting resource so people have additional information about where they can get support if needed. We share the presentation in case they have additional reflections after the session. We did a check-in, to see how people are feeling after the session, and offer continued contact if people want to come back to us to discuss anything the session brought up for them.

We told people during the session that the information they provide will help CQC decide what changes to make.

Experts by experience information

- 1x CAMHS expert by experience
- 6x low and medium secure services experts by experience
- 8x carers / professional (carers of people with experience of AED services, CAMHS, low and medium secure services, Deaf secure services, and some professional experience across various specialist inpatient mental health services)
- 1x adult eating disorder (AED) services expert by experience

Experts by experience were aged 19 – 65 years.

We held 1x co-production session with 3x experts by experience, to sense-check the questions, and co-design the engagement sessions.

In the engagement sessions, experts by experience identified as:

Experience	**# of EbEs***	**Identification**	**# of EbEs / carers****	**Identification***	**# of EbEs**
Currently in services	8	Female	9	Learning disability	2
In services within last 12 months (*not including people currently in services*)	4	Male	4	Autism	2
In services between 1-10 years ago	4	Transgender male	1	Physical disability	3
6 months – 5 years in services	6	Pansexual	1	White British	6
> 5 years in services	2	Gay / lesbian	1	White Irish	1
		Straight	2		

* These numbers relate to the person with lived experience of services. It is based on the information provided by the person with experience of services, or their carer.

** These numbers relate to the person we spoke to (expert by experience or carer). It does not include the gender identities of the people that carers care for.

We were unable to gather demographic information from all people who participated, hence why some of the numbers do not add up to the total number of people involved.

We're unable to provide further breakdown without potentially identifying people.

The reflections below are not generalisable across all people with lived experience of services, and families and carers. There are, however, consistent themes that arose frequently, even given the small number of participants. We recognise that this work will only ever be a 'snapshot' of the experiences and issues faced by those with experience of being in these services.

We also recognise that due to the type of engagement we had, and the limited time to build relationships with various stakeholders, we may not have captured issues relating to race and racism. Such issues have been reflected in the Challenges section of the report.

Follow-up and report

The 'key themes' in this report are led by the voice of lived experience, with every effort to ensure no assumptions were made on our behalf. We have also included a section with reflections from our team as well as suggested areas for consideration, linked directly to the feedback from those with lived experience.

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3. Key themes identified by people in engagement sessions

These were the key themes that tie together the individual reflections from the experts by experience who were involved in the project. All the points mentioned below are captured throughout the body of the report, in the reflections from people. Many of the quotes and comments overlapped between multiple themes identified, across services.

Key themes

What safety and care looks like

- **Holistic & person-centred approach**: Experts by experience told us that emotional and psychological safety as part of relational security were important – not just physical safety. And that staff who got to know them, who took time to interact with them, and understood their individual needs made them feel safe and cared for.

- **Adequately trained staff:** Experts by experience told us that staff needed training in topics such as: de-escalation techniques to reduce restraint; gender identity awareness; specific conditions such as autism and specific mental health diagnoses, and how to appropriately treat and/or care for them, in particular eating disorders.

- **Staff who are compassionate and have the time to provide the right care and build trusting relationships**: People we spoke to told us that staff appeared overworked and there was overuse of agency staff, and don't feel that they are familiar with the individual needs and experiences of the people in the service. In some cases, people told us that people in services didn't feel safe or cared for if staff didn't know them well (agency staff, in most cases), that could lead to risk e.g. suicidal intent not being picked up on early enough. People told us that when staff didn't spend 'quality' time with them doing 'meaningful' activities, they couldn't identify changes in their behaviour or mental health, and that it also made them feel uncared for.

- **Staff who have the right knowledge, support and resources to provide the right care**: Experts by experience told us that in certain settings like adult eating disorder (AED) services and secure services, the 'hands off' approach by staff put them at risk of self-harm or acting upon suicidal ideation. People mentioned the importance of independent mental health advocates (IMHAs) in their care and safety, to know their rights, and have someone to talk things through with. Several experts by experience told us that staff's wellbeing and mental health was important too, as when staff were appeared overworked and stressed, they felt that they might miss things, and the quality of care could be impacted.

- **Reducing restrictive practices:** Many experts by experience said that they had experienced excessive restraint and that it only worsened their mental health. Others spoke about the restrictions placed on them when they were deemed at risk of harm, although some agreed that, at times, restrictions were necessary. People said that Sometimes they felt that these restraints seemed excessive and impacted on a person's sense of dignity, an example given was being observed for 3 weeks, including during showering.

- **Carer involvement**: Several experts by experience and carers told us that ensuring carers are involved throughout the time in services (where consent is given by the person in services) is vital to good care being delivered, and the person being and feeling safe in services.

- **Other people living in the service:** We heard from people that they felt that their physical, psychological, and emotional safety could be jeopardised by other people in a service, for example if people were unwell, unpredictable, or engaging in challenging behaviours, with examples given such as self-harming, shouting, or trying to enter someone's room or space. However, people said that peer relationships were invaluable, across wards, and from the community e.g. peer support workers.

Assessment of safety and care

- **Person-centred approach**: was said to be necessary to assessing and delivering care and safety (individualised care plans) and advance decision and advance statement documents.

- **Building relationships**: with people in services, and carers, was said to be important when assessing and delivering care and safety (not just observing / collecting data). Taking time to meet with people, to get to know the people in services and their carers will all support the assessment of safety and care.

- **Broadening the scope**: A number of carers and people with lived experience said that assessment should include more than data, and should include speaking to a broader range of people, and looking at a wider range of information. Carers also welcomed inspections at unannounced times, including during evenings and weekends, and possibly even doing undercover inspections to get a real sense of what was happening.

- **Providing information about the process**: Many experts by experience told us they weren't aware of the CQC, of the process for providing feedback or complaints, that they didn't see any information in the hospital, and that they hadn't been informed them about how, when and why they could contact CQC.

- **Carer involvement**: Several carers suggested that having a 'pool' of carers or family members to call upon for feedback, and/or a panel during inspections would be beneficial.

- **Respect and being listened to:** is important when assessing safety and care.

- **Involvement in discharge:** Some experts by experience told us that they felt that poor discharge planning resulted in risks to their safety. They suggested the CQC inspection should ensure that discharge planning is clear from the outset of someone's stay in hospital.

Hearing experiences of safety and care

- **Providing people with a variety of options:** Some experts by experience told us they felt that they would have wanted to give feedback, or make complaints, but often wouldn't know how to. People with lived experience and carers also told us they would welcome an organisation such as CQC to contact them via email, with a questionnaire, or in person to ask about the experiences of safety and care so they could provide feedback during or after time in a service.

- **Feedback loop:** Experts by Experience said they would welcome a way to keeping people updated about feedback, complaints, assessments.

- **Actions taken**: Experts by experience and carers told us they welcomed having clearly communicated updates / accessible information about actions that had been taken by the services, as a result of feeding back to CQC about issues with a service. They told us this made them 'feel heard'.

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4. Experiences and reflections from engagement sessions

These were the individual reflections and experiences captured from the experts by experience who were involved in the project.

Question 1: What does safety and care in these services mean to you?

Reflections from carers supporting those with experience of living in AED, CAMHS and secure services

- Mental health professionals should be trained well, especially in how to give compassionate care and support.
- When we get into poor practice, I think we need to constantly have that conversation about how we can work more effectively as a professional with that individual and their carer. This conversation should remain open.
- There's a culture of going straight into restraint (and medication), and it's overused. De-escalation and compassion is key. Needs more of a holistic approach.
- There are many different layers to us as people. We need to consider things like safeguarding and wellbeing, all in a holistic way. By not doing that, then this culture will become (already is) systemic.
- Ultimately it is about the wellbeing of the individual. But safety can mean different things to different people. To me it means more 'mental health safety' and 'wellbeing safety'.
- There is a power imbalance in services, and still mostly works on a clinical/medical model, rather than focused on the individual as it should be. Sometimes we lose sight of the individual and make sure there's an appropriate care plan for them.
- It's always about building positive relationships with individuals.
- Don't think I would've had any idea about my daughter's safety and care in hospital, as you don't hear from anyone there, it's me calling them. You're kind of cut out.
- Some of the people you speak to don't know her or her case because they're agency staff. Only main nurses give you more feedback from about how she's doing, or tell you about her care.
- It can be quite scary from a mother's perspective; I don't know what the other patients are going to be like in that service.
- I would call the hospital every day trying to get some feedback about how she is, and what I should be doing to help. If you speak to agency staff, you didn't get proper feedback.
- The main nurses are the people I would've wanted to speak to, to have feedback about how she's doing, if she was offered meds, if she was taking it.
- I had no idea about the procedures of what's happening, what checks they're doing on the ward or why.
- I would want to now if she was behaving differently. My daughter would go along with things. If she wasn't behaving that way, I would've wanted to know, as it would mean she's not okay.
- I knew about consent, and my daughter must've given it as I was allowed to have information. But only if I called and asked for it. The hospital weren't forthcoming.
- The hospital was a good thing for my daughter though, as it got her a diagnosis, and medication, and she's doing much better now.

- My son is totally isolated. It’s like, once the meds are there it’s ‘bye bye’. It’s an aftercare thing. I've always been worried about abuse, as my son is very sensitive. He’s very inward, wouldn’t speak up for himself.
- To me, my daughter is not home because I struggled to keep her safe within her surroundings in the community and so I trust that she's taking somewhere where she is kept safe. But I find that actually she's caused more harm to herself.
- Safety and care in these services, it's really important because they are still people and they might be poorly, but they're just poorly. If it was a broken leg, it would be a different treatment just because it is a mental illness for some reason that that seems to mean that they get less care.
- When we think about safety I think we often think about physical safety… I think safety needs to be seen much broader than that.

Reflections from people with experience of living in adult eating disorder services

- Emotional, physical, and psychological safety
- The physical safety side of things such as correct observations, staff knowledge, etc. then there’s emotional safety where you feel like you can talk to staff.
- Sometimes staff make mistakes, due to lack of training and sensitivity.
    - I feel like the staff don’t have training in physical and mental safety. They’ll be so busy that they won’t have time to deal with you.
- Staff can be very hands off and you’re not checked on very often. You can end up staying in your room for hours on end and no one will check in on you. That can be dangerous.
- Experience of a staff member falling asleep during their 1:1. Did not feel safe.
    - I think things like this happen because they’re tired and overworked, or they don’t have the passion and empathy for this job.
- I’m a wheelchair user, I was restrained on my chair anywhere I was – in the common areas, in my room, etc.
    - I felt this treatment was inhumane. I was malnourished so I understand I needed to get food, but the way it was done was not right.
- Staff don’t understand how traumatising it is to be forced to eat (even if you accept it) while you have an eating disorder.
    - “its just a bit of food, why don’t you eat it”, “its not that many calories, don’t worry”. Things like that make you feel unsafe.
- Lack of male eating disorder beds is unsafe. By the time of getting a bed, I was severely unwell and days/weeks away from death. It’s not safe to leave someone in the community when really, they need a bed.
- I’ve gotten comments from staff about being trans, but I think that because I pass as male, I’m safer. If I didn’t pass, I’m afraid I would have worse treatment. They (staff) don’t understand trans identity.
- Lack of understanding of autism can impact care and safety

Reflections from people with experience of living in children and adolescent mental health services

- Someone just being comfortable. Able to just exist safely. Getting your basic needs met.
- And also, I sometimes think, in inpatient settings, there can kind of be a lot of focus on physical safety.

    - Obviously, preventing people from harming themselves. But I think there needs to be a focus on psychological safety alongside it.
    - Personal experience – they deal with the physical safety then ‘we’ll get to the psychological safety’. It makes more sense for them to go alongside each other.
- Only having restraints and restrictions in place when they are necessary. Making sure they are *absolutely* necessary.
    - Personal experience, I sometimes felt that not a lot of thought was put into it.

Reflections from people with experience of living in low and medium secure services

- I think care means making sure your mental and physical health needs are assessed and responded to so people can move out of that setting and into recovery.
- I think safety means patients not experiencing harm as a result of the treatment.
    - There’s iatrogenic harms [being given a treatment when you’re not ready for it. Important to know your options] from the treatment itself which are unintended or there can be harms from the care environment.
- I was thinking of physical safety, things like self-harm or from other service users. But there’s also the psychological aspect to it. One of the things I found difficult is there were instances where people kicked off, restraint issues, things like that.
- The tension and fear that there would be violence, all the time. It wears you down. That can be worse than the couple of times of getting attacked.
- Teams are doing more and more formulation of need. Formulation looks at ‘what brought you to be here, how did you come to be ill?’ in the context of your life history and how you acted in society, the relationships you had. Looking at what you need to move forward in your recovery and be the person you want to be.
- You can feel like a conveyor belt when they go from patient to patient doing assessments, it feels quite deindividualised.
- I made the mistake of telling the nurse I was having suicidal feelings. I was put on level 3 obs where you’re observed having a shower or whatever. For about 3 weeks.
    - There’s an intrusive nature of not having any privacy for 3 weeks. But it raises a question of, I didn’t like it but maybe it was necessary?
- Thinking about respect and dignity made me realise that part of safe care is having your human rights upheld.
    - Obviously, article 2, your right to life. No one wants a sudden unexpected patient death on a ward.
    - Also article 3 your right to liberty – the sanctions imposed on you should be the minimum required to keep you safe.
    - Article 5, the right to a fair trial – this means the right to challenge that detention.
    - Article 8, right to privacy and family life autonomy – this is around having contact with family and friends and not too intrusive observations.
    - Article 12 on discrimination – this could relate to your offending history.
    - Freedom of speech – people interpret their mental health differently and they should be able to.
    - People should be able to interpret it in relation to whatever makes sense to them.
    - With regards to religious practice, should be able to follow their faith while in hospital.

- Thinking about moving people back into the community, wanting to move on early. Experience of a friend who moved into community, didn’t have issues picked up, sent back to inpatient care. There’s something about having to make these decisions and what are the impacts if they get it wrong.
- ‘Safety and care’ means that we can rely on the staff and the nurses on the wards and healthcare assistants (HCAs) and other staff on the frontline, in the hospital, to effectively do their job.
- If you do have any problems, you can approach the staff and speak to them without feeling judged.

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Question 2: What makes you feel safe and cared for in these services?

Reflections from people with experience of living in adult eating disorder services

- Having a member of staff who *really gets it* [the different mental health diagnoses / behaviours].
- Having the right diagnosis helps.
- Last admission would be like: self-harm -> punishment. This admission, they understand that self-harm is part of the experience, and hopefully it can change. So it’s less punitive and there’s more understanding.
- Members of staff who really take care me.

Reflections from carers supporting those with experience of living in AED, CAMHS and secure services

- Overall, it’s just the way staff approach you and build relationships with you.
- You can feel a bit disempowered.
- Promoting independence and autonomy, and feeling listened to, is needed. Feeling safe and cared for is something we all want, and feeling listened to is essential.
- We don’t talk to people enough about what makes THEM feel safe.
- We don’t look at different crisis interventions and recovery techniques to use.
- Having reassurance, compassion, and care from those caring for you is needed.
- People who know her, understand her background, spent a bit more time with her building up a bit more of a relationship with her. Specific nurses who were really nice and kind.
- When my daughter became more well after taking medication, she had more insight. She liked being in hospital which was a shock. But when she became well, she didn’t like it any more. Possibly because she understands it’s really restrictive being in there, not being able to go out when you want, everything being taken away. She described it as a prison.
- At the start, she spent most of her time in bed sleeping, with nobody waking her up, or trying to engage her in activities. As time went on, she realised this was horrible. It was horrible hearing people screaming, and banging their heads against walls – it’s traumatic.
- Understanding later she could have leave, helped. She behaved well. We went on leave together. I took her out for a whole day, but then taking her back was horrible for her.

- Communication between me and her main doctor; I'd never had that from anyone (in community services) before. He was so good at taking the time to speak to me, answer my questions, get my opinion of the situation and listen to me about how my daughter presented. Felt more heard and acknowledged by her doctor than any other services prior to that. That was huge for me.
- Safety-wise, if my daughter had a problem, and something wasn't right, she would have told me. Visiting her, I would have picked up on things I hope because we have that relationship.
- My only concern was the other patients.
- Updates from staff is wildly different among settings and some will offer you a daily updates and will inform you of every incident. Some will not tell you a thing.
- My son is not safe in his mind. Safety is bigger than this [physical safety]. Safety in a building, safety in an environment. That isn't all it is.
- I think in order for people to be looked after in the system, I think there ought to be more scrutiny.
- I think in order for my son to feel safe it needs to be a co-production.
- I think there it has to be person centred.
- I think it should be very much a recovery approach.
- There should be a consistent recovery approach in which its focused on them [service users].
- In terms of people with autism or a learning disability, they're not being offered the service that they should, they're not being assessed.
- Safety and care for me is when your child is going to be looked after.
- Somebody who either written or pick up the phone saying we understand what you're saying and we will do something about it.

Reflections from people with experience of living in children and adolescent mental health services

- Person-centred care. Making sure everything's done *with* you, and for you, rather than done *to you*. Making sure it's completely tailored to who you are, rather than a generalised care plan.
- Getting what you need. Which isn't always necessarily what you want. But what you need.
- I personally felt like I wasn't really listened to a lot of the time. People didn't really trust me to have my own voice in my care.
- It's a very vulnerable situation to be in. There are small things that can have quite a massive impact on your situation at the time. I think sometimes it can be overlooked.
- I think being heard is important.

Reflections from people with experience of living in low and medium secure services

- I think it's where the ward is well managed, good structure and there are meaningful things to do in the day. There's the possibility of gaining more independence and clear criteria to getting greater autonomy. Being listened to about what you need to get better and what would work best for you.
- Having 121 support available. A specific person to go to about any issues. We had a named nurse each. Someone who knows your case on the ward. Having that continuous relationship and trust built there is very important to me.
    - If you don't have a named person you have to explain your situation over and over again whenever you need to do something like have a prescription refilled.

- I've felt safest on leave as I can do the things that are meaningful to me. I've felt safest when it's been recognised that I'm responsible.
- It's a pain when people leave and you have to get to know someone all over again. Having a consistent person to do therapeutic work with can help you to feel safe.
- Inability to find out about the day and date as it was not displayed in a way someone could find easily [seen as poor quality of care].
- Particular staff sitting outside a person's room for as many hours as they could, to stop other patients with bad intentions entering someone's room.
- I think that those who have been away to another Trust – out of area – ironically will feel safe to say more [about their experiences].
- There are some incredibly simple solutions to all this. A checklist for which a nurse takes full responsibility and even signs along the lines of:
    - Have valuables been removed and given to a family or statutory carer?
    - Is the day and date clearly displayed in the patient's room?
    - Is their full name clearly displayed in the patient's room? [person forgot their own name and they were called the wrong name for 2 weeks by staff]
    - Does the patient have on foot wear?
    - Does the patient sleep with or without a light?
- Some of these things can be covered off with an Advanced Statement.
- There is a bigger question of whether those with addictions should be on the same ward as people with psychosis or suicidal ideology.
    - A lot of their belongings go missing.
    - Those with addictions are often desperate to raise money. Those with psychosis cannot protect their things - or bodies - from those who might wish to exploit them.
- Impossible to know who any of the staff were. There needed to be names and photos of the staff, outside in the hallway, on a board.
    - I still do not know who they were, today.
    - That would have also have allowed me to name those I wished to be treated by and those I did not.
    - Instead, what they did was put up who was on duty, in marker pen on the board.
- If you've got issues with anybody else on other wards, they'll put safeguarding measures in place to stop things from happening. Like if you don't get on with someone else.
- It's important we have access to IMHAs. That gives us another opportunity to understand what our safety and care looks like from an outside perspective. Regular interactions with and access to the IMHA is important.
    - I can speak to my community social worker, or IMHA. They don't work in the hospital and see the day-to-day. They just know what you tell them. They might not know if you don't tell them.
- Being able to express your views. Feeling like you all work as a collaborative team. That you can share with staff, your advocate, others.
- You see all these bad things on the TV about the NHS and [mental health] hospitals, so it's always good to know you've got support. Some people might not feel confident to speak to staff, so they might suffer.
- Staff in the service are important to make you feel safe. The main thing is having regular staff on the wards, the same people who know you and understand your problems.
- Regular contact with your peers on the ward and off the ward. If you have good relationships with your peers, they can stand in and help you when you need support.

But not the same kind of support from staff. Sometimes you need a shoulder to rest your head on. That's where peers, friends, in and out of hospital, can be really helpful. If they can work well with you, it can impact your safety and care.

- There was a peer support worker who came on the ward a few times. He shared his experience. It was good.
- There was a person who had [lived] experience who came with CQC into the hospital a while back. That was good. It shows you people who've been in the same situations; if they can pull through so can you. I would say it adds to safety and care. If they can put their trust in the CQC, then surely we can too, or at least try to.
- On another ward, a friend took his own life. No one noticed it [the fact he was not okay], he was just going about his daily life like nothing was wrong. Staff could have intervened, maybe if they'd approached him on a daily basis, they might have been able to help. If I was in charge I would promote staff approaching people on a daily basis. Not waiting for community meetings. Daily, or a couple of times a week, asking the questions "would you like to have an intervention, a conversation about your care this week", or to ask you about how you're feeling. Hopefully that would reduce the risk of suicide in services, or people hurting themselves. ***Comment from facilitator****: given the nature of the discussion topic above, we are following up with the staff member who was present during the discussion.*
- It's a difficult place to work. They say you shouldn't take your work home.. but if you, as staff, can't manage that yourself, you need support. The staff need help just as much as we do. They need time to discuss things too, especially with covid, and burnout.
- They [staff] come out every few months to ask you to fill in a form about how you've been feeling you just tick the boxes. We think, "Oh it's just another one of those things, another piece of paper" for the NHS. It shouldn't just be in a community meeting where you bring up all your problems, or a piece of paper where you're feeling pressured. If you offer it [1:1s], more people will speak up.
- A lot of people asking for 1:1s, but only 1 staff member available, so they can't take us into the quiet room for a chat. Or with the levels of staffing, some work 4-5 days a week, and by day 3 or 4 they're knackered, and they can't really do that much.
- And I've noticed that when you when you want a 1:1, you've got a knock on the office door. They'll say, "just doing these notes, or this matrix". It's always "2 minutes, 2 minutes…". You feel you're taking them away from their job. But technically that is their job is to be there for us and you feel a bit like a pain in the a**, for taking them away from a task just because the ward manager delegated a lot of jobs to them, you know.
- Safety and care means enough staffing, followed by regular interventions and 1:1s, not all these tick-box things that go into a folder and get shredded 6 months later.
- I've had times where I haven't called home regularly. Then [my family member] would call the ward and say "XX hasn't called in a while". It makes it like the family should be responsible for your care, they have a certain level of responsibility, but it shouldn't take your family to notice that something's wrong. It should be noticed on the ward first. We see these staff face-to-face every day, not our family. The staff should be there to care for us and assess our needs on a daily basis.

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Question 3: How should safety and care be assessed in these services?

Reflections from people with experience of living in adult eating disorder services

- There could be questionnaires for patients and carers, but shouldn't be the only way.

- There's a lack of support for carers in the system. Many carers know what's going on and have an opinion, and they should be listened to.
- Interviews could help to, as speaking to patients is the best way to go.
- Recently the CQC came and assessed this ward, and they didn't speak to any patients or carers. They only looked at their data.
- Another way CQC could assess is to speak to staff – are they overworked, what's the environment like, etc.
- Speaking to people is the best way to assess service.
- It would be good to get patients, carers, and staff experiences assessed and compared.
- Agency staff should not be allowed in the ward if they've never received training, which happens often.
- Their training and experience need to be assessed before they join any ward.
- Service users at the ward made a book "handy things for service workers to know", with the support from a peer support worker.
    - The peer support worker is the best person in the ward.
    - They were admitted to this ward many years ago for anorexia.
    - Every ward should have a peer support worker (with lived experience). This role should be included in the staff organisation.
- The peer support worker is a massive asset to the ward. CQC should assess via interviewing peer support worker too.

Reflections from carers supporting those with experience of living in AED, CAMHS and secure services

- Individual approach of the inspector done in slightly different ways, can change outputs.
- Training is essential, but even if you did training on the various Acts, it doesn't mean you know what to do. So regular re-training should be done every year or so.
- It's about that person's care but it's also about *talking* with that person.
- Seeing someone as a *person* and not defining them by their diagnosis is important.
- Training around record-keeping is essential too.
- Service user involvement/feedback from patients is absolutely essential. They are the experts and should be a part of the assessment.
- Tailoring the care for specific needs of individual needs to happen, as part of this assessment.
- The main question we should be asking while assessing this is, how can we ensure that each individual is getting the most effective support. Assessment is a collective process. The patient's voice needs to be heard.
- There's nothing more valuable than speaking to the individual who received said care. Very much about speaking to the individual.
- I appreciate the data and recording, but having conversations with the individual/s is equally if not more important. It is essential.
- I didn't know anything about CQC. Some sort of info or procedures for carers to know what's going on, and info given to carers to know they can contact CQC.
- There isn't anything written for people to go to, to know. But every hospital might operate differently, something in dividual for each hospital of how things work so people know.

- Worry would be, having people actually going into the hospital. We're aware of how people can present when people are there observing [from an organisation like CQC]; they'll be different from when people aren't there to observe.
- It's a locked, closed place – unless you're there all the time, you're never really going to properly know how things are or what's going on.
- I think unplanned visits rather than planned would work better – going to see more just turning up rather than and people are aware [before you go].
- There needs to be more done around making sure that the information they get about those basic care needs and the safety of those people is actually - evidence based beyond observation sheets and data exports. And perhaps maybe speaking to the patient, speaking to the families about how that's reported to them, if it's reported to them.
- I think the CQC, they need to do more, unannounced visits.
- I think going in for three days during an inspection just doesn't really give enough information. I think it would be more beneficial if they had staff that went and worked in those services. And they speak to the patients. We've all seen really good patient feedback…
- I know from experience my daughter, even in times where she needed to complain, she would never complain. She would never put anything formal in process. And I don't really understand why. So unannounced visits would be good.
- Perhaps they could do undercover inspections. They would get a true picture. At the end of the day, you have to think about the patient and the quality of the service that they're getting. I don't think there would be any comeback from the patients [regarding undercover inspectors].
  - I feel the only thing about undercover is that person would be lying about the purpose of the role and in reality, we want the service to be more transparent.
  - It's about openness and transparency so under cover I feel it's not appropriate.
- I would want inspections to cover all days of the week and all parts of the day and night.
- I'd like to see CQC speak to bank staff and agency staff, and check the agencies they work with, and to know if CQC really look into the background of people that are being pulled into cover these shifts.
- I'm wondering if in each hospital there should be a carer/family panel that the CQC can seek when inspecting that CQC could seek input from at the time of the inspection.
- Why haven't we got a cohort of ex patients who are going in with inspectors to say, right. Look, under that look under that, look under that.

Comment from facilitator*: explained that CQC have experts by experience in the inspection teams.*

- They [CQC] need to broaden who they are asking. Sometimes they're asking family members who aren't really involved in the person's care.
- They need to be asking people who are actually active in what their son, daughter, or whoever, on how they're doing.
- CQC need to broaden their scope on where they gather their information from.
  - I think what the CQC need to do is speak to people in those kind of positions [experts by experience and carers engaged in involvement 'work' with the service], where they can share their experience. And I think there's also a lot of kind of patient governors and carer governors that they can speak to. So it's broadening their scope.
- Oner carer told us that 'CQC is only looking at paperwork'.

Reflections from people with experience of living in children and adolescent mental health services

- I know when I was in hospital, the staff were very overworked. There just was not enough staff.
- A lot of the time there were situations where people were unsafe, and they didn't really have the capacity to deal with it. So they weren't dealing with it.
    - Dealing with it *at all* would be a starting point, in that sense.
- Making space for people to be able to talk about safety. Maybe on a 1:1 basis. It can be quite a scary environment sometimes. I know, for me, I was thrown into it. I didn't really expect any of it. I didn't really know who to talk to, if say I did feel unsafe. Making space for that.
- Just coming in and asking can be difficult, because you're not always going to get honest answers from people.
- When I was in hospital, we had an outside advocate that came in. They were there nearly every day. So, maybe if you're speaking to patients, independent organisation to feed back to is important. Then you don't feel as bad feeding back to the people doing it directly.
- Making sure it's someone you're comfortable with, that makes it easier.
- I think they could face the difficulty of whether they can trust the person. If they can reassure them about what they're doing with the information, explaining exactly what will happen, that can help.
- Giving the option to people if they don't feel comfortable feeding back outside… e.g. if they have a worker they trust, that they can do it through them.
    - Several routes to go down. Some people would want this.

Reflections from people with experience of living in low and medium secure services

- Interviewing service users in the hospital, getting a first-hand account of how safe people feel to pick up on the vibe of that, more so than staff. Good to talk to more 'on the ground' staff who know about the service users [rather than more strategic staff who might not know service users as well].
- Looking at data on meds errors, people going AWOL, trips to A&E.
- But more importantly, talking to staff and patients and where possible their family and friends.
    - Then triangulating to build a full picture painted by the data, staff, service users and family and friends. Then seeing where it matches and where discrepancies are. So the situation can be clarified.
- It's about getting a multidimensional and multi-layered map.
    - Using some sort of tool that allows you to compare and contrast the different bits of data that you get.
    - Having some sort of benchmark of what a safe environment is, how it presents in the data and in what service users, staff and friends and family are saying.

Question from facilitator*: Would this fit with the current rating system or should a new one be brought in?*

- Criteria are fine, but it's about how you arrive at those ratings that might need to change.
- [An English NHS Trust's] Acute Wards have been identified as "Inadequate" in several areas, over several years by the CQC - but nothing ever changes.
    - If that kind of thing happened in a school OfSTED report, the school would have gone into Special Measures.

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Question 4: How could CQC make it easier for people using these services, and their families and carers, to share their experiences?

Reflections from people with experience of living in adult eating disorder services

- Having some sort of website, where you can put in a request to be interviewed.
- Writing letters to them about your experience, without it being a complaint but just sharing feedback.
- There needs to be a "non-complain-y" way of giving feedback. I've complained several times now and sometimes you feel heard, but other times you don't.
    - Recently made a complaint and its being taken more seriously. I've been told that change is being made because of me, which is empowering.
    - But I've also felt unheard [not heard back] in other instances like when complained about staff member falling asleep during their 1-1.
- They should also come in more regularly for casual check-ins, which can lead to formal inspections if they think sometimes wrong.
- Having the feedback loop is important.

Reflections from carers supporting those with experience of living in AED, CAMHS and secure services

- Service user involvement is key. The needs of the individual are priority, but there should also be support for carers.
- Focus groups/consultations could be a way to go.
- The person you're supporting might not want to do this, but maybe they'll want to disclose it to a family member, professional, or friend, and that should be supported.
- They should also consider cultural differences. Overall, the opportunity to speak up about their experience in whatever capacity. We need to create this inclusivity for people to feel open to share.
- CQC inspector & the individual (*if they're well enough/consenting*) should be able to talk about the experience they've been having.
- Real open dialogue is needed.
- Speaking to the individual has to be paramount every time. Making sure that this is included is essential.
- If it was me, at that time, I would have definitely responded to a questionnaire asking for feedback and my experiences of my daughter's stay in hospital. It's an easy way to share your experiences.
- An email can work better than a call as you have more time to think about your responses, and a questionnaire for feedback.

- I would definitely want CQC to come to me, rather than the other way around.
- Not aware of CQC or anything, I wasn't aware of them at all – had no idea that they were there for me to be able to do that, so whether posters or leaflets in hospital reception to let people be aware.
- It would be good for the CQC having open online forums with parents / carers.
- More avenues for complaints for all and CQC can access.

Reflections from people with experience of living in children and adolescent mental health services

- There needs to be a relationship between these people and you, so they can learn to trust you.
- It's hard to trust people you don't know.
- You do the work, and never really see anything changing from it… Having feedback and constant re-engagement with these people, so it kind of fosters a relationship of trust with them would be good.
- Going to where people are. Rather than expecting people to come to you. If you're wanting feedback from people in patient services, going to people and asking them for feedback. Not expecting them to come to you.
- Yes [building relationship, hearing about changes made, even if nothing has happened – being told that. Going back to people rather than expecting them to come back to you]. I think generally, more opportunities, more widely available, so that more people know about them.
- I had no idea how it worked whatsoever [how, when and why we could get in touch with CQC]. Someone explaining to me how it worked, would have been helpful. Even if you just had some information leaflets or posters up that explained it in a simpler way for people might be helpful.

Reflections from people with experience of living in low and medium secure services

- With secure services it might be sending someone down to the ward to simply talk to people. I think you have to be that proactive, just putting up a poster with contact details won't get you anywhere.
- I agree completely, some people can be reticent at expressing their opinions. Some people are scared of complaining about treatment for fear of retribution from services and either themselves or their loved one suffering.
- The CQC needs to assure them that they will be safe and making services aware that they have a duty not to treat people differently according to how they feedback. Making sure that confidentiality is not breached.
- I'm also thinking about junior employees, they have the most contact with service users and whether they feel comfortable feeding back to CQC. They might feel like they've been thrown under the bus.
- Making sure people have anonymity, so it's like 'patient x' [to reassure people when giving feedback to CQC].
- I felt powerless to feedback myself and unclear as to how to. Being under [an English NHS Trust's] care, I did not feel that I dare bite the hand that fed me. Some time later. I told my community psychiatrist. It was obvious they weren't going to do anything about it. So, I wrote it in a letter to be uploaded to my medical files. I took a look at the

upload one day - all the parts about the [specific instances of poor care] had been removed! So, that's what we are dealing with.

- I've been in touch with CQC regarding something. Took a while for them to get back to me with a response. Tried phoning them, on the phone for ages trying to get through to them.
- There should be a way for families & carers to actually access the CQC themselves. Without CQC having to come into the hospital, then offer advice. A hotline for families to contact the CQC. Then they can get their point across, and feel heard.

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Question 5: How could CQC make it easier for people using these services, and their families and carers, to feel heard?

After the co-production session, we separated out the question around having the opportunity to share experiences, and feeling heard.

People reflected that 'sharing experiences' was process-oriented e.g. practically, how can CQC ensure people have the opportunity to feedback on services. Whereas 'being or feeling heard' was about the impact of the opportunity to share the experiences e.g. feeling empowered by change made after sharing the experience.

Reflections from a carer supporting someone with experience of living in AED services

- Written and verbal feedback, via family member or carer.
- Follow up care in the community or other means.
- No wrong door, and it means should be open.
- Open dialogue is very important.
- Questionnaires that are super long are not engaging, but short and clear questionnaires could be a way to go.
- The way someone feeds back should be catered to the individual. The method should be kept completely open, flexible, and tailored to them. The choice should be up to them.
- It should be flexible for various reasons including people have fluctuating capacity.

Reflections from people with experience of living in children and adolescent mental health services

- When I was in hospital, I was under 18, so my mum was taking care of me. My mum found a lot of things hard to understand about what was going on. Because she wasn't there every day. Need to make it more accessible in that way.
- Letting people feedback through carers. If they want to. A lot of the time, it was easier for me to speak through my mum and let her feedback for me. So, facilitating that as well.
- Having a space away from that person… not sure about adult services… but with young people, letting the parents or carers feedback *on their own*. As they might not want to upset the young person.

Reflections from people with experience of living in low and medium secure services

- I think some feedback around what they've done with the feedback as well as a copy of the report that they do and what the services have been asked to do off the back of that.
- If they had people going to the wards to do questionnaires then part of that is speaking directly to them about what came up since the last time they visited, what's been happening in the last 6 months.
    - Like a 'holiday rep' type thing where it's the same person who comes back.

Question from facilitator: *So if it's a named person from CQC then you know they're going to be back and you can feed things back to them now?*

- You do often have CQC people for certain areas so I think that could be practicable.
- That puts some light pressure on the hospital if they know that someone's going to be back to see if issues have been resolved.

Comment from facilitator: *Having a CQC named person who will attend a regular meeting and expect a list of actions to be updated on.*

- More staffing on the ward would help us feel heard. When they're not rushing you. When you're rushed, you don't feel heard.
- It would very accessible if there was a page you could go to. Like FAQs on their website. That's updated so your carers can see what's going on. And leaflets.
- You know you're being heard, when they tell you what's changed; because they can physically show you they're starting to make changes.

Reflections from carers supporting those with experience of living in low and medium secure services

- Somebody who either writes to us, or picks up the phone saying "we understand what you're saying and we will do something about it".

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5. Additional reflections from people with lived experience, and families and carers

These are additional reflections that did not fall under any of the previous questions but we felt should still be included.

Reflections from people with experience of living in adult eating disorder services

- Transition when coming out of in-patient wasn't very good.
- They just shoved me into the real world, and I relapsed.
    - There needs to be careful planning for patient's discharge and transition, otherwise the system is failing them as they just return to hospital.

- It's important you're treated like a human being in hospital and not just "patient at room X".
- Disability access in services is difficult. They have not thought about disabled people at all.
    - Some hospitals won't accept him because they don't have wheelchair access. It's wrong, people should not be refused care due to their disability.
    - Currently, the ward is not set up in an easy and comfortable way for wheelchair users. I can't get into the kitchen, so I can't do parts of my recovery plan such as going into the kitchen to pick up my own food.
- There should be step down units where you go in-patient to day-patient, with varying frequencies (5 days a week -> 3 days a week -> 1 day a week).
- It should be a slow transition leaving inpatient care.
- Care and safety needs to be extended to before, during, and after admission.

Reflections from people with experience of living in children and adolescent mental health services

- Constantly involving people involved in the services. It's gotten a lot better, but people are experiencing it.. getting a lot more involved. Really important. Not really an experience that can be understood unless you've been involved in it. Making sure you are developing relationships where they can be honest with you.
- Even if it's not necessarily someone you've seen before, might not always be possible. Having things explained to you and being open to questions and just thoroughly explaining what's going on, it can be a bit confusing.

Question from facilitator: *Did you know about CQC? Did you meet anyone from CQC? Have them explained to you?*

- Kind of explained about CQC, but didn't interact with anyone. Vaguely knew what they were doing. I know we were told that they're a last resort if somethings' going wrong. Go up the chain then go to CQC. Ward Manager explained it should go to nurse, then head nurse, then ward manager, then CQC if issue wasn't sorted by then. Not explained what you could go to CQC for.

Reflections from people with experience of living in low and medium secure services

- One thing is the actual ward environment. Some of them are in very old and outdated buildings. One was just 2 corridors with everyone squashed in. The locks from when they used to lock people in were still there. They didn't use them, but they were still there. They got some money to redo it and it was like a different place when I went back for some engagement work, it was light and airy, people weren't on top of each other.
- Is it a homely environment or is it barren because they've gone too far on the safety front?
- Whether someone gets discharged or not should not rely on whether the Psychiatrist is on (extended) leave or not.
    - Both on and off the ward, my treatment centred around the leave of the psychiatrists.

    - It was clear that they were also anxious to clear the bed. Once in the community, I did not see a psychiatrist or psychology for many months / a year, because they were on extended leave / on sabbatical.
- I just want to know where this will go from here.
- Do we get a copy of the report [you send to CQC]?

Reflections from carers supporting those with experience of living in AED, CAMHS and secure services

- Originally, I didn't know anything about the processes or procedures, what I could be involved in in terms of meetings. There should be some sort of booklet or info about processes and how things work within a hospital environment. Just had to find out myself.
- I think that the problem is though that there are systems and better methods put in place, but it's getting the actual staff to follow them that in my experience seems to be an issue. Because I've read all the guidelines and everything and they all sound like great and amazing. But if you haven't got the staff and those staff aren't trained to follow those procedures and guidance correctly then it doesn't work.
- His care needs to extend way more than just discharge.
- It's a constant battle… it never ends and it shouldn't be this way.
- If you can try and get an LPA (last in power of attorney). It will give you more clout. They can't ignore you then.
- Unless you stumbled across it [this engagement session about patient safety and care], you would have no idea this was going on. CQC need to communicate more widely about what they're doing.
- Be keen to hear about CQC involvement as a parent and any opportunities to influence.

6. Feedback on the experience of the engagement sessions

People provided some feedback as we went through the sessions, which we felt was valuable to share with CQC.

We also plan to have a satisfaction survey, to gather more feedback about the process. We will share the results of this survey with CQC once complete.

"Thank you for a great meeting today to scope how to engage and gather vital feedback for the above project."

- **Person with lived experience of secure services (co-production session)**

"Yes I'm doing ok, I found the session really good and interesting; thank you for checking in."

- **Person with lived experience of adult eating disorder services**

"The project you are working on, is superb. I am so glad it is being done and that some basic changes may be made to patient safety and care - often the simplest ones do not even require much money."

- **Person with lived experience of secure services**

"I think I found it (the session) quite empowering to speak about my experiences. For me personally, it's been really good. I feel like I've been listened to. It's been empowering to have my voice listened to."

- **Carer of someone with lived experience of AED services**

"I would love to know what happens next!"

- **Carer of someone with lived experience of AED services**

"Rethink do this [engagement] really well. I think they do it the best."

- **Person with lived experience of secure services**

"It's a really important issue. There are serious consequences when it does go wrong."

- **Person with lived experience of secure services**

"I feel good [after the session]. It's really good, makes you feel heard, and listened to and understood, and that is lacking so much in services with regards to carers and their involvement."

- **Carer of someone with lived experience of CAMHS**

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7. Areas for consideration and reflections

Person-centred approach

- Regular reviews of individualised care plans and a person-centred approach as part of assessment of care, through triangulation of findings from conversations with both staff and people in services, ensuring there is a greater understanding of the quality of care people receive.

Greater and improved access, options and knowledge for making complaints and/or providing feedback through closed feedback loop

- Ideally multiple options for providing feedback and complaints, through surveys, focus groups and in association with advocates will enable inspectors to have a greater understanding of current issues in a service.

- Clear information provided on a regular, updated basis to people in services, and families and carers, about the options for feedback, and complaints, to ensure people are aware of the mechanisms for having their voices heard by the CQC.

- Regular engagement to be available, such as a 'named CQC focal point' who attends on a semi-regular basis (announced and unannounced) to check-in on ongoing situation, rather than waiting for formal inspection or reports to be investigated. This will contribute to greater trust, as mentioned by people in the sessions.

- For announced visits, information could be sent to people on the ward ahead of the visit and ask them to complete a ‘feedback survey’, so CQC is aware of what issues might be raised during visit (and what to look out for). This will help ensure that the visit can be more focussed and tailored to the information already received about any highlighted issues.

Widening engagement with the CQC Inspection team

- Look into how people living in services could have more access to the inspection team throughout the visit, both to build trust and maximise the involvement of people in services in the inspection.

- It is important that the inspection team are able to engage with a wide range of staff on the ward, including peer support workers to gather a wide range of views, in addition to the managerial staff and data provided.

- Ensuring other stakeholders are involved in inspection visits e.g. allied health professionals, advocacy, external organisations to provide a broader perspective during the inspection.

- Having an ‘open access’ process to enable families and carers to engage with the inspection team throughout and after a visit in order to capture their perspectives.

- People in services could have access to information about the CQC role.

- Flagging CQC contact information on a regular basis when visiting or attending services, as well as ensuring printed communications and other accessible formats are available to people.

Reflections on the observational methodology

- Engaging and speaking with people living in services was said to be the most productive and effective way to learn more about their experience of patient safety. Although we are aware that Experts by experience on the inspection panels do this already, giving Inspectors this time to engage with people living in services would be beneficial to gathering the wider experience.

- The benefits to those living in services of being able to have an open dialogue and time to build trust has been a common theme throughout the feedback sessions. This would also give the inspection experts by experience focused time to have 1:1 conversations.

- There could be a greater balance of data collection and observation alongside speaking with people and getting qualitative feedback.

- The questions asked by experts by experience could also be accompanied by time to focus on having 1:1 conversations, which may aid in building trust and gathering more relevant information. However, experts by experience would need additional training to conduct a more flexible mix of asking direct, structured questions and a more conversational approach.

- The observational methodology approach could be extended to include one or two 30-minutes ‘drop-in’ slots for people to talk to the inspection team directly.

- A full day is needed on a ward to build relationships and see people throughout the day and to incorporate these suggestions.

CQC involvement in transitions (discharge / moving between services)

- The CQC may want to reflect on how they could be involved in assessing safety and care in the transitional stages of inpatient care, Especially for services where high readmission rates due to relapse after step-down / discharge e.g. AED services.

Feedback loop

- Multiple people involved in the project suggested that the report be made available to participants in the engagement project. The CQC may want to consider sharing the report with all inspectors, and experts by experience involved in inspections, also.

8. Recommendations for system wide improvement

This report has identified many systematic and cultural issues that may sit outside the CQC's remit but have major impacts on patient safety and care. We have therefore set out the following broader recommendations for government, that we hope the CQC may help champion:

- The government must ensure there are clear recommendations as part of the NHS workforce plan with a commitment to more funding for the mental health workforce. This should include a mental health inpatient workforce plan that includes peer support and commissioning VCSE to deliver services on wards.
- The government must prioritise and properly resource the reform of the Mental Health Act.
- The government's response to improving patient safety must focus on relational security (building better relationships between staff and patients) as much as physical security (e.g., ward design) and procedural security (e.g., safeguarding procedures).

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9. Reflections from Rethink Mental Illness on overall project process

Challenges

We recognise that this work is a 'snapshot' of the experiences and issues faced by those with experience of being in these services at a specific time.

Planning and Recruitment

We also recognise that shorter timelines for planning and recruiting will reflect the limitations in the ability to engage with an appropriately diverse pool of people living in services.

Recruitment and engagement

- **Time for preparation**: recruitment is only effective if there is time to build relationships with the stakeholders you're asking to share the opportunity via. Having this initial time with to build relationships with key stakeholders is key to meaningful engagement. Especially to engage with diverse organisations, and gathering consent to contact existing connections about such opportunities

- **Building relationships** with people with who are or have experience living in services requires time and trust. And **diverse engagement** requires more time to work with existing structures and systems and organisations who hold these relationships, to build trust.

- **More time** will also allow for more options for engagement such as 1:1 calls, small groups, online, in-person, anonymous survey options. This will enable us to support people where they are on their recover journey.

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10. Annexes

Background information and eligibility screening

EASY READ version: Background information and eligibility screening

Signposting resource

Co-production session slides

Engagement session slides

EASY READ version: engagement session slides

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