Care Quality Commission inspections of high-security hospitals

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Abstract

Research paper

Purpose. Patients detained in high-security psychiatric hospitals are particularly vulnerable to excessive restrictions and exploitation. In the UK, the Care Quality Commission (CQC) monitors and regulates forensic healthcare provision. This study seeks to identify key concerns highlighted in CQC inspection reports of the three high-secure hospitals in England between 2010 and 2018.

Design/methodology/approach. In this qualitative study, 49 CQC inspection reports from three high-secure hospitals were subjected to thematic analysis.

Findings. Five central themes emerged: (1) *Staffing and management*; (2) *Restrictive practice*; (3) *Physical environment and ward atmosphere*; (4) *Patients' needs and involvement in their care*; and (5) *Legal and statutory matters.* There was some variation in overall quality of care between the hospitals. Positive staff-patient interactions and good practice in assessing and delivering care were consistently observed. However, enduring staff shortages within each hospital were experienced negatively and sometimes co-occurred with concerns over restrictive practices, poor care-plan procedure, and inadequate legal documentation. Over time, Rampton and Broadmoor Hospitals appeared to worsen with regards staffing levels, staff morale and management involvement. While services progressed over time in providing patients with access to advocacy and information concerning their rights, in some recent inspections it remained unclear whether patients were adequately involved in the care-plan process.

Practical implications. These findings provide preliminary indicators for areas requiring further attention from policy makers, clinicians and advocates.

Originality/value. This study appears to be the first systematic analysis of key concerns expressed in CQC reports of English high-security hospitals.

Keywords: high-security hospitals; quality of care, Care Quality Commission

INTRODUCTION

Forensic-psychiatric services provide treatment and care for patients who suffer from a mental disorder and have offended or are undergoing legal proceedings. In the UK, in-patient treatment for this group is provided in high, medium, or low secure forensic-psychiatric facilities which aim to treat the disorder and any behavioural disturbance, and reduce the risk of re-offending. In England, patients with severe behavioural disturbance who are considered a particular risk to others receive treatment in one of three high-secure hospitals which are run independently under the administration of local NHS Trusts. All patients entering high-secure services are detained under the Mental Health Act 2008, although not all are detained under criminal sections of the Act. In accordance with the National Health Service Act of 2006, these individuals 'require treatment under conditions of high security on account of their dangerous, violent or criminal propensities'. They will likely experience complex, co-morbid mental disorders, substance misuse problems and are liable to attempt absconding (NHS England, 2015). This allows an individual to be incarcerated and treated against his or her will.

The importance of monitoring care-quality in high secure hospitals

There are significant ethical considerations that arise in relation to the detention of mentally disordered offenders in inpatient settings. In contrast to other areas of mental-health care, the treatment and management of patients in forensic settings is not solely for the advantage of those individuals, but also for public protection and a difficult balance needs to be struck between the needs of the patient (e.g. Coid and Maden, 2003) and the need for security and public protection (e.g. Turner and Salter, 2008). This gives rise to a number of ethical dilemmas, particularly as patients in forensic-psychiatric settings often have long admissions (Völlm et al., 2016), and often at inappropriately high levels of security as demonstrated by Harty et al. (2004) in which 40% of surveyed high secure patients were judged to be suitable for transfer to lower security levels.

High secure hospitals are particularly restrictive settings. Intensive security measures impact upon patient choice, privacy, independence and contact with family outside of hospital (Tomlin, Egan, Bartlett, & Völlm, 2019). Daily routines are often repetitive and therapeutic activities may be limited due to risk management considerations, and the quality of life in these restrictive environments is often poor (Vorstenbosch et al., 2014).

Monitoring and regulation of care-quality is therefore of particular importance in high secure hospitals to protect the patients they serve from unnecessarily prolonged admissions,

excessive restrictions on autonomy, reduced quality of life, exploitation and victimisation (Scott et al., 2013).

The Care Quality Commission

In England, the Care Quality Commission (CQC) currently monitors mental health services. The CQC was established in 2009 as a non-departmental public body of the Department of Health which regulates health and social care; it aims to monitor and inspect health and social care services to ensure they provide high-quality care that is safe, effective and compassionate. There is evidence to suggest that the key domains assessed by the CQC have been adopted by healthcare providers, who see such inspection as important for quality improvement (Smithson et al., 2018). Providers have taken responsive action before, during and after CQC inspections, demonstrating positive impact. However, there are some limitations to the efficacy of its investigative model, the range of adequate quantitative measures of impact, and it's perception by some as a tick-box exercise (for a discussion of the impact of the CQC see: Smithson et al., 2018)'.

Care Quality Commission inspections observe care provision; seek the views of service users, their caregivers and clinicians; review information gathered about a service; and check procedures and systems. The CQC identifies five domains as markers of quality, and assessment of the degree to which services meet standards is based on five broad questions about the service (CQC, 2018a): (a) is it safe, (b) is it effective, (c) is it caring, (d) is it responsive, and (e) is it well-led? One of four possible ratings is assigned in response to each question: 'outstanding', 'good', 'requires improvement' or 'inadequate'. In addition, an overall rating is given to the service (CQC, 2018b). Prior to 2013, the CQC used a less rigorous methodology critiqued for a lack of robustness (Smithson et al., 2018).

Each criterion is operationalized through series of questions or 'key lines of enquiry' (CQC 2018c). These are described in guidance documents; examples of questions asked include: 'How are safety and safeguarding systems, processes and practices developed, implemented and communicated to staff?', 'Do services run on time, and are people kept informed about any disruption?', and 'Do staff show an encouraging, sensitive and supportive attitude to people who use services and those close to them?' (CQC, 2018c).

Inspections are conducted by a team of clinicians, pharmacists and Experts by Experience ((ex-)service users or carers). Depending on the service inspected teams can comprise 1 to 50 members (CQC, 2018d). All services registered with the CQC are monitored and routine information is collected in advance of a visit and collated into a pack for the inspectors. This

includes feedback from the public, consumer agency 'National Healthwatch', concerns raised by staff, and directly from the care provider.

During inspections, data are collected from local and national databases, interviews with patients and staff, observations of environments and practices, and records and documentation (CQC, 2018e). Inspections can be announced or unannounced and comprehensive or focused on a particular concern. Feedback sessions with senior staff follow the conclusion of an inspection. Good practice and areas of concern are then detailed in published reports. Care providers are then asked to respond to areas of concern and in the case of specialist mental health providers, attend a quality summit in which results are discussed with partners in the local social care and health system (CQC, 2018f). Quality assurance panels are established to review samples of reports and examine consistency in rating judgements.

Aims

This qualitative study aimed to identify, synthesize and contextualize the key issues highlighted in CQC inspections of the three high secure hospitals in England over the nine-year period the CQC has been established from 2010 to 2018, and to identify any change over time.

METHODS

Sample

CQC reports relating to each of the three high-secure hospitals in England were examined between 2010 and 2018: Ashworth Hospital (Liverpool) currently containing fourteen wards caring for up to 228 patients; Broadmoor Hospital (Berkshire) containing sixteen wards caring for 210 patients with 24 flexible beds; and Rampton Hospital (Nottinghamshire) caring for about 350 patients. Rampton Hospital is the only high secure service in England which caters additionally for women, men with learning disabilities, and deaf men.

Data collection

All relevant inspection reports from the three hospitals published between 2010 and 2018 were downloaded from the CQC website or requested from the CQC archive by email. All reports made over this period were requested for two reasons. First, this enabled an analysis of changes in areas of concern over time. Second, whilst the framework for CQC inspections is prescriptive, there is scope for unique or unanticipated areas of concern not routinely

inquired about to present themselves during inspections. All reports were therefore included to capture a range of areas of concern so that these could be included in our analysis to highlight those that may reoccur in the future, thereby maximizing possible lessons learnt.

Analysis

Qualitative analysis of the content of each report was undertaken. Thematic analysis was selected as an appropriate analytic method (Strauss and Corbin, 1998) as it allows the most prominent patterns of meaning in the data to be highlighted and is able to provide a rich, detailed account of data (Braun and Clarke, 2006). Six phases of thematic analysis were followed. The first involved familiarisation with the data, where the reports were read multiple times and initial ideas noted. In the second phase, initial codes were generated and a coding framework developed based on relevant characteristics of the data which were extracted from the CQC reports inductively (Bazeley, 2009). In the third phase, codes were combined into overarching themes to represent the meaning of the data (Braun and Clarke, 2006). A recursive approach was used in which the text and subsequent codes were examined numerous times to identify the central themes. These themes were further analysed and a thematic map was formed to demonstrate how the emergent themes interacted. Finally, themes and sub-themes were reviewed, categorised and refined before being given definitions and names. Coding was undertaken by the lead author (SR). Reliability checks were carried out by the third author (BV) who independently extracted key themes; this independent extraction identified highly similar themes to those identified by the lead author. The themes emergent in both analyses were discussed. No inter-rater reliability was calculated.

Ethical approval

Permission to use the reports for the purpose of this study was obtained from the CQC. The project proposal was reviewed and approved by the ethics committee at the Division of Psychiatry and Applied Psychology at the University of Nottingham. This work was undertaken independently, but with the agreement, of the CQC.

RESULTS

Forty-nine CQC reports published between 2010 and 2018 were analysed. Table 1 summarises these reports and the CQC ratings of care quality. Five overarching themes emerged.

[Table 1 about here]

Theme 1: Staffing and management

This theme captured concerns relating to levels of staffing and the management of staff. Five sub-themes were identified.

Staff shortages

'Staff shortages' emerged as the most frequent sub-theme across reports, and with two connotations. The first concerns an actual shortfall in the number of staff deemed necessary for the delivery of safe care. Such shortages were perceived negatively by both staff and patients, were exacerbated during the summer months across all three hospitals, and appeared to have worsened in recent reports at Rampton and Broadmoor.

> *'Low staffing levels meant that safety to both patients and staff was at times compromised. Because of low staffing on some shifts, staff were having to undertake unsafe practice that breached trust policy by working alone on wards.'* (Rampton, 2017)

Concern was also raised about situations where a ward, despite having the minimum number of staff, experienced restricted ability to cope when staff were re-tasked with specific escorting or therapeutic duties, or were temporarily relocated. Issues relating to staffing appeared to be a particular problem within the female wards.

Impact of staff shortage on standards of patient care

The impact of staff shortages was felt in several areas. First, patient care and safety was felt to be compromised because such shortages led to inconsistencies in care provision. Existing staff were frequently moved around wards, resulting in a lack of regular professionals who knew the patients well. Second, patients flagged staff availability as an important issue, with widespread perception of receiving insufficient attention when staffing levels were reduced:

> *'….A patient told us she previously received occupational therapy input during her long-term segregation. However, she had not had this for five weeks. She did not know why …'* (Rampton, 2016)

Third, shortages led to cancelled occupational and therapeutic activities both on and off the ward, and reduced one-to-one time with patients. Concerns were also expressed that patients were sometimes denied access to fresh air and the garden.

Recruitment efforts

All three hospitals demonstrated continued efforts to recruit new staff and ensure that safe staffing levels were maintained. The overall impact of these efforts appeared limited, however.

Staff morale

Low staff morale emerged frequently, and was particularly significant in the recent reports for Broadmoor and Rampton Hospitals. One source of discontent was that reduced staffing levels were perceived as insufficient to allow delivery of quality care. Low staff morale appeared more prominently in reports where staffing levels were also low. Issues of staff shortages and low morale were reported less frequently at Ashworth Hospital in reports published after 2012, whereas the opposite was the case for Broadmoor and Rampton Hospitals. Wards for female patients appeared to suffer more from low staff morale than wards for male patients.

Management and training

Recent reports regarding Rampton and Broadmoor Hospitals highlighted a lack of supervision, poor feedback, and insufficient involvement from the Trust's management that were seen as contributing to low staff morale. Frontline staff felt they had only limited dialogue with Trust leaders, and reported a 'them and us' culture. Staff quoted not being 'heard', as well as fears of victimization in relation to raising concerns or whistleblowing.

Many reports indicated that access to good training was available, and most staff were up-to-date with mandatory training.

Theme 2: Restrictive practice

This broad theme encompassed two conflicting views of services. On one hand, some restrictions were perceived as excessive and unnecessary; on the other hand, continued efforts were being made to reduce restrictive practices across each of the three hospitals.

Excessive restrictions

In all three hospitals, inspectors and patients identified the use of excessive restrictions which were typically perceived as unnecessary or unlawful. Blanket restrictions which impacted on privacy, food, and kitchen areas were identified. In one example, patients were denied access to the garden due to insufficient supervisory staff. Patients in long term segregation (LTS) and seclusion were particularly disadvantaged by restrictions on accessing the outdoors.

Views on night-time confinement and segregation were less than positive across all hospitals. The practice was perceived as excessive and reinforced feelings of imprisonment and isolation:

> *'One patient expressed concern about the number of patients in segregation in the hospital, which together with night-time confinement led to patients being isolated for long periods, and stated that it did not contribute to good mental health.'* (Rampton, 2016)

Examples of restraint and seclusion being used pre-emptively were also noted:

> *'Some findings highlighted that seclusion may have been used pre-emptively, as a way of managing the ward environment rather than a response to the violent or disturbed behaviour of individuals'* (Broadmoor, 2013)

Patients and inspectors commented on excessive restrictions placed on all patients when accessing snack-type food, regardless of their health condition. However, differences in opinion between patients and staff emerged, with staff justifying certain food restrictions for a patient's own benefit.

Privacy and dignity were promoted adequately according to staff and patients. However, inspectors observed a lack of privacy in patient bedrooms and while using the telephone or email. These forms of unnecessary restriction were recognised as being more widespread at Broadmoor and Ashworth Hospitals in reports published between 2010 and 2012 compared to those published thereafter; however, the more recent reports suggested that these issues continued to persist at Rampton Hospital.

Reducing restrictive and coercive practices

There was widespread evidence of all three services implementing programs to reduce restrictive practices and segregation. It was evident that all three hospitals communicated with each other when developing guidance and implementing programs on restrictive practices, and particularly on the use of LTS. Inspectors also noted the efforts made to use certain restrictions only as a final resort:

> *'The Trust had a programme they used to reduce the use of restrictive interventions on their wards, called 'no force first', and this was central priority for the organization.'* (Ashworth, 2017)

Theme 3: Physical environment and ward atmosphere

Three sub-themes were identified.

Physical environment

No consistent patterns emerged as the physical environment clearly varied across wards. Reports prior to 2013 suggested a number of widespread problems relating to ventilation and the presence of safety risks, such as ligature points. Later reports contained more positive feedback in terms of ward facilities, cleanliness, and general décor with indications that patients felt safer and more comfortable in their physical environment. Newly-opened wards generally received positive feedback.

Ward atmosphere

Ward atmosphere, defined as the social state of a particular ward, was taken as including the perception of safety and the general mood of the ward as sensed by staff, patients and the visiting inspector. On some wards, nighttime confinement was perceived to impact negatively on ward atmosphere, particularly on high-dependency wards where patients were confined to their rooms in the afternoon and at night. Ward atmosphere was also negatively affected by tensions arising from staff shortages and in some cases by the types of patients admitted. For example, where there were patients with a diagnosis of personality disorder, the atmosphere was described as *"tense and volatile"* (Broadmoor, 2010).

Patient and staff engagement

Positive patient engagement and staff-patient interactions emerged as an important and recurrent sub-theme across all three hospitals and over time. Staff were consistently observed treating patients with care and respect even under hostile or challenging circumstances:

> *' 'I feel they [the staff] understand most aspects of me and my personality, they are calm, good at their jobs.' Another patient told us, 'I'm fully occupied and enjoying my therapies. The staff treat me well and I have no complaints.''* (Rampton, 2013)

However, these relationships became strained at times as demands on observations grew and staff were relocated.

Theme 4: Patients' needs and involvement in their care

Two sub-themes were identified.

Management of care plans

Reports on the quality of care plan management varied over time. Those published in 2010 revealed multiple instances where care plans had not been regularly reviewed. Poor documentation meant that inspectors often struggled to confirm whether patients were involved in reviewing their care plans, or even provided with copies. Although later reports were more positive, recent inspections at Broadmoor and Rampton Hospitals were still unable to confirm whether services were involving patients in the care planning process or were carrying out regular reviews.

Patients' care needs

Patients' care needs appeared to be adequately addressed across all three hospitals. There was ample evidence to suggest good practice in assessing need and delivering care and treatment according to individual care plans. Overall, patients provided positive feedback about their treatment and care, whilst also voicing concerns on the impact of cancelled activities on their treatment and recovery prospects.

Patients generally reported that services appeared to cater to diverse linguistic, cultural, religious, and dietary needs, often by utilising staff from other wards. Some instances of diverse needs not being met at Rampton and Broadmoor Hospitals were recorded in 2010, with a further occurrence at Broadmoor Hospital in 2013.

Physical healthcare needs and access to health services appeared to be addressed consistently and effectively:

> *'We saw staff talking with people in a respectful and calm way and responding promptly to patients' needs. We found effective arrangements were in place to meet patients' healthcare needs. Where necessary, patients were referred to external healthcare providers, such as local hospitals to have assessments and treatments.'* (Rampton, 2017)

The standards of the food provided in the high-secure hospitals generally received negative feedback from patients, and sometimes from staff. Issues included inadequately sized portions, poor food quality, and menus that were repetitive or which lacked options.

Theme 5: Legal and statutory matters

Two sub-themes emerged.

Legal documents and recordings

A pattern of outdated, incomplete or missing legal files, as well as the use of legally obsolete language emerged frequently in reports published in 2010, although subsequent reports demonstrated improved adherence to the MHA and its guiding principles. Reports published after 2013 indicated that staff had good knowledge of the MHA and their responsibilities, although inadequate documentation of incidents, restraint or seclusion was evident over time.

Patients' rights

A number of disparities in good practice were identified when applying the Mental Capacity Act to patients' consent or refusal of treatment. Failures to adequately record these discussions were reported across all three hospitals, especially in reports published in 2010.

Patients detained under the MHA are required by law to have access to support and help from an independent advocate. Earlier reports revealed instances where staff were not fully aware of the Independent Mental Health Advocacy (IMHA) system, and the visiting inspector did not see sufficient information about the IMHA on display to patients. In more

recent years, however, the presence of IMHA advocates has become more prominent and access to advocacy appears to have been promoted across all three hospitals:

DISCUSSION

Five core themes were identified in a thematic analysis of 49 CQC inspection reports from the three high security hospitals. Encouragingly, these reports contained a number of references to high standards of patient care, ongoing efforts to reduce restrictive or coercive practices, and good patient-staff interactions. These and other positive aspects are acknowledged in the following discussion, alongside recognition of a number of important concerns raised by the CQC inspectors.

Under the theme of *'Staffing and management'*, concerns about staff shortages and their impact on patient care were manifold in the CQC reports. Despite clear evidence of on-going recruitment efforts at each of the settings, it appears that staff shortages persist and these were perceived negatively by both staff and patients. The most prominent area of concern was the impact that deficient staffing had on daily activities, specifically the cancelling of occupational and therapeutic arrangements, and the reduction of one-to-one time with patients. These impacts have been reported elsewhere (Paparella, 2015), and the CQC itself has recognised the importance of adequate staffing levels in the delivery of safe, dignified and effective care, and the danger of failing to provide staff with the necessary time to remain responsive to individual needs (CQC, 2017b).

Meaningful activity is an important part of the therapeutic environment in high-secure settings. Boredom and idleness have been identified by patients as a basis of frustration and aggressive behaviour (O'Connell, Farnworth, & Hanson, 2010). In one study patients directly associated this frustration to a cancellation of planned activities due to staffing issues (Meehan et al.2006). In another, patients described engaging in critical incidents such as barricading a room or escaping onto the roof to kill time (Ireland, Halpin, & Sullivan, 2014). Cancelled activities can also impact on the potential for service users to broaden both vocation and social skills which can help future reintegration into occupational life (Völlm et al., 2014). It should be acknowledged that aggression is multifactorial and thus other phenomena should also be the target of sustained, complementary therapeutic intervention including: individual psychopathology, substance misuse, psychopathy, relational and situational triggers, and coping and resilience skills (Fazel, Gulati, Linsell, Geddes, & Grann, 2009; Hill, Rogers, & Bickford, 1996; NICE, 2015).

Issues of staffing were of particular concern in relation to wards for female patients, which are provided only at Rampton Hospital. This may arise because the female forensic ward environment has the potential to be particularly volatile and stressful (de Vogel et al., 2016). Managing aggressive behaviour and self-harm exposes staff to high levels of emotional and sometimes physical distress (Scanlon and Adlam, 2011) which are likely to be felt more keenly when staff levels are inadequate.

It is of note that some staff reported feeling that they were not being heard by those that managed them, and that some feared being victimised if they raised concerns. Apprehensions about whistleblowing are not unusual – it has been suggested that around 43% of staff in the NHS are not confident raising anxieties regarding unsafe practice and feel that their concerns would go unaddressed if they did (Francis, 2015) – but a reluctance to report such issues may be of special importance in high-secure forensic settings where the need for safety is paramount and challenging behaviour is common.

Under the theme of *'Restrictive practice'*, it is encouraging that the hospitals are reflecting on their restrictive practices in line with the recommendations made by the Department of Health (2014). However, reports of seclusion being used pre-emptively to manage the ward environment rather than in response to disturbed behaviour require consideration. In high-secure hospitals, seclusion practice is regulated under the MHA and underlined by the policies and guidelines of each NHS Trust. As a consequence, there are no precise limitations on the use or duration of seclusion and, perhaps quite reasonably, much is left to the discretion and judgment of healthcare professionals who are directly involved with the patient's care. However, such judgment can at times be highly subjective (Exworthy et al., 2001) with the potential for seclusion to be used in a manner that is restrictive or unethical. The existence of pre-emptive seclusion practice suggests there is scope for management intervention in the form of enhanced guidelines or accountability procedures.

Some of the reported opinions on other restrictions demonstrate the difficult balance that must often be struck between the provision of care and promotion of recovery principles with maintaining a secure and safe environment (Gudde et al., 2015). One example is the conflict between efforts made by the service to restrict unhealthy foods and patients' views on snack-type foods. Oakley and colleagues (2013) have described this particular issue as a tension between care providers' obligation to protect the lives of those it cares for and the right of patients to exercise individual autonomy. The CQC advises that blanket restrictions on food are excessive, and suggest a shift in focus to support healthy eating as an alternative (CQC, 2017b).

Under the theme of *'Physical Environment and ward atmosphere',* ward facilities, cleanliness and décor were all noted to have improved considerably since 2013. Also widely reported were examples of positive patient engagement and staff-patient interactions, characteristics which often determine the atmosphere and culture of locked wards (Johansson et al., 2007). There were, however, a number of reports of ward atmosphere negatively affected by the practice of nighttime confinement and by tensions arising from staff shortages, particularly the perceived lack of staff availability for supervising activities and individual contact. Good staff availability is one way of demonstrating respect and interest to patients (Olofsson and Jacobsson, 2001) and maintaining a positive ward atmosphere, again illustrating the importance of running high-secure settings with a full complement of staff.

Although it is encouraging that the reports contained a number of references to high standards of patient care, and that this was recognised by the service users, reports of poor documentation and uncertainty regarding patients' involvement in their care plans is concerning. There is evidence that patients link respect with being involved and conveyed accurate information, especially in relation to their legal rights and treatment (Hopkins et al., 2009). Furthermore, the value of involving patients' in care planning is widely recognised, and no less so in environments where violence and aggression are prevalent (NICE, 2015).

Although case studies of each hospital were not conducted, it is possible to make some long-term observations. Staff morale appeared to decrease in Rampton and Broadmoor, but Ashworth reported higher staff morale in later reports. Patient privacy was identified as especially problematic in Broadmoor and Ashworth between 2010 and 2012 but improved thereafter. Across all hospitals the CQC reported widespread problems in the built environment, including ventilation issues and ligatures points; however, they noted improvements after and around 2013.

To understand these results it is helpful to consider the wider context within which high secure hospitals provide care. Our findings suggest that there have been improvements across services over time but that issues of patient involvement in care persist.

One reason for this was the lack of resources and staffing, both of which were linked to low staff morale. This mirrors systemic inadequacies in mental health resourcing nationally. For instance, the funding and staffing recommendations made by the Royal College of Psychiatrists (the College) for the NHS's 2019 Long Term Plan look unlikely to be met. The College listed as a priority an additional £6.198bn for mental health services between 2019/20 and 2023/24 (Royal College of Psychiatrists, 2018). The Long-Term Plan however provided for an additional £2.3 billion by 2023/24 (NHS, 2019c).

A further priority for the College was the recruitment of an additional 70,348 mental health staff. No specific targets for the recruitment of mental health staff were made in the NHS Long Term Plan (NHS, 2019c). However, in its Interim People Plan, the NHS acknowledges that there is a need 'to take urgent, accelerated action to tackle nursing vacancies, especially in primary and community, mental health and learning disability settings' (NHS, 2019a: 3) and in its Mental Health Implementation Plan indicates that 27,460 additional staff need to be employed to meet growing need by 2023/24 (NHS, 2019b). It is apparent therefore that high security hospitals are not an anomaly vis-a-vis funding and staffing.

Second, there is a clear tension between the CQC's expectations on patient involvement in care and the idiosyncrasies of forensic environments. Promoting patient choice is an NHS priority and is embedded in the principles of the consumer rights movement and recovery paradigm (Foot et al., 2014). However, risk management, custodial practices, media and public attitudes, and the treatment characteristics of the patient group receiving care might make efforts to maximize patient choice and involvement more difficult (Livingston, Nijdam-Jones, & Brink, 2012).

Patient involvement in care includes engagement in: planning, evaluating, care, research, training and recruitment across the healthcare landscape (Tambuyzer & Van Audenhove, 2015). It has been an explicit policy goal in a national context for over 20 years (Foot et al., 2014). Drives towards involvement in care come from various social thrusts: consumerism, patient-centeredness, deinstitutionalization, patient advocacy groups, and shifts away from paternalistic care models. Effective involvement has been positively associated with outcomes like empowerment, satisfaction, ward milieu, decision-making and resource-allocation (Foot et al., 2014; Livingston et al., 2012; Tambuyzer & Van Audenhove, 2015).

Foot and colleagues (2014) highlight obstacles to the uptake of involvement strategies. A lack of clarity over philosophical perspectives, approaches, terminologies, disciplinary histories and orientations towards patient involvement has led to an inertia in some disciplines. The NHS and the government have demonstrated a tendency to respond to significant adverse events, such as the GP Harold Shipman affair, with policy and a politics of regulation and protection and not liberation and empowerment. The authors write that following tragedies across the NHS, 'creating conditions in which people have more say has not been the dominating narrative' (Foot et al., 2014: 7).

When considering high secure settings, it is clear these considerations may be more challenging. Forensic services understandably employ risk-reduction techniques to keep

patients, public and staff safe. However, forensic services, especially high security settings, have been criticized for promoting risk management over positive risk-taking, individual choice or maximizing patient autonomy (Mann, Matias, & Allen, 2014; Markham, 2018; Tomlin et al., 2019). Studies have highlighted the tension between the role of forensic staff as sometimes custodial over therapeutic, prioritizing containment or punishment over empowerment (Holmes & Murray, 2011). These attitudes are widespread in popular media and political discourse, further reducing forensic patient empowerment narratives (Morley & Taylor, 2016). Other factors include restrictive measures taken to quell fear of some patients, antisocial personalities, treatment non-adherence, risk of aggression and suicidality (Livingston et al., 2012).

Given that the high security hospitals employ some staff with custodial attitudes that can influence their work, are subject to close media scrutiny, have been the location for preventive and restrictive treatment programmes (see for instance the Dangerous and Severe Personality Disordered programme; Rutherford, 2006), offer treatment to patients with histories of aggressive behavior; and have been the focus of parliamentary investigations (e.g. the Fallon Enquiry) it becomes clearer why patient involvement strategies have not yet been implemented to a degree satisfactory to the CQC as indicated in the present study.

Strengths and limitations

This study furthers understanding of the quality of care provided in high-secure hospitals in England by identifying common themes of concerns and issues reported in CQC inspections over time. The study has a number of limitations, however. First, unequal numbers of reports were available for the three hospitals, making it difficult to form a balanced overview of services. Significantly fewer reports were available for Ashworth Hospital, although this may arise because the quality of care was higher than at the other two hospitals and there was less need for follow-up inspections. Second, regulations and guidelines have tightened over the period studied and the implied deterioration in certain areas of care found at Rampton and Broadmoor Hospitals must be viewed relative to the increased scrutiny and enhanced standards pertaining to the more recent inspections (William, 2014). Third, concerns have been raised regarding objectivity of CQC inspectors and the inferred meaning of ‘quality’ in their reports (Newman, 2017). Inspectors’ subjective views may influence what is reported, and the accuracy and consistency of reports often varies with an inspector’s experience (House of Commons, 2015). Fourth, given the rigid nature of CQC inspections and the standardised formatting of reports, the use of thematic

analysis may have obscured other potentially important themes. It is also an inherent limitation of thematic analysis that investigators may arrive at different interpretations (Braun & Clarke, 2006). To minimize this risk, we maintained rigor in the coding by following the method of analysis prescribed by Braun and Clarke (2006) and using a second coder to independently explore themes.

IMPLICATIONS FOR PRACTICE

Policy makers and those responsible for care in the high-security hospitals should

- recognise the positive staff-patient interactions and good practice in assessing and delivering care that were consistently observed in CQC reports.
- be aware of the level of negative feeling arising from enduring staff shortages occurring within each hospital and its impact on staff morale.
- address the restrictive practices, poor care-plan procedure, and inadequate legal documentation identified by the CQC.
- address the possibility that some patients are inadequately involved in the care-plan process.

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