Care Quality Commission’s Monitoring the Mental Health Act in 2017/18

Today the Care Quality Commission (CQC) has published Monitoring the Mental Health Act in 2017/18, under its statutory duty to provide Parliament with an annual review of how health services in England apply the Mental Health Act. This briefing summarises the report’s key findings, but for a comprehensive overview of challenges facing improvement in applying the Act with appropriate regard to individual’s rights and preferences, we encourage providers to read the report in full.

Key points:

- There has been an overall improvement in some aspects of care in 2016-2018 compared with findings in 2014-2016, which is commendable at a time of rising demand and increased pressure on mental health services.
- In particular, there has been improvement in the quality of care planning and patient involvement. A higher proportion of care plans are detailed, comprehensive and developed in collaboration with patients and carers. However, there is still considerable room for further improvement.
- The provision of information about legal rights to patients and relatives is still the most frequently raised issue from CQC visits. In many cases, patients may struggle to understand information given to them on admission because they are most ill at this point.
- The greatest concern from Mental Health Act monitoring visits is about the quality and safety of mental health wards; in particular acute wards for adults of working age.

Part 1: Key findings from CQC Mental Health Act activities

National figures on the use of the Mental Health Act

- NHS Digital reported just over 49,500 new detentions in hospital under the Mental Health Act (MHA) during 2017/18. Of these, 27,971 took place at the point of admission to hospital, 2,983 following assessment under section 136 of the MHA, 18,349 following informal admission to hospital, and 257 revocations of community treatment orders.
- Available data continues to show overrepresentation of black and minority ethnic (BME) groups in the detained population. ‘Black or black British’ has the highest rate of detention (288.7 per 100,000 population), more than four times that of the broad ‘White’ group, which has the lowest rate (71.8 per 100,000 population).
- Repeat admissions of the same people are not a major factor in the rising levels of detention in England. 84.6% (33,680) of people were detained only once in 2017/18; 2.4% (966) of people were detained three
or more times in the year. People from ‘black’ and ‘mixed’ BME groups had the highest rates of repeated detention (18.4% and 18.1% of people were detained more than once, respectively, compared with 15.3% in the ‘white’ group).

**MHA visits**

- CQC made 1,165 MHA visits in 2017/18. The number of visits has reduced in recent years.
- A major factor in the reduction in visits is that there are fewer wards open to visit. Some of the change could also relate to changes to the way MHA reviewers work with inspection teams and record activity, and MHA reviewer time being spent on activities other than visits.

**Key issues found in people’s experiences of the Mental Health Act**

**Providing information to patients**

- How information is being provided to patients accounted for 14% of actions raised from non-individual patient issues in 2017/18, with varying degrees of concern. This is the most frequently raised area of practice from CQC analysis of records during visits.
- CQC has seen some progress in this area and an overall improvement in services meeting the code’s expectations in 2016-18, compared with findings in 2014-16.
- There has been an increase in evidence of patients being provided with this information in an appropriate format from 89% to 94%.
- There has been an increase in further attempts to explain rights, or to explain rights to nearest relatives, from 83% to 85%.
- There has been an improvement in rates of discussions about rights and assessments of the patient’s levels of understanding from 91% to 93%.

**Involving people in care planning**

- Care planning is still one of CQC’s greatest concerns, based on the frequency with which it is raised by MHA reviewers. Specifically, CQC continue to find issues with recording adequate evidence of whether patients consent to treatment, discharge planning and involving patients in care planning.
- However, this is also an area that has shown the most improvement when comparing results from 2016-18 and 2014-16. There has been an increase in evidence of patients’ involvement in care plans (from 73% to 83%) and an increase in care plans showing consideration of the person’s view about their treatment (from 75% to 80%).
- Evidence of consideration of the person’s diverse needs in care plans and evidence of consideration of minimum restrictions to liberty have also increased – from 91% to 95%, and 91% to 94% respectively.
- CQC has found an increasing amount of care planning is detailed, comprehensive and developed with patients and carers being involved. However, a substantial proportion of the care plans it has examined are still of a poor quality.
Accessing independent mental health advocacy

- Patients state they have some degree of access to independent mental health advocates (IMHAs) on almost every ward CQC visits, as has been the case for the last three years. Exceptions (less than 1% of visits) appear to reflect short term breakdowns in provision during retendering contracts for advocacy services, or handovers from one provider to another when contracts change.
- CQC found an increasing majority of services appear to be following the code of practice’s advice around referring an incapacitated patient to an IMHA.
- However, CQC still hear from service user groups that advocacy services are not as fully available and responsive as they would like, and of concerns over the quality of advocacy.

Challenging restrictive practices

- CQC MHA reviewers commonly raise concerns about restrictive practices. It is a concern that ‘long-term segregation’ (LTS), an intervention once thought of as extreme and usually limited to higher-security forensic hospitals, is now viewed to be much more commonplace.
- CQC said that the physical fabric of wards, which are often located in old and unsuitable buildings, a lack of access to the full range of care interventions, and problems with staffing – both number and level of expertise – are underpinning problems.
- CQC is currently carrying out a thematic review of the use of restraint, prolonged seclusion and long-term segregation on people with mental health problems, a learning disability or autism. An interim report will be published in May 2019 and a final report published by spring 2020. CQC will share learning with partner organisations as the review progresses.

Identifying physical health issues on admission

- There has been an increase in evidence of physical health checks being carried out in 2016-18 (98%) compared with findings in 2014-16 (95%).
- There has been an increase in the number of hospital wards where staff, when asked on visits, report no difficulty with access to GP services in the period 2016-18 (93%) compared with 2014-16 (90%). However, 110 wards CQC visited reported problems in the period 2016-18.

Second opinion appointed doctor service

- In 2017/18, second opinion appointed doctor (SOAD) service carried out 14,503 visits. This is similar to the number carried out during the previous three years.
- This year, SOAD reviews resulted in 27% of all treatment plans considered being changed, which is similar to the previous year’s figure of 26%. Treatment plans for electroconvulsive therapy (ECT) or community treatment order (CTO) patients were more likely to be left unchanged in 2017/18 than medication (detained) patients.
- SOAD visits appear to be marginally more likely to change treatment proposals where the patient is refusing to give consent, which is consistent with previous years’ findings.
- CQC is working with government to evaluate the potential resource impacts of shortening the three-month period before which a SOAD authorisation is required where a detained patient receives medication for mental disorder without consent.

**Equalities data and SOAD visits**

- 59.9% (8,688) of SOAD visits in 2017/18 were made to men, 40% (5,800) to women, and 0.1% (12) to transgender people.
- In 2017/18, SOAD visits for women were over two times more likely to be for ECT than is the case for men. For 2016/17 this was three times more likely.
- Plans for younger adults (18 to 40) were changed in 33% of 2017/18 visits, which is more often than other age groups. This continues the trend of 2016/17. Plans for people aged 61 and over were changed in 20% of 2017/18 visits, making this age group the least likely to have their plan changed following a SOAD visit.
- 10,766 (77%) of the SOAD visits with ethnicity recorded in 2017/18 were made to white people with 3,180 (23%) made to people from BME groups.
- SOAD visits to consider ECT are almost twice as likely to be for white patients than for patients from BME groups, although this may reflect the older demographic of patients usually referred for ECT.
- The older patients are, the more likely that the SOAD visit involves the use of ECT (20% of visits are to people aged 61 and over).
- Treatment plans for white people (21%) were changed slightly less during 2017/18 than that of people from BME groups (26%).

**Individualised risk assessments**

- There has been an increase in identified risks being matched by the care plan judged to be appropriate by the MHA reviewer, from 92% in 2014-16 to 95% in 2016-18.
- 92% of care plans are being re-evaluated following changes to care needs in 2016-18, compared with 88% in 2014-16.

**Supporting people in discharge planning**

- There has been an improvement in care plans showing evidence of discharge planning in 2016-18 (80%) compared with findings in 2014-16 (69%).

**Part 2: CQC and the Mental Health Act**

- In 2017/18, CQC carried out 1,165 visits, met with 3,993 patients and required 6,049 actions from providers.
- Second opinion appointed doctor service carried out 14,503 visits to review patient treatment plans, and changed treatment plans in 27% of their visits.
• CQC was notified of 189 deaths of detained patients by natural causes, 48 deaths by unnatural causes and 10 yet to be determined verdicts.

• CQC was told about 11 deaths that occurred within seven days of restraint being used. CQC’s review of these deaths had not identified any deaths during or immediately (within 24 hours) following restraint by staff.

• CQC received 2,319 complaints and enquiries about the way the MHA was applied to patients. Common themes for complaints and concerns were: medical treatment, staff attitude, communication, diagnosis, and availability of leave.

• CQC were notified of 714 absences without leave from secure hospitals, which is 72 more than were recorded in 2016/17. Around three-quarters (74%) of incidents were recorded by low secure units, as in the previous year.

• In 2017/18, there was a 22% fall in the number of notifications received by CQC of a person under 18 years old being placed in a psychiatric ward or unit intended for adults for a continuous period of more than 48 hours, compared with 2016/17.

• Data provided by the Tribunal Service shows that there was a slight fall in applications, and a proportionate fall in absolute discharges, for both detained and CTO patients.

NHS Providers media statement

Further improvement in mental health services must be supported by front line investment

Responding to Monitoring the Mental Health Act in 2017/18 by Care Quality Commission, the deputy chief executive of NHS Providers, Saffron Cordery said:

“We are pleased to see that Care Quality Commission has noted the improvements in care for mental health patients made over the last year.

“There is further to go, but it is a credit to the efforts and dedication of trusts and front line staff who have worked incredibly hard against rising demand, financial pressures and staffing challenges to provide a good level of care for patients at their most vulnerable.

"It is vital that investment earmarked for the sector reaches the frontline if we are to meet growing need and improve quality. Mental health services must receive an appropriate share of capital funding to invest in the specialised facilities they need. We also need urgent action to address a severe shortage of mental health staff.

“We were pleased to contribute to and welcome the recommendations put forward by Professor Sir Simon Wessely’s independent review of the Mental Health Act. These changes will strengthen the voice of patients and improve variation in care across services. We look forward to seeing progress.”

Contact: Ella Fuller, Senior Policy Officer ella.fuller@nhsp provid ers.org