next day BRIEFING NHS Providers

Briefing on three recent mental health publications

This is a briefing gives an overview of three mental health reports that were published on 21 March 2024:

- Government response to the rapid review into data on mental health inpatient settings
- Government response to the Joint Committee on the draft Mental Health Bill
- The Care Quality Commission's (CQC's) Monitoring the Mental Health Act in 2022/23 report

If you have any questions or comments on these announcements, please contact NHS Providers policy officer, Emily Gibbons (emily.gibbons@nhsproviders.org).

1) Government response to the rapid review into data on mental health inpatient settings

The government has responded to the report of the independent rapid review into data on mental health inpatient settings, chaired by Dr Geraldine Strathdee, published on 28 June last year.

The review was commissioned by ministers to produce recommendations to improve the way data and information is used in relation to patient safety in mental health inpatient care settings and pathways. It followed a number of undercover investigations in 2022 that raised serious questions about the quality of care and safety of individuals receiving care in these settings. The rapid review recommended several improvements in the way local and national data is gathered and used to monitor and improve patient safety in mental health inpatient pathways.

The government has set out how the review's recommendations complement existing work by NHS England to improve inpatient safety and therapeutic care, including within the three-year mental health, learning disability and autism inpatient quality transformation programme. It will work with healthcare system partners to take forward the key deliverables and provide an update on progress by July 2024. NHS Providers will continue to work with the national bodies on implementation of the recommendations, including as part of a steering group convened by the Department of Health and Social Care (DHSC).

Government response

The rapid review organised its findings into five key themes: 1) measuring what matters; 2) patient, carer and staff voice; 3) freeing up time to care; 4) getting the most out of what we have; and 5) data on its own is not enough. Below we have summarised how the government has addressed each.

Measuring what matters

The government supports the recommendations focused on agreeing how to ensure providers, commissioners and national bodies are 'measuring what matters'. NHS England, in collaboration with partners, will deliver a programme of work to agree the most impactful metrics in spotting early warning signs of quality and safety by early 2024. It will also agree principles for reducing the data burden and consider what's needed to improve data sharing and timeliness of reporting.

Patient, carer and staff voice

The government says that provider boards should consider how the voices of carers and family members are currently heard and acted on at board level. DHSC and NHS England expect that by Spring 2024, local systems and providers will:

- review their approach to board reports to ensure they can identify, prevent and respond to patient safety risks in inpatient mental health settings
- review lived experience at board level and, where required, communicate how it will be strengthened

review approaches to gathering and acting on patient experience measures in inpatient mental health settings.

The government supports the recommendation that trust and provider leaders should prioritise spending time on inpatient wards to gather informal intelligence from patients and staff about their experience, including unannounced visits. DHSC and NHS England will work with system leaders to continue to build on best practice to highlight the importance of senior leadership visibility on wards.

DHSC and NHS England expect providers to implement relevant carer standards, routinely seek carer feedback, develop co-produced quality improvements, and identify ways to incorporate the expertise of carers to, for example, co-deliver staff training programmes. The CQC is currently looking at the best way to monitor compliance with the carer standards, with one option under consideration being to request providers' most recent report, detailing how they monitor their own action to comply with the carer standards and asking specific questions at service level while inspecting. CQC is also making

changes to the way it approaches regulating mental health settings to ensure they are better able to identify issues early on, including working with people with lived experience to develop an observational-based methodology, to enable focused onsite inspections of mental health services where closed cultures and restrictive practice are at greatest risk of developing.

In addition, the government agrees more should be done to strengthen the expectation that all mental health inpatient settings facilitate visitors, and mechanisms are in place to record and act upon their feedback. The government is working with the CQC to develop guidance for when the fundamental standard on visiting is introduced on 6 April 2024.

Furthermore, DHSC and NHS England expect that all providers give relevant information to patients and carers as a matter of course, in accessible formats, including on the ward environment and therapeutic activity.

Freeing up time to care

The government recognises that providers and commissioners should have access to digital platforms that allow easy access, benchmarking, and avoid duplication. However, it emphasises this is likely to have significant funding implications. As a first step, NHS England will scope out options in early 2024, setting out how this could be delivered for mental health providers.

Getting the most out of what we have

DHSC and NHS England will work with integrated care system (ICS) leaders to help them facilitate sharing good practice across the healthcare sector and will make use of existing forums to showcase examples of good practice. It is expected that the outcomes of the 'measuring what matters' programme will support ICSs to better understand and facilitate this work.

ICS leaders are expected to ensure appropriate data availability and take a leading role in commissioning of mental health services that meet the needs of the local population.

Data on its own is not enough

The government supports the recommendation that provider board members should have the skills and capacity to identify, prevent and respond to risks to patient safety. DHSC and NHS England will work with system leaders to highlight the importance of improving boards' capacity in this area. A key tool is the National Patient Safety Syllabus module for board and senior leaders, and it is highlighted

that all provider boards should review their approach to board reports and board assessment frameworks.

The government recognises that all mental health inpatient settings should be designed to reduce patient safety risks and improve the capacity for therapeutic interventions. It highlights that integrated care boards (ICBs) are currently developing ICS infrastructure strategies to support improved long-term planning across their estates and assets and cite the £500m for multi-year capital programme to improve mental health facilities. The government has also said it will consider mental health capital requirements at the next comprehensive spending review.

Data on deaths in mental health inpatient settings

The government agrees that work is needed to build on the data-mapping work of the rapid review to identify improvements needed for data collections on deaths in mental health settings. DHSC will bring together relevant organisations to consider what improvements can be made to the timeliness, quality, and availability of that data, and identify actions to be taken forward over the coming months.

NHS Providers press statement

Government commitments welcome but sustained support still needed

Saffron Cordery, deputy chief executive at NHS Providers said:

"We welcome progress in taking forward the rapid review's recommendations, and in particular, the government's commitment to incorporating patient and family perspectives into care delivery. This will help to make sure their voices are heard – a key part of patient safety.

"Trust leaders are clear that better information recording and sharing has a vital role to play in quality of mental health care, as well as in preventing abuse and improving culture and practice. Enhancing data collection, quality and use, alongside bolstering digital infrastructure is therefore essential.

"While the government rightly recognises the importance of digital platforms for benchmarking, these goals demand sustained capital funding and workforce support. Long-term, sustained investment is vital to translate commitment into action."

Government response to the Joint Committee on the draft Mental Health Bill

The government has responded to the Joint Committee's report on the draft Mental Health Bill, which was published in January 2023. The government's draft Bill will reform the Mental Health Act 1983. Below we summarise the government's response to the committee's key recommendations.

Government response

Overall approach

Fundamental reform versus amending legislation

The government welcomes the committee's recommendation that there should be ongoing development of mental health legislation reform, confirming that under reforms in the draft bill, people will be more involved in decisions about their treatment with detentions only taking place when absolutely necessary. Protections provided by the Mental Health Act (MHA) will be made clearer in guidance, and an update to the code of practice will take place. The government confirmed mental health legislation will be kept under review including the matter of more "fusion" between relevant legislation and a rights-based approach.

A mental health commissioner

The government rejected the recommendation that a post of a statutory mental health commissioner should be created, highlighting that there was previously an MHA commission whose functions were absorbed into CQC and the Healthcare Inspectorate Wales in 2009. While it appreciates that some of the proposed responsibilities of the new commissioner would be unique, the government is concerned that where a role already exists, it would be better for it to continue to be carried out by the currently responsible organisation, eg, supporting individuals to raise complaints is the role of CQC and the Parliamentary and Health Service Ombudsman (PHSO).

Principles

The government noted its support of the four principles that were co-designed with service users during the independent review (choice and autonomy, least restriction, therapeutic benefit, and the person as an individual). However, the government does not support replacing the current list of matters addressed by the statement of principles in section 118 with the four principles. Instead, the government's view is that the most effective approach to deliver impact and to drive culture change is to embed them in in specific, practical measures in the act and then give full prominence to the principles in a revised code of practice.

Resourcing and implementation

The government agrees that an updated impact assessment should accompany the final bill, reflecting changes to the proposals, workforce and economic indicators where relevant. It will consider interactions with non-legislative measures and existing programmes that fall within the scope of the reforms.

Racial inequalities

The government does not consider it necessary to amend the section 118 list of matters that the Secretary of State must address in the code of practice to include the need to respect racial equality. This is because the need to respect racial equality is already a requirement of the Equality Act 2010, which is applicable to those carrying out functions under the MHA.

Responsible person

The government has confirmed it will consider the introduction of a responsible person to oversee workforce training to address bias and discrimination, noting it envisages this being an additional duty on senior staff as opposed to the creation of a new role. The proposal will be considered further, including how this aligns with existing duties under the Equality Act and the public sector equalities duty.

Community Treatment Orders (CTOs)

The committee raised concerns regarding longstanding issues, notably people being on a CTO for too long and black people being disproportionately made subject to CTOs. However, the government does not agree with the recommendation to abolish CTOs for part II of the 1983 Act. It will also not abolish or include a statutory review of CTOs for part III patients in the draft bill, as recommended by the committee. The government believes it should continue to reform CTOs as the independent review recommended and for which the draft bill currently provides. It will be introducing greater scrutiny of their use through the involvement of community clinicians in arrangements for care after discharge from hospital, and by providing greater oversight by the mental health tribunal. The government is concerned that abolishing CTOs would risk an increase in delayed discharges, and an overreliance on other areas of the Act that are not designed for longer term cases. It will monitor the impact of the new safeguards being addressed in CTO provisions, including monitoring the impact on racial disparities.

Capacity

The government agrees with the committee that denying patients treatment in circumstances where the concept of 'capacity' has been misused goes against the spirit of the MHA and the Mental

Capacity Act (MCA), and may also fall short of professional standards. The government will consider amendments to the code to make guidance on this point clearer and will work with professional bodies to investigate whether they can improve the way clinicians communicate and engage with patients about capacity and suicide. The occurrence of this issue in relation to people with complex emotional needs and/or a diagnosis of 'personality disorder' or eating disorders is noted and ongoing work set out in the NHS Long Term Plan to improve the pathway for these patients is highlighted.

The government has decided to delay liberty protection safeguards (LPS) beyond the lifetime of this Parliament, and therefore will not be considering the three related 'gaps or ambiguities' in the law identified by the committee regarding the interface of the MHA and the MCA.

Detention criteria

The government agrees that it will be important to clarify the new detention criteria in the code of practice, including setting out how the terms 'serious harm' and 'likelihood' should be interpreted in practice by decision makers. It also agrees it will be important to explain, including in relation to the new detention criteria, what is meant by 'appropriate medical treatment' in the code of practice.

The committee recommended that the consideration of 'how soon' harm might occur should not be included in the draft bill itself and would be better handled in the code of practice. The government will review the wording in response to the independent review's finding that detentions currently could be justified by concerns about harms that may only occur far in the future.

The committee recommended that the changes in detention criteria should be consistent for individuals under either part II or part III of the MHA. Although the government acknowledges the committee's concerns, it states that leaving the detention criteria for part III patients as currently drafted will ensure that, for example, vulnerable neurodivergent offenders in the criminal justice system, who would otherwise go to prison, can continue to be diverted to hospital where appropriate, where they are more likely to receive more therapeutic and specialist support.

Patient choice

The committee recommended that there should be a statutory right for patients who have been detained under the MHA to request an advance choice document (ACD) be drawn up. However, the government thinks this is best achieved by placing a duty on services to carry out activity in relation to ACDs as opposed to introducing new rights for individuals to request an ACD. It will be exploring how best to take this forward and agrees that a mechanism to store ACD information digitally is the best

means of ensuring they can be shared easily and readily accessed by the relevant professionals at the point of need.

The government agrees that the person should be at the centre of their ACD and therefore it is critical that they are meaningfully involved in its creation. The support of a person who is independent of the individual's treatment team, as recommended by the committee, can be important (eg, a peer support worker or clinician), but the person should also be able to rely on the input of their treatment team.

Children and young people

The committee recommended that the government consults on the introduction of a statutory test for competency, or 'child capacity', for children under 16. The government appreciates the differences in opinions in this space but is concerned these considerations are relevant to people in all settings, not just those detained under the MHA. Therefore, it believes the MHA is not the appropriate forum for setting a statutory test for child competence in wider settings, and Gillick competence remains the accepted competence test for under 16s across all settings. Furthermore, the government is concerned that a statutory test for competence could potentially put under 16s in a more complicated position, particularly those assessed as having competence under the MHA definition but who would be considered not to have competence using the existing test of Gillick competence, or vice versa. The government will set out how practitioners should assess children and young people's competence and capacity under the Act in the code of practice.

The committee recommended the government strengthen the protections in the MHA against children and young people being placed in inappropriate settings, such as adult wards or placements out of area. It suggests amending the bill so it includes duties on hospital managers to ensure there are sufficient services for children and young people and stronger procedural requirements where inappropriate placements are considered. However, the government has agreed to explore what more can be done outside of legislative changes.

Learning disabilities and autism

The committee called on the government to urgently review the operation of the MCA. This was with a view to amending the deprivation of liberty safeguards (DoLs) so they cannot be used as an alternative route to the MHA to deprive people with learning disabilities or autistic people of their liberty in inpatient mental health units for lengthy periods of time. The government believes that it is always inappropriate for the MCA to be used to authorise a deprivation of liberty for the treatment of

mental health conditions. In certain circumstances, where a person lacks the relevant capacity but is not objecting to admission to hospital or treatment, it may be the most appropriate option. The government will work to improve and clarify the interface between the MCA and the MHA in the code of practice. The government will review the impact of changes to the detention criteria regarding people with a learning disability and autistic people, with the aim of ensuring detention in hospital is only used where there is a direct therapeutic benefit to the person, and not simply a displacement from the MHA to the DoLS.

The government has accepted the recommendation that it monitors outcomes for people with learning disabilities and autistic people who are no longer eligible for detention under section 3, confirming it is committed to reducing the number of people with a learning disability and autism who are detained in hospital. The government will commission an evaluation of the reforms that it plans to commence, and will then consider how to monitor the implementation and impact of the full set of reforms. Under the proposed reforms, the government requires ICBs to establish and maintain a register of people with a learning disability and autistic people who are at risk of detention under the Act. This register will provide a useful tool for monitoring outcomes.

The government has accepted the recommendation that it should follow through with existing plans to provide enhanced care for people with learning disabilities and autistic people in prisons. The government noted that NHS England's health and justice team is also undertaking actions to improve the experience of healthcare for neurodivergent people in the criminal justice system, such as the introduction of autism prison healthcare champions and by developing neurodiversity pathways and guidance materials.

The government will consider the development of non-legislative safeguards to prevent inappropriate use of part III for those with learning disabilities or autism. The government noted its intention that the draft bill will help ensure that commissioners understand the risk of crisis at an individual level in their local area via the establishment of risk registers so that they can ensure adequate supplies of community service for those at risk of admission under part II of the Act. It is hoped that this will help people to avoid reaching a crisis point which brings them into contact with the justice system.

The government accepted the recommendation that reasonable adjustment flags are attached to the record of those with a known learning disability and/or autism. NHS England is working to implement this flag, which will allow health and social care staff to record, share and view details of a person's individual needs and wishes so that services can tailor support appropriately.

The government agrees with the committee that some people with a learning disability and autistic people, particularly those under 18, should receive care (education) and treatment reviews (C(E)TRs) more frequently than every 12 months, as set out in the current NHS England policy. It highlights that the 12-month interval set out in the draft bill is intended to be a maximum time limit between reviews, but recognises the risk that they will be carried out to the maximum timings set out in legislation as opposed to those specified in guidance. The government is therefore considering the best way of ensuring that individuals receive C(E)TRs at the appropriate intervals.

Crisis care

The committee recommended that the government should consult further on a short-term emergency detention power, and whether this would provide greater legal clarity to clinicians and accountability for what is happening in A&E services. The government recognises that there are pressures in A&E which can prevent people in mental health crisis from having timely access to mental health crisis care. It highlights work already underway to improve this, such as the delivery plan for recovering urgent and emergency care services, the National Partnership Agreement: Right Care, Right Person, and £150m of capital funding for crisis services. However, the government accepts that it may need to provide greater legal clarity to clinicians in A&E and will continue to engage with stakeholders to understand how the current legal framework is being applied and what, if any, legislative changes may be required.

Transfers from prisons and immigration removal centres to hospital

The government plans to publish an action plan for how services will achieve the statutory 28-day deadline for transfers from prisons and immigration removal centres to hospital, which will be set out alongside the introduction of these provisions in Parliament.

NHS Providers view

We welcome the government's support for a number of the Joint Committee's recommendations, in particular around care for people with learning disabilities or autistic people and establishing stronger safeguards against their inappropriate detention. Reform to the Act is essential and long overdue, and we urge a clear statement by the government on when this will be taken forward given its notable absence in the King's Speech.

Addressing racial disparities in the use of the Mental Health Act is an important driver of legislative reform. We recognise the work underway here, in particular implementation of the Patient and Carer

Race Equality Framework (PCREF), and the government's reference to the existing requirements of the Equality Act. We are concerned though that opportunities to progress this imperative are not missed, and would support continued consideration by the government of, for example, culturally appropriate advocacy, robust data collection, and clear metrics for improvement.

The Joint Committee's emphasis on consultation, better data collection and research was welcome, and we would urge the government to embed these approaches in reform of mental health legislation. We would further suggest continued consideration of the interface between the Mental Health Act and the Mental Capacity Act given the complexities in their interaction and application and the potential for unintended consequences arising as and when the Bill progresses through Parliament.

Trust leaders are very concerned about the mental health care deficit for children and young people and are clear that meeting their needs must be a national priority. It is imperative any reforms coincide with developments in the provision of specialist services for children and young people to address the core driver of the problem of individuals being placed out of area or in inappropriate settings such as adult wards.

We welcome reference to ensuring there is sufficient workforce capacity across the sector, and beyond legislative change, greater capital funding and more money for wider public services are vital steps in improving access to and outcomes from mental health services.

Monitoring the Mental Health Act in 2022/23

This report sets out CQC's activity and findings during 2022/23 from its engagement with people who are subject to the Mental Health Act 1983 (MHA) as well as a review of services registered to assess, treat and care for people detained using the MHA. The findings of the report are based on formal and informal conversations with 4,515 patients who are subject to the MHA, along with 1200 carers. Conversations with advocates and ward staff are also included, along with quotes from feedback letters issued after monitoring reviews.

Report summary

Workforce and staff wellbeing

The report echoes findings from 2021/22 and 2020/21, with mental health services continuing to experience issues in recruiting and retaining staff alongside rising demand. This is one of the greatest

challenges for the mental health sector, with 1 in 5 mental health nursing posts vacant in the first 3 months of 2022/23. Shortages have had an impact on the quality and safety of care that providers are able to give to patients.

The report finds that the use of temporary staffing can present a challenge in providing meaningful therapeutic relationships and personalised care to patients. Monitoring activity also identified some services operating with lower than recommended staffing levels. Workforce challenges are found to be negatively affecting staff, with patients reporting their concerns around the wellbeing and morale of staff members.

Findings also indicate that staffing issues extend beyond frontline workers. Uncertainty regarding long-term funding for the second opinion appointed doctor (SOAD) service is creating problems with resourcing the service and impeding its ability to provide vital safeguards for people in more vulnerable circumstances. Requests for a SOAD have been consistently high in both 2022/23 15,370) and 2021/22 (15,832) with waiting times increasing by 22% from 2021/22.

Inequalities

In the 2021/22 report, the CQC highlighted that inequalities in mental health are 'systemic issues needing a system wide response'. Since the release of the 2021/22 report, there have been examples of trusts making progress in tackling inequality and celebrating diversity, but the report notes that further work is needed, such as addressing the over-representation of black people who are detained under the MHA. The CQC will be assessing the Patient and Carer Race Equalities Framework (PCREF) under the quality statement 'equity in experiences and outcomes' in all planned regulatory assessments in NHS-funded mental health services. Providers will also be assessed on whether the PCREF has been implemented under the quality statement 'shared direction and culture'.

The report notes positive examples from 2022/23 where mental health services have promoted an inclusive and respectful culture, but there are still concerns that some patients may be 'at risk of direct or indirect discrimination in services where staff do not recognise and respect people's protected characteristics'.

The CQC highlights concerns that local pathways are not meeting the needs of those who require specialist support. This can lead to prolonged detention in hospital. Specific issues were found around the lack of community provision for autistic people and those with a learning disability. At the end of October 2023, 2,035 inpatients were autistic people or people with a learning disability. Of these, 92%

(1,880) were subject to the MHA. Information about how far away patients were placed from their home was known for 1,675 of the 2,035 patients. Of these, around half (855) had been in hospital for over two years.

Children and young people

Whist there has been additional investment into mental health services, the report acknowledges that rising demand and a lack of community support has meant that children and young people are impacted by lengthy delays to receive mental health care. These delays increase the risk of worsening symptoms and/or patients being cared for in inappropriate environments. There were 496,897 open referrals to children and young people's mental health services in November 2023. The average waiting time in England between referral and the start of treatment increased to 40 days, up from 32 days in the previous year.

The report notes that in 2021/22 there was 32% rise compared to the year before in notifications of the number of people under 18 being admitted to adult wards. Encouragingly, figures in this year's report show a 25% drop in these notifications, and of these notifications, the majority (85%) were classed as an emergency. Where specified, most of these patients were given a single room (76%). The report also highlights concerns that children and young people with mental health needs are being treated on paediatric wards intended to treat children with physical health needs, meaning they may not have access to appropriate support or advocacy under the MHA. CQC were also told about concerns around the way in which children and young people are transitioned from children's services into adult services, citing examples of young people being moved onto adult wards as soon as they turn 18 and appropriate planning not being undertaken.

Concerns about the suitability of inpatient settings were raised within the report, with many of the settings not meeting people's sensory needs. Many wards were also in need of repair, which were found to negatively affect the experiences of children and young people. In a similar vein, monitoring activity found that a lack of designated inpatient beds for children and young people has led to inappropriate ward layouts. This has led to concerns that, coupled with workforce issues, blanket restrictions are being applied that unintentionally restrict people's liberty and infringe on human rights.

The Five Year Forward View for Mental Health set a target of ending out of area placements for adults and children by 2020/21. However, between April 2022 and March 2023 on average there were still 388 out of area placements started each month.

Restrictive practices

CQC notes that everyone is aware of the more extreme forms of restrictive practice (such as restraint, seclusion, and segregation) but there are also more subtle forms of restrictive practice that can easily become automatic, standard responses to a perceived risk or lack of time, such as denying patients access to visitors or food. In the 2021/22 report, improvements in reducing the risk of restrictive practice were shown but findings in the 2022/23 report highlight that there is still work to be done. This is particularly significant where concerns remain that there is disproportionate use of force against people with protected characteristics.

Monitoring activity has identified many positive examples of people being involved in their care and supported as individuals, but it has also shown examples of services struggling to provide personalised care which can lead to unnecessary use of restraint. The report notes the significance of services implementing safety and learning cultures, particularly in scenarios where restrictive practices have been used.

During CQC's engagement with staff, it was found that there was variation across services on how well staff knew and understood policies around restrictive practices. Poor understanding of the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) also contribute to the over-use of restrictive practices, along with unsuitable physical environments.

Closed cultures

Monitoring activity has shown that more people, including staff, are more aware of the factors that can lead to a closed culture developing. This increased awareness has led to CQC directly receiving concerns via complaints or through staff speaking up which has allowed for quicker action. Monitoring activity also identified many positive examples of good practice where patients were involved in decisions about their care, which is enabled by the existence of open and inclusive cultures. However, concerns about abusive cultures persist.

Many of CQC's concerns revolve around staffing issues, as a high turnover of staff, consistent staff shortages and a lack of training/supervision of staff are all inherent risk factors for services developing a closed culture. Staffing shortages can also lead to increased restrictive practices. Examples of services taking steps to mitigate these risks were seen during monitoring activity, including reducing the use of blanket restrictions and introducing open-door policies.

Monitoring activity also identified warning signs that closed cultures were at risk of developing, which included factors such as not adequately addressing concerns about the condition and suitability of the physical environment or a lack of monitoring or limited interaction with outside agencies. Limited interaction with outside agencies is a particular risk as a legacy of Covid-19. CQC plans to spend more time on site to better monitor behaviours, attitudes, working practices and environments during assessments.

Data published by CQC as part of the report

- In 2022/23, CQC received 15,370 requests for a SOAD, a fall of 6% since 2017/18. Of these requests, 91% were for patients detained under the MHA. Most requests (92%) were made for patients recorded as having no capacity to consent to treatment. There was a 22% increase in waiting times (28 days in 2022/23, compared with 23 in 2021/22) between receiving a request and the appointed SOAD starting their second opinion. In many cases (3 in 4), the second opinions resulted in no change to the treatment plan.
- There were 853 incidents of absence without leave (AWOL) in 2022/23, which presents an increase in AWOL notifications to pre-pandemic levels. Most AWOL notifications were due to a failure to return from authorised leave. 83% of these notifications were for males.
- Monitoring showed a 13% rise in complaints (2,759) from 2021/22 levels and an 8% rise compared with 2016/17. London had the highest number of cases per location, at 4.60. Staff attitude was the subject of the largest number of complaints.
- During 2022/23, 318 deaths were reported (264 detailed patients and 54 on a community treatment order [CTO]). The report notes that the reporting of CTO deaths is not compulsory so this may be an underestimation. Most deaths (59%) were from natural causes. 64% of those who died in detention were male.
- With regards to First-Tier Tribunal data, data shows that success rates for appeals remain similar to previous years' levels. The Tribunal discharges patients in about 10% of its decisions relating to detention overall, and 25% of appeals by restricted patients result in some form of discharge decision.

NHS Providers view

We welcome CQC's annual Monitoring the Mental Health Act report. The report highlights several areas of good practice from providers, reflecting trusts' commitment to improving patient experience. However, this year's report also makes clear the challenges that trusts continue to face. This includes

the gap between the level of demand and available capacity, with funding, capital, and workforce availability all highly constrained, and the impact this has on the quality and safety of care.

The report makes clear the critical importance of improving inpatient environments to ensure settings are therapeutic and offer sufficient capacity. We also need investment in the health and care workforce to overcome the severe shortage of specialist staff needed to ensure safe, effective care. Investment in these areas is particularly important in supporting trusts' ongoing work to address the issues raised in this report in relation to closed cultures and the use of restrictive practices. This is alongside the welcome improvement work underway to transform the quality of mental health inpatient care.