

Mental Health Act Code of Practice 2015

An evaluation of how the Code is
being used

Contents

Key findings and recommendations	3
Introduction	5
How is the Code of Practice being used?	8
Enablers and barriers to good practice	13
Conclusion	16
Appendix: Section 140.....	17
References	18

Key findings and recommendations

- The Mental Health Act (MHA) Code of Practice is still not being used as it was intended to be, with variation in providers' understanding of the Code and how it should be applied.
- We looked at three key areas for more insight into the issues. These included understanding and application of the guiding principles, engagement and involvement of patients, and local area working and section 140. We found that:
 - Providers lacked understanding about how to promote, apply and report on the guiding principles in the Code of Practice.
 - Providers did not support staff well enough to enable them to have meaningful and productive conversations with patients so that they can better understand patients' goals and how patients can take ownership of their recovery. Independent Mental Health Advocates (IMHA) offer an additional safeguard and support for patients, but our review of MHA reports shows ongoing difficulties with providing IMHA support.
 - Local areas, including commissioners, local authorities, police and providers, should work together better to make sure that people receive the right care across organisations, including making sure that people in need of urgent care have timely access to a bed that is close to home, in line with the expectation of section 140 of the MHA.
- Feedback from stakeholders and experts throughout our review also identified a number of overarching themes that were common across our three key areas of focus.
 - Awareness of the Code of Practice and/or the easy read version remains low among patients, families and carers. Like providers, even when they knew about the Code, they found it difficult to navigate or use in a meaningful way.
 - The current format of the Code is not easy for staff and professionals to use. Over the years the Code has grown from 135 pages to over 450 pages. While the 2015 version is available as an electronic file, it is not fully accessible and does not include easy navigation or links to other relevant care standards.
 - The quality, content and focus of training for staff on the Code of Practice varied. While we saw some examples of good practice, the size and breadth of the Code was a challenge, with some providers still not having updated their training to reflect the 2015 Code.
 - The quality of governance and oversight of the MHA and the Code varied. While we accept local arrangements can vary, these need to make sure that the MHA and Code are used effectively, and that changes are driven forward to improve the experience of detained patients.

Recommendations

Based on our findings, we recommend, as part of their response to the independent review of the MHA, the Department of Health and Social Care (DHSC) takes a lead in:

- **Developing standardised resources, support and training for patients, carers and staff** so that they understand how the Code applies to individuals, practice, services and local partnerships.

- **Promoting the use of the guiding principles to improve practice and enable meaningful engagement with families and carers.** The guiding principles need to be recognised as a support tool for human-rights based approaches by staff and services.
- **Making sure that the Code of Practice gives clear and consistent guidance on providers' governance arrangements.** This includes guidance on ensuring that how the MHA and Code are being applied is reported on at senior leadership level.
- **Improving the usability of and access to the Code of Practice,** taking into account the way the Code is intended to be used in practical situations between patients and their care team. This should include considering how to make the Code digitally accessible to patients, carers and clinicians. For example, a search function with accessible links to other relevant guidance would enable professionals to find relevant guidance quickly to support their day-to-day work.

Introduction

As the independent regulator of health and social care services and the monitoring body for the Mental Health Act (MHA), CQC is responsible for assessing the care, treatment and support offered to people subject to the MHA in services across England. When we review how services are using the MHA, and what this means for people's care and treatment, we compare what we find with available standards, legislation and guidance. In this way, we know what good looks like and can identify and report on areas that require improvement.

Following a request from the Department of Health and Social Care (DHSC), we have worked with stakeholders to evaluate how well the MHA Code of Practice ('the Code') is being used across mental health services since it was updated in 2015. We looked for the enablers and barriers that services have found in using the guidance and what impact this has had on people's experience of detention, care and treatment. The request to evaluate the Code followed a recommendation in the *Five Year Forward View for Mental Health* (recommendation 51) and a commitment made by DHSC in the Equality Impact Assessment prepared for the revised Code (2015).

We carried out this evaluation at the same time that the MHA independent review was under way. The MHA review report was published in December 2018, with the government response expected later in 2019.¹ Any changes made to either legislation, policy or practice will require a new Code of Practice. This report highlights the key areas of improvement and learning from the current Code. These must all be addressed in future revisions if the Code is to provide a strong safeguard for patients, families, carers and support professionals and services.

Background to the Code of Practice

The MHA Code of Practice was first created in 1993 to help professionals and others working in services to interpret the MHA as it applies to decision-making in day-to-day practice, and to provide safeguards for involving and protecting people in mental health services. The Code includes guiding principles that should always be considered when making decisions in care, support or treatment. The government expects the Code's principles and guidance to be used in all services that detain patients. One of the purposes of the Code is to help local services to support the empowerment and involvement of patients and carers, and to make sure that safeguards are in place to support and protect the dignity and respect of people.

History of the Code of Practice

- **1993 – 135 pages:** covered assessment, admission in hospital, guardianship, treatment and care in hospital, leaving hospital and standards for people with a learning disability and children and young people under the age of 18.
- **1999 – 115 pages:** updated to include guiding principles and reflect changes in law and policy.
- **2008 – 394 pages:** new guidance added relating to the Mental Capacity Act, Human Rights Act added, as well as developments in law, policy and practice.
- **2015 – 459 pages:** new sections for the role of CQC, complaints and commissioning, plus additional guidance to reflect and embed developments in areas including restrictive interventions, seclusion, use of police powers and use of community treatment orders.

DHSC last reviewed the Code in 2015. Many stakeholders were involved in this review and identified the changes needed to make sure that guidance in the Code would be up to date with current law and policy, so that it offered patients stronger safeguards. DHSC also committed to making the document as accessible as possible for people affected by the MHA.

National reports, including the *NHS Five Year Forward View for Mental Health* (2016) and our report *Mental Health Act – The rise in the use of the MHA to detain people in England* (2018), have shown that the number of people detained under the MHA has risen across England in recent years. This means that the use of the MHA to detain people in inpatient mental health services is much more common than when the Code was first created. As a result, it is more important than ever to make sure that the Code is clear, accessible and supports the legal safeguards that protect people's human rights and autonomy.

What we did

The 467-page Code covers many aspects of the care pathway for people subject to different types of detention under the MHA, as well as informal admissions and treatment in the community. It uses the legal framework of the MHA to provide guidance on applying the MHA at various stages of the patient's journey, from assessment and admission to hospital, through to leaving hospital and aftercare. We worked with stakeholders to identify three key areas that would provide a good insight into how well providers are applying the Code in practice. The questions we sought to answer were:

1. Have the revised guiding principles had an impact in practice?
2. Have providers taken action to improve the way they are empowering and involving patients in their care?
3. Did the new guidance in the Code have an impact on the way local services work together when people need urgent admission to a mental health bed?

We looked at data from our annual programme of work with patients and providers. This included our visits to services and interviews with patients across NHS and independent mental

healthcare providers registered to assess and treat people subject to the MHA in their inpatient services.^a We also used information from:

- Qualitative sampling of over 400 issues raised during MHA monitoring visits about the use of the guiding principles between July 2012 to March 2018.
- A literature review by the Collaborating Centre for Values-based Practice in Health and Social Care in Oxford of published materials referencing the history and use of the guiding principles. The literature review also included telephone and face-to-face meetings with expert witnesses including people who use services, clinicians, regulators, lawyers and clinical educators.
- Engagement with people with past or current lived experience at our Service User Reference Panel.
- A workshop with commissioners, providers, police, social workers and local authority staff.
- A provider-level engagement webinar with professionals working with the current Code.
- Engagement with expert stakeholders from our MHA External Advisory group.^b

Findings have been corroborated and, in some cases, supplemented with expert input from stakeholders involved in the review.

^a The Health and Social Care Act requires healthcare providers to register for this separately to their other services. We also have several acute service providers registered for the less frequent situation of a detained patient being cared for in their service while receiving medical treatment. We do not carry out regular monitoring visits to these services, although would look at their MHA systems and processes during an inspection or in response to any concerns.

^b This includes representatives from NHS England, Department of Health and Social Care, service user networks, Royal College of Psychiatrists and mental health provider representatives.

How is the Code of Practice being used?

Through our review, we have seen services using and applying the Code of Practice in different ways. For example, we have heard positive examples of activities to raise awareness and understanding of the Code, such as updating local policies and procedures, or delivering local training packages. But we have also found that understanding of the Code varies, even within services. This includes variation in the level of understanding about how the Code should be applied and the perceived benefit of doing so.

1. Have the revised guiding principles had an impact in practice?

Overall, we found that the impact of the guiding principles was limited. In general, providers lacked understanding about how to promote, apply and report on the guiding principles.

The guiding principles were first introduced into the Code of Practice in 1999. Their intended purpose is to guide providers as to how they should apply the MHA to individuals in specific circumstances, what care options need to be considered and how to make sure that they consider patients' individual values, wishes and views. Following the revisions made in 2015, the current guiding principles are:

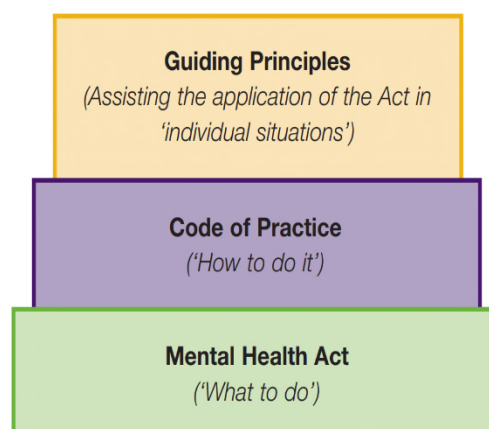
- Least restrictive option and maximising independence
- Empowerment and involvement
- Respect and dignity
- Purpose and effectiveness
- Efficiency and equity.

When the new Code was published in April 2015, providers were asked to make sure that they were applying the new Code and guiding principles by October 2015.

We found some good examples of providers applying the guiding principles for the benefit of individuals. This included local services that had taken steps to support staff in applying the principles. These services saw the principles as a useful tool for achieving human-rights based approaches and providing a helpful overview for patients and carers to understand how decisions were made.

However, our reports highlighted particular areas of concern where we found that the guiding principles were not being routinely implemented to inform practice in the way they should. These included:

- **Least restrictive principle.** MHA reviewers were most likely to request services to take action to improve practice relating to the "least restrictive" principle. This was often in connection with the use of blanket restrictions, routine searches or high observation levels to manage risk.



Brief Workbook to Support Implementation of the Mental Health Act 2007, Care Services Improvement Partnership and National Institute for Mental Health in England (2009)

- **Respect and dignity, and purpose and effectiveness.** We were most likely to require services to report how they are applying the guiding principles of “respect and dignity” or “purpose and effectiveness” when we found problems with the physical, social and therapeutic environment of the ward. This included the presence of dormitories, as well as a failure to make sure that they were complying with guidance on eliminating mixed sex accommodation. This was also the case when we saw poor care planning (including access to information or advocacy), and problems with staffing (including the numbers of skilled staff available to support patients).
- **Empowerment and involvement.** We asked providers to look at how they are applying the MHA and Code when we heard concerns about the way people felt supported to be involved in their care, raise concerns about the service they are in or told us that they did not feel listened to. We also asked them to consider how they can improve care for individual patients through the “empowerment and involvement” guiding principle.

Providers’ responses to our concerns about the way principles are being applied often include details about how they plan to address these issues. This includes, for example, discussions in ward meetings, carrying out local audits, training or updates to policies and procedures to improve adoption of the principles.

Our overall conclusion was that many providers lack understanding about how to promote, apply and report on the guiding principles. We passed these findings, and our conclusion, directly on to the independent MHA review in 2018. The review has since made recommendations to include principles on the face of the MHA – making them a statutory requirement to be applied – and to include reference to them in the statutory paperwork used when detaining patients.

While we wait for any national changes, we can report that during our evaluation we saw some examples of providers applying the guiding principles well. For example, this included local services who had taken steps to support staff in applying the principles, seeing them as a useful tool for achieving human-rights based approaches and providing a helpful overview for patients and carers to understand how decisions have been made.

2. Have providers taken action to improve the way they are empowering and involving patients?

People who are subject to the MHA are in a vulnerable position because it allows for the forced treatment of individuals who do not agree, or are unable to agree, to their treatment plan. The principle of “empowerment and involvement” in the Code of Practice is intended to provide safeguards for people to make sure that they are encouraged, supported and involved in their care as fully as possible. The Code provides specific guidance on how patients subject to the MHA can be involved in decision-making. This guidance should be considered against the general expectations that apply for all people undergoing medical care and treatment, such as those set out in the Mental Capacity Act and by the National Institute of Clinical Excellence (NICE).

Through our review, we have not found evidence that the Code has prompted a substantial change in the way services are empowering and involving people in their care. As highlighted in our report *Monitoring the Mental Health Act 2017/18*, we are still receiving frequent complaints, through our MHA complaints service, from people who do not feel appropriately involved in or informed about their care.

We looked at a sample of 40 reports where MHA reviewers had raised concerns with providers about the involvement of patients, carers and relatives in decisions about their care and treatment. In around half of these, providers told us they would carry out audits, reviews and seek feedback from patients and staff to address the issue of lack of involvement.

However, out of the 40 cases in our sample, only 10 providers had identified the need for further staff training and development. This is essential for staff to give them the skills and knowledge they need to be able to engage effectively with patients and to involve them in decisions about their care and treatment. Providers need to consider how they support staff to have meaningful and productive conversations with patients, so that they better understand individual patient's goals and how patients can use their qualities and strengths to take ownership of their recovery.

Learning from the Welsh MHA Code of Practice

The guidance in the Welsh MHA Code of Practice includes information on the type of training that should be provided, as well as learning outcomes and how evidence-based best practice should underpin all learning.² The guidance set out expectations that, as well as receiving training on the Welsh Code, professionals working with detained patients should receive training on communication and a range of specialist-related skills and topics. These include understanding the significance of developing a supportive relationship with patients, treating people with dignity, being culturally sensitive and respecting individuals' diversity, and the importance of providing a safe and positive environment for patients.

The Code sets out the training areas as including the core elements that all service providers and commissioners should consider as part of their training strategy, training about specific patient groups, learning for specific roles and broader training for commissioners and managers.

Independent Mental Health Advocates (IMHA) offer an additional safeguard and support for patients to make sure that they are meaningfully involved in their care. Introduced in 2007 as part of amendments to the MHA, IMHAs are trained specifically to work with detained patients to help them to take part in decision-making, and to support them to express and communicate their views. However, our review of MHA reports shows ongoing difficulties with providing IMHA support. This includes ward staff not always knowing when a referral should be made, a lack of knowledge about the differences between the various advocacy services available and a reduction in IMHA services nationally.

3. Did the new guidance in the Code have an impact on the way local services work together when people need urgent admission to a mental health bed?

Section 140 of the MHA places a duty on commissioners to notify local authorities in their areas of arrangements for:

- admitting people in need of urgent care
- people who need appropriate accommodation or facilities designed for children and young people under the age of 18.³

Although this duty has been part of the MHA since 1983, the 2015 Code was the first to identify how this should be managed locally. The new guidance in the Code, “Commissioning and section 140”, proposed that local authorities, providers, NHS commissioners, police forces and ambulance services should make sure that a clear joint policy is in place for the safe and appropriate admission of people in their local area. This should be agreed at board level and each party should appoint a named senior lead.⁴

As part of our review, we looked at whether the new advice and guidance led to improved joint agency responses for the urgent access and admission of patients. We worked with NHS England and others to hold a workshop with commissioners, local authorities, police, ambulance services and providers to discuss what local arrangements exist to support their implementation of section 140. Participants told us that there continued to be a lack of understanding on the roles and responsibilities of each organisation in implementing section 140. This included how this differs from bed management and agreement on what the definitions in section 140 mean and how they should be applied. For example, the term “special urgency” may be applied to both people assessed as needing detention under the MHA, or people not meeting criteria for detention but urgently needing a mental health bed. Attendees reported that only two clinical commissioning groups in the country were known to have a section 140 policy in place, which is recommended as good practice in the Code. The fact that we found limited evidence of section 140 policies suggests that clinical commissioning groups are not aware of the guidance and support that the Code offers on section 140.

Greater awareness, senior oversight and monitoring of information relating to section 140 processes could help patients, medical staff and approved mental health professionals to find mental health beds, avoid delays when people require admission to specialist settings and help inform the commissioning needs for alternative services, including crisis houses and community support services. However, we found that the revised guidance has not had an impact on making sure that there are locally agreed joint protocols in place to support the implementation of section 140.

Our evaluation of how well section 140 is being implemented suggests that commissioners are not doing enough to make sure that they are meeting their statutory responsibilities and applying the supporting guidance in the Code. If the legal obligation under section 140 is not discharged as intended, approved mental health professionals are often left in a difficult situation when they have assessed someone as requiring detention under the MHA but are unable to find a bed. In some cases, a suitable bed can only be located out of area, miles away from a person’s home and family. Additionally, people who are arrested under criminal law are staying in police cells for too long, often unlawfully, after it has been established that they need to be admitted to hospital following an assessment under the MHA.

The independent review recognised that section 140 needs to be applied more consistently and effectively. To achieve this, the independent review made a number of recommendations, including that NHS England, DHSC and CQC should work with CCGs, local authorities, the

AMHP Leads Network and providers to understand how section 140 is being used currently. The independent review has also recommended that clear joint guidance is issued to support commissioners to discharge their statutory duties under section 140.

The way services are commissioned is evolving. There is a trend towards commissioning over larger areas and there are examples of CCGs and local authorities working together to support the integration of services across health and social care. With changes being made to the way commissioning is delivered in practice and with organisations working more collaboratively, there is an opportunity to provide further practical tools and guidance to commissioners to support them to implement section 140 and the associated Code guidance in Chapter 14.

Enablers and barriers to good practice

Feedback from stakeholders and experts identified a number of overarching themes that were common across our three key areas of focus. These included:

- awareness and understanding of the Code
- quality of staff training on the Code
- increasing usability for staff and professionals
- clear and consistent governance, monitoring and reporting.

This section looks in more detail at these themes and identifies some of the barriers and enablers to good practice.

Improving awareness and understanding of the Code

During the last revision of the Code, DHSC highlighted that there were challenges around awareness and accessibility of the Code for providers, patients and carers (see section [‘Increasing usability’](#)).⁵ Our evaluation found that this continues to be one of the most significant barriers to implementing the Code’s guidance for both statutory requirements and advice on best practice.

In particular, we heard that there was very low awareness of the Code of Practice and/or the easy-read version among patients, families and carers. Even when they knew about the Code, they found it difficult to navigate or use in a meaningful way in its current format (see section [‘Increasing usability’](#)). Patients who understood the Code, felt able to participate more in decision-making, to consider challenging services or to request additional support. However, for many people the way the Code is written acts as a barrier to understanding “what good care looks like” that people should expect to receive. This is a particular problem at admission when they receive a lot of information, often when in distress.

Quality of staff training on the Code

The quality, content and focus of training for staff on the Code of Practice varied nationally. We saw some excellent examples of good practice where providers had tailored training on the Code for different teams. But the size and breadth of the Code was a challenge for others, with some providers still not having updated training to reflect the 2015 Code, or considering how the MHA and Code could have implications for all clinical training.

Training and support are essential for all staff involved in caring for detained patients. This enables them to work innovatively and challenge practice where it falls below expected standards of care. However, registered nurses and healthcare workers are often offered different types of training. In some cases, healthcare workers are not offered training on the MHA and the Code, even though they spend a larger proportion of their time with patients.

Participants in our provider webinar told us about their local approaches to MHA training. These included multi-agency training sessions held with the police on subjects such as section 136. We also heard examples of MHA awareness training for support workers and healthcare assistants caring for detained patients, which recognised that these staff would benefit from training as well as qualified staff. Some participants also told us that they included recurring themes and learning from MHA monitoring visits in their MHA training.

However, we also heard concerns about the varying quality of training. For example, there were concerns that training on the Code was given only alongside basic training about the MHA, allowing little time to explore how to apply or use of the Code in practice, or how the guiding principles can be used to inform human-rights based decision making or clinical approaches.

Participants told us that they would welcome a national training plan, which would help to make sure that there was consistency of training and that there were resources for local training needs. This would be similar to the Welsh MHA Code of Practice 2016 that sets out what should be covered in training and what level of training should be delivered to different professionals working with the Code.⁶

Increasing usability for staff and professionals

Since the Code was first created in 1993, there has been an expectation that a hard copy of the book would be available on wards, available on wards, to both patients and clinicians. Over the years, the Code has grown from 135 pages to over 450 pages. The 2015 Code is available as an electronic file but is not fully accessible, and does not include easy navigation or links to other relevant care standards for best practice and legal frameworks, for example, NICE guidance or the Mental Capacity Act and associated Code of Practice.

We heard that the current format of the Code is not easy for staff and professionals to use to support clinical or professional decision-making and practice. Doctors, approved clinicians, managers and staff of provider services are more likely to rely on support staff (usually MHA administrators who are appointed to make sure the administrative tasks for the Act are followed) to search or advise on areas of the Code that would be relevant to their clinical decision-making. Reasons for this included the length of the Code making it difficult to navigate in clinical settings with patients and families. While some staff had downloaded electronic versions, there was a call to create a more innovative digital version and develop it with clinical situations and use in mind.

The Code is not widely used by commissioners or other services involved with people who are or may be subject to the MHA. There is a lack of understanding among commissioners about how to support provider services in meeting the Code for the benefit of patients. The 2015 Code states that it is beneficial for everyone involved in the care and support for people who may be affected by the MHA, including commissioners, ambulance, police and social services, to be aware of the guidance. It calls for these services to have training on the Code to make sure that they are familiar with its requirements. However, we heard that stakeholders did not feel this is happening in practice, and that training programmes were not consistently offered or identified as a need for those beyond provider services.

Clear and consistent governance, monitoring and reporting

We found that the quality of governance and oversight of the MHA and the Code also vary nationally. We accept that local arrangements may differ. However, any arrangements need to make sure that the MHA and Code are used effectively, and that changes are driven forward to improve the experience of detained patients.

Involving people who use services in local MHA groups and multi-agency committees is important as it helps to make sure that the patient voice is heard, and enables system-wide improvement. However, there needs to be clearer guidance in the Code of Practice to make sure that this happens consistently across the country.

This issue was raised in the consultation for the 2015 Code, with 71% of respondents agreeing that the Code should provide more guidance about the governance arrangements for monitoring duties and powers under the Act.⁷ While updates to drive improvements to governance were included in the revised Code, these are spread throughout the document. This makes it difficult for services and multiagency committees to know what to prioritise and how to make changes.

As a result, it would be helpful for any revisions to the Code of Practice to include a new chapter on best practice for governance of the MHA. This should include providing suggestions for governance structures and reporting templates.

South London and Maudsley NHS Foundation Trust

Background: In 2018, the trust board agreed a new approach to the oversight and monitoring of the MHA. This was to make oversight of the MHA 'business as usual' to make sure that the use of the MHA, as well as quality of care, is monitored routinely in monthly trust quality and performance reviews. The trust board approved a new Mental Health Law Committee Terms of Reference with two key aims:

1. To achieve 100% compliance with the MHA, CQC regulatory standards and the Code of Practice.
2. To provide least restrictive and 'appropriate' high-quality care, delivered with a focus on promoting equalities and human rights.

The Mental Health Law committee is presented with information on:

- local population profiles and how local diverse populations accesses services
- local patterns of detention and pathways into care
- compliance with the MHA, CQC regulatory standards and the Code of Practice
- the people who are detained at the service including equalities characteristics, social and risk determinants, whether they are new to the service and the nature of their mental illness
- whether care delivered is least restrictive and of high quality.

The Mental Health Law committee also strengthens multi-agency partnership working by having representatives from local partner organisations as members. People who use services and carers are also invited to committee meetings to feedback to members on their experience.

Conclusion

Our evaluation has highlighted that the MHA Code of Practice guidance and best practice expectations are not well understood or consistently being translated into practice, oversight or decision-making. The issues raised in this report reflect those identified during the DHSC work on the last Code.

Based on our findings, we recommend, as part of their response to the independent review of the MHA, DHSC takes a lead in:

- **Developing standardised resources, support and training for patients, carers and staff** so that they understand how the Code applies to individuals, practice, services and local partnerships.
- **Promoting the use of the guiding principles to improve practice and enable meaningful engagement with families and carers.** The guiding principles need to be recognised as a support tool for human-rights based approaches by staff and services.
- **Making sure that the Code of Practice gives clear and consistent guidance on providers' governance arrangements.** This includes guidance on ensuring that how the MHA and Code are being applied is reported on at senior leadership level.
- **Improving the usability of and access to the Code of Practice,** taking into account the way the Code is intended to be used in practical situations between patients and their care team. This should include considering how to make the Code digitally accessible to patients, carers and clinicians. For example, a search function with accessible links to other relevant guidance would enable professionals to find relevant guidance quickly to support their day-to-day work.

The Code and its principles remain one of the bedrocks for CQC's approach to monitoring and regulating mental health services. This includes our ongoing work to strengthen our assessment of the quality and safety of wards. In last year's State of Care report, we flagged this up as our greatest concern about mental health services. Our 'Getting it Right' programme responds to the recommendation in the MHA review that CQC develops new criteria for assessing and monitoring the physical and social environments of these wards. Also, our MHA visits will continue to highlight specific issues with how the Code is applied, and we will report on our findings in our MHA annual reports.

We will also be using findings from our activities to engage with senior stakeholders leading the next phase of the independent review of the MHA to influence future legislative reform and practice improvements.

Finally, we are sharing our findings from this evaluation with DHSC to influence what can be done now to improve how the Code is being implemented and how any future Code could be improved in terms of content and implementation.

This report and our findings should be considered by those involved in leading the development of the Liberty Protection Safeguards in their development of the Code intended to support and protect the rights of people being cared for using that legal framework.

Appendix: Section 140

What is section 140?

The section 140 duty has existed in law since 1983. The Mental Health Act requires *“every clinical commissioning group to give notice to every local social services authority for an area wholly or partly comprised within the area of the clinical commissioning group, specifying the hospital or hospitals administered by or otherwise available... a) for the reception of patients in cases of special urgency; b) for the provision of accommodation or facilities designed so as to be specially suitable for patients who have not attained the age of 18.”*

In response to issues raised by stakeholders, including CQC’s formal response to the consultation, the 2015 Code introduced guidance for clinical commissioning groups to follow. Although the Code is not statutory guidance for clinical commissioning groups (CCGs), there is an expectation that CCGs will have regard to the Code. The guidance in Chapter 14 of the Code was intended to inform how local protocols are created and includes:

- CCGs should provide a list of hospitals where they commission mental health beds in the area, including specialist beds, to local authorities.
- Local authorities, providers, NHS commissioners, police forces and ambulance services should have a clear joint policy for the safe and appropriate admission of people in the local area. This should be agreed at board level and each party should appoint a named senior lead for oversight of the policy.
- All parties should meet regularly to discuss its effectiveness, in the light of experience and review the policy, and to decide when information about specific cases should be shared between parties for the purposes of protecting the person or others.
- People carrying out functions for all parties should understand the policies and their purpose, the roles and responsibilities of others involved, and follow the local policy and receive the necessary training to be able to fully carry out their functions.
- Local recording and reporting mechanisms should be in place to make sure that the details of any delays in placing patients, and the effect on patients, their carers, provider staff and other professionals are reported to commissioning and local authority senior leads.
- All details of delays should feed into local demand planning – helping commissioners and providers to work together to identify issues with the beds, processes or crisis provision locally.
- Commissioners should, in partnership with providers, make sure that alternative arrangements to meet the person’s needs pending the availability of a bed are available, for example crisis houses, and should communicate those arrangements to the local authority.

References

- ¹ Department of Health and Social Care. [*Modernising the Mental Health Act Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983*](#), December 2018
- ² Welsh Government, *The Mental Health Act 1983 Code of Practice for Wales. [Guidance to professionals about their responsibilities under the Mental Health Act 1983](#)*, October 2016
- ³ Department of Health, [*The Mental Health Act 1983: Code of Practice, 2015*](#). Annex 2, page 269 – 273, paragraph 14.78
- ⁴ Department of Health, [*The Mental Health Act 1983: Code of Practice, 2015*](#). Para 14.80
- ⁵ Department of Health, [*Stronger Code: Better Care Consultation on proposed changes to the Code of Practice: Mental Health Act 1983*](#), July 2014
- ⁶ Welsh Government, [*Mental Health Act 1983: Code of Practice for Wales Review*](#), Revised 2016, Annex 2
- ⁷ Department of Health, [*Stronger Code: Better Care Consultation on proposed changes to the Code of Practice: Mental Health Act 1983*](#), July 2014, page 78

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