SUMMARY

Monitoring the Mental Health Act in 2014/15
There are 57 mental health NHS trusts and 86 independent mental health hospitals registered with CQC. Throughout the year we visit these services to interview patients and review practice.

During 2014/15, 51% of all mental health inpatients were subject to the Mental Health Act 1983 (MHA) with 19,656 detained inpatients on 31 March 2015. We carried out 1,292 MHA visits, meeting over 5,900 patients to discuss how the MHA and its Code of Practice were being applied to them. Our Second Opinion Appointed Doctors also made 14,375 visits to patients in hospital and the community and we received 227 notifications following the death of people detained in hospital.

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

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

“Everyone including carers and families need to know about the Code, and all communication channels — from bottom to top and vice versa including sideways — should remain open for the benefit of all.”

Expert Reference Group carer, Code of Practice 2015 Project, Department of Health

The Mental Health Act

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

The MHA includes safeguards for people’s rights when they are being detained or treated by professionals. It does this by providing rules and requirements for professionals to follow and the MHA Code of Practice, which is the statutory guidance for mental health professionals and services, explains how this should be done in practice.

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

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

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

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

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

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

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

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

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

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

While subject to the MHA, people are not only prevented from choosing whether or not to receive treatment and care, but also how and where this is provided. We check that the safeguards prescribed by the MHA are being applied effectively to empower patients and maximise their independence while they are subject to the Act. We also look at the way services support people to raise concerns, understand their rights and be as involved as possible in decisions about their care.

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

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

In our report, we include the latest figures from the notifications we receive when a patient dies while they are detained. In 2014/15, we received 227 notifications including 34 deaths as the result of suicide, self-harm and other unnatural causes, 11 from unknown causes and 182 deaths from natural causes, including eight for people aged under 40.

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

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

A view of people who use services

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

Service User Reference Panel member
Providers must manage and monitor their use of the MHA better

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

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

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

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

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

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

A view of people who use services

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

Service User Reference Panel member
Understanding and improving the way the Mental Health Act is being applied for patients must be a priority for all

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

- The way people had been involved in decisions about their care
- Awareness of advocacy services
- Consent to treatment practices
- Restrictive practices
- The way providers were using information from the MHA to inform service plans.

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

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

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

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

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

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

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

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