

# Monitoring the Mental Health Act in 2015/16



STATE OF CARE



Care Quality Commission

**Monitoring the  
Mental Health Act in  
2015/16**

Presented to Parliament pursuant to Section 120D(3) of the Mental Health Act 1983

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# Contents

Foreword	5
Summary	6
Introduction	10
<b>Part 1: The Mental Health Act in action</b>	12
1.1 Regulation and the Mental Health Act	13
1.2 Implementing the revised Code of Practice	14
1.3 Deaths in detention	15
1.4 The use of the Mental Health Act	17
1.5 Protecting patients' rights and autonomy	20
1.6 Assessment, transport and admission to hospital	25
1.7 Additional considerations for children and young people	29
1.8 Care, support and treatment in hospital	31
1.9 Leaving hospital	37
<b>Part 2: CQC and the Mental Health Act</b>	42
2.1 Monitoring visits	43
2.2 The administration of the Second Opinion Appointed Doctor service	45
2.3 Complaints	47
2.4 Withheld mail and telephone monitoring in high security hospitals	49
Appendices	50
Glossary	58
References	63





**1,349** monitoring visits by CQC

**6,867** actions from providers to improve were required by CQC

# Foreword

The work of monitoring the Mental Health Act 1983 (MHA) is a distinct but supportive role to CQC's wider regulatory task. It is distinct, in part, because our focus is on reviewing and understanding the experience and effects of care provided for individual patients, rather than assessment of systems and processes. This report sets out our key findings from our work in 2015/16 based on more than 4,000 private meetings with individual patients during our visits to 1,300 wards. It acts as both an account of our activity to Parliament and an outline of the important issues and concerns we heard from patients about their day-to-day experience when subject to the MHA.

In many respects, mental health inpatient services are better places now than in past decades. The expectations of people who use services and professionals around patient involvement, respect for individual rights and the avoidance of unnecessary institutional rules are higher than ever. CQC has played a significant role in this, but we are aware that there is still much to be done to improve.

This is a tough environment for mental health services. We know that mental health funding is tight. The overall reduction in the numbers of inpatient mental health beds, necessary to redirect resources into alternative, less restrictive community provision, may have created pressures on acute admission wards in some areas. We have noted the rising use of the MHA in our previous reports, perhaps in part due to some areas not yet having the right balance of provision in place. The process of changing the balance of provision also requires careful management to make sure wards continue to provide a safe and therapeutic environment for all patients. We will be working with other national partners to look at how this affects the patients behind the numbers, as part of our monitoring activity in 2017.

Our findings in 2015/16 show that managers and staff are not receiving the support to understand and meet the requirements of the MHA and the recommendations of its Code of Practice. We are impatient to see change because the end result is for

patients to receive good quality care. Mental health care is only likely to be effective and humane when patients have their voice heard and their preferences are taken fully into account. In particular, I would highlight the need for care planning to be truly co-produced with patients, and individualised to their needs. In many cases, there needs to be better communication between patients and staff, and more time spent in individual discussion.

What is striking is that some services do get this, and show this in what they do. There is good practice in many different types of mental health inpatient units and this report provides some examples. If some can get it right, others can learn from them and adopt their approach. We have had positive engagement with NHS England, NHS Improvement and the Department of Health during the production of this report, and look forward to working with them as they deliver on their priorities for implementing the *Five Year Forward View for Mental Health*.

I am grateful to the many patients who have shared their experiences with us on visits, and also to our Service User Reference Panel for their input into this report.



**David Behan**  
Chief Executive

# Summary

The Mental Health Act 1983 (MHA) is the legal framework that provides authority for hospitals to detain and treat people who have a serious mental disorder and who are putting at risk their health or safety, or the safety of other people. The MHA also provides more limited community-based powers, called community treatment orders and guardianship.

The MHA includes safeguards for people's rights when they are being detained or treated by professionals. It does this by providing rules and requirements for professionals to follow. It also provides statutory guidance to mental health professionals and services in the MHA Code of Practice. Managers and staff in provider services should have a detailed knowledge of the Code and follow its guidance, or document the justification for not doing so in any individual case.

Our job is to check that patients' human rights are being protected, and look at how services in England are applying the MHA safeguards. We carry out visits to see how mental health services are supporting patients, make sure providers have effective systems and processes to meet the MHA, and check that staff are being supported to understand and meet the standards set out in the Code.

There are 57 NHS trusts and 161 independent hospitals that provide mental health care for people under the MHA in England. During 2015/16, we carried out 1,349 monitoring visits, and met with 4,282 patients.

Detention rates have continued to rise in recent years, and 2014/15 saw the highest ever year-on-year rise (10%) to 58,400 detentions. It is a challenging time for all health services, including mental health care: resources are tight and as outlined in our State of Care 2015/16 report – our annual overview of the quality of health and adult social care in England – the sector is under significant financial pressure. But over the last few years, reports such as the *Winterbourne View – Time for Change* have highlighted inequalities and failings

of care for some people who are detained under the MHA, and changes are needed in response.

Throughout our monitoring visits and inspections, we saw many examples of good practice, and met hundreds of dedicated staff who provide the best support and treatment for their patients. We hope that examples of good practice shared in this report will support and encourage other providers to improve quality of care. Further examples can be found in State of Care 2015/16.

However, good practice is not consistent across the country. Our concerns are supported by our findings in State of Care 2015/16, which found that inpatient mental health services performed less well in general than community-based services. Some services are not meeting the expectations of the Code of Practice, leading to variation in the quality of care for people detained under the MHA. These are not technical issues of legal process, but failings that may disempower patients, prevent people from exercising legal rights, and ultimately impede recovery or even amount to unlawful and unethical practice.

In 2015/16, we have found little or no improvement in some areas that directly affect patients, their families and carers and that we have raised as concerns in previous years. This includes:

- For 12% (515 out of 4,344) of patients interviewed on our visits in 2015/16, there was no evidence that they were informed of their right to an Independent Mental Health Advocate (IMHA). Advocates are an important safeguard, offering support to patients and enabling them to be involved in decisions about their care. Many services have adopted the Code of Practice's recommendation that IMHAs should automatically be asked to visit patients who may lack the capacity to ask for help. We expect all services to do this. We have seen some examples of innovative practice enhancing the support provided by IMHA services at key points of treatment and care, such as during care planning or when interventions such as seclusion are used.



- There was no evidence of patient involvement in care planning in 29% (1,214 out of 4,226) of records that we examined. Similarly, 10% (452 out of 4,407) of care plans showed that patients' needs had not been considered. Research suggests that co-production of care plans and developing advance statements with patients can be an effective way for services to address the rising number of detentions.<sup>1</sup> Some services have shown good practice in involving patients from the moment they are admitted, including staff taking time to explain everything as often as the patients needed to help them feel informed and reassured about their care and treatment.

We expect all services to consistently make it possible for patients to be fully involved in their care and treatment, understand their rights and exercise their autonomy. Only through such an approach can services ensure that those powers are used proportionately and fairly, and that they help the recovery process.

Overall, we required more than 6,800 actions from providers to improve practice as a result of our monitoring visits. Although we do not rate how well services apply the MHA, if we find poor practice we limit a provider's rating for the question 'are services effective?'

## Priorities for change

In this, our seventh report on the MHA, we find too many repetitions of our previous findings. There is an urgency for change, with more needing to be done by all stakeholders – providers, commissioners, national bodies and regulators – to ensure people receive high-quality and effective care and treatment under the MHA. The priorities we have set are intended to offer greater help, support and involvement of patients, their families and carers when detention under the MHA is necessary. We are committed to making sure our findings inform and

It is clear from our visits that, one year on from its introduction, that some providers are not doing enough to implement the revised Code of Practice or inform patients of their rights. The revised Code came into force in April 2015. We asked providers to update their policies and practices by October 2015, to make sure they supported delivery of the new standards. We also expected services to make sure that staff with statutory MHA roles are trained with the right skills and knowledge to meet the Code's standards to support the delivery of high-quality care.

However, fewer than half of the wards we looked at from September 2015 to April 2016 had provided staff with any form of training on the revised Code, or updated their policies and procedures to reflect the new guidance. All staff in statutory MHA roles must be provided with training – staff need to be better supported in looking after people with mental health issues, and they need stronger leadership to make this happen.

Where we have found failures to comply with the recommendations of the Code due to lack of staff training or policies, we have made sure, and will continue to make sure, that our teams use our enforcement powers to improve the support for staff and patients.

influence the improvement work taking place across mental health services, for example delivering the aims and ambitions set out in the *Five Year Forward View for Mental Health*.

## 1. Providers

Providers need to do more to ensure that the MHA is properly applied, and that this supports better care of people detained under the Act. In particular, they must demonstrate stronger leadership, making sure they train and support their staff to have a thorough understanding and knowledge of the Code of Practice and how patients should be involved in their care from the moment they are admitted, to aid their recovery.

Services should also focus on improving their oversight of the MHA safeguards for patients. This is an important part of ensuring good outcomes for patients and failure to have good oversight will always affect the provider's 'well-led' rating.

## 2. Commissioners

Commissioners should work together to deliver services informed by national guidance and best practice. They should review commissioning contracts to make sure they commission services where they have evidence on how the Act is being applied and that the Code is being met. They should consider how to ensure a model for commissioning, procuring and delivering services locally that is based on co-production and collaboration with people who use services, and how they are ensuring inequalities are monitored and addressed.

The experiences and views of detained patients should be a routine part of local MHA monitoring, including actively seeking the involvement of local user and advocacy groups.

## 3. The Department of Health and national agencies

The Department of Health and national agencies should work together on solutions to the issues we identify, and focus particularly on early intervention to reduce the rates of detention. NHS England and NHS Improvement need to ensure that the use of the MHA is closely monitored at both local and national level, and focus on providing earlier interventions, and care planning for people repeatedly detained, to reduce rates of detention by 2020/21. This includes targeted work to reduce the over-representation of Black and minority ethnic and other disadvantaged groups.

All agencies must work with NHS Digital to improve intelligence available via the Mental Health Services Dataset (MHSDS), to have better personalised data, across pathways, about the way the MHA is working for people and how different groups are experiencing detention. We expect that provider Boards should be robustly assured that their organisations' monthly returns are complete and accurate.

National agencies should ensure that solutions are identified and implemented in partnership with organisations representing people with mental health problems.

CQC will use its regulatory approach and powers to further encourage improvement in the use of the MHA to ensure better experiences for detained patients. We will:

- Work closely with NHS Digital, NHS England, NHS Improvement and the Department of Health to publish more detailed reports on areas of our monitoring during 2017. This will include carrying out focused visits to look at rising detentions and a review of the way Approved Mental Health Professional services are being delivered.
- Create additional guidance for inspection teams and MHA reviewers on how to assess the way providers continually review the way the MHA operates.
- Review the way we present MHA information in our provider inspection reports, with a focus on how providers monitor the application of the MHA and its safeguards for patients.
- Work with our external advisory group to strengthen how we review equalities information during regular and focused monitoring visits.

There is an urgency for change, with more needing to be done by all stakeholders – providers, commissioners, national bodies and regulators – to ensure people receive high-quality and effective care and treatment under the MHA.

A close-up, profile view of a man's face, showing his nose, eye, and mustache. The lighting is dramatic, highlighting the texture of his skin and the intensity of his gaze.

**58,400**

detentions in 2014/15 – the highest ever  
year-on-year rise in recent years

# Introduction

The Mental Health Act 1983 (MHA) is the legal framework that provides authority to admit, detain and treat patients in mental health hospitals. This can only be done to people who have, or appear to have, a mental disorder, and who are putting their own health or safety, or other people's safety at risk. The MHA also provides more limited community-based powers in the form of community treatment orders (CTOs) and guardianship.

The MHA includes safeguards for people's rights when they are being detained or treated by

professionals. It does this by providing rules and requirements for professionals to follow. It also provides for statutory guidance for mental health professionals and services in the Code of Practice and expects doctors, clinicians, managers and staff in provider services to have a detailed knowledge of the Code and follow the standards it sets out, or document reasons why the Code has not been followed.

CQC has a duty under the MHA to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship. We visit and interview people whose rights are restricted by the MHA, and we require actions from providers when we become aware of matters of concern. We also have duties to provide a Second Opinion Appointed Doctor service (see page 45), review MHA complaints (see page 47) and make recommendations for changes to the Code.

Our role is to check that patients' human rights are being protected, and look at how mental health services in England are applying the safeguards of the MHA and the Code of Practice. We are required to carry out visits and activities to see how providers are supporting patients, making sure they have effective systems and processes in place to meet the requirements of the MHA, and that staff are being supported to understand and meet the standards set out in the Code. Part 2 of this report sets out the activities that inform our work and this report in more detail.

In addition to our MHA duties, we also work to highlight and seek action when we find practices that may breach human rights standards during our MHA visits. This is part of our work as one of several bodies that form the UK's National Preventive Mechanism (NPM) against torture, inhuman or degrading treatment. More information about this important role and our activities can be found in the full UK NPM annual reports that are published in Autumn each year.<sup>a</sup>

Footnote:

a [www.nationalpreventivemechanism.org.uk/](http://www.nationalpreventivemechanism.org.uk/)

## Part 1 THE MENTAL HEALTH ACT IN ACTION

The main picture of our findings on the Mental Health Act in action.

## Part 2 CQC AND THE MENTAL HEALTH ACT

An outline of CQC's statutory duties in monitoring the Mental Health Act.

## The context of the MHA in 2015/16

As outlined in our State of Care 2015/16 report, our work over the year took place in the context of a number of developments and emerging concerns for mental health and learning disability services. Several reports highlighted implications for the Mental Health Act and inequalities in care for people with mental health problems, which are putting lives at risk. These included the *Five Year Forward View for Mental Health; Winterbourne View – Time for Change* (Sir Stephen Bubb's final report); The Commission on Acute Adult Psychiatric Care; and the NHS England commissioned report on the investigation of deaths at Southern Health NHS Foundation Trust.<sup>2-5</sup>

The Independent Mental Health Taskforce set out key concerns and issues for inpatient psychiatric provision, echoing those of our previous annual MHA reports, and made commitments to identifying solutions that will improve the experience for people subject to the MHA. This includes reducing the uses of the MHA by 2020/21, increasing the focus on the over-representation of Black and minority ethnic (BME) groups in compulsory detention, and evaluating the way the MHA is working for patients.

Tackling the issue of reducing the number of people being moved away from their home has also been high on the agenda this year. Available experimental data suggests that, in March 2016, up to 10% of patients in adult mental health beds (569 patients) may have been sent out of area for treatment.<sup>6</sup> Lack of local bed availability appeared to be the main reason for acute out-of-area placements in March 2016.<sup>4</sup> This is a serious concern, and patients' understandable reluctance to be admitted to distant hospital beds may be one cause of rising rates of detention. We will be working with NHS England, NHS Improvement and the Department of Health to support the development of new commissioning tools and new metrics to help reduce this practice, following on from initial guidance issued by the Department of Health at the end of September 2016.<sup>7</sup>

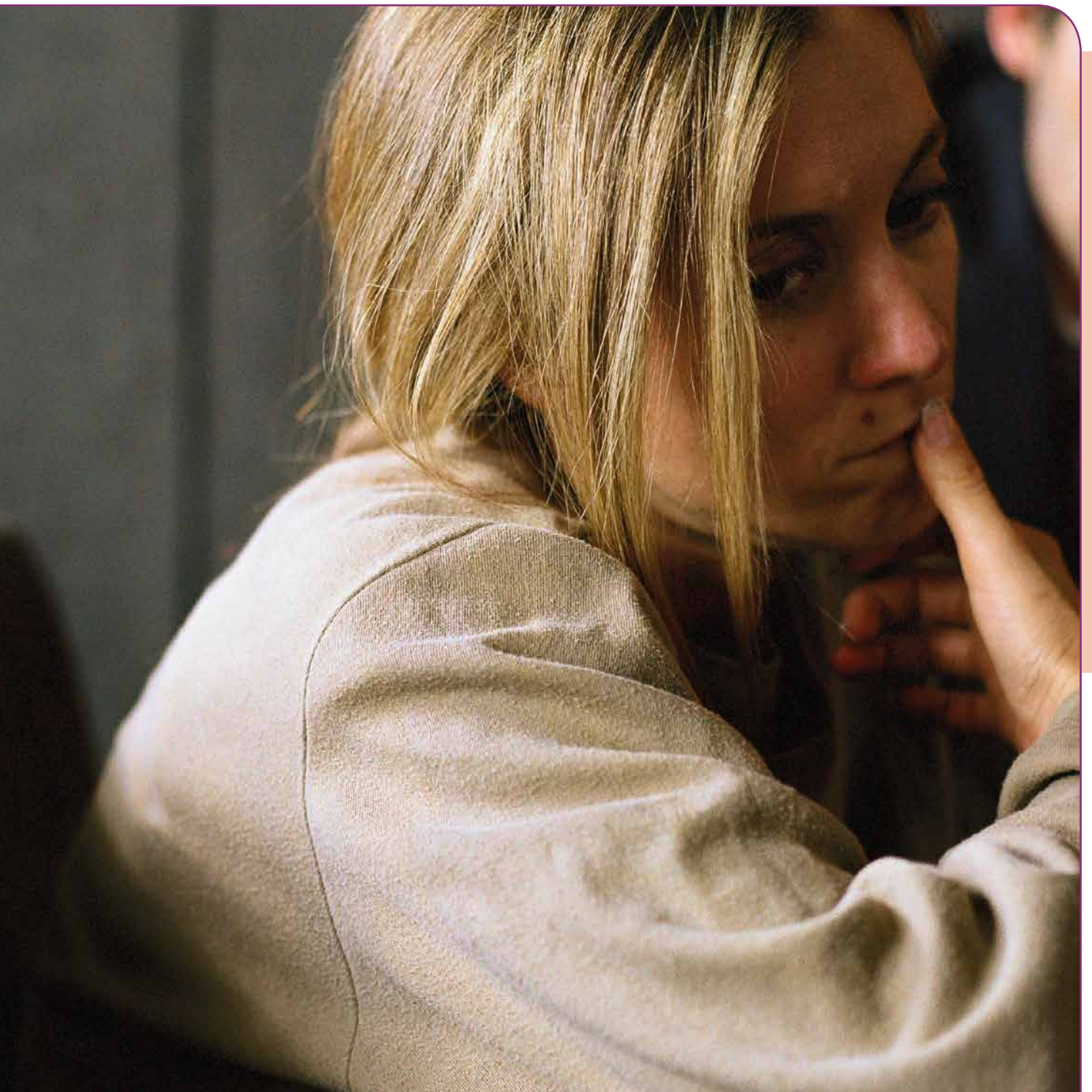
There are notable examples of services that have successfully reduced out-of-area placements of acute patients, such as Sheffield Health and Social Care Foundation Trust, which announced in March 2016 that it had eliminated the need to send adult acute patients out of area for treatment due to lack of local capacity. This has been achieved by redirecting resources to strengthen community services and develop alternatives to admission.<sup>8</sup> This is an impressive result as the trust previously had large numbers of people who use services sent out of area for acute care.

## Focus for 2015/16 report

Following feedback from our external advisory group and service user reference panel, this year's report will form one of a suite of products relating to our findings on the MHA. This report focuses on our monitoring activities and the way services are meeting the MHA and its Code of Practice. Future products will look in depth at specific topics and their impact on patients subject to the Act, such as the rising numbers of detentions. By taking this approach, we will be able to provide more detail on the topics that people who use services and providers have told us they would find helpful.

**10%** of patients in mental health beds sent out of area for treatment

Some services have successfully reduced out-of-area placements of acute patients by redirecting resources to strengthen community services and develop alternatives to admission.



# Part 1

## THE MENTAL HEALTH ACT IN ACTION

## Key points

- We have seen examples of good practice and innovative approaches to overcoming areas of concern highlighted in our previous reports. We have met thousands of staff who are compassionate and dedicated to providing the best support and treatment they possibly can for their patients.
- Staff had received training on the changes in the Code, or the revised policies and procedures to reflect its guidance, on less than half of wards we sampled. From 2016, we have taken these failings into account and use them to inform the ratings we issue to providers.
- Overall, the figures for care planning, patient involvement and discharge planning subject areas show unacceptable variation in meeting the Code's expectations, similar to those recorded in the 2014/15 report. Some services need to address the quality of care in these areas for people detained under the MHA.
- One in 10 records do not show evidence that patients have had their rights explained to them at the point of detention. This leads to patients not knowing what to expect, or understanding their rights under the MHA.
- We were notified of 201 deaths of detained patients by natural causes, 46 deaths by unnatural causes and 19 yet to be determined verdicts.

### 1.1 Regulation and the Mental Health Act

We monitor how the MHA and its Code of Practice are applied through our MHA reviewer visits and our comprehensive inspections. Our comprehensive inspection teams of NHS mental health services always include an MHA reviewer and findings from our previous MHA monitoring visits are used to inform the inspection. Although we do not rate how well services are applying the MHA, our findings do influence the overall rating for the key questions 'are services effective?' and 'are services well-led?'. If we find significant issues with the way the MHA is working for patients, core services will only be able to achieve a maximum rating of requires improvement.

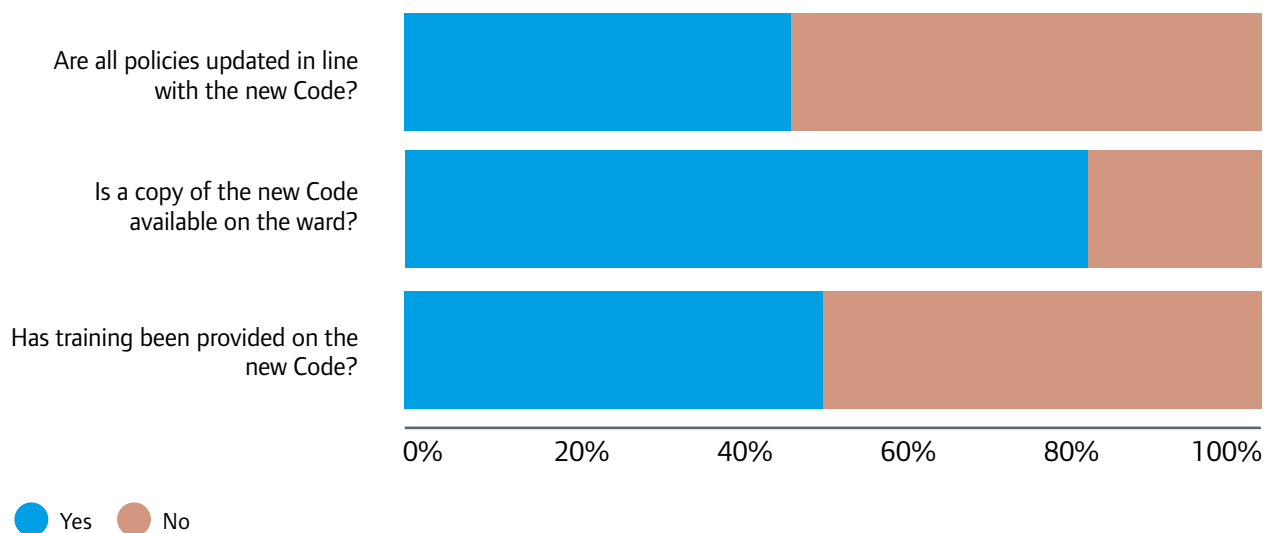
Through our MHA visits and comprehensive inspections, we have seen some good care and have met thousands of staff who are compassionate and dedicated to providing the best support and treatment for their patients. However, there are many mental health provider organisations that need to improve. Particular concerns include staff not providing patient-

centred care, staff not fully respecting people's rights, and people not being fully involved in decisions about their treatment and support.

Another concern is that inpatient care is often provided in outdated buildings that do not meet modern standards. This can affect patient safety and their experience of the service, and create additional problems for services already under significant pressure. Problems include a lack of clear lines of sight (making unobtrusive observation difficult), ligature points and other hazards that need attention, and the layouts of wards compromising same-sex accommodation rules.

Our strategy for 2016 to 2021 builds on what we have learnt from our comprehensive inspection programme and aims to create a more targeted, responsive and collaborative approach to regulation.<sup>9</sup> This will include making greater use of focused and unannounced inspections, to target areas where our monitoring of services suggests patients are at the greatest risk. Underpinning this will be continued, regular MHA reviewer visits to all mental health services that are registered to provide care and treatment to people

Figure 1 Implementation of the Code of Practice, September 2015 to April 2016



Source: CQC

subject to the MHA. Although the majority of our MHA visits are currently unannounced (over 95% of visits), we are reviewing how we identify and carry out visits, and how our MHA focused activity can be completed in alignment with the inspections planned.

## 1.2 Implementing the revised Code of Practice

The revised Code of Practice came into effect from April 2015 and is designed to promote and support the best possible care, ensure patients’ rights are protected, and must be considered by health and social care professionals. The MHA Reference Guide was also updated at the same time, and provides an explanation of the provisions of the Act.<sup>10</sup>

In last year’s report, we were clear that we expected providers to have revised their policies and practices and to make sure staff are trained so that they have the right skills and understanding to support patients (paragraph 4.61 and 4.62). This is a clear requirement in the Code of Practice, where it states that professionals (including managers, staff, doctors and approved mental health

professionals) should “have detailed knowledge of the Code, including its purpose, function and scope” (page 12).

From September 2015 to April 2016, we asked MHA reviewers to answer a questionnaire on 214 visits to hospitals. In this sample, staff had been provided with training on the changes in the Code, or with revised policies and procedures to reflect its guidance, on less than half of wards (figure 1).

Where we found that staff did not have support from managers to implement the revised Code’s recommendations, through a lack of training, outdated policies, or other governance failings that

“One of the most common themes has been the issue of practitioner training. We know that best practice, throughout all the different scenarios in mental health care, is detailed in the Code. These guidelines now need to be enforced, without exception, and for this to happen, training has to be consistent and robust across the board.”

Code of Practice expert advisory group member



affect the safeguards offered to detained patients, we raised this with the provider. On our comprehensive inspections, issues around complying with the Code have contributed to lower ratings and been subject to enforcement actions.

Our overall findings suggest that providers and staff need to do more work to promote the importance of the standards in the revised Code, but national agencies also need to understand the reasons for the lack of implementation. *The Five Year Forward View for Mental Health* recommended that the MHA and relevant Code of Practice are reviewed to see if they require attention or further updates.<sup>2</sup> We understand that the Department of Health will be carrying out an evaluation of the effect of the latest changes to the revised Code, and we will look at ways we can support their review through our review and findings from provider visits.

### 1.3 Deaths in detention

In our previous reports we have highlighted the importance of investigating, reporting and learning from any death of a person detained under the Mental Health Act, particularly when they are 'in state detention' and receiving care and treatment in hospital at the time of their death. Over the last year, there has been an increased focus on how the NHS learns from all deaths, following the avoidable death of Connor Sparrowhawk in 2013 and the subsequent reports into Southern Health NHS Foundation Trust which was found to have a lack of oversight and monitoring in place to learn from deaths in its services.

Following the publication of the NHS commissioned report into the deaths at Southern Health NHS Foundation Trust, the Secretary of State asked us to look at how NHS trusts across the country investigate deaths to find out whether similar problems can be found elsewhere. The review, which is currently taking place, will look particularly closely at how trusts investigate and learn from deaths of people using learning disability or mental health services, including deaths in detention.

As part of this review, we have included a more detailed enquiry into the way services are responding to, reviewing and reporting the deaths of detained

## Compliance with the Code of Practice as a regulation issue

On a comprehensive inspection of an NHS mental health trust we found that, although the trust had a governance structure for monitoring the MHA, the senior management we spoke with did not have a good understanding of the operation of the MHA throughout the trust. The governance structure was not effective to oversee and monitor the implementation of the MHA.

We saw compliance with some aspects of the Code of Practice; this was only in relation to the aspects of the Code that had not changed since its 2015 revision. There was no consistent training in the trust that included the 2015 Code of Practice and its implications for staff delivering care. The trust did not have an overall implementation plan for the 2015 Code of Practice. The trust was rated as 'requires improvement' for effectiveness.

On an inspection of another NHS mental health trust, we were concerned that the policies and procedures reviewed had not been updated following the implementation of the revised Code of Practice. For example, we were shown a copy of the 'prevention and management of violence and aggression' policy on a ward that had been updated in October 2015, and we accessed the 'absent without leave' policy that had been updated in November 2015 but both continued to refer to the previous Code of Practice. Both policies had been reviewed and approved by the MHA scrutiny committee. We found a trust to be in breach of Regulation 9 (person-centred care) and a requirement notice was issued.

patients. This includes working with stakeholders, our expert advisory group and NHS Improvement to review relevant information relating to deaths in detention. We will look at the implementation of previous recommendations, including those from the Equality and Human Rights Commission inquiry into non-natural

deaths; the National Confidential Inquiry into Suicide and Homicide of mental health patients; and the *Five Year Forward View for Mental Health*. We will be published the findings from our review in December 2016.

All providers registered under the Health and Social Care Act 2008 must notify us about the deaths of people who are detained,<sup>b</sup> or liable to be detained under the MHA. In 2015/16, providers notified us of 266 deaths of detained inpatients (figure 2). There were 201 deaths attributed to natural causes in 2015/16 (figure 3). Full details of the notifications we received are in appendix C.

### Reporting deaths to the coroner

Last year we reported our concern of the lack of an independent system for investigating the deaths of detained patients in health care settings, and our belief that there is much greater opportunity for learning and improvements to take place when deaths occur. In the absence of such a system, the role of the coroner is typically the only independent review of a detained patient death. Section 1 of the Coroners and Justice Act 2009 states that coroners must conduct an investigation into all deaths in state detention, including people subject to the MHA in hospital and those subject to a Deprivation of Liberty Safeguards authorisation at the time of death.

Footnote:

- b Patients 'liable to be detained' include detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. For the purposes of deaths notifications, 'detained patients' include patients subject to holding powers such as sections 4, 5, 135 or 136, and patients recalled to hospital from CTO.

Coroners establish how the person died either by carrying out an investigation or a jury inquest. When notifying CQC about a death we ask providers to tell us when the coroner was informed of the death and provide the details of the coroner's office.

Following the publication of the annual bulletin of coroner statistics by the Ministry of Justice, we were alerted to a discrepancy between the number of detained patient deaths reported by coroners and those reported by our notifications system between 2011 and 2014.<sup>11</sup> The coroner fulfils the requirements of the Human Rights Act, making sure anyone who dies under the MHA has an independent investigation, and any failure to inform the coroner would be considered a significant issue for detained patients and their families. We carried out a review of the 2015/16 data and found that in two of the 266 cases from the 2015/16 data, providers had not reported the death to the coroner, probably due in part to an incorrect assumption that the coroner did not need to be informed of deaths that appear to be clearly from natural causes. We have raised this with the providers concerned but also made changes to our notifications process to reinforce that all deaths, irrespective of whether or not the provider believes them to be from natural causes, must be reported immediately to the coroner as expected by the Coroners and Justice Act 2009.

### Physical health and mortality for people aged 40 and under

It is well known that people with mental health problems are at a higher risk of dying prematurely because of physical health problems. Looking at

Figure 2 Cause of death of detained patients, 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
Natural causes	191	200	126	182	201
Unnatural causes	36	48	36	34	46
Unknown	9	27	36	11	19
<b>Total</b>	<b>236</b>	<b>275</b>	<b>198</b>	<b>227</b>	<b>266</b>

Source: CQC

data over the last five years, the number of natural cause deaths has fluctuated, with a continuous rise since 2013/14, but the underlying trend is broadly flat. That the number of deaths from natural causes has not reduced has been highlighted for discussion and review with leads, in both CQC and NHS England, for improving and integrating physical health and mental health as part of implementing the recommendations in the *Five Year Forward View for Mental Health*.

This year, we were told of 20 deaths from natural causes of people aged under 40 years old, 16 of whom were detained in hospital and four on community treatment orders. Twelve deaths were from circulatory events. Circulatory diseases are the third most common form of death in the comparable general population under 40, with external causes (including road traffic accidents) being the most common, followed by cancer.

Our sample is too small to provide meaningful conclusions. However, circulatory diseases are made worse by some types of psychiatric medication, as well as obesity, lack of exercise or smoking. NHS England has also highlighted the potential benefits to mortality if people with mental health conditions receive interventions of the same quality as the general population, underlining the importance of detained patients receiving good quality physical health care.<sup>12</sup>

### Deaths where restraint had been used within seven days of death

We were told about 16 deaths that occurred within seven days of restraint being used. Coroners' verdicts are not yet available for all 16 deaths to confirm the causes of deaths within seven days of restraint, although all had been reported to coroners. For the 13 where coroners' verdicts are now available, none were found to be related to restraint.

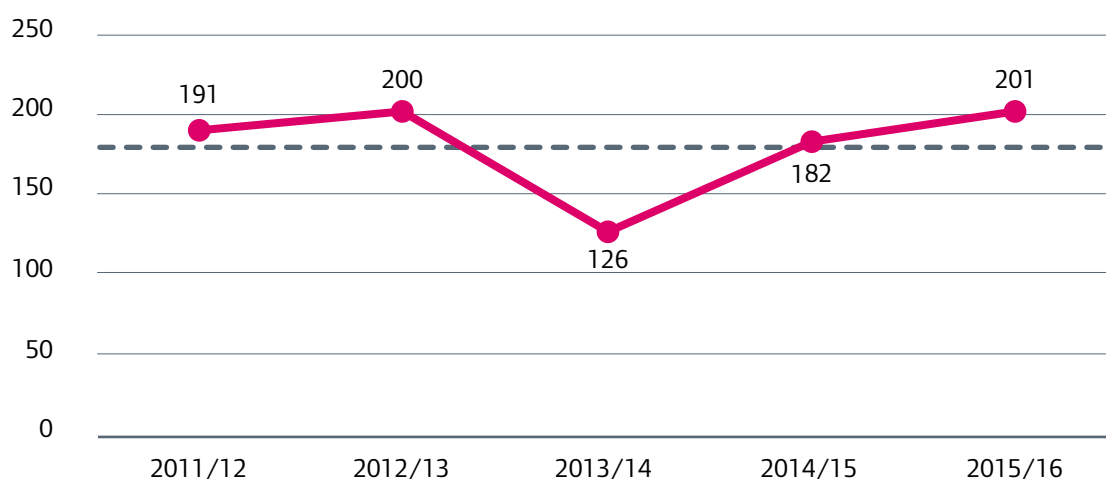
## 1.4 The use of the Mental Health Act

In recent years, the number of uses of the MHA has been rising, with the highest ever year-on-year rise (10%) to 58,400 detentions (excluding holding powers) in 2014/15.<sup>c</sup> At the time of writing this report, the 2015/16 data is not available. The effect of rising detention rates on patients and services needs to be reviewed at a local level. Following the release of 2015/16 data, we will be working with NHS England, NHS Improvement, NHS Digital and our inspection teams and MHA reviewers to carry out

Footnote:

c As recorded in the NHS Digital data collection using KP90 returns. The 2015/16 dataset from these returns will be the final collation, as the system is retired to be replaced with MHSDS.

Figure 3 Natural cause deaths of detained patients, 2011/12 to 2015/16



Source: CQC

a programme of focused activities with individual providers. We will look at the reasons for changes in activity in their areas, what this has meant for patients and any actions local health economies have taken in response to rising detention rates.

The reasons why increasing numbers of mental health patients are being detained are likely to be complex and may differ from area to area. Focused work is needed to investigate this. For example, data on community-based services for the same period show a decline in patient contact. This could suggest that reductions in the support that would keep patients out of acute crisis and reduce hospital admissions are a factor in the rising numbers of detentions.<sup>13</sup> It may also be that rising detention rates are related to repeated admissions of the same patient on a rapid cycle, or that the threshold for accessing one of the reduced number of beds is now that a patient meets the criteria for detention under the MHA. These uncertainties highlight that they need to continue to develop our methodology for assessing MHA information during our assessments of inpatient and community services, ensuring this is highlighted clearly in our provider reports.

Another potential cause is the Cheshire West court ruling in 2014. This redefined and broadened the

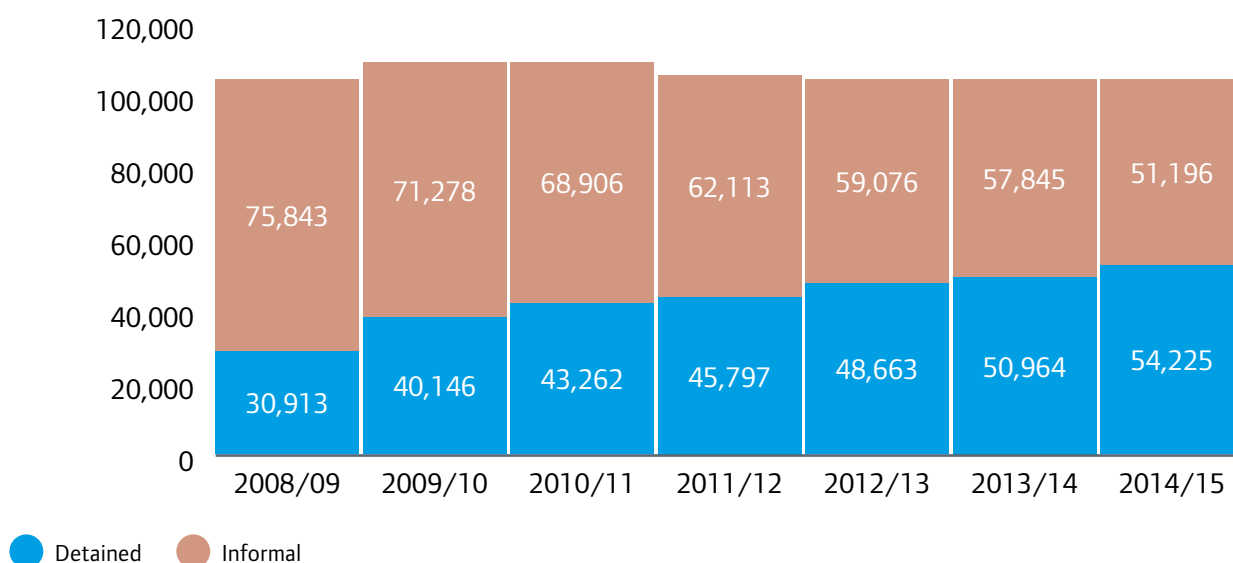
test for deprivation of liberty, to encompass any patient who is under continuous supervision and control and not free to leave a place of care. It is likely that this has reduced the proportion of patients admitted to mental health beds on an informal basis, as services become more sensitive to issues of unauthorised deprivation of liberty (also referred to as 'de facto detention') and seek to avoid it. Allowing for some caution as the dataset is not complete, the number of beds occupied by patients detained under the MHA at any one time may now be surpassing the number of beds occupied by informal patients (figure 4). This would be an important change in the profile of resident patients: before 2014/15, there were always more informal than detained patients in mental health beds.

From April 2016 the Mental Health Services Dataset (MHSDS<sup>d</sup>) is the only official collation of statistics on the use of the MHA. In contrast to the previous annual collections, MHSDS is collected monthly and offers person-level data, which will provide more timely information about the people who

Footnote:

d Previously called the Mental Health and Learning Disabilities Data Set (MHLDDS). This dataset was renamed the Mental Health Services Dataset (MHSDS) in 2016 and is referred to by its new title throughout this report.

Figure 4 Mental health patients at year end, March 2008/09 to 2014/15



Source: Mental Health Minimum Data Set / Mental Health and Learning Disabilities Data set and Hospital Episode Statistics, NHS Digital; Office for National Statistics

are experiencing detention. It also offers previously unavailable detail about patient pathways through detention and the different groups who experience detention, including equalities information that will be vital to understanding and improving inequalities in the use of the MHA.

However, in last year's report we highlighted significant concerns about considerable under-reporting to the monthly data collections, with at least 29% less uses of the MHA being reported by providers to the MHSDS (41,592) compared with the annual KP90 collection (58,399). Similarly, the number of people reported by the KP90 to be subject to the MHA at the end of March 2015 was 25,117, compared with the most recent published monthly MHSDS figure of only 16,769 at the end of June 2016.<sup>14</sup> The coverage of MHSDS is improving each month, but this highlights the importance of all service providers returning complete data to make sure we can realise the benefits of having a single data collection, improving the consistency of data for use by providers and national bodies. We expect that provider Boards should be robustly assured that their organisations' monthly returns are complete and accurate. NHS Digital is placing particular emphasis on providers across secure and non-secure care in the independent sector. We will be carrying out joint activities to look at individual provider issues in the year ahead, taking any action necessary to make sure we support the delivery of high-quality data and transparency in the way the MHA is being used.

We encourage commissioners to monitor the MHSDS data, and all national NHS bodies should continue to work with NHS Digital to review and improve compliance with the requirement to submit information about uses of the MHA.

### **Equalities and the use of the Mental Health Act**

It has long been recognised that there is inequality in the use of the MHA between population groups. The *Five Year Forward View for Mental Health* sets out the need for greater priority to be given to tackling these inequalities. For example, men of Black or Black British ethnicity are much more likely to be detained

under the MHA when compared with White British men (56.9 detentions per 100 people who spent time in hospital compared with 37.5). However, the reasons why the MHA is used more in some Black and minority ethnic (BME) groups are complex and not well understood.

The *Five Year Forward View for Mental Health* called for NHS England and NHS Improvement to ensure that use of the MHA is closely monitored at both local and national level, and for rates of detention to be reduced by 2020/21 through the provision of earlier intervention, with targeted work to reduce the current over-representation in acute care of people from BME groups, and other groups of people that experience inequality. We will be discussing how we can support this work with NHS England, NHS Improvement and others, ensuring we are collectively working on improving the MHSDS data that will be critical to informing the programme of work needed to deliver this recommendation.

As highlighted in our 2014/15 report, practical guidance for commissioners of mental health services has been available since April 2014 to ensure there is a greater transparency about how areas are monitoring and addressing inequalities.<sup>15</sup> The guidance promotes a co-production, values-based model for commissioning, procuring, and delivering services, and its suggestions include that:

- Commissioners should expand community residential alternatives to hospital admissions, and increase community services that support psychosocial rehabilitation of people from BME groups.
- Procurement and delivery of such services through third sector organisations from BME communities should be prioritised.
- Peer support services and advocacy services specific to the needs of BME communities should be an integral part of mental health service provision in diverse communities.

We continue to encourage providers to work with their local commissioners to consider how to apply these suggestions in practice. We will also be looking

at equalities when we carry out focused reviews, and how the areas we visit have implemented the guidance or alternative improvements, and the effect this has on patients.

## 1.5 Protecting patients' rights and autonomy

This section looks at our findings on the way services support the empowerment of patients to be involved in their care and treatment, understand their rights and exercise their autonomy while detained. The MHA and Code require services to provide patients (as well as carers and relatives where appropriate) with information and opportunities to be consulted and involved in treatment.

In May 2016, we published our report *Better care in my hands*, a review of how people are involved in their care.<sup>16</sup> This report looked at the extent and quality of people's involvement in their care and how services are meeting their statutory duties to offer person-centred care as a fundamental standard. The report made recommendations for providers and commissioners, and we will be using these to inform our MHA visits and how this has affected patients subject to the MHA.

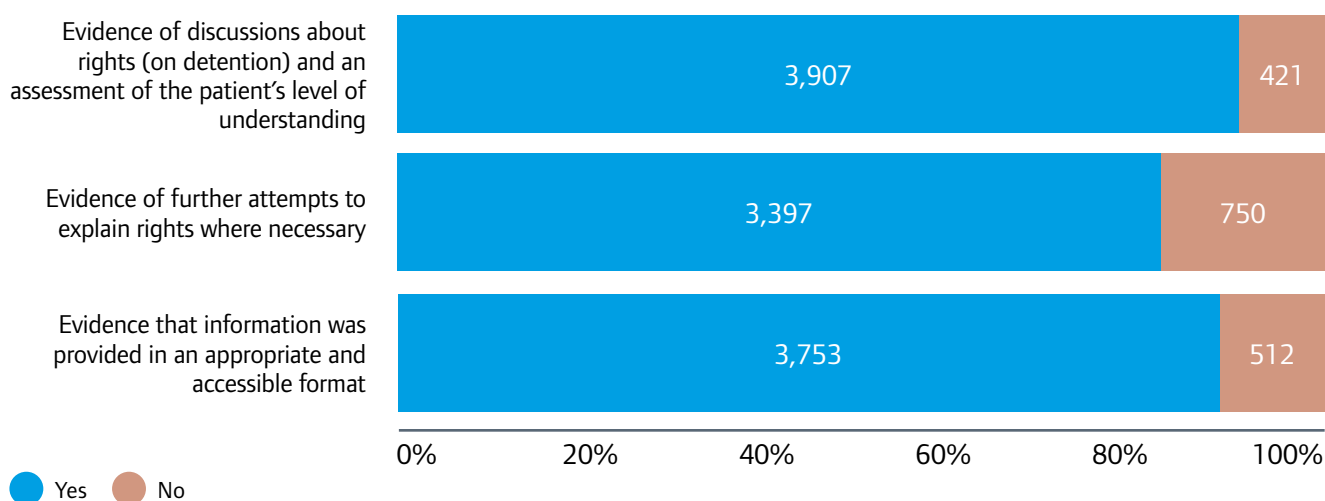
### Information for patients

Under the MHA, providers need to give patients information about their rights, verbally and in writing, as soon as possible after the start of their detention or community treatment order. This allows patients to understand how the MHA will affect them, be involved in their care and treatment and discuss any issues or concerns with staff. It also gives them the opportunity to exercise their rights if they wish to do so, for example by requesting their discharge through an appeal to the tribunal or hospital managers.

During our inspections and MHA monitoring visits, we check that hospital managers have given patients this information. We also look at what information is available for patients, families and carers on how to raise a complaint, and if they have access to the Code, so they are aware of the standards of care they can expect to receive.

While the majority of records showed that patients had received information about their rights, there was no evidence that staff had discussed rights with the patient on admission in 10% (421) of the patient records. In 12% (512) of records, there was no evidence that patients received the information in an accessible format. The Code requires staff to remind patients of their rights and of the effects of

Figure 5 Evidence of discussions of rights in examined records, 2015/16



Source: CQC

the Act from time to time, to ensure that the hospital is meeting its legal duties. However, there was no evidence of this happening in 18% (750) of records that we checked (figure 5).

These national-level findings on the proportion of services that we judge to be meeting their duties under the MHA show no improvement from the previous year. We cannot tell whether this is a

temporary halt or a significant reversal of the trend towards continuous improvement in the figures from 2010/11 to 2014/15, but providers should reflect on this in relation to their own practice and feedback from our visits.

Some services have taken effective action to improve practice after we raised concerns over the way information was provided. For example, some learning

## Good practice: providing information to patients and carers

“It should be part of the duty of the named nurse to ensure that patients are supported to understand their rights in a number of different ways: it should be done individually according to need, and documented.”

Service User Reference Panel member, September 2016

### What good looks like

Chapter 4 of the Code of Practice states that staff should receive adequate and appropriate support and training to understand the importance of providing patients with their rights and, where necessary, have specialist skills so that rights can be given in a number of different ways, tailored to individual patient and carer needs. Individual records should be kept by staff with a policy to support this and regular checks made by the hospital managers that information has been properly given and understood by patients.

### Examples from practice

We found good use of notice boards on an acute ward. A wide range of information was displayed, including a comprehensive explanation of the MHA and the meaning of each section. There was also creative use of notice boards to give appropriate personal information about staff, such as who they were, what they liked and so on. There was a notice board on support available to carers, from which we noted that the trust had set up a secure social networking site for carers containing posts from doctors, relatives and carers and contact details to obtain advice from pharmacists and therapists.

Berkshire Healthcare NHS Foundation Trust,  
Prospect Park Hospital, Snowdrop Ward,  
April 2016

Another acute ward had the direct number for the modern matron available for patients and carers in the reception area, notice boards and on individual notice boards in the patients' bedrooms. We spoke with the modern matron who confirmed that patients and carers were encouraged to contact her directly.

5 Boroughs Partnership NHS Foundation Trust,  
Coniston Ward, May 2016

On a learning disability ward, staff made sure that all information for patients was written in a format they could understand. This included all signs on the ward, psychology reports, records of one-to-one meetings between nurses and patients, information about patients' rights, activity plans and care plans.

Black Country Partnership NHS Foundation Trust,  
Orchard Hills, June 2016

disability services have ensured that a wide range of legal and clinical information is available in accessible formats, and some services have been able to use ward notice boards to provide accessible legal information alongside information about staffing on the day and activities available.

It is important that the duties under the MHA to provide information to detained patients are not read too narrowly by services. We sometimes hear these duties referred to as 'reading the patient their rights', which has unhelpful echoes of police procedure. It is not enough to focus on rights to appeal detention. The duty under the MHA should enable patients to understand and engage with staff and others in exercising agency over their immediate and longer-term involvement with services.

### **Independent Mental Health Advocacy**

Under the MHA, providers are required to take practicable steps to make sure that patients subject to the MHA are aware of the help that is available from Independent Mental Health Advocates (IMHAs). In our last report, we highlighted that many providers did not have effective systems in place, or were not supporting staff well enough to meet the expectations of the Code or their duties under the Act regarding IMHA services.

We continue to look at the availability of advocacy. In 2015/16, for 12% (515) of patients interviewed on our visits there was no evidence that the patient was informed of their right to an IMHA. In most cases, services have taken action on this as a result of MHA reviewers' reports. A small number of our comprehensive inspections of mental health services have found difficulties in providing patients with information about, or access to, MHA services. We have used our enforcement powers, issuing requirement or warning notices, to require providers to take actions to improve this, and it has also contributed to services being rated 'requires improvement'.

Services should make sure that staff tell patients about their right to access advocacy and support

"The initial shock of being taken forcibly from your home and put in a ward that you know you hate makes you worse: you are not in a fit state to take in your rights at that time, and they're written in a sort of jargon anyway. So you need to have your rights explained to you when you are at the right moment, by someone willing to let you question them. It's no good just reading it to you, that's a waste of time. There's no substitute for talking to people. The most important thing a psychiatric nurse can do is talk to a patient."

Service User Reference Panel member

patients to make contact with an advocate, particularly where patients may lack capacity to decide whether to ask for help from an IMHA. The Code of Practice recommends that hospital managers should arrange for an IMHA to visit any patient who lacks capacity to decide whether or not to request help from an advocate, to explain directly what the IMHA service can offer (paragraph 4.23 and 6.16). We are looking at whether services are following this guidance on our MHA visits, and have already seen many services using this approach.

We welcome the government's proposals to consider changing regulations to make sure that advocacy services are more formally provided on an opt-out (rather than opt-in) basis for patients who lack such mental capacity.<sup>17</sup>

"I think advocacy is very hit and miss. Some trusts use them to their full advantage, but others don't. I've not seen one and I've been detained 10 times."

Service User Reference Panel member



## Good practice: implementing the Code's guidance on advocacy referrals

In MHA monitoring visits to a dementia unit in May 2015 and June 2015, we noted that automatic referrals to the IMHA service were not being consistently completed. However, by the time of our comprehensive inspection in May 2016, staff were completing timely and regular referrals to the IMHA service on behalf of their patients. IMHAs also visited the wards regularly to offer patients independent support and advice. The IMHA service told us that the hospital provided appropriate support to patients who were detained under the MHA.

Abbey Court Independent Hospital,  
May 2016

We have also seen some excellent and innovative practice, demonstrating how advocacy can help to empower patients. We have also noted advocacy services developing tools to enable them to intervene and support patients at key points of their treatment and care, and a service expecting and appreciating advocacy involvement at these points.

### Blanket restrictions

Chapter 8 of the Code of Practice emphasises that services should avoid the use of blanket restrictions, which it defines as rules that restrict patients' liberty or other rights, and that are routinely applied to all patients without individual risk assessment (paragraph 8.5). We now see many examples of services reflecting on their practices to ensure that unnecessary blanket restrictions are identified and challenged. Many services have established governance around this that appoints specific members of staff to be champions of the process. All services are expected to have a restrictive practices reduction programme that can demonstrate a year-on-year reduction on restrictive practices. Local

"It's not the willingness of services that is the problem, it is the advocacy resources available."

Service User Reference Panel member

champions take the lead on identifying restrictive practices, make plans to appropriately reduce them, and involve patients individually and in group meetings when discussing their concerns. It is a welcome shift in culture for many services, which empowers patients and staff to challenge long-standing practices.

As we visit wards that are both places of psychiatric treatment and detention, we expect to see some tensions between individualised care and treatment and maintaining control and safety. We do not expect there to be a time when all issues of 'blanket restrictions' are resolved, but instead, look to see that services are regularly monitoring how their reduction strategies are being delivered and reviewing their practices to remove unnecessary restrictions.

There is a role for NHS commissioning to encourage the development and use of least restrictive practices through service contracts. For example, in a unit that otherwise had a strong rehabilitation focus, with many of the patients having unescorted leave, we found staff reluctantly working through a timetable of patient room searches. Staff told us that they did not think such routine searching was necessary, but that it was specified in their service contract. It is likely that service contracts may be more flexible than some services presume, and we encourage secure services and NHS England to talk about these matters. If contractual conditions set between NHS commissioners and providers are not in tune with the application of the Code of Practice principles, they should be revised.

### Locked wards

In 2015/16, 91% of the 1,234 wards we visited were locked. The proportion of locked wards has risen slightly every year over the last decade or more.<sup>18</sup> Any informal patient who is admitted to a ward that is permanently locked is at risk of unlawful de facto detention. We often raise concerns about this on our

## Good practice: Independent Mental Health Advocacy

“I think advocates have a great role, and there’s not enough money invested in them. In our service there’s only two of them and they’re both overworked. Especially when you’re on a Psychiatric Intensive Care Unit, it’s really nice to have an advocate who’s based in the building and who comes to see you and have a chat. They’re so different from the nurses, and so non-medical.”

Service User Reference Panel member

### What good looks like

Staff should promote, encourage and support patients to access advocates. This includes their ability to support preparations for meeting, enabling and empowering patients to take part and understanding the outcomes of meetings or hearings that are taking place.

Chapter 6 of the Code of Practice states that local services and commissioners should work together to maintain the effectiveness and provision of advocacy services and how they are working for patients, discuss any improvements needed and promote awareness for patients of the statutory support available to them.

### Example from practice

In a medium secure unit, we observed the Independent Mental Health Advocate (IMHA) engage with a number of patients. The IMHA supported patients to complete the questionnaire we used on our visit. We observed the IMHA meet with a patient before their Care Programme Approach (CPA) meeting, following which she attended the CPA meeting at the request of the patient, and fed back to the patient afterwards.

The IMHA service had also developed two forms that it used to support patients:

- A CPA form helped the IMHA guide the patient through the care planning process, and the CPA meeting and document issues to be addressed and actions agreed.

- The IMHA was notified when a patient was admitted to seclusion and would conduct an independent review within 24 hours. The IMHA completed the seclusion form, presented as a checklist, with the patient and cross-referenced with staff and records. We observed this process on the day of our visit, and noted that concerns were raised and addressed immediately.

The ward staff said that these interventions were helpful and supported them to improve practice.

Mersey Care NHS Foundation Trust, Scott Clinic, June 2016

visits and ask services to make sure that informal patients are aware that they are allowed to leave wards with locked doors.

There are many possible reasons why the number of locked wards is increasing, but few are based on evidence. There is often the assumption that the door has to be locked to prevent patients leaving or to prevent strangers or items that are banned, such as drugs and alcohol from coming onto the ward. Research into locked doors in acute wards suggests that they do significantly reduce the number of people absconding. However, they do not eliminate it altogether and have no effect on the rate of use of alcohol or illicit drugs by inpatients.<sup>19</sup> There is also evidence that locked doors are associated with increased patient agitation and treatment refusal, because patients feel trapped and confined: “The emotional burdens of the locked door fall on patients (anger and depression) whereas those of the open door fall on staff (anxiety).”<sup>20</sup>

The Code of Practice recommends that services should consider how to reduce the negative psychological and behavioural effects of having locked doors, and we expect to see services following this approach (paragraph 8.15). Research suggests that this should lead to a focus on high-quality ward physical environments, involving patients in planning engaging activities, and patients having access to garden areas.<sup>20</sup>

In some wards, we have seen examples of good practice in enabling patients to engage with planning life on the ward and being involved with activities. Some services have found good ways to engage patients in daily planning meetings that are a part of ward life in most units.

### **Separate facilities for men and women**

We have found issues with gender separation on many of our visits during 2015/16. The Code of Practice is clear that all sleeping and bathroom areas should be separate, and that patients should not have to walk through an area occupied by a person of another sex to reach toilets or bathrooms (paragraph 8.25). However, on many of our visits we have found the layout of wards did not allow for this, for example where female patients can only access toilets by walking past male patients’ bedrooms. Where

we found these issues, we identified them as areas that providers must improve on.

There were a number of other occasions when female patients reported feeling threatened by, or receiving unwanted attention from, male patients. Nobody should experience this as a hospital inpatient, but it may be particularly traumatising for someone who is detained under the MHA. Some female patients raised concerns over being observed by male staff when they felt vulnerable, such as when sleeping, bathing or undergoing seclusion or restraint. All staff and managers need to be constantly alert to the vulnerabilities of women in detention, some of whom may have previously experienced sexual abuse, and pay special attention to upholding privacy and dignity.

## **1.6 Assessment, transport and admission to hospital**

Approved Mental Health Practitioners (AMHPs) play an important role under the MHA. A key aspect of this role is to decide whether to apply to have someone detained in hospital when two medical recommendations for this have been made.

Local authorities are responsible for providing AMHPs, as well as their approval systems and standards. However, there are no nationally set governance processes for local authorities over AMHP services. As there is no national oversight and reporting, knowledge about the way AMHP services and individual AMHPs are supported across England is limited.

In 2016, we carried out a review with the Department of Health to evaluate the effectiveness of the way AMHP services are currently monitored nationally.

Stakeholders told us that:

- There are continuing concerns about the low numbers of AMHPs and the ability of services to provide a 24-hour service that can respond effectively to patient needs.
- There is wide variation in the way AMHP services are running across the country and local oversight, reporting and data captured is poor in many areas and variable across the country.
- AMHP services continue to be affected by

## Good practice: challenging blanket restrictions

“The way round blanket restrictions is to write down what should be done and what shouldn’t be done in individual care plans. So that does away with blanket restrictions. Everybody has a right to an individualised care plan to say what is and is not required. And that makes ward staff justify and reflect on what they do.”

Service User Reference Panel member

### What good looks like

Managers, staff and clinicians must have an awareness of the Code’s guidance and expectations for avoiding practice that may amount to a blanket restriction. This includes impact assessments for changes to policies and procedures that may result in unnecessary restrictions being placed on patient settings or groups of patients using the service.

Clear guidance should be available to all staff and patients that promotes independence and recovery, offering clear instructions on how to challenge practice that may amount to blanket restrictions.

Chapter 8 of the Code of Practice states that provider Boards and governance processes should be clear about the Code’s requirement for any restrictions that apply across patient settings, necessary for patient safety or others, to be supported by a clear rationale, agreed only by hospital managers and subject to governance procedures.

### Example from practice

In 2014, MHA reviewers raised serious concerns about blanket restrictions that we considered unnecessary in some secure wards managed by Tees, Esk and Wear Valleys NHS Foundation Trust.

On one ward, we also had concerns over staff attitudes and interaction with patients.

After receiving our visit report, senior managers in the trust visited the ward in question, interviewed all staff and made some staff changes. A new ward manager abolished nearly all of the blanket rules and addressed all of the concerns raised. We revisited in June 2014 and saw that facilities on the ward were open for use by patients, routine searching had ended, internet equipment was ordered, and visits were no longer supervised.

Since then, MHA reviewers have acknowledged that the trust is making ongoing progress in challenging restrictions across all its secure services. In September 2015, we visited a ward that had changed to medium secure status from a low secure environment. Despite this change, staff described how most of the blanket restrictions previously in place had been replaced with restrictions only being imposed as a result of individual risk assessments.

For example, on this and other wards there had been blanket requirements for staff to search every patient’s bedroom routinely and to search every patient who returned from unescorted leave outside of the hospital. Some wards had blanket

rules that patients' visits and telephone calls were supervised, and that they must open their post in front of staff. These restrictions were now only put in place following an individual risk assessment.

The trust is continuing to address blanket restrictions, the result of which has included better staff morale and interaction with patients. In our visit of June 2014, staff said "from receiving your report we dropped a lot of the restrictions"; "I am happy with the way things are going and the patients are happier in themselves"; "we are looking to make even more changes, and these will continue to be based on individual patient's assessments"; and "this is the best ward ever, there is less restriction and it's better for patients."

In 2015/16, the trust was rated outstanding for the key question 'are services well-led?'

Tees, Esk and Wear Valleys NHS Foundation Trust, January 2014 to February 2016

problems in accessing Section 12 approved doctors, ambulances for transporting patients and local and specialist beds.

In March 2016 we presented our findings in a briefing to the Mental Health Crisis Care Concordat, a collection of 27 services and agencies involved in the care and support of people undergoing a mental health crisis:<sup>e</sup>

- We recommended that CQC will use its focused visits to build an evidence base for the future development and monitoring of AMHP services.
- The Department of Health should work with the AMHP Leads Network to set national standards for AMHP services, identifying best practice and supporting a high-quality service.
- The Department of Health and the Department for Education should seek to produce legislation to establish a new social work body that will introduce a new system of registration for individual AMHPs.
- CQC and the Department of Health should work with NHS Digital to establish a new national dataset that allows monitoring of AMHP services and outcomes.

We are continuing to work with the Department of Health and others to implement our recommendations and improve oversight of AMHP services. We are planning to complete focused activities in 2016/17 and publish national findings.

## 1.7 Additional considerations for children and young people

In our last report we noted that NHS England had acknowledged gaps in provision of child and adolescent mental health services (CAMHS).<sup>21</sup>

### **The use of the MHA for children and young people**

There are no age-related criteria for use of the MHA. In October 2016, there were more than 400 children and young people (those aged under 18 years) detained in hospital under the MHA (figure 6).

The age of people detained under the MHA has not

Footnote:

e See [www.crisiscareconcordat.org.uk/](http://www.crisiscareconcordat.org.uk/)

## Good practice: engaging patients in life on the ward

“We had a morning meeting, and you can sit around talking, and generally is there anything – have we got any visitors coming in – and sometimes we’d have the newspaper and just talk about the newspaper, talk about things that are going on. All just sitting around, talking, with the staff was lovely. You felt more engaged with them and with everybody else..”

Service User Reference Panel member

### What good looks like

Commissioners, providers and professionals should consider the broad range of interventions and services needed to promote recovery not only in hospital but also after a patient leaves hospital, including maintaining relationships, housing, opportunities for meaningful daytime activity and employment opportunities. Staff should ensure that patients have the opportunity to be involved in planning and discussing life on the ward while they are inpatients, acting on feedback given and seeking ways to improve the activities available based on the needs of individuals and their recovery plans.

### Examples from practice

We attended the daily morning meeting with patients and staff. We found this to be a good example of empowerment and involvement, with all patients playing an active part in planning their activities for the day. All of those present at the meeting, including staff, gave an account of their plans for the day, and detailed who they would be spending time with in or at various activities.

Oak Lodge Rehabilitation Centre (Alternative Futures Group Ltd), June 2016

In addition to a daily planning meeting where practical matters such as leave requirements were addressed, all patients and staff attended an additional evening ‘debriefing’ session. This focused on a review of the day to talk about what had gone well, and any issues, with a view to resolving difficulties quickly. The session also encouraged attendees to recognise and acknowledge positive outcomes and their own strengths and abilities. This was an effective method of ensuring open and meaningful communication between patients and the care team on a regular basis, showing that they were meeting the guiding principles of the MHA Code of Practice.

Cygnets Hospital Beckton, Bewick Ward, April 2016

previously been collated. As a result, we do not know whether the above snapshot is typical of children and young people inpatient numbers in mental health services.<sup>f</sup> If it is, this suggests a different pattern to adult services, where we have seen that there may now be more inpatients subject to the MHA than informal patients. The 2016 snapshot shows a third of children and young people inpatients detained under the MHA, with most of the remainder treated on an informal basis. For some patients, this will be simply because they have capacity or competence to consent to admission and treatment, and do so. For others, parental consent may be the legal authority for admission and treatment.

It seems possible that there is a greater proportionate use of the MHA today for children and young people than in the past, because of recent changes in emphasis on the "scope of parental responsibility" in the Code of Practice (paragraph 19.40 to 19.43). We understand that many clinicians are less willing to rely on parental consent as the legal authority for admission or treatment. This may be a positive thing, due to the safeguards that the MHA provides for

patients (and also because it takes the burden of being the primary legal authority for an intervention away from parents, who may not want to take on a role that can lead to conflict with the patient).

NHS England acknowledges that inpatient care can lead to adverse care pathways, even when it is based on concerns that children or adolescents are a risk to themselves. This could include a spiralling of worsening symptoms and increased suicidality,

“Carers can object to out-of-area placements; some AMHPs are very good at explaining this, but some don’t. Other AMHPs are very good at saying – as in the case of my husband, who said that ‘you’re not taking her out of area’ – the AMHP said ‘I completely support you’, and turned round to the psychiatrist and said ‘you will not get an application’. I know carers all over the country who didn’t know you could do that – weren’t aware that they could step in and stop that section.”

Service User Reference Panel member

Footnote:

f From January 2016, the MHSDS monthly release has included experimental data from children's and young people's mental health services, including CAMHS, and so in future data will become available for comparison.

g For example, MHA sections 37, 47 and 48 with or without restrictions.

Figure 6 Inpatients aged under 18 years of age, October 2016

Legal status	Number of patients
Informal	870
MHA, s.2	159
MHA, s.3	242
MHA, part 3 <sup>g</sup>	10
MHA holding powers	7
Other acts (ie Children Act)	2
Not known	30

Source: NHS England

leading to increased levels of security and delayed discharge.<sup>22</sup> As well as understanding which legal authority is used for inpatient care, local areas will want to examine patterns of hospital admissions to determine whether sufficient community-based interventions are available to avoid inpatient care in the first place.

### Second opinions for children and young people

In 2015/16, CQC arranged 371 second opinions for patients under 18 years of age (figure 7). Roughly two-thirds of these were for female patients. Only two of the visits were to consider treatment with electroconvulsive therapy (ECT), both for 17-year-old patients. All other visits were to consider treatment with medication for mental disorder. Eight visits were to consider medication for patients subject to CTO. Very few visits (14 overall) resulted in no certificate being issued to authorise some form of treatment without consent. In most of these cases this was because the patient had begun to give consent, or was discharged from being subject to the MHA.

### Notification of placement of children and young people on adult wards

Services are required to notify CQC after any child or young person under 18 years of age spends more than 48 hours on an adult mental health ward. We are not notified about whether the child is detained or not. The numbers of notifications have increased by 2% (from 235 to 240) from 2014/15 to 2015/16. This contrasts with a jump of 22% from 2013/14 to 2014/15 (from 193 to 235). We do not know whether this reflects changes in practice, or changes in the level of compliance with

the reporting requirement.

Some services have refused to allow children or adolescents access to places of safety that are based in adult facilities in the mistaken concern that to do otherwise would breach age-appropriate accommodation guidelines. We have suggested that such an approach is a misunderstanding of the guidelines, and of the nature of a place of safety, which should be relatively self-contained and not a part of the ward that shares some facilities or staffing. While we understand that health-based places of safety may not be ideal accommodation for children or young people, they are generally the best facility available, and refusing to allow a child or adolescent to enter could lead to the use of police cells as the only alternative.

### CQC monitoring and inspection of CAMHS units

When visiting CAMHS units in 2015/16, our MHA reviewers and inspectors found issues that were not markedly different from those raised in adult services. Matters raised on our visits included:

- lack of patient involvement in care planning
- lack of recording of consent and decisions about capacity/competence to give consent
- failures to provide information about legal rights, both for patients who were detained under the MHA and for those who were not
- lack of information about advocacy, and some advocacy services that did not appear to have specialist training in dealing with children and adolescents
- patients complaining of boredom and lack of activities, or lack of access to fresh air.

Figure 7 Second opinion requests for patients aged under 18, 2015/16

	Detained	CTO
Under 16	108	1
16 or 17	255	7

Source: CQC



On many units we engage staff over issues of blanket restrictions. We accept that many CAMHS units will have more rules than roughly comparative adult services, either because of their specialist nature (such as eating disorder units) or because of the vulnerability or young age of patients. However, on a number of wards we have challenged policies that imposed restrictions, not based on individual risk assessment, that limited bedroom access during the day; kept toilets and other facilities locked to patients; banned many personal items (including mobile phones); and restricted access to sanitary products and items of underwear. Where we have raised these, services have agreed to revise their practices to make sure that restrictions are based on individual risk assessment and not placed unnecessarily on any patient.

## 1.8 Care, support and treatment in hospital

In the Code of Practice, chapters 23 and 24 on medical treatment and care in hospital emphasise the importance of detained patients being offered appropriate treatment. To determine if treatment is appropriate, staff need to consider whether the patient has consented to or refused treatment, whether the patient has the capacity to consent, and if they need to use the powers given under the MHA to impose treatment without consent. The Code also expects services to promote good physical health care and healthy living for detained patients, assess individual needs and have clear processes for managing behavioural disturbance in a safe and therapeutic way.

### Consent to treatment

Under the MHA, services have legal powers to give psychiatric care and treatment without consent to some detained patients.<sup>h</sup> For the first three months of treatment with psychiatric medication, and for the range of nursing and other interventions that can fall within the broad category of treatment for mental disorder, the statute simply states that the consent of a patient is not required (section 63). These are sweeping powers, and the Code of Practice emphasises that exercising them in ways that comply with the rights and freedoms guaranteed under the European

Convention on Human Rights requires providers to adhere closely to the requirements of legislation and good clinical practice (paragraph 2.44).

Where the MHA allows treatment to be given without consent, the Code of Practice is clear that the patient's consent should still be sought wherever practicable. Consent, refusal to consent, or a lack of capacity to consent need to be recorded. Providers should consider carefully whether to go ahead with treatment if the patient refuses or is unable to give consent (paragraph 24.41). During visits we check to see whether clinicians have recorded evidence of their conversations with detained patients over the proposed treatment, and recorded the patients' views on that treatment, as well as whether the patient consents, refuses consent, or is incapable of consent. If a patient is recorded to be incapable of consent, we expect to see a capacity assessment to support this view and, unless it would clearly be inappropriate to expect this, evidence that ways in which the patient might be helped to gain or regain capacity have been considered.

Discussions about consent to give psychiatric medication should always happen before treatment begins, as the first three months of treatment comes to an end, and when ongoing treatment is reviewed, unless there are clear reasons recorded why this was not possible for that individual patient.

However, on many visits we have found that these discussions are not taking place. The impact of failing to engage with patients could be to deny them the chance to contribute towards their care planning, or give valid consent. This could lead to unlawful treatment, or to less than good care for people that would hinder quick or sustainable recovery. During

Footnote:

<sup>h</sup> The treatment provisions of the MHA (and therefore the authority to treat without consent discussed above) apply to patients detained under sections 2, 3, 17A, 36, 37, 38, 44, 45A, 46, 47, 48 and 49 of the MHA. They do not apply to patients held under short-term holding powers such as sections 5, 1345 or 136, or conditionally discharged or CTO patients who have not been recalled to hospital, who are in the same position as informal patients in relation to treatment without consent.

2015/16, we have revised the methodology for our visits, which has given us a greater focus on this area. Not holding discussions about consent will limit the rating that we give for the key question 'are services effective?'

To help patients understand the nature, purpose and likely effects of their medication, some services have helped patients to speak to hospital pharmacists. This helps patients to understand the treatment they are being given, and ensures that the consent given is valid. In addition, by providing a partially independent source of information and advice it may help services gain the trust and consent of patients.

### **Promoting good physical health**

In our 2012/13 report, we showed that a worrying proportion of wards did not have ready access to GP services, and gave examples of undiagnosed or untreated physical conditions in detained patients that were compromising both their physical and psychological wellbeing (page 32/33). In our last two reports, we have highlighted the importance of improving the physical health care and healthy living of mental health patients (page 25). Our State of Care report for 2015/16 expressed our concern that some long-stay units are not sufficiently focused on the assessment and treatment of physical health problems (page 97). Patients detained under the MHA are at particular risk of co-morbidity, where physical health conditions are overshadowed by mental health conditions and remain undiagnosed or untreated. Patients using antipsychotic medication may also be at increased risk of cardiometabolic disorders.<sup>23</sup> As a result, hospitals must routinely assess the physical health needs of patients alongside their psychological needs (paragraph 24.57). The Working Group for Improving the Physical Health of People with Serious Mental Illness has provided detailed recommendations on this, which we wholly support, for service providers, commissioners and regulators.<sup>24</sup>

We continue to review how well the physical health of detained patients is monitored. In 2015/16, we

looked at the care records of 3,031 patients who had been detained for less than a year in hospital. Of these, there was no evidence in 5% (163) of records that a health assessment was carried out at admission. This is similar to our findings in 2014/15 where 5% (137 records) did not have this evidence. In addition, 10% (76) of the records we looked at in 2015/16 reported having problems with arranging GP services for detained patients. Again, this is the same proportion as in 2014/15.

However, we have also seen some good examples of services addressing the physical healthcare needs of patients. A number of services have addressed issues with accessing GP services by arranging regular GP clinics on the ward. Some services have told us that their primary concern is addressing high levels of smoking and obesity in patients with a severe mental illness. We recognise that these are major health issues for many patients subject to the MHA, and encourage services to have a primary focus on physical healthcare advice and support, rather than simply restricting access to tobacco or food. We recognise that NHS standard contracts will require mental health services to ensure that their premises are smoke-free by no later than 31 December 2018. Services should ensure that they make full use of available resources to help promote smoking cessation in mental health settings, including secure settings, in line with the National Institute for Health and Care Excellence

“Good practice requires that doctors listen to the patient’s preference because they may know that certain medications affect them in a bad way and others they get on well with – that should be listened to. And psychotropic drugs should only be part of the holistic treatment of a patient; talking therapies should go along with this.”

Service User Reference Panel member

(NICE) guidance to support smokefree policies.<sup>25</sup> NHS England is also (at the time of writing) engaging on a new set of draft national Commissioning for Quality and Innovation (CQUINs) for 2017 to 2019, including the continuation of a CQUIN for improving physical health care to reduce premature mortality for people with severe mental illness.<sup>26</sup>

Throughout 2016/17, we are looking at how we can use our powers to encourage better integration between mental and physical health care. We are working to improve how we assess how well the physical healthcare needs of people with a mental health problem are monitored and addressed. We are also looking at how we assess the provision of mental health care in primary care and acute hospitals. MHA reviewers will be a part of this work, and are taking part in pilot visits to acute hospitals in 2016.

### **The safe and effective management of behavioural disturbance**

The Code of Practice places a helpful emphasis that the best form of managing behavioural disturbance is prevention, with a focus on a positive and therapeutic culture over restrictive interventions such as seclusion or restraint (paragraph 26.4). This emphasises the importance of the care environment, staff communication and engagement with individuals and their families, and the involvement of patients in decisions about their care and support as preventive measures against behavioural disturbance.

### **Seclusion**

The Code of Practice recommends that “seclusion should only be undertaken in a room or suite of rooms that have been specifically designed for the purposes of seclusion and serves no other function on the ward” (paragraph 26.105). As with all of the Code’s recommendations using the terminology ‘should’, services may depart from it where they have documented and recorded a reason to do so (paragraph ix). We have seen a variety of services that can demonstrate valid reasons why dedicated seclusion facilities may not be routinely needed, for example children’s units. We have issued a brief guide for inspectors that informs assessments and factors

that will need to be considered when services do not have a dedicated seclusion facility in place. However, all services will be expected to be able to demonstrate what approach would be taken if the need for seclusion arose for individual patients.<sup>27</sup>

## **Good practice: information about treatment**

“I did see one example of good practice on a visit – a room with a sign on the door saying come in and discuss your medication – people could come in and talk about their individual medication and I thought that was excellent.”

Service User Reference Panel member

### **What good looks like**

Staff and services have a duty to consider the different ways in which patients’ understanding, level of involvement and opportunity for discussion can be increased when making decisions about their medication. This should include inviting patients to ask questions, explaining their right to withdraw or withhold consent, providing access to other professionals, such as pharmacists or advocates, and, with the support of the patient, involving family and carers in discussions (paragraph 24.34 to 24.53).

### **Examples from practice**

A rehabilitation unit for men ran a monthly drop-in session with one of the trust’s pharmacists where patients could raise issues, request information and discuss medication. These issues were also discussed in ward rounds and in one-to-one sessions with named nurses, and the unit gave patients the opportunity to discuss this area with a professional outside of their treatment team.

Manchester Mental Health and Social Care Trust,  
Anson Road, April 2016

Staff may not expect to use seclusion at all on many wards where patients are detained, for example because the patients on the ward are elderly, or the ward is for rehabilitation before discharge. We have seen examples where such wards have had to improvise safe containment of patients who suddenly exhibit extremely challenging behaviour,

pending their transfer to a facility appropriate to their changed circumstances. By their nature such improvisations are rarely perfect, but it seems more reasonable to focus on services' ability to arrange timely appropriate transfers, than to expect all units to be equipped for any eventuality.

In some services that do not have dedicated

## Good practice: physical health checks for detained patients

"I put on all my weight when I went into hospital, all I could do was comfort eating and I had no way to exercise. It happens to a lot of people" ... "side effects of psychiatric medication can really harm your general health. I've got friends who are young people, in their 30s, really overweight, heart disease, thyroid trouble, all sorts."

Service User Reference Panel members

### What good looks like

Services should consider how to help patients' engagement with physical health care, including healthy living promotion, and steps taken to reduce any potential side effects associated with treatments. Commissioners and services should work together to ensure the physical needs of patients are assessed routinely alongside their psychological needs and long-term physical health conditions are not undiagnosed or untreated, and that patients receive regular oral health and sensory assessments and, as required, referral (paragraph 24.57 to 24.62).

### Examples from practice

Our comprehensive inspection of a mixed low and medium secure unit in June 2015 found good standards of meeting patients' physical healthcare needs. On a subsequent MHA visit to the women's medium secure unit in April 2016, we saw that the service was working on a female health project to improve access to breast screening, smear tests and sexual health through an external service provider.

Brockfield House, South Essex Partnership University NHS Foundation Trust, April 2016

On a visit to an acute ward we saw the piloting of a physical health check programme to improve physical health care in people with long-term mental health needs. A comprehensive physical and mental health assessment form was completed for all patients on admission to the ward. This was designed to lead to tailored lifestyle advice and signposting, and appropriate referrals and follow-up. On discharge from the ward, all patients were given a 'health passport' to take to their GP or to an alternative ward if transferred.

Central and North West London NHS Foundation Trust, St Charles' Centre, April 2016

“We’ve got a garden in our Psychiatric Intensive Care Unit. It’s just a tract of grass that is never used because you need two staff for one patient to go out, and they go ‘we haven’t got anybody’, and the door stays locked” ... “How can you be healthy if you’re cooped up all the time? Everyone needs some fresh air every day. Prisoners get that.”

Service User Reference Panel members

seclusion facilities, occasionally staff will take a patient to their own room or a quiet part of the ward for additional support. Where this can be achieved safely, the patient may view it as a less restrictive or less upsetting option than being taken to a dedicated seclusion room. As long as staff recognise that preventing a patient from leaving an area they have been taken to falls within the definition of seclusion, and they are applying the appropriate safeguards, we accept that this is a rational reason to depart from the Code’s guidance over only using dedicated seclusion facilities.

It is encouraging to see initiatives, such as the example given below, to provide alternatives to seclusion in some psychiatric intensive care units (PICUs), which are services that will often have an expectation of frequent use of this intervention.

Where services are trying alternative approaches to seclusion, or using a non-dedicated seclusion room to isolate patients on occasion, they should periodically review practice to ensure that all interventions falling within the broad definition of seclusion are recognised as such, and that the seclusion episodes are reviewed as required by the Code. Services must also make sure that patients’ comfort or safety is not disadvantaged by the physical environment of the spaces used, which is unlikely to meet all the recommendations relating to seclusion rooms in the Code.

### Physical restraint

In comprehensive inspections, we ask services to provide audit data on the number of physical restraint

episodes in their hospital, and indicate whether prone (face-down) restraint was used. If prone restraint is used, we expect the provider to be able to state the circumstances that justified this, and what arrangements they have in place to get immediate medical attention. This needs to be clearly recorded in individual care plans, and regularly monitored and reviewed.

In line with the Department of Health’s policy Positive and Proactive Care, providers should have a policy on the use of restraint and a programme for reducing the use of restrictive interventions, for which the board is accountable.<sup>28</sup> Use of all restraint, including any use of mechanical restraint, should always be in line with this policy, and any staff need to be appropriately trained.

### Mechanical restraint

We expect services to follow the recommendations of the Code of Practice in the way they govern the use of mechanical restraints. However, the Code’s approach conflicts with NICE guidance, which suggests that mechanical restraint should only be used in, or in transit to, one of the three high security hospitals.<sup>29</sup>

## Good practice: personalised arrangements to manage patient distress

Special arrangements had been made for a patient who found it difficult to manage his behaviour. The ward had converted the neighbouring bedroom into a de-escalation room to remove the need for him to have to be taken off the ward when he was distressed.

Cheswold Park Hospital (Riverside Health care Ltd),  
Gill Ward, May 2016

“Empowerment – the providers need to listen to what the patients want. That is empowerment... so the service provider is driven by what the patients require. Listening to what the patients want and doing what the patients want...”

Service User Reference Panel member

A number of services and clinicians have approached us with concerns over the NICE guidance. We have taken the view that all local policies on restraint should be clear that the least restrictive option for patients is the priority. Monitoring by local teams should include all uses of restraint and specifically identify mechanical restraint use, ensuring there is a clear reason recorded that this has been done in the best interests of individual patient, irrespective of the security level of the service.<sup>30</sup> We believe the issue of this conflict between the NICE guidance and the Code of Practice should be considered by the Department of Health and further guidance should be issued to providers to clarify the position for services and regulators.

We continue to see wards following good practice in considering whether to use mechanical restraint. The type of intervention used (for example, soft hand restraints that impede but do not immobilise the patient) needs to be based on the best interests of the individual patient, rather than whether it is a low, medium or high secure hospital. Whenever mechanical restraint is used, this should be reported to the managing board of the service.

We have found that mechanical restraints are sometimes being used as a blanket measure when transporting patients off-site (for example to court or other appointments, or when given leave of absence for leisure). Some uses of handcuffs or soft cuffs will be a Ministry of Justice requirement for granting leave to a restricted patient. However, services need to ensure that they are not using these measures unnecessarily. Some forensic units have told us that they audit the use of handcuffs. This helped one service to recognise its use was too high, and led

## Good practice: a non-seclusion policy in a psychiatric intensive care unit (PICU)

We visited a PICU ward that had been rated outstanding in our comprehensive inspection six months earlier. The ward was at the forefront of developing national standards within PICUs, and has been the recipient of several national and international awards. The trust had a non-seclusion policy and did not have any dedicated seclusion rooms. We found that the ward had developed innovative ways of treating patients with challenging behaviour. This included using verbal de-escalation techniques and intensive staff support to reduce the need for seclusion and other restrictive interventions. Staff told us that when patients became upset or agitated they would be taken initially to their rooms. Staff would stay with patients until they became calmer and could re-join the ward.

2gether NHS Foundation Trust, Wooton Lawn Hospital, Greyfriars Ward, June 2016

to the service ensuring that a risk assessment was completed for each patient. We encourage other services to adopt this approach and ensure that Ministry of Justice caseworkers know when patients have been assessed as not requiring handcuffs so that any requirement established by its caseworkers can be reconsidered.

## 1.9 Leaving hospital

In its chapters on leaving hospital, the Code of Practice provides guidance on care planning in the context of the Care Programme Approach, including aftercare planning and individualised risk-assessment.

We check the quality of care plans, including whether they are detailed, comprehensive and developed with the involvement of patients and carers. While some services are doing this well, and using innovative practices, overall we continue to find issues with a worrying proportion of care plans and we urge services to look at this closely.

### **Patient involvement in care planning**

Although the MHA provides authority for treatment without consent, the principles that should underpin its use require patients to be involved in decision-making and that clinicians should consider and fully document patients' views on proposed treatment. Guiding principles of the Code of Practice also requires providers

to fully explain and document reasons why they take any decision that is contrary to the patient's preferences.

During our visits in 2015/16, MHA reviewers found no evidence of patient involvement or patient views in 29% (1,214) of the care plans they reviewed (figure 8). There was no evidence that the patient's views about treatment were considered in 26% (1,118) of care plans examined. We recognise that for some people, the nature or degree of their mental disorder may make it difficult for them to engage with the care planning process. However, it is clear in some of our visit reports that staff had failed to make adequate attempts to make such engagement happen. We expect all services to carry out and document measures to support patients' engagement with the care planning process, including building patients' capacity to engage where there is an issue.

There has been a drop in the overall proportion of care plans that we judged to be meeting Code of Practice expectations in 2015/16, compared with the previous year.<sup>i</sup> We cannot tell whether this is a temporary halt or a significant reversal of

Footnote:

- i In 2014/15, we found no evidence of patient involvement or patient views in 25% of records examined, and no evidence of the patient's views about treatment in 24% of records examined.

## **Good practice: mechanical restraint in a medium secure unit**

Staff on a women's medium secure unit demonstrated being open, transparent and looking at all possible least restrictive ways of supporting a patient being nursed in long-term segregation with mechanical restraint. Staff also sought feedback on their intervention through the Royal College of Psychiatrists' Quality Network for Forensic Mental Health Services.

Nottinghamshire Healthcare NHS Foundation Trust, Arnold Lodge, Coniston Ward, April 2016

the trend towards continuous improvement in the figures from 2010/11 to 2014/15, but providers should reflect on this in relation to their own practice and feedback from our visits.

In 2015/16 we found 10% of care plans that showed that patients’ needs had not been considered, or that staff had not considered the minimum restrictions required for the individual. This is the same proportion as for the previous year. However, some services have addressed this issue very well, and we have commended a number of services for the levels of patient involvement in their care.

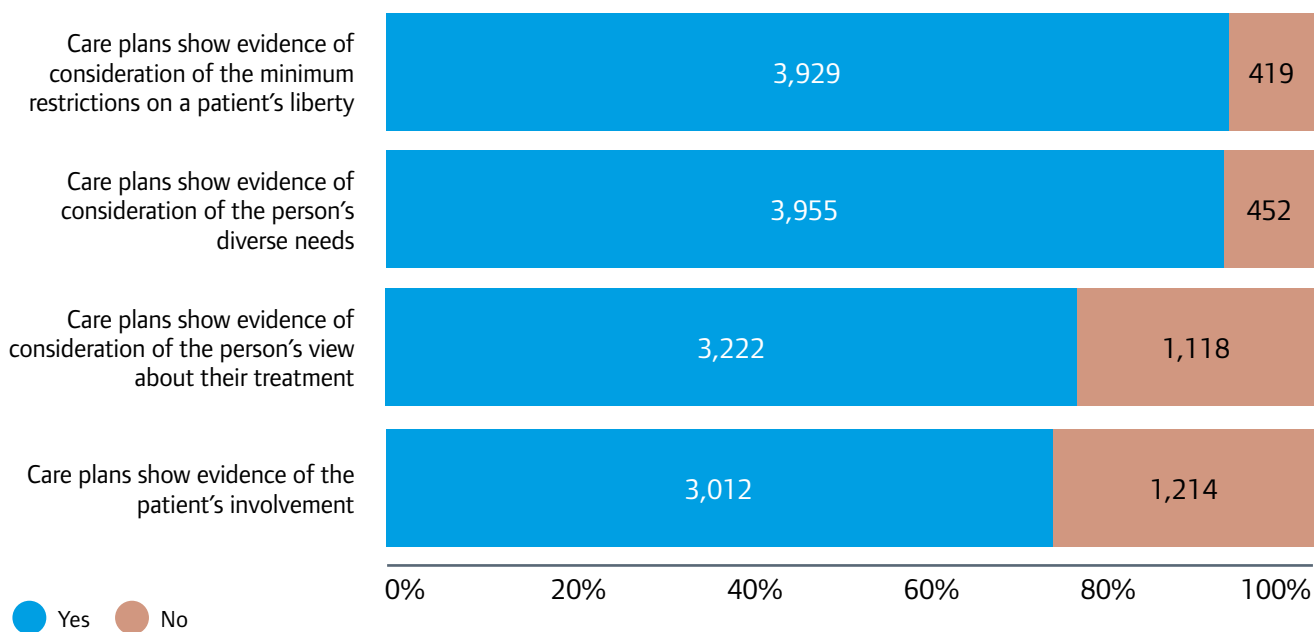
Many services accept the principle of patient involvement in care planning, but can struggle to turn this into practice. Effective involvement requires a person-centred approach, and an openness towards co-production of care plans. There is much user-led research and support for services on such implementation, including the narrative for person-centred care produced by National Voices, which we commend to services.<sup>31</sup>

“When we talk about patient involvement, I’d like to use the word co-production. So care plans should be co-produced, so it’s less something done to people” ... “When you change the language, you can change the practice” ... “When you’re not cutting and pasting from another care plan, but co-producing care plans.”

“It’s very important that you write your own care plan – it’s your chance to say how you want to change your life. People should be encouraged to make advance decisions and planning in advance for any future relapse.”

Service User Reference Panel members

Figure 8 Evidence of patient involvement in care planning in examined records, 2015/16



Source: CQC



## Good practice: patient involvement in care planning

“What else I hate is them having a meeting before you’re invited in, and then another after you’ve been in and gone. I want to see no decisions about me without me, and no discussions about me without me: I want to be in on every discussion.”

Service User Reference Panel member

### What good looks like

Services should have clear strategies in place to actively involve and engage patients as fully as possible in the co-production of care plans. This should include the allocation of named individuals responsible for coordinating and regularly reviewing care plans in close partnership with patients and others involved in implementing the care plan.

Commissioners and providers should have processes in place to monitor how effectively aftercare needs are being planned and whether these are started as soon as possible following hospital admissions, ensuring steps are taken to jointly identify appropriate aftercare services for patients in good time for their eventual discharge from hospital (paragraph 34.10 and 33.10 to 33.15).

### Examples from practice

We found that each patient had a comprehensive integrated care plan that included a positive behavioural support plan. Each patient’s care plan was tailored to their needs and contained the patient’s own views and wishes throughout, even when these contradicted the views of the staff. Both the care plan and the risk assessment (“my shared risk”) were provided in an easy read format. In addition to an active advocacy service, Women in Secure Hospitals (WISH), a national user-led charitable organisation working with women with mental health needs in prisons and hospitals, held a monthly surgery to provide additional advocacy, peer support, supervision and practical guidance to both staff and patients on the unit.

Calderstones Partnership NHS Foundation Trust, Coniston & Grasmere wards, April and June 2016

On an unannounced visit to a learning disability assessment and treatment unit, we found comprehensive evidence of full patient involvement in all aspects of care planning. All documents were in easy read format and demonstrated patient input from their admission onwards. Staff took great care at all stages and took time to explain everything as often as needed to involve and reassure patients.

Humber NHS Foundation Trust, Townend Court, June 2016

Recent research analysing random-controlled trials also shows that the use of advance statements may lead to a statistically significant and clinically relevant reduction in compulsory admissions of adult psychiatric patients, whereas community treatment orders, compliance enhancement, and integrated treatment showed no evidence of such a reduction.<sup>1</sup> Advance statements are a form of care-planning: they can state preferences for actions to be taken or not taken in a crisis. It is possible that such agreements, if made in co-production with clinical teams so that they are realisable in practice, could prevent some patients from ending up in a position where they refuse consent to hospital admission they do not want, for example, by stating a preference for certain hospitals or wards over others, or other details to do with admission, or could ensure that interventions are carried out and accepted before hospital admission becomes necessary. As such, co-production of care plans could be the most effective way in which services might address the rising number of detentions under the MHA and seek to reverse this trend.

### Discharge planning

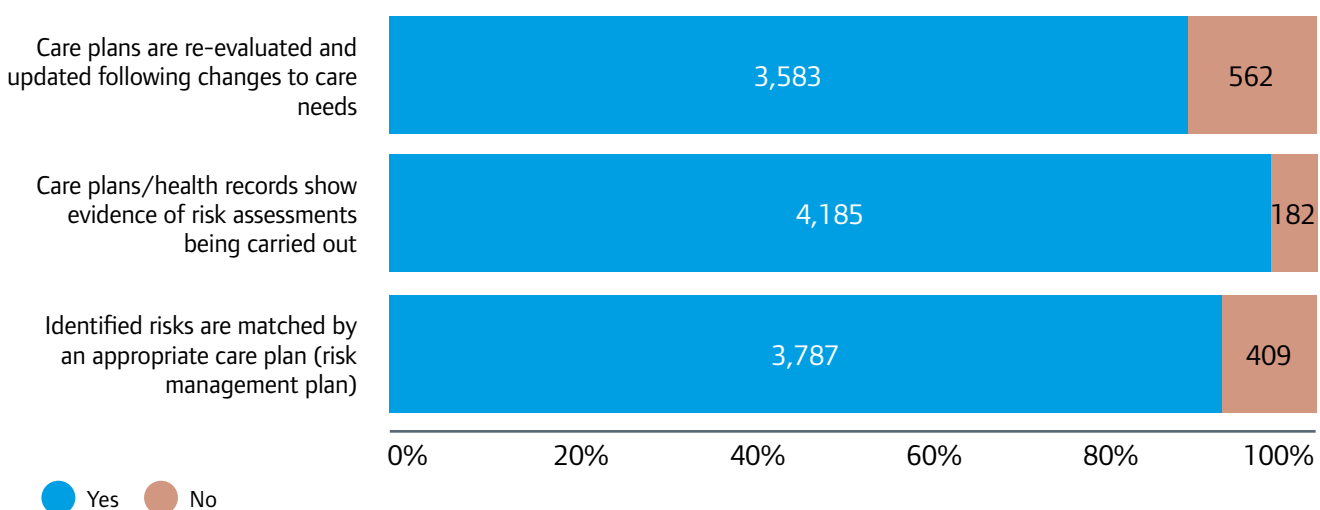
The Code and Care Programme Approach expect service providers to begin discharge planning

as soon as the patient is admitted. Services also need to ensure that patients are clear about plans and goals for their recovery and discharge. We see some excellent practice in such care planning, showing that patients are listened to and their views are recorded, even when these do not match the clinicians' views. Other examples of good practice include a particular focus on engaging with and supporting carers and family members, both in understanding the patient's care and treatment in hospital, and in developing skills to help them after the patient's discharge.

Commissioners and all services involved should give particular attention to the Code of Practice's chapter on mental health aftercare, that states that they should interpret the definition of aftercare services broadly. This should include health care, social care, employment services, supported accommodation and services to meet the patient's wider social, cultural and spiritual needs, to the extent that they meet a need arising from or related to that person's mental disorder and could help recovery.

However, 32% (1,324 out of 4,086) of care plans we reviewed during 2015/16 showed no evidence of discharge planning. This is a slightly larger proportion than 2014/15, when the equivalent

Figure 9 Evidence of risk assessments in examined records, 2015/16



Source: CQC

measure showed 29% of records had no evidence of discharge planning. As with other such findings discussed in this report, we cannot tell whether this is a temporary halt or a significant reversal of the trend towards continuous improvement in the figures from 2010/11 to 2014/15, but providers should reflect on this in relation to their own practice and feedback from our visits. Where we find issues, we ask providers to review their procedures to make sure that aftercare planning is regularly reviewed from the point of admission, and fully documented in care plans.

We have seen a number of examples where services have been particularly supportive to carers. Many of these services are using guidance from the *Triangle of Care* initiative.<sup>32</sup>

Involving carers in hospital care and aftercare planning can be complicated for patients in out-of-area placements, despite guidance in chapter 14.85 of the Code of Practice. Some families have to pay their own travel costs and are struggling to sustain this. Nearest relatives may claim travel expenses from the Tribunal service to attend Tribunals. However, there do not appear to be any other agreed sources of funding for them to visit hospitals for other purposes. With current financial restrictions, local authorities may be less willing to cover such costs through their local welfare provision. Many hospitals provide financial assistance to relatives but this is not universal. To make sure that carers are fully involved, specialist service providers and commissioners of out-of-area placements should consider how they may offer support and guidance for families and carers' visits.

### **Individualised risk assessments**

MHA reviewers check care plans for individualised risk-assessments, which should be updated as patients' circumstances change. In 2015/16, our MHA reviewers found that 14% (562) of care plans had not been re-evaluated and updated following a change in circumstances (figure 9).<sup>j</sup> This is a larger proportion

Footnote:

<sup>j</sup> In 2014/15 we found that 11% (425) care plans examined had not been re-evaluated and updated following a change in circumstances.

than the previous year. The majority of services do have appropriate processes for managing risk. In these services risk assessments are completed with patients; updated in response to significant events, such as taking leave from hospital; and actively used by staff in the day-to-day care on the ward. Providers whose feedback from our visits raises concerns over individualised risk assessment should reflect on this in relation to their own practice.

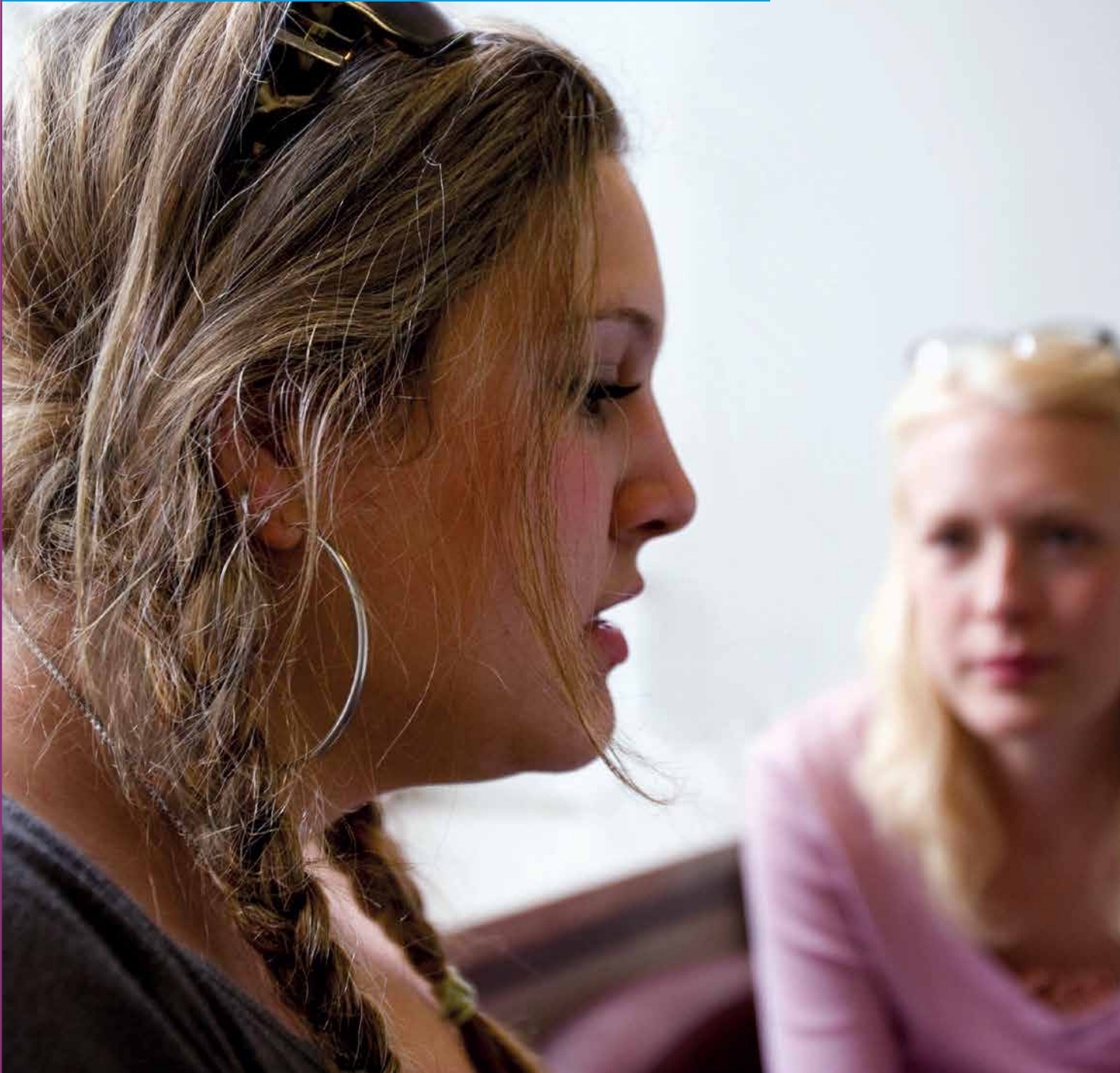
## **Good practice: involvement of carers**

We were particularly impressed with the way that one learning disability assessment and treatment unit involved both patients and carers in developing and implementing individualised programmes of care. We spoke with the parents of a patient who was resident on the unit and had been admitted following a breakdown in care arrangements elsewhere. They described how times for multidisciplinary meetings were changed to accommodate their travel arrangements, how visiting times had been flexible (they lived some distance away) and how there was regular contact when anything changed or there was an issue that the staff felt they needed to be informed or consulted about.

Cheshire and Wirral Partnership NHS Foundation Trust, Greenways, June 2016

# Part 2

## CQC AND THE MENTAL HEALTH ACT



## Key points

In 2015/16:

- We carried out 1,349 visits, met with 4,282 patients and required 6,867 actions from providers.
- Our Second Opinion Appointed Doctor service carried out 14,601 visits to review patient treatment plans, and changed treatment plans in 27% of their visits.
- We received 1,422 complaints and enquiries about the way the MHA was applied to patients. Issues identified included medication, care provided by doctors and nurses, leave arrangements and safeguarding concerns.

### 2.1 Monitoring visits

In 2015/16, our MHA reviewers conducted 1,349 MHA monitoring visits to 1,309 wards and met with 4,282 detained patients.<sup>k</sup> We aim to visit all providers on a regular basis, and during 2015/16 we visited 95% of NHS mental health trusts registered to treat people under the MHA.

The central focus of our monitoring visits remains the experience and concerns of detained patients. Our private meetings with detained patients are the core of our visits. MHA reviewers also speak with patients and staff, and produce a report for the provider setting out areas that providers need to act on to improve the quality of care for patients subject to MHA powers.

#### Impacts and improvements

At the end of our visits, we meet with local teams and explain what we have seen during the day and heard about during our interviews with patients. This can include general observations about how the MHA is being applied, examples of good practice, and areas where we think that the provider needs to take action to improve care. After the visit, we write to the provider to set out our findings, and request an action plan to address matters of concern. In 2015/16, we raised 6,867 individual matters following our visits. The themes of these were similar to those raised in our previous years' visits:

- choice and access, including food options and ward activities (1,101 instances)

- treatment and medication (691 instances)
- section 17 leave from hospital (698 instances)
- patient information and rights (506 instances)
- personal needs, such as care planning, raised by individual patients (568 instances).

#### The influence of MHA monitoring on inspection ratings

We use the findings from our MHA reviewer visits to inform our regulatory inspections of specialist mental health services and, in some cases, use of our enforcement powers to require change. On our inspections, we check that people subject to the MHA are assessed, cared for and treated in line with the Act and its Code of Practice, under the key question 'are services effective?' This includes whether hospital managers routinely monitor and manage information about how they are meeting their duties under the MHA, and take action when issues are identified.<sup>33</sup>

Although we have not introduced a specific regulatory rating for the way providers operate the MHA, our MHA reviewers work closely with our inspection teams and use information from the MHA

Footnote:

<sup>k</sup> This is 97 more visits than we reported in our 2015/16 Annual Report and Accounts (published July 2016), due to late entry of visit data into our records. This means that we were one visit short of our target number of visits in 2015/16, and met the target by 100% (as a rounded figure) rather than by 93% as reported in July.

to inform the final rating for mental health and learning disability services that are registered to detain patients. We issue enforcement actions if we find matters that breach regulations, proportionate to the impact that the breach has on the people who use the service and how serious it is. For example, during our inspection of the provider below, we found a number of issues

relevant to the standards in the Code, which amounted to a significant risk and led to the provider service being deregistered.

## Inspection example of enforcement powers

In February 2016 we inspected a brain-injury unit in London. It had eight patients, three detained under the MHA, four subject to Deprivation of Liberty safeguards, and one informal. We had inspected the unit five times since 2010. On our previous visit, in July 2015, we had issued a requirement notice over the lack of effective systems to assess, monitor and improve the quality and safety of the services provided, but we continued to find systemic failure to address this, alongside other serious concerns including:

- That one patient, who was not formally detained, had been locked in their room for several weeks. This had not been recognised as long-term segregation. We took the view that the situation was a breach of the patient's human rights and amounted to mistreatment.
- Physical interventions not being recognised or recorded as restraint, with inadequate physical monitoring during or after restraint or rapid tranquilisation.
- Patient's risk assessments did not include all potential patient risks. Risk assessments and management plans were not updated after incidents, including serious incidents.
- Patient's care plans did not include their psychological, spiritual and cultural needs. Patients were not involved in developing their care plans. Patients did not receive psychological treatment appropriate to their needs.
- The service was not clean and was neglected. Redecoration and maintenance were required. One patient's bedroom had a stained floor and an overwhelming smell of urine. The environment was institutional.
- Patients said they were bored and there were very few activities. There was no activity programme in the service.
- There was no effective system for ensuring that best practice and legal requirements were met regarding the Mental Health Act and the Mental Capacity Act. There was a lack of clinical audit. Important standards for the care, treatment and safety of patients were not monitored.
- Patients reported they did not feel listened to by staff.
- Patients were unable to access an advocate easily.

Following the February 2015 visit we rated the unit as inadequate and decided to cancel its registration. The provider closed the service two weeks after we conducted the inspection.

## 2.2 The administration of the Second Opinion Appointed Doctor service

The Second Opinion Appointed Doctor (SOAD) service is an additional safeguard for patients detained under the MHA, providing an independent medical opinion to state whether certain treatments are appropriate.

The law requires this for authority to provide the following treatments in the absence of consent, except in an emergency:

- medication for mental disorder after three months from first administration when a patient is detained under the MHA
- medication for mental disorder after the first month of a patient being subject to a community treatment order (CTO)<sup>l</sup>
- Electroconvulsive therapy (ECT), at any point during the patient's detention.

The administrative functions for this service are provided by CQC, but SOADs are independent of CQC and reach their own conclusions using their clinical judgment. When we receive a request from the provider caring for the patient, we will appoint a SOAD to make arrangements to visit, assess the proposed treatment plan, and discuss it with a minimum of two professionals involved in the patient's care. SOADs can issue certificates to approve treatment plans in whole, in part, or not at all depending on their assessment of the treatment plan in any individual case.

In 2015/16, SOADs carried out 14,601 visits. Eighty-two per cent (11,991) of these visits were to look at proposed medication treatment plans for patients who were subject to the Act in hospital. This is the highest number of medication visits we have ever recorded since starting the visits in 1985. However, the number of visits to consider treatment plans for patients on CTOs continued to decline, with 12% fewer visits taking place than last year. We believe this is likely to be a consequence of continued uptake of the MHA provision, introduced in the

2007 amendments, enabling responsible clinicians to certify patient's agreement to treatment.

In last year's report, we highlighted a rise in the number of visits requested to approve ECT. This year, there have been a similar number of ECT visits to 2014/15, with 1,627 visits taking place compared with 1,631 visits the previous year.

### Outcome of SOAD visits in 2015/16

This year, SOAD reviews resulted in 27% of all treatment plans considered being changed (figure 10). This is similar to the previous year's figure of 28%.<sup>m</sup>

Changes to a treatment plan range from minor adjustments to dosages or numbers of drugs prescribed, to major changes to the proposed treatment. The most common changes result in the patient receiving lower medication doses or

Footnote:

<sup>l</sup> Or the expiry of the original three month period applicable from the start of treatment under detention, if the CTO was instigated when this still had more than a month to run. See Code of Practice, paragraph 25.31.

<sup>m</sup> In 2014/15, 21% of ECT and CTO second opinions, and 30% of medication second opinions, resulted in some change to the treatment plan.

## Equalities monitoring of second opinion referrals

We have reviewed the equalities data on the age, gender and ethnicity of patients referred for a second opinion. We found that SOAD visits for women are three times more likely to be for ECT than is the case for men, and SOAD visits for white people are more than twice as likely to be for ECT than is the case for people from Black and minority ethnic groups, although these differences could be due to differences in referrals for ECT treatment.

fewer multiple preparations than first proposed. Feedback collected from patients suggests that they value such intervention.

SOADs may certify that treatment with medication is appropriate and can be given to detained patients who have capacity but refuse to agree to the treatment (there are no equivalent legal provisions in relation to ECT, or to patients subject to community treatment orders). Of the 11,991 SOAD visits in 2015/16 to consider medication for detained patients, 2,179 (18%) were to consider authorising the treatment of patients refusing to consent. SOADs are more likely to make changes to the proposed treatment plan in these circumstances where, arguably, the treatment is more contested, with 34% (735 of 2,179) being changed compared with 28% (2,695 of 9,745) when patients are found to be incapable of consenting.

**Meeting the demand for second opinions**

Although the number of requests for a second opinion visit continue to rise, the number of doctors on our SOAD panel has been reducing. This means that it is taking longer for a SOAD to see the patient, which can lead to services using urgent or emergency powers. Many providers have expressed concern at these delays.

In addition to the general shortage of psychiatrists, there are two specific reasons

why fewer qualified psychiatrists are putting themselves forward to become a SOAD.<sup>34</sup> These are restrictions on the fees that we are able to pay SOADS, and the new consultant contract which gives employers more control over the activities of their consultants. Employers are more reluctant to allow their consultants to perform duties that do not seem to contribute to local targets and organisational performance.

Providers need to recognise the value of SOAD work, not only to help protect patients, but also to the overall sector’s ability to meet the expectations of the MHA. We are talking to the Department of Health and Royal College of Psychiatrists about the current situation and looking at future developments that may affect the demand for SOAD work. We recommend that the government works with us to consider how to influence service providers to take a wider view of meeting the requirements of the Act and of contributing more evenly to the service to increase SOAD availability.

**Neurosurgery for mental disorder**

Before any patient can undergo neurosurgery for mental disorder (NMD), a CQC-appointed panel must approve the treatment. NMD is a surgical operation that destroys brain tissue, or the function of brain tissue, for the treatment of a mental disorder.

**Figure 10 Outcomes of second opinion visits, 2015/16**

Outcome	ECT (detained)		Medication (detained)		Community treatment orders	
	Number	Percentage	Number	Percentage	Number	Percentage
Number of visits	1,627	100%	11,991	100%	1,226	100%
Plan not changed	1,257	77%	8,494	71%	964	79%
Plan changed	357	22%	3,430	29%	250	20%
Missing data	13	1%	67	1%	12	1%

Source: CQC



In 2015/16, the CQC panel considered and agreed four proposals for NMD. The operations proposed to treat severe and debilitating depression or obsessive compulsive disorder. In two cases, these were second operations, with earlier interventions having given limited or short-lived improvements that were likely to be enhanced with larger lesions.

## 2.3 Complaints

We review all complaints made to us about the way providers exercise their powers and duties under the MHA, and investigate if appropriate. All providers must inform patients of our complaints role and enable them to contact us as part of the information on patients' rights. We received 1,422 complaints and enquiries in 2015/16 (figure 11). This is an increase of 121% from 2014/15, and continues the overall rise we have seen since 2009.

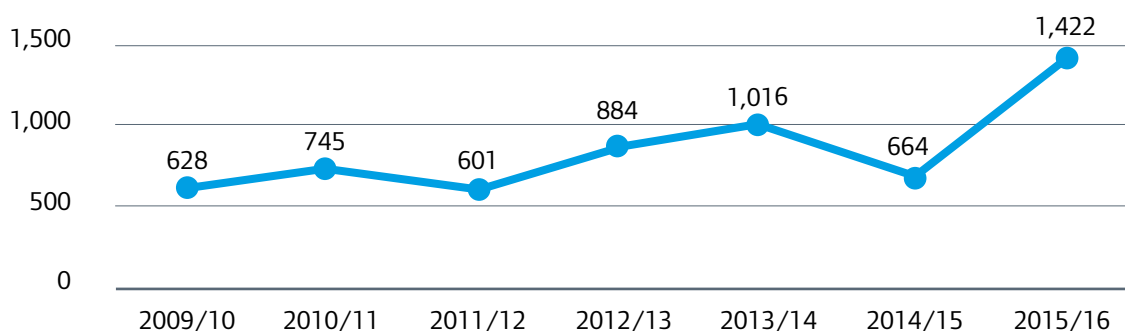
The sharp rise in complaints and enquiries received in 2015/16 could reflect better recording of complaints and enquiries made by telephone, with 76% of complaints being made through our call centre in 2015/16, compared with 63% the previous year (figure 12). We have recently reviewed and improved our handling systems for MHA complaints so that telephone calls from detained patients are now directed to a dedicated team, with a 100% quality check on records made and regular engagement with inspection staff.

We review all contacts from people who have concerns about the MHA, either directly from patients or others, such as family, carers or advocates, and try to resolve, redirect or investigate complaints. Some contacts will be general enquiries about the MHA, or from people subject to the MHA and looking for information about their care. Enquiries are usually dealt with by providing information or explaining where to go to find out more. For complaints or concerns, we can speak to the provider to see if it can be resolved locally through the provider's complaints procedures before investigating further. We may also pass a complaint that is about general health or social care to the Parliamentary and Health Service Ombudsman or the Local Government Ombudsman.

Only a very small percentage of contacts received become investigations. In many cases, our MHA complaints team and inspection teams are able to work with the complainant and provider to resolve complaints and enquiries without needing an investigation. However, it is also important to note that not all contacts made amount to a discernible complaint, and not all complaints fall within our legal powers, which are limited to investigating matters relating to the care and treatment of patients subject to the MHA.

During 2015/16, we escalated 26 complaints (less than 2% of all contacts made that year) to our MHA reviewers to investigate further. Eighteen of these

Figure 11 Complaints and enquiries received, 2009/10 to 2015/16



Source: CQC

Figure 12 Complaints and enquiries received as per method, 2009/10 to 2015/16

Method	Number (%) of contacts 2014/15		Number (%) of contacts 2015/16	
Telephone call	421	(63%)	1,086	(76%)
Letter	153	(23%)	181	(13%)
Email	71	(11%)	123	(9%)
Website	8	(1%)	17	(1%)
Share Your Experience	4	(1%)	12	(1%)
Unknown/other	5	(1%)	3	(0%)
<b>Total</b>	<b>664</b>	<b>(100%)</b>	<b>1,422</b>	<b>(100%)</b>

Source: CQC

Figure 13 Withheld mail and telephone monitoring in the high security hospitals, 2015/16

	Withheld items of mail	Telephone monitoring
Ashworth Hospital	159 (42%)	125 (60%)
Broadmoor Hospital	33 (9%)	9 (4%)
Rampton Hospital	188 (49%)	75 (36%)
<b>Total</b>	<b>380 (100%)</b>	<b>209 (100%)</b>

Source: CQC

were completed at the time of this report. In the concluded cases, two were withdrawn by the complainant, three were decided to be outside of our remit, seven were not upheld and six were partially upheld.

Where we uphold or partially uphold complaints, we can make recommendations to the service provider. This year, recommendations to specific services included issues of care planning, the use of emergency holding powers, and apologies and explanations of actions taken offered by services to complainants.

## 2.4 Withheld mail and telephone monitoring in high security hospitals

Under the MHA, most hospitals have very limited powers to withhold detained patients' mail. Outgoing mail can only be withheld from the post at the written request of the intended recipient.<sup>n</sup> In the three high security hospitals outgoing or incoming mail may be withheld if it is likely to cause distress to the intended recipient, or could be considered a danger to any person. These hospitals also have powers to monitor telephone calls (figure 13). It is notable that Broadmoor Hospital uses the powers much more rarely than the other two hospitals, despite it being similar in size to Ashworth Hospital.

Footnote:

n National data on the extent to which this power under section 134 of the MHA is used does not exist for us to review because providers are not required to tell CQC directly.

The MHA states that if an item of mail is withheld by any of the high security hospitals, the patient (or the sender of any incoming mail) may appeal to CQC, who will review the decision and can require the hospital to release the item (section 134A). In 2015/16, we dealt with seven appeals relating to withheld mail, and for one patient we instructed the hospital to release the item concerned.

### Example of an MHA complaint

In November 2015 we concluded an investigation into a complaint from a patient who had been detained at an NHS mental health hospital after initially agreeing to informal admission. We upheld complaints that paperwork relevant to the clinical record had been lost, that the patient had been subject to de facto detention as an informal patient when staff refused to allow her to leave the ward without invoking holding powers under the MHA, and that the hospital had failed in its duty to provide information to the patient once she had been lawfully detained.

The hospital accepted our findings, apologised to the patient and provided us with an action plan to address these issues for future care, through staff training and audit of practice.

# Appendix A: Involving people

## **Involving people who have experience of the MHA**

We expect mental health services to give the people who use their services a central voice in the planning and delivery of care and treatment. We involve people in our own work in the following ways.

### **Service User Reference Panel**

The Service User Reference Panel gives us helpful information on conducting visits and helps to steer different projects in the right direction. The panel is made up of people who are, or have been, detained under the Mental Health Act 1983 (MHA). Each member is encouraged to share their views on our work and advise us about how we can involve more members of the public.

Some of the members of Service User Reference Panel also attend our MHA monitoring visits and inspections of health and social care services as 'Experts by Experience'. Their main role is to talk to people who use services and tell us what they say. They can also talk to carers and staff, and can observe the care being delivered.

We have found many people find it easier to talk to an Expert by Experience rather than an inspector. This is just one of the benefits of including them in our visiting and inspection programme, and we include an Expert by Experience on all of our regulatory inspections.

### **Mental Health Act Expert advisory group**

An expert advisory group provided experience and expertise on the approach and scope of this Mental Health Act annual report. The group met three times in 2016 and offered comment and advice on the themes and issues covered by the report, and reviewed draft copies.

We are grateful for the time, support, advice and expertise given to the report by the group.

The members are:

- Association of Directors of Social Services
- Birmingham MH NHS Trust
- Black Mental Health UK
- British Association and College of Occupational Therapists
- British Institute of Human Rights
- Burke Niazi Solicitors
- Central and North West London NHS Foundation Trust
- Department of Health
- East London NHS Trust
- Human Rights Implementation Centre
- Mental Health Alliance
- National Survivor User Network for mental health
- Mental Health Provider Forum
- NHS Confederation
- NHS Digital
- NHS Providers (Foundation Trust Network)
- Royal College of Nursing
- Royal College of Psychiatrists
- Service User Reference Panel representative (CQC)

The terms of reference for the advisory group can be found by visiting:

[www.cqc.org.uk/advisorygroups](http://www.cqc.org.uk/advisorygroups)

## Appendix B: First-tier Tribunal (Mental Health)

The First-tier Tribunal (Mental Health) does not publish a separate report of their MHA activity. We have reproduced the tables provided to us by the Tribunal Secretariat for information.

Figure 14 Outcomes of applications against detention to the First-tier Tribunal (Mental Health), 2015/16

		Section 2	Other unrestricted	Restricted	All detained patients
<b>Applications and hearings</b>	Applications	10,093	16,298	3,417	29,808
	Withdrawn applications	850	3,955	1,246	6,051
	Discharges by clinician prior to hearing	3,206	4,617	64	7,887
	Hearings <sup>o</sup>	6,957	8,259	2,628	17,844
<b>Decision of Tribunal</b>	Absolute discharge	430	394	71	895
	Delayed discharge	211	158	0	369
	Conditional discharge	1	0	405	406
	Deferred conditional discharge	0	0	193	193
	Total discharge by Tribunal	642	552	669	1,863
	No discharge	5,097	6,631	1,477	13,205

Source: Tribunal Secretariat

Footnote:

- o The number of hearings and the number of applications will not match as hearings will be outstanding at the end of each financial year.

Figure 15 Applications against CTOs to the First-tier Tribunal (Mental Health), 2015/16

Applications	4,317
Withdrawn applications	873
Full hearings (with patient present)	3,942
'Paper' hearings (without patient present)	528
Discharges by Tribunal	132
No discharge by Tribunal	3,196

Source: Tribunal Secretariat

# Appendix C: Deaths of detained patients and people subject to community treatment orders

CQC data from notifications 2011/12 to 2015/16.

Figure 16 Causes of death of detained patients, 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
Natural causes	191	200	126	182	201
Unnatural causes	36	48	36	34	46
Unknown cause	9	27	36	11	19
<b>Total</b>	<b>236</b>	<b>275</b>	<b>198</b>	<b>227</b>	<b>266</b>

Figure 17 Cause of death of detained patients (natural causes), 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
Pneumonia	34	33	24	35	34
Pulmonary embolism	18	16	13	21	19
Myocardial infarction	6	11	7	19	14
Cancer	18	12	4	13	14
Heart disease	27	17	21	24	49
Aspiration pneumonia	5	11	5	13	6
Respiratory problems	4	2	5	6	7
Chronic obstructive pulmonary disease	6	3	4	8	9
Other	28	51	34	38	49
Unknown	45	44	9	5	0
<b>Total</b>	<b>191</b>	<b>200</b>	<b>126</b>	<b>182</b>	<b>201</b>

Figure 18 Age at death of detained patients (natural causes), 2013/14 to 2015/16

Data for previous years is unavailable for the same age categories so has not been included in the table.

	2013/14	2014/15	2015/16
20 and under	0	0	0
21 to 30	3	3	7
31 to 40	6	5	9
41 to 50	15	8	14
51 to 60	21	19	29
61 to 70	29	36	38
71 to 80	27	49	46
81 to 90	20	52	48
91 and over	5	8	8
Unknown date of birth	-	2	2
<b>Total</b>	<b>126</b>	<b>182</b>	<b>201</b>

Figure 19 Cause of death of detained patients (unnatural causes), 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
Hanging	10	14	16	9	6
Jumped in front of vehicle/train	3	6	1	1	3
Jumped from building	3	5	4	3	5
Self-poisoning	3	0	2	5	7
Drowning	2	4	2	4	0
Self-strangulation/suffocation	8	10	4	2	12
Method unclear	2	3	0	0	1
Unsure suicide/accident	0	2	4	5	8
Accidental	2	0	3	3	4
Another person	3	3	0	0	0
Iatrogenic	0	1	0	1	0
Fire	0	0	0	1	0
<b>Total</b>	<b>36</b>	<b>48</b>	<b>36</b>	<b>34</b>	<b>46</b>

**Figure 20 Age at death of detained patients (unnatural causes), 2013/14 to 2015/16**

Data for previous years is unavailable for the same age categories so has not been included in the table.

	2013/14	2014/15	2015/16
20 and under	3	2	1
21 to 30	7	9	16
31 to 40	11	9	13
41 to 50	5	5	11
51 to 60	5	6	1
61 to 70	0	0	2
71 to 80	3	1	1
81 to 90	2	0	0
91 and over	0	0	0
No date of birth supplied	0	2	1
<b>Total</b>	<b>36</b>	<b>34</b>	<b>46</b>

**Figure 21 Deaths of detained patients by region, 2015/16**

Region	Number of deaths		
	Natural causes	Unnatural causes & unknown/awaiting	All deaths
London	34	12	46
South East	32	13	45
Yorkshire & Humber	23	9	32
North West	20	12	32
East Midlands	22	6	28
North East	25	0	25
East of England	16	5	21
South West	14	5	19
West Midlands	15	3	18
<b>Total</b>	<b>201</b>	<b>65</b>	<b>266</b>



## Community treatment order (CTO) patients 2011/12 to 2015/16

Figure 22 Deaths of CTO patients by cause, 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
Natural causes	27	26	21	29	27
Unnatural causes	10	9	7	15	11
Unknown or undetermined	2	10	6	2	2
<b>Total</b>	<b>39</b>	<b>45</b>	<b>34</b>	<b>46</b>	<b>40</b>

Figure 23 Cause of death of CTO patients (natural causes), 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
Pneumonia	5	3	6	5	3
Pulmonary embolism	1	2	0	3	1
Myocardial infarction	0	2	2	3	2
Cancer	4	1	2	1	5
Heart disease	4	1	3	4	5
Aspiration pneumonia	1	0	0	0	2
Respiratory problems	0	1	1	2	2
Chronic obstructive pulmonary disease	1	0	1	4	2
Other	5	7	3	6	5
Unknown	6	9	3	1	0
<b>Total</b>	<b>27</b>	<b>26</b>	<b>21</b>	<b>29</b>	<b>27</b>

Figure 24 Cause of death of CTO patients (unnatural causes), 2011/12 to 2015/16

	2011/12	2012/13	2013/14	2014/15	2015/16
Hanging	3	2	1	5	3
Jumped in front of vehicle/train	1	1	1	2	1
Jumped from building	2	1	1	1	2
Self-poisoning	1	1	1	1	1
Drowning	1	2	1	2	0
Self-strangulation/suffocation	0	1	1	1	0
Method unclear	2	0	0	1	0
Accidental	0	1	1	1	0
Another person	0	0	0	0	1
Unsure suicide/accident	0	0	0	1	3
<b>Total</b>	<b>10</b>	<b>9</b>	<b>7</b>	<b>15</b>	<b>11</b>

Figure 25 Deaths of CTO patients by region, 2015/16

Region	Number of deaths		
	Natural causes	Unnatural causes & unknown/awaiting	All deaths
London	8	4	12
South East	5	1	6
East of England	2	3	5
West Midlands	2	3	5
North West	4	1	5
North East	2	1	3
East Midlands	2	0	2
Yorkshire & Humber	2	0	2
South West	0	0	0
<b>Total</b>	<b>27</b>	<b>13</b>	<b>40</b>

Figure 26 Age at death of CTO patients, 2015/16

	Natural causes	Unnatural causes & unknown/awaiting	All deaths
20 and under	0	1	1
21 to 30	3	4	7
31 to 40	1	2	3
41 to 50	4	3	7
51 to 60	4	2	6
61 to 70	7	1	8
71 to 80	4	0	4
81 to 90	4	0	4
<b>Total</b>	<b>27</b>	<b>13</b>	<b>40</b>

# Glossary

The following are definitions of some of the key terms used in our report, taken where possible from the glossary of Mental Health Act terms in Annex A to the Code of Practice.<sup>p</sup>

<b>Advance statement</b>	<p>A statement made by a person, when they have capacity, setting out the person’s wishes about medical treatment. The statement must be taken into account at a future time when that person lacks capacity to be involved in discussions about their care and treatment. Advance statements are not legally binding although health professionals should take them into account when making decisions about care and treatment.</p>
<b>Aftercare (also known as section 117 aftercare)</b>	<p>Health, care and support services in the community following discharge from hospital; especially the duty of the responsible health services and local authority to provide aftercare under section 117 of the Act, following the discharge of a patient from detention for treatment under the Act. The duty applies to community patients, transferred prisoners returned to prison from hospital and conditionally discharged restricted patients, as well as those who have been fully discharged.</p>
<b>Approved mental health professional (AMHP)</b>	<p>A social worker or other professional approved by a local authority to carry out a variety of functions under the Act.</p>
<b>Blanket restriction</b>	<p>A blanket restriction or a blanket restrictive practice is any practice that restricts the freedom (including freedom of movement and communication with others) of all patients on a ward or in a hospital, which is not applied on the basis of an analysis of the risk to the individual or others.</p>
<b>Capacity</b>	<p>The ability to take a decision about a particular matter at the time the decision needs to be made. Some people may lack capacity to take a particular decision (for example to consent to treatment) because they cannot understand, retain, use or weigh the information relevant to the decision. A legal definition of lack of capacity for people aged 16 or over is set out in section 2 of the Mental Capacity Act 2005.</p>
<b>Carer</b>	<p>An adult who provides or intends to provide care for another adult, except where this is their professional role.</p>
<b>Community treatment order (CTO)</b>	<p>The legal authority for the discharge of a patient from detention in hospital, subject to the possibility of recall to hospital for further medical treatment if necessary. Community patients are expected to comply with the conditions specified in the community treatment order.</p>

Footnote:

p [www.gov.uk/government/publications/code-of-practice-mental-health-act-1983](http://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983).

<b>Co-production</b>	When people who use services are involved as an equal partner in designing services. Co-production recognises that people who use social care services (and their families) have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need social care. <sup>35</sup>
<b>De facto detention</b>	Any situation where a patient is deprived of liberty without legal authority, often in ways unrecognised by the treating authority.
<b>Deprivation of Liberty Safeguards</b>	The framework of safeguards under the Mental Capacity Act 2005, as amended by the Mental Health Act 2007, for people who need to be deprived of their liberty in their best interests for care or treatment to which they lack the capacity to consent themselves.
<b>Detention</b>	Unless otherwise stated, being held compulsorily in hospital under the Mental Health Act for a period of assessment or medical treatment. Sometimes referred to colloquially as 'sectioning'.
<b>Electroconvulsive therapy (ECT)</b>	A form of medical treatment for mental disorder in which a small, carefully controlled electric current is introduced into the brain. It is administered in conjunction with a general anaesthetic and muscle relaxant medications and is occasionally used to treat very severe depression.
<b>European Convention on Human Rights (ECHR)</b>	The European Convention for the Protection of Human Rights and Fundamental Freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998.
<b>First-tier tribunal (mental health)</b>	See Tribunal
<b>Guardianship</b>	The appointment of a guardian to help and supervise patients (aged 16 or over) in the community for their own welfare or to protect other people. The guardian may be either a local authority or someone else approved by a local authority (a private guardian).
<b>Holding powers (section 5)</b>	The powers in section 5 of the Act that allow hospital inpatients to be detained temporarily so that a decision can be made about whether an application for detention should be made. There are two holding powers. Under section 5(2) doctors and approved clinicians can detain patients for up to 72 hours. Under section 5(4), certain nurses can detain patients for up to 6 hours.
<b>Hospital managers</b>	The organisation (or individual) responsible for the operation of the Act in a particular hospital. Hospital managers have various functions under the Act, which include the power to discharge a patient. In practice, most of the hospital managers' decisions are taken on their behalf by individuals (or groups of individuals) authorised by the hospital managers to do so. This can include clinical staff. Hospital managers' decisions about discharge are normally delegated to a 'managers' panel' of three or more people.

<b>Independent mental health advocate (IMHA)</b>	An advocate available to offer help to patients under arrangements that are specifically required to be made under the Act.
<b>Informal patient</b>	Someone who is being treated for a mental disorder and who is not detained under the Act.
<b>Leave of absence (also known as section 17 leave)</b>	Permission for a patient who is detained in hospital to be absent from the hospital for short periods, for example to go to the shops or spend a weekend at home, or for much longer periods. Patients remain under the powers of the Act when they are on leave and can be recalled to hospital if necessary in the interest of the patient's health or safety or for the protection of other people.
<b>Mechanical restraint</b>	Mechanical restraint is a form of restrictive intervention that involves the use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.
<b>Mental Capacity Act 2005</b>	An Act of Parliament that governs decision-making on behalf of people, aged 16 years and over, who lack capacity, both where they lose capacity at some point in their lives, for example as a result of dementia or brain injury, and where the incapacitating condition has been present since birth.
<b>National Preventive Mechanism (NPM)</b>	A body appointed by a state signatory to the optional protocol to the United Nations convention against torture and inhuman or degrading treatment. CQC is one of several UK bodies that form the UK's NPM, and its visits to detained patients are a key element of its role as such an NPM.
<b>Nearest relative</b>	A person defined by section 26 of the Act (and in relation to children and young people, sections 27 and 28) who has certain rights and powers under the Act in respect of a patient for whom they are the nearest relative.
<b>Neurosurgery for mental disorder (NMD)</b>	A form of medical treatment (sometimes called 'psychosurgery') that destroys brain tissue, or the function of brain tissue, for the treatment of mental disorder. Must be approved by a specially constituted panel appointed by CQC.
<b>Place of safety</b>	A place in which people may be temporarily detained under section 135 or 136 of the Act, as defined in section 135(6).
<b>Prone restraint</b>	Restraint where a person is forcibly laid face down.
<b>Provider</b>	Either an NHS or an independent sector hospital.
<b>Responsible clinician</b>	The approved clinician with overall responsibility for a patient's case. Certain decisions (such as renewing a patient's detention or placing a patient on a community treatment order) can only be taken by the responsible clinician.
<b>Seclusion</b>	Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance that is likely to cause harm to others.

<b>Second Opinion Appointed Doctor (SOAD)</b>	An independent doctor appointed by CQC who gives a second opinion on whether certain types of medical treatment for mental disorder should be given without the patient’s consent.
<b>Tribunal</b>	The First-tier Tribunal (Mental Health) called in the Code ‘the Tribunal’ was established under the Tribunals, Courts and Enforcement Act 2007. This is a judicial body that has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge.
<b>Values-based commissioning</b>	<p>Commissioning decisions have traditionally been guided by the idea that policy making and practice will be more effective if based on particular forms of scientific and objective research (‘evidence-based practice’). Critics of this model have suggested that this has the potential to overlook the thoughts, feelings and opinions of people who use services and carers.<sup>36</sup></p> <p>To address some of these issues, the concept of ‘values-based practice’ has been developed as the values counterpart of the evidence-based approach.<sup>37</sup> It does not seek to replace evidence-based practice, but instead aims to make clinical decisions on the basis of ‘values’ as well as ‘facts’. It aims to empower people who use services and carers to have more direct control over decisions relating to treatment, access to services and choice about care. It also aims to identify and make explicit the diverse values of all those involved in the process of clinical decision-making.</p>

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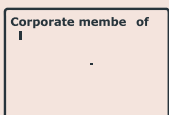


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