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Care Quality Commission's Monitoring the Mental Health Act in 2018/19

The Care Quality Commission (CQC) has published Monitoring the Mental Health Act in 2018/19, under its statutory duty to provide Parliament with an annual review of how health services in England apply the Mental Health Act (MHA). This briefing summarises the report's key findings, but for a comprehensive overview of CQC's findings, we encourage members to read the report in full.

Key points:

- The Care Quality Commission (CQC) has identified the use of human rights principles and frameworks as a key area of concern. CQC state services must apply human rights principles and frameworks, and their impact on people should be continuously reviewed to make sure people are protected and respected. The report focuses in particular on oversight of the Mental Health Act (MHA) at board level.
- CQC MHA monitoring visits suggest that since 2015 the number of services meeting the basic expectations of the MHA code of practice have improved. CQC has seen improvements in the way patients receive information regarding their rights at different points during their detention and being offered the support of an independent mental health advocate (IMHA) in particular.
- However, despite these improvements, CQC recommended that patient involvement needed to improve in 26% of care plans it reviewed in 2018/19. CQC also state more should be done to support people to give their views and offer their expertise when decisions are being made about their care.
- CQC has expressed concern that people do not always get the care and treatment they need, with some services struggling to offer appropriate options, both in the community and in hospital. CQC state commissioners are still not doing enough to make sure they are meeting their statutory responsibilities under Section 140 of the MHA and CQC remain concerned that community mental health provision is not compensating for the reduction in inpatient beds. CQC is also concerned about a lack of availability of health-based places of safety and the number of people in long-term segregation.
- CQC has concluded it is difficult for patients, families, professionals and carers to navigate the complex laws around mental health and mental capacity. CQC has called for the codes of practice for the MHA, the Mental Capacity Act and Deprivation of Liberty Safeguards to be updated and provide clear guidance on these complex interface issues, as a matter of urgency in current reforms to law.
- CQC acknowledges that services face challenges in providing care for people detained under the MHA, including issues with the availability and quality of community care, challenges with people being placed far from home, as well as the decline in the number of inpatient mental health nurses and other clinical staff. CQC also highlights that it needs to change the way it assesses mental health and learning disability wards so that it can better understand their safety and quality, and the experiences of people who use them.

Part 1: Human rights and the use of the MHA

While CQC has seen some improvement in services complying with their human rights duties, it has concluded that more improvement is needed. CQC has stressed providers have the primary responsibility for making sure that people receiving care are free from abuse and that they have their human rights upheld.

However, CQC states that services face challenges in providing care for people detained under the MHA, including issues with the availability and quality of community care, challenges with people being placed far from home, as well as the decline in the number of inpatient mental health nurses and other clinical staff.

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Overseeing the implementation of the MHA at board level

- Providers must make sure that they are overseeing how the MHA is working at a local level, including any impacts on human rights and equality issues, to improve people's experience.
- Providers should consider how they will review the culture of wards to make sure that environments are therapeutic and that patients are treated with dignity and respect, as well as seeking out and acting on feedback from all patients to improve the experience of detained patients locally.
- CQC will be encouraging local areas to consider the needs of people in different equality groups through its work at a local area level.

Information for patients

- Over the last four years, CQC have seen a continued improvement in the number of people being given information about their rights. In 2018/19, CQC found good evidence of accessible and appropriate information in 91% of all records, initial discussions about rights in 87% of all records and repeated discussions about rights in 80% of all records.
- However, CQC is concerned that there are still people who do not understand their legal rights as they are not having meaningful discussions or being given this information in a format they can understand.
- The report also raises concerns about the information provided for informal patients around their right to leave the ward and arrangements for moving around the hospital and its grounds.

Independent mental health advocacy

- Over the last three years, CQC has found that patients in nearly all wards visited (99%) have had access to an IMHA service. Over the last two years, 91% of wards visited have automatically referred patients to an IMHA.
- However, CQC are concerned that the levels of engagement and visibility of IMHA services varies, and that some mental health professionals do not fully understand or appreciate the role of IMHAs, which may affect the way in which they explain the role to patients.

- CQC state that there is no nationally available evidence to show the effectiveness of IMHA services, and it would welcome consideration of more formal roles for, and expectations of, IMHA services in any future revisions to the MHA.

Involving patients in care planning

Findings from CQC visits suggest that since 2015 the number of services meeting the basic expectations of the MHA code of practice have improved, but further progress is still needed.

Patient and carer involvement

- In 2018/19, CQC recommended that patient involvement was absent or needed to improve in 37% of care plans that it reviewed. 19% of care plans showed insufficient or no evidence that a person's diverse needs were considered, and 17% showed insufficient or no evidence that the service had considered the minimum restriction on a patient's liberty. CQC found no evidence of patient involvement in 11% of care plans reviewed.
- In 2018/19, 68% of patient records showed good evidence of carer involvement and 20% showed some evidence but required improvement. 12% of care records reviewed by CQC showed no such evidence of carers having been involved appropriately.

Advance statements, risk assessment and care planning

- 68% of records checked by CQC in 2018/19 showed services had good mechanisms in place to store and check for advance decision documentation. However, 22% of records checked showed that there were no such mechanisms in place.
- CQC has found evidence that services have continued to improve how they identify and manage risk, but there is some evidence that a small number of services remain risk averse.
- In 2018/19, 15% of reviewed care plans showed insufficient or no evidence of being based on identified individual risk assessments. 20% showed insufficient or no evidence of some re-evaluation after a person's care needs had changed.

Care of detained patients' physical health and discharge planning

- CQC found that most detained patients receive a physical health check on admission. However, CQC is concerned that some people are not getting access to a GP while detained.
- In the last two years the majority of care records were judged by MHA reviewers to be good or adequate in terms of the quality of discharge plans, however, CQC would have expected to see less variation in the quality of discharge planning.

People in long term segregation

- CQC reiterates its ongoing concerns that people in long-term segregation can experience more restrictions than necessary, as well as delays in receiving independent reviews.

- CQC states that this is particularly true for people with a learning disability and autistic people, who are often in hospital because of a lack of local, intensive community services and a better system of care is needed.
- CQC state that all patients who are segregated from their peers must be safeguarded through regular and independent review of their situation, and the principle of least restriction needs to be applied more robustly.

Delays in admission and/or assessment

- CQC states commissioners are still not doing enough to make sure they are meeting their statutory responsibilities under Section 140 of the MHA (which places a duty on commissioners to notify local authorities in their areas of arrangements for admitting people in need of urgent care).
- CQC remains concerned that community mental health provision is not compensating for the reduction in inpatient beds. CQC states that the Department of Health and Social Care is currently developing a practical briefing to support how the system implements section 140.

Use of police powers

- Over the last three years there has been a sharp fall in the use of a police station following a section 136 detention, from 912 in 2016/17 to just 116 in 2018/19.
- Where the method of transport was recorded in 2018/19, in 40% of cases people were taken to a place of safety in a police vehicle, despite the expectation that an ambulance or similar vehicle is used.
- CQC has raised concerns about the amount of time people are spending in a health-based place of safety. It suggests that trusts using swing beds closely monitor how this is working and make sure contingency plans are in place.

Community treatment orders

- CQC have raised concerns about the use of community treatment orders (CTO) varying between different demographic groups. It is carrying out several CTO-focused visits over 2019/20 to get a better sense of issues in practice and to inform future MHA reform.

The interface between the MHA, the MCA and the DoLS

- CQC states that the interface between the MHA, the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS) is constantly evolving and recent legal developments have led to challenges in transferring patients to community settings, delayed discharges and the legality of some existing placements being challenged.
- CQC stresses that the codes of practice for the MHA, the MCA and DoLS must be updated and provide clear guidance for professionals on these complex interface issues, as a matter of urgency in current reforms to law.

First-tier tribunal (mental health) and second opinion appointed doctor service

- The success rate of applications against CTO that proceed to a hearing is 5%. The first-tier tribunal (mental health) discharged 178 people from CTO in 2018/19.
- CQC's second opinion appointed doctor service carried out 14,354 visits to review patient treatment plans in 2018/19. This changed treatment plans in: 22% of visits to detained patients to consider electroconvulsive therapy (ECT) treatment; 31% of visits to consider medication for detained patients; and 18% of visits to consider medication treatment for patients on CTOs.

Part 2: CQC activity in monitoring the MHA

- In 2018/19, CQC made 1,190 MHA visits to 1,199 wards in total. The most common types of ward visited were forensic wards, acute admission wards, and rehabilitation wards.
- The number of notifications received to inform CQC that a child has been placed in an adult psychiatric ward in 2018/19 has decreased.
- In 2018/19, CQC received 782 separate absent without leave notifications from low and medium secure facilities, which is 68 more than were recorded in 2017/18. Over half of such absences (58%) occurred when patients stayed away longer than had been authorised, which CQC states may reflect positive risk taking by providers.
- In 2018/19, providers notified CQC of 195 deaths of detained inpatients. CQC were also notified of 16 deaths of patients subject to CTOs.
- Between June 2018 and March 2019, coroners made CQC aware of at least seven deaths of people who were assessed as requiring admission, but for whom no mental health bed was available. CQC has written to NHS England to alert them to this finding and other areas of concern.

NHS Providers' view

We welcome the latest report from CQC on the application of the Mental Health Act, which acknowledges the improvements made over the past year whilst highlighting the areas where further progress is still needed. Trusts and frontline staff are working incredibly hard, in the face of rising demand, financial pressures and significant workforce shortages, to provide high-quality care to patients at a time when they are often at their most vulnerable.

CQC rightly acknowledges that services face significant challenges in providing care for people detained under the act, including issues with the availability and quality of community care, challenges with people being placed far from home, as well as the decline in the number of inpatient mental health nurses and other clinical staff.

Services must be properly equipped to address the underlying issues affecting how and where good quality mental health facilities are accessed. This includes ensuring investment reaches the frontline, taking further action to address workforce shortages, particularly of specialist staff, and for the mental health sector to receive its fair share of capital investment to invest in specialised facilities.

We agree that trusts have a vital role to play in overseeing how the act is working at a local level, ensuring that there is the right culture on wards, and feedback from service users is actively sought out and acted upon to improve people's experience of care. The wider health and care system working effectively together in partnership is also

crucial to ensuring the nature of care being delivered to people is appropriate and available in the right setting area to area.

It is encouraging to see that there has been a reduction in the use of police stations as 'places of safety'. However, CQC have highlighted that there is a lack of availability of health-based places of safety and we remain concerned that changes to the way services are managed under the act are putting additional pressure on trusts.

We look forward to the government taking the necessary steps later this year to progress the targeted and sensible proposals Professor Sir Simon Wessley's independent review of the Mental Health Act put forward more than a year ago now , so that further improvements to people's experience and the quality of mental health care can be made.

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