Closed cultures

Key points:

- Through our monitoring activity this year, we have seen that more people, including staff, are now aware of the factors that can lead to a closed culture developing.
- We have seen positive examples of good practice where patients have been involved in decisions around their care and treatment, highlighting the benefits of an open and inclusive culture.
- However, we are still concerned that too many abusive and closed cultures persist. Many of the concerns raised in this report, for example around consistent staff shortages and lack of training and supervision of staff, are inherent risk factors and potential warning signs of when closed cultures could be developing.
- While it is positive to see awareness of the risk factors of closed cultures we, along with providers and staff, need to continue to be vigilant to the inherent risks and warning signs to ensure people are not being put at risk of deliberate or unintentional harm.

We define a closed culture as “a poor culture that can lead to harm, including human rights breaches such as abuse”.

In services where there is a closed culture, people are more likely to be at risk of deliberate or unintentional harm. As a regulator and a member of the UK National Preventive Mechanism, we have a duty to act when we believe that people are at risk of ill treatment, so their human rights may not protected.

The likelihood that a service might develop a 'closed culture' is higher if an inherent risk factor is present. Certain features of services will increase the potential for inherent risks. For example:

- services where people are unable to leave of their own accord
- live-in services such as shared lives or supported living services
- any service where one-to-one care is provided
- where a provider changes the type of service it offers in response to market or other influences.

While closed cultures can develop in any type of health and care setting, we are particularly aware of the increased risk in services that care for people with a mental health condition, autistic people and people with a learning disability.

In 2021, we published guidance on how we identify and respond to closed cultures. This guidance highlights the impact of closed cultures on people's human rights and raises awareness of the signs we look for that may suggest a service is at risk of developing, or has developed, a closed culture. The guidance recognises that where there is a risk of a closed culture, we may carry out an unannounced inspection or inspect out of hours. This is separate to our monitoring visits.

Through our monitoring activity this year, we have seen that people, including staff, are aware of the drivers that can lead to a closed culture developing. This wider awareness has led to concerns being raised with us directly through complaints and staff speaking up, allowing us to act quickly and ensure issues are appropriately escalated.

However, as we reported last year, we are still concerned that too many abusive and closed cultures persist. Many of the concerns raised in this report, for example, are inherent risk factors and potential warning signs of when closed cultures could be developing.

In this section, we look at some of the issues raised in this report in relation to the inherent risk factors and warning signs we identified in our guidance on closed cultures. We summarise our findings under the 4 indicators of closed cultures identified in our guidance:

- people may experience poor care, including unlawful restrictions
- poor skills, training and supervision of staff providing care
- weak leadership and management
- lack of external oversight.

We also highlight some of the good practice we have seen through our monitoring activity that help to prevent this from happening. While it is positive to see awareness of the risk factors of closed cultures we, along with providers and staff, need to continue to be vigilant to the inherent risks and warning signs to ensure people are not being put at risk of deliberate or unintentional harm.

Patient experience

Empowerment and involvement is a guiding principle of the MHA Code of Practice, and states clearly that patients should be fully involved in decisions about care, support and treatment.

As outlined in our guidance on closed cultures, where this is not happening and care plans are not being individualised or do not reflect the person's voice, this could be a warning sign that closed cultures may be developing.

Through our monitoring activity, we are pleased to see many positive examples of good practice where patients have been involved in decisions around their care and treatment, highlighting the benefits of an open and inclusive culture:

> "The feedback we received from patients was overwhelmingly positive. All patients felt staff were incredibly kind, helpful and supportive. One patient told us that being on Ladden Brook and the 'incredible' support he had received from the staff team had 'saved his life'. All patients we spoke with told us that the responsible clinician was very nice and that they felt he listened to them and involved them in decisions about their medication and treatment. Patients told us they were involved in their care plans and that they had been offered copies."

Fromeside Ladden Brook (medium secure rehabilitation ward for men), Avon and Wiltshire, April 2022

> "All care plans we read showed patients' involvement. Staff documented the level of engagement the patient had in writing their care plan, mental capacity concerns, whether the patient agreed or disagreed with the content of their care plan and if the patient signed their care plan. All care plans we read were frequently reviewed by staff and the patient. Staff documented whether the patient accepted or declined a copy of their care plan."

Silverstone ward (specialist dialectic behavioural therapy rehabilitation ward), St Andrew's Hospital, January 2023

Carers also play a key role in ensuring that the patient voice is listened to and in reducing the likelihood of closed cultures developing. At one service, a carer told us they were grateful that staff sought their views on communicating with their autistic relative:

> "The carer said it was also the only ward to have taken notice of their experience as a carer, to have sought their insight and to have used that information to best

> communicate with the patient."

Mixed-gender acute ward for adults of working age, February 2023

However, we continue to see evidence of people not being involved in their care. As an example, we received a complaint that the specific needs of a deaf person with a learning disability were not adequately addressed. Neither the patient nor their family were given information about rights and the family members were excluded from care and treatment decisions.

This complaint is also a potential warning sign that the service is not safeguarding people against discrimination, harm or abuse. This is just one of multiple examples where providers have not enabled inclusive and respectful cultures. Other examples, as highlighted in our section on inequalities include:

- incidents of patients making racially abusive comments to other patients
- services not respecting patients' choice of pronoun
- providers not considering inclusive ways of communicating with people with protected characteristics as defined by the Equality Act 2010.

Hospital managers have a duty to ensure that patients who are detained under the MHA are aware of their rights, such as in relation to complaints, appeals, advocacy, legal advice, safeguarding and the role of CQC. Some patients find it difficult to understand their rights, especially when they are very unwell. We expect services to provide information to patients, and their families, in a format that is appropriate for the individual person to help them understand. This should happen as soon as possible after detention and then regularly throughout their period of detention. Our monitoring visits have enabled us to see evidence of patients being told about their rights, and in some cases, we have seen good examples of providers ensuring that patients are informed of more detailed information, such as policies on mobile phone use.

However, we have also seen examples of patients not being told their rights or not understanding them. We interviewed people with lived experience and asked them whether they knew about their right to a tribunal and whether they knew which section of the MHA they, or their loved one, were detained under. Some of the people we asked could not recall being told about tribunals or what section the detention was under. Where patients are given no or poor information about their rights, this could be a warning sign of closed cultures developing.

Staffing

Many of our concerns around closed cultures are linked to issues with staffing. High turnover of staff, consistent staff shortages and lack of training and supervision of staff are all inherent risk factors for services developing a closed culture. In our section on workforce, we highlight multiple examples of services operating with lower than recommended staff levels, and examples of staff, in many cases agency staff, not being given the training they need to be able to care for people in detention.

We have also seen examples where staffing shortages are leading to the inappropriate use of restrictive practices, including the use of blanket restrictions. For example, in our section on workforce we highlight that patients in multiple services told us about times when they were not able to access fresh air because there were not enough staff available to escort them or planned leave was cancelled. We have also seen evidence of strict blanket policies around access to fresh air.

The MHA Code of Practice is clear that access to fresh air and leave is important for people's recovery, and that decisions around people's ability to take leave should be based on risk. However, at one service we saw evidence of leave being used as a reward or punishment. Not only is this completely unacceptable and dehumanising, it is also a potential warning sign that the service could be developing a closed culture.

Positively, we have seen examples of services taking steps to mitigate against these risks. This includes, for example, reducing the use of blanket restrictions and encouraging patients to move around service environments freely. In our section on restrictive practices, we highlight the example of an acute unit that had safely introduced an open-door policy.

Leadership and management

As highlighted in our 2020/21 State of Care report, problems with oversight of leadership and management are a common theme in services with a closed culture. As well as playing a key role in setting the culture of an organisation, managers are responsible for ensuring that services are fit for purpose.

As we highlight through this report, this year we have continued to raise our concerns about the condition and suitability of the physical environment that people are living in. This includes, for example, wards with broken equipment, lack of en-suite facilities in seclusion rooms, and the increased risk of restrictive practice due to unsuitable physical environments. Not adequately addressing concerns around the physical environment could be a warning sign that a closed culture could be developing.

We have seen some good examples where services have been alert to this risk and have taken steps to address it. For example, in our section on restrictive practice we highlight the example of a new long-term seclusion suite that had its own secure garden and bathroom arrangements that were both safe and dignified.

Where things aren't working well, we would expect that managers would engage and respond well to recommendations from external agencies. This may include, for example, making changes to the physical environment in response to a MHA monitoring visit.

External oversight

Warning signs that a closed culture could develop include where there is a lack of monitoring by, or limited interaction with, outside agencies. The outbreak of the COVID-19 pandemic, and the restrictions introduced in response to this, increased the risk of closed cultures developing as it prevented external bodies, such as reviewers, and friends and family from visiting.

While these restrictions have not been in place for a long time, we continue to see the legacy of COVID-19 in restrictions around cleanliness and reduced visiting. However, we have also seen examples of NHS mental health trusts demonstrating open and inclusive cultures. For example, at one trust we visited there was continual external oversight from the independent mental health advocates (IMHAs) who were based at the hospital:

> "There were two IMHAs who shared the role, so there was always cover. They were based at the hospital, so could meet with patients very readily. The IMHA said they always attend the community meeting on a Monday. The IMHA said that they would welcome more engagement from the consultant psychiatrist."

Acute ward for men, October 2022

As well as formal regulation, such as our monitoring visits, visits from family, friends and independent mental health advocates (IMHAs) all play an important role in providing external scrutiny and preventing closed cultures from developing.

However, we remain concerned about patients, particularly autistic people, people with a learning disability and children and young people, being placed in hospitals far from family and carers for prolonged periods. Being placed far from home can make it more difficult for families and carers to be involved in their relatives' care and in turn increase the risk of closed cultures developing.

We know that more needs to be done to understand whether the culture in mental health services is safe and caring. We are committed to improving how we can be better at understanding the culture of a service, and how we identify potential risks or actual harm, neglect, discrimination, abuse, inequalities and human rights infringements in care provision.

We will spend more time on site so we can focus on behaviours, attitudes, working practices and environments during our assessments of inpatient mental health settings. This will enable us to observe activity and interactions over extended periods of time and it will provide us with the opportunity to talk for longer to more people, their friends and family and to members of staff. Our focused approach has been co-produced with people with lived experience, and covers themes such as:

- respectful and compassionate communication
- positive, supportive and kind ward cultures
- providing access to support
- safe, caring and therapeutic environments
- positive relationships with families and carers
- promoting the principle of least restrictive practice

If people are at risk of or experiencing unsafe care, inequitable or disrespectful treatment or if the standard of their care falls below that which we would expect, we will take action to protect them. We want our strengthened approach to also positively influence providers to identify warning signals of unsafe and uncaring cultures on their own wards and to make the necessary improvements.

As part of our commitment to tackling closed cultures, we are looking at how we can incorporate this into our monitoring of the MHA and strengthen our assessments of a service's culture and understanding of the experiences of detained patients.