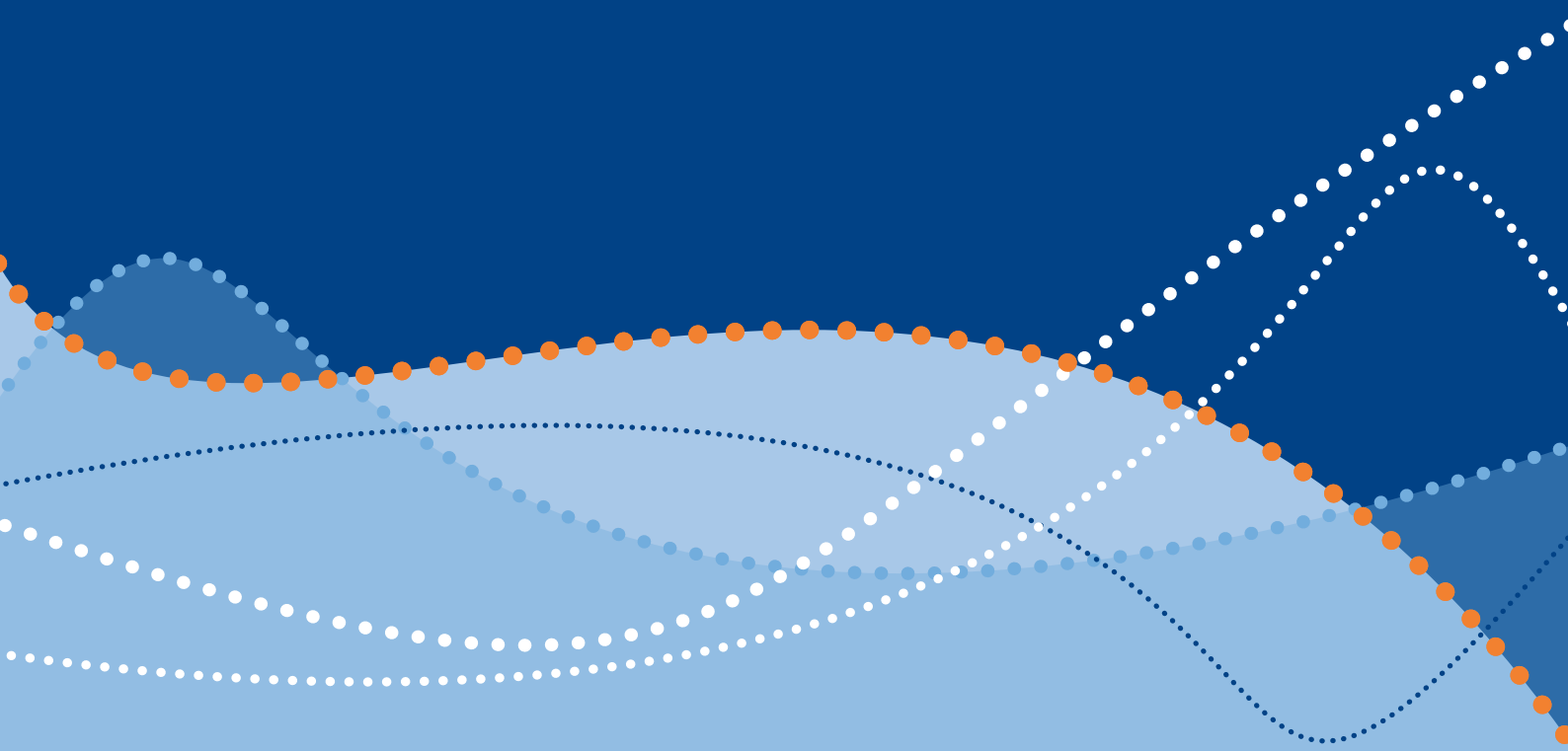
Care Quality Commission

Monitoring the **Mental Health Act** in **2013/14**



Care Quality Commission

Monitoring the Mental Health Act in 2013/14

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

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Foreword

UNDER THE MENTAL HEALTH ACT 1983 (MHA), THE CARE QUALITY COMMISSION (CQC) HAS A DUTY TO MONITOR HOW SERVICES IN ENGLAND EXERCISE THEIR POWERS AND DISCHARGE THEIR DUTIES IN RELATION TO PATIENTS WHO ARE DETAINED IN HOSPITAL OR SUBJECT TO COMMUNITY TREATMENT ORDERS OR GUARDIANSHIP.

The primary purpose is to provide a safeguard for individual patients whose rights are restricted, and to review how legal powers of compulsion are being used.

In 2013/14, we started work to integrate or align our MHA monitoring responsibilities with our new approach to regulation. We are redefining how we discharge our duties under the MHA to ensure that we have both better oversight of the MHA and better regulation under the Health and Social Care Act 2008. This work is underpinned by a clear and unambiguous purpose – to make sure that health and social care services provide people with safe, effective, compassionate and high-quality care, and to encourage care services to improve.

Over the last year, we have made good progress against our 2013–16 strategy, *Raising standards, putting people first*. We established our specialist sector for mental health, including my own appointment by our Chief Inspector of Hospitals, and introduced eight dedicated, regional mental health inspection teams. When we inspect specialist mental health services, one of our key lines of enquiry is whether people subject to the

Act are assessed, cared for and treated in line with the MHA and the Code of Practice. Continued breaches of the MHA can limit the rating we give to services or providers. We also developed specific MHA prompts for inspections of acute hospitals and community health services.

Our regional mental health inspection teams include full-time Mental Health Act Reviewers, who undertake the work previously carried out by the Mental Health Act Commissioners. We tested how best to use the expertise of the Mental Health Act Reviewers during the pilots of our new inspection approach. In 2015, we will be carrying out work to evaluate our approach to our regular MHA monitoring visits, which take place outside of inspections. This includes how we report what we find on the visits and how we take action to address concerns.

Through our new approach we saw great variation in the quality of care provided to people accessing health and social care services. This is a message that we have repeatedly reported for people subject to the Act in our previous MHA annual reports. We will continue to shine a spotlight on services that fail to recognise the impact of their systems and processes on this patient group.

Early findings and feedback about these new ways of working are promising. Our inspectors and MHA Reviewers benefit from closer joint working. Also, people who use services and staff tell us that they like to see this greater coherence between out MHA monitoring and our inspection programme.

In this year's report we reflect on the lifetime of the MHA and our role as an independent safeguard protecting patients affected by the MHA. One of our key powers under the Act is to make formal proposals to the Secretary of State for changes to the MHA Code of Practice. In 2013/14, we provided our most detailed external consultation return to date on proposed changes to the Code. This highlights how highly we regard the Code in relation to our duties as a patient safeguard. The Code of Practice, which the Department of Health published in January 2015, incorporates many of the changes we recommended to strengthen it and offer better care to all those affected by the MHA.

While we recognise the improvements made, there remain areas of serious concern for people who are subject to the MHA. For example, this year we found that one in five people detained under the Act have no record of having their rights explained to them. It is unacceptable that we were unable to find evidence that patients have been given their legal rights, or offered an opportunity to discuss these, in so many cases.

Other areas for concern include people being managed away from home when they can't access local services, the understanding of people and their families of their legal rights and the way providers and commissioners are using MHA data to inform their service planning. These issues are of great importance to our role as a regulator and in discharging our MHA monitoring and our National Preventive Mechanism functions.

One of the emerging themes that we highlighted in our State of Care report 2013/14 was the variation in quality and safety of care received by people. Alongside this, we are aware of the increasing financial challenges in health and social care. In this report, we look at some of the ways that staffing and resource issues may directly impact on MHA patients. Going forward we will be looking at how we can collect intelligence on the effect on local services.

Paul Lelliott

Deputy Chief Inspector of Hospitals (Mental Health)

Summary

THIS YEAR MARKS THE 30TH ANNIVERSARY OF MONITORING OF THE MENTAL HEALTH ACT (MHA) AND FIVE YEARS SINCE CQC BECAME RESPONSIBLE FOR KEEPING THE MHA UNDER REVIEW.

Since 2009, uses of the MHA have grown. At the end of 2013/14, there were 23,531 people subject to the Act, either detained in hospital or under a community treatment order. This represents an increase of 6% from 2012/13. As the number of detained patients continues to increase, we continue to make sure that health and social care services provide them with safe, effective, compassionate and high-quality care.

During 2013/14, we carried out 1,227 MHA monitoring visits, meeting more than 4,500 patients, and our MHA Reviewers carried out 174 inspections with the mental health inspection teams. Our inspections highlighted the variation of care provided to detained patients. Too often we found services that are not routinely involving patients in their treatment. In addition, we are concerned with the issue of bed availability and the increasing number of patients being detained far away from home.

Independent Mental Health Advocacy (IMHA) services are an important safeguard for detained patients. However, we found that many local authorities are not conducting a needs assessment before commissioning these services. This is worrying and could mean that not everyone who needs it has access to an advocate. We are also concerned that we are still seeing examples of poor practice in restrictive practices, particularly seclusion and long-term segregation.

CQC is committed to further strengthening our inspection and monitoring approaches for the MHA.

Providers must ensure that people, and their families or carers, understand their legal rights and are involved in their treatment. Local policies, training and audits should help staff to understand the specific needs of people and their families or carers, while hospital managers should work jointly with other services, including local IMHA providers. Following the publication of the revised Code of Practice in January 2015, we also encourage all providers and commissioners to work together to develop a plan for implementing the new Code that will improve the experience and outcomes for people subject to the MHA.

In addition, CQC expects commissioners and providers to use the local data available from the use of the MHA and work together to plan services that meet the needs of patients. They should pay particular attention to the issues we have highlighted in this report. We also encourage services to look at their systems and make sure that providers are completing returns to national datasets. This information is essential to help inform local and national improvements to patient care by policy makers, commissioners and providers who use the data to understand the state of care for people affected by the Act.

CQC is committed to further strengthening our inspection and monitoring approaches for the MHA.

As part of our comprehensive inspections we will review providers' application of the MHA, and assess their governance systems and processes. We will look at how we can use our new approach to meet a wider range of people affected by the MHA. Our inspection teams will look at how the MHA is being delivered. This includes reviewing how providers monitor their use of the MHA, such as carrying out audits for local needs assessments. We will be looking for evidence that the issues we raise through our inspections, on behalf of patients, are considered by board members and used to inform local action plans. And we will review our MHA monitoring visits so that they are more focused on patient rights, the experience of being detained and the principles of the MHA.

We will continue to monitor the implementation of the revised Code of Practice. We will work with the Department of Health and others to learn from Code of Practice consultation responses, and to shape our own approaches to regulating and monitoring the MHA. Many of the proposals for change we made to the Department of Health during the consultation are reflected in the new Code. These changes should help patients to understand what happens when they are detained under the MHA, and to challenge services when they do not receive good care.

We are aware of the increasing financial challenges in health and care services. As a result, we will be looking at how we can understand the impact of these on local services going forward. We will also continue to review how we evaluate our MHA activities, how we can continue to improve our role, and how we can encourage improvement for patient care as a result.

Introduction

THIS IS THE FIFTH ANNUAL REPORT BY THE CARE QUALITY COMMISSION (CQC) ON OUR MONITORING ACTIVITIES OF THE MENTAL HEALTH ACT 1983 (MHA).

Since CQC was formed in 2009, we have carried out a range of activities each year in our role to ensure the general protection of patients affected by the MHA. We acknowledge and applaud services that operate with a patient-centred approach to their application of the Act, detaining patients for the minimum amount of time, and taking steps to make sure that patients are involved and understand their legal rights. This includes services that make every effort to support patients in involving those close to them in their care, and working, from the initial detention, to make sure that patients are supported in their recovery.

In this report, we highlight concerns that people are not always treated with this level of respect, and that recovery is restricted by a lack of focus on self-management of medication and promoting patient choice. This is not acceptable and we will hold providers to account and take regulatory action as appropriate, if we find this to be true of their service.

We are reviewing the way we discharge all our MHA responsibilities and have made progress in integrating and aligning our regulatory responsibilities under the MHA and the Health and Social Care Act. We are already seeing the benefits of including MHA expertise from staff in our regulatory inspections, particularly in respect of reviewing governance systems and processes. We set out in this report the ways we expect our MHA role to be strengthened through the integrated approach to regulating and monitoring.

This year saw the first review of the MHA Code of Practice since CQC was formed. This has provided us with an opportunity to review what we know from the work we have carried out in the last five years, as well as look at where we think our work has highlighted the biggest gaps between legislative intent and practice for patients. This opportunity has also made us look at the ways we support the national policy agenda for MHA patients and what we can do to improve the way our findings are used in future developments.

Through the patient focus of our role, the MHA offers us a unique insight into the issues that matter to individuals when receiving services. Our findings demonstrate some of the effects that our MHA activities have on services, and MHA Reviewers' ability to be patient-focused and work with providers to encourage improvements for people who are subject to the MHA. MHA Reviewers may use our combined powers under the MHA and Health and Social Care Act to respond to concerns. They can require services to provide an action statement using the MHA or work with the inspection team to take enforcement action if they find serious failures in services.

Through the patient focus of our role, the MHA offers us a unique insight into the issues that matter to individuals when receiving services.

To improve services we are continuing to strengthen our approach to the MHA. Our priorities will be highlighting variation, and carrying out greater scrutiny when failures to deliver high-quality care have an impact on this specialist group of patients. We are prioritising and focusing our efforts on the new ways we can support but also challenge services when we find poor care, and how we can encourage them to improve.

1

CQC and the Mental Health Act

THIS YEAR MARKS CQC'S FIFTH YEAR OF MONITORING THE MENTAL HEALTH ACT 1983 (MHA) AND 30 YEARS SINCE THE INTRODUCTION OF THE ACT.

It is therefore an appropriate time to reflect on the changes and improvements to services during this period. This includes the impact of having an independent monitoring body and looking at the issues that people using services still experience.

In producing this report we reviewed the content from the first biennial report, published by our predecessor body the Mental Health Act Commission in 1985.[1] While there have been improvements to patient care and support, some of the issues in the first report remain an all too familiar story for people detained using the MHA today.

This section looks at the changes to the MHA over the last 30 years and our role in keeping the Act under review, including activities completed through our inspections, review visits, complaints about the MHA and the Second Opinion Appointed Doctor (SOAD) service.

1.1 Monitoring the MHA

- In the 30 years since the introduction of the Act, protecting the rights of patients has been the driver for the independent monitoring of the MHA.
- While there have been improvements to patient care and support during this time, it is unacceptable that we are still seeing some of the same issues reported by the Mental Health Act Commission in 1985.
- We have a unique role in requiring actions and using our enforcement powers where we find failures in local services. Through integrating our MHA monitoring role with our role as a system-wide regulator, today we are better able to hold providers to account.
- Our approach to MHA visits is patient-driven, with the patient telling us what they would like to cover in our interviews. We will maintain this patient focus but also improve our MHA data collection so that we are better able to set benchmarks of good care for providers, and use our increased knowledge to influence policy and legislative changes for the benefit of patients.

Five years of CQC monitoring

CQC was established under the Health and Social Care Act 2008. As well as being the quality regulator for health and social care, we have a statutory duty to monitor the use of the MHA and we are designated as the National Preventive Mechanism (NPM) against torture and ill-treatment of people detained in health and social care establishments.

Establishment of an NPM is a legal requirement for states who are signatories of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), an international human rights treaty designed to strengthen the protection of people deprived of their liberty. The treaty acknowledges that detainees are particularly vulnerable to ill-treatment and advocates that efforts to end ill-treatment focus on prevention through a system of independent and regular visits to all places of detention. The NPM's annual report provides more details on the work completed by the NPM in 2013/14. This includes two fact sheets: *Introducing the UK's National Preventive Mechanism* and *The First Five Years of the UK NPM*.[2]

Since 2009, we have incorporated monitoring of the MHA into our role as a system-wide regulator. While we still undertake MHA-specific monitoring visits, with 1,227 carried out last year, we now also look at the MHA during our regulatory inspections. The knowledge and expertise of MHA Reviewers is used during our regulatory inspections to form judgements about the quality of care. From 2014, the comprehensive inspections we carry out in mental health services always include MHA expertise.

As a result of this integration, today we are better able to hold providers to account and to take action when we find failings that are having an impact on the care and treatment of people affected by the MHA.

The changes we have been making to our inspections and our monitoring of the MHA have used evidence that we have gathered over the last five years. These changes are focused on protecting patients. For example, our review of individual activities highlight issues for a particular patient and seek resolution with providers. This helps inform our Intelligent

Monitoring. This is a new tool we have built to look at the data (or indicators) that help us to decide if a service is safe, effective, caring responsive to people's needs and well-led.

Through the MHA evidence that we gather across all our activities, we can also look at ways to improve patient care for all. We routinely do this through our annual report, but this year we have also used our findings to influence the changes in the latest revision to the MHA Code of Practice.

Our current model for MHA visits is patient driven, with the patient telling us what issues they would like to cover in our interviews. This is an important focus of our approach and we would not seek to change this. However, our new model will also look at how we use the data we hold on the MHA. This will improve our ability to benchmark services and improve our understanding about how the MHA is being used for different settings. In turn, we will be able to use this knowledge to influence policy and legislative changes for the patient groups we protect.

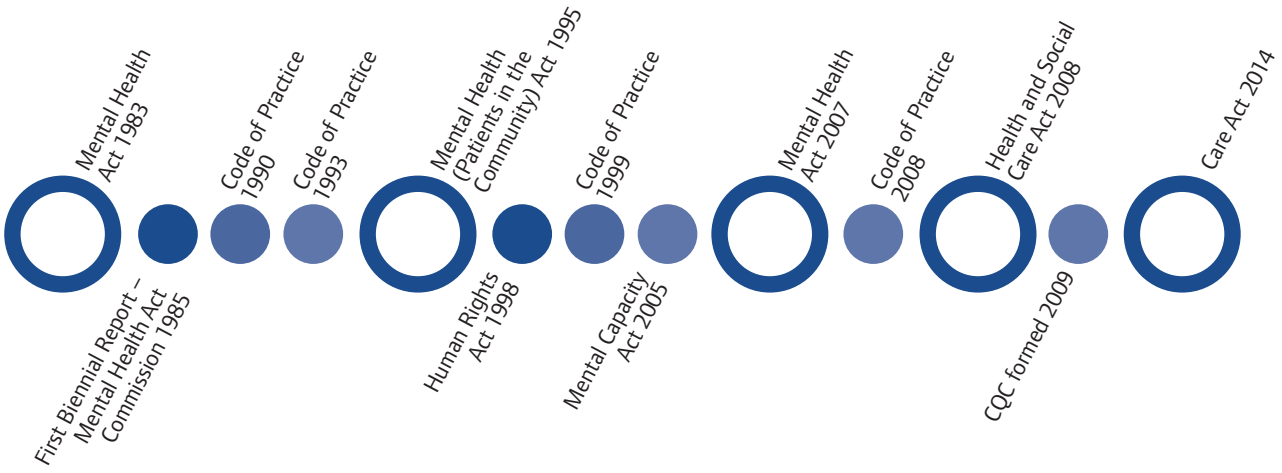
Thirty years of monitoring the MHA

Since its introduction in 1983, the MHA has been periodically reviewed to reflect the changes in mental health care and legislation, such as the Human Rights Act 1998. Information from MHA monitoring activities has been used to inform and influence each of these reviews. Figure 1 highlights some of the developments and impacts on the MHA since 1983.

Protecting people's rights has been the driver for the independent monitoring of people detained in hospital, on community treatment orders or subject to guardianship over the last 30 years. In our MHA role, we act as a safeguard for patients and encourage services to improve and report on the national picture to help drive legislative, practice and policy changes. Since 1983, CQC and previously the Mental Health Act Commission have acquired a number of new powers and roles. As well as broadening our work and focus, these have complemented our MHA duties. This includes our role as a regulator of services and as the National Preventive Mechanism to prevent ill-treatment for anyone deprived of liberty in mental health settings.

We are keenly aware that we are operating in a very different environment to when MHA monitoring visits were originally introduced. We are now one of many independent agencies, such as Healthwatch, who may visit the areas where people are detained, and the Independent Mental Health Advocacy service that provides statutory advocacy for patients who are subject

FIGURE 1: Developments and impacts on the MHA 1983 to 2014



to the MHA. However, we remain the only agency to have a legal duty to keep the MHA under review and investigate poor care when we think appropriate. In addition, over the last three decades CQC and previously the Mental Health Act Commission have had unrestricted access to settings where people are being detained and attended, with a focus on the experience of patients who are detained using the Act.

Uniquely, we are able to issue recommendations and require action statements when we find failures in local services. We do this using our MHA monitoring functions and enforcement powers under the Health and Social Care Act 2008 and associated regulations. We are also the only organisation that has a statutory power to make formal proposals to the Code of Practice. We do not underestimate the level of influence we have on the safety and quality of care for people subject to the MHA, and we are committed to continuing to review and refine our methodology for carrying out our monitoring role for the benefit of patients affected by the MHA.

We do not underestimate the level of influence we have on the safety and quality of care for people subject to the MHA.

We have been learning from our new approach to inspections, and looking at how we can continue to increase our understanding of areas that are having an impact on the application of the MHA and the Code of Practice. This includes, for example, the impact of increasing demand for independent sector beds on patients and services as the number of NHS beds available decreases.

We have committed to reviewing the operating model for both our monitoring functions under the MHA and our regulatory inspection model between 2014 and 2016 for mental health services. We want to keep the parts that we believe have the most impact on patients and outcomes – for example, our expert MHA Reviewers and regulatory inspection staff speaking with patients. We also want to look at how our activities can play the most effective role in the very different health and care landscape we operate in today.

Update on the 'five key areas of action'

In our 2012/13 report, we set out five key areas of action for CQC in respect to the MHA. These were aligned to our 2013 to 2016 corporate strategy, *Raising standards, putting people first*.[3] Throughout the year we have worked with other agencies across all these areas, and we will continue to focus on these areas until 2016. A full review of these actions will be published in our 2015/16 report, but below is a short progress update.

Use of the MHA: We have worked with the Health and Social Care Information Centre to look for ways we can increase providers' use of national data returns, such as the Mental Health Minimum Dataset. This includes using MHA data in our Intelligent Monitoring of mental health providers, and seeing how we can increase reporting against the protected equality characteristics.

We reviewed our own publication of MHA data and how we can increase local interpretation of our findings. This has included the increased use of regional data wherever possible in this report. We will test the impact of this with providers and our inspection teams and will continue to develop it.

Deaths of detained patients: We committed to publishing annually the data we receive from our death of detained patient notifications. Information on the wider policy work we have completed, including our work with the

Ministerial Board on Deaths in Custody, can be found later in this section.

Access to care during a mental health crisis: We published our map of local health-based places of safety in April 2014. We are progressing with our crisis care thematic programme; this is expected to complete later in 2015. We have also been involved in the steering group for the Department of Health and Home Office joint consultation on Sections 135 and 136.

Complaints about the MHA: Last year we set out our plans to look at the way MHA complaints are addressed locally, and the system-wide learning from our own complaints reviews and investigations. An update on the progress so far and our next steps appears later in this section. We will be publishing annual data in all our future reports.

Involving people who use services: All our comprehensive inspections now include people who use services acting as Experts by Experience. During 2013/14 we regularly met with our Service User Reference Panel, and their views directly informed our response to the MHA Code of Practice review. We are looking at ways we can involve people who use services more in our MHA work, including helping us to review our MHA approaches and our own implementation of the Code of Practice.

We have made sure our inspection teams carry out specific activities to involve people affected by the Act. We have committed to increasing public awareness of MHA issues by combining our MHA inspection and findings from our regulatory inspections in a single report. Over the next 12 months we are reviewing whether this can be improved. We have also been working with Healthwatch England on their special inquiry into unsafe discharges.

1.2 CQC monitoring activities 2013/14

- Monitoring visits are a key way that we keep the Act under review. In 2013/14 we carried out 1,227 MHA visits, meeting with over 4,500 patients and our MHA Reviewers carried out 174 inspections with the mental health inspection teams.
- We have continued to strengthen our involvement of the public through our Service User Reference Panel and MHA Advisory Group.
- In 2013/14, we received 1,016 complaints about the Act, an increase of nearly 15% since 2012/13. We are committed to keeping complaints under review and ensuring we share learning from this with others.
- A key focus of our work during 2013/14 was making recommendations for changes to the MHA Code of Practice. We formulated our proposals from patients' experiences and other sources, and outlined where we believe the Code needed to be clearer and stronger.
- We expect services to make sure that staff understand their responsibilities under the Code and that they address any gaps in practice highlighted by the new guidance following its publication in January 2015.

The MHA requires us to review the application of the MHA by visiting hospitals and meeting with patients, providing the Second Opinion Appointed Doctor (SOAD) service, withholding of mail and complaints about the MHA. We also have a power to make proposals for change to

the MHA and Code of Practice. This section reviews our activities under these areas in 2013/14, as well as our involvement of our Service User Reference Panel and Experts by Experience.

Overview

In 2013/14, we carried out activities with more than 18,000 people subject to the MHA through our MHA roles. A summary of our activities over the last year is outlined below.

MHA activity during 2013/14

- 4,517 detained patients interviewed by a MHA Reviewer.
- 175 patients on a community treatment order interviewed by a MHA Reviewer.
- 13,645 patients assessed by our Second Opinion Appointed Doctors.
- 1,227 MHA visits completed and reports issued to providers.
- 174 inspections included a MHA Reviewer on the inspection team.
- 1,324 mental health wards visited by our MHA Reviewers.
- 24 community treatment order visits.
- 47 seclusion and long-term segregation visits.
- 49 MHA visits to high security hospitals by our MHA Reviewers.
- 1,016 complaints and enquiries about the MHA received and responded to.
- 240 notifications received for patients who died while detained.
- 909 notifications for patients who were absent without leave.

Despite the large number of people we speak to, we are very aware there are thousands more stories and experiences we have not heard. By integrating our MHA activities with our comprehensive inspections we can reach different patient groups, including those who have previously been detained. It will also give us access to new information and intelligence. This will help us to address comments from our Service User Reference Panel who have told us the current model of speaking to people detained under the Act has limitations.

"The only time people will speak out about things that have happened to them as an inpatient is after they have left the hospital. It can help if people know whatever they say to CQC is in confidence, but some people will still be too scared to speak out when they know they have to stay on the ward after CQC have left. For others they may not know what is going on is wrong, and a lack of knowledge only adds to a fear of talking to someone you don't know."

Service User Reference Panel member

We are looking for ways to address these concerns in our future monitoring. This report, however, covers the last period before we introduced our new inspection approach. More details on the information and data we are gaining through our new tools and methodology will be published in next year's report.

Our MHA activities are carried out across providers who have registered with CQC as providing the regulated activity of 'Assessment or medical treatment for persons detained under the Mental Health Act 1983'. In April 2014, there were 290 registered providers offering this service in 1,125 locations. A breakdown of the number of locations per region is included in table 1.

TABLE 1: Number of locations by region in April 2014

Region	Active locations	NHS locations %	Independent locations %
East Midlands	107	66%	30%
East of England	142	71%	27%
London	137	73%	24%
North East	57	82%	18%
North West	148	76%	24%
South East	185	82%	16%
South West	88	78%	18%
West Midlands	121	80%	19%
Yorkshire and the Humber	140	80%	19%
Total	**1,125**	**76%**	**22%**

Source: CQC

Monitoring visits

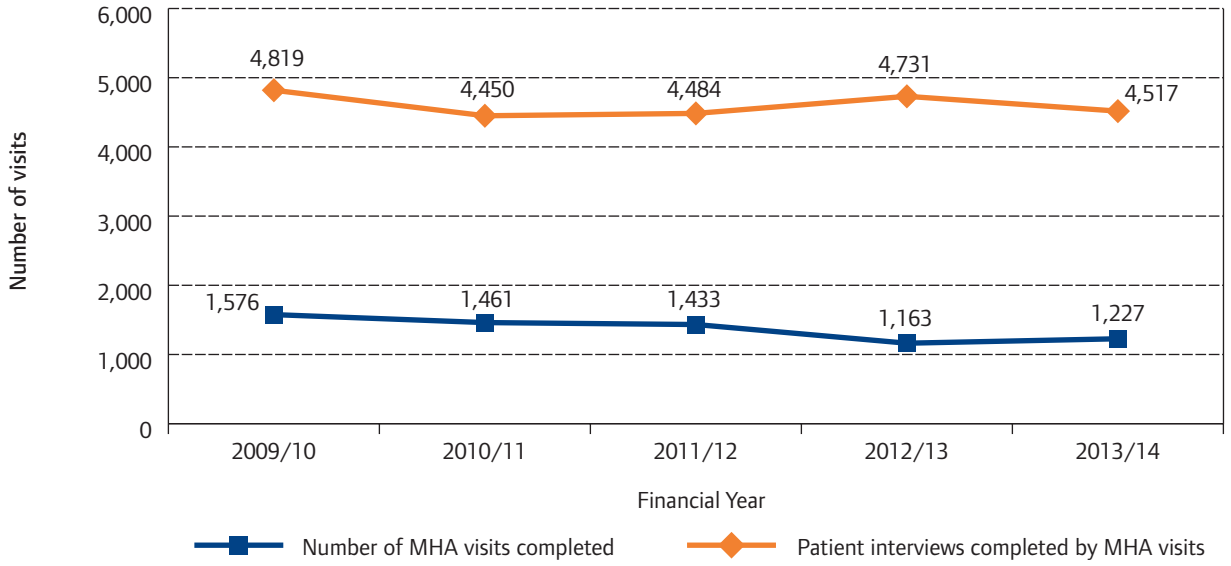
Throughout the year, our MHA Reviewers (previously known as MHA Commissioners) carry out different types of MHA visits, outside our regulatory inspection programme, to keep the MHA under review. MHA Reviewers meet with patients, staff and stakeholders, observe practice and highlight any concerns about how the MHA and Code of Practice are applied. Some MHA visits will have a specific focus (such as seclusion monitoring), but our routine MHA visits, which are usually unannounced, are designed to meet detained patients in private to identify individual issues or concerns, discuss the operation of the Act with professionals, and prepare a report to the provider requesting action to be taken.

On the MHA monitoring visits, we usually meet with patients at the start and ask for their views before identifying the specific areas of focus for the visit. This approach makes sure that we always put the patient at the heart of our activity and helps us to target our visits to the areas of most concern to the patients. Where appropriate we also try to capture good practice examples.

Alongside visits to inpatient wards, we also arrange meetings with mental health professionals, including Approved Mental Health Professionals, and other stakeholders (such as the police, advocacy groups and carers), to look at how people are assessed and admitted under the Act.

Our routine MHA visits are carried out on a cyclical basis and we aim to visit each registered area every 18 months to two years. Last year we made 1,227 visits (1,194 or 97% of which were unannounced) to 1,324 wards and met with more than 4,500 patients. Figure 2 (page 20) compares the number of MHA visits completed in 2009/10 with those in 2013/14. It appears to show a drop in the number of routine visits from last year, but in this period our MHA Reviewers attended 174 inspections under the Health and Social Care Act (table 2, page 20).

FIGURE 2: Number of MHA visits completed and numbers of patients interviewed on visits, 2009/10 to 2013/14



Source: CQC

TABLE 2: Number of Health and Social Care Act inspections completed with a MHA Reviewer by organisation type 2013/14

Location type	Number of Health and Social Care Act inspections completed with a MHA Reviewer
Independent healthcare organisation	91
NHS healthcare organisation	75
Social care organisation	8
Total	**174**

Source: CQC

Regional visits

As part of our activity review for this report, we looked at the regions we have visited over the last year. This is the first time we have reviewed our activity in this way and we are looking at ways our new regional inspection teams can use this information to plan their visits.

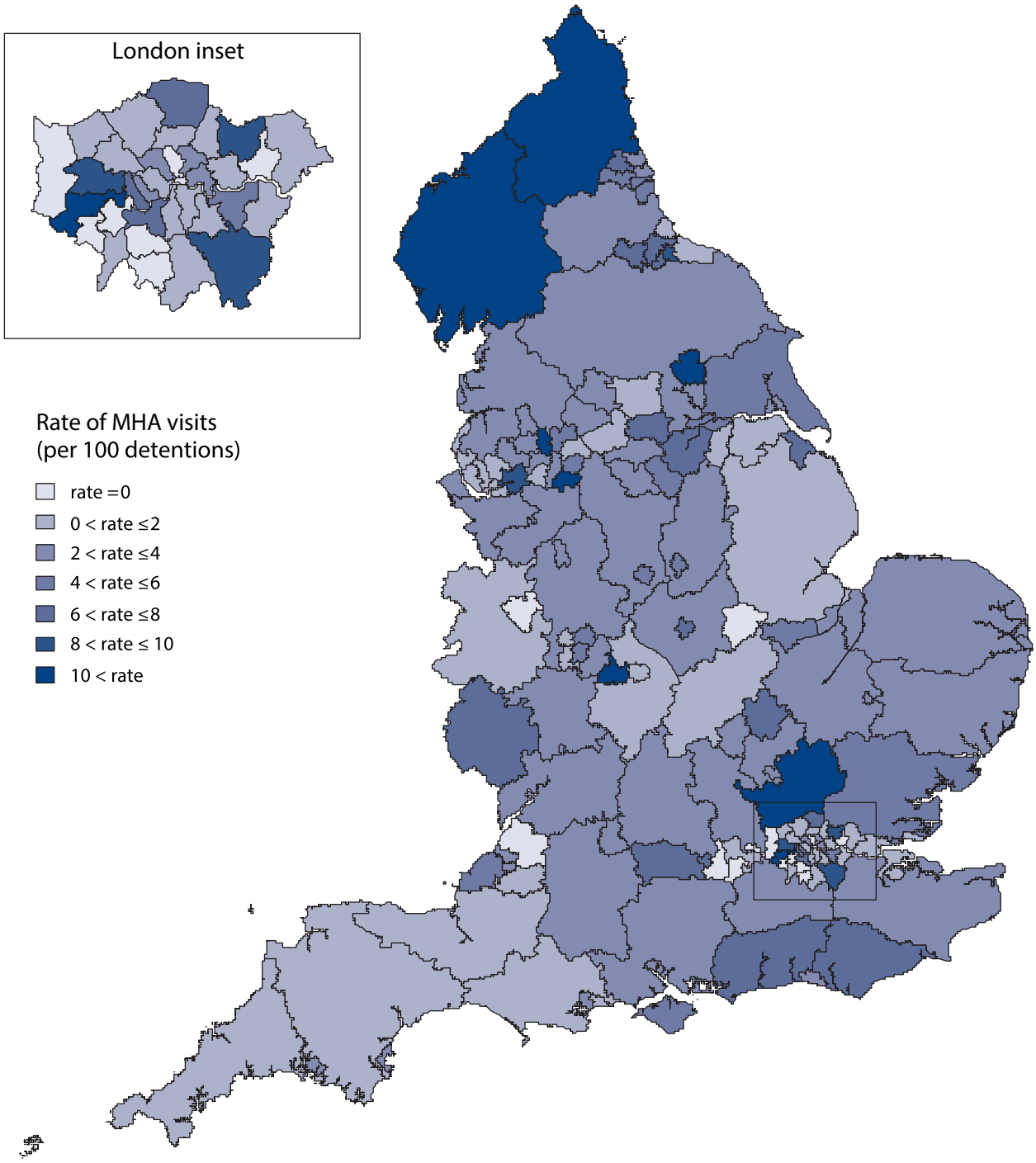
In this first review, we have used the rate of MHA visits per 100 hospital detentions per year, across the 152 local authorities (figure 3). Where a zero rate is recorded this means there is no unit or service in that local authority with detained patients, so we have not carried out a visit.

MHA and comprehensive inspections

From January 2014, regulatory inspections of mental health services have included MHA Reviewers on the inspection team. They work with the inspection team to advise on the system and process issues that are relevant to the MHA. They also hold engagement events with detained patients and interpret the findings of MHA visit reports and data for the services being inspected. During the inspection, they also conduct a MHA monitoring visit to wards.

Inspections completed between January and September 2014 piloted the different ways the

FIGURE 3: Rate of MHA inspections by CQC per 100 hospital detentions across upper tier local authorities in 2013/14



Source: Mental Health Minimum Dataset and CQC

MHA Reviewers may be used in regulatory inspections. We will report on the findings from the inspections in our next annual report when we will have a full year of data available.

These inspections did highlight that the board members and non-executive directors of some NHS trusts and NHS foundation trusts are unfamiliar with our MHA reports, and the emerging themes and issues around quality and safety raised in them. This is unacceptable. The MHA identifies the trusts themselves as the 'hospital managers'. This means that they are responsible for making sure that the MHA is

followed in their service. As a result, leadership teams must be aware of our findings and taking action against the issues and themes we highlight from our discussions with patients.

We will take board and managers' understanding and awareness of our reports into account when rating a service during a regulatory inspection. In particular, it will affect our assessment of whether a service is well-led. We will expect to see evidence that providers are making sure their boards and managers have governance arrangements in place to monitor and review the operation of the MHA in their services. They should also have a system in place to review and respond to our MHA monitoring visit reports.

Involving people who use services

Our 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 Act. Each member is encouraged to share their views on our work and advise us about how we can involve more members of the public.

Some of the members of the 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 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.

Our MHA Advisory Group involves key stakeholders from a range of organisations, including providers and interest groups such as the Survivor User Network. It provides experience and expertise on the approach and scope of our MHA duties. Over the last year, we have continued to work with the advisory group, to seek their opinions and guidance on our monitoring, complaints and the development of our annual report. In May 2014, we increased the number of members of the advisory group and expanded the terms of reference. The new terms of reference are on our website.†

Working with others

Throughout the year, we have been represented on national policy groups to offer our own intelligence and influence policy changes – particularly relating to emergency mental healthcare and deaths in custody.

* Visit: **http://www.cqc.org.uk/content/involving-people-who-use-services** to find out more about our Experts by Experience including how apply to become an Expert by Experience.

† Visit: **www.cqc.org.uk/content/advisory-groups** for more information.

Examples of national policy groups where we have provided intelligence from our MHA activities

- Royal College of Psychiatrists', Quality Network for Forensic Mental Health Services
- Crisis Concordat Steering Group
- Steering group of the Independent Mental Health Advocacy (IMHA) Implementation
- First-tier Tribunal (Mental Health) stakeholder group
- Independent Advisory Panel on Deaths in Custody
- Home Office's Administrative Tribunal stakeholder group
- Department of Health steering group's review of the MHA Code of Practice and Positive and Proactive Care
- Ministerial Board on Deaths in Custody
- Royal College of Psychiatrists Section 136 Working Group

In 2014/15, we continue to work with national agencies to identify new opportunities. This includes the way we use information available on the use of the MHA in our monitoring approaches, and how we can improve sharing our findings in a useable format for local authorities and clinical commissioning groups to support improvements and benchmarking in local services.

Second Opinion Appointed Doctors

We provide the Second Opinion Appointed Doctor (SOAD) service at the providers' request for treatment that needs to be certified under the Act. The role of the SOAD is to decide whether the treatment recommended is appropriate for the patient.

Although we are responsible for ensuring a SOAD service is available for patients, the SOADs who carry out the visits act independently of CQC. This means that while we set standard approaches, provide guidance and offer support, we do not have any powers to determine the outcome of the visits the SOADs make, or try to influence their assessment.

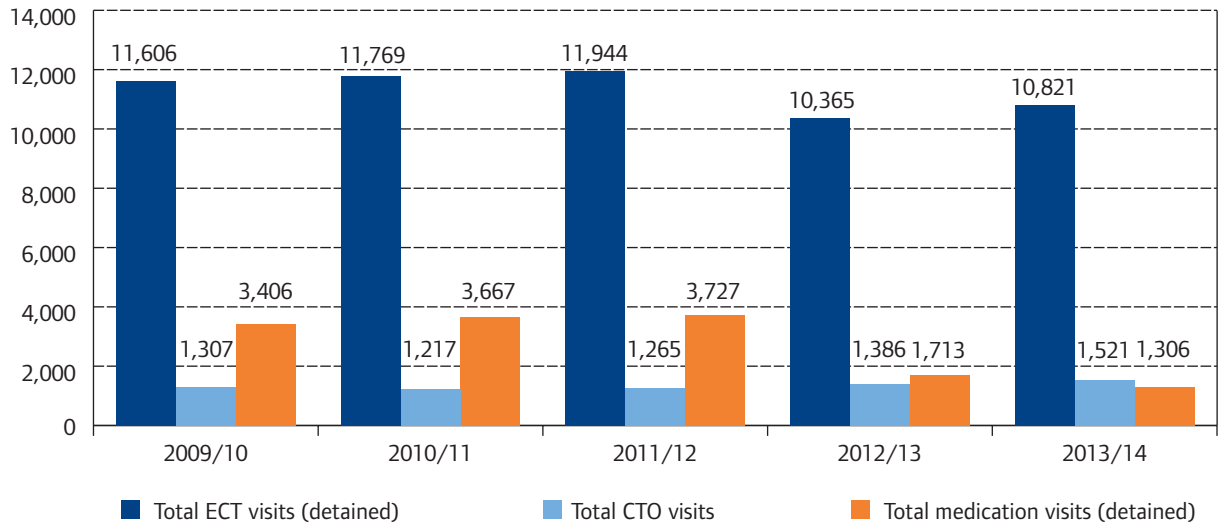
Our SOADs are led by a Principal SOAD. He provides leadership and support across the service, and makes sure that there is quality improvement and ongoing development of the SOAD systems and processes.

Since 1984, the number of SOADs and requests for the service have increased substantially. For example, in 1984 there were 70 psychiatrists appointed to the SOAD panel for England and Wales, which received an average of 183 requests per month.[4,5] In August 2014, there were 120 SOADs on our panel for England, receiving an average of 1,050 requests every month.

Second opinion activity 2013/14

The number of SOAD visits arranged by CQC are shown in figure 4 (page 24). While the overall number of visits to detained patients has not changed since 2009/10, changes in the law relating to second opinions for people under community treatment order have led to reduced demand for CTO second opinions (CTOs).[6]

FIGURE 4: Second opinion visits, 2009/10 to 2013/14



Source: CQC

Figure 5 shows the regional variation in numbers of SOAD visits in 2013/14 against the number of longer-term detentions, lasting over 72 hours, per 100,000 population. The number of SOAD visits and longer-term detention varies for some areas. There are a number of reasons for this including different clinical approaches to consent, which vary across different patient groups, for example people with a learning disability, elderly patients and people with personality disorders. While we have not been able to identify any practical or immediate concerns from this particular variation, we will be using the data from this report to look into this issue further.

The role of the SOAD is to certify treatments that they consider to be appropriate. SOADs do not always certify all of the proposed treatments put forward in a treatment plan. Changes the SOAD may make include not certifying some or all treatments, limiting the dosage on some treatments, and adding or substituting a treatment not featuring in the original plan.

As shown in table 3, treatment plans for detained patients, who are deemed to lack capacity to consent to treatment by the SOAD, were changed in 24% of cases. This was an increase from 22% in 2012/13. There may be a number of reasons a SOAD asks for a treatment plan to be changed. We have previously noted this is more likely to occur when the person is prescribed medication above the recommended dosage of the British National Formulary. This shows how important SOAD visits are in safeguarding against unwarranted treatment.

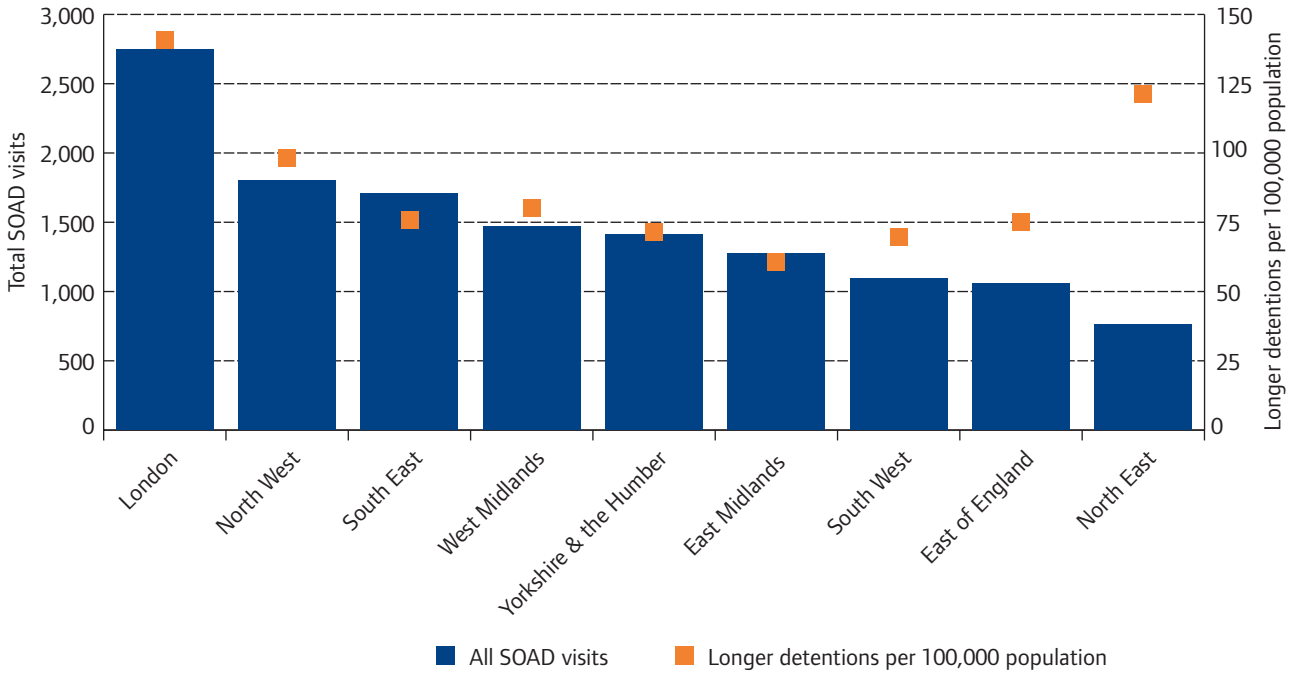
Many of our SOADs report practical difficulties in carrying out their assessments including:

- Access to patient records.
- Contacting other named professionals involved in the patient's treatment plan.
- Incomplete information on the treatment plan for the patient.

This can cause delays in assessments, such as SOADs having to return to sites or carry out additional activities before providing their decision to the clinical team. Providers have a responsibility to make sure that arrangements are in place and routinely reviewed to enable SOADs to carry out their work.

We have begun sharing the intelligence collected by our SOAD service with our inspection teams. This includes where SOADs have encountered

FIGURE 5: Total number of SOAD visits by region and longer detentions (over 72 hours) per 100,000 population 2013 to 2014



Source: CQC and HSCIC

TABLE 3: Changes to treatment following a SOAD visit, patients incapable of consent, 2013/14

	Plan changed	%	Plan not changed	%	Total	
Medication	1,868	26%	5,209	74%	7,077	72%
Electroconvulsive therapy	215	15%	1,201	85%	1,416	14%
Community treatment orders	284	21%	1,067	79%	1,351	14%
Total	**2,367**	**24%**	**7,477**	**76%**	**9,844**	**100%**

Source: CQC

difficulties carrying out the visits and in speaking to professionals involved in patients' care and treatment.

Withholding correspondence

Before the Mental Health Act, hospital doctors had powers to withhold incoming or outgoing mail from any psychiatric inpatient, including informal patients.[7] The 1983 Act specifically abolished such powers in almost all cases, but retained them for patients in high security hospitals. The Mental Health Act Commission, and now CQC, was designated as the body responsible for reviewing decisions to withhold correspondence, and had a broad power to direct that a withheld item should be released (as CQC now does).

We recognise that interfering with a patient's mail is a serious decision and impacts directly on the patient's rights to private and family life. Although the number of appeals we receive is not large, we consider each with great care. Table

4 shows the number of times we received an appeal against withholding of mail, and the number of appeals that we upheld without qualification (that is, where we directed the withheld mail should be released to the intended recipient). A larger number of appeals result in a compromise, for instance where elements of the postal packet are released or alternative arrangements are made that are acceptable to the sender or the intended recipient of postal packages. In 2013/14, four cases were resolved in that way.

We have also carried out audits during visits to the high security hospitals to review and investigate the systems they have in place to support the withholding of patient correspondence. Although the individual appeals allow us to challenge practice with particular patients, reviewing each provider's systems allows us to engage in wider discussion with them. Our inspection managers report that these audits highlight areas that require further investigation with the individual hospital.

Security directions were introduced following the Tilt Review in 2000.[8] These gave high security hospital patients equivalent rights for appealing against the withholding of internal post (that is, letters sent between patients in the hospital) and monitoring of telephone calls. Table 5 shows the outcomes of appeals received since CQC was formed in 2009. These were all received from patients at Rampton Hospital. As with the appeals under section 134, very few are upheld totally (and no appeal against telephone monitoring has led us to require that such monitoring stops immediately). However, in many cases compromise positions are reached or further action is taken to make sure that any interference with patients' rights is minimised. We do not view the exercise of patients' rights of appeal as a negative reflection on the hospital.

Complaints

CQC has a specific duty to review and investigate, if appropriate, complaints about the way providers exercise their powers and duties under the MHA. Our role in receiving and responding to MHA complaints is fulfilled in a similar way to those of the ombudsmen for non-MHA complaints. In our role as a regulator, CQC is not directly responsible for resolving individual complaints about the general quality of care for people who are under the care of the mental health services. This role is carried out by providers and the NHS ombudsmen when the care is provided by or on behalf of the NHS.

TABLE 4: Section 134 withheld mail appeals and outcomes, 1983 to 1985 compared with 2009/10 to 2013/14

	Sept 1983 – August 1985		2009/10		2010/11		2011/12		2012/13		2013/14	
	Received	Appeal upheld	Received	Appeal upheld	Received	Appeal upheld	Received	Appeal upheld	Received	Appeal upheld	Received	Appeal upheld
Ashworth	5	0	1	0	2	–	2	0	1	0	0	0
Broadmoor	2	1	1	0	0	0	4	0	0	0	1	0
Rampton	2	1	6	1	2	0	6	0	10	3	8	1
Total	**9**	**2**	**8**	**1**	**4**	**0**	**12**	**0**	**11**	**3**	**9**	**1**

Source: Mental Health Act Commission (MHAC)/CQC

In 2013/14, there was a national focus across all health and social care complaints including our report *Complaints Matter*, published in December 2014.[9] Our MHA staff have contributed specific learning from MHA complaints to a number of activities, including:

- Submitting evidence to the Health Committee Complaints and Raising Concerns – call for written evidence.
- Working with Healthwatch to look at mapping agencies with a role in complaints across health and social care.
- Responding to the Clwyd-Hart Report: *A Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture*.

The learning from these activities is already building a picture of how complex the health and social care system can be for anyone wishing to make a complaint about the care and treatment they receive. We recognise this becomes even more complicated when the issue relates to the MHA. As a result, in February 2014 we started a review of the way we carry out our duties to improve access and awareness, and to share information with others on the learning from MHA complaints and enquiries.

Part of our review will look at the way we work with external agencies, including the Parliamentary and Health Service Ombudsman and Healthwatch. We want to make sure that we are improving the experience for people who need to make a complaint about the MHA, and that we share intelligence from MHA complaints.

Complaints activity 2009 to 2014

Table 6 (page 28) details the number of enquiries that we have received and dealt with under our MHA complaints function over the last five years. Since 2009, the number of complaints and concerns has risen by 62%. This is a bigger increase than would be accounted for by rising numbers of detentions alone.

Capturing and recording of complaints

For the first three years of our MHA complaints work, at least 90% of complaints were received in writing, by letter or by email. In the last two years we have received an increasing numbers of complaints by telephone, and in 2013/14 telephone contacts made up 60% of enquiries received.

The majority of complaints we receive come directly from patients, with an average of 75% of all contacts since 2009. Relatives of patients are the next most represented group, accounting for 16% of all contacts over the last five years.

TABLE 5: Security direction withheld internal mail and telephone monitoring appeals and outcomes, 2009/10 to 2013/14

	2009/10		2010/11		2011/12		2012/13		2013/14	
	Received	Appeal upheld	Received	Appeal upheld	Received	Appeal upheld	Received	Appeal upheld	Received	Appeal upheld
Internal post	–	–	1	0	–	–	1	0	4	1
Telephone monitoring	1	0	2	0	2	0	4	0	2	0

Source: MHAC/CQC

TABLE 6: Enquiries received by MHA complaints function staff, 2009/10 to 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14
Enquiries received – MHA complaints function	628	745	601	884	1,016

Source: CQC

The remaining 9% come from a mixture of legal representatives and other agencies such as Independent Mental Health Advocates or through referral from the other ombudsmen.

Table 7 shows the regional distribution of complaints made, where this data was available. We are sharing this information with our regional teams to offer an overview of the number of complaints we receive. We also hope regional surveillance groups will find this additional information of interest and that it will contribute to their own monitoring of services.

From the data available, we can see London had the highest recorded number of complaints and concerns. This is as expected given the higher population density, the higher number of people subject to detention and the higher volume of providers of services for those with a mental illness. Where 'not stated' is recorded this includes instances where the complainant has not provided details of the provider or where multiple providers may be involved in the complaints.

Proposals of change to the MHA Code of Practice

We have a statutory power to make formal proposals to the Secretary of State for changes to the MHA Code of Practice, which we primarily do through this report. A revision of the Code of Practice was announced in 2012 and we joined the steering group in October 2013. The review

TABLE 7: Complaints and enquiries received 2009/10 to 2013/14, by region

Region	2009/10	2010/11	2011/12	2012/13	2013/14	Average % for 5-year data
East	56	62	47	59	66	8%
East Midlands	58	88	91	143	123	13%
London	113	133	118	136	163	17%
North East	13	16	18	26	37	3%
North West	77	81	58	79	69	10%
South East	79	83	61	72	94	10%
South West	34	56	30	48	76	6%
West Midlands	45	51	31	44	49	6%
Yorks & Humberside	49	59	27	64	57	7%
Not stated	104	116	120	213	282	21%
Total	**628**	**745**	**601**	**884**	**1,016**	**100%**

Due to rounding, percentages may not total 100%.
Source: CQC

gave us an opportunity to consider all the proposals that we have published in our previous annual reports, and to look again at the findings from the reviews and investigations we have carried out since the Code's last revision in 2008.

The key focus of the steering group was to look at the system-wide variations in the way the MHA principles and safeguards are applied to patients, as well as to address the recommendations for changes to the Code following national reports such as *Closing the Gap: Priorities for essential change in mental health*[10] and *Transforming Care: A national response to Winterbourne View Hospital*.[11]

In our initial response to the Department of Health team, we provided more than 70 separate proposals for change. These were formulated from the patient experiences we have heard through our MHA work since the last revision of the Code. Our response outlined where we believe the Code needed to be clearer and stronger to help people using it. This included our own use of the Code in our assessments of services.

Our final response to the Code of Practice consultation was one of the most detailed external consultation returns we have provided. We included some broad messages and asked for these to inform ongoing reviews of the Code and how it is applied in practice by both CQC and providers.

The following messages were developed based on the feedback from our consultation engagement event with our Service User Reference Panel and have been addressed in the new Code:

- The key to good care and treatment is the involvement of the person at all stages, including a commitment to advanced decision making and statements of wishes and feelings.
- The Code needs to clearly identify what is considered to be good practice and what people should expect as an absolute right and necessity for the service they receive. For people using services this will help them to understand when they should raise a concern or complaint.
- It should be clear throughout the Code that relatives, carers and significant others will only be involved in the care and treatment of their loved one when the person wants them to be. People who use services felt confidentiality should be key when the use of advocates or representatives is considered, to make sure that the person is helped to involve significant others when appropriate, as opposed to this being an expectation.
- People who use services feel that the Code should highlight where options for choice continue to exist when detained. This will allow them greater involvement and empowerment throughout each stage of their care.

We also made a number of formal proposals for change during the drafting of the Code. Details of our consultation return and specific recommendations are on our website* and our proposals have largely been addressed in the final version of the Code laid before Parliament.[12]

As the regulator of health and social care in England, our challenge to every health care provider is to deliver consistent and high standards of care that we all have a right to expect. We see our involvement in reviewing the Code of Practice as one of the ways we will continue to challenge practice and encourage improvement. We expect to see services making sure that their staff understand their specific responsibilities in the Code and that they are addressing any gaps in practice highlighted by the new guidance.

The review of the Code and discussion with people, inside and outside CQC, has informed how we will improve our use of the Code in carrying out MHA activities. For example, in

* **www.cqc.org.uk/content/mental-health-act**

assessing whether our inspection teams or providers need any additional guidance to deliver the consistent and high-quality care we expect.

We have aligned the structure of this report to that of the new Code. This should help patients, policy makers and services to easily identify the areas of the Code we have observed practice against, good and bad, and what may need to change. We also believe that this will be a useful and easily accessible way for us to present the outcomes of our MHA monitoring work.

1.3 Health and Social Care Act notifications: Absences without leave and deaths in detention

- Through our work with the Department of Health, a reduced scope for absent without leave notifications was introduced in 2013. This accounts for a drop of almost 77% in notifications since 2012/13.
- The number of unnatural deaths has remained consistent for the last four years, with 36 reported deaths in 2013/14. We reiterate our expectations that providers use local investigations to prevent future deaths.
- Over the last year, we have continued to work with external organisations, such as the Coroners' Society, to strengthen our information sharing and improve our learning from deaths in detention.

Providers registered under the Health and Social Care Act 2008 must notify us about any unauthorised absences and deaths of people detained, or liable to be detained, under the MHA.

We have previously committed to providing the information we receive from the notifications in each of our annual reports. We also regularly use the data to inform our Intelligent Monitoring and to provide returns to other national stakeholders, such as the Independent Advisory Panel to the Ministerial Board on Deaths in Custody.

Absent without leave notifications

Section 18 of the MHA (absence without leave notifications) applies to a range of different situations for people subject to the MHA. However, patients detained in hospital must have all their leave agreed and signed by their responsible clinician under section 17 of the Act. If they leave without this being in place they are classed as absent without leave.

Since 1 April 2010, providers have been required to notify us of any inpatients who are absent without leave, which is defined by certain parameters.* For the first three years of this data collection, providers had to tell us of all patients absent without leave still open at midnight on the day the absence began. Incidences of absences at any time from high security hospitals, and the return of persons from unauthorised absences, had to be reported to us as well.

Absences without leave are also monitored by the Mental Health Minimum Dataset (MHMDS). We recognised that the requirements for notifying us were putting an additional burden on general security wards, which were already required to complete this information for the MHMDS. As a result, in 2011 we worked with the Department of Health to change the regulation and reduce the scope of when providers had to notify us of

* The current regulations are *Care Quality Commission (Registration) Regulations 2009* Regulation 17, as amended by the *Care Quality Commission (Registration) and (Additional Functions)* 2011 and Health and *Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012*

TABLE 8: Notifications of absence without leave, 2010/11 to 2013/14

	2010/11	2011/12	2012/13	2013/14
Notifications of unauthorised absences received	4,183	4,896	3,923	909

Source: CQC

people who were absent without leave. Since April 2013, only services designated as low, medium or high security are required to notify us of any unauthorised absences, and of the return of persons from unauthorised absences.

The reduced scope of when providers must notify us explains the fall in the number of notifications we have received since 2010 (table 8).

Deaths of detained patients notifications

All providers must notify us of the death of any patient detained under the Act.* The notifications make sure we can take appropriate monitoring action in response to individual cases. This will primarily be recorded as a significant notification in our Intelligent Monitoring of provider services. However, in some circumstances we may use our powers under the MHA or Health and Social Care Act to investigate further.

The figures for the death notifications we have received over the last three years are provided in table 9, with 232 notifications of death in 2013/14. This includes the information on patients subject to a CTO, which we continue to ask providers to report using the notification system, although they are not required by law to report these. As this is not a clear requirement in regulation we cannot offer absolute assurance that the data provided in this report is a complete picture of all deaths of people subject to a CTO during the periods reported.

TABLE 9: Notifications of deaths of detained patients under regulation 17, 2011/12 to 2013/14 (type of detention)

	2011/12	2012/13	2013/14	Total
Detained	236	275	198	709
CTOs	39	45	34	118
Total	**275**	**320**	**232**	**827**

In table 10, the figures for 2013/14 show a drop in the number of natural deaths reported to us for people detained in hospital. We categorised deaths into 'natural' or 'unnatural' causes based on the information given in the original notification to CQC, or from further investigation, or from the verdict of the coroner's inquest. Where the cause of death was categorised as 'undetermined' this may be because the coroner recorded an open verdict or we are waiting for an updated cause from the coroner's inquest.

TABLE 10: Notifications of deaths of detained patients under regulation 17, 2011/12 to 2013/2014 (causes of death)

	2011/12	2012/13	2013/14	Total
Natural causes	191	200	126	517
Unnatural causes	36	48	36	120
Undetermined	9	27	36	72
Total	**236**	**275**	**198**	**709**

Source: CQC

Detailed data tables received from our notification system are in appendix 2 of this report.

* Visit: **www.cqc.org.uk/content/mental-health-notifications** for more information.

For detained patients, we have looked at the factors and variation between regions for 2013/14 (table 11). We will be sharing this with NHS England regional teams to discuss potential developments of this regional level data.

When providers report a death they must tell us where someone has been restrained within seven days before their death. In 2013/14, there were four incidences where this occurred. We have reviewed the notification forms from the providers for each individual case and do not believe the death occurred immediately following or during restraint.

Key developments

In our last report we set out our plans to include death notifications in our Intelligent Monitoring of provider services.* In 2014, we released the first version of our Intelligent Monitoring which helps us to decide when, where and what to inspect. For all mental health services we have included a specific indicator which looks at the number of deaths for people detained in hospital settings and which seeks to identify outliers. The inspection teams have been using the indicators since we implemented our new approach in October 2014 and we will be issuing a second release of the Intelligent Monitoring in 2015. This will be informed and developed by the feedback that we receive from our inspections and from stakeholders, including the Independent Advisory Panel and NHS England.

Our previous reports have outlined the key messages and themes arising from analysis of deaths by CQC and other organisations. They have also highlighted our commitment to using the learning available to inform our regulatory and MHA monitoring methodology. We have used these themes to inform the development of the key lines of enquiry in our new inspection model.

When inspecting mental health providers we now look at specific themes including:

- The availability of specialist community services.
- Care planning practice for inpatient and community teams.

TABLE 11: Natural and unnatural cause deaths of detained patients by region, where known, 2013/14

	Natural causes	Unnatural causes	Total
East	20	1	21
East Midlands	10	2	12
London	11	7	18
North East	8	1	9
North West	15	6	21
South East	25	4	29
South West	7	3	10
West Midlands	14	7	21
Yorkshire & Humberside	10	4	14
Total	**120**	**35**	**155**

Source: CQC

* Visit: **www.cqc.org.uk/content/intelligent-monitoring-trusts-provide-mental-health-services** for more information on Intelligent Monitoring.

- Evidence of compliance with National Institute for Health and Care Excellence (NICE) guidance.
- Information sharing protocols with other agencies.
- Safety procedures for inpatients, such as the provider's approach to people absconding from inpatient units.
- How providers ensure a learning culture is in place across the service, with a particular focus on safety events.

In 2014 we also continued our work with other organisations that have a role in the deaths of detained patients. This joint working allows us to bring together the various work programmes to prevent deaths of people subject to the Act. It also allows us to share learning from across our different activities. Some of the work completed in 2014 is summarised below:

NHS England: We have worked with the team leading the review of the Serious Incident Framework to improve the standard approach to investigations following deaths. This is planned for publication in 2015. We have also contributed to the discussions about the role of NHS England in individual investigations and how we share learning from the work carried out by individual providers and commissioners.

Independent Advisory Panel: We have continued to share the data we hold with the Independent Advisory Panel (IAP) on a quarterly basis. This forms part of the statistical analysis of deaths produced by IAP.* In 2014 we met with the panel and used the learning from its work to prepare our Intelligent Monitoring indicators. In 2015 we will work with IAP to release our second version of the indicators for mental health services. The outcomes of this work will help to improve the national dataset available for people who die while in detention. It will also include reviews of data from HSCIC and NHS England.

Coroners Society: In 2014 we developed a memorandum of understanding with the Coroners Society. We now receive information from individual coroners' reports about any deaths in health and care settings and how these could be prevented in future. This information is provided to our inspection teams who use the details of the report in their work with individual providers.

National Confidential Inquiry into Suicide and Homicide of People with Mental Illness (NCISH): As reported in our 2012/13 report, we have shared data with the NCISH to compare the deaths reported to the inquiry team against our own data. We have also used the NCISH reports in our own plans for reviewing deaths in services and the areas we look at when visiting mental health providers, including community services.

Equality and Human Rights Commission (EHRC): In 2014 the EHRC announced their inquiry into non-natural deaths of people with mental health conditions in state detention.† The inquiry is looking at historical data on suicide, homicide, unknown and accidental deaths of people in psychiatric hospitals, prisons and police custody in England and Wales. We have worked closely with the inquiry team, including attending roundtable discussions throughout the year with other agencies. We have also provided a range of data and reports from our work to inform the inquiry. The findings will be published in spring 2015 and we will be working with the inquiry team to look at ways their recommendations can be used to inform our work with providers.

* See: **http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/statistics/**

† Website for the Equality and Human Rights Commission Inquiry: **www.equalityhumanrights.com/legal-and-policy/our-legal-work/inquiries-and-assessments/inquiry-non-natural-deaths-detention-adults-mental-health-conditions**

2

The Mental Health Act in action

THROUGH OUR CORE ACTIVITIES OF MONITORING THE MENTAL HEALTH ACT 1983 (MHA) AND IN INSPECTING AND RATING PROVIDERS OF MENTAL HEALTH SERVICES, WE HAVE A UNIQUE VIEW OF THE WAY SERVICES ARE SUPPORTING PEOPLE AND HOW THE NATIONAL AGENDA IS CHANGING THE WAY THE MHA IS APPLIED. THERE ARE A NUMBER OF AREAS WHERE WE CONTINUE TO SEE ISSUES IN PRACTICE.

2.1 Using the Act

- Data collection, through our own Intelligent Monitoring and working with other bodies such as the Health and Social Care Information Centre (HSCIC), gives us an important picture about the MHA in action and improves our understanding about how it affects people.
- Figures from HSCIC show that there were 23,531 people subject to the Act at the end of March 2014, an increase of 6% since 2012/13. In 2013/14, this means 18,166 people were detained in hospital, compared with 16,989 the previous year.

- HSCIC data also shows that there is a higher rate of black and minority ethnic people being detained than we would predict from the population demographics. We reiterate our call for providers to carry out ethnic minority monitoring of their activities, to ensure accurate data is available to inform future analysis.
- Some providers are not consistently reporting through national returns. We welcome all approaches, for example from NHS England, to improve provider data returns.

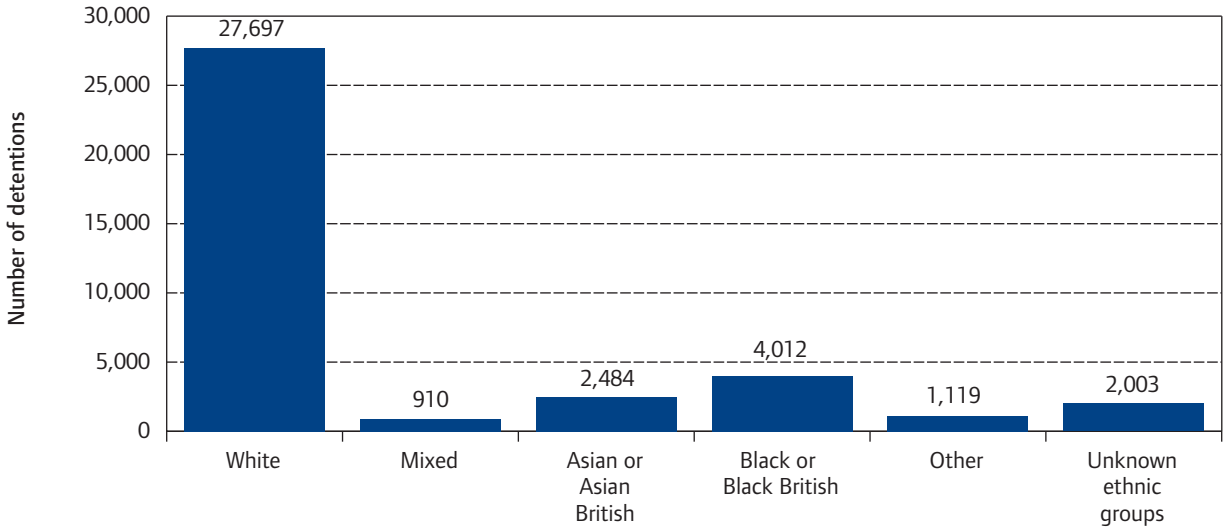
Before setting out our findings for the year, we have included in the box below some of the key statistics and messages from the Health and Social Care Information Centre's (HSCIC) report, *Inpatients Formally Detained in Hospitals Under the Mental Health Act 1983*.[13] Although this is not our own data, we have included it to provide a context for how the MHA is used across the organisations we regulate in England. The data return is completed by all hospitals, including high security hospitals, and by both NHS services and independent hospital providers.

We work closely with HSCIC to look at how we can improve the use of the data while reducing the burden on providers. We are still finding that

Summary of findings from the 2013/14 HSCIC report

- The MHA was used 53,176 times to detain patients in hospital for longer than 72 hours, 5% (2,768) more than 2012/13 and 30% more than 2003/04.
- In 2013/14, there were 23,531 people subject to the MHA at 31 March 2014. This was 18,166 people detained in hospital and 5,365 people being treated on a community treatment order (CTO).
- There was a 6% increase in the number of people subject to the Act from 2012/13 and a 32% increase since 2008/09, the year CTOs were introduced.
- Since 2010, the number of people in hospital subject to the MHA has increased by 9% (1,544). In that time, the population in England has increased by 3% (1.67 million), so the number of people being detained cannot be linked to an increase in the number of people in the general population.
- In 65% (34,806) of cases, detentions were made on admission to hospital. They were also made following a stay as an informal patient and/or when a short-term or emergency detention order had been used (14,087 cases), following a section 136 order (2,882), or after a CTO had been revoked (1,401).
- The number of people detained in care from non-NHS providers is increasing. This year independent hospital providers have reported an increase of 21% in detained patients. This is 10% of all longer-term detentions and more than double the proportion of 10 years ago.
- The number of new CTOs was 5% lower than during the previous year (4,434 compared with 4,647). This suggests the uptake of CTOs following their introduction may have levelled off.

FIGURE 6: Longer-term detentions by broad ethnic group, 2013/14



Source: HSCIC

some providers are not regularly returning data to the Mental Health Minimum Dataset (MHMDS). We are pleased that NHS England has been looking at ways to tackle this through different approaches led by clinical commissioning groups.

Our new Intelligent Monitoring will support the national data collection, as it enables our inspection teams to identify when providers are not consistently reporting through the national returns.

Over-representation of black and minority ethnic people in detention/CTOs

Over the last 30 years of monitoring the Act, we (and previously the Mental Health Act Commission) have highlighted the continued over-representation of black and minority ethnic people groups in the detained population. We have also highlighted that this over-representation continues and increases for people under CTOs.[14] In our last report, we provided detailed statistics on mental health detention by ethnic group, and recommended that services should undertake ethnic monitoring of their activities. We also encouraged services to make sure they submit accurate returns to the MHMDS.[15]

The HSCIC report includes information from the MHMDS. This shows that 72% of all detentions were applied to patients in the 'White' ethnic group. However, the data also shows 'Black or Black British' continue to account for more longer-term detentions than any other category, with 10% or 4,012 people in longer-term detentions being Black or Black British (figure 6).

2.2 Protecting patients' rights and autonomy

- In 2013/14, 84% of records examined showed that patients had received information about their legal rights.
- There was also evidence of staff discussing rights with patients in 82% of records – an increase from 71% last year.

- However, we have found that staff do not always provide carers with the information and support they need. We strongly recommend hospital staff have additional training and support about their duties under the Care Act 2014.
- Awareness of, and access to, Independent Mental Health Advocates (IMHAs) is still not good enough. In 2014, the IMHA implementation project produced training materials for providers to address this. We will continue to work with the project to look at ways we can improve IMHA provision.
- Since April 2014, the Tribunal doctor no longer screens all patients before their hearing. All section 2 and unrepresented patients are now sent a leaflet advising them of their legal rights to representation. We expect the Tribunal to remain vigilant in seeking capacity assessments for patients who do not have representation.

Information for patients, nearest relatives, carers and others

Through our monitoring work over the last five years, we have emphasised the importance of developing a stronger culture of human rights in mental health care. However, we are still meeting patients who are not made aware of their legal rights. Making sure patients are supported to understand their legal position and rights is the foundation of a human rights approach to operating the Act. We have seen some examples of good practice in action.

There is an audit document that records when staff have told patients about their rights and repeated this, if necessary. In addition, this audit tool records referrals to an IMHA and applications for Tribunals and Managers' Hearings. There is also a regular monthly entry in the office diary to remind staff to speak with detained patients about their rights. Responsibility for reminding patients of their rights falls to staff on shift on the day in the diary, rather than the named nurse. Patients have a written explanation of their rights in 'easy read' format in the 'Patient Information Booklet' they keep in their room.

The Unit, Birmingham Community Healthcare NHS Trust, August 2013

We noted good practice on the ward in relation to the explanation of rights to detained patients. In particular we heard that the Mental Health Act manager runs 'surgeries' on the ward for detained patients.

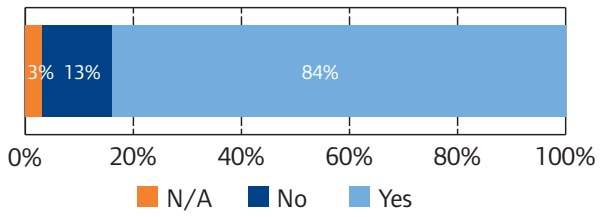
Prospect Park Hospital, Berkshire NHS Trust, March 2014

However, MHA Reviewers still meet detained patients (and patients on a CTO, as discussed in section 2.8) who are not aware of their legal position, or who do not understand what it means, even though there is no clinical reason for this. The Code of Practice expects providers to have systems in place for telling people their rights and ensuring that this is recorded properly. From our own observations, we have seen this is not the case. We continue to look at how this statutory duty is being administered to make sure that patients are being given every opportunity to learn about their legal rights so they can make informed decisions.

In 2013/14, we found that 84% of 140 records examined showed evidence that patients had received information about their legal rights (figure 7). There was evidence of staff discussing legal rights with patients in 82% of records (figure 8). This is an increase from the 71% we reported on last year. However, this still means one in five people who have been detained have no record that their statutory rights have been explained to them. It is unacceptable that we could not find evidence that patients have been given their legal rights, or offered an opportunity to discuss these with staff, in so many cases.

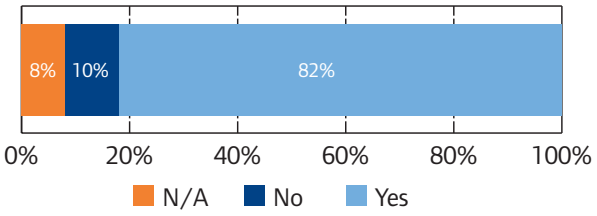
Where we see issues on particular wards we always make a recommendation for action. In our new style inspections, the provision of rights forms one of our key lines of enquiry. As a result, from next year our inspectors will be able to look for evidence of whether the issues we identify are system-wide. We continue to use the MHA and the Code of Practice, which give statutory guidance on the expectations on providers, as our standard in all cases.

FIGURE 7: Evidence that information about patients' rights was provided to patients, from records examined on MHA visits, 2013/14



Source: CQC

FIGURE 8: Evidence of discussion about patients' rights in records examined on MHA visits, 2013/14



Source: CQC

The nearest relative, carers, family and significant others

Under the MHA, family members of detained patients who are identified as the patient's legal 'nearest relatives' are given specific rights to access information, request assessments and powers to request discharge. The involvement of other people, including carers, family and significant others, is subject to the patient's agreement and normal considerations of patient confidentiality. In some, but not all, cases the nearest relative will also be the main carer. Patients who are able to make decisions for themselves should always be supported to discuss matters about their treatment with people of their choosing, rather than professionals taking a lead in the discussions.

Although carers do not have the same legal standing under the MHA as a nearest relative, even though they will be the same person in some cases, the Code recognises that carers should be informed and involved wherever possible. This is particularly important following detention. However, we still receive feedback from patients and carers that their views are not being sought or taken into account often enough.

Where carers report concerns that staff are uncommunicative with them, patient confidentiality is the most common reason given. The Code of Practice is clear that confidentiality should not prevent staff communicating with carers, relatives or friends of the patient (see Code of Practice, chapters 2 and 18). However, in order to meet the duties of the Care Act 2014 to provide carers with information and support, hospital staff may need additional training and support to work alongside local authority colleagues.

Our primary responsibility in monitoring the MHA is to visit detainees in hospital. Our visits are

largely unannounced, so there are limited opportunities to speak with carers. In some cases, we carry out announced visits so that patients, carers and others can attend. Going forward, our comprehensive inspection model will allow us to meet carers more frequently and we are looking at ways we can specifically reach out to carers with experience of the Act through our MHA monitoring and regulatory inspection models.

In 2013/14, we engaged with the carers of detained patients. With the co-operation of one mental health provider, a MHA Reviewer contacted and interviewed eight carers, through a mixture of telephone interviews and attendance at a carers' group. As well as forming part of our comprehensive reviews of mental health services, these activities will inform our future MHA monitoring activity.

The initial results of our interviews with carers underlined how bewildering and complex the process of detention under the Act can be for patients and their family. Carers' understanding of their legal position some weeks or months after their relative's crisis was worryingly low. We also heard stories of families not receiving support until a crisis made detention under the Act much more likely.

On a visit in December 2013, we raised concerns from carers that they were not being involved in the care of their relative and that their views were not taken seriously. The provider in question undertook a programme of education and awareness sessions for its staff to support their understanding of information sharing and confidentiality. Responsibility for developing this training was delegated to the MHA lead for the provider.

MHA monitoring visit to the Isle of Wight, December 2013

We have been told of some good practice examples, which can play an important role in providing information and support. These include, for example, access to carers' groups where people can meet with staff and ask questions about the service. Feedback on communication with relatives informs our inspections and we expect providers to make sure staff are clear on how they can engage carers, as well as their responsibilities around confidentiality and information.

Good practice: Mental health carer support in Reading

In Reading, a social worker trained in psychosocial intervention has been identified as a specialist mental health carers' Lead for the local authority. She runs a 10-week course for families of patients, involving crisis work with up to three home visits, family work and psycho-education classes. These include information about signs and symptoms of relapse, strategies for dealing with difficult behaviour and stress management. At the end of the course, carers can join more informal support groups. The carers we spoke to were complimentary about the course and the support offered by this dedicated resource.

Independent mental health advocacy services

It is now five years since providers and commissioners were given a legal duty to make sure that patients subject to the Act are aware of, and have access to, an Independent Mental Health Advocate (IMHA).

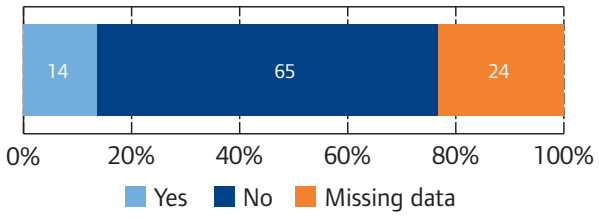
In November 2013, we joined the Department of Health's advisory group for the IMHA Implementation Project. Over the course of the year, the project has produced practical resources

for implementing IMHA services, including training materials and video resources, which we recommend to services. We are using these in our own activities, including training our MHA staff.

This has been the first year that local authorities have been responsible for commissioning IMHA services. In August 2014, the IMHA Implementation Project requested data on local authority commissioning arrangements. Of 152 authorities approached, responses were received from 103 (68%). Project members are preparing a publication using this data, but we highlight here that only a small proportion of the 103 respondents (14%) were able to state they had undertaken a needs assessment to inform their commissioning, even though this is a basic requirement of good commissioning practice (figure 9). The Implementation Project is producing guidance for commissioners to address this and other shortcomings.

To help us to understand the impact that this is having on the quality of services, we will be asking additional questions, designed and agreed with the IMHA Implementation Project, when we speak with patients and providers during our MHA visits from January to March 2015. We will include the outcome of this work in our next annual report and share it with the IMHA Implementation Project.

FIGURE 9: Local authorities' response when asked if they had undertaken a needs assessment for commissioning IMHA services, August 2014



Source: IMHA Implementation Project

To be effective, IMHA services should be funded so that they can proactively reach out to patients who qualify for their support. For example, IMHAs should be able to attend inpatient wards and introduce themselves to qualifying patients to explain their role. Some referral and funding arrangements for IMHA services make this difficult. This may mean that not everyone has equal access to the service.

Given the uncertainties over commissioning and provision of IMHA services, we would like to see a centralised data collection and an annual report introduced to make recommendations for service development. Such arrangements have been successful in developing the IMCA service. We recommend the Government considers how this may be achieved.

We have been increasing our engagement with IMHA services to help us better understand the services we are inspecting. To date, the IMHAs have been a valuable source of information. We have included an IMHA as specialist advisor on at least one of our inspection teams and, using their experience and knowledge, we have been able to identify new areas to review. We hope to continue working with individuals and agencies in this way and will be looking at how we can increase our contact with IMHAs during our dedicated MHA monitoring visits in 2014/15.

CQC survey of visit findings on IMHA service provision

To understand more about the specific issues for IMHA provision, we analysed the reports of our MHA visits between 1 July and 31 December 2013.* This provided a baseline of 740 visits, in which our MHA Reviewers met with 2,238 patients who were detained or subject to a CTO.

Through the survey, we identified reports that had evidence of issues with the IMHA provision. In total, 145 recommendations, issued over 122

* The majority were visits to detaining hospitals, but this figure includes some 'special' visits (e.g. 27 'assessment and admission' visits), and 13 visits focusing on CTO where the principal focus was not inpatient detention.

TABLE 12: Issues identified related to IMHA services from visit reports, 1 July to 31 December 2013

	Number	%
Lack of information on ward about IMHA	44	30
Limited evidence that patients told of IMHA service	32	22
Individual patient referred to IMHA at request of MHA Reviewer	25	17
Concern about access because of referral arrangements	15	10
Incapacitated patients and IMHA access	9	6
IMHA suggested to help record patient views in care plans	4	3
No access to IMHA	4	3
Concern about access for people subject to a CTO	4	3
IMHA complaints about services	2	1
Complaint about advocate	2	1
No IMHA link to hospital management	2	1
Other	2	1
Total	**145**	**100**

Total percentages fall 2% short of 100% due to rounding.
Source: CQC

visit reports, related to 'IMHA'. We then categorised the issues raised (table 12).

The most common type of comment related to a lack of ward-based information about IMHA (44 examples). In half of these (22), MHA Reviewers found there was no information about IMHA services on the ward. Where they found some information, they considered that it was not good enough. For example, some wards had leaflets but no posters, or some had information available to patients but did not explain how they could contact IMHA services directly.
In a smaller number of visits, we were concerned that patients did not have practical access to IMHA services.

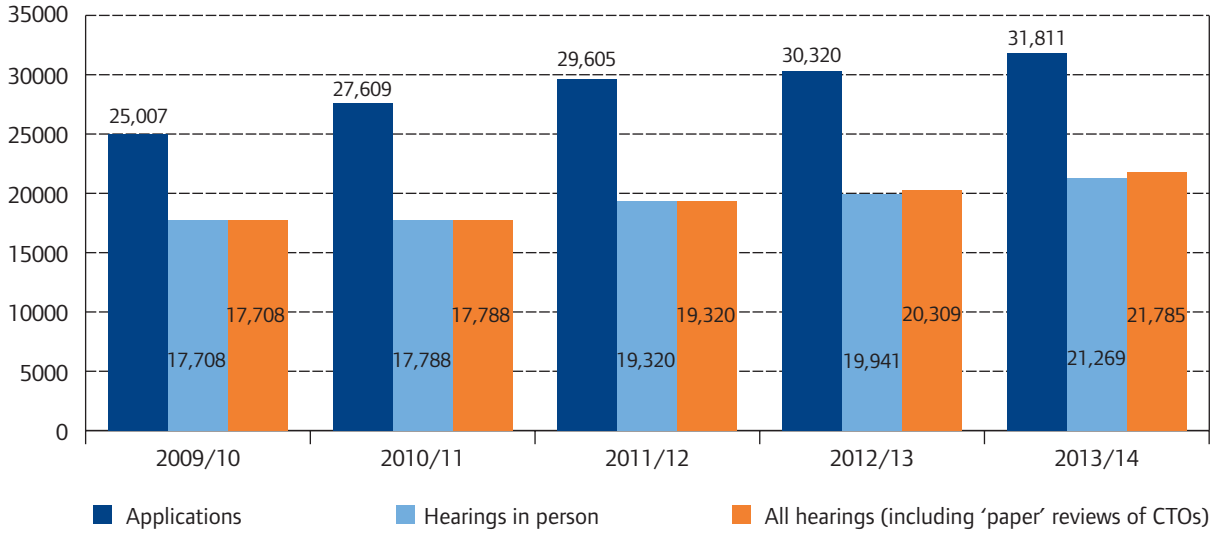
The Tribunal

The First-tier Tribunal (Mental Health) is the primary way that people in England can appeal against the use of the MHA's powers of detention, guardianship or supervised community treatment. It is an independent judicial body administered by the Tribunals Service and provides one of the key safeguards under the Act.

The Tribunal Secretariat has provided us with their activity in 2013/14 (tables 13 and 14, page 42). Figure 10 (page 42) also illustrates the number of applications and hearings taking place each year from 2009 to 2014. This shows that the number of Tribunal applications has increased by 27% (6,804) in the last five years. The number of full hearings has increased by 20% (3,561) over the same period.

In 2012/13, the Tribunal introduced a system of 'paper reviews' for automatic referrals of CTO cases. This means that the Tribunal will not meet with the patient, but will carry out a review of the patient's records and reports. Since it was introduced, the Tribunal has reviewed 884 cases in this way. Patients are given the opportunity to

FIGURE 10: Tribunal applications and hearings, 2009/10 to 2013/14



Source: Tribunal Secretariat

TABLE 13: Outcomes of applications against detention to the First-tier Tribunal (Mental Health), 2013/14

		Section 2	Other unrestricted	Restricted	All detained patients
Detention only (excludes CTOs)	Applications	9,081	15,096	3,203	27,380
	Withdrawn applications	724	3,109	1,138	4,971
	Discharges by clinician prior to hearing	2,877	5,057	56	7,990
	Hearings[1]	6,111	10,239	2,401	18,751
Decision of Tribunal	Absolute discharge	487	312	74	873
	Delayed discharge	198	143	0	341
	Conditional discharge	0	0	324	324
	Deferred conditional discharge	0	0	138	138
	Total discharge by Tribunal	685	455	536	1,676
	No discharge	4,468	6,489	1,426	12,383

Source: Tribunal Secretariat

object to having their case determined through a paper review, and will have a full hearing if they do so. In 2013/14, paper reviews accounted for 17% (516) of CTO cases considered by the Tribunal.

Last year, the Tribunal made changes to its administration processes for hearings. Previously, all patients (unless they declined) were examined by the Tribunal doctor before their hearing. Since April 2014, the Tribunal doctor has only examined patients under section 2 of the MHA (unless they decline), and not for any other

TABLE 14: Applications against CTOs to the First-tier Tribunal (Mental Health), 2013/14

	Number
Applications	4,431
Withdrawn applications	873
Hearings	3,550
Discharges by Tribunal	185
No discharge by Tribunal	3,430

Source: Tribunal Secretariat

section hearing. The exception to this is when they or their representative asks the Tribunal in writing for a pre-examination. This must be done 14 days before the hearing. The Tribunal can also direct that a pre-examination must take place.

All section 2 and unrepresented patients will now be sent a leaflet at an early stage advising them of their legal rights to representation and/or rights to see the Tribunal doctor before the hearing. Lawyers of patients with legal representation must provide their clients with appropriate and timely advice.

The Tribunal recognises there is a potential risk associated with this approach. To reduce this risk, the Tribunal has committed to making sure it seeks capacity assessments for patients without representation. This should make sure that legal representatives are appointed promptly for patients who are deemed not to have the capacity to decide for themselves whether or not they should have legal representation.

2.3 Assessment, transport and admission to hospital

- The mental health inpatient system was again running over capacity. The number of available mental health NHS beds in quarter 4 2013/14 had decreased by almost 8% since quarter 1 2010/11.
- This is putting Approved Mental Health Professionals (AMHPs) under extreme pressure, and may lead to the Act being used just to obtain a bed. While it would not be lawful to use detention powers solely as a means to secure access to hospital treatment, AMHPs may be forced to choose this as the least worst option available.
- In 2012/13, there were 21,814 reported uses of section 136* in England. This rose to 24,489 in 2013/14, an increase of 12%. Last year, we carried out a themed programme of work around crisis care, with a specific focus on health-based places of safety, and called for urgent action on our key findings. We reiterate our call for action and again highlight our concern about the use of police stations for people detained under section 136.

* Section 136 is the power that police officers have to detain people, believed to have a mental disorder, in a public place and to take them to a place of safety for assessment.

Applications for detention in hospital

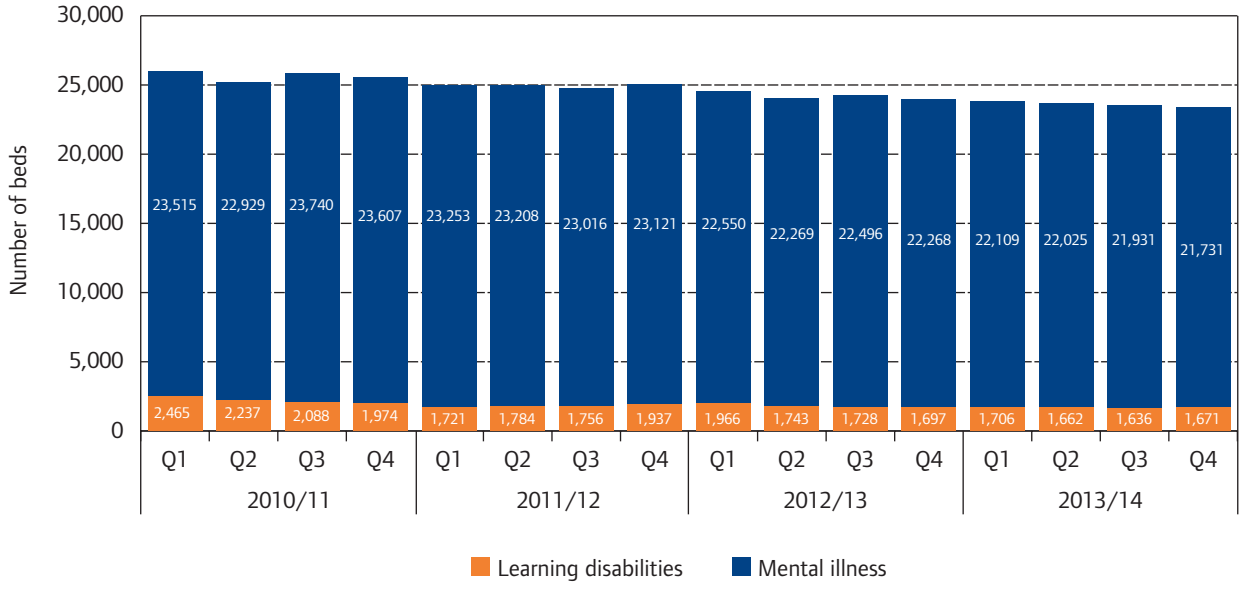
Between quarter 1 2010/11 and quarter 4 2013/14, the number of available mental health NHS beds has decreased by almost 8% (figure 11). Through our visits we have seen the effect that this has had including difficulties in accessing beds at a time of crisis. As in our last report, we again note the mental health inpatient system is running over capacity and AMHPs are under pressure to admit people under the Act just to obtain a bed. Since 2013, we have also seen an increase in the number of patients being detained out of area. We are looking at ways we can work with others to continue to monitor this through our new approach to inspections.

We hear information on the impact of this change through our meetings with social service departments, the police and stakeholder organisations, such as patient and advocacy groups. We have mostly completed this through our MHA visits, and our new inspections use a number of methods to increase engagement and gather feedback from local people and services. By meeting with the various agencies involved in the assessment and admission of patients under the MHA, we can get a better overview of care pathways in a local area. It also provides us with information on the challenges and opportunities of inter-agency working and infrastructure.

The rise in compulsory admissions and bed provision

The rise in compulsory admissions to psychiatric hospitals has been a common, but not universal, feature of European health systems since the 1990s.† In our last report we noted the possible link

FIGURE 11: Mental illness and learning disability NHS beds open overnight, 2010/11 to 2013/14



Source: NHS England KH03 data collection*

* See **www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/**

† Scotland had appeared to reverse its own upward trend in the use of compulsion since the coming into force of the Mental Health (Care & Treatment) (Scotland) Act 2003 and detentions have been relatively stable over the last few years. See Mental Welfare Commission for Scotland (2014) *Mental Health Act Monitoring 2012/13*, p36. **www.mwcscot.org.uk/media/138265/mha_monitoring_report_final_25_sept_2013.pdf**

Case study: Bed provision in Oxfordshire

On a visit in Oxfordshire in October 2013 staff reported difficulties in accessing a bed. Members of staff agreed that delays in admission and high levels of occupancy were having a direct effect on the quality of care delivered. We observed this in practice when, on the day of the visit, a patient was held in the place of safety while waiting for a bed. However, at the time of our visit there were particular pressures around adult male bed capacity as a result of improvement work to one ward. This had led to a number of beds being temporarily closed. The trust told us in their response to our visit report how they had taken action to address their bed management and capacity issues. This included:

- A comprehensive review of mental health services for adults and older adults, which were being remodelled to provide a more responsive seven-day service. There was a particular emphasis on enhancing crisis support and intervention to further reduce the need for inpatient admissions.
- As a result of the service remodelling, there was now a 'night team' of senior nurses in place to support the wards. The community was to be mirrored in Buckinghamshire and both teams were given more staff.
- Basing a newly commissioned psychiatric in-reach liaison team in the accident and emergency department at Stoke Mandeville Hospital. This was to cover seven days a week and extended hours, and would assess and manage patients presenting with psychiatric symptoms in A&E and designated wards. It was anticipated that this would result in more appropriate referrals for inpatient psychiatric admission and reduce the number of patients who were being inappropriately admitted to hospital.
- Redesigning its inpatient services so that each ward had a dedicated modern matron and consultant psychiatrist, to provide more focused clinical leadership and assist in capacity issues.
- Developing a new clinical model for both inpatients and community services, that aimed to standardise the patient pathway. This would allow inpatient clinicians to plan care and begin treatment at the point of admission, actively engage patients and carers in their care, and in turn reduce lengths of stay while smoothly transitioning care into the community.

The trust told us that it would continue to measure its progress by monitoring capacity in acute admission wards, with an aim to drop below 100% and move towards the optimum of 85%.

MHA monitoring visit, Oxford Health NHS Foundation Trust, October 2013

between the decline in numbers of available beds and the increasing use of compulsory detention.[16]

In June 2014, the Royal College of Psychiatrists' Psychiatric Trainees' Committee published the results of a survey of junior doctors working in psychiatry. From this survey, the committee concluded that "cuts to mental health services mean patients are being sent home in the absence of a bed – or being sectioned to secure one".*

* Royal College of Psychiatrists . 'Trainee psychiatrist survey reveals mental health beds crisis', June 2014. **www.rcpsych.ac.uk/mediacentre/pressreleases2014/traineesurvey.aspx**

In the survey, more than 400 doctors (out of 576 respondents) said they had experienced difficulties in finding an appropriate bed for a patient at least once in the previous six months. Doctors said they had resorted to prematurely discharging patients to free up beds, or sending patients long distances out of area as a result of bed shortages.

It is important to note here that there is a possibility of selection bias in these results, as the 576 respondents were only 16% of doctors who were sent the survey. However, it does show that some clinicians believe difficulties in finding beds are affecting their practice. This includes whether they recommend the use of detention under the Act rather than informal admission.

In our last report, we highlighted that AMHPs have also reported being under pressure to use compulsory admission under the Act to obtain beds.[17] It seems likely that such pressures are having a distorting effect on detention figures. While it would not be lawful to use detention powers solely as a means to secure access to hospital treatment, we are aware that in practice the decision to detain a person may be influenced by what alternatives are available.

For example, in our last report we highlighted the case of a patient who might have been prepared to accept voluntary admission to a bed nearer to home, but was detained in an out of area placement because there were no beds available locally. AMHPs must be supported to make the best decision for the patient at the time of admission. We expect local systems to help AMHPs report, record and understand how to escalate their concerns when they have difficulties in accessing a bed. This information should be reviewed by senior leads identified within local commissioners and providers, and used as evidence to inform action planning and local needs analysis.

Case study: Bed provision in Sussex

On a visit in Sussex shortly after the publication of our last annual report, we heard from AMHPs and doctors that they found it very difficult to secure a bed for informal patients. This was seen as a real disincentive to applying the least restriction principle. The trust responded to our findings and said, "Inpatient hospital beds are allocated regardless of the legal status of the patient. Detained patients are not prioritised over informal patients. We understand that we are obliged to fulfil all admission needs requested."

Concerns about detained patients being prioritised over informal patients for bed allocation were raised at the MHA monitoring group meeting on 13 June 2013. In response to this, it was agreed that each of the AMHP leads in each locality, West Sussex, Brighton and Hove, and East Sussex, would start a three-month monitoring programme to assess the difficulty in securing a bed for informal patients and whether, ultimately, this resulted in detention under the MHA. The group agreed that if an informal patient is subsequently detained due to difficulties securing a bed, a serious incident will be raised.

We commend this as a good practice model that may be adopted by other services.

MHA monitoring visit, Sussex Partnership NHS Foundation Trust, March 2013

Under section 140 of the Act, clinical commissioning groups (CCGs) have a duty to notify their local authority about arrangements for receiving patients in cases of special urgency. They are also obliged to notify them about the provision of appropriate accommodation or facilities for patients under the age of 18. In our last report, we raised concerns that CCGs were not aware of, or did not have in place, arrangements for admitting patients in special urgency. We stated we expected CCGs to notify their local authorities about the arrangements in place.

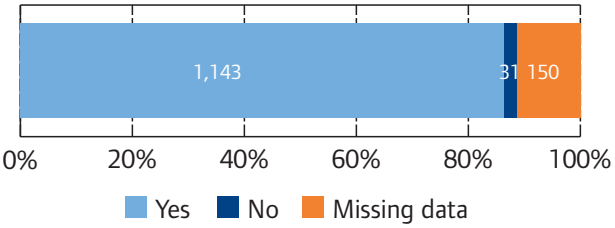
We raised this matter during the review of the Code of Practice. We are pleased to report that the revised Code includes a new section on commissioning and section 140 of the Act (see Code of Practice paragraphs 14.77 to 14.86). This sets out the role of CCGs and also states that local authorities, providers, NHS commissioners, police forces and ambulance services should work together to create clear policies and procedures for patient admission. There is an expectation that there should be a senior review of the operation of the arrangements by all parties. The Code also emphasises the need for commissioners and providers to work together to make sure that patients are placed in hospitals as close to home as possible (see paragraph 14.81). We look forward to reporting on the impact of this development in our future reports.

Mental capacity and deprivation of liberty

The MHA is based on the premise that inpatient psychiatric treatment should, wherever possible, be provided on an informal basis. This is the principle of least restriction in the Code of Practice.

In past reports we have noted an increasing trend of wards being locked. Of all the wards we visited in 2013/14 (including both secure wards and those not designated with a specific security), 86% were locked at the time of the visit (figure 12). In the non-secure sector, wards may be locked for a number of reasons, not all of which are specifically designed to contain patients. However, in all such services locked doors present a risk of *de facto* detention and must be managed carefully by ward staff.

FIGURE 12: Was the ward locked at the time of the visit? Data from all wards visited 2013/14

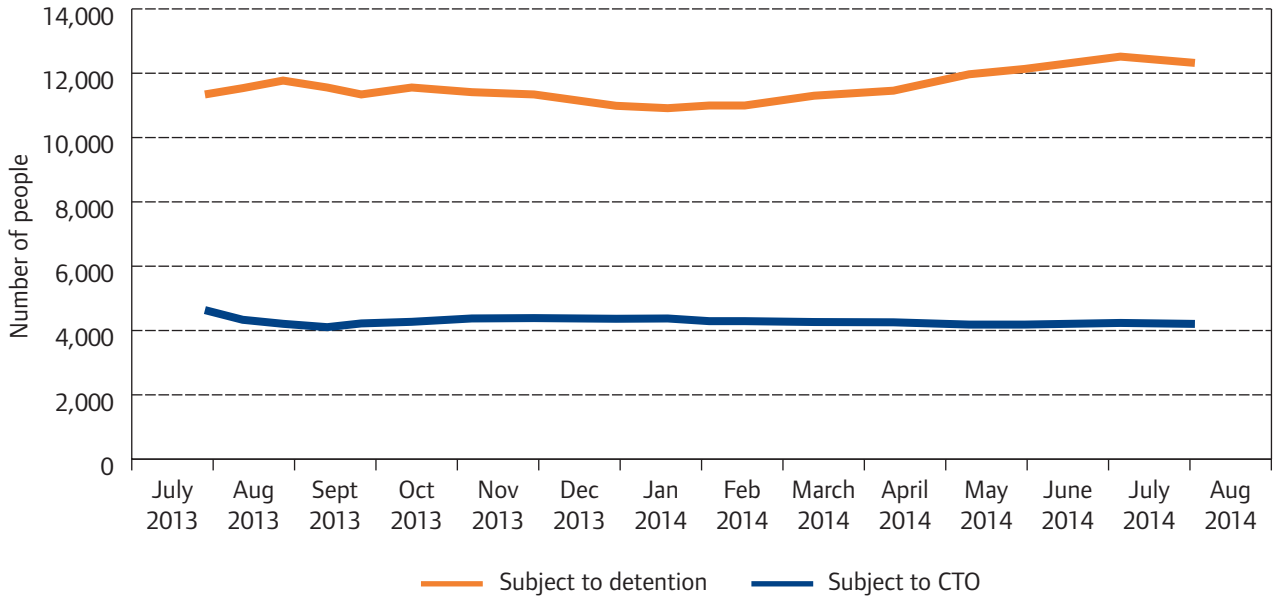


Source: CQC

Following the Supreme Court's ruling in March 2014, which clarified the definition of deprivation of liberty,[18] we issued a briefing for providers that acknowledged that clinical staff of inpatient settings should review the situation for informal patients who lack capacity to consent to admission, and consider if they are deprived of their liberty.[19] The 'acid test' for a deprivation of liberty is if the person is not free to leave and is under continuous supervision. This is likely to be met for any incapacitated patient who requires psychiatric hospital admission. A key role for CQC, in our monitoring both of the MHA and in our wider activities, will be to understand whether the safeguards for these patients have any practical effect.

The Court's ruling has, as expected, resulted in a substantial increase in the number of Deprivation of Liberty Safeguards applications. Some professionals have also reported a resulting increase in the number of MHA assessments carried out. Where a patient is incapacitated but compliant to be deprived of their liberty then, in principle, both a Deprivation of Liberty Safeguards authorisation (or potentially a Court

FIGURE 13: Number of people subject to MHA detention and CTOs, July 2013 to August 2014



Source: Monthly Mental Health Minimum Data Set (MHMDS) Reports, England – August 2014.

of Protection order) and detention under the Act would be available. In these circumstances, decision makers must decide which regime is more appropriate (see paragraphs 13.49 and 13.57). The revised MHA Code of Practice provides some guidance on this (see paragraphs 13.58 to 13.60). We will have to wait for the figures for 2014/15 to analyse the true impact of the Supreme Court ruling, and will look at this information alongside our own data collected from MHA visits and regulatory inspections.

National data available at the time of writing showed that in the five months from April 2014, 893 people were detained in hospital under the MHA (figure 13). This was an 8% rise to a total of 11,510. This is not conclusive evidence of the effect of the Supreme Court judgement, particularly given the general increasing trend in the use of the MHA, although we are aware that some NHS trusts have noted such an effect at local levels.

In March 2014, the Deprivation of Liberty Safeguards were described by the House of Lords Select Committee on the Mental Capacity Act 2005 (MCA) as poorly drafted and overly complex, with the committee recommending a comprehensive review to "start again".[20] The committee highlighted research commissioned by the Department of Health, which showed that the interface between the MHA and the Deprivation of Liberty Safeguards was poorly understood by practitioners. The reasons for this include the fact that "the principles and scope of, and criteria for, the MHA and the MCA are fundamentally different".[21] Witnesses who gave evidence to the committee described how the complex eligibility criteria in the Deprivation of Liberty Safeguards, and their interface with the MHA, caused unnecessary difficulties and uncertainties in decisions about care, which were added to and not resolved by legal judgements.[22]

The Government has responded to the recommendation in their report, *Valuing every voice, respecting every right: Making the case for the Mental Capacity Act*.[23] In it, the Government agreed with the overall finding that, while the MCA was a "visionary piece of legislation", the Act has "suffered from a lack of awareness and a lack of understanding". Their response sets out a system-wide programme of work to improve the implementation of the MCA.

It also highlighted the action CQC has taken and how we have prioritised the MCA in our regulation and inspection model. In addition, the Government has commissioned the Law Commission to carry out a comprehensive review of the Deprivation of Liberty Safeguards, both to consider a simpler mechanism to protect people's rights and also to extend the new provisions to community settings as well as care homes and hospitals.*

Review of mental health crisis care

In 2013/14, we carried out a themed programme of work around crisis care. This was in addition to our routine monitoring of assessment and admission procedures. It met one of our commitments under the Mental Health Crisis Care Concordat.

The review has assessed the quality, safety and responsiveness of care provided to those in crisis, focusing on the three key ways a person may experience the health and care system. It looked at people who experience a mental health crisis and who:

- Go to accident and emergency departments (with a particular focus on people who self-harm).
- Require access and support from specialist mental health services.
- Are detained under section 136 of the MHA (the power police officers have to detain people, believed to have a mental disorder, in a public place and to take them to a place of safety for assessment).

We are also exploring how organisations and agencies work together to provide an effective response within their local area. This includes placing a specific focus on the inequalities and outcomes for particular groups (such as the inequalities experienced by some Black and minority ethnic groups, or by children and young people).

We published a tool that allows people to review information for their local area and healthcare organisations. We also published summary feedback from people who use services and local groups with an interest in mental health crisis care. The tool puts the data into the context of each local authority population. It also highlights how people's experiences and outcomes compare to other local authorities across a range of measures for each pathway.†

We will publish our national report on the crisis care programme in spring 2015. This will highlight our key findings and make recommendations for agencies engaged in improving the help, care and support for people experiencing a mental health crisis.

We will use the results to develop the way we monitor and inspect services. We will:

- Identify indicators developed for the review that could be included in the ongoing Intelligent Monitoring of services.
- Develop tools and methods that can be made part of the new way we inspect health and social care services, to check how they respond to people experiencing a mental health crisis.
- Make sure that the views of people who use services and stakeholders are reflected in the monitoring and inspection of services and localities.

* See **www.lawcommission.justice.gov.uk/areas/capacity-and-detention.htm** for more information.

† The tool is available at: **www.cqc.org.uk/content/thematic-review-mental-health-crisis-care-initial-data-review**

Police powers and places of safety

In 2012/13, there were 21,814 reported uses of section 136 in England. This rose to 24,489 in 2013/14. The use of police stations for people detained under section 136, which has been a continuing cause for national concern reported in our previous report, has been declining in 2013/14.

As part of our review of crisis care, between January and February 2014 we collected information from 56 mental health trusts and two social enterprise organisations across England that are responsible for health-based places of safety. The survey gathered information on the availability and accessibility of places of safety, staffing and training, target times and delays in MHA assessments, governance and multi-agency working, and the role of police and ambulance services. We received a 100% response rate from the organisations surveyed.

In 2012/13, there were 21,814 reported uses of section 136 in England. This rose to 24,489 in 2013/14.

We have used the information collected through this survey to publish an online map,* which shows the location of designated health-based places of safety across England. This map also includes details of opening hours, capacity, the age groups accepted, and the local areas they are intended to serve. In addition, we published a full report of our findings,† and a dataset of the quantitative data collected. While we found that some health-based places of safety are effective, others are less responsive to people's needs and require far reaching improvements. There are four key findings that we believe need to be urgently addressed:

1. Places of safety are turning people away or requiring people to wait for long periods with the police, because they are already full or because there are staffing problems.
2. Providers operate policies excluding young people, people who are intoxicated, and people with disturbed behaviour from all of their places of safety.
3. Commissioners are not adequately fulfilling their responsibilities for maintaining an oversight of the section 136 pathway.
4. Providers are not appropriately monitoring their own service provision. This makes it difficult for those providers and their commissioners to evaluate if provision is meeting the needs of local people.

We have made recommendations to, and shared the report with, providers, CCGs, health and wellbeing boards, multi-agency section 136 groups, local authorities and NHS England. We have called for urgent action on these issues and have asked all agencies involved in the operation of section 136 and health-based places of safety to review the findings and take appropriate action where there are shortfalls over the next year.

We will use this report to plan future inspections, helping to target areas for improvement where we find that practice is not meeting national standards.

* See **www.cqc.org.uk/hbposmap**
† See **www.cqc.org.uk/content/safer-place-be**

2.4 Additional considerations for specific patients

- While there have been small improvements, we are still finding that the provision of, and access to, children and adolescent services is not good enough.
- The needs and best interests of patients under 18 must be taken into account when accessing mental health services, with admissions to adult wards only made when necessary and for limited periods.
- Since April 2013, providers have been legally obliged to notify us when a child or young person is detained in an adult ward for more than 48 hours. We are already seeing limitations with this requirement and have called for a review of the scope of these notifications.
- Services for people with a learning disability continue to vary. We are particularly concerned that hospital placements for people with a learning disability are still not appropriate. In 2013, the HSCIC learning disabilities census showed that 1,000 inpatients (40%) were in hospitals more than 50km from their home.
- Admission to hospital can also make mental and behavioural difficulties worse for people with a learning disability, leading to disproportionately long stays in hospitals. The 2013 HSCIC census showed that 65% of patients with a learning disability had been in hospital for over a year.

Children and young people under the age of 18

We continue to develop our inspection methodology with specific focus on children's services, which we described in evidence submitted in April 2014 to the Health Select Committee's inquiry on child and adolescent mental health services (CAMHS).* As a result, our monitoring of the use of the MHA in respect of children and adolescents now links into wider arrangements focused on children's services.

The core component of this wider focus is our children's services team. This team has looked at the provision of CAMHS services to children since the beginning of their original safeguarding programme, which was conducted with Ofsted from 2009 to 2012. Our new inspection programme started in October 2013.

While we are wary of generalising from limited data, the initial findings that we reported to the select committee suggest that there have been small improvements in some areas in the provision of, and access to, CAMHS services. However, at present there is also evidence to suggest there is not enough provision of tier 3 and 4 services, and that children and young people are still experiencing delays in accessing help and support when they require CAMHS services in other areas.

Notifications of admissions of children and young people to adult wards

The managers of any hospital, to which a patient under 18 years is admitted, must make sure that the environment is suitable and that they have taken the patient's age and needs into account. They are also required to consider the child's needs and best interests in consultation with a

* See **http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/childrens-and-adolescent-mental-health-and-camhs/written/8069.pdf** for more information.

person who has knowledge or experience of cases involving patients under 18.

Since April 2013, providers have been legally required to notify us when a child or young person under 18 is detained in an adult ward for more than 48 hours. This means that we are currently unable to capture data about children and young people who are detained in adult wards for less than 48 hours. However, the Health and Social Care Information Centre (HSCIC) collects data on all admissions of under 18s through the Mental Health Minimum Dataset (MHMDS). In the first year of this notification system being in place, providers told us about 175 children were admitted nationally. The lowest number of admissions in any month was three in June 2013 and the highest was 23 in February 2014. As this is the first year we have captured the data it will provide an initial benchmark, but we will need to look at the data available to HSCIC and align our two systems to identify any gaps.

Two young people had recently been detained on the unit due to a lack of an alternative CAMHS bed. We were satisfied that nursing staff on the unit had done their best to comply with the Code of Practice in these circumstances, and arranged appropriate oversight by CAMHS professionals, according to the local protocol. The trust investigated and reported admissions to adult wards of patients under 18 years old as risk incidents within the organisation, with those involving detention also reported to the Mental Health Act Scrutiny Committee. Following its own review of these admissions, the trust had raised the issue of lack of access to specialist beds for under 18s with service commissioners at a quality contract review meeting.

MHA monitoring visit to St James Hospital, September 2013

In the notifications we received, the reasons given for young people being placed on adult wards varied. The main issues were two exceptional circumstances when it may be appropriate to admit a child or young person to an adult ward:

- **Where admission to an adult ward is clinically and socially the most appropriate environment.** In such cases, patients were older adolescents presenting unacceptable levels of risk for CAMHS services.
- **Where the need for immediate admission was urgently needed to protect the person or others, and there were no specialist resources available.** Reasons recorded on notifications included the phrases, "lack of beds on adolescent wards in an area" and, "emergency – no other service available".

We are aware that the scope of the notifications we receive is limited, particularly as a way of measuring patterns of service provision. Our notification system, which is established by Health and Social Care Act Regulations, only captures placements that last more than 48 hours. As a result, we are not told about the inappropriate admission of people that are transferred to another hospital within 48 hours. However, it is important to note that these types of admission could be an important indication of systemic issues in providing appropriate mental health crisis services to children and young people. Our notification procedure must be seen as the way CQC monitors individual cases, and takes appropriate follow-up action where needed, rather than as a data collection exercise. We would welcome a review about whether the 48-hour threshold for such notifications is appropriate, or whether there should be a shorter threshold, or that all cases where a young person is admitted inappropriately to an adult service should be notified irrespective of the length of that admission.

During 2013/14, all the notifications we received of admissions to adult wards were considered by our MHA monitoring staff and the relevant inspector. We provided guidance to help our inspectors identify when an admission may raise concerns, and how review the factors relating to the individual notification. Such a review might include contacting the provider to ask for more details, or examining the data we hold for that provider, for example information on previous admissions of children and young people and any other available data.

In our guidance, we set out the possible outcomes of a desktop review including: undertaking a separate MHA monitoring visit in response to the notification; action by the inspector in response to the notification; or using the information to inform the next inspection. As a result, on our inspections we look for information about how local services are managing the individual risks to the child or young person. We seek reassurance over general policies and procedures relating to the admission of children and young people and how providers are addressing problems and supporting patients when there are issues outside of their control, such as in the case below.

On a visit to a London trust in May 2013, we were told about the delays and problems in identifying and accessing appropriate inpatient services for children and young people experiencing mental health problems, which have led to patients being cared for in the hospital with increased support. Clearly, this was an ongoing issue that the trust itself had limited power to affect, although we were reassured that there appeared to be a thoughtful and patient-centred approach when trying to identify appropriate services in a timely manner.

MHA monitoring visit to Chelsea and Westminster Hospital NHS Foundation Trust, May 2013

People with a learning disability

Learning disability placements and the MHA

People with a learning disability and their families have not always been served well by the health and social care systems, particularly when they are admitted into mental health hospital environments. Such admissions are not always appropriate or extend beyond the point when alternative community provision should have been identified.

Over the last 30 years, we have seen some changes to the landscape of service provision for people with a learning disability, including the closure of many long-stay hospitals with the intention of "dispersal to small-scale services in home neighbourhoods".[24] Since 1987/88, there has been an almost 90% reduction in hospital-based learning disability beds. There are now fewer than 4,000 such beds in England.[25]

However, some hospital placements of people with a learning disability are still not appropriate. People with a learning disability may particularly be at risk of being admitted to services far from home, to services that are more restrictive than is necessary, or to services that cannot adequately meet their needs. Admission to a hospital that does not provide the specific service a person needs may make mental health or behavioural difficulties worse, leading to the person becoming more deeply embedded in a system of inpatient care.

The scale of the problem was initially set out in December 2013 by the Government publication *Winterbourne View: Transforming Care One Year On*.[26] However, by June 2014, the milestone of having all hospital residents with a learning disability moved to appropriate placements had not been met.[27]

In February 2014, CQC hosted an event chaired by board member Professor Louis Appleby, in conjunction with the Challenging Behaviour Foundation. The Three Lives event was attended by senior stakeholders from across the health, social care and criminal justice systems. Participants listened to the experiences of three people who had been in learning disability assessment and treatment centres. The event led to an agreement to address the remaining gaps. We published an account of that meeting and a list of the actions identified.[28] We were represented on the resulting steering group, chaired by Sir Stephen Bubb who produced the 'Bubb report'.[29] This sets out recommendations for a national framework of service commissioning of community services providing a genuine alternative to institutional care.

In April 2014, the HSCIC published a census of people with a learning disability who were staying in hospital on the night of 30 September 2013. It found that almost four-fifths (78% or 2,536 people) were subject to the MHA, compared with 22% (714 people) who were classed as informal patients.[30] This change may be a reflection of the current types of service, with more than half the existing learning disability beds in the forensic sector and fewer than a quarter in the acute admission sector.

The census showed that the majority of patients had been in hospital for more than a year (figure 14). This illustrates that short-term assessments and interventions for people with a learning disability that involve hospital placements, can become disproportionately long-stay institutional care. Of those subject to the MHA, the majority (99.5% or 2,524 people with a learning disability) were subject to 'longer-term hospital orders' (which lasted more than 72 hours).

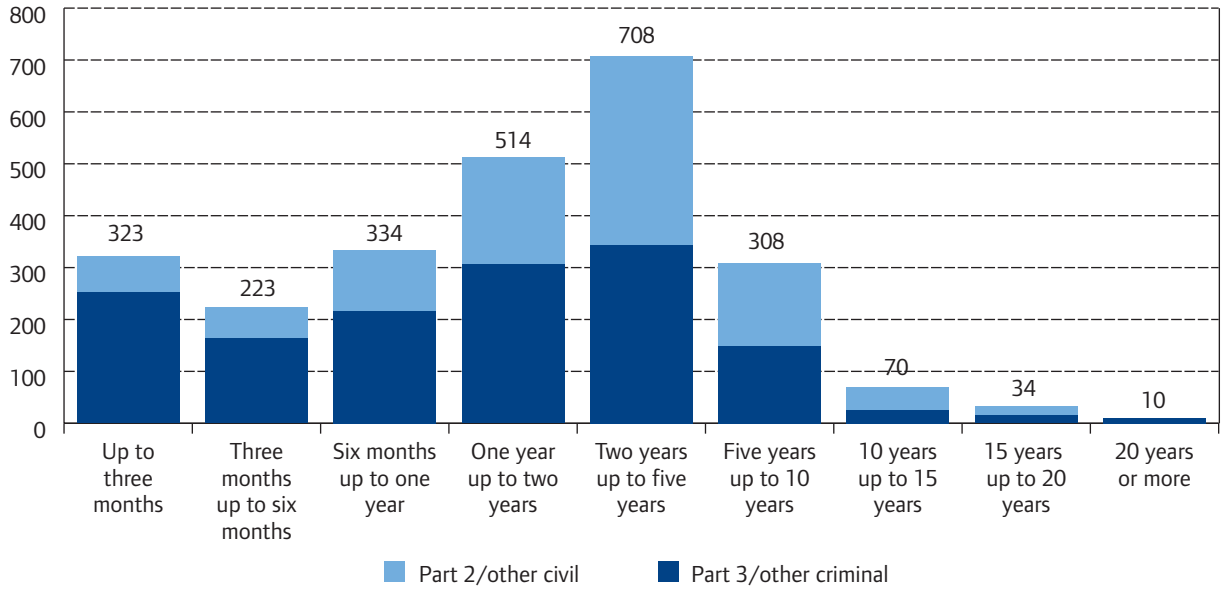
In the 2013 census, 40% of inpatients were in hospital wards more than 50km from their home (figure 15). In some cases, hospital admission takes place many miles from people's homes and families and limits their families' level of involvement. This approach indicates a breakdown in personalised care, where individuals and families are central to care planning.

Services for people with a learning disability continue to vary in consistency of quality of care and we recognise that, alongside commissioning bodies, we have a role to make sure services are safe, effective, caring, responsive and well-led. In 2013, we introduced a programme for registering new learning disability services. Through the programme we have put in place a more robust review of the provider's approach to providing services. This requires them to show us how they intend to provide the service in line with their statement of purpose. This helps us to make a judgement about the service. Learning from this programme will inform our registration improvement programme for all providers.

In the 2013 census, 40% of inpatients were in hospital wards more than 50km from their home.

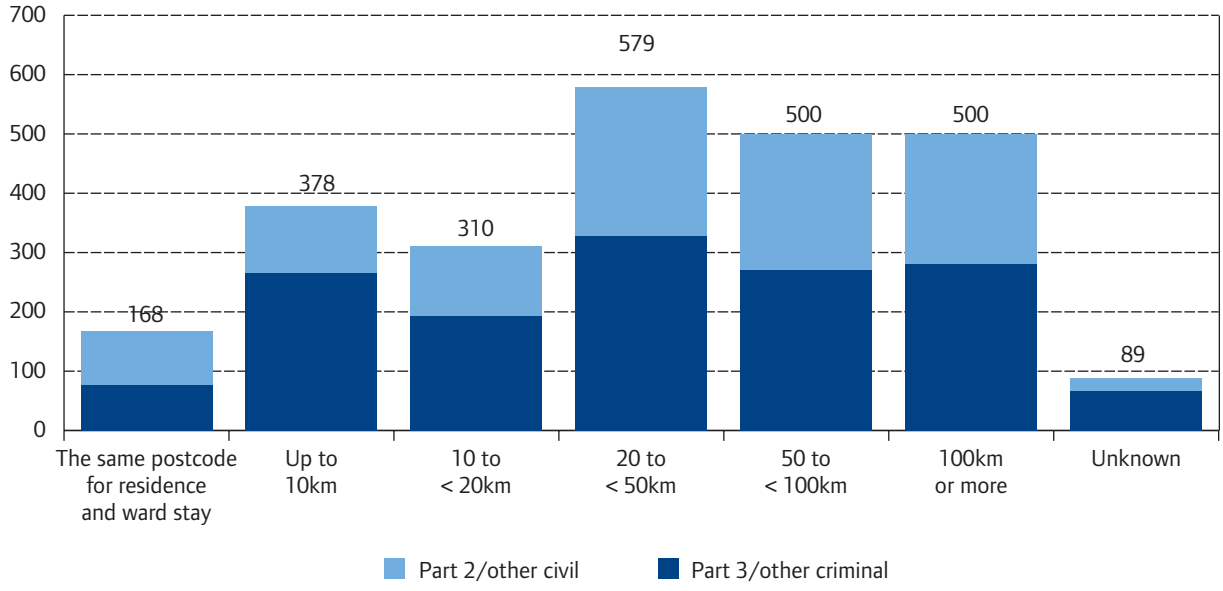
Registration inspectors may contact commissioners about new registration applications, especially if there are concerns that the care they intend to provide may not be consistent with best practice. So far, this has proven to be an effective approach, For example, we refused a registration application for an inpatient facility for people with a learning disability, because of concerns that the model of care was not consistent with *Transforming Care*.[31]

FIGURE 14: HSCIC census 30 September 2013: inpatient length of stay in hospital



Source: Learning Disabilities Census 2013

FIGURE 15: HSCIC census 30 September 2013: distance of hospital ward from inpatient's home



Source: Learning Disabilities Census 2013

The provider subsequently withdrew their application and CQC accepted their withdrawal.

In some specialist learning disability units, we found inadequate care planning that led to prolonged detention. For example, in one service the language and style of the care plans did not meet the communication needs of the patients, and the patients had no specialist speech and language input:

Of the nursing care plans seen, the language and style of presentation did not meet the communication needs of the patients, with no specialist speech and language input. There was little evidence of participation or person-centred planning that is a recognised method of communication for people with a learning disability. There was no evidence of

discharge care plans and, although we were shown a new format for Care Programme Approach reviews that has a discharge planning component, this is yet to be reflected in care planning. Four of the care plans of one patient did not show evidence of review from December 2012.

MHA monitoring visit to Bigfoot Independent Hospital, Equilibrium Health Care Limited, May 2013

There was also little evidence of discharge planning, person-centred care plans, or patients' participation in service planning or care planning. Where we found these issues, we required the services to address them.

Even though the MHA Code of Practice provides guidance to make sure that people with a learning disability can access appropriate specialist care, we have found that some services have been slow to make reasonable adjustments to meet people's needs. For example, some services did not provide people with information about their rights in appropriate and accessible formats. Again, we required the services to address these issues where we found them.

Advocacy services for people with a learning disability

Patients detained under the MHA have a statutory right to be informed that advocacy services are available. The Bubb report recognised the value of having high-quality independent advocates to challenge professionals' decisions about people with learning disability, including decisions about continued inpatient care.[32] However, accessing advocacy services may still be a problem.

On a visit to one specialist learning disability hospital in June 2013, we spoke with advocates, patients and carers. The hospital provided general advocacy in addition to the Independent Mental Health Advocate, but both advocates told us that they were only able to respond to direct referrals due to their workload, and that patients would benefit from an increase in advocacy provision. Experiences of carer and patient involvement were mixed, with some feeling that they were listened to, and others feeling that their involvement in care planning was tokenistic. One carer was frustrated by trying to find out about a patient's care, saying: "[There] have been times when I've spoken to staff and we've had trouble understanding each other. [I] have come off the phone in utter confusion." Another carer said that "staff don't give any information". The IMHA recognised a lack of patient and carer involvement in care planning and review.

At our the Three Lives event in February 2014, we highlighted that individuals with a learning disability do not routinely have access to high-quality independent advocacy services that meet their needs. We recommended that NHS England collect data on the provision of generic independent advocacy services and address any gaps.* NHS England has already begun work on this and plans to include a need to review advocacy in future contracts with provider services.

* See **www.local.gov.uk/place-i-call-home**

2.5 Care, support and treatment in hospital

- Through our MHA visits we continue to find issues with processes around consent to treatment. Although practice has improved over the last five years, it is unacceptable that in over a quarter of the records checked in 2013/14 there was still no evidence of a patient's consent to treatment on admission.
- We are also concerned that patients are still telling us that they had little or no discussion about their treatment. This is unacceptable and may lead to unlawful treatment.
- We will continue to look closely at these issues during our inspections. We commit to sharing examples of good practice where we find these to help ensure that people are involved in their treatment plans and medication choices.

Medical treatment under the Act

Capacity and consent to treatment

The Code of Practice states that, although the Act permits some treatment of mental disorder without consent, the patient's consent should still be sought before treatment is given, wherever practicable, and a record made of consent or of its refusal.

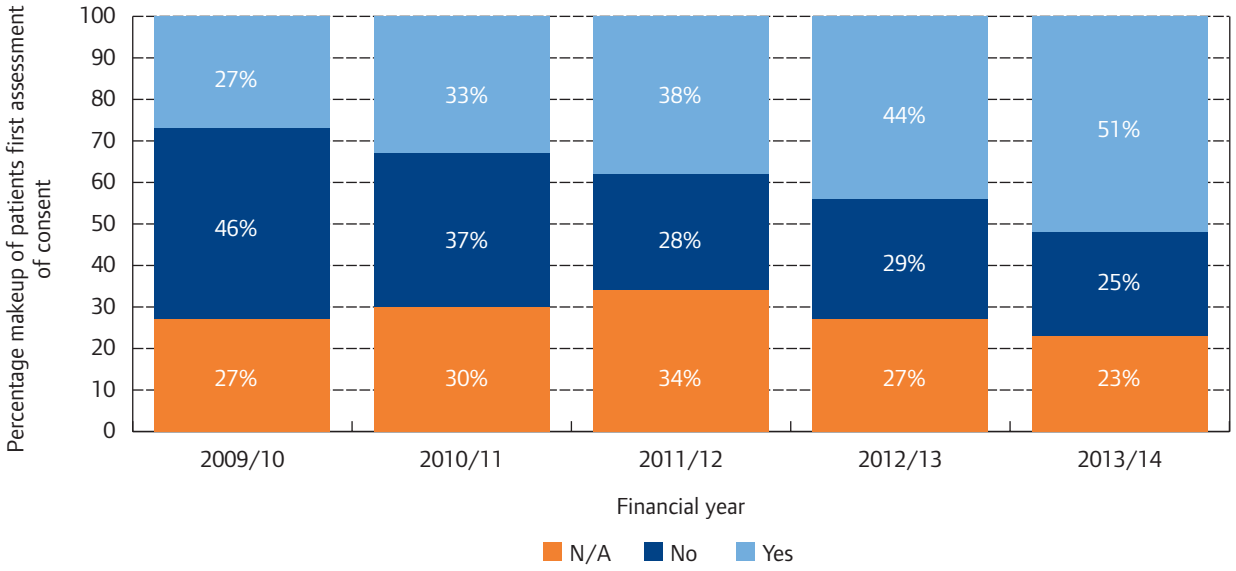
For a number of years, we have been reporting on the high number of issues we have found on our visits about consent to treatment processes and in relation to the standards required by the Code of Practice. For example, clinicians starting treatment without considering whether the patient is able to consent or without documenting the patient's views on the treatment provided. Although practice has improved over the last five years, it is still unacceptable that we found no evidence of an assessment of the patient's consent to treatment on admission in over a quarter of the patient records we checked in 2013/14 (figure 16, page 58).

In addition, on our MHA visits we continue to find clinicians assuming a patient's consent, without considering whether they have the capacity to consent or having meaningful discussions with them about the treatments on offer. We also continue to meet patients who tell us that they had little or no discussion about their treatment. This undermines the safeguards relating to compulsory treatment under the Act. It is unacceptable and may lead to unlawful treatment. In some cases, patients had expressed refusal of consent to treatment, but were still being administered the treatment under certification of consent by their treating doctor.

The Code of Practice states that it is not good practice simply to state a patient's consent status on the statutory form. There should also be a documentary record of the process that led to the decision, and evidence that the patient was able to give informed consent. This includes an outline of discussions with the patient.

Consent to treatment now forms a key line of enquiry in our new inspection approach. We will use the MHA Code of Practice and the MCA Code of Practice to guide our assessments on capacity and consent. We will continue to look at the links between staff training, patient concerns and the application of the law in this area. Our aim is to understand whether the continuing lack of evidence of consent discussion in patient records is because the discussion is not being documented, or because the discussion is not taking place. If we find that the provider is in breach of the Act and regulations in this area, we

FIGURE 16: Examination of patient records 2009/10 to 2013/14: evidence of assessment of capacity of consent to treatment at admission



Due to rounding, percentages may not total 100%.
Source: CQC

are able to use our enforcement powers to make sure they meet the required standards.

As a starting point in our inspections and reviews, we ask our staff to look for evidence that the patient's capacity and consent has been considered. A lack of evidence is an indication that our inspection teams need to investigate further. This may include discussions with patients, clinicians and managers to determine why there is no evidence available.

Our ability to look in more detail at the practice and policies, particularly for serious interventions such as those listed in section 2.6, is a key benefit of our new integrated approach to our regulatory framework. We are looking at how we can maximise opportunities to increase reviews carried out by specialist professionals in inspection. This includes testing the way our Second Opinion Appointed Doctors could help to inform our inspection teams in early 2015. Through our commitment to look for good practice in our inspections, we also hope to be able to report on examples of the innovative ways services have found to make sure that people are involved in their treatment plans and medication choices, as well as any adaptations they have made to these for MHA patients.

2.6 Treatments subject to special rules and procedures

- In 2013/14, we continued to see a decline in the number of requests for electroconvulsive therapy (ECT) treatment certification, with 127 SOAD visits per month in 2013/14.
- We were concerned to hear that operating centres offering neurosurgery for a mental disorder (NMD) may be taking on patients without there being a close and continuing link to a mental health service in the patient's home area. This is poor practice and may lead to decisions that are not in the patient's best interests. We will be focusing more on this area.

- We were alarmed that urgent or emergency treatment powers are being used beyond their intended purpose. Providers must make sure that these powers are only being used for the direct and immediate benefit of the patient.
- Throughout 2013, we developed and introduced a process for reviewing section 61 forms. We were concerned that for a high proportion of the 693 forms we reviewed, we could not be sure if patients were receiving treatments using a legally valid certificate. We will be reviewing this as a matter of urgency.

Electroconvulsive therapy

In our previous reports, we have noted the decline in the number of requests for certification of electroconvulsive therapy (ECT). In 2013/14, we arranged an average of 127 SOAD visits each month to consider ECT certification. As there are now more patients detained under the Act than in any previous year, this suggests that detained patients are now less likely to be referred for ECT than in previous years. We have also suggested reasons for this decline may include the falling numbers of beds, the availability of more alternative antidepressants, patient resistance to ECT treatment, or a reduction in the number of ECT facilities.[33]

We do not have comparable statistics on the administration of ECT to patients who are not subject to the MHA, although data published in August 2013 by the Royal College of Psychiatrists provides a baseline figure. Of the 1,894 courses of ECT reported in a survey of ECT use over 2012/13, 832 (56%) were administered to patients on an informal basis. In 80 of these cases (4% of ECT courses given), the patient was deemed to lack capacity to consent, so that legal authority would have come from the Mental Capacity Act.[34]

Section 57: neurosurgery for mental disorder

The MHA requires that before any patient can undergo neurosurgery for mental disorder (NMD) it must be approved by a CQC-appointed panel. This is defined in the Act as a surgical operation for destroying brain tissue, or the function of brain tissue, for the treatment of mental disorder. Referrals for the treatment over the last five years are shown in table 15.

The main reason our panels decline to certify treatment is that the patient lacks the capacity to consent to the treatment. Withdrawals of requests usually result from patients asking for a different treatment, or clinical teams agreeing to try something else before reconsidering neurosurgery. Today, patients for whom surgery is proposed usually have a long history of depressive disorders, often with additional complicating psychological issues. As NMD is a treatment of last resort, patients who are referred can see it as their only hope for otherwise intractable illness. However, in some cases the review process has demonstrated to clinical teams that all other options have not yet been tried.

TABLE 15: Referrals to the CQC section 57 panel for consideration of NMD, 2009/10 to 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14
Referrals	1	0	2	6	7
Treatment certified	1	–	2	2	2

Source: CQC

We believe these cases demonstrate the important safeguard provided by the requirement for approval via a panel.

We have become aware of an emerging practice whereby operating centres may be taking on patients without there being a close and continuing link to a mental health service in the patient's home area. We consider this to be poor practice and without such a link both the post-operative follow-up, and indeed the pre-operative exploration of other options, may not be pursued in the patient's best interests. This is an area that we intend to focus on.

Deep brain stimulation

In our first report on monitoring the MHA in 2009/10, we expressed concern that treatment with deep brain stimulation (DBS) was beginning to be used as a treatment for mental disorder on a trial basis.[35] DBS is a procedure related to leucotomy, but carried out by placing electrodes in the brain rather than cutting brain tissue. As such it is not subject, in England and Wales, to any of the safeguards of older forms of neurosurgery. We do not know the extent to which DBS is being undertaken in England as a treatment for mental disorder. It is worth noting that DBS has been made subject to special safeguards in Scotland, following clinical advice received by the Scottish Executive.[36]

We repeat our suggestion to Government that the Mental Health regulations should extend the safeguards of section 57 to the use of DBS as a treatment for mental disorder.

Urgent or emergency treatment

The MHA provides powers to administer treatments that the responsible clinician believes must be given with some immediacy, before a SOAD can attend to explore the issues in the usual manner. It is important that these provisions are available, as there are clinical situations where time is of the essence and where an intervention under these provisions can be truly lifesaving.

Section 62 sets out powers for "urgent" treatment for detained patients, while section 64G refers to "emergency" treatment for those subject to a CTO. The necessary steps for using these sections are fundamentally similar. They allow any treatment to be given that is considered immediately necessary to save someone's life. However, treatments designed to prevent the patient from behaving violently or being a danger to themselves must not be irreversible or hazardous and must involve the minimum amount of interference.

As a result, we expect responsible clinicians to make urgent or emergency treatment decisions by prioritising the least invasive method, of the least problematic treatment, for the most justifiable reason.

We are concerned that information from our SOAD service shows these measures being used beyond their intended purpose, in situations neither urgent nor an emergency as defined by the Act. Providers must make sure that urgent or emergency treatment powers are being used for the direct and immediate benefit of the patient, and not for clinical convenience as in the case study on page 61.

Some providers seem to take the view that urgent treatment can be approved retrospectively by the attendance of a SOAD and the issuing of a certificate. The legal position is that the SOAD cannot and does not certify treatments already provided under section 62 by the time of their visit. Treatments given before a SOAD visit stand alone and are for the treating team to justify.

The Code of Practice states that hospital managers should monitor the use of urgent

Case study: Clinical convenience

A 56-year-old woman, detained under section 3, was visited by a SOAD on a general hospital ward in April 2014. The SOAD agreed with the diagnosis of a frontal lobe dementia and that medical treatment was necessary due to agitation and challenging behaviour. Antipsychotics were not warranted because they may have caused a side effect, which led to a cardiac arrest. The proposed treatment plan, excluding antipsychotics, was agreed by the SOAD and a T3 certificate issued.

The patient was visited again by the same SOAD five months later in September 2014 having been transferred to a mental health unit. This second opinion had been requested shortly before the visit by the responsible clinician appointed following transfer from the general hospital.

The SOAD then discovered that on the same day as his previous visit in April, a section 64G form had been completed to support the use of antipsychotic drugs and they were then prescribed for the next five months without a request for a further SOAD opinion.

We had serious concerns with this practice:

- The wrong piece of legislation was used (section 64G is for community patients; this patient was a detained inpatient).
- The statutory certificate was in effect ignored – perhaps by another doctor who seemingly disregarded the SOAD's certificate and prescribed a medication which had been excluded – thus placing the patient at risk of a potentially fatal side effect.
- The urgency criteria had not been met and there had been no change in the patient's condition in the time between the SOAD's visit and the certificate of "urgency".
- Having decided to commence "urgent" treatment this was sustained for many months, during which there was no request for a second opinion nor any scrutiny of the certification requirements made.

Therefore the legal basis on which this treatment was given was plainly questionable and the patient had no statutory safeguard during that time.

treatments and exceptions to the certificate requirements to make sure that they are not used inappropriately or excessively. They are advised to provide a form (or other method) by which the clinician in charge of the treatment in question can record details of:

- The proposed treatment.
- Why it is immediately necessary to give the treatment.
- The length of time for which the treatment is given.

We also expect providers to make sure that treatments given on this basis are reviewed regularly. Clinicians must specify review periods at the point that the urgent or emergency treatment is instigated.

Statutory review of treatment

Section 61 contains a number of provisions aimed, for the most part, at reviewing the treatment of patients who have had a second

opinion certificate and who remain detained for a significant period after this is issued. There are two components of section 61 which are of particular interest:

(i) For such a patient, the responsible clinician must complete a form on the next (and every subsequent) renewal of the person's detention (or when submitting annual review forms to the Ministry of Justice in the case of restricted patients), explaining what treatments have been given, what the response has been, and whether it is intended to continue treatment as authorised.

(ii) CQC can obligate the clinical team to provide information as to treatment and progress, as described above, at whatever intervals it appears to them to be appropriate. Typically, the SOAD will indicate on the report form which accompanies their certificate that such information should be provided sooner than at the next renewal of the detention. This measure is used where, for example, the SOAD considers that aspects of the treatment need special monitoring, or the necessity for it may not be sustained, or the clinical condition of the patient is likely to alter so the treatment becomes unnecessary or inappropriate.

Throughout 2013, we developed and implemented a mechanism for the clinical review of section 61 forms submitted by providers. The forms are allocated to a member of a panel of trained reviewers, which is drawn from the SOADs. The panel examines the information supplied by the provider, and compares it against the data on the original second opinion certificate, together with the report the visiting SOAD completed. Outcomes of the review may be that there are no issues arising, there is a recommendation that further information is sought from the provider, or there is a recommendation that a new SOAD visit takes place. This process allows for robust scrutinising of provider practice. This system also provides an opportunity to review the practice of the SOADs, in addition to the system of quality improvement audits we complete.

This scrutinising system has now been in operation for one year, and we can provide figures for the number of section 61 forms scrutinised in 2012/13 (table 16). We asked providers to give us further information in 693 of the records we reviewed. Disappointingly, for a high number of these cases we could not be sure if patients were receiving treatments using a legally valid certificate. We continue to follow these cases up with individual providers and take the appropriate action.

This is a matter we are reviewing closely. Data arising from the scrutiny process may also form part of the intelligence used by inspectors when carrying out comprehensive inspections.

TABLE 16: Number of section 61 forms scrutinised and outcomes in 2012/13

Section 61 form scrutinised	No further action needed	Letter sent to provider for more information	New SOAD visit advised	Practice improvement for SOAD highlighted
2,588	67% (1,747)	27% (693)	2% (58)	4% (90)

Source: CQC

2.7 Safe and therapeutic responses to disturbed behaviour

- We continue to influence national policy on restrictive practices. In 2014, we worked with the NHS Confederation to develop guidance for providers and what we expect providers to do.
- We carried out 47 seclusion monitoring visits in 2013/14. Although many services are now meeting our expectations, some are still inadequate. We re-emphasise our expectation that providers must make sure patients feel supported, involved and respected by their care team, particularly after a period of seclusion.
- Data on physical restraint practices are still incomplete, with only 27 organisations submitting data to the Mental Health Minimum Dataset. This is unacceptable. All providers must make sure that they are consistently recording all incidents of restraint.
- In 2013/14 we carried out 49 visits to the three high security hospitals. We found issues with long-term segregation and night time confinement.

Restrictive practices

Due to the impact on patients, we have constantly prioritised the monitoring of restrictive practices in our duties under the MHA. We look at the ways providers make sure restrictions are kept to a minimum for all patients, and that any restriction is being applied for the minimum period and in a way that protects their rights and dignity.

This year, our work has been driven by the findings we made in our last report and we have, and will continue to, influence the national policy agenda on restrictive interventions. This includes using our findings and the issues that patients report to us during our interviews to make recommendations to the Secretary of State on the content and specific requirements of the Code of Practice.

In April 2014 the Department of Health published their guidance to promote the development of therapeutic environments and to develop a culture where restrictive interventions are only ever a last resort.[37] We have since worked collaboratively with the NHS Confederation to produce a summary of the guidance and what we expect providers to do in practice.[38] The summary sets out our monitoring and inspection approach with the guidance and our intention to look at the implementation of the guidance across providers in a phased approach. This means we can outline what 'good' looks like for providers now and in six and 12 months' time.

Seclusion

As part of our work in 2013/14, we made 47 visits to 51 wards to review seclusion and long-term segregation practices. The format of these visits varied, although most were announced so services could prepare information for our review. We visited unannounced if we had concerns at practice in a unit and wished to see the situation without giving notice. Our MHA reviewers interviewed patients and staff, looked at facilities, and reviewed documentation relating to seclusion and long-term segregation. In some cases, we extended our visits to also look at rapid tranquilisation, the prevention and management of violence and aggression, and searching of patients.

Our announced visits prompted hospitals to look at their own practices and identify areas for improvement to discuss with us. One trust had already established an action plan, which included plans to improve seclusion records, to discuss incidents at team and governance meetings, and to carry out routine audits.

Although many services now meet our expectations for seclusion practices, including arrangements for reviewing, monitoring and governance of practices, we still see inadequate services. We expect all professionals who provide support after any period of seclusion, to work on the basis that they will always need to take additional steps to make sure that the patient continues to feel supported, involved and respected by the team caring for them.

We are pleased to note that the revised Code of Practice stresses the need for debriefing and support after seclusion ends and some services are already implementing this following the advice of our past annual reports.[39,40]

Physical restraint

On our visits, we look closely at restraint practices. This includes reviewing the policies and processes relating to restraint and discussing issues with individual patients. In particular, we look for evidence that staff only use physical restraint as a last resort, and providers are addressing factors in the ward environment that can contribute to disturbed behaviour.

Data held by the MHMDS provides services with a useful tool for comparing their own practices against regional and national averages, such as inequalities in restraint practices. At present, not all providers submit data to the MHMDS. We always look for providers to be submitting complete data sets to MHMDS and make sure that they are monitoring and benchmarking practices.

Current MHMDS data on physical restraint appears to be incomplete, with only 27 of 67 organisations submitting data. This is less than half the number of organisations represented in MHMDS returns overall. In October 2014, HSCIC published their report, *Measures from the Mental Health Minimum Dataset (MHMDS), England: 2012-13 physical restraint*, which analysed 48 providers, and found that only 27 had returned data in 2012/13.* This is not good enough and all providers should make sure they are consistently recording all incidents of restraint. MHMDS returns form part of the Intelligent Monitoring that guide our comprehensive inspections, and we are holding providers to account if we find they are not submitting data.

At present, data held by the MHMDS does not yet cover the majority of independent providers and is not limited to patients subject to the MHA. Nevertheless, it shows that such datasets can provide rich data that could be used to inform local practices, for example ethnic monitoring of restraint practices (table 17).

High security hospitals

There are three high security hospitals in England: Broadmoor, Ashworth and Rampton. In 2013/14, we made 49 visits to the hospitals and met with 90 patients. Through our visits we found issues around long-term segregation and night time confinement. We are looking at the ways we can improve our monitoring arrangements for the high security hospitals through the integration programme, but this section highlights some of the key issues we have found over the last five years.

Since the introduction of the MHA, the number of patients resident in high security hospitals has halved from around 1,650 in 1985 to around 800 today.[41, 42] In the last five years we have made an

* See **http://www.hscic.gov.uk/suppinfofiles**

average of 48 visits each year (figure 17, page 66), with 49 visits in 2013/14.

Since the introduction of the MHA, the number of patients resident in high security hospitals has halved from around 1,650 in 1985 to around 800 today.

In each of the last five years, we have met with an average of 115 patients detained in high security hospitals. Last year, we met with 90 patients. Over the last two years, the number of patients we have met with has decreased, and we have alerted our visit managers to this trend to review practice (figure 18, page 66).

Long-term segregation

During our visits to the high security hospitals, we look at the arrangements for segregation and long-term segregation. Over the last two years we have had to challenge some of the regimes in place. We have sought, and received, reassurance from the hospitals that formal reviews have been carried out to reduce unnecessary restrictions. Below is a case study of long-term segregation in practice at Broadmoor Hospital.

The hospital has stated that they found no link between the incident in July 2013 and staffing levels, and we have no reason to dispute this. MHA Reviewers have subsequently discussed the incident with the hospital management and continue to pay a close interest in the management of the ward when visiting the hospital.

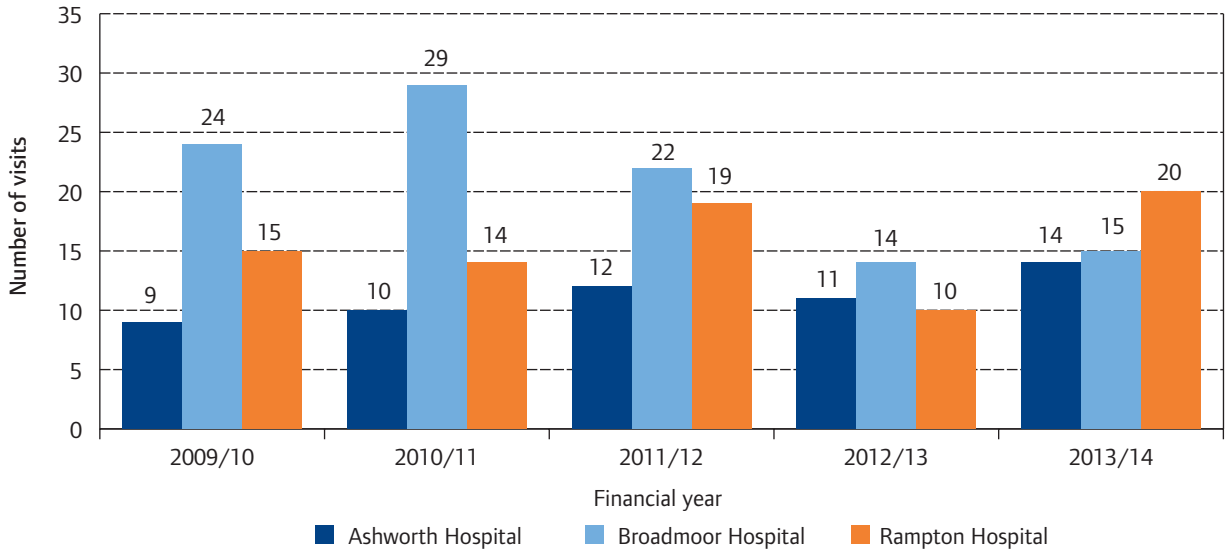
In 2014/15, we are planning to conduct focused work on the issues relating to segregation, across the sector and including the high security hospitals, which will help us to draw from wider learning. This work will also look at the ways we can learn from practices carried out by other regulators and monitoring bodies that work in other settings where segregation may be used.

TABLE 17: Physical restraint by ethnicity and quarter, 2012/13

	Apr – Jun 2012		Jul – Sept 2012		Oct – Dec 2012		Jan – Mar 2013	
	Number of restraints	Number of people	Number of restraints	Number of people	Number of restraints	Number of people	Number of restraints	Number of people
White	2,625	878	3,006	846	3,966	1,033	3,441	931
Mixed	81	32	64	35	119	33	140	33
Asian or Asian British	136	63	151	61	200	49	138	44
Black or Black British	188	84	250	73	396	102	182	93
Other ethnic groups	47	24	31	18	67	27	43	20
Unspecified	1	1	2	2	7	3	1	1
Not known	33	17	46	16	48	23	59	29
Not stated	342	80	454	98	504	90	590	105
Total	**3,453**	**1,179**	**4,004**	**1,149**	**5,307**	**1,360**	**4,594**	**1,256**

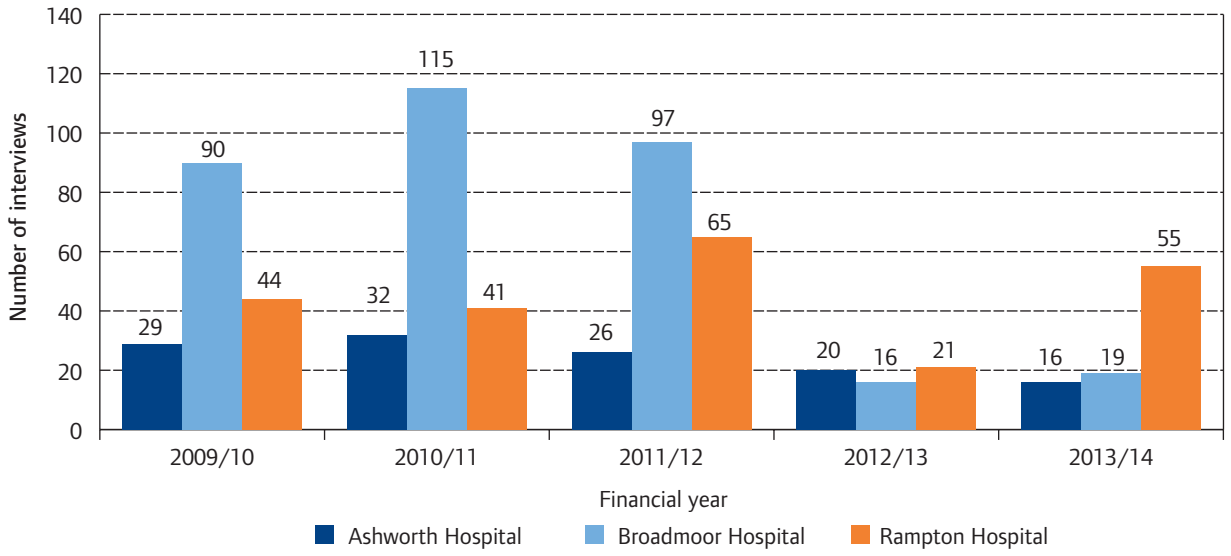
Source: MHMDS Version 4.1

FIGURE 17: MHA monitoring visits to high security hospitals, 2009/10 to 2013/14



Source: CQC

FIGURE 18: Meetings with detained patients in high security hospitals, 2009/10 to 2013/14



Source: CQC

Night time confinement

In our last report, we included information on the pilot and partial introduction of night time confinement in the high security hospitals. In 2013/14, all three high security hospitals extended their implementation of night time confinement.[43]

By November 2013, Ashworth Hospital had introduced it across the whole the hospital.

Patients on the eight wards already confined in July and August 2013 had been asked by the management team in Ashworth to complete a short survey on their views and experience of confinement. The survey results (from 58 patients who completed this questionnaire) showed that 45% of respondents rated their experience as positive, 31% stated they did not mind, with the remaining 24% stating their experience had been negative.

Case study: Long-term segregation in practice

In July 2013, there was a serious incident on a high dependency ward for personality disorder at Broadmoor Hospital, when some patients broke into a nursing office and caused damage on the ward. The incident was contained by hospital staff although police and ambulance services were called.

We had visited the ward at the end of April 2013, and listened to complaints from patients that the regime was limiting access to fresh air and activities. From July 2012, patients on the 12-bedded ward had been divided into two groups, with each group allowed out of their rooms for association for two hours in the morning and two hours in the afternoon. Hospital managers explained that this arrangement was to deal with the high risk of violence and to the hospital's security posed by some of the patients on the ward.

We sought and received reassurance from the hospital that the arrangements on the ward had been subject to formal review, and that there had been several relaxations in the initial regime following these reviews, including increased access to off-ward activities for some patients. The hospital acknowledged that not all the patients on the ward required such a strict regime and told us that those who did not were allowed to spend time on a medium dependency ward during the day. However, capacity for this is limited and on the day of our visit we did not see any patients attending the medium dependency ward. We were told that the ward regime had had a positive impact on some of the patients who were very withdrawn due to the threats and bullying they faced from some of the other patients.

We acknowledged the reasons for introducing long-term segregation, but expressed concern that this regime was imposing unnecessary restrictions on some patients who do not warrant them, which could hinder their progression through the care pathway. Our concerns were linked to whether resource levels, including staffing, were adequate to avoid this. The managers acknowledged these concerns and committed to monitoring and reviewing the arrangements closely. They informed us that since the introduction of the new ward regime there had been a steady progression of patients out of the high dependency ward.

Ashworth commissioned further research by the Ashworth Research Centre which commenced in August 2013, in partnership with the University of Central Lancashire, to evaluate the impact of night time confinement across all remaining wards.[44] The analysis will include a survey of patient and ward staff perceptions of night time confinement; examining the possible effects on the general atmosphere of wards; reviewing patients' engagement with therapy, patients' sleep quality and sleep hygiene, and patients' emotional recognition acuity. In addition to this, researchers will survey the rate of incidents, seclusion and other metrics of overall ward safety, security and patient agitation.

2.8 Leaving hospital

- There were 5,365 people subject to CTOs on 31 March 2014.
- In 2013/14, we made 24 visits to look at the use of CTOs and spoke to 175 people under CTOs.
- We urge commissioners and providers to compare the evidence base on the benefits of placing people on CTOs (for example, impact on patient outcomes and budgets) with their local data.
- Providers must make sure that good care planning is in place for all patients and recognise that the success of a CTO depends on the individual's care plan.

Community treatment orders

Community treatment orders (CTOs) were introduced in November 2008. They are an option for discharging patients detained in hospital for treatment under the Act. Patients subject to a CTO can have certain conditions imposed on them, such as where they live, but these conditions cannot compel treatment or authorise a deprivation of liberty. In certain circumstances, a patient under a CTO can be taken back into hospital for a period of up to 72 hours. Within that time, the CTO can be revoked, reinstating the detention order in force before the CTO took effect.

On 31 March 2014, there were 5,365 people subject to CTOs and 18,166 people detained under the Act in hospital.[45] The number of people detained in hospital has continued to increase at a similar rate to that reported before the introduction of CTOs (table 18). In last year's report, we noted the view of the House of Commons Health Committee that further research is needed to look at the impact of the use of CTOs on readmission rates and the value of CTOs in different clinical and social circumstances.[46]

In October 2013, the Government responded to the concerns of the Health Committee, highlighting that it was reviewing guidance around CTOs as part of the wider review of the Code of Practice. It also pointed to phase two of the Government-funded research from the Oxford Community Treatment Order Evaluation Trial (OCTET), which will be looking at 'coercion in mental health: patterns and prevalence of coercion in mental health care' and a trial of the effectiveness and costs of CTOs.

At the time of writing this report the research has not been published, but we would like to repeat our call to commissioners and providers of services to compare the evidence base on the benefits of placing people on CTOs with their local data. This includes reviewing the positive outcomes and cost benefits that can be achieved through social care, social network and employment focused interventions, and how this impacts on decisions about service priorities.

Care planning and CTOs

In past reports, we have noted examples of poor care planning and engagement with patients on CTOs. We continue to find such cases. In the following examples, the service responded quickly to require the relevant clinicians to meet with the patients concerned.

Following feedback from stakeholders and our own findings across CTO patients and inpatients, the revised MHA Code of Practice includes an updated chapter on care planning. The revised Code re-emphasises that care planning, along with the input of a care co-ordinator, is essential to the success of a CTO (see paragraph 29.20). The Code also underlines the duties to inform CTO patients of the legal and factual grounds for

the CTO, and provide information about legal rights, including the continuing right to independent mental health advocacy (see paragraphs 29.17 and 29.33). We will be looking to see that these requirements and good practices are being met when we make regulatory inspections of community services.

Monitoring the use of CTOs

In 2013/14 we made 24 visits specifically to look at the use of CTOs and to meet with patients, relatives and professionals. We met with 175 patients subject to CTO during the year (table 19, page 69).

During the last year, our visit programme has primarily focused on visiting places of detention, so arranging to meet CTO patients can be challenging. As all CTO patients will have been detained in hospital, many are understandably reluctant to return there to meet MHA Reviewers. As a result, we have developed guidance for MHA Reviewers on organising their visits. This suggests more user-friendly environments in which to hold meetings, and also protocols for contacting patients by telephone through arrangement with hospitals' MHA administrators. In some cases we have organised CTO visits on days when Second Opinion Appointed Doctor visits have been arranged. We also pay the travelling expenses of any CTO patient who has arranged to meet us.

TABLE 18: Patients detained in hospital or on community treatment orders on 31 March 2014 – rates per 100,000 population

		Subject to the MHA		*of which*			
				Subject to detention		Subject to CTOs	
	Estimated population	Number	Rate	Number	Rate	Number	Rate
2014	53,865,800	22,531	43.7	18,166	33.7	5,365	10.0
2013	53,493,700	22,207	41.5	16,989	31.8	5,218	9.8
2012	53,107,200	22,267	41.9	17,503	33.0	4,764	9.0
2011	52,642,500	20,938	39.8	16,647	31.6	4,291	8.2
2010	52,196,400	19,947	38.2	16,622	31.8	3,325	6.4
2009	51,815,900	17,828	34.4	16,073	31.0	1,755	3.4
2008	51,381,100	–	–	15,181	29.5	–	0.0
2007	50,965,200	–	–	15.339	30.1	–	0.0
2006	50,606,000	–	–	14,625	28.9	–	0.0
2005	50,194,600	–	–	14,681	29.2	–	0.0
2004	49,925,500	–	–	14,000	28.0	–	0.0

Source: HSCIC

TABLE 19: Number of community treatment order visits and patient interviews completed, 2009/10 to 2013/14

	2009/10	2010/11	2011/12	2012/13	2013/14	% increase
CTO visits	7	14	35	12	24	242%
CTO patient interviews	82	41	109	20	175	113%

Source: CQC

Case study: CTO poor planning

- Patient A reported that he had been on a CTO for three years. He stated that he did not know why he was on a CTO, why it had been renewed and in what circumstances he would be discharged from it. The patient stated that he "would like to go back to work, but the CTO is stopping me". He felt that he needed more support from the community team, but didn't know how to get it. The patient appeared to know little about the contents of his care plan, other than he has to take medication. "If I don't take the medication, I will have to go back to hospital."
- Patient B was unclear as to why she was on a CTO and the reasons for renewal. In addition she stated that her care plan had not been discussed with her. The current care plan incorporates information going back to 2011 and has not been updated to reflect a reduction in the medication. The patient was also due to go on a holiday, but there was nothing in her care plan about the arrangements for this.

MHA monitoring visit to North East London NHS Foundation Trust, July 2013

3 Looking forward

Conclusion and next steps

THIS REPORT HAS PRESENTED FINDINGS FROM OUR WORK TO KEEP THE APPLICATION OF THE MHA UNDER REVIEW AND ACT AS THE GENERAL PROTECTION FOR PATIENTS SUBJECT TO THE ACT.

This year we have looked at the ways we work with others to prevent variation and address some of the recurring themes that we have reported on over the last five years. We need to continue to work closely with providers and commissioners to see real change for patients. We believe that this will be helped by our programme of work to strengthen our monitoring of the MHA and our regulatory function, as well as by the updated principles and requirements of the revised Code of Practice. Some of our priorities for the year ahead are set out below.

Our challenge to providers and the system

Ensure local planning of services is completed using the data available from the operation of the MHA

- Commissioners and providers need to work together to look at the way MHA specific services are established, with particular attention to the issues we discuss in this report. These include availability of sufficient beds, appropriate treatment and independent mental health advocacy (IMHA).

- In the report, we highlight several areas where national datasets are not being completed by providers. Local services should look at their systems, and remedy any exceptions to data returns to make sure we can use this to inform improvements to patient care.
- Providers and commissioners should carry out audits and investigations to assess local needs if the data does not exist. Under the MHA Code of Practice, hospital managers are required to audit and manage the MHA. Such audits should be routinely completed and available for use.

Help people to understand their legal rights and be involved in treatment

- Local policies, training and audits should help staff to understand the specific needs of people and their families or carers, and their role in making sure that people are informed of their rights.
- Hospital managers should carry out improvements and shared learning using the local evidence available. They should also work jointly with other services, including local IMHA providers, wherever possible.
- Complaints from people subject to the MHA should be used to inform practice. They should also be used to highlight any difficulties patients have in accessing information about the MHA or their individual care. Complainants, and the staff responsible for processing complaints, must be aware of CQC's role in complaints.

Providers and commissioners should work together to prepare a plan for implementing the revised Code of Practice

- The revised Code of Practice is an opportunity for local services to look at their current practice and assess this against the latest best practice guidance about people subject to the MHA.
- We encourage all providers to review all services that will be affected by the changes to the Code. Working with patients, staff and other agencies, they should develop a plan for local implementation that will improve the experience and outcomes for people subject to the Act.

CQC will:

Strengthen our inspection and monitoring approaches for the MHA – We will look at providers' application of the MHA as a priority in all our mental health inspections. We have increased our opportunities to meet with people affected by the MHA, and are routinely collecting and assessing information of providers' governance systems and processes. This includes the training available to staff, and how patients' rights are protected by the systems in place across services. We will continue to review our MHA functions and test improvements to MHA work outside the inspections.

Monitor the implementation of the revised Code of Practice – We will be working with the Department of Health and others to learn from the hundreds of responses to the consultation on the Code of Practice. This will shape our own approaches to regulating and monitoring the Act. We will also work with our Service User Reference Panel to develop our own implementation plan.

Evaluate the way the MHA is used –
Our inspection teams look at the different ways providers keep their use of the MHA under review. This includes the collection and analysis of data, submission to national reporting bodies, and audits carried out that inform local needs analysis and discussions with commissioning bodies. We will also be looking for evidence that the issues we raise on behalf of patients are being considered by board members, and are being used to inform local action plans. We are also reviewing the way we evaluate our activities carried out under the MHA and how we can continue to improve our role and encourage improvement for patient care as a result.

Our *State of Care report* (pages 79–80) also sets out recommendations for providers of health services, which are equally important for people affected by the MHA, and we would encourage providers to review these.[47]

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Appendix 1

MHA report Advisory Group

An external Advisory Group provided experience and expertise on the approach and scope of this Mental Health Act (MHA) annual report. The group met twice in 2014, offered comment and advice on the themes and issues covered by the report, and reviewed the detailed draft.

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

Julie Alexander, Department of Health

Anthony Beschizza, Central and North West London NHS Foundation Trust

Alison Cobb, MIND

Guy Davis, East London NHS Foundation Trust

Louise Finer, Her Majesty's Inspectorate of Prisons

Dorothy Gould, National Survivor User Network

Dr Nicola Guy, Department of Health

Netta Hollings, Health and Social Care Information Centre

Ian Hulatt, Royal College of Nursing

Evan Humphries, Mental Health Commission, Wales

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

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

Appendix 2

Deaths of detained patients and people subject to community treatment orders

Under the Health and Social Care Act 2008, providers must notify 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 is also collected by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness from national statistics.

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 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 CQC. The notification form is on the CQC 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 are on their website at **http://iapdeathsincustody.independent.gov.uk/**

We have been piloting information from the Hospital Episodes Statistics (HES) and the Mental Health Minimum Dataset (MHMDS) in preparing this report. Early outputs have provided additional data that will allow us to compare our own notifications with other information, including all admissions and deaths within six months of leaving a service. This experimental data requires further development and discussion with other organisations, but we will include the first outputs from this in our 2014/15 report.

CQC data from notifications 2011/12 to 2013/14

Causes of death of detained patients, natural causes

	2011/12	2012/13	2013/14	Total
Pneumonia	34	33	24	91
Pulmonary embolism (blockage in the artery)	18	16	13	47
Myocardial infarction (heart attack)	6	11	7	24
Cancer	18	12	4	34
Heart disease	27	17	21	65
Aspiration pneumonia	5	11	5	21
Respiratory problems	4	2	5	11
Chronic obstructive pulmonary disease	6	3	4	13
Other	28	51	34	113
Unknown	45	44	9	98
Total	**191**	**200**	**126**	**517**

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
20 and under	0
21 to 30	3
31 to 40	6
41 to 50	15
51 to 60	21
61 to 70	29
71 to 80	27
81 to 90	20
91 and over	5
Total	**126**

Cause of death of detained patients, unnatural causes

	2011/12	2012/13	2013/14	Total
Hanging	10	14	16	40
Jumped in front of vehicle/train	3	6	1	10
Jumped from building	3	5	4	12
Self-poisoning	3	0	2	5
Drowning	2	4	2	8
Self-strangulation/suffocation	8	10	4	22
Method unclear	2	3	0	5
Unsure suicide/accident	0	2	4	6
Accidental	2	0	3	5
Another person	3	3	0	6
Iatrogenic (Illness caused by medication or a doctor)	0	1	0	1
Total	**36**	**48**	**36**	**119**

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
20 and under	3
21 to 30	7
31 to 40	11
41 to 50	5
51 to 60	5
61 to 70	0
71 to 80	3
81 to 90	2
No date of birth supplied	0
Total	**36**

Causes of deaths of detained patients where restraint used in 7 days before death

	2011/12	2012/13	2013/14	Total
Natural	7	9	1	17
Hanging/self-suffocation	0	2	0	2
Jumped from building	0	1	1	2
Unascertained	0	2	0	2
Awaiting information	0	4	2	6
Total	**7**	**18**	**4**	**29**

Deaths of people subject to CTOs, by cause

	2011/12	2012/13	2013/14	Total
Natural causes	27	26	21	74
Unnatural causes	10	9	7	26
Undetermined	2	10	6	18
Total	**39**	**45**	**34**	**118**

Cause of death of people subject to CTOs, natural causes

	2011/12	2012/13	2013/14	Total
Pneumonia	5	3	6	14
Pulmonary embolism	1	2	0	3
Myocardial infarction	0	2	2	4
Cancer	4	1	2	7
Heart disease	4	1	3	8
Aspiration pneumonia	1	0	0	1
Respiratory problems	0	1	1	2
Chronic obstructive pulmonary disease	1	0	1	2
Other	5	7	3	15
Unknown	6	9	3	18
Total	**27**	**26**	**21**	**74**

Cause of death of people subject to CTOs, unnatural causes

	2011/12	2012/13	2013/14	Total
Hanging	3	2	1	6
Jumped before vehicle/train	1	1	1	3
Jumped from building	2	1	1	4
Self-poisoning	1	1	1	3
Drowning	1	2	1	4
Self-strangulation	0	0	1	1
Self-suffocation	0	1	0	1
Method unclear	2	0	0	2
Accidental	0	1	1	2
Total	**10**	**9**	**7**	**26**

How to contact us

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Follow us on Twitter: **@CareQualityComm**

Please contact us if you would like a summary of this report in another language or format.

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The Care Quality Commission is a member of the UK's National Preventive Mechanism, a group of organisations that independently monitor all places of detention to meet the requirements of international human rights law.

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