Care Quality Commission

Monitoring the Mental Health Act
in 2014/15

STATE OF CARE

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Contents

Foreword

The Mental Health Act 1983 (MHA) was used more than 58,000 times to detain people between April 2014 and March 2015. This is an increase of 10% on the previous year and the highest year-on-year increase ever. It is important that we understand better the likely causes of this.

Given the increasing use of the Act, it is timely that the revised Code of Practice came into force in April 2015. The new Code incorporates many of the changes we recommended in response to the Department of Health's external consultation. The Code provides clearer and stronger guidance on how to apply the MHA to make sure that people who experience mental ill-health and are subject to the Act get the right treatment, care and support.

We have continued our work to integrate and align our responsibilities under the MHA with our programme of comprehensive inspections of mental health services. This has both enhanced our insight into the way that providers discharge their responsibilities under the MHA, including compliance with the Code, and ensured that we use our regulatory powers when needed to bring about improvement. We will take enforcement action when we find poor practices, that relate to the MHA or Code of Practice, that are also breaches of regulations under the Health and Social Care Act 2008. We expect that this will have an effect on some of the persistent problems that we flag up in our MHA report year after year.

It is encouraging that we can report some excellent examples of how providers are applying the MHA. However, this is not a consistent finding and some services are not meeting the standards in the Code. We reported similar variability in quality in our State of Care 2014/15 report.

One of the Code's guiding principles is empowerment and involvement. As a result, we are particularly concerned that clinicians do not always involve the patient and their family or carer fully in decisions about their care. This is about more than simply a person's right to be involved. Not engaging a person fully in decisions could hinder their recovery and future willingness to accept help.

In 2014/15 the MHA was used more than 58,000 times

58,399 +10% ⬆

compared to 53,176 in 2013/14

Staff who work with people who are liable to be detained have a personal responsibility to learn about the MHA and elements of the Code of Practice that are relevant to their job. Managers of provider services must make the discharge of their duties under the MHA a high priority. They must do all they can to support their staff to develop the necessary skills. Service managers must also make sure that they know how well their service is meeting the requirements of the MHA and Code of Practice.

At a local area level, partners need to work together better and take shared responsibility for how well the MHA is operating and how the Code is being followed in their area. A system-wide effort is needed to ensure that individuals receive the care and support they need. This applies particularly to people who are subject to the MHA at a time when they are in crisis. In this respect, we have greatly valued our involvement in the work of the Crisis Care Concordat and will continue to take full account of the implementation of local area action plans when we inspect services over the coming years.

Dr Paul Lelliott
Deputy Chief Inspector of Hospitals (Mental Health)

Summary

There are 57 mental health NHS trusts and 86 independent mental health hospitals registered with CQC. Throughout the year we visit these services to interview patients and review practice. During 2014/15, 51% of all mental health inpatients were subject to the Mental Health Act 1983 (MHA) with 19,656 detained inpatients on 31 March 2015. We carried out 1,292 MHA visits, meeting over 5,900 patients to discuss how the MHA and its Code of Practice were being applied to them. Our Second Opinion Appointed Doctors also made 14,375 visits to patients in hospital and the community and we received 227 notifications following the death of people detained in hospital.

The period covered in our report ends just before the revised and strengthened Code of Practice came into force on 1 April 2015. The revisions made to the Code ensured it reflects policy and practice developments, although there were very few 'new' requirements. We have measured our findings against the previous expectations on services. This means that where we have identified failures in this report, we are now even more concerned about services meeting the standards in the 2015 Code and delivering better care for patients, their families and carers.

This report complements our State of Care 2014/15 report, our annual overview of health and adult social care in England. While we do not attempt to repeat the findings for mental health services from State of Care, we do refer to the report where specific MHA impacts were identified.

There is unacceptable variation in the way providers are applying the Code of Practice

We know that the number of times the Act is used is increasing, with 58,399 uses this year compared to 53,176 in 2013/14. This is an increase of 10% on the previous year and the highest year-on-year increase ever. During 2014/15, we looked at how providers and services are implementing the MHA and used our MHA Reviewer reports to encourage improvements to the care people receive and how the MHA is applied. We found many examples of services making improvements following our visits and observed good practice in the way providers are supporting and protecting patients' rights. However, we also highlighted issues with the way the Code is being applied. Issues we found include:

25%
of 3,836 care records MHA Reviewers looked at did not show any patient involvement

51% ⬆

Half of all mental health inpatients were subject to the Act in 2014/15

19,656
detained inpatients on 31 March 2015

The Mental Health Act

The Mental Health Act 1983 (MHA) is the legal framework that allows mental health patients to be admitted to hospital, detained and treated against their wishes or cared for in the community under community treatment orders or guardianship. This can only be done if they are putting their own or other people's health or safety at risk and they have, or appear to have, a mental disorder.

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 and the MHA Code of Practice, which is the statutory guidance for mental health professionals and services, explains how this should be done in practice.

CQC's job is to check that patients' human rights are being protected and to look at how providers are applying the safeguards of the Act and the guiding principles and standards of the Code of Practice, while they are being cared for or treated under the Mental Health Act in England.

The differences between the legal frameworks for admission to mental health settings

MHA – the legal framework for compulsorily treating people with mental health conditions where it is in the interests of their health or safety or the safety of others to do so, alongside the safeguards required to protect their rights while receiving such treatment.

Mental Capacity Act (MCA) – the legal framework for people who need to make decisions on behalf of someone else who lacks capacity. Its sets out who can take decisions, in which situation and how they should go about this. This ensures they act in the person's best interest and empower people to make their own decisions wherever possible.

Deprivation of Liberty Safeguards – the part of the MCA that provides safeguards which protect the rights of people who are deprived of their liberty so that they can be given necessary care or treatment. The Safeguards apply specifically to care homes and hospitals.

Children Act – is the legal framework for children and can be used when children (under 16) need to be admitted to formal care settings, whether or not they have a mental disorder. This would not in most circumstances allow a child to be deprived of liberty and Deprivation of Liberty Safeguards cannot be used for under 16s. Parental consent, an application to the Court of Protection or the MHA may have to be used in these cases.

- Support for patients in understanding their rights – 395 out of 3,838 (10%) records reviewed by our MHA Reviewers did not document whether patients had received information about their rights, although this was a slight improvement from the 13% last year.

- Problems with medication and treatment practices – 964 of 3,000 (32%) of the records we examined did not include a capacity assessment for medication on admission for patients. There had been little change from the 33% we reported in 2013/14.

- The level of patient involvement in the care planning processes – 25% of 3,836 care records our MHA Reviewers looked at did not show any patient involvement. This is similar to the 26% we found last year.

- Lack of evidence of discharge planning – 1,052 out of 3,675 (29%) care plans reviewed did not show any evidence of discharge planning. This is better than in 2013/14, when the equivalent measure showed that 38% of records seen had no evidence of discharge planning.

Due to the important role that Independent Mental Health Advocates (IMHA) play, we also carried out a specific review of the way services were making sure that patients could access support from advocacy. We asked 210 wards how they monitored the use of the IMHA service and the support and training offered to staff on the safeguards offered by advocacy. In total, 171 wards told us they did not keep a record of the referrals made, and 82 wards had not received training on the role of the IMHA or how to refer a patient. This is a serious concern for us and we make specific challenges to providers and the Department of Health in the involvement section of this report to address this issue.

Issues with staff training and support have been a concern in many of our visits, with wide variation in the provision or uptake of MHA training. Making sure that staff have the right skills and knowledge they need around their roles and duties under the MHA, and ensuring that the right training is provided would address many of the problems we have found.

Through integrating our MHA monitoring visits into our mental health inspections, we now have a greater insight into the way provider services are operating the MHA, and the impact that this has on patients. While it is too early to give absolute figures, we are finding the providers that are well-led have policies and systems in place to ensure that the MHA is applied effectively and consistently across all of their services and locations. However, where providers are not well-led we have found issues such as variation in the reports submitted to national datasets on mental health, or compliance with the consent to treatment requirements in the Act. We are particularly concerned that providers are failing to notify us of the death of a detained patient in the expected timescales in nearly half (45%) of all cases. This does not meet our expectations for incident reporting or effective governance systems in well-led services.

The issues we have found with variation in how the Act and Code are operated are consistent with our findings in our State of Care 2014/15 report. We reported a level of variation in quality, and we see many people continuing to experience large differences in the quality of care they receive – both between different services from the same provider and between different providers.

Providers are failing to make sure patients receive the support they need to be involved in their care
While subject to the MHA, people are not only prevented from choosing whether or not to receive treatment and care, but also how and where this is provided. We check that the

safeguards prescribed by the MHA are being applied effectively to empower patients and maximise their independence while they are subject to the Act. We also look at the way services support people to raise concerns, understand their rights and be as involved as possible in decisions about their care.

The biggest issue we found for patients who were subject to the MHA in 2014/15 was a lack of support to be involved in their care and treatment. This included the information they were given, access to external support such as advocacy, and care planning. We are concerned by this finding, as not supporting patient, family and carer involvement may limit people's recovery and could result in longer stays in hospital, poor discharge or an increase in the potential for readmission. These types of difficulties will have both an emotional and physical impact on patients and will have significant financial implications for the health and care system overall, which is facing unprecedented challenges with many services reporting overspends.[1, 2]

Services, leaders and staff must apply the guiding principles of the Code in all areas of practice to make sure that care planning is focused on recovery and that patients are involved in their care, with their individual needs taken into account. Our report highlights where the principles are not being applied consistently to guide practice. We have also found some examples of outstanding care, including around reducing the use of restrictive interventions and the involvement of carers. We encourage other services to learn from these and consider how they can be applied in their local areas.

Greater priority needs to be given to deaths in detention
In our report, we include the latest figures from the notifications we receive when a patient dies while they are detained. In 2014/15, we received 227 notifications including 34 deaths as the result of suicide,

self-harm and other unnatural causes, 11 from unknown causes and 182 deaths from natural causes, including eight for people aged under 40.

We are concerned by the lack of an independent system for investigating the deaths of detained patients in healthcare settings, and believe there is much greater opportunity for learning to take place when deaths occur, and for improvements to be put in place. We are awaiting the publication of the Mental Health Taskforce recommendations, but we would welcome suggestions for the Department of Health to consider establishing a new system for investigations. This would offer a coordinated approach to investigating the deaths of patients detained in mental health settings and should address many of the concerns we have highlighted in this and previous reports.

Alongside this, we encourage the new body currently being set up as the Independent Patient Safety Investigation Service (IPSIS) for the NHS to carry out independent system-wide investigations on safety issues in this area.

Providers must manage and monitor their use of the MHA better
In our monitoring of the MHA we expect to see providers following the standards of the Act and its Code of Practice, and have information and data systems in place that tell them where improvements are needed. However, our findings have shown that services were struggling in 2014/15 to meet the previous Code and failing to collect or review information for use by leadership teams. This includes significant underreporting to the national datasets in 2014/15, with variation between the returns to the KP90 (of 58,399 uses of the Act) compared to the returns to the Mental Health Learning and Disabilities Minimum (of just 41,592). We highlighted the importance of data and transparency in our State of Care

report and the Code has expectations for all services to collect and share information about outcomes when the Act has been applied to patients.

To meet the increased expectations of the revised Code services must make sure that the systems in place throughout their organisations are focused on recovery and support the person-centred delivery of care. Staff must be supported to listen and respond to the needs and concerns of patients and protect their rights. This includes a commitment to reviewing how using the revised Code has affected delivery of care for patients or any challenges staff are finding in practice.

Areas of practice that we believe would improve how services are applying the Act and Code include:

- Making sure that staff have the right skills and knowledge to understand the safeguards that the Act provides and their role in supporting patients to be involved in decisions about their care and recovery.

- Reviewing local governance frameworks to make sure they have information and data on the way the MHA and the Code are being applied across services and using this to decide what action needs to be taken to improve the care and support available for patients.

- NHS England and the Department of Health must look at ways to ensure arrangements are in place across system partners to work together to assess the way the MHA is operating and the outcomes for patients. This includes the quality of reviews, investigations and learning when patients die while detained.

- All services must make sure that they are gathering and using information to inform joint action plans and improvements for care, across all sectors and mental health care pathways.

Understanding and improving the way the Mental Health Act is being applied for patients must be a priority for all

The messages in our report are consistent with those we have set out in previous reports. For example, in last year's report we also found problems with:

- The way people had been involved in decisions about their care

- Awareness of advocacy services

- Consent to treatment practices

- Restrictive practices

- The way providers were using information from the MHA to inform service plans.

At a time of national commitment to ensuring parity exists for people using mental health services, our findings demonstrate this is not being consistently realised for the people we have spoken to over the year. Although we will continue to monitor the way the MHA and Code are applied, we will not see a real change without a system-wide effort to tackle these issues and improve the care provided.

We will continue to support the wider work plans for mental health by evaluating the impact of the Code, supporting patients and working with providers to encourage services to improve through our inspection and monitoring activity. We will continue to champion the good practice we find, as well as expose the challenges for providers. However, where we find providers are continuing to fail in their duties to apply the principles and safeguards of the MHA and Code, we will be using our enforcement powers under the Health and Social Care Act to ensure they take action to correct this.

Introduction

CQC has a duty under the Mental Health Act 1983 (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 19) and review MHA complaints (see page 20).

As one of several UK bodies that form the UK's National Preventive Mechanism against torture, inhuman or degrading treatment, we are also required to work preventatively to highlight and seek action when we find practices that may be breaching human rights standards during our MHA visits.

For the last five years, we have seen the number of uses of the MHA increasing each year, and in 2014/15 the Act has been used more than 58,000 times to detain people, with 51% of inpatients in mental health services subject to the Act at any time. This is an increase of 8,982 (18%) since CQC began monitoring the Act in 2009/10, and a 10% increase on 2013/14 – the highest year-on-year increase ever.

In our 2011/12 MHA report, we called for policy makers to consider the rising numbers of detentions and to develop an appropriate response. Further research and a national review of the reasons for the increases is still needed to help us understand whether figures reflect specific changes in the way services are being delivered or operated. Data produced by the Health and Social Care Information Centre each year is helpful but raises more questions, for example:

- What impact have developments in mental health law, particularly increased awareness about detaining incapacitated patients, had on the rates of detention?

- What has been the impact, positive and negative, of policy changes to the way community services are being delivered?

- Are we seeing an increase that can, in part, be explained by a higher number of providers submitting reports to the national datasets?

All uses of the Act represent a loss of liberty and increased restrictions for people, so it is imperative that policy makers prioritise further national research. In addition, local services must use their own data to understand the reasons for any rises in detentions and what the appropriate response may be in their area.

At the time of writing, we are planning focused activities for early 2016 to look at the reasons why providers have reported significant rises in the 2014/15 data. We will report on our findings in next year's report and will share these with policy makers to agree further action or inform additional research.

There are 57 mental health NHS trusts and 86 independent mental health hospitals registered with CQC. We visit these services throughout the year to interview patients and review practice. Since April 2014, as part of our work to better integrate our functions under the MHA and Health and Social Care Act 2008, every comprehensive inspection we carry out for NHS mental

health services includes Mental Health Act Reviewers as part of the inspection team. Independent hospital visits may include a MHA Reviewer or, for smaller sites, we may request a visit before or after the inspection. Our MHA Reviewers have specialist knowledge of the Act and work with our mental health inspectors to look at how the provider applies the MHA, checking that patients' rights are protected and reviewing the quality of care patients are receiving when subject to the Act.

We assess providers against the standards expected in the MHA and Code of Practice, including the leadership and governance in applying them. Our findings influence the rating a provider receives across all our key questions. For example, where we find that providers are breaching the Code's expectations for managing seclusion, the provider would receive a maximum rating of 'requires improvement' under the key question of 'are services safe?'.

When we find a provider is not meeting the standards expected by the MHA or Code, we will include details in our inspection reports about where they should or must take action. If we have concerns about how the MHA is managed at provider level, or we find problems in the way the MHA is applied at ward or team level, we can issue a Requirement Notice, which requires a provider to give us a report on how they plan to improve practice. Where we have serious concerns, we will take further enforcement action against the provider.

To inform the areas of the MHA we look at during the visit, we use a combination of data from our own intelligence systems and national datasets. This includes the monthly returns made to the Health and Social Care Information Centre (HSCIC) through the Mental Health and Learning Disability Minimum Dataset (MHLDDS). However, we continue to find providers are not consistently making the required returns.

What good governance for the MHA looks like

There are a number of factors we look for when assessing how well providers are managing the MHA:

- Clear policies, guidance and training are in place to support staff working with patients affected by the MHA.

- Information from our monitoring activities is used to identify and take action to address issues, both on individual wards and in sharing lessons across services.

- Data is collected on the operation of the MHA, which is analysed and shared with staff and other organisations involved in operating the MHA in the local area.

- Relationships with stakeholders, such as local authorities and the police, are guided by joint policies, and providers regularly review how well the MHA is operating in their area with them.

- Management or the board receive reports on the way their staff are applying the MHA and they monitor the performance of the MHA, for example patients' rights, hospital manager's hearings, Second Opinion Appointed Doctor activity and taking improvement action when required.

In 2014/15 there was a significant difference between the number of returns made to the MHLDDS compared to the annual KP90 return (figure 1) which are not solely due to the exclusion of children's services and acute services from this dataset.* KP90 data are also collected by HSCIC, but as an annual rather than monthly return it is less frequent and although it also includes children's and acute services returns, offering a more complete picture of the uses of the MHA, it does not offer detail at an individual patient level. This limits the way we can assess outcomes for individual providers, for example to compare uses of the Act to number of patients impacted, look at repeat admissions or identify people who are being cared for away from home.

Historically, independent providers have made fewer returns to the MHLDDS but we are still finding NHS provider numbers are much lower than those of KP90. We will look at the returns made by individual providers when we inspect their service, but we urge all provider leadership teams to make sure that their services are meeting the expectations of the national data returns and helping to inform analysis of the way the Act is applied for patients.

Our inspection teams and MHA visits also employ Experts by Experience, who are people with lived experience of using mental health services or experience of being detained under the MHA. They meet with patients during the visit, look at areas relevant to patient experience and help us to identify things that we may not notice using their knowledge of services. We also work closely with our Service User Reference Panel (see appendix A) to plan, inform and design the way we keep the MHA under review during our visits.

To assess the way the Act is applied, our MHA Reviewers carry out MHA visits to wards during the inspection and produce a separate MHA report to providers following the visit. They also inform the final comprehensive inspection report, which contains specific MHA information against the regulations of the Health and Social Care Act 2008 and is published on our website.† This approach allows us to meet our duties under both of the acts. However, we continue to carry out standalone monitoring visits to wards registered to treat people under the MHA at least once every 18 months outside the inspection programme. Although the MHA does not

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* MHLDDS contains returns from mental health providers including independent mental health providers that have NHS-funded patients. KP90 collection has returns from all providers with detained patients, including non-mental health providers.

† www.cqc.org.uk/content/mental-health

Figure 1 Comparison of data between the KP90 and Mental Health and Learning Disability Minimum Dataset (MHLDDS) 2014/15

	Detentions	Section 136	Number of organisations NHS	Number of organisations independent
KP90	58,399	19,403	129	233
MHLDDS	41,592	11,247	62	11

Source: Health and Social Care Information Centre

specify the frequency of these visits, our role as the National Preventive Mechanism requires a programme of 'regular' visits to be carried out.

Focus for 2014/15 report

By including MHA Reviewers and MHA specific data in the comprehensive mental health inspections we carried out during 2014/15, we have a better insight into how providers are applying the Act. For the first time, this year's annual report includes the findings from the MHA visits we have carried out as part of our comprehensive mental health inspection programme, as well as those carried out as standalone visits.

Where possible, we have included data on actions taken by both our inspectors and MHA Reviewers. It should be noted that the reports from our MHA visits are largely qualitative and descriptive in nature, explaining our observations, judgements and actions. Their main purpose is to help providers improve and deliver better services for patients. Each report is unique and tailored to the services we visit, and focuses on the key issues we find on the visit. As a result, assessing and quantifying data from MHA visit reports is challenging and we ask that this is taken in account when reviewing our data.

1,292
visit reports reviewed to identify examples of good practice and areas of concern

How our MHA monitoring influences our inspection ratings

In March 2015, we visited a mental health trust in the East Midlands, where we found several problems with how the trust was following the Mental Health Act (MHA) that contributed to their overall rating. In particular, under the effective section of the report we noted that:

> "Systems were not robust to ensure compliance with the MHA and the guiding principles of the MHA Code of Practice. There were insufficient processes for the scrutiny of MHA documentation. Patients had not always received their rights, and capacity and consent procedures were not always well managed. Leave was not always granted in line with the MHA requirements. Staff did not always recognise and manage people's seclusion within the safeguards set out in the MHA Code of Practice."

We also noted in the report that:

> "Within three acute wards and the [psychiatric intensive care unit] there were no female-only lounges as required by the MHA Code of Practice and Department of Health guidance."

Our report, published in July 2015, gave the trust an overall rating of requires improvement, and stated that our concern about how the trust was meeting its MHA obligations was a contributory factor to its rating.

The revised Code of Practice came into force on 1 April 2015. This updated the standards of the Code, introduced some new requirements and made it clearer for services what their roles, responsibilities and expectations are when caring for people detained, or otherwise subject to the Act. Although this report covers the period just before the revised Code came into force, when assessing providers' practice we have referenced the new Code. In doing so, we aim to review providers' readiness for the revised Code, and highlight new requirements that will be challenging for services to put in place. We also look at the impact of current practice on patients, their carers and families.

The report complements our State of Care 2014/15 report. While we do not attempt to repeat the findings for mental health services from State of Care, we do refer to the report where specific MHA impacts were identified.

As part of our research for this report, we have:

- Reviewed 1,292 visit reports to identify themes and cases studies for our analysis to identify examples of good practice and identify areas of concern where improvement is needed.

- Analysed a sample of 7,036 action statement requests to providers, which are issued by our MHA Reviewers following each ward visit.

- Analysed 10 comprehensive inspection reports where ratings had been given and the 66 MHA visit reports carried out during the inspections, including any enforcement actions taken.

- Reviewed 664 complaints from patients, families, carers, legal representatives or the ombudsmen about how the MHA was applied.

- Reviewed data from external sources, such as the HSCIC and the Tribunal Service: Mental Health, to support our findings.

- Spoken to our inspection teams, MHA Reviewers, MHA Complaints staff and our Second Opinion Appointed Doctors about our report findings and issues they have found from their activities.

- Worked with our Service User Reference Panel and Expert Advisory Group to plan and prepare our report.

Encouraging improvement: change in a low secure personality disorder ward

In March 2014, we visited a low secure personality disorder ward in an independent hospital. Patients and staff on the ward told us on our visit that they felt the culture of the ward was too restrictive, with the majority of patients saying that they were unhappy on the ward. Many also told us that there were more restrictions on this ward than at other low and medium secure facilities they had previously lived in.

Patients said that there were a number of blanket rules and procedures which they found frustrating and difficult to deal with. For example, patients were only allowed to access certain toiletries and razors at set times in the day, by queuing at the door to the room where they were kept. Managing this tied up a member of staff for four hours every day. We agreed with patients' concerns about whether this was the best use of staff time. In addition, we were concerned that patients had to queue up for medication to be dispensed over the stable door to the clinic, with very little privacy and dignity or the opportunity to discuss medication.

In some cases it was clear that blanket rules were being used because there were not enough staff. Patients talked about a culture of "them and us", with some commenting that their frustration about the restrictions in place affected their behaviour. As behaviour determines progress and discharge, patients said that they felt as though they were being set up to fail. Patients said that they were reacting to the restrictive nature of the environment, rather than focusing on their care and treatment. Nursing staff were also spending a large amount of time justifying rules and calming down frustrated patients, which had a big impact on therapeutic relationships.

When we returned to the ward in September 2015, we were pleased to see that restrictions had been significantly reduced. Patients were now being actively supported to understand their behaviour and develop the skills they would need to live in the community. For example, patients were able to keep their own mobile phones and chargers and no longer had to hand these in at night. In addition, some patients were being supported to self-medicate, with bedrooms being equipped with appropriate lockable spaces for the safe storage of medicines.

There were still areas of practice that we challenged, but the improvement was very encouraging. Patients told us that they were receiving very good care and treatment from the nursing team. We were told, "Staff are good. They are very helpful. [I'm] always able to find someone when I need them, only need to ask them once." Another patient told us "I've been in a lot of places – there's a lot of things I don't like, but this is the best place I've been in. We have a lot of freedom."

Part 1
CQC AND THE MENTAL HEALTH ACT

What we did

- In 2014/15, we carried out 1,292 visits, met with 5,937 patients and required over 7,000 actions from providers as a result.

- The actions we requested from providers identified five areas of concern: treatment, choice and access, leave from hospital, patient information and personal needs.

- Our Second Opinion Appointed Doctor service carried out 14,375 visits to review patient treatment plans and made changes to treatment plans in 28% of cases.

- We received 664 complaints about the way the Mental Health Act 1983 (MHA) was applied to patients. Issues included medication, care provided by doctors and nurses, leave arrangements and safeguarding concerns.

- Last year, we were notified of 182 deaths by natural causes, 34 deaths by unnatural causes, four open verdicts and seven deaths where the cause was unknown. Only 45% of notifications were reported to us in the expected timescale of three days after death.

- We expect services to make sure they are monitoring how their processes and systems are supporting the way MHA activities are carried out, including the outcomes of our visits to inform improvements for patients.

1.1 CQC activities in 2014/15

Monitoring visits

In 2014/15, our MHA Reviewers conducted 1,292 visits and met with 5,937 patients. This is a slight increase from the 1,227 visits we carried out in 2013/14, and a 31% increase in the number of patients we met from the 4,517 in 2013/14. The majority of visits and patient meetings were carried out during MHA monitoring visits outside the comprehensive inspection programme, and of these 95% were unannounced. While all our comprehensive inspections are announced, we do not confirm which wards will have a MHA visit until the week of inspection.

Of the visits we carried out in 2014/15, we issued 7,036 requests for providers to take action. Although the types of actions we request will vary depending on each service, we can broadly group them into specific areas of practice. The five most common

areas of concern reported for the last year were:

- Treatment and medication (1,119 actions)

- Choice and access, including food options and ward activities (881 actions)

- Section 17 leave from hospital (784 actions)

- Patient information and rights (608 actions)

- Personal needs, such as care planning, raised by individual patients (466 actions).

5,937
patients met by our MHA Reviewers in 2014/15

7,036
requests made in 2014/15 for providers to take action on issues we found on our visits

Figure 2 Second opinion visits, 2009/10 to 2014/15

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Medication visits (detained patients)	11,606	11,769	11,944	10,365	10,821	11,610
Electroconvulsive therapy visits (detained patients)	1,307	1,217	1,265	1,386	1,521	1,631
Community treatment order patients	3,406	3,667	3,727	1,713	1,306	1,394
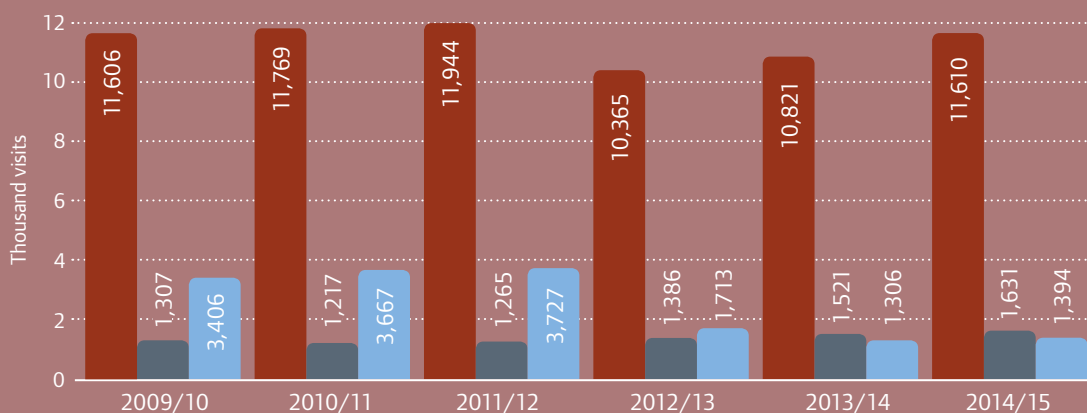
Source: CQC

● Medication visits (detained patients)   ● Electroconvulsive therapy visits (detained patients)   ● Community treatment order patients

The detail of what we found, actions requested and the responses from providers have informed our analysis of the way the MHA is being applied to patients in section 2 of this report.

Second Opinion Appointed Doctor activities

Our Second Opinion Appointed Doctor (SOAD) service provides an additional safeguard for patients detained under the MHA, either in hospital or on a community treatment order (CTO). When a patient lacks capacity or refuses to consent to their treatment, providers can request a SOAD to review the patient's treatment plan. SOADs are responsible for approving whether it is appropriate to continue with the patient's proposed medical treatment.

When we receive a request, a SOAD will arrange a visit to see the patient. They will work with the patient's responsible clinician, and other professionals involved in the patient's care, to assess the proposed treatment plan. SOADs use their own clinical judgement and may issue a certificate to approve treatment plans in whole, in part, or not at all as they see fit.

Since 2012/13, there has been a year-on-year increase in the number of SOAD visits we have completed. In 2014/15 we carried out 14,375 visits – an increase of seven per cent from the 13,645 visits completed in 2013/14.

In our 2011/12 report, we noted that over the previous decade there had been an overall decline in the number of SOAD visits to review the use of electroconvulsive therapy (ECT).[3] However, over the last three years we have seen the figures begin to rise again, with 1,631 visits last year for detained patients (figure 2). To explore possible reasons for this change, we will be looking more closely at our national data on ECT second opinions, for example to see whether there are regional differences, and will discuss our findings with the Department of Health.

Of the records we reviewed, in 2014/15 SOADs made changes to 28% of treatment plans they authorised.* This is only a slight

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* For consistency with last year we calculated the percentage using the total number of visits. This will differ from figure 3 which splits certificate type for ease of reference.

14,375

Second Opinion Appointed Doctor visits carried out in 2014/15

Figure 3 Outcome of SOAD visits in 2014/15

	Electroconvulsive therapy (detained)	%	Medication (detained)	%	Community treatment orders	%
Number of visits	1,632	100%	11,610	100%	1,394	100%
Plan not changed	1,283	79%	8,089	70%	1,099	79%
Plan changed	345	21%	3,511	30%	292	21%
Missing data	4	0.2%	10	0.1%	3	0.2%

Source: CQC

increase from 2013/14, where we reported that changes were made in 24% of cases.

In 294 visits we did not provide a certificate for treatment, of which 78 cases were declining the use of ECT.

Neurosurgery for mental disorder

Before any patient can undergo neurosurgery for mental disorder (NMD), a CQC-appointed panel of clinical experts 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. Referrals for NMD have remained largely consistent over the last three years, with four referrals in 2014/15, all of which were approved for surgery.

Review of withheld correspondence

Under the MHA, a detained patient's outgoing mail can be withheld if requested by the person it is addressed to.* In high security hospitals, outgoing or incoming mail may be withheld where it is likely to cause distress to the person it is addressed to, or is a danger to any person. If correspondence is withheld by any of the high security hospitals, the patient or their family may apply to CQC for it to be released. Following our review, we may ask the provider to release the item.†

In 2014/15, our MHA Reviewers dealt with six appeals relating to withheld correspondence, which is a decrease from the nine we reported in 2013/14. In all cases, we found that the provider was right to withhold the mail and we upheld the hospital's decision.

Complaints

As part of our duties under the MHA, we are responsible for reviewing complaints about the way providers use their powers or carry out their duties under the MHA, and to investigate individual complaints when we feel it is appropriate to do so.§

Providers are required to inform patients of our complaints role for people subject to the Act and must ensure they offer support to patients who would like to raise any concerns with us about how the Act is, or has been applied to them. This is especially important for those patients lacking capacity.¶

When patients contact us, we review their complaint and ask if they have raised the complaint locally, as local resolution is more likely to solve the concerns. However, if the patient is not happy with the provider's response, or if there are other reasons they cannot do this, we may investigate the complaint. We also receive enquiries from patients about the way the MHA has been applied to them. We may anonymise this information and share this intelligence with our inspection teams to give us a better picture of how providers are operating the Act or inform areas they will review during their next visit. In addition, if we believe the enquiry may warrant a complaint, we will inform the person who contacted us about how they can do this.

The scope of our duty for complaints in the MHA means we can only look at areas that relate to how the MHA is applied and areas covered by the Code of Practice, such as treatment, detention and leave arrangements, rather than the general quality of care patients are receiving. If we receive a complaint that relates to care services provided by a local authority, we work closely with the Parliamentary and Health Service Ombudsman (PHSO)

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* Mental Health Act 1983, section134

† Mental Health Act 1983, section120(4)

§ www.cqc.org.uk/content/complain-about-use-mental-health-act

¶ MHA Code of Practice (2015), paragraphs 4.25 and 4.26

for health or the Local Government Ombudsman to resolve the issue. The MHA and Code of Practice help us to decide if the scope of the complaint falls under our remit. Due to the broad nature of the Code there are very few concerns that we would redirect to the Ombudsmen, and in some cases we prepare a joint response to complaints.

During April 2014 to March 2015, we received 664 MHA complaints from patients, family and carers, legal representatives or the Ombudsmen. Each complaint raised one or more problems and our review of all complaints identified the following themes:

- Issues with medication, including allegations of inappropriately prescribed medication and or/poor side effects of drugs.

- Concerns with the care and services provided by doctors and nurses. These related to the detention process, medical professionals not explaining rights, or not providing documents to make an appeal.

- Challenges with taking leave from hospital, including leave not being granted on clinical grounds, or escorted leave being agreed but the patient not being able to take it because there were not enough staff.

- Safeguarding concerns, including issues or allegations of offences against the person, and allegations of physical or verbal abuse by staff or other patients.

In the majority of cases, our MHA complaints team and inspection teams were able to work with the patient and provider to resolve the complaint without it needing to be escalated further. In 2014/15, we escalated 16 complaints to our MHA Reviewers to investigate further. Of these, we have completed the review of evidence in 12 cases and there are four ongoing investigations at the time of publication.

Of the 12 closed complaints, we requested action in response to four specific concerns in the complaints. These related to matters of privacy and dignity, including: a patient's assessment being completed in a corridor; a failure to identify minor errors in section papers; out of date information leaflets for patients; care plans not being discussed with patients; and incorrect patient information about how to raise a complaint with CQC. We may also carry out follow up MHA visits if we are concerned that there are implications for the wider service.

We also use information from all complaints in our Intelligent Monitoring to highlight areas that the inspection teams may want to assess during their inspection. When necessary, we also pass this information to local safeguarding teams.

We are continuing to review our processes for handling MHA complaints. This will improve the accuracy and detail of the data on complaints we are able to present in future reports.

1.2 Health and Social Care Act notifications: deaths in detention and absences without leave

Deaths of detained patients

Providers registered under the Health and Social Care Act 2008 must notify us about the deaths of people who are detained, or liable to be detained, under the MHA as well as any unauthorised absences. We use this data in our Intelligent Monitoring to look at the safety of services, and to provide returns to other national stakeholders, such as the Independent Advisory Panel to the Ministerial Board on Deaths in Custody.*

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* Full deaths notifications data is available in appendix C.

Figure 4 Inpatient deaths of detained patients

	2011/12	2012/13	2013/14	2014/15
Natural causes	191	200	126	182
Unnatural causes	36	48	36	34
Undetermined (including those reported as open verdicts by coroners)	9	27	36	11
Total	**236**	**275**	**198**	**227**

Source: CQC

Figure 5 Notifications of deaths of detained patients, 2013/14 and 2014/15

	2013/14	2014/15
Natural causes	126	182
Unnatural causes	36	34
Not known	8	0
Open verdict	15	4
Awaiting coroner verdict	13	7
Total	**198**	**227**

Source: CQC

Figure 6 Notifications of deaths of community treatment order patients, 2013/14 and 2014/15

	2013/14	2014/15
Natural causes	21	29
Unnatural causes	7	15
Not known	2	0
Undetermined	0	1
Awaiting coroner verdict	4	1
Total	**34**	**46**

Source: CQC

Figure 7 Age at death of detained patients (natural causes) 2013/14 and 2014/15

	2013/14	2014/15
20 and under	0	0
21 to 30	3	3
31 to 40	6	5
41 to 50	15	8
51 to 60	21	19
61 to 70	29	36
71 to 80	27	49
81 to 90	20	52
91 and over	5	8
Date of birth unknown	0	2
Total	**126**	**182**

Source: CQC

We have recently reviewed the indicator we use in our Intelligent Monitoring for the deaths of detained patients. We now look at suicides and suspected suicides for patients of all ages, together with deaths from natural causes for those aged under 75 (as a proxy for premature deaths) when we are routinely analysing a provider's quality and safety. We recognise that some wards and hospitals are likely to have higher death rates than others because of the age and health profile of the patients, and we account for this as part of the indicator.

In 2014/15, providers notified us of 227 inpatient deaths. Although this is an increase of 15% from 2013/14 (figure 4), when there were fewer natural cause deaths reported to us, this year's figures are more consistent with previous years' data.

While not included in the regulations, we also ask providers to tell us about the deaths of patients subject to community treatment orders (figures 5 and 6). In 2014/15, providers reported 46 deaths of patients on community treatment orders, which is an increase from the 34 reported the previous year.

Mortality rates for people aged 40 and under

National data tells us the mortality rates for people in mental health services are almost four times higher than the general population.* For people aged 30 to 39 this increases to five times higher. In preparing this report, we looked at the eight cases reported to us where the person was aged 40 or under at the time of their death while under the care of mental health services (figure 7). The information shared with us offers learning points for others and highlights the need for organisations, providers or national bodies with a role in

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* Mental Health Minimum Dataset report 2011/12. Health and Social Care Information Centre www.hscic.gov.uk/catalogue/PUB10347

Focus on clozapine and monitoring

In two of the cases we looked at, patients had been prescribed clozapine. The provider reports demonstrated the importance of carrying out regular reviews and close monitoring of physical health by staff, both on the ward and by primary care services when not in hospital. In one of the cases a patient started clozapine therapy, which led to serious complications within the month of treatment. In this case, the provider felt they had completed all required checks for monitoring clozapine and ensured that multidisciplinary team worked together to review the results. This included involving the patient who wanted to continue the clozapine, as it was having a positive effect on her mental health.

Unfortunately the difficulties persisted, leading to a heart attack, and the patient being placed in a medically-induced coma. The patient died two weeks later. The requirements for clozapine monitoring are clearly set out in national guidelines, with compliance monitored by our inspection teams and this case offers a tragic reminder of the need for such stringent safeguards.

At the time of writing this report, the inquest for this patient had not been listed so the information used has been taken largely from the reports and clinical care records we received from the provider.

deaths to make sure they routinely review and learn from all deaths in detention and not focus solely on the unnatural or self-inflicted deaths reported.

The under 40s deaths included five females and three males with the youngest recorded as 22 years old and the oldest 38 years old at the time of death. In cases where we had been given the provider investigations or coroners' reports they highlighted the need for:

- Improving physical health reviews for all patients.

- Increasing physical health training for mental health staff, particularly training in Early Warning Scores (a scoring system that allows clinical staff to monitor changes in a patient's physiology).

- Making sure staff understand and can identify clinical signs of physical health problems.

- Processes for sharing information or joint working practices with primary care and general practitioners for inpatients.

Deaths where restraint had been used within seven days of death

We identified 11 death notifications where restraint had been used within seven days of death (figure 8). In our review of the cases, we found no evidence of a link between the restraint and the medical cause of death.

Since September 2014, we have asked providers to tell us how many days before the death the restraint occurred and eight of the notifications we received in this reporting period include this new information. Two cases reported restraint on the same day as the death; one of the cases was of self-strangulation and the second is awaiting the coroner's verdict but we were told the death occurred away from the hospital site.

Notifications to CQC

We ask providers to notify us of deaths within three working days, but the majority of notifications are received between three and 10 working days. This requirement is linked to a provider's registration and compliance with NHS England's serious

Figure 8 Causes of deaths of detained patients where restraint used within seven days before death

	2011/12	2012/13	2013/14	2014/15
Natural	7	9	1	7
Hanging/self-suffocation	0	2	0	1
Jumped from building	0	1	1	0
Accident	0	0	0	1
Unascertained	0	2	0	0
Awaiting information	0	4	2	2
Total	**7**	**18**	**4**	**11**

Source: CQC
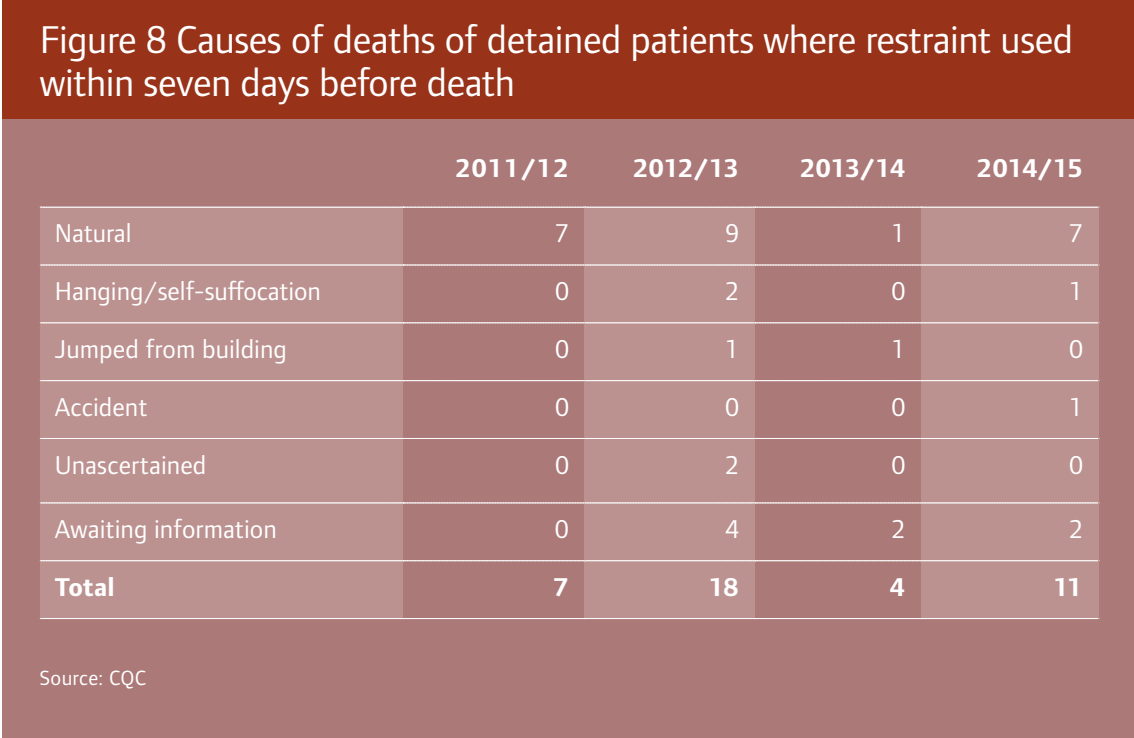
incident framework.* In 2014/15, providers sent just 45% of the notifications about deaths of detained patients in the prescribed timeframe, with 10% taking 14 working days or longer. Failing to meet this reporting requirement suggests that the provider has poor governance systems in place. It also affects the quality of national datasets, which are a key tool in helping us to understand more about deaths in mental health services and identifying outliers in our Intelligent Monitoring.

During inspection we review a provider's approach to incident reporting, staff understanding of the requirements for reporting patient safety incidents, and how services are learning from incidents – particularly the death of a detained patient. Where we identify serious concerns we rate services as inadequate under the key question 'are services safe?'. Where we find ongoing areas of concern for providers who fail to notify us we may take enforcement action.[†]

We will always use notifications about the deaths of detained patients to inform our monitoring and regulation of MHA practice in providers. Using this information for our Intelligent Monitoring means we can look at a variety of factors and assess the level of risk of mental health providers, helping us to decide when, where and what to inspect.

Enforcement powers
In previous reports, we have noted that we are not required to investigate the individual circumstances when a patient dies while detained. From 1 April 2015, we now have the power to prosecute registered providers and managers for failures to provide safe care and treatment that result in avoidable harm or a significant risk of exposure to avoidable harm. This includes deaths of detained patients where the provider, Coroner, Police or others have

raised concerns about the care or treatment the deceased received.

Where concerns are identified, we will carry out an initial assessment to help us to decide whether to investigate a criminal offence of failing to provide safe care and treatment. In our initial assessments, we will look at the circumstances of the death and whether we should carry out a criminal investigation. Where we decide to investigate an offence we will gather evidence about the circumstances, medical cause of death and the safety of the care or treatment provided.

Coroners and reports preventing future deaths
To make sure we are informed about deaths where there has been unsafe care or treatment, we have agreed a Memorandum of Understanding with the coroners' Society. This requires individual coroners to tell us promptly about relevant cases and share evidence or information.

As highlighted above, when a patient detained under the MHA dies the coroner will carry out an independent investigation.[§] Where a coroner's investigation reveals lessons that could prevent future deaths, they may issue a report addressed to one or more organisations, which requires action to prevent further deaths occurring. The organisation(s) must respond within 56 calendar days of receiving the report, setting out what action they will take.

The Memorandum of Understanding agreed with the Coroners' Society aims to ensure we receive copies of all 'Prevention of future deaths' reports. We will use this information to feed into our Intelligent

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*   www.england.nhs.uk/patientsafety/serious-incident/

†   Regulation 17 of the CQC (Registration) Regulations 2008

§   As required under Article 2 of the European Convention on Human Rights (ECHR).

Monitoring of a provider, assess risk and identify how quickly we need to take action when a risk is identified. We provide the reports to our inspection teams so they can ask questions and look for evidence about how providers are addressing the issues raised.

Between December 2014 and June 2015, we received three 'Prevention of future death reports' concerning patients who were receiving mental health services at the time of their death; one report related to a detained patient. The Memorandum of Understanding agreed with the Coroners' Society in 2015 should mean that in the future we receive all relevant prevention of future death reports.
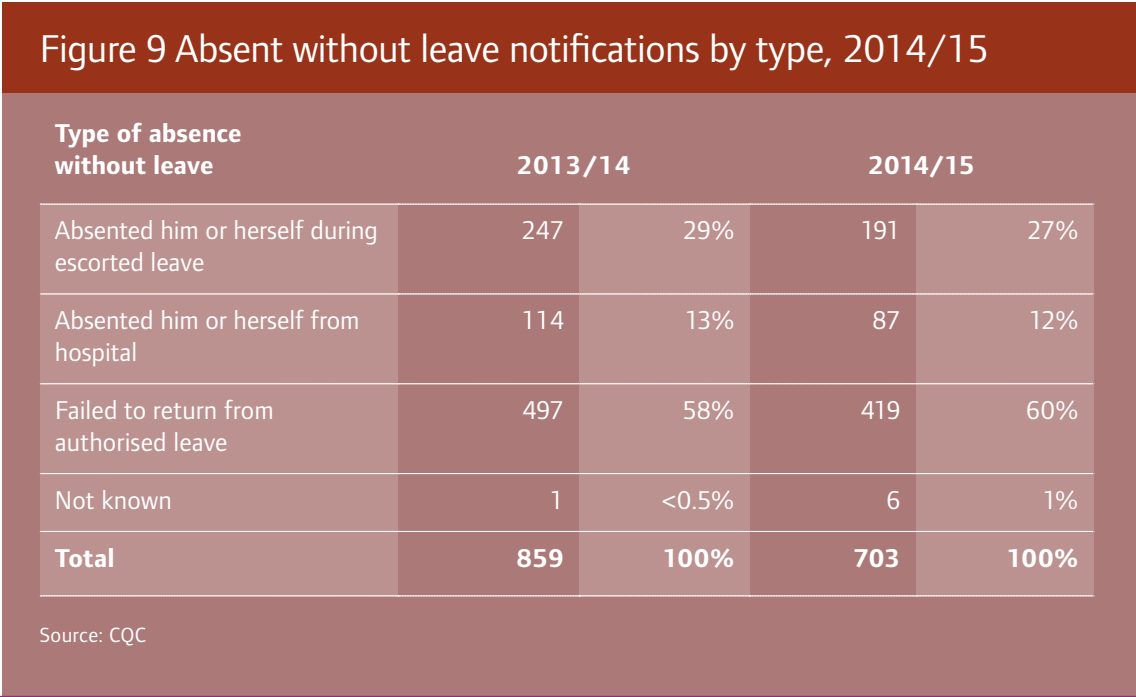
The reports we did receive highlighted concerns with monitoring physical health needs, local services failing to have coordinated approaches when a patient is in crisis, and a lack of arrangements and policies in place when a patient is on temporary leave from the hospital. We will continue to review how providers sent these reports respond to coroners' concerns. However, we expect all services to have systems in place that learn from national data on deaths including the coroners' reports and national inquiries.

Independent investigation system

We will be using the information gathered from our role in considering deaths, both for MHA patients and across services, to support implementation of any recommendations by the Mental Health Taskforce in this area. At the time of writing this report we are awaiting the publication of the Taskforce's recommendations, but we would welcome suggestions for the Department of Health to consider establishing a new, fully independent system for investigating all deaths in mental health settings. We would also welcome proposals for a new framework that sets out standards for staffing, culture, policies and practices for carrying out investigations and ensuring the involvement of families and carers.

Alongside this, we encourage the new body currently being set up as the Independent Patient Safety Investigation Service (IPSIS) for the NHS to carry out independent system-wide investigations on safety issues in this area.

Figure 9 Absent without leave notifications by type, 2014/15

Type of absence without leave	2013/14		2014/15	
Absented him or herself during escorted leave	247	29%	191	27%
Absented him or herself from hospital	114	13%	87	12%
Failed to return from authorised leave	497	58%	419	60%
Not known	1	<0.5%	6	1%
Total	**859**	**100%**	**703**	**100%**

Source: CQC

Absences without leave

Hospitals designated as low or medium security must notify us when any patient liable to be detained under the MHA is absent without leave, if that absence continues past midnight on the day it began. High security hospitals have to notify us of absences without leave under any circumstances.* Providers must also notify when any patient absent without leave returns.

During 2014/15, we received 703 notifications of patients who were absent without leave which is less than the 859 we received in 2013/14. Low secure units reported 79% of the incidents, with 19% reported by medium secure units. There were no incidents of absence without leave from high security hospitals.

Sixty per cent of the incidents reported were patients failing to return from authorised leave at the agreed time (figure 9). In at least 32% of cases, patients voluntarily returned themselves to the ward (figure 10).

We do not assume that every absent without leave incident is a failure of care. However, data for 2014/15 suggests that there are some areas of concern. For example, in 27% of reported cases the police were involved in the return of absent patients. Not only is this a drain on police resources, but being apprehended and transported by the police can be very distressing for the patient.

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* Care Quality Commission (Registration) Regulations 2009. Regulation 17, as amended by the Care Quality Commission (Registration) and (additional Functions) 2011 and the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012.

Figure 10 Absent without leave notifications by mechanism of return, 2014/15

Type of return from absence without leave	2013/14		2014/15	
Returned by family member(s)	39	5%	28	4%
Returned by hospital or other staff	113	13%	102	15%
Returned by police	265	31%	189	27%
Returned voluntarily	296	34%	226	32%
Not specified	123	14%	137	19%
Other	23	3%	21	3%
Total	**859**	**100%**	**703**	**100%**

Source: CQC

Part 2
THE MENTAL HEALTH ACT IN ACTION

What we found

- Patients tell us that they need more support to be involved in their care, especially in care planning, understanding their rights and treatment decisions.

- Many services do not have an effective governance system in place. How well providers collect and analyse data, and report on the use of the MHA, varies both between providers and across wards in the same provider.

- Patients have told us they experience difficulties throughout the care pathway, including problems with admission to services and discharge arrangements.

- Services are having difficulties in applying the Act, particularly more complex areas of the legislative frameworks such as consent to treatment rules and where the Mental Health Act crosses over with the Mental Capacity Act and Deprivation of Liberty Safeguards.

- Many providers are demonstrating that they are learning from national policy, and improving their seclusion and restraint practices, including implementing programmes to reduce or end their use.

- Providers have improved, and reduced, their use of restrictive practices for patients, but we are continuing to find problems with the use of blanket policies.

- Training for staff, and the support they are offered by management, is not good enough. We found examples of poor practice due to a lack of knowledge about the Act, with only 40% of ward staff telling us they received training on the Independent Mental Health Advocacy service or how to refer patients.

The revised Mental Health Act 1983 (MHA) Code of Practice, published in January 2015, has given commissioners, providers, professionals and others providing care under the Act clearer and stronger guidance to follow, with the aim of improving care for people detained under the Act.

CQC was clear that we expect providers to have policies and practice in place by October 2015 to enable them to implement the new code. However, of 58 visits to wards in September and October 2015, only 26 wards were confident that they had updated policies and procedures.

Staff had access to a copy of the new Code on all but nine of the 58 wards. Only half of wards (29) had provided staff with any form of training on the revised Code. This is unacceptable and services should make sure that staff, patients and carers can access the Code, and that staff have the correct skills and understanding to meet the standards in the Code.*

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* MHA Code of Practice (2015), paragraphs 4.61 and 4.62

The guiding principles

The Code of Practice's new guiding principles ensure that each decision made under the MHA is tailored to an individual patient and their circumstances, promoting person-centred working and ensuring their personal needs are addressed.

It is expected that the principles inform decisions made at all levels of the service and that providers have documented any decision that departs from the Code or its guiding principles. We look for evidence of the way the principles are applied during our inspections, either in care records or through our observations and discussions with staff and patients. The principles, with page numbers of where we look at these in the report, are:

- **Least restrictive option and maximising independence** (page 31): patients should be treated without detaining them where this is safe and lawful, and a recovery approach adopted focusing on encouraging and supporting independence.

- **Empowerment and involvement** (page 39): patients should be fully involved in all decisions about care, support and treatment. Carer and family views should be fully considered where appropriate. Where decisions are taken that are contradictory to expressed views, professionals should explain the reasons for this.

- **Respect and dignity** (page 49): professionals should treat patients and families with respect and dignity.

- **Purpose and effectiveness** (page 53): decisions should be appropriate to the patient, with clear therapeutic aims, in line with best practice guidelines and with the aim of promoting recovery.

- **Efficiency and equity** (page 59): the quality of commissioning and provision of mental health care should be of high quality and given priority equal to that of physical health and social care services. Joint working should ensure timely, safe and supportive discharge from detention.

Following the Code's new guiding principles (see below), this section sets out what we are finding from our monitoring visits and inspection work, and highlights the issues we continue to see in practice.

We have structured our findings in this section of the report against the principles of the Code so that we can review current practice against them. The aim of this is to raise awareness about how important it is for providers to monitor how the principles are being used across their services.

2.1 Least restrictive option and maximising independence

To meet the principle of least restriction and maximising independence we expect services to be working together to reduce detention, promote recovery and justifying any restrictions in place for patients. We expect safe, responsive and effective services to have a joined-up approach to prevention and early intervention with local partners, which uses information from the MHA to inform commissioning decisions. When admissions do take place, we look at the way providers ensure they are for the shortest time necessary for the patient, use the most appropriate legal framework and avoid unnecessary restrictions on a person's rights and freedom of action.

The interface between the MHA and the Mental Capacity Act Deprivation of Liberty Safeguards
Patients who lack capacity to make decisions regarding their care and treatment

MHA and the Deprivation of Liberty Safeguards: detained patients' rights

Under the MHA, the Responsible Clinician must certify a patient's treatment after three months or, when the patient refuses or lacks capacity to consent to their treatment plan, must request a visit from a Second Opinion Appointed Doctor (SOAD).

In one provider we visited in 2014/15, a patient detained in an older persons' unit was discharged from section the day before their treatment plan needed to be certified. At this point CQC had not been contacted to arrange the SOAD visit. The following day, the provider referred the patient to the Deprivation of Liberty Safeguards team. However, when we visited two weeks later no Deprivation of Liberty Safeguards assessment had been made, even though an urgent authorisation had expired, and the patient continued to be deprived of their liberty. This meant that the patient did not have access to a SOAD or the safeguards provided by the MHA or Mental Capacity Act. Our MHA Reviewer passed this information to our inspection team and follow-up action is in progress.

may be cared for under either the MHA or the Deprivation of Liberty Safeguards depending on the individual factors for the patient's admission and treatment. Both pieces of legislation aim to ensure that the fundamental human rights of people who have been deprived of liberty by the state are protected and upheld. We report on the Deprivation of Liberty Safeguards in our annual report *Monitoring the Deprivation of Liberty Safeguards in 2014/15*. We expect providers to have systems in place that support staff to understand the different frameworks and monitor how these are applied in individual situations. The revised Code of Practice introduced chapter 13 – Mental Capacity and Deprivation of Liberty, which aims to make the crossover between the MHA, the Mental Capacity Act and the Deprivation of Liberty Safeguards clearer.

We raised 52 actions in relation to the use of the Mental Capacity Act Deprivation of Liberty Safeguards through our MHA visits. These include requests to improve staff training and knowledge, improve relationships with local authorities, transparency in decision making and making sure that patients and carers have information about the Deprivation of Liberty Safeguards and the way it applies to them. We continue to find many professionals are struggling to know when they should be using the MHA or Deprivation of Liberty Safeguards in particular cases, and how it applies to issues around the admission and treatment of the patients they are caring for. This means that patients' rights are not being adequately protected.

On some visits we recommended that staff receive additional training on when to use the Deprivation of Liberty Safeguards and the MHA, especially where patients are potentially being de facto detained under neither authority. Services have responded positively to our requests with, for example, plans to run joint training with local authority leads, case review workshops and the development of training materials for ward staff, including flowcharts and e-learning programmes.

We recognise that the lines between the MHA and Deprivation of Liberty Safeguards are blurred, making good practice in hospitals difficult. The issues with the crossover between the two pieces of legislation have been highlighted by the Law Commission's review of the Deprivation of Liberty Safeguards. We welcome this review and hope that these issues will eventually be resolved through legislative revision.

However, providers' leadership teams and managers must have effective systems in place for managing the implementation of the two powers as they currently stand. This includes making sure that their staff understand that depriving someone of their liberty must be legally authorised, so that patients are not left in positions of unlawful de facto detention. Where we identify regulatory breaches during our inspections, we will use our enforcement powers against the provider.

Admission to local services
As patients cannot choose which service they are admitted to, we expect them to be admitted as close as reasonably possible to somewhere they believe would help them to recover. For example, this may be remaining close to home or family, friends and carers. To support this aim, when clinical commissioning groups (CCGs) receive a new application under the MHA, they have specific duties to identify suitable local services that Approved Mental Health Professionals can access. We welcome the new standards in the revised Code that provide CCGs with guidance on how to fulfil this duty.

The new standards expect NHS commissioners, local authorities, providers, police and ambulance services to have a clear joint policy for safe and appropriate admission. The policy, signed at board level for each organisation, expects all parties to meet regularly to discuss how effective the policy is and to make sure that the people carrying out functions for each organisation are clear about their roles and responsibilities.

In our State of Care report, we highlighted some problems around accessing beds in mental health services that we have found through our inspections.[4] Although our MHA visits do not routinely focus on access, we have also found some issues with bed availability for detained patients. These include over-occupancy of wards and out of area placements because of a lack of beds in the patient's local area. Patients have told us about the difficulties that out of area placements have caused them and their families. We remind providers and commissioners of the National Confidential Inquiry recommendation that acute admissions out of area should end because they are likely to make care planning more difficult, and may increase suicide risk for patients at the time of discharge.[5]

We are pleased to see that the new Code is clearer for commissioners and about their responsibility to commission adequate local services. In particular, we welcome the new requirements for commissioners to develop a clear joint policy and to hold regular meetings to review this. We will be looking at the impact of this policy on patients during our inspections and MHA monitoring visits, and asking local services how the new standards are working in their services.

Challenging unnecessary restrictions on patients

In previous reports, we have highlighted the ongoing challenges with unnecessary blanket restrictions on wards, including locked door policies and the impact these can have on a patient's liberty and freedom. Unnecessary restrictions may amount to a breach of the Human Rights Act,* and the revised Code of Practice requires hospital managers, senior managers or boards, to make sure that any restrictions are documented including their reasons, and that there are systems in place to manage any type of blanket rule.†

In 2014/15, our MHA Reviewers raised 93 issues directly relating to blanket rules and restrictions during their visits. Forty-six of these specifically related to locked door

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* Article 5 (right to liberty) or Article 8 (right to respect for private and family life, home and correspondence)

† MHA Code of Practice (2015), paragraph 1.6 and chapters 8 and 34.

93

issues raised on MHA visits relating to blanket rules and restrictions

52

actions raised in relation to the use of the Mental Capacity Act Deprivation of Liberty Safeguards through our MHA visits

A view of people who use services

"Commissioners need to know what happens when the Act is being used – otherwise how will they know when things need to change for us?"

Service User Reference Panel member

policies. In some services, we have rated the provider inadequate for the key question of 'are services safe?' because of the inappropriate use of blanket restrictions. However, where staff have explained to patients why the restrictions are in place, this has contributed to a positive judgement under the key question of 'are services caring?'.

The problems we found include restrictions on leave regardless of individual patient risk assessments, patients being locked out of bedroom, bathroom and kitchen areas, and items, such as toiletries and electrical items, being restricted for all patients. Our MHA Reviewers have challenged these practices and asked providers to respond with plans, which make sure that local policies and practices avoid unnecessary blanket restrictions, or provide a reason why they should continue.

Many of the concerns we raised can be relatively easy to address, but have a significant effect on how patients view their relationship with staff and whether they are treated with respect, or fully involved in their care and treatment. In addition to the policies and procedures required, we believe ward staff play a significant role in helping patients to understand the restrictions that may be in place, and working with the patients to come up with alternative solutions, particularly where restrictions were put in place in response to incidents or safety issues.

Locked door policies

Our MHA visits look at the risks of informal patients being deprived of their liberty or 'de facto detained', often as the result of locked door policies.* During our visits in 2014/15, we found 86% of wards (1,109) had locked doors, 11% (135) had unlocked doors, and in 3% (39) of records it was 'not stated or not known'. This is the same as our findings from 2013/14 where 86% (1,143) of wards had locked doors, 11% (150) had unlocked doors and in 3% (31) of records it was 'not stated or not known'.[†]

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* MHA Code of Practice (2015), paragraphs 4.49 to 4.51 and 8.10 to 8.14

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† Figures may not add up to 100% due to rounding.

86%
of wards on our MHA visits had locked doors

Responding to patient concerns about unnecessary restrictions

On a visit to a provider in the north west, patients told us that they were unhappy that the use of a lounge had been restricted because other patients had been involved in arguments while nursing staff were not in the lounge. We asked the provider to look at how they could involve the patients in discussions and review their decision about restricting use. The provider told us that they would review how the room was used and work with individuals to give them access to the lounge. The provider also introduced a 'you said, we did' poster on the ward and said that they would work with the patients to develop a patient charter based on the provider's values and develop further plans for the lounge to address all patient needs.

In 2014/15, we issued 46 requests for action in relation to the way locked door policies were being operated, highlighting to the service where they were potentially depriving people of their liberty. The actions required providers to make sure signs are clearly posted near exits for patients (29), provide information to informal patients of their legal position (15), and address the reports from informal patients who believed they were not free to leave the ward (10).

Other problems arising in our reports relate to:

- Restrictions around smoking, with 69 reports of patient issues with smoking bans

- Frequency of breaks or access to outside areas

- Patients' access to and choice of food.

These restrictions may be justifiable on the grounds of health promotion and in line with national policy guidance, but services should consider how they enable, rather than force, detained patients to participate in interventions to improve their physical health.[6]

All restrictions must be in keeping with the guiding principles, and staff should appreciate that the MHA cannot be used to prevent patients from making unwise, but otherwise unexceptional, decisions about their lifestyle. We recognise that it may be difficult for services to achieve this aim while also following other policies, such as a ban on smoking across hospital sites. However, we will continue to work with individual providers to make sure that the implications for detained patients are considered and that plans to minimise the negative effects are in place.

Access to internet
The Code of Practice specifically requires services to make every effort to support patients' contact with family and friends by telephone, mobile, email and social media.[§] However, we are continuing to find problems with patients accessing the internet and this year requested 65 actions requiring providers to improve the situation for patients.

Many services, outside of the secure sector, reported that their local policies state patients should have access to the internet unless there is a valid reason for not allowing this. One ward told us they have started to provide Wi-Fi internet access, so that patients may use their own devices, and that they provide a laptop for others. We welcome this change and encourage other services to learn from this good practice.

Safe and therapeutic responses to disturbed behaviour
Physical restraint and restrictions such as seclusion are last resort interventions, and services need to have a clear focus on skilled de-escalation and relevant security measures to avoid unnecessary use of force. The use of restraint and restrictions can have serious potential implications for patients' physical safety, emotional and psychological wellbeing.

Our inspection reports, for all mental health providers, always include details about restraint practices and the number of times they are used. This highlights to us where providers have a high use of restrictive practices and, when found, we investigate the causes for this.[¶] We have issued requirement notices and rated services as 'inadequate' under the key question of 'are services safe?', where we found a

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§   MHA Code of Practice (2015), para 8.16

¶   Brief guide for inspection teams: restraint (physical and mechanical. www.cqc.org.uk/content/brief-guides-inspection-teams

high use of prone restraint and errors with consistency, completeness and accuracy of recording keeping for restraint use in the service.

We are pleased that this year at least four detaining authorities have told us they are putting in place programmes to reduce or end the use of restraint and seclusion in inpatient settings. This includes Merseycare NHS Trust's No Force First programme, which prioritises the relationship between staff and patients and uses a range of tools and techniques to de-escalate tensions in inpatient environments.* These providers have reported over 50% drops in the use of restraint and have reduced absence rates for staff. Other providers have told us they are looking at ways they can apply the programme to their own strategies. This is very encouraging and we will watch their progress with interest.

The revised Code of Practice gives detailed guidance on the processes to follow when considering the use of mechanical restraint. This includes requirements for a multidisciplinary review before use and regular medical review during use.[†] In 2014/15, our MHA Reviewers found four concerns relating to the use of mechanical restraint in mental health and learning disabilities settings. These included a patient alleging it was used inappropriately, no policy in place and a lack of appropriate care plans for using mechanical restraint.

Guidance published in May 2015 by the National Institute for Health and Care Excellence (NICE) states that mechanical restraint should only be used in high-secure settings, or when transferring patients between medium and high-secure settings.[§] However, under the Code of Practice mechanical restraint can be used when it is the least restrictive option available. It can also be used in any setting where patients are detained.

Where a service provider can show that it has followed the Code, and that mechanical restraint is the least restrictive intervention in any individual case, we accept that this would be a valid reason for its use. The reasons for using mechanical restraint should always be demonstrated through a risk assessment, and should be supported by local policies.

In past reports, we have responded to services who have told us that they were intending to introduce any mechanical device to control a patient's movements in an inpatient setting.[¶] We encourage other providers to do this so that we can review arrangements and consider whether we should visit the patient concerned.

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*   www.merseycare.nhs.uk/about-us/striving-for-perfect-care/no-force-first/

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†   MHA Code of Practice (2015), paragraphs 26.88 to 26.90.

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§   NICE, *The Short-term management of Violence and Aggression (NG10)*, 2015, paragraph 8.4.6.1. It is unclear that this is an evidence-based recommendation. The guidance at paragraph 6.7.1.3 calls for further research asking whether mechanical restraint is "effective".

¶   See for example CQC's Monitoring the Mental Health Act in 2013/14. 2015, page 49.

The use of seclusion

Last year we required 145 separate actions to be taken in relation to seclusion and isolation. In addition, where we found poor seclusion practices on our inspections we rated services as 'inadequate' for the key question of 'are services safe?'. We issued this rating where we found problems with access to a seclusion room, issues with record keeping and updating management plans for patients in seclusion, as well as problems with staff being able to carry out observations during seclusion. Our brief guide on seclusion rooms for our inspection teams highlights the types of areas we will look at during our visits, and is available for providers on our website.[#]

Many of the actions we issue require providers to make improvements to the seclusion rooms. The revised Code of Practice includes a list of factors to be taken into account in the design of seclusion rooms to make sure that patients' safety and dignity is maintained.[‡] Services can use this as a tool to audit their own facilities and arrangements, and we will use the factors as a benchmark during our visits.

[#]   Brief guide for inspection teams: seclusion rooms. www.cqc.org.uk/content/brief-guides-inspection-teams

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[‡]   MHA Code of Practice (2015), paragraph 26.109

[◊]   MHA Code of Practice (2015), paragraph 26.29

Observation in seclusion

The revised Code of Practice includes more detailed advice on observations in seclusion. It emphasises that it is important for staff to be 'caringly vigilant and inquisitive' to help ensure attempted suicides are discovered and prevented.[◊] Of the 145 actions required for seclusion practices, our MHA reviewers identified problems with 19 practices relating to observation while in seclusion.

145

actions required in relation to seclusion practices

A view of people who use services

"Seclusion is sometimes used when the incident is really over – not as a response to sustained attack. Seclusion isn't a punishment, but it can be used as one. And as a threat."

Service User Reference Panel member

Two patients on a women's ward in January 2015 mentioned that high numbers of staff were required to carry out observations. On the day of our visit, two patients required two-to-one observations, and two other patients required one-to-one observations. This meant that all six healthcare assistants were on observations duties. One patient who was not on observations said that they felt they were "invisible" and that they did not get the one-to-one time they needed. Patients also complained that there were high numbers of male staff assigned to the ward. In response the hospital reviewed its core staff rota to make sure that there are enough female staff on duty, ensure daily allocations and facilitate one-to-one talk time and patient engagement.

Our challenge to services

- Providers must make sure that staff understand the impact of the crossover between MHA and Deprivation of Liberty Safeguards, including the potential for unlawful de facto detention. Managers must have effective systems for managing how the Acts are applied in their services.

- Local services must make sure that they have implemented the revised Code requirement for a clear joint policy for safe and appropriate admission, signed at board level. All parties should meet regularly to discuss the effectiveness and to ensure that the people carrying out functions for each organisation are clear about their roles and responsibilities, and monitoring information about the MHA.

- Providers should make sure that any restrictions on patients are in keeping with the guiding principles, and those acting as hospital managers, board or management have agreed to any blanket or global restrictions. This should be documented, including their reasons, for the hospital, group or ward to which they apply and there must be systems in place to keep their use under review and monitor the impact for patients.

- Providers should consider how they might adopt and implement programmes to reduce or end the use of restraint and seclusion in inpatient settings. We encourage providers to tell us in advance if they are intending to introduce any mechanical device to control patients' movement. Our inspection teams will review the arrangements and consider whether we should visit any affected patient.

2.2 Empowerment and involvement

We expect to find evidence of the empowerment and involvement principle across services. Our visits and complaints highlight a number of occasions where patients, families and carers have not been fully involved in care, support and treatment decisions. We also find and champion the services who are proactively involving patients and others in local service decisions, using data from patient experience to inform their improvements, and embedding a culture that puts patient views at the heart of everything they do.

The revised Code has introduced a range of new standards that seek to protect and promote the patient voice in decision making throughout their care pathway. We will be ensuring these standards are central to our future monitoring and inspection frameworks for the MHA.

During our inspections, we have found many positive examples of the way staff provide patients with information and support them to understand their rights in mental health settings. For some

Factors that have contributed to a rating of outstanding under the key question of 'are services caring?'

- Patients gave consistently positive feedback about how staff treated people.
- Staff spent time explaining restrictions.
- Staff spent one-to-one time with each patient.
- Patients were actively involved in their care.
- Patients were empowered as partners in their care.
- Culture of empowerment and trust between patients, carers and staff.
- Patients and carers were involved in their care from admission to discharge.
- Patients were actively involved in their care plans, in treatment planning and decisions.
- Care plans reflected patients' needs and choices.
- Patients were involved in their care and the way services were run and they understood the services they were receiving.
- Robust and innovative practices were used consistently across the service to engage and involve patients in their care and treatment.
- Carers were involved in their relative's care planning. Staff were flexible with timings of the care planning meetings so carers could attend.
- Staff spent time explaining treatment options.
- Staff were flexible and adapted scheduled activities when a patient requested this.

Source: CQC s mental health comprehensive inspection reports

providers we have rated their services as 'outstanding' under the key question of 'are services caring?' and noted the way patients are provided with information as a contributing factor to the rating.

Independent mental health advocacy

The role of the Independent Mental Health Advocate (IMHA) is an extremely important safeguard for patients. Since the introduction of the statutory advocate role in 2008, our reports have highlighted concerns with the provision and access for patients, and the understanding of staff working with detained patients on how and when to refer to advocacy. The revised Code of Practice advises hospitals to make sure patients who lack the capacity have an opportunity to meet an IMHA so they can explain to the patient what the service can offer. It is expected this will help increase the number of patients who have access to the support from the IMHA service from the point of admission.*

On our MHA visits between 1 January 2015 and 31 March 2015, we carried out a survey to see how ready services were

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* MHA Code of Practice (2015), paragraphs 4.23, 6.16.

to implement the new Code, specifically around the IMHA service. We asked ward managers to tell us how they monitored IMHA provision. We found that out of 200 wards, fewer than one in five monitored referrals and IMHA contacts (figure 11).

Over half of all ward managers (58%) said they automatically referred patients who lacked capacity to an IMHA service. Of the remaining 42%, managers told us the decision to refer a patient would be made in multidisciplinary reviews of care plans, or was subject to whether it was in the patient's best interests (figure 12).

Most wards in our survey (88%) had IMHA posters and leaflets on display. Where

A view of people who use services

"Even the most articulate person, when detained under the MHA, could use help from advocacy in making a complaint, or expressing concerns. It's difficult to speak up then."

Service User Reference Panel member

Figure 11 Findings from MHA monitoring, January to March 2015: governance arrangements

	Yes	No
Is there a record of how many patients referred to IMHA service?	39	171
Is there a record of how many patients receive IMHA support?	38	172
Are records used to review whether patients had IMHA contact?	33	177

0   20%   40%   60%   80%   100%
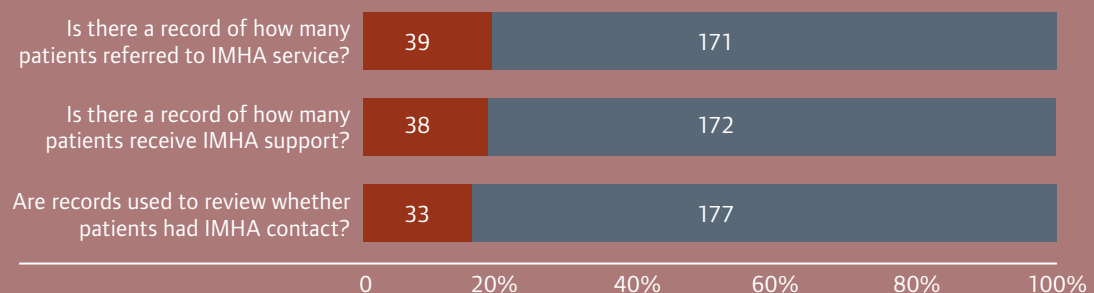
Source: CQC

● Yes   ● No

this was not the case, some wards were waiting for material from new IMHA service providers following retendering, and in others existing material had been damaged or removed and not replaced.

In almost 40% of wards visited as part of the survey, staff had not received training on the IMHA service or how to refer a patient to that service. In some of these cases we were told that, because the hospital's MHA Administrator had been given the responsibility for managing IMHA referrals, it was not considered necessary to train other staff on IMHA. All staff involved in the clinical care of eligible patients should receive training on IMHA, to make sure that they understand their role and that they recognise when patients need to be referred. We expect training on IMHA to be a part of routine training on the Act

for staff, particularly in relation to their duties to provide patients and relatives with information.

The Code of Practice explicitly states that providers have to take whatever steps are practicable to ensure patients understand the help available from the IMHA service and how to obtain that help.[†] The findings from our visits demonstrate that many providers do not have effective systems in place or are not supporting staff well enough to meet the expectations of the Code and their duties under the Act. This is unacceptable, and we will issue requirement notices or take enforcement action where providers have failed to put in place systems that enable staff to support the important IMHA role.

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† MHA Code of Practice (2015), paragraph 6.27

A view of people who use services

"If people think about it – the outcomes of treatment would be better if people are involved in their care plans. Medication works better – in physical illness too – when people have confidence in their treatment."

Service User Reference Panel member

Figure 12 Findings from MHA monitoring, January to March 2015: referral arrangements

	Yes	No	Not applicable
Staff are trained on IMHA and how to refer a patient	128	82	
Qualifying patients who lack capacity are automatically referred	121	86	3
IMHA posters and/or leaflets on public display	184	26	

0   20%   40%   60%   80%   100%
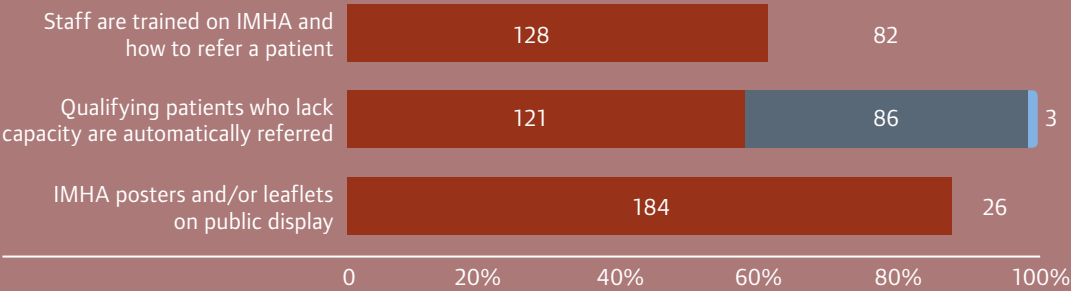
Source: CQC

● Yes   ● No   ● Not applicable

Care planning and advance statements

As part of the principle of empowerment, the revised Code of Practice emphasises that it is most important that care plans are produced in partnership with the patient.* Care planning is one of the most frequently cited areas in our requests for action to providers. We reviewed over 4,000 care plans last year and looked for evidence that services were involving patients and following the standards in the Code and Care Programme Approach guidance.

While some services have improved their practice in care planning, findings from our document checks on visits have not changed significantly since we last looked at this in our 2012/13 report.[7] In that report, we also highlighted the work of the Mental Health Foundation's user-led research into recovery and the effectiveness of involving people who use services in care planning, and a focus on what recovery means to individuals.[8] We highlighted the checklist of good practice for mental health professionals that was developed as part of the research, which we recommended to all detaining authorities and service commissioners as a tool to improve care planning.

During our visits in 2014/15, MHA Reviewers examined care plans and found no evidence of patient involvement or patient views in 25% (961) of cases. This is similar to 2013/14, where our MHA Reviewers examined 3,209 care plans during their visits and found no evidence of patient involvement in 26% (980) of cases. We recognise that in some cases, the nature or degree of patients' mental disorder may prevent this engagement. However, it is clear in some of our visit reports that staff had failed to engage with patients in the care planning process. This is also a failure to follow the recommendations of the revised Code.

Where the care provided does not reflect the patient's views, and past or present wishes or feelings, this must be recorded in the plan along with the reasons why. In our visit reports, we found 103 references to patients' wishes and feelings, with 46 provider action requests relating to advance decisions. The problems we found typically included a lack of evidence of the use of advance statements in care planning or treatment decisions, and patients not being aware they could develop an advance statement for their future treatment decisions if they wished to do so.

Other measures of care planning consistently show a more positive picture: over 90% of care plans we reviewed showed that staff had considered the least restrictive principle and/or patients' needs (figure 13).

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*   MHA Code of Practice (2015), paragraph 34.10

A view of people who use services

"Care plans are important for anyone in mental health services and on care programme approach, but when I am detained they become one of the most important documents to me. They hold all the info we need (me and the staff) to understand my goals. The things you put in there when I am detained can be even more pervasive and intrusive so they need to be planned with me being as involved as possible."

Service User Reference Panel member

Figure 13 Evidence from patient records examined on MHA visits: personalised care planning 2014/15

Care plans show evidence of:

Care plans show evidence of:	Yes	No
Consideration of the person's diverse needs	3,696	317
Consideration of the minimum restrictions on a patient's liberty	3,598	346
Consideration of the person's view about their treatment	3,011	939
The patient's involvement	2,875	961

Source: CQC

● Yes ● No
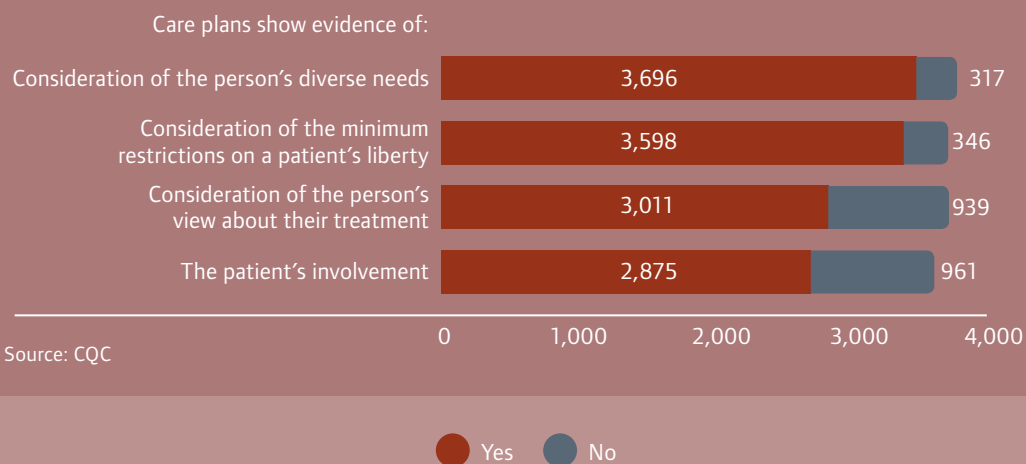
Figure 14 Evidence from patient records examined on MHA visits: care planning and personal assessments 2014/15

Care plans show evidence of:

Care plans show evidence of:	Yes	No
Re evaluation and update following changes to care needs	3,343	425
Risks matched by an appropriate care plan/risk management plan	3,515	229
Risk assessments being carried out	3,813	127

Source: CQC

● Yes ● No
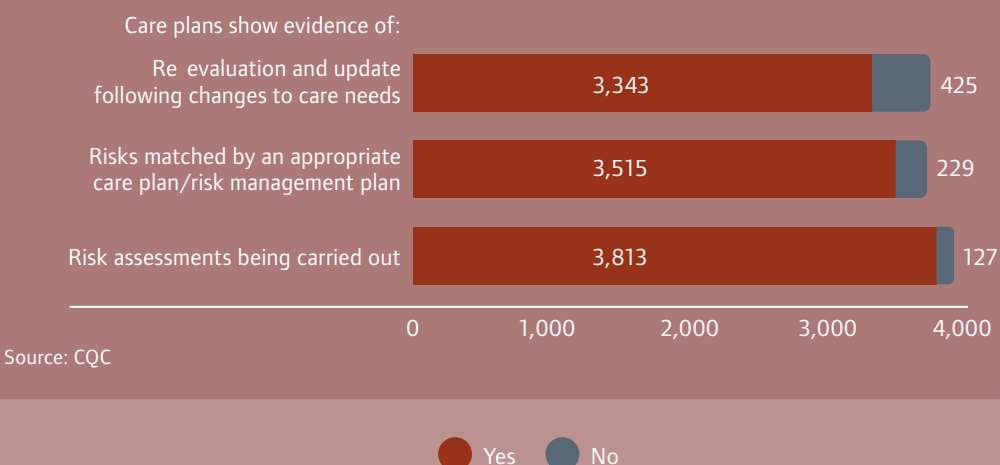
One aspect that MHA Reviewers consider is whether care plans are based on individualised risk-assessment and if they are updated as people's circumstances change. MHA Reviewers judged that care plans had not been re-evaluated and updated following a change in circumstances in 11% (425) of records checked, which has not changed from 2013/14 (figure 14). This means not all providers were following the Code and making sure that risk assessments led to updates in patient's care plans.

To meet the Code's recommendations, we expect providers to begin aftercare planning as soon as the patient is admitted and make sure that patients are clear about the plans and goals for recovery and discharge from

service.* However, during 2014/15 we found no evidence of discharge planning in 29% of records our MHA Reviewers examined (figure 15). This is better than our finding in 2013/14, when the equivalent measure would show that 38% of records seen had no evidence of discharge planning, but it is still unacceptable.[†] 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.

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* MHA Code of Practice (2015), paragraph 33.10.

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† For the sake of comparison we have compared only data entries that recorded either 'yes' or 'no' to the questions on care planning, thus setting aside records of 'not applicable' and missing records from the dataset. Excluding such records adjusts the finding from 2012/13 to 38% from 29% as shown in figure 14 of CQC (2014) *Monitoring the Mental Health Act in 2012/13*, p. 29.

A view of people who use services

"Don't just list my rights to me; medication, tribunal, complain…. I want you to explain to me *how* I can use them and spend time helping me to understand them properly."

Service User Reference Panel member

Problems with care plans

Problems we have found with care plans that have led to action requests or formed part of our reason for rating effective as 'requires improvement' following inspections include:

- The use of jargon and unexplained acronyms, or plans are written in a way that patients cannot understand.

- Patients have multiple care plans to address different areas of need, but there is no overarching plan that would clearly identify to the patient the purpose of their admission and progress made.

- Case notes and other records only have the healthcare professionals' account of patients' behaviours and actions, with no record of patients' own views or participation in their care.

- Problems with electronic care records including having multiple electronic systems in place for providers or no method of recording MHA required information on the systems.

Giving patients information

Under the MHA, providers must 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 the impact of the MHA on them, discuss this with staff and exercise their rights if they wish to do so, for example by requesting their discharge and appealing to the tribunal or hospital managers.

During our inspections and MHA monitoring visits, we will always look to see that hospital managers have fulfilled their duties to give patients this information. We also always check what information is available for patients, families and carers on how to raise a complaint and how they have access to the Code so they understand the standards expected.

While the majority of records we checked showed patients had received information about their rights, we are concerned that 10% (395) of the 3,838 records we checked in 2014/15 still had no evidence of this. However, this is better than 2013/14 when we found 13% of records had no evidence of this.

In nine per cent (339) of 3,899 records examined, there was no record of staff attempting to discuss rights with the patient on admission, but this is better than the 2013/14 figure of 11% (425) of the 3,851 records we had examined. It is vital that patients are able to discuss and understand their rights. Not only does this help them to be involved in their care and treatment, it also helps them to raise concerns about the Act or Code when they do not think it is being applied correctly.
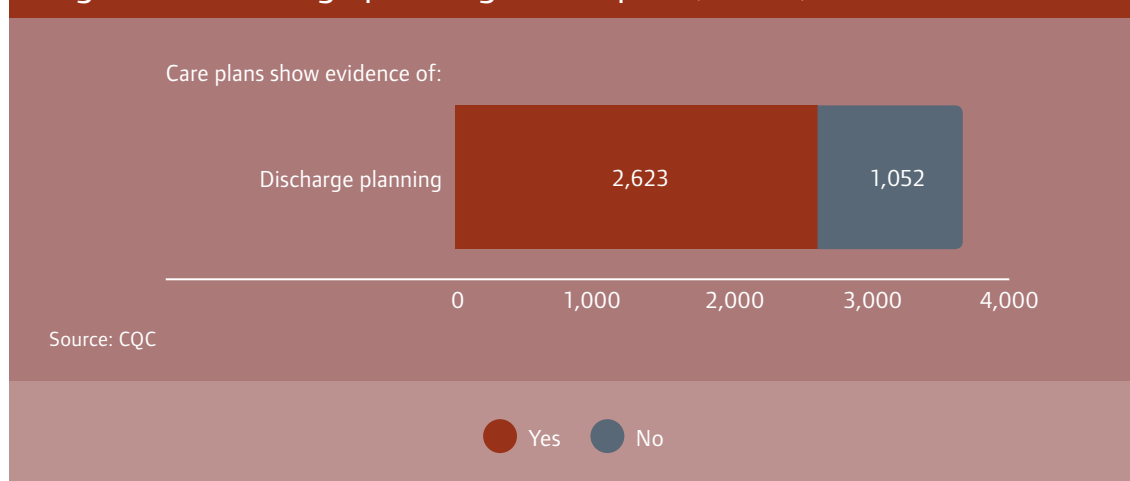
The Code of Practice advises that patients are reminded of their rights and of the effects of the Act from time to time, to ensure that the hospital is meeting its legal duties.[§] However, our MHA Reviewers found that this was not happening in 16% (589) of the 3,701 records examined.

Providers are also required to take every effort to place a copy of the Code in areas accessible to patients and, as appropriate, their visitors. However, we found that some wards do not have a hardcopy available and rely on electronic versions for staff.[¶] All providers should consider how they will ensure that patients can access the Code if a hardcopy is not available on the ward and make sure they have alternative arrangements in place.

[§]   MHA Code of Practice (2015), paragraph 4.28

[¶]   MHA Code of Practice (2015), paragraph 4.63

Figure 15 Discharge planning in care plans, 2014/15

Care plans show evidence of:

	Yes	No
Discharge planning	2,623	1,052

(x-axis: 0, 1,000, 2,000, 3,000, 4,000)

Source: CQC

● Yes   ● No

Where we note gaps in the recording of these basic legal duties, we expect hospital authorities to take effective action to correct this. Where problems persist, these have contributed to a rating of 'requires improvement' in comprehensive inspections of mental health hospital services.

Involving carers

When applying the empowerment and involvement principle, the revised Code of Practice emphasises that services need to involve and engage with carers of patients subject to the MHA. The Code requires services to make sure that carers have access to practical and emotional support, and timely access to up to date and accurate information to enable them to participate fully in decision making.

Providers should work with local authorities to support carers, including joint approaches to decision making, and checking carers' wellbeing following assessments or section 17 leave arrangements involving them. Providers should ensure their staff are familiar with the Care Act's 2015 new legal duties on local authorities, in place from 1 April 2015.* These require an assessment of carers' current and future needs for support, and what this means to the joint support for carers when patients are detained.†

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* www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/assessing-needs/enacted

† MHA Code of Practice (2015), paragraphs 4.42 and 14.84-6. From April 2015, local authorities had such duties under the Care Act 2014 and Children and Families Act 2014.

A view of people who use services

"Staff need to remember that the medication you have put me on makes me forget things easily or takes me a bit longer to get my thoughts together when you are asking my opinion on things. This means you just need to keep on trying, then try again and again until I can be really involved. Being detained is too important to me for me not to know my rights or for people to make decisions for me."

Service User Reference Panel member

Patients' rights to information

On a visit to an acute ward in February 2015, some patients had refused to accept leaflets from staff on admission, and were recorded as being incapable of understanding their rights on initial presentation. Staff had not attempted to provide the information at a later time, and no referral to an Independent Mental Health Advocate service was made.

In one case, a patient under section 2 was detained beyond the initial 14 days in which they could appeal to the Tribunal, with only one attempt to explain his rights to him.

We highlighted our concerns to the trust and, in response, the trust tasked the ward administrator to conduct a weekly audit of case notes to prevent this happening again.

A view of people who use services

"There are lots of things you can do to help me to understand and be involved at the start of the admission. Involve other people who know me and understand what I need when I am ill – family, carers or other health professionals who have worked with me before."

Service User Reference Panel member

GOOD PRACTICE A STUDY ON CARER INVOLVEMENT

In August 2015, we carried out a study on carers' experiences in Berkshire that highlighted a number of areas for action by the trust to ensure:

- Staff reach out to relatives and do not wait to be approached.

- There is a joint agreement with the local Approved Mental Health Professionals about who makes a follow-up call to the nearest relative following the detention of a patient, answering any questions and checking on the relative's welfare.

- Wards comply with the MHA Code of Practice and consider consulting relatives or carers before leave is granted, especially where the patient is to reside with them.

- The percentage of carers who receive an assessment of their own needs.

- Ward staff check that carers are aware of their right to an assessment and refer them if necessary.

In response to our study, the trust has already implemented the following good practice actions:

- All wards have a dedicated carer champion.

- Staff receive awareness training on the importance of reaching out to carers.

- Electronic forms for registering new admissions prompt staff to give carers and relatives the opportunity to be registered, and to ask whether they would like to have a conversation or meeting with a member of staff. The record also requires staff to ask carers whether they would like to request a carer's assessment.

- All wards have a carer information board, and carer-specific information leaflets that are available to take away, including one about the right to request a carer's assessment.

- Online support network for carers have been developed, offering a point of contact for questions and concerns as well as providing information and resources.

For adult patients, the Code references *Triangle of Care – carers included: a best practice guide in acute mental health care.*[9] This is a useful document setting out ways to achieve better working between service users, their carers and providers. The document offers examples of good practice, developed by carers and staff, to improve engagement in acute inpatient and home treatment services. We have used the document to inform a pilot study we carried out in 2013/14 and will be developing tools for our MHA visits based on the key elements of the guidance.

Where applicable, the provider must inform the nearest relatives, who may or may not be the main carer, of the discharge of patients from detention.* Contact may not occur if a patient objects to this, but providers need to make a careful judgement about balance competing rights.†

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*   Mental Health Act1983, section133.

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†   See comments by Aikens LJ in *TW v Enfield Borough Council [2014] EWCA Civ 362*, in relation to assessments.

A view of people who use services

"The triangle of care becomes even more important when I am detained. Although my family aren't involved, my best friend acts as my next of kin and if she is involved in my treatment when I am ill then it helps me to talk things through with her and understand things better which means I can be more involved."

Service User Reference Panel member

Our challenge to services

- Local services should carry out regular monitoring of their care planning practices, using our findings as a benchmark, and make sure that staff understand and are able to support detained patients to be involved in care planning and developing advance statements wherever appropriate.

- Services must ensure patients are given information on CQC's role in complaints about the MHA, staff are trained to support patients and they take every effort to ensure copies of the Code are available to patients.

- Local practice relating to information and support for patients, families and carers must be reviewed, with specific attention given to the training available for staff on the role of the IMHA services.

- The Department of Health should consider how centralised data collection and reporting for IMHA services may help the issues we have identified.

2.3 Respect and dignity

Ensuring the respect and dignity of patients is maintained is relevant across all our activities with patients and providers. We look for evidence that services are caring for patients in a way that protects and respects their rights, recognising and meeting the diverse needs, values and circumstances of each patient.

Gender and race equality

The MHA Code of Practice emphasises that services must make sure they are following the Equality Act 2010 and adds a new requirement to have a human rights and equality policy in place. The policy should include detailed guidance on how providers are addressing areas such as robust monitoring of equalities, how information about equalities will be publicly available and transparent and how staff will be provided with learning, development and training on human rights legislation and the Equality Act.§

Overrepresentation of some Black and minority ethnic (BME) groups in the detained population has been widely reported for many years, with compulsory admission rates for people of black ethnicity almost three times greater than those of white patients. Compulsory admission rates of black people tend to be highest in areas with higher levels of deprivation and, unsurprisingly, areas where there is a higher proportion of non-white residents.

Although the causes of overrepresentation of some BME groups in the use of the MHA are unknown, from July 2014 commissioners of mental health services have access to practical guidance to ensure that inequalities are monitored and addressed. The guidance promotes co-production with patients and carers to achieve a values-based model for commissioning, procuring, and delivering services, and we expect providers to work

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§   MHA Code of Practice (2015), paragraph 3.15

The need for gender and cultural sensitivity

On a visit to a women-only ward, one patient complained of being 'manhandled' by male staff during restraint and that this was an infringement of her religious and cultural beliefs. We saw a number of entries in patients' files suggesting that they had been restrained by male staff. In response to our concerns, the hospital managers told us that male staff made up 20% of the ward's staffing; that patients had access to female staff at all times; and that any planned restraint intervention would only involve female staff. The ward had links with the local population, and in particular, with the orthodox Jewish community who provided guidance and education to the staff team, so religious, cultural, and spiritual needs should be reflected in patient care plans. We were reassured by the consideration given to gender and cultural needs in this response (although it cannot detract from the distress of the patient who spoke with us) and flag it as an example for other services to consider.

with local commissioners to consider how they can apply these suggestions in their local area.[10]

The Code of Practice states that it is essential that professionals who assess patients are able to communicate with the patient effectively and reliably to prevent misunderstandings. Hospital managers need to ensure that interpretation services are available to detained patients whose first language is not English.

Language barriers can both isolate patients and lead to failures of assessment and treatment. In 11 of our MHA visits, we have highlighted difficulties with involving interpreters including the lack of interpreter use in care planning, informing people of their rights and admission processes. Where we have identified difficulties, we have required providers to make sure that staff arrange an interpreter for the patients we have met, and to carry out a review of the procedures they have in place for this.

Children and young people

The revised Code's chapter on children has been significantly updated and is now clearer about some of the complex issues that arise. While we welcome these improvements, we are still finding problems in services' approaches to children with mental health needs. In part, these

stem from gaps in the provision of child and adolescents' mental health services (CAMHS) that have been acknowledged by NHS England.[11]

NHS England's report on CAMHS recognises that placing a patient in hospital can itself lead to adverse care pathways for some people in the CAMHS system. It warns putting someone in hospital because of concerns that they are a risk to themselves can lead to a spiral of worsening symptoms and increased suicidality, leading to increasing levels of security, and delayed discharge for some young people.[12] Since the NHS England report in 2014 the CAMHS Taskforce has reported in *Future in Mind*, recommending that real alternatives to admission are developed and that alternative models should be explored which recognise multi-agency approaches are needed in supporting young people who present with risk behaviours.[13]

We will use the NHS England and Taskforce reports when assessing services to make sure that such adverse pathways are guarded against through close review of patient placements, transition plans and the involvement of commissioning bodies in decision making over secure placements.

The Code of Practice's guidance on capacity and consent matters in relation to children

Failure to address interpretation needs

On a visit to an older persons' ward in November 2014, we were concerned that the provider carried out initial assessments without an interpreter for a patient whose first language was not English. The doctor had felt able to assess the patient's mood and presentation, but correctly declined to take a view about her capacity to consent to treatment without an interpreter. We questioned whether it was best practice to carry out any assessment without an interpreter, and noted that staff were not recording which language was used subsequently to communicate with the patient.

and young people has also been improved. In our review of comprehensive inspection reports, we found some problems relating to assessment and understanding of consent to treatment and care for children. Although staff were aware of the 'Gillick competence' test, an assessment of children and young people's ability to give consent, some wards struggled to incorporate this into their documentation and practice. For example, we saw poor practice in recording discussions with children about their care, and examples of patients being treated under 'parental responsibility' without assessment of Gillick competence.

Where we find these issues, we ask providers to assure us that they have the MHA Code of Practice requirements in place. This includes making sure that practitioners with expertise in working with children are consulted about assessments of competence in children under 16 and capacity to consent for 16 to 17-year-olds.* We look for evidence of this during our inspections and MHA visits, and require action from providers where we find difficulties in accessing expertise.

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* MHA Code of Practice (2015), paragraph 19.24

Problems in CAMHS provision

In August 2014, we visited two patients who were in long-term segregation on a CAMHS ward. Both patients were assessed as requiring treatment in a medium-secure unit, and funding was agreed for this by their home areas. However, the hospital managers and staff were frustrated that the transfers were delayed because of a lack of suitable beds. Both patients were moved within eight weeks of our visit, but such delays may seriously inhibit the recovery process.

GOOD PRACTICE GILLICK COMPETENCE

During a comprehensive inspection, our team noted that staff understanding of Gillick competencies was good.

- The use of the Mental Capacity Act and Gillick competency formed part of the mandatory mental health law training in the trust, and staff received annual updates.

- Supervision and consultation with senior clinicians were also available to help with issues of Gillick competence.

- There was monitoring of consent to treatment processes. For example, in one ward audits were completed in 2013 and 2014 on the standards of record keeping in relation to obtaining informed consent for treatment with psychotropic medication. Findings showed an improvement in recording treatment options and capacity to consent.

- Although we saw good examples of discussion over capacity, we did suggest that staff should increase their use of the trust's formal capacity assessment forms. The service acknowledged that this needed improvement and agreed to take action to address this following our visit.

Deaf patients

Although a provider may be required to make reasonable adjustments to ensure disabled people are not put at a disadvantage compared with other people, the Code of Practice has introduced a new chapter that looks at the standards expected when a deaf person is detained.

The Code's new requirements expect to see assessments for detention carried out by professionals with the appropriate specialist skills to assess the person based on their individual needs. We expect staff working with deaf patients to have completed deaf awareness training or seek help from specialists as required.*

Questioning care pathways in CAMHS services

On a visit to a CAMHS service in August 2014, we noted that two patients had been moved to higher security as a way of managing suicidal and other challenging behaviour. We asked the managers of the hospital to consider whether the purpose and effectiveness principle of the MHA Code of Practice was being applied in these cases, especially in light of the NHS England report's warning over adverse pathways of care. The hospital management told us that risk of suicide or self-harm was never used as the only reason for moving up levels of security, but that other risk factors, such as assaultive behaviour, were used. They also told us that all patient placements were kept under close review daily, that transition plans were created where appropriate, and that NHS England commissioners were informed whenever a patient moves up or down a level of security.

Unit for people who are deaf: response to CQC visit

We revisited a 14-bedded ward for deaf male patients, 10 of whom were detained on our visit. All areas for action raised on our previous visit had been addressed and patients reported positive changes.

The ward had fully addressed patients' concerns about knowledge of British Sign language (BSL) and deaf culture among staff. A deaf member of staff had taken the role of communication lead, and all seven staff on duty on the day of our visit were BSL users. Patients told us that they no longer felt that staffing arrangements adversely affected their treatment, and the issue of a lack of activities on the ward had been fully addressed with an extensive weekly programme: patients had elected to have non-structured weekends. Access had been arranged to local deaf clubs.

One patient told us, "It's good now. The staff are very good, most sign and are deaf aware. There is clear communication, I'm aware of my care plan and there is a definite sense of improvement here now."

In 2014/15, we carried out visits to four of the eight specialist deaf services registered with CQC. We found problems relating to communication, care planning, therapeutic needs, training and advocacy. Examples included staff not being trained in British Sign Language, which one service told us was a particular problem over the weekends when they had more agency staff on duty. We asked providers to send us action plans to address the issues we found, which they have all done.

Generally, the difficulties we find in specialist deaf services with regard to care planning and advocacy access are similar to those in other areas. However, we will be looking to see how these providers have responded to and implemented the increased standards for this group of patients in the revised Code.

Providers are also required to make reasonable adjustments for other disabled people, such as people with mobility impairments and blind and partially sighted people. There are no specialist mental health services for these groups, but we would consider reasonable adjustments for disabled patients in our MHA monitoring of all mental health services.

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*   MHA Code of Practice (2015), paragraph 3.13

Our challenge to services

- All providers should make sure that their local training and policies on equality, diversity and human rights have been updated to reflect the revised Code's standards and that these include guidance on how MHA equality monitoring and outcomes information will be collected, analysed and shared with partners.

- Providers and commissioners must consider how they are meeting the requirements of the Code throughout the care pathway for patients with diverse needs, giving particular attention to the way services can access specialist practitioners when working with children and young people, deaf patients and those experiencing language barriers.

2.4 Purpose and effectiveness

When assessing and monitoring services against this principle and our own rating of 'are services effective?', we expect to find clear systems and processes in place to ensure care and treatment decisions are appropriate to individual patients. We look for evidence of best practice and a clear commitment to the promotion of recovery across the patient pathway.

Ward activities
Commissioners, providers and professionals must consider a broad range of interventions to promote recovery. This includes using activities, inside and outside hospital, to meet needs and reduce the risk of behavioural disturbance on the ward.[†] Contracts also require NHS commissioners to establish access to social, educational and occupational opportunities.

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†   MHA Code of Practice (2015), paragraphs 1.16 and 26.18

Types of activities will vary depending on the environment, type of unit and patients. However, we expect services to have a clear approach for providing activities, for the staffing for these and how the activities are meaningful to individual needs. We capture information on activity under the category of 'choice and access'. In 2014/15, we recorded 881 provider actions, of which 50 actions made comments about the perceptions of patients and/or staff. These comments indicated that there were not enough staff to hold activities, or to enable agreed escorted leave to take place. As a result, we asked providers to review their staffing arrangements and explain the situation to patients affected and respond to their concerns.

We are also concerned that our comprehensive inspection and MHA visit reports are highlighting problems with wards having the right number and skill mix of staff. During 2014/15, staffing levels and skills mix have influenced our decision to rate a provider as inadequate in the safe domain on a number of inspections, including where we found impacts on patients' ability to take leave or take part in activities.

We raised our concerns about adequate staffing arrangements and the use of agency staff, including the impact of this on the safety of patients, in our State of Care 2014/15 report.[14] Detained patients have told us that the use of bank or agency staff disrupts continuity of care, or limits the effectiveness of care provided to them.

In some of our visit reports, we have required providers to tell us how they will make sure that they have enough staff available, and how they plan to respond to the concerns. In response to this, hospital managers have reviewed their current processes and introduced new ones. These include MHA training programmes for bank staff, inviting bank staff working on the ward to attend group reflective practice as a way of maintaining high standards, the development of a group 'pool' of staff to respond to annual leave, training and other absences, and proposed new shift rota patterns.

Other services should consider using these types of innovations to make sure that the standards of the Code and MHA are applied by all staff delivering care to patients subject to the MHA.

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actions raised in 2014/15 in relation to how staff interacted with patients

Challenging staffing arrangements

On an acute ward visited in June 2014, staff and patients raised concerns about staffing and occupancy levels. Staff told us that they were concerned that the ward was always fully occupied, with patients sent on leave to manage beds. They also thought that there were not enough staff, which was made worse by staff retention problems and staff sickness. Patients were concerned that this reduced activities and availability of escorted leave. We shared these concerns. In response, the hospital managers told us that they would complete safe staff audits and display staffing on every shift for patients to see. They were also talking with commissioners about resourcing crisis beds to ease the pressure on the ward.

Staff interaction with patients

Building good relationships means that staff can provide more effective care and offer better treatment to patients. However, when building therapeutic relationships, staff must balance familiarity and professionalism to provide care in line with the principles of the Code of Practice.

During our visits in 2014/15, we raised 284 actions relating to staff interactions, which included 16 specific concerns about staff attitudes. These highlighted a number of concerns patients had about the way staff spoke to them or responded to requests, and the negative impact on ward culture. Depending on the type of issue, our MHA reviewers encourage patients to make formal complaints or require responses from the provider. This is something we look at through our Intelligent Monitoring, and discuss with the lead inspectors for the service where the visits are carried out separately from inspection.

Assessment of consent and capacity for medical treatment

Under the revised Code of Practice, patients' consent, refusal of consent, or lack of capacity to give consent to medication for mental disorder should be recorded in their case notes. This includes the initial three-month period when providers do not need to have treatment plans certified.*

We look for evidence that providers ask patients for their consent before treatment is given and that their consent or refusal, including an outline of discussions with the patient, is recorded.

We expect to find records of consent discussions for every detained patient. This discussion should occur:

- Before the first administration of treatment or as soon as it is practicable

- As the 'three-month period' comes to an end, and the clinician in charge of the treatment has to decide whether the patient consents or whether a SOAD review is required

- At each subsequent significant change or review of prescribed treatment.

In 2014/15, 32% (964) of 3,000 records examined by our MHA Reviewers on their visits had no record of a capacity assessment for when the patient was admitted to hospital. This has changed very little from 2013/14 when our MHA Reviewers noted that no record of a capacity assessment was made in 33% (846) of 2,564 records examined.

The Mental Capacity Act 2005 states that patients must be presumed to have mental capacity, and the MHA Code of Practice includes specific reference to this for all detained patients.[†, §]

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*   MHA Code of Practice (2015) para 24.41

†   Mental Capacity Act 2005, section 1

§   MHA Code of Practice (2015), paragraph 13.15. The assumption should always be that a patient subject to the Act has capacity, unless it is established otherwise in accordance with the Mental Capacity Act.

Staff interaction

On a visit to a forensic hospital, some patients told us that it was not uncommon for staff to swear at patients in a way that they found unhelpful to their mental health. It appeared that banter between staff and patients had led to a culture where swearing had become commonplace and, as such, offence caused was unintentional. Staff may have meant no harm, but needed to reflect on the dynamics of power operating on the ward.

Our MHA visits reference capacity assessments over 231 times, although this includes multiple references in some visit reports. When reviewing practices, our MHA Reviewers expect to find a clear statement in the patient's notes of whether or not the patient has capacity to consent to treatment, ensuring that they were involved in the treatment decision or additional support was offered where a patient lacked capacity. Where a patient is deemed to lack capacity, this should be recorded as an assessment of mental capacity under the Mental Capacity Act.*

We expect well-led services to have systems and processes in place that make sure staff are completing capacity assessments and are monitoring this across their services. Providers responding to the actions we raised in 2014/15 identified a number of steps they would take to improve their completion of capacity assessments. These include monthly audits, prompts added to admission documents, training for staff, and introducing 'spot checks' carried out by ward managers or matrons.

Consent to treatment scrutiny
After the initial three-month period of detention, Responsible Clinicians, with the patient's consent, must seek authorisation from the Second Opinion Appointed Doctor (SOAD) service to continue with a patient's treatment plan.[†]

In 2014/15, the SOAD service was involved in some of our comprehensive inspections to look at whether the provider was meeting the 'consent to treatment requirements' of the MHA. We also tested new tools that the inspection teams may be able to use to audit this.

Using the tool, we have examined 800 patient records to date and found technical mistakes on the 'T2 forms' completed by Responsible Clinicians. On average, we found an error rate of 75% on these forms, with particular deficiencies in the recording of patients' consent to treatment.[§,¶] Although many of these errors would not compromise patient safety, they were so frequent it highlighted that services need to improve their own monitoring, including routinely involving both clinical and administrative scrutiny to avoid errors.[#] The errors we found also suggested that staff do not understand the purpose and processes involved. We urge services to consider how they can address this through educating and training staff, including Responsible Clinicians.

We found that some T2 forms are being produced locally, with checklists incorporated into them. While introducing an audit tool and additional prompt is positive, we have

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*   The four points of such a test being ability to (1) understand the information relevant to the decision; (2) retain the information; (3) use/weigh the information as part of the decision making process; and (4) communicate the decision.

†   Responsible Clinicians have overall responsibility for a patient's care and treatment.

§   This is based on the lowest provider figure of 55% errors and the highest rate of error being 94%.

¶   T2 forms (Regulation 27(2) of "The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008)

\#   The most common problem is a failure to delete the non-applicable phrase at the top of the form, which differentiates between whether the Responsible Clinician, or a Second Opinion Appointed Doctor, is completing the certificate.

found examples where the same person is responsible for completing and auditing the form. We urge providers to introduce such audit tools as a separate checklist to make sure that the T2 form is protected as a statutory form with the correct wording.

On some forms, we also noted that doctors had indicated patients' consent to substantially high doses of antipsychotics – in one case this was three times above the British National Formulary recommended maximum.[‡] Where a person is unwell enough to seemingly justify higher than normal doses of treatment, it is more likely that they may not fully understand the possible benefits and disadvantages of taking above normal doses. For this reason, we expect patients with complex or high-dose medication regimes to have detailed accounts of the consent discussion in their records. However, in many cases we could not always find records, or sufficiently detailed records, of the discussions with the patient that had led to the doctor's assessment that the patient can and did consent to this.

Our inspection teams will continue to look for evidence that consent to treatment rules are applied appropriately. We expect services to look at the way they keep the consent to treatment requirements under review, as well as the support for staff who are responsible for these important aspects of safe and lawful patient care.

Discharge planning

Detaining hospitals should make sure that they meet the Code's recommendation that aftercare planning starts as soon as a patient is admitted.[◊] As highlighted in section 2.2, during 2014/15 MHA Reviewers found no evidence of discharge planning in 29% of records they examined (15, page 45). This is better than in 2013/14, when the equivalent measure would show that 38% of records seen had no evidence of discharge planning, but it remains unacceptable.[Δ] A lack of discharge planning will prevent patients from understanding or being involved in their recovery. Where we have found this, we have raised the matter in reports and asked providers for assurance that procedures would be put in place to make

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‡   www.bnf.org

◊   MHA Code of Practice (2015), paragraph 33.10.

Δ   For the sake of comparison we have compared only data entries that recorded either 'yes' or 'no' to the questions on care planning, thus setting aside records of 'not applicable' and missing records from the dataset. Excluding such records changes the finding from 2012/13 to 38% from 29% as shown in figure14 of CQC's *Monitoring the Mental Health Act in 2012/13*. 2014, p. 29.

A view of people who use services

"When I was admitted a few weeks ago, I was asked to sign a form to say I had capacity – does this mean I was there under the Mental Capacity Act or Mental Health Act? It wasn't really clear to me and the staff member didn't seem sure why they were filling it out either."

Service User Reference Panel member

sure that aftercare planning takes place from admission, and is fully documented.

Physical healthcare

The revised Code of Practice places greater emphasis on the need for better physical healthcare in mental health units.
It explicitly requires providers to assess and address physical healthcare needs, including promoting healthy living and taking steps to reduce potential side effects of psychiatric

treatment.* In 2014/15, our MHA Reviewer visit reports questioned the adequacy of physical health checks for detained patients on approximately 50 occasions.

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* MHA Code of Practice (2015), paragraph 1.17

A view of people who use services

"Discharge planning is one of the most important things we need to know, we need to understand your plan and goals for me then how you are going to support me to recover. A good discharge plan will make it clear to me what needs to happen including my health, finance, family and friends or other things that are important to me. The less I know about my discharge plan, the more likely I am to relapse and the longer it's going to take me to get better."

Service User Reference Panel member

Our challenge to services

- Commissioners and providers should establish benchmarks for access to activities and that support patients' recovery. This should include access to social, educational and occupational opportunities and monitoring of the impacts that staffing and skill mix has for patients.

- Providers should make sure there is a systematic programme of consent to treatment audits and that they identify any issues with practice relating to assessment and recording of consent and capacity decisions relating to treatment for detained patients.

- Services must ensure staff begin aftercare planning as soon as a patient has been admitted to hospital, and that hospital managers routinely monitor the effectiveness of discharge planning across their services.

2.5 Efficiency and equity

The principle of efficiency and equity requires providers, commissioners and other organisations to work together to achieve parity for mental health with physical health and social care. This includes ensuring high-quality commissioning and provision of mental health services. In meeting this principle, we expect well-led services to demonstrate that they are working effectively with other agencies to make sure that people affected by the MHA have access to safe, effective, responsive and caring services and support.

Through our MHA work and our assessment of the way local partnerships are working, we are often told of the challenges facing services. This includes the impact of commissioning and local partnership arrangements, quality of discharge arrangements, and the parity of esteem agenda for mental health services, which are central to this principle.

Police powers and places of safety

Uses of Section 136 in hospitals have increased over the last five years, from 14,111 in 2010/11 to 19,403 in 2014/15, an increase of 5,292 (or 37.5%) over the period, although this also reflects the decreases reported by police services in the use of Section 136 in police custody. Chapter 16 of the Code of Practice sets out guidance on the use of police powers. It recognises that effective local partnership arrangements are important to achieving positive outcomes for patients in crisis. This includes requiring local services to make sure local agencies understand their purpose, roles and responsibilities when police powers are exercised, and that they collect and share information to promote good practice and resolve any matters that may impact on patient experience.

In 2014/15, we made 11 specific requests through our MHA monitoring reports for providers to take action regarding police powers and places of safety. We required providers to improve the physical environments of their places of safety, improve record keeping, and make sure that there are enough staff available, and that they have policies in place.

We expect local policies to be clear about the process and responsibilities for reporting and monitoring of the use of the Act and the outcomes for patients admitted to places of safety. This includes the length of stay or assessment delays for patients. We have found issues with the way providers are collecting data, analysing it and discussing outcomes and issues with other agencies. Where we find this is not being completed, we will issue improvement actions.*

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* MHA Code of Practice (2015), paragraphs 16.64, 16.63 and 16.71

A view of people who use services

"Managers and commissioners should make sure the data that's being collected is focused on the things that are going to help our recovery the most. Not just collecting for collecting's sake but making sure they know what is happening for us, especially when we are in crisis or being detained in their areas."

Service User Reference Panel member

Our own thematic review of mental health crisis care in England, *Right here, right now* published in June 2015, identified a number of practice issues.[15] These related to the experience of patients during a crisis and local procedures when applying section 136 of the MHA, and they have relevance to the efficiency and equity principle of joint agency working. They included clear variations of the quality of crisis care, uses of police powers (section 136) and patient outcomes when police powers are applied in the different regions, problems for people moving between different services and a lack of information sharing.

Right here, right now made a number of recommendations for local Crisis Care Concordat groups. These included making sure ways into crisis care are providing the right help, holding commissioners to account for the quality of crisis services based on evidence-based good practice, and engaging with partners to improve the experience of those in crisis. We expect providers to have reviewed and embedded these into their local practices.

In May 2015, the Home Secretary announced an additional £15 million of funding for the delivery of health-based places of safety in 2016/17.[16] The aim of the funding is to reduce the use of police cells. We are part of the national group that is working together with the Home Office, Department of Health and NHS England to ensure the funding is allocated to commissioners and providers that can demonstrate sustainable and positive impacts for patients. This work has been informed by information from CQC's health-based place of safety survey, plans in place to reduce use of police cells through Crisis Care Concordat action plans and findings from published reports of CQC comprehensive inspections.

Aftercare arrangements

For the first time, the Care Act 2014 has provided a statutory definition of aftercare under the MHA. Aftercare services are services that meet a need arising from or relating to the patient's mental disorder, and reduce the risk of the patient's mental condition deteriorating (and, accordingly, reduce the risk of the patient requiring readmission to hospital).

The revised Code of Practice urges clinical commissioning groups and local authorities to interpret the definition of aftercare broadly. It suggests that it should encompass healthcare, social care and employment services, supported accommodation and services to meet a person's wider social, cultural and spiritual needs.*

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* MHA Code of Practice (2015), paragraph 33.4.

Health-based places of safety

At one health-based place of safety based in a psychiatric intensive care unit, approved mental health professionals (AMHPs) would only start the assessment once they had identified a potential bed for admission. On the basis of our comments, which expressed concern that this was both a cause of unnecessary delay and assumed that the person would need to be admitted to hospital after assessment, the trust raised this with the local authority. We received assurances that this was not a policy position and any further incidents would be reported to AMHP leads by health staff. The local authority stated that it would aim for an AMHP to attend within three hours of notification, and would establish a reporting system for any occasion when attendance exceeds four hours.

Discharge planning and aftercare arrangements are another area of the Code where local care planning arrangements and joint agency working must be effective. If not, they will have significant impact on patient outcomes, resulting in longer stays in hospital or risking repeat admissions where appropriate arrangements have not been put in place. We have noted our concerns about providers ensuring discharge plans are in place for patients.

In 2014/15, our Mental Health Act Reviewers required 11 specific actions to be taken by providers relating to delayed discharges for detained patients, both back to the community but also between service types such as children's service to adult. Our findings include examples where providers have had difficulties in discharging patients because of reasons outside their control, for example having to negotiate with commissioning bodies or other provider agencies to ensure appropriate community service support or identify step-down beds for patients.

Hospital managers' discharge power
Chapter 38 of the Code gives providers guidance on exercising their power to discharge patients from section. The power is usually delegated to a committee of people appointed specifically for this purpose by the provider, who cannot be employees or, in the case of independent providers, have a financial interest in the organisation. The 'managers' panels' may carry out reviews of patients' care and circumstances at any time, including at the point of renewal or following a request for discharge from detention by the patient or their nearest relative. Providers are expected to work with the people they have appointed to this role to be clear they understand their responsibilities and the working of the Act to make sure that they are providing patients with a fair, reasonable and lawful hearing before making their decision.

The Code states that ideally this should take place before the renewal date, although the clinician's report will provide authority for continuing detention if the panel meets after the period of detention ends.[†] There are negative impacts for patients if the process is delayed. This includes limiting the ability to empower patients to feel involved in the renewal of their detention or seeking the involvement of others at the hearing such as relatives, carers, Independent Mental Health Advocates (IMHAs) or legal representatives.

To ensure positive outcomes can be achieved services should arrange the hearings before, or as close as possible to, the renewal date. However, we have found examples where the panel meeting had not taken place for up to three months after the renewal date, which is unacceptable. The revised Code of Practice states that a failure to do this 'is a very serious matter' and, as such, it should be reported to CQC as a serious incident.[§] We do not agree that a failure to hold the hearing warrants a serious incident to CQC because the patient's detention remains lawful if the Responsible Clinician's report is completed. However, it is good practice, therefore local systems should monitor how often this is achieved and seek to remove any challenges to hearings being planned before the renewal date.

Even though it is not a legal requirement, we expect well-led providers to have systems in place that consider the renewal before the end of the period of detention or CTO and involve patients fully in the process.[¶] This would include explaining to patients if their hearing needs to take place after the renewal date and ensuring they are supported by others, such as an IMHA, as required.

[†] MHA Code of Practice (2008), paragraph 31.13 and MHA Code of Practice (2015) paragraph 38.14

[§] MHA Code of Practice (2015), paragraph 38.50

[¶] MHA Code of Practice (2015), paragraphs 38.14

The Tribunal

The First-tier Tribunal (Mental Health) is the primary route of appeal against the use of the MHA's powers for detention and community treatment order. It is an independent judicial body and we look at the way providers are supporting patients to appeal to the Tribunal, prepare for their hearings and make sure that they are involved throughout the process. By doing this, we can highlight a number of areas, including difficulties with discharge arrangements or ensuring a provider has systems in place to support patients, staff and other agencies involved, or impacted by the Tribunal process.

In 2014/15, there were 28,892 applications to the tribunal from hospital patients with 17,635 hearings taking place. For CTO patients there were 4,349 applications and 3,629 full hearings (patient present) and 486 paper hearings (without the patient present).* For hospital patients, 46% of applications do not result in a hearing, as they are discharged by their clinician or the application is withdrawn by the patient. However, the preparation for a hearing will still have a resource impact for providers and the Tribunal service.

We have raised a number of actions for providers to make sure that patients understand and are informed of their right to apply to the Tribunal and supported to do so by staff. We are often told that there is confusion between the rights of appeal to hospital managers and to the Tribunal, and IMHAs can play an important role in helping patients to understand and discuss the options for individual patients.

There have been some less frequent examples, where patients have told us they are 'discouraged from applying for tribunals'. We worked with the providers to identify the origins of this perception and were reassured by their response and local investigation.

We met with the Tribunal service in 2015 who shared concerns they are responding to using their powers. This included delays in receiving reports, the quality of professional reports and the accommodation for hearings to take place at some of the hospital sites. The Code includes guidance on both of these areas, which we expect providers to follow, and we have raised actions during our visits where we identified direct patient impacts. We will continue to work with the Tribunal service and consider completing joint reviews when we identify issues that are having direct impacts on patients, including delays to hearings, and problems in involving the patients before and during the hearing because submission of reports from professionals is delayed.

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*   Full dataset from the Tribunal Secretariat is in appendix B.

Our challenge to services

- Providers need to ensure that they have embedded the learning from our *Right here, right now* report on crisis care into their health-based places of safety practices and review how local partnership agreements are meeting the requirements of the revised Code. This includes having a clear framework for collecting, analysing and sharing outcomes data from the use of police powers.

- Hospital managers should have systems in place that support holding managers' hearings before renewal date or monitor the reasons when this cannot be done, ensuring steps are in place to allow patients, families, carers and others an opportunity to be fully involved in the process.

Conclusion and recommendations

Our report shows that the way providers are applying the MHA and Code of Practice continues to vary, and that is having a direct impact on the quality and safety of services that patients subject to the Act receive. These variations are consistent with our findings in our State of Care 2014/15 report.

During 2014/15, we found some excellent examples of staff and services that are committed to making sure people affected by the Act are supported and empowered, and that their experience is used to help shape the future planning of services. In addition, we have found services that have used the learning from our previous MHA visits to make important changes for people in their service, including how the MHA and Code are being met in their organisations.

However, as part of our monitoring and talking to patients and staff, we found a lack of support for patients to be involved in their care and treatment, including issues with information, access to external support such as advocacy, and care planning. In addition, capacity assessments were not always recorded as completed (32%) when patients were admitted. This suggests that some patients are not being involved in decision making and that their views are not routinely being sought by clinicians, even when they have the capacity to consent.

We have also found examples of patients subject to the MHA being prevented from choosing whether or not to have treatment and care, as well as how and where this is provided. As a result, we are concerned that the safeguards in the Act, which are there to make sure patients are involved where possible in their care, are not being effectively applied.

The above failings by some services in applying the MHA may limit people's recovery, and could result in longer stays in hospital for patients. This has implications not only for the individual, but across health and care sectors which are facing financial challenges with many NHS providers operating at a deficit.[17,18]

Many of these issues could be addressed with better training of staff, so that they fully understand the Code and how this applies both to their role and to the patients in their care. This should be addressed by providers across all of their services and by senior managers within individual services. As part of the integration and alignment of our MHA monitoring visits with our mental health comprehensive inspection programme, we will be able to make better judgements on how well-led a provider is in respect of this and other aspects of the MHA. Initial analysis suggests that providers who have fewer challenges in implementing the Code are generally well-led overall.

We expect providers to be working in collaboration with local partners. However, we found a lack of monitoring and reporting on the way the Act is applied, that creates a barrier to using the intelligence from the MHA to change practice. This results in challenges between local services and stakeholders including

commissioners, providers, and advocacy and emergency services.

Our report looks at the period just before the revised and strengthened Code came into force on 1 April 2015. As this has very few 'new' requirements, we have measured our findings against the previous expectations on services. Where our report has identified failures, we are even more concerned about services meeting the standards in the 2015 Code and deliver better care for patients, their families and carers.

This year's report again highlights the same issues as we have found in previous reports. For example, problems with involving people in decisions about their care, awareness of advocacy services, issues with consent to treatment practices, restrictive practices and the way providers were using information from the MHA to inform service plans.

At a time of national commitment to ensuring parity exists for mental health patients, we encourage all sector partners to work together to address the issues we have highlighted. Although we will continue to monitor the way the MHA and Code are being applied, we will not see a real difference to the care provided for patients without the support of other partners. We ask NHS England and the government to look at ways to ensure that collaborative working arrangements are in place across system partners to assess the way the MHA is operating and outcomes for patients.

We also need services to make sure they are assessing their own local monitoring arrangements against the expectations of the Code. The standards and increased clarity in the revised Code should help services to refocus their efforts and improve outcomes for patients who are affected by the Act. However, this cannot be achieved without a number of system-wide improvements and investment in developing the knowledge and understanding of staff.

We have already taken action where we find providers failing to effectively monitor the Act, train staff and support patients, but there is still a lot of work to do and we expect services to focus on:

- Using the findings of this report, and the specific challenges we have included for providers, to reflect on local practice and make improvements.

- Making sure staff have the right skills and knowledge to understand the safeguards that the Act provides and their role in supporting patients to be involved in decisions about their care and recovery.

- Reviewing local governance frameworks to make sure they have information and data on the way the MHA and the Code are being applied across services and using this to decide what action needs to be taken to improve the care and support available for patients.

- Ensuring they are gathering and using information to inform joint action plans and improvements for care, across all sectors and mental health care pathways.

NHS England and the Department of Health must look at ways to ensure collaborative working arrangements are in place across system partners to assess the way the MHA is operating and the outcomes for patients, including the quality of reviews, investigations and learning when patients die while detained.

CQC will

- Ensure that we continue to use our powers as the regulator of health and social care providers in England to drive and encourage improvement in how providers discharge their responsibilities under the MHA.

- Work with national partners, including the Department of Health, to evaluate the impact of the Code of Practice for patients, supporting this work with the findings from our MHA activities.

- Review our individual visits and national report methodology for collecting, analysing and reporting on our MHA visits to improve the way we report on underlying causes, patient outcomes and links to Health and Social Care Act regulations.

- Continue to align our MHA functions with our comprehensive inspection programme so that we have a holistic picture of how a provider is discharging their MHA responsibilities across all of their services.

STATE OF CARE
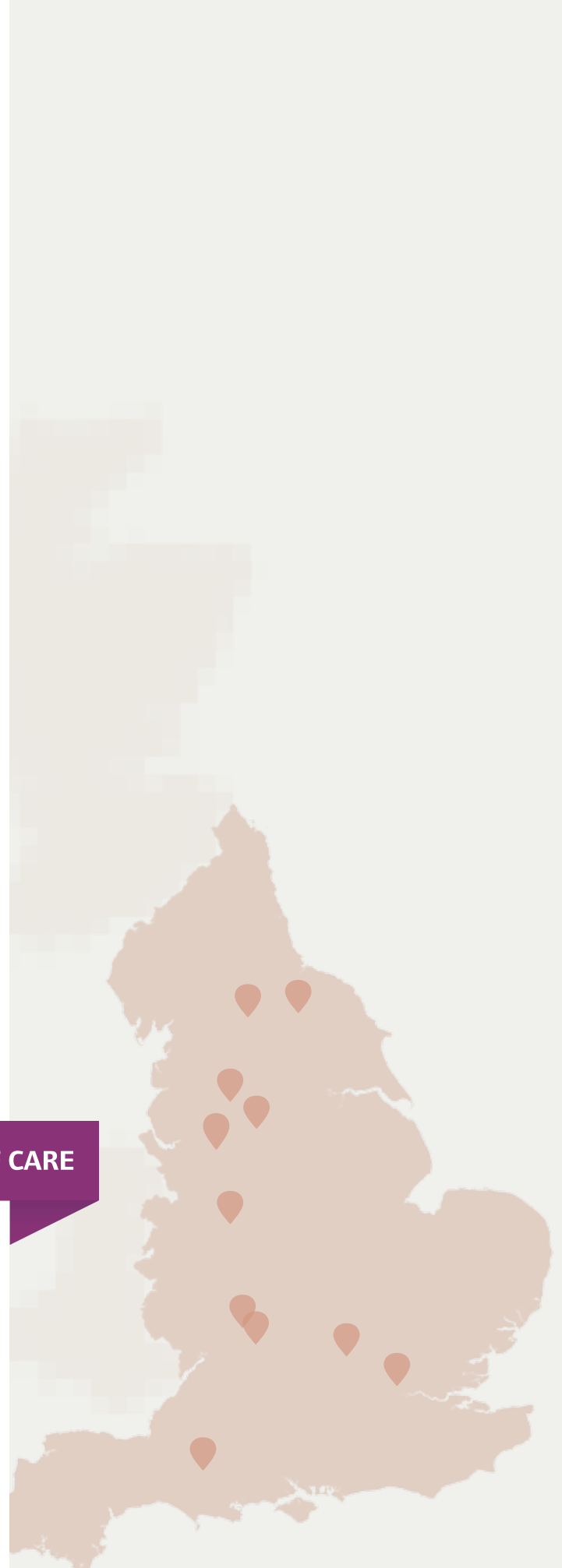
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Appendix A Involving people

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.

From 1 April 2014 to 31 March 2015, we have consulted the Service User Reference Panel members on a range of projects including: the new approach to inspection, MHA annual report, MHA engagement plan and the Mental Health Handbook. Service User Reference Panel members have also reviewed public information about CQC's mental health activity and have facilitated training on the patient's experience of tribunals for the Judicial College.

Some of the members of the 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 an Expert by Experience in our visiting and inspection programme, and we include an Expert by Experience on all of our regulatory inspections.

Mental Health Act External Advisory Group

An external advisory group provided experience and expertise on the approach and scope of this Mental Health Act annual report. The group met twice in 2015, offered comment and advice on the themes and issues covered by the report, and reviewed draft copies.

CQC is grateful for the time, support, advice and expertise given to the report by the group. The members are:

- Anthony Beschizza, Central and North West London NHS Foundation Trust
- Guy Davis, East London NHS Foundation Trust
- Paul Farrimond, NHS Providers
- Dorothy Gould, National Survivor User Network (NSUN)
- Netta Hollings, Health & Social Care Information Centre
- Ian Hulatt, Royal College of Nursing
- Brenda Jones, Service User Reference Panel
- Dr Judy Laing, University of Bristol
- Matilda Macattram, Black Mental Health UK
- Louise McLanachan, Birmingham and Solihull NHS Foundation Trust
- Zoe Mulliez, Healthwatch England
- Kathy Roberts, Mental Health Provider Forum
- Dave Sheppard, MHA and MCA Law Ltd
- Helen Wildbore, British Institute of Human Rights
- Faye Wilson, Chair of the British Association of Social Workers

The terms of reference for the advisory group can be found by visiting: www.cqc.org.uk/mhaadvisorygroup

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.

		Section 2	Other unrestricted	Restricted	All detained patients
Applications and hearings	Applications	9,729	15,707	3,456	28,892
	Withdrawn applications	839	3,538	1,183	5,560
	Discharges by clinician prior to hearing	3,065	4,734	63	7,862
	Hearings*	6,455	8,607	2,573	17,635
Decision of Tribunal	Absolute Discharge	485	370	109	964
	Delayed Discharge	204	160	0	364
	Conditional Discharge	0	0	323	323
	Deferred Conditional Discharge	0	0	122	122
	Total discharge by Tribunal	690	530	553	1,773
	No Discharge	4,710	6,287	1,425	12,422

Figure 17 Outcomes of applications against detention to the First-tier Tribunal (Mental Health), 2014/15

Source: Tribunal Secretariat

* 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 18 Applications against community treatment orders to the First-tier Tribunal (Mental Health), 2014/15

	Number
Applications	4,349
Withdrawn applications	834
Full hearings (with patient present)	3,629
'Paper' hearings (without patient present)	486
Discharges by Tribunal	165
No discharge by Tribunal	3,238

Source: Tribunal Secretariat

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

Under the Health and Social Care Act 2008, providers must notify the Care Quality Commission (CQC) of all deaths of detained patients or those liable to be detained. NHS England and clinical commissioning groups have access to a wide range of data about deaths and serious incidents requiring investigation, but detained patients are not identified as a specific group in this data. Data relating to suicides are also collected from national statistics by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

In previous reports, we have highlighted that more work is needed to improve the accuracy and detail of the data on deaths. As a result, all the figures on deaths should be read with the awareness that they may change depending on future information or review. This is because the figures are extracted from a live database, at a specific point in time, and the data input will be changed when we receive further information from providers, our reviews, inquests and other investigations.

The data we have used to produce the tables in this appendix has been taken from the notification forms that providers return to us. The notification form can be found on our website at: www.cqc.org.uk/content/mental-health-notifications

We also submit data on a quarterly basis to the Independent Advisory Panel on Deaths in Custody. The statistical reports produced by the panel can be accessed on their website: http://iapdeathsincustody.independent.gov.uk/

We piloted information from the Hospital Episodes Statistics (HES) and the Mental Health and Learning Disabilities Data Set (MHLDDS) in last year's report. This additional data allows us to compare our own notifications with other information, including all admissions and deaths within six months of leaving a service. This experimental data continues to be developed, but has been included within this report for information.

CQC data from notifications 2011/12 to 2014/15

Figure 19 Causes of death of detained patients, 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Natural causes	191	200	126	182
Unnatural causes	36	48	36	34
Undetermined (including those reported as open verdicts by coroners)	9	27	36	11
Total	**236**	**275**	**198**	**227**

Figure 20 Cause of death of detained patients (natural causes), 2011/12 to 2014/15

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

Figure 21 Age at death of detained patients (natural causes), 2013/14

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

	2013/14	2014/15
20 and under	0	0
21 to 30	3	3
31 to 40	6	5
41 to 50	15	8
51 to 60	21	19
61 to 70	29	36
71 to 80	27	49
81 to 90	20	52
91 and over	5	8
Date of birth not known	0	2
Total	**126**	**182**

Figure 22 Cause of death of detained patients (unnatural causes) 2011/12 to 2014/15

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

Figure 23 Age at death of detained patients (unnatural causes), 2013/14

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

	2013/14	2014/15
20 and under	3	2
21 to 30	7	9
31 to 40	11	9
41 to 50	5	5
51 to 60	5	6
61 to 70	0	0
71 to 80	3	1
81 to 90	2	0
91 and over	0	0
Date of birth not known	0	2
Total	**36**	**34**

Figure 24 Causes of deaths of detained patients where restraint used within seven days before death

	2011/12	2012/13	2013/14	2014/15
Natural	7	9	1	6
Hanging/self-suffocation	0	2	0	1
Jumped from building	0	1	1	0
Accident	0	0	0	1
Unascertained	0	2	0	0
Awaiting information	0	4	2	2
Total	7	18	4	10

Community treatment order (CTO) patients 2011/12 to 2014/15

Figure 25 Deaths of CTO patients by cause

	2011/12	2012/13	2013/14	2014/15
Natural causes	27	26	21	29
Unnatural causes	10	9	7	15
Undetermined	2	10	6	2
Total	**39**	**45**	**34**	**46**

Figure 26 Cause of death of CTO patients (natural causes), 2011/12 to 2014/15

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

Figure 27 Cause of death of CTO patients (unnatural causes), 2011/12 to 2014/15

	2011/12	2012/13	2013/14	2014/15
Hanging	3	2	1	5
Jumped before vehicle / train	1	1	1	2
Jumped from building	2	1	1	1
Self-poisoning	1	1	1	1
Drowning	1	2	1	2
Self-strangulation	0	0	1	1
Self-suffocation	0	1	0	0
Method unclear	2	0	0	1
Accidental	0	1	1	1
Unsure accident / suicide	0	0	0	1
Total	**10**	**9**	**7**	**15**

Glossary

The following are definitions of some of the key terms used in
our report, taken from the glossary of Mental Health Act terms in
Annex A to the MHA Code of Practice.*

Absence without leave (AWOL)	When a patient absconds from legal custody, i.e. when a detained patient leaves hospital without getting permission first or does not return to hospital when required to do so; when community treatment order patients and conditionally discharged restricted patients do not return to hospital when recalled, or leave the hospital without permission after they have been recalled.
Advance statement	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.
Aftercare (also known as section 117 aftercare)	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.
Application for detention	An application made by an approved mental health professional, or a nearest relative, under part 2 of the Act for a patient to be detained in a hospital either for assessment or for medical treatment. Applications may be made under section 2 (application for admission for assessment), section 3 (application for admission for medical treatment) or section 4 (emergency application for admission for assessment).
Approved mental health professional (AMHP)	A social worker or other professional approved by a local authority to carry out a variety of functions under the Act.
Blanket restriction	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.
Capacity	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.

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*   www.gov.uk/government/publications/code-
     of-practice-mental-health-act-1983

Carer	An adult who provides or intends to provide care for another adult, except where this is their professional role.
Child and adolescent mental health services (CAMHS)	Specialist mental health services for children and adolescents, including inpatient units for children and young people with mental illness staffed with a multidisciplinary workforce with specialist training in child and adolescent mental health.
Community treatment order (CTO)	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.
Compulsory treatment	Medical treatment for mental disorder given under the Act, which may be against the wishes of the patient.
Deprivation of Liberty Safeguards	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.
Detention	Unless otherwise stated, being held compulsorily in hospital under the Act for a period of assessment or medical treatment. Sometimes referred to colloquially as 'sectioning'.
Detention for assessment	The detention of a person in order to carry out an assessment. Can normally only last for a maximum of 28 days. Also known as 'section 2 detention'.
Detention for medical treatment	The detention of a person in order to give them the medical treatment for mental disorder they need. There are various types of detention for medical treatment in the Act. It most often means detention as a result of an application for detention under section 3 of the Act. But it also includes several types of detention under part 3 of the Act, including hospital directions, hospital orders and interim hospital orders.
Electroconvulsive therapy (ECT)	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.
Equality Act 2010	A law making it unlawful (either directly or indirectly) to discriminate against a person on the basis of a protected characteristic (as defined in that Act). Imposes a public sector equality duty on public bodies.
European Convention on Human Rights (ECHR)	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.
First-tier Tribunal (mental health)	See Tribunal

Gillick competence	This term refers to a child under the age of 16 who is considered to have sufficient understanding and intelligence to enable them to understand fully what is involved in a proposed intervention that requires consent, including admission to hospital and medical treatment, and who is therefore competent to consent to that intervention. A child may be unable to make the particular decision in question due to their mental condition or because they do not have the maturity to do so: they are not 'Gillick competent'.
Guardianship	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).
Holding powers (section 5)	The powers in section 5 of the Act which 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.
Hospital managers	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.
Independent Mental Health Advocate (IMHA)	An advocate available to offer help to patients under arrangements which are specifically required to be made under the Act.
Informal patient	Someone who is being treated for a mental disorder and who is not detained under the Act.
Leave of absence (also known as section 17 leave)	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.
Long term segregation (LTS)	Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a patient is not allowed to mix freely with other patients on the ward/unit on a long term basis. In such cases, it should have been determined that the risk to others is not subject to amelioration by a short period of seclusion combined with any other form of treatment; the clinical judgement is that if the patient were allowed to mix freely in the general ward environment, other patients or staff would almost continuously be open to potentially serious injury or harm.

Mechanical restraint	Mechanical restraint is a form of restrictive intervention which 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
Mental Capacity Act 2005	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.
National Preventive Mechanism (NPM)	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.
Nearest relative	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.
Neurosurgery for mental disorder (NMD)	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.
Place of safety	A place in which people may be temporarily detained under section 135 or 136 of the Act, as defined in section 135(6).
Responsible clinician	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.
Provider	Either an NHS or an independent sector hospital.
Seclusion	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 which is likely to cause harm to others.
Second Opinion Appointed Doctor (SOAD)	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.
Tribunal	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 which has the power to discharge patients from detention, community treatment orders, guardianship and conditional discharge.

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