

Summary

Monitoring the Mental Health Act in 2017/18



 STATE OF CARE

Foreword

This report shows improvement in the aspects of practice that are the focus of our work to monitor the use of the Mental Health Act (MHA). In particular, we have seen improvement in the quality of care planning and how patients are involved in their care. This is commendable at a time of rising demand and increased pressure on mental health services.

However, it is important that this does not mask the fact that many of the wards, in which people are detained under the MHA, are unsafe and provide poor quality care. In our State of Care report, we said that this was our greatest concern. This is echoed by both the Long Term Plan for the NHS and the report of Professor Sir Simon Wessely's Mental Health Act review.

We have highlighted the high use of restrictive interventions on mental health wards (and the great variation in use between wards), the high number of assaults on patients and staff and the frequency of incidents of sexual assault and harassment.

Underpinning these are problems with 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.

We therefore welcome the statement in the Long Term Plan that capital investment from the forthcoming Spending Review will be made available to upgrade the physical environment for inpatient psychiatric care. Action is also needed to ensure that all wards are staffed with a full multidisciplinary team.

We will act on the recommendation of the report of the Mental Health Act review that it revises the criteria used to assess the physical and social environments of mental health wards. We will ensure that our monitoring and inspections of mental health inpatient services assess whether wards offer a fit environment for safe and dignified care, whether they have enough staff with the necessary skills, whether patients and staff are



protected from harm and whether patients have access to the full range of effective treatments—and not just medication. It is important that our ratings and judgments reflect both what we find and the experience of patients.

We will pay particularly close attention to the use of restrictive interventions. The Secretary of State for Health and Social Care has asked CQC to carry out a review of segregation, prolonged seclusion and restraint in settings that accommodate people with mental health problems, a learning disability or autism. We will publish an interim report in May 2019 and a final report by spring 2020. However, we will share learning with partner organisations as we go along.

We have also raised concerns over mental health rehabilitation hospitals that are a long way from the patient's home and which may not work actively to enable recovery and discharge. Most of the patients in these hospitals are detained under the MHA – and some are

detained for years. It is vital that national agencies work with local health and care systems to move these patients to a less restrictive setting closer to their home.

During 2017/18, we worked with the advisory panel for Mental Health Act Review and with its working groups. Over the coming months and years, we will make our contribution to implementing the report's recommendations. In 2019, we will publish a report of our evaluation of the way the MHA Code of Practice has been implemented. We have done this work in collaboration with patients, providers and experts. We hope that it will identify practical solutions to help improve areas of practice.



Paul Lelliott
Deputy Chief Inspector of Hospitals (Mental Health)

The Mental Health Act 1983 (MHA) is the legal framework that provides authority to detain and treat people who have a mental illness and need protection for their own health or safety, or the safety of other people. The MHA also provides more limited community-based powers, community treatment orders (CTO) and guardianship.



1,165

We carried out 1,165 visits



3,993

We met with 3,993 patients



6,049

We required 6,049 actions from providers



14,503

Our Second Opinion Appointed Doctor service carried out 14,503 visits to review patient treatment plans



27%

and they changed treatment plans in 27% of their visits



2,319

We received 2,319 complaints and enquiries about the way the MHA was applied to patients

189

We were notified of 189 deaths of detained patients by natural causes, 48 deaths by unnatural causes and ten yet to be determined verdicts

714

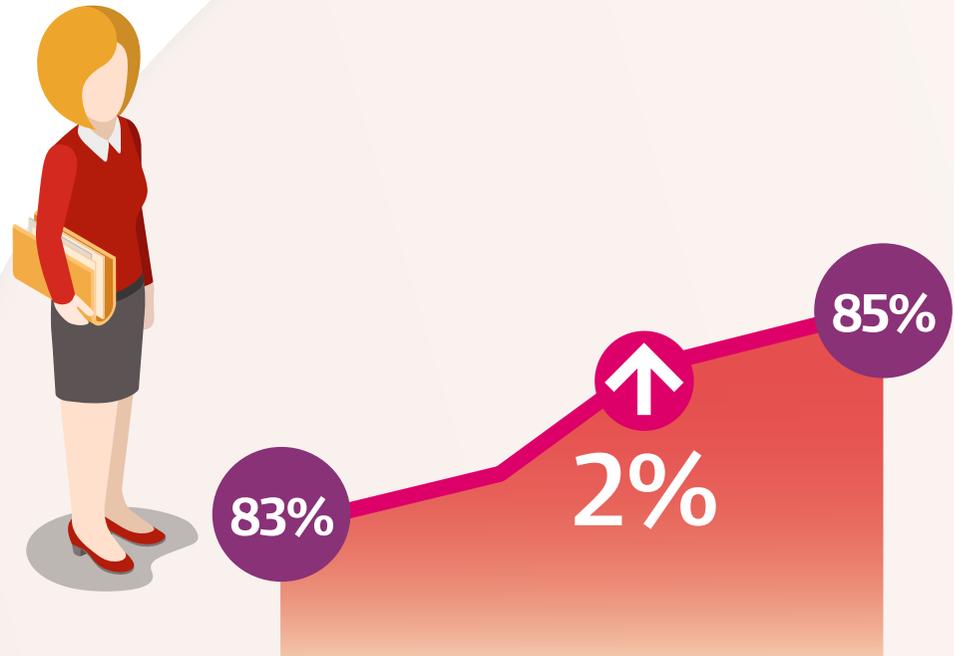
We were notified of 714 absences without leave from secure hospitals



During our visits, we triangulate information by speaking with patients, reviewing records and speaking with staff. We discuss findings with staff throughout the visit to make sure we understand local processes and record systems. We often report on what we find in care records and highlight if we think there is a recording or care issue when we report to the local leadership team.

Information being provided to patients has improved

- There has been an increase in evidence of patients being provided with information about their rights in an appropriate format, from 89% of records examined (7,204 out of 8,110) in 2014-16 to 94% (6,833 out of 7,253) in 2016-18.
- There has also been an increase, from 83% (6,513 out of 7,853) to 85% (5,482 out of 6,464) in further attempts to explain rights, or to explain rights to nearest relatives.
- Rates of discussions about rights and assessments of patient's levels of understanding has improved, from 91% (7,474 out of 8,236) to 93% (6,784 out of 7,300).



INCREASE
in further attempts to explain rights

Care planning has improved but it is still one of our greatest concerns

- There has been an increase in evidence of patient's involvement in care plans, from 73% (5,888 out of 8,054) of records examined in 2014-16 to 83% (6,029 out of 7,307) in 2016-18.
- However, we continue to find issues with recording adequate evidence of whether patients consent to treatment, discharge planning and involving patients in care planning.

The availability and quality of advocacy services is not consistent

- On almost every ward we visit, patients state that they have some degree of access to Independent Mental Health Advocates.
- We 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.



INCREASE
in evidence of patient's involvement in care plans

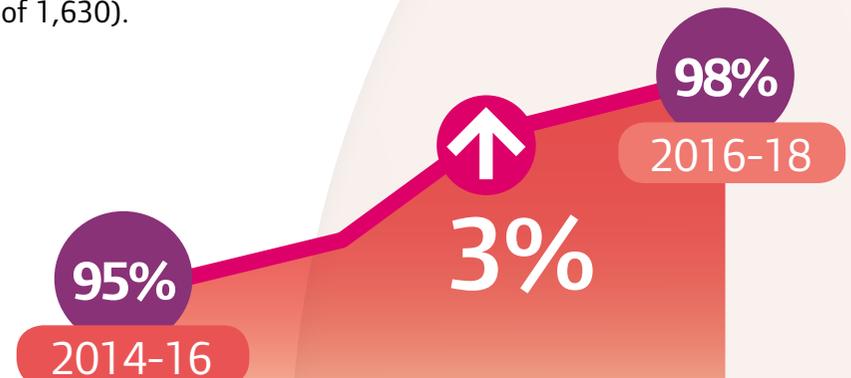
We are concerned about the use of restrictive practices in mental health services

- We are concerned about the way that mental health services apply the Code of Practice recommendation to reduce restrictive interventions when responding to challenging behaviour.
- It is a concern that 'long-term segregation' is now viewed to be much more commonplace. We are carrying out a thematic review of the use of restraint, seclusion and long-term seclusion on young people with mental health problems, and on patients with a learning disability or autism who are receiving care on mental health wards or in other types of residential settings.

By restrictive practices, we mean it in the wider sense that encompasses general restrictions on patients through blanket rules, as well as restrictive interventions such as restraint or seclusion.

Services have improved at identifying patient's physical health issues on admission

- We sample records for evidence of whether patients who have been in hospital for less than a year had a physical health check on admission. Compared with findings in 2014-16, there has been an increase in evidence of such health checks in 2016-18, from 95% of records examined (5,471 out of 5,771) to 98% (4,832 out of 4,947).
- There has also been an increase in hospital wards which, when asked on our visits, report no difficulty with access to GP services, from 90% (1,392 of 1,550) to 93% (1,520 of 1,630).



INCREASE

in evidence of physical health checks on admission to hospital

The Second Opinion Appointed Doctor service is an additional safeguard for patients detained under the MHA, providing an independent medical opinion to state whether certain treatments are appropriate.

The Second Opinion Appointed Doctor service (SOAD) is an important additional safeguard for patients

- In 2017/18, SOADs 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. This is similar to the previous year's figure of 26%.

Discharge planning has improved

- The Code and Care Programme Approach expect providers to begin discharge planning as soon as the patient is admitted.
- There is an overall improvement in services meeting the Code's expectations to show evidence of aftercare planning in 2016-18 (of records examined 4,872 out of 6,055, or 80%). This is compared with 69% in 2014-16 (5,382 out of 7,754).





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