Monitoring the Mental Health Act in 2019/20

State of Care

Care Quality Commission

Monitoring the Mental Health Act in 2019/20
The Mental Health Act in the COVID-19 pandemic

Foreword

Our function is to promote quality and human rights: ultimately to make sure that patients subject to the Mental Health Act (MHA) are kept safe from harm, abuse or neglect. We have faced an unprecedented public health challenge in the last six months, but this has not changed our basic purpose and we have continued to monitor and intervene on behalf people who use services and patients. We may have changed some of our processes but not our intent or outcomes.

At the start of the pandemic, there was a system wide change in the approach to how services were run, with a move to more use of technology in outpatient settings and various configurations of inpatient services evolved. There were some great innovations that we saw in service design, including new types of emergency access models to decrease pressure on emergency departments and COVID-19 only psychiatric intensive care units and acute wards. This type of innovation is to be welcomed and applauded. However, it was clear that access to personal protective equipment (PPE) at the start of COVID-19 was difficult and this impacted on services. We received many whistleblowing complaints from staff about this and the very understandable concerns about their own health and the health of the patients they looked after.

We were very concerned about the patient voice during the first wave of the pandemic. With most visiting stopped, including from relatives, friends and outside agencies such as independent mental health advocates there was a significant risk that patients and people who use services were not being heard. We did continue virtual MHA review visits and Second Opinion Appointed Doctor visits through remote contact. We continued to talk to patients and their relatives, and we used information from these conversations to inform our CQC inspection on site visits, which restarted in late April/ early May. We have, this year, included many comments from people who use services about their experiences, which is a mixture of positives and negatives.

We will continue to monitor services and intervene when necessary. In our last report we highlighted the issues of inequality and the differential use of the MHA across different ethnic groups. We know that the early evidence is that people Black and minority ethnic people have been more severely affected by COVID-19 and that they were more likely to die as a result of infection. As part of our well-led assessments we will be looking at how the senior leaders in an organisation are dealing with the health inequalities that exist in their organisations, and the degree to which they have thought about and acted on these effectively.

Dr Kevin Cleary
Deputy Chief Inspector of Hospitals and lead for mental health

Summary

This annual report on our monitoring of the Mental Health Act (MHA) puts a specific focus on the impact that the COVID-19 pandemic has had on patients detained under the MHA, and on the services that care for and treat them.

The pandemic has presented mental health services with an unprecedented challenge. Services have been faced with the difficult balance of a duty of care towards patients while at the same time upholding the principle of least restriction.

It is vital that we share with providers, mental health care staff, system stakeholders and policy makers, the learning from the initial stages of the pandemic so that this can be applied as quickly as possible in the current wave of COVID-19 and any future resurgence.

The majority of the findings in the report are drawn from a combination of our remote monitoring carried out during the pandemic and contacts both with services and national health system bodies. The pandemic has had an unprecedented impact across the system, and this will continue to be felt for some time as we enter a challenging winter period and beyond.

Many of the services we considered through our remote monitoring coped well with the pandemic situation. In particular, we found that services that focused the most on carefully applying the principles of least restriction were the most successful in empowering their patients (and staff) to cope with the extra restrictions imposed on society in general, especially during the first national lockdown.

Good services also put emphasis on care planning to involve and empower patients, as well as co-production with patients in order to improve the ward environment.

Our evidence and findings point to the actions we want to see to support people subject to detention under the MHA.

1. Planning for individuals' discharge from hospital continues to be essential and is particularly important during the pandemic period due to the increased burden on all services, including those in the community. **It is vital that discharge planning is carried out in co-production with patients and their families/support networks in order to ensure better outcomes.**

2. Some services showed exemplary practice in the co-production of care with patients, including infection control measures, and where this was done patients were generally supportive and cooperative with the steps to limit COVID-19 infection. **Patients must be involved in decisions about their care, including infection control. Where this is done, the negative impact of restrictions on detained patients during a pandemic can be limited.**

3. In many services the physical environment requires modernisation and doing so would have the added positive impact of making infection control easier. **Modernising physical estates would help with infection control measures.**

4. Some services continued to uphold restrictions on patients' movement, activities and leave for longer than seemed necessary, which we saw could have an adverse impact on patients' wellbeing. **Services should recognise the significant impact restrictions on leave of absence and activity can have on detained patients and ensure these are lifted as quickly and as safely possible to avoid very damaging 'closed cultures' from emerging.**

5. Many services invested in software to help detained patients to stay connected with their family and other sources of support during the pandemic. Some also lifted restrictions around the use of technology such as mobile phones and tablet computers. **Relaxing the rules around using personal technology, such as mobile phones, should continue in future, and services should prioritise linked issues such as WiFi connectivity in future estates development.**

6. Detained patients' access to advocacy services was made more difficult during the pandemic, but such services played an even more crucial role where patients' lives were more limited by infection control measures. **We believe that advocacy should move to be offered on an opt-out basis in future.**

7. We observed the use of remote technology such as video conferencing for clinical meetings and assessments, as well as assessments for detention, tribunal procedures and advocacy services. We also put in place a remote Second Opinion Appointed Doctor service. **There needs to be careful evaluation of using remote technology should aspects of them continue after the pandemic abates.**

In April 2020, we moved most of our MHA monitoring to remote technologies and we have continued to use these through the pandemic. We will return to regular, unannounced site visits once it is safe to do so. In the meantime, we will continue to evaluate our remote MHA methodology and develop it to make improvements where necessary.

Introduction

CQC has a statutory duty to publish an annual report on its monitoring of the Mental Health Act (MHA). Information about our monitoring of the MHA in 2019/20 is given in chapter 6 of this report, but, given the extraordinary impact of the COVID-19 pandemic from the end of that financial year, this report unusually focuses on events that occurred from that time. We have decided to do this so as to make widely available our observations and learning about the care and treatment of patients detained under the MHA at a time of pandemic while this is most relevant and useful. We intend this report to be of use to providers, mental health care staff, system stakeholders and policy makers, so that the learning from the initial stages of the pandemic can be applied as quickly as possible in the current wave of COVID-19 and any future resurgence.

The NHS had begun to prepare for a possible pandemic of coronavirus (COVID-19) from the end of January, shortly before the World Health Organization declared the situation to be a public health emergency of international concern.[1] The first case of COVID-19 was reported in the UK on 31 January 2020, and by 12 March, when the Chief Medical Officer raised the UK threat level from moderate to high, mental health hospitals were preparing to manage their services in the context of a serious outbreak in England. The first 'lockdown' – where people were asked to 'stay at home' – applied across England from 24 March to 10 May. Since this time the range of restrictions aimed to prevent the spread of the virus were gradually eased, and then tightened again from mid-September 2020 on both a local and national basis to deal with the current second wave of the pandemic, leading to the second lockdown currently in force.

The pandemic has presented mental health services with an unprecedented challenge and new ethical and practical problems in relation to those who are detained under the MHA.

People with pre-existing mental health disorders may be particularly vulnerable to COVID-19 infection because of their life circumstances.[2,3] In addition, the common co-morbidities of serious mental disorder – including those related to obesity, smoking and harm from psychiatric medication – are likely to increase the risk of people becoming seriously ill if they are infected.

Since the start of the pandemic, mental health inpatient services have been faced with the difficult balance of a duty of care towards patients who could not be discharged but who did not (in general) consent to be in hospital, while upholding the principle of least restriction at a time when extraordinary restrictions were being placed on the general public. The restrictions of lockdown, and the necessities of shielding and self-isolation, also disrupted core procedural aspects of the operation of the MHA.

Evidence used in this report

Our main source of evidence for this report is the activity of our MHA reviewers in carrying out monitoring visits. These are usually unannounced

visits to hospitals where we speak in private with detained patients, talk to staff and examine records. We have a specific legal duty under the MHA to carry out monitoring visits, and a general requirement as part of the UK National Preventive Mechanism against torture and ill-treatment of detainees.

Our data on our monitoring activity for most of 2019/20, before the pandemic, is set out in chapter 6. This covers the number of MHA reviewer and Second Opinion Appointed Doctor visits we made, the MHA enquiries we received, the number of notifications for absences without leave that we received, and the numbers of deaths of detained patients.

At the start of the first lockdown, we suspended our routine on-site MHA monitoring visits, to avoid spreading the infection between providers. In early April we restarted our monitoring activity through 'remote monitoring'. Details of this are set out in appendix A.

Chapters 1 to 5 set out our findings during the pandemic period to date. They are based on more than 355 remote monitoring exercises carried out from April to October 2020. Throughout our remote monitoring we aimed to provide support to services through video calls to patients, carers, advocates and many staff. This was followed by a summary letter to the ward manager outlining observations and any areas of concern. We have quoted from these letters in the report and in the main, have not identified the services concerned, with some exceptions when we are describing good practice.

We spoke to over 1,000 detained patients and more than 570 carers during our remote monitoring (figure 1).

Figure 1: **MHA Reviewer remote monitoring activity from April to October 2020**

Wards Receiving Remote Reviews	Patients interviewed	Carers contacted	No. wards where IMHA* contacted	No. of IMHAs contacted	Staff interviewed
358	1,016	578	284	337	993

Source: CQC
*IMHA – Independent Mental Health Advocate

State of Care

1. What patients and carers told us about the impact of the pandemic

Although patients and carers will have had a range of experiences over how services managed during the COVID-19 crisis, a number of priorities and key themes can be drawn from what we have heard from them.

The restrictions applied to the whole population during the first lockdown and after were also experienced by patients detained in hospital and their carers.

Being asked to 'stay at home' could be particularly frustrating for patients whose home life had been disrupted by illness and involuntary hospital admission. The most pressing concerns seem to include:

- not being able to continue with community activities
- feeling 'cooped up'
- having less contact with friends and family
- possibly having to spend longer in hospital than might otherwise be the case.

> Patients said they had meetings with staff about what was happening because of the virus. One patient told us they were angry at first about not being able to go out, but when staff explained they accepted that it was to keep everyone safe.
>
> **Low secure learning disability unit for men, July 2020**

Public health measures around the crisis significantly limited activities for the general population, and this meant some struggled to follow them. This was the same for some inpatients. Some symptoms of mental disorder, such as paranoia, could make such understanding more difficult.

But many detained patients did both understand and support the need for measures to limit the impact of COVID-19 and keep them safe. People appreciated being given opportunities to understand, discuss or question arrangements. Involvement in decision-making was a key factor in avoiding a sense of helplessness, or that arbitrary rules were being applied.

Many patients we spoke with told us how grateful they were to staff, who they often saw making additional efforts to address problems caused by the pandemic. The things that make a service good in normal times were still the most important: individualised approaches; therapeutic relationships; and staff having the caring skills and autonomy to work effectively to help patients regain their own autonomy after detention in hospital.

> Patients largely described a sense of 'being in it together'. There was a lot of praise for the staff for the way in which they had explained the situation and appreciated the efforts staff were making to keep everyone safe. On one ward, a longstanding patient died as a result of COVID-19. Staff and patients seemed united in their grief. Neither patients nor staff were able to attend the funeral, but planted something in the garden as a memorial instead. Patients appreciated that staff had come up with ways to remember their fellow patient. They spoke about her death in meetings and one-to-ones, as patients were both very sad and very scared.
>
> **Three secure wards for people with learning disability, June 2020**

Practical things that people appreciated were the additional efforts to bring activities onto the wards; ensuring access to outdoors and fresh air, off the hospital site where possible; ensuring families could stay in touch; and the many ways that services found to do things differently under adverse conditions, many of which are found in this report.

Carers appreciated, most of all, good communication from the hospital staff and innovative ways of keeping in touch with their loved ones.

We also spoke with people who had particularly negative experiences as patients or carers, often because that experience involved the opposite to what we have just described. The following are examples of patient comments to us on visits.

In the summer of 2020, NHS England and NHS Improvement commissioned Rethink Mental Illness to undertake the co-production and coordination of a survey with people who use services, their carers and families across adult secure and forensic services to understand the impact of COVID-19. The survey gathered responses from 368 people from high, medium and low and community forensic services. We are grateful for early sight of the survey report and note how its findings echo areas discussed during our monitoring activity.[4] We hope that it will be read, particularly by mental health service providers, alongside this report to give the broadest view of lessons to be learned.

"There is always something to do and it's homely here. There is a good cohort of staff here, even the bank and agency [staff] are regular so that you can build up trust with them. They've set up a system so that they check on each of us after an incident, which helps so much and was in response to our feedback. It's really about patient-led recovery here and very individualised treatment."

"It's the best ward I've been on in terms of patient involvement, the key nurses are really good at one-to-ones and there is always someone to talk to."

Cedar ward, Priory Hospital Cheadle Royal, September 2020

Patients told me that being in isolation whilst waiting for the result of their COVID-19 was like being in seclusion. They said that the only time that they saw staff was when they asked for them, or when they brought meals. They said that they only had the clothes they were wearing when admitted and it took several says to get more clothes and toiletries.

Acute women's ward, June 2020

"COVID-19 got in the way of leave. I had leave before COVID-19 but haven't got any now"

October 2020

Patients told us they were not feeling motivated to engage in activities that were offered. They often chose to spend time in their bedrooms as they were feeling frustrated about not being able to leave the ward.

Medium secure unit, June 2020

"Staff seemed to be dragging restrictions out a bit when lockdown ended. They have been slow to reinstate leave and there is still no unescorted leave. There is not enough staff to do everyone's leave everyday."

June 2020

"All good when you need them and interact with you off their own bat"

Acute ward, April 2020

Patients told us that staff were highly supportive around mealtimes and a larger table had been brought in to allow for social distancing. But both staff and patients told us that the use of masks by staff in communal areas had initially impacted on care as staff had previously sat to eat with patients and this did not happen now. Patients told us that they had got used to this new way of working so it had become the "new normal."

Eating disorder ward, 1 July 2020

From patient feedback we heard that due to COVID-19 staff were no longer able to eat with patients on the ward. A patient told us they missed this as they felt this supported them to normalise their experience of eating with others.

Acute women's ward, June 2020

One young male patient told us there was not enough to do, he was bored out of his mind, with so little to do. He saw the occupational therapist (OT) once a week, he liked the cooking with the OT and would do it every day if could. He told us he liked to go to gym, but this was only available once a week. He liked to sit in the communal lounge but found it was often not a nice place to be, and therefore he often spent time lying on his bed. The OT team explained that due to social distancing sessions were run for individuals and therefore availability was reduced as patients had to take turns to access things.

Mixed adult acute ward, September 2020

"I didn't have any clothes with me. I couldn't get sanitary wear whilst I was in the COVID-19 room. Being in isolation was like being in solitary confinement."

Acute ward, June 2020: patient was isolated waiting for COVID-19 swab result

A number of patients said that they had not been able to have a haircut since the lockdown began in March and were aware that barbers' shops had now reopened and asked whether it would be possible for a barber to visit the ward.

Rehabilitation ward, August 2020

Patients told us they were understanding of staff wearing masks, although one patient told us they found it difficult not to be able to see the staff smile. Patients told us they could request masks and gloves if they needed them.

Acute ward, June 2020

Patients told us how much they enjoyed the range of activities on offer and how useful it was for their recovery. All activities had been adapted for social distancing and included outdoor circuit training, music, art, reflective journals, pampering sessions, cookery, one-to-one psychology and regular walks. Patients told us how innovative and meaningful the activities were. The ward team had consciously increased activities during the lockdown.

David Barlow Unit, North Devon District Hospital, June 2020

Patients and the IMHA [Independent Mental Health Advocate] told us that activities had been impacted since the outbreak of COVID-19. Most patients did activities in the community and many of these activities had not resumed. This included volunteering work. To compensate for this you told us that patients had plenty of grounds leave, and played cricket and other sports on site. In addition, one of the empty flats was used as an activity space.

Learning disability unit, June 2020

2. Mental health inpatient services' preparation for the pandemic

Key points

- The experience of hastened hospital discharges at the start of the pandemic shows the importance of patient-led and **effective care planning for discharge** from the earliest opportunity. Some patients were released from detention with unsafe or incomplete care plans, and this could be avoided through earlier and better planning.

- With fewer beds and limited community support delivered through remote contact, there will have been significant unmet need during lockdown. This may **increase the risk of coercive pathways into mental health care**, including detention under the MHA. This has the **potential to exacerbate the overrepresentation of some Black and minority ethnic groups** who are already more likely to enter services through these routes. Services also need to consider outreach to people without access to digital technologies.

- For a limited time early in the pandemic, the urgency to clear bed spaces reduced barriers to accessing placements and agreeing funding for discharge.

- We saw some evidence of temporary service reconfigurations leading to complex ward mixes, and some patients feeling that their progress had been reversed, especially when lockdown delayed movements through or out of the system. Many services used remote technologies to minimise delays in assessments or replace site visits. **All services must focus on facilitating patients' involvement in decision-making at these times.**

- Services were creative in the redistribution of staffing to manage pressures over the pandemic, for example redeploying occupational therapy or psychology staff onto wards. In many cases, this has provided lessons for **continuing work to reach harder to engage patients by increasing ward-based interventions.**

- Services should be monitoring key MHA indicators during the pandemic period, to ensure good governance and forward planning. We welcome the organisation of specific **MHA groups** and clinical ethics committees. These should include the perspectives of people who use services and carers, and have proved able to react quickly to changing circumstances and help develop government guidance.

The discharge of patients at the start of the pandemic

In the immediate run-up to the first lockdown, health services across England watched with concern as Italian hospitals were overwhelmed by COVID-19 cases.[a] On 17 March, all NHS hospitals were instructed by the NHS Chief Executive to free-up inpatient capacity and maximise staff availability. NHS guidance to mental health services on 25 March continued to press for a review of all inpatients with a view to discharge where it was possible and safe to do so. This stated that patient discharge must be completed in partnership with the patient and their support network, on a case-by-case basis, and involve close working with social care and other partners to achieve quicker agreement on funding and provision of care.[5]

A similar call was also made by international bodies. For example, the United Nations Committee for the Prevention of Torture and the Committee for the Rights of Persons with Disabilities both called on authorities to speed up the discharge of psychiatric patients in preparation for the crisis.[6,7]

Mental health services responded rapidly to the call to discharge patients. Available statistics show that in March 2020, discharges of all inpatients increased by 26% from the previous month (figure 2).[8,9,b] During April and May, discharges dropped sharply to levels below the pre-March period. It is likely that the fall in discharge numbers in April and May is a combination of fewer admissions during that time (figure 3), and that some of the people who would have normally been discharged in this period were discharged early in March.

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a   Localised quarantine measures in Italy started from 23 February 2020: the Italian national lockdown was declared on the 9 March. Throughout March, international media reports on the Italian crisis showed its hospital services struggling to cope.

b   In its Mental Health Services Monthly Statistics Performance for May, NHS Digital noted that "available statistics must be interpreted with care over the disruption of the COVID-19 period, which is likely to have affected the quality and coverage of some statistics, such as an increase in non-submissions for some datasets. See reference 10."

Figure 2: **Monthly discharges from mental health hospitals, January 2019 to May 2020**

Mar 2020
11,829

May 2020
7,835

Jan 2019 · Feb · Mar · Apr · May · Jun · Jul · Aug · Sep · Oct · Nov · Dec · Jan 2020 · Feb · Mar · Apr · May
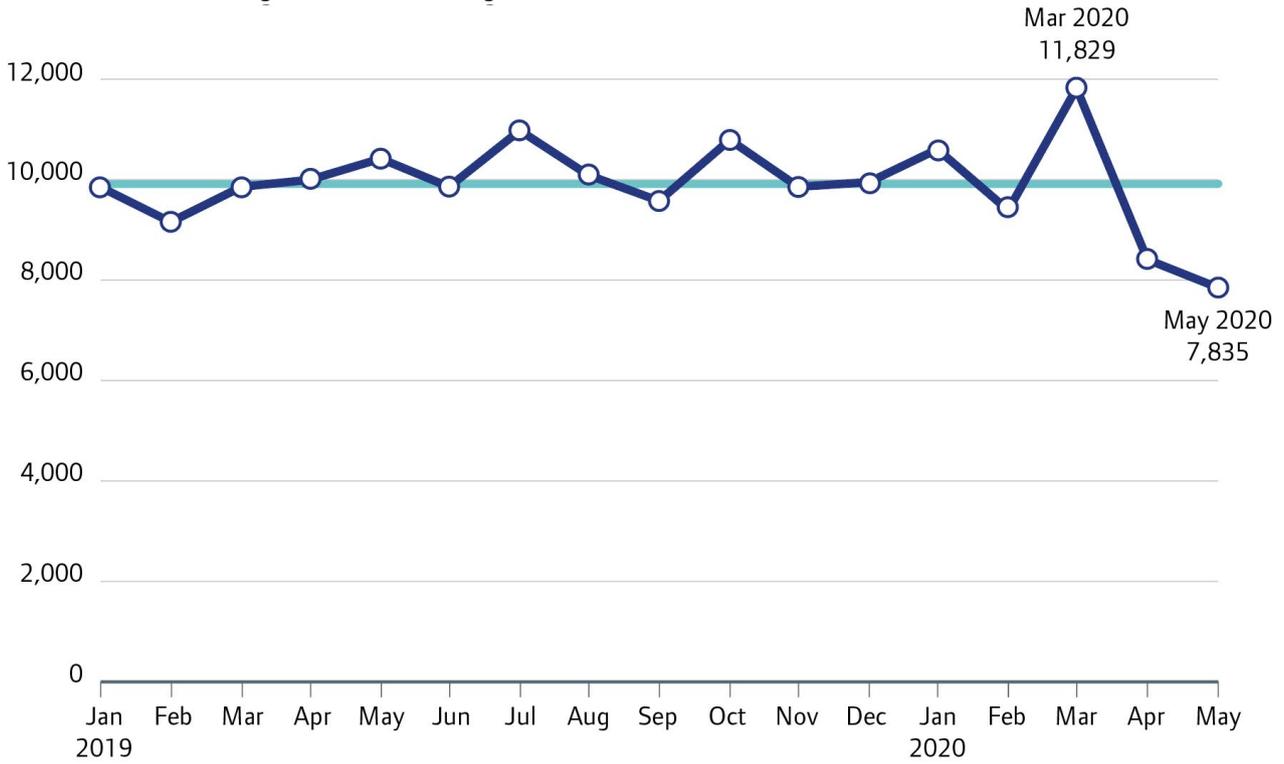
Source: NHS Digital, Mental Health Services Dataset

Figure 3: **Monthly admissions to mental health hospitals, January 2019 to May 2020**

Apr 2020
7,646

Jan 2019 · Feb · Mar · Apr · May · Jun · Jul · Aug · Sep · Oct · Nov · Dec · Jan 2020 · Feb · Mar · Apr · May

⎯⎯⎯ Average number of monthly admissions January 2019 to May 2020 (9,791)

Source: NHS Digital, Mental Health Services Dataset

17
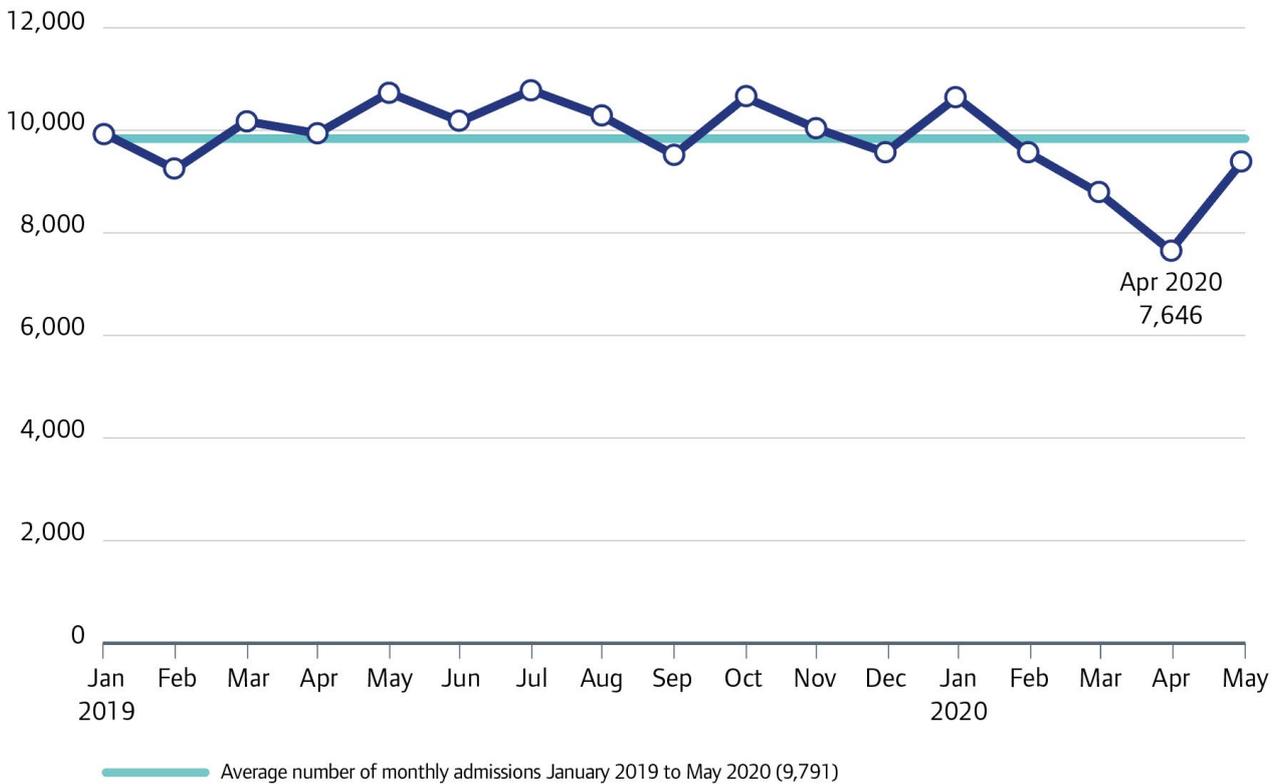
Official statistics on the use of the MHA report 20,312 people detained in hospital under the MHA on the 31 March 2020, compared to 21,196 a year earlier.[10] Statistical coverage has increased over the year but remains incomplete, and so the data must therefore be treated with caution. However, this suggests that only a week on from the instruction to empty beds, large numbers of patients had been discharged.

In some cases, services found that this new push to discharge patients reduced barriers to accessing placements and funding and resolved long-standing delayed discharges. However, bringing patient discharges forward at a time of disrupted face-to-face psychiatric care in the community posed risks including relapse, suicidal behaviour, lack of access to medical care, and social isolation.[11] Such risks might be managed, to some degree, through careful aftercare planning. Mind documented that in the rush to discharge patients in March and April 2020, some patients had unsafe or incomplete follow-up support plans, due to aftercare planning meetings being called with minimal notice.[12]

Our Monitoring the Mental Health Act reports have always stressed the importance of patient-led and effective care-planning, including comprehensive and personalised support plans and planning for discharge, being initiated from the point of admission.[13,14] This is especially important for admission wards while the pandemic is still active, as part of readiness for further waves of infection.

Advance planning is crucial to planning discharges, but where a patient is returning to families or carers, they must be fully consulted and communicated with at the time discharge is imminent. Healthwatch England's recent report on hospital discharge during the pandemic stresses that decision-makers should not make assumptions about the availability of family and carers appropriate for pre-pandemic times.[15] The lack of visiting imposed by COVID-19 disrupts normal methods of informal communication, and families or carers may be ill or isolating themselves. Similarly, it is vital that services ensure that any community health or social care support planned for discharge is still operating during pandemic conditions.

To ensure safe practice in discharging patients from inpatient detention, mental health services need to receive parity of funding and support from the government to cope with rising demand in services and any further wave of infection over the winter. Mental health services were excluded from the August 2020 announcement of additional funding for care and support for people being discharged from hospital up to April 2021.[16] NHS Providers have called for absolute clarity on mental health funding during this period, although we do note assurances that government will continue to meet the costs to mental health providers discharging patients during the pandemic.[17]

Patterns of Mental Health Act admissions and discharges during the pandemic

At the start of the crisis, many services saw a reduction in mental health inpatient admissions overall. Several told us that, within that context, they experienced a larger proportion of first-time admissions under the MHA and more emergency admissions. They noted that patients who were admitted often seemed to be more acutely unwell than previously.

> The ward manager told us that the threshold for admission appeared higher and the ward had more unwell patients during COVID-19. The number of patients detained under the MHA reflected this change and informal patient admissions were less frequent.
>
> **Acute women's ward, 9 June 2020**

It is possible that the factors behind these changing admissions patterns may have included the closure of some referral routes, including gaps in community support and/or patients actively avoiding hospital because of fears of COVID-19.

We have heard many professionals and some patients suggest that the use of police powers under the MHA may have increased during the COVID-19 crisis, leading to a higher use of health-based places of safety. We have also noted some examples, including through our complaints work, where a lack of access to community support has led to first-time detentions for some patients. This included examples where the police were the first point of contact for people in crisis.

Some services suggested that A&E departments were functioning, for want of any alternative, as a first contact with people in mental health crisis during the COVID-19 lockdown. Not all of these services are adequately equipped to manage acute psychoses in patients new to services, or incidents of violence and aggression while protecting people and preventing infection spread. As highlighted in our October 2020 report on our assessment of mental health services in acute trusts, a minority of acute trusts do not have arrangements for round the clock mental health liaison services. This puts people in need of mental health care at risk.[18]

We heard further examples of the impact of reduced community support during the lockdown from Approved Mental Health Professionals (AMHPs). Although it is likely that there were fewer assessments for possible detention under the MHA at the height of the crisis in March and April, we heard that some services experienced increased demand for MHA assessments out of hours. We also heard of instances where routine checks on the wellbeing of people who use mental health services were re-routed from community teams to AMHP services for MHA assessments.

These could be factors of a proportionate increase in the use of MHA detention at a time of reduced hospital admissions.

Detailed statistics on the use of the MHA over this period are not yet available, although we have some data on numbers of people in hospital at each month end (figure 4). The total detained population recorded at the end of March 2020 was 1,047 less than that recorded at the end of the previous month. The detained population recorded at the end of April 2020 had dropped by a further 665 patients. This decline sharply reversed in May 2020.

Figure 4: **Patients detained at month end in mental health hospitals, January 2019 to May 2020**
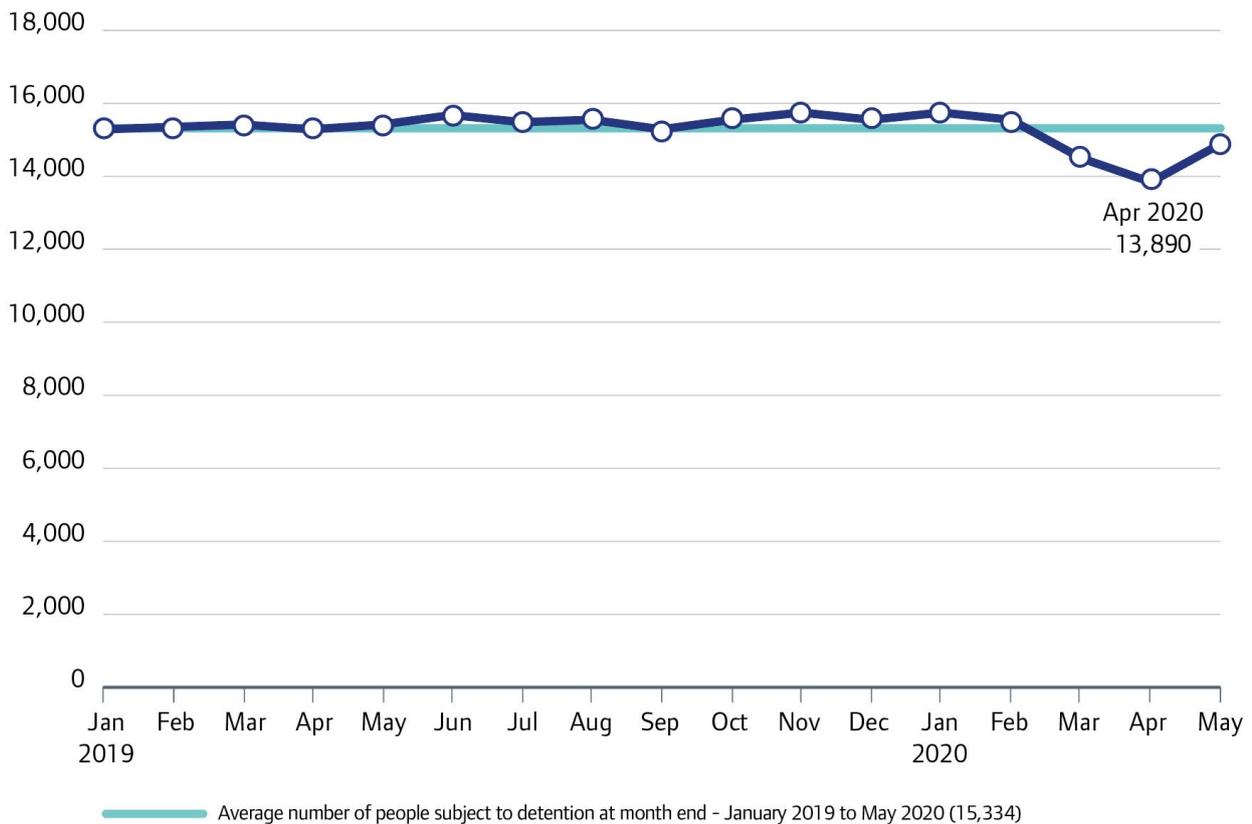
Source: NHS Digital, Mental Health Services Dataset

Acute adult wards saw a particularly large reduction in the number of detained patients over March and April 2020 (figure 5). This fell from 5,724 in February to 4,688 in April, a reduction of 18%. Over the same period the total number of people detained under the Act fell from 15,602 to 13,890, a reduction of 11%.

Figure 5: **Patients detained at month end in adult acute care wards, January 2019 to May 2020**

Average no of people subject to detention in adult acute mental health care each month - January 2019 to May 2020 (5,607)
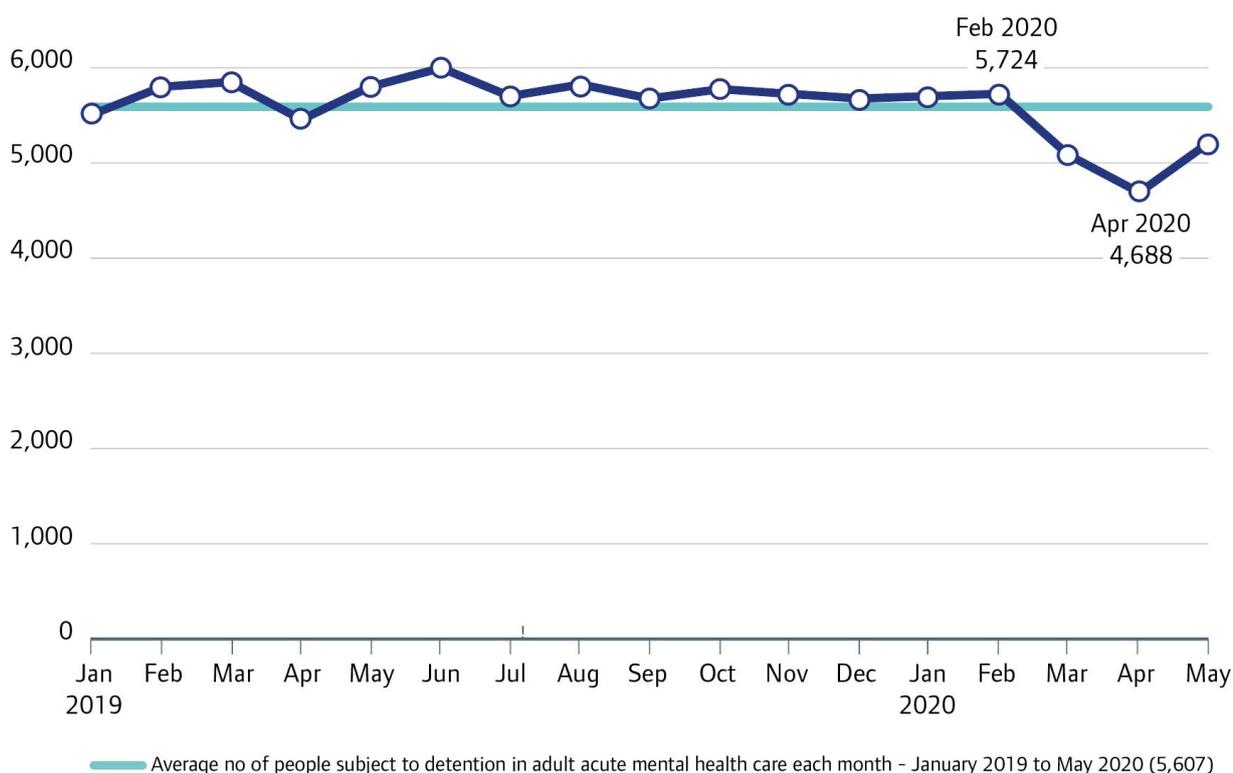
Source: NHS Digital, Mental Health Services Dataset

NHS Providers noted that, once lockdown restrictions started to lift, general mental health referrals appeared to be rising to above pre-COVID-19 levels.[19]

We have previously stated our concerns that the unavailability of beds can have serious consequences for patients who are not able to access inpatient care.[20,21] Such pressures can themselves be a factor in rising rates of detention.[22] The reduced capacity in inpatient care is not likely to change while social distancing, and the possibility of further waves of infection, persist. This may lead to severe stresses in bed management. NHS Confederation reported some providers' predictions of a 20% increase across all their mental health services, while also facing a 10% to 30% decrease in how many patients they could care for at once because of the required infection control and social distancing measures.[23] It is likely that pressures on services will be subject to marked regional variation, and as such it is important that local governance takes this into account.

The impact on Black and minority ethnic people

The adverse impact of COVID-19 on people with Black and minority ethnic (BME) backgrounds has been well-documented. All BME backgrounds are, to some degree, associated with higher risk of getting the infection, experiencing more severe symptoms and higher rates of death.[24] In some parts of England, people from BME backgrounds are overrepresented in the detained patient population, and highly represented in ward staff, so some wards will have many people at increased risk of harm.

It is likely that adverse pathways into contact with mental health services are a factor in the overrepresentation of BME people in the detained population. BME groups may be less likely to access support earlier (for example through referral by primary care providers), and more likely to first present through use of police powers under the MHA or other arrest, or through self-referral in crisis to A&E departments where the likelihood of subsequent detention under the MHA appears to be increased.[25]

With limited community support delivered through remote contact, and fewer inpatient beds, there will have been significant unmet need during lockdown. This may have increased the risk of people accessing services only in crisis, increasing the risk of coercive pathways, including detention under the MHA. This had the potential to exacerbate the overrepresentation of some Black and minority ethnic groups who were already more likely to enter services through these routes.

We will expect mental health services' own governance processes to have considered and addressed equalities issues in their operation over the crisis, in preparation for any future event posing similar challenges.

Being a 'well-led' service during the pandemic

As part of our regulation of services, we check to ensure that services are 'well-led'. Our monitoring of the MHA informs our regulatory judgement. In our last annual report, we wrote that 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.[26]

We expect a well-led service to have established MHA-related routine monitoring into board reports, and into their mandated COVID-19 situation report meetings and reports to NHS England and NHS Improvement. Similarly, we expect services to ensure that they have considered and addressed any equalities issues through their governance processes, in preparation for any future event posing similar challenges.

We urge services to collect core data on trends in MHA practice during the pandemic, to inform and influence management actions. This includes:

- detentions under the MHA, including by type of detention (holding powers, police powers, section 2 or 3 powers and others) by age, gender, and ethnicity (to track increased potential inequalities)

- community treatment orders by age, gender, and ethnicity

- unmet need such as delays in (or any cancellation of) community mental health assessments of those acutely and severely unwell, especially where reduced bed availability is a factor

- emergency crisis presentations to A&E or health-based places of safety, including length of stay data and any breaches of assessment standards or legal timeframes

- access to Independent Mental Health Advocates (IMHAs)

- access to interpreters

- use of leave of absence and absence without leave

- hospital manager hearings and Tribunals, including patient experience of remote working and timeliness and/or quality of reports

- the use of restrictive practices such as restraint and seclusion.

We heard of some services setting up MHA specific groups to inform discussions on managing the COVID-19 pandemic in the context of MHA care and treatment. Members of the groups included people who use services, carers, clinicians, advocates and mental health managers. These groups supported services to adapt policies and practices, as well as provide information for patients, carers and staff, at pace during the pandemic. Discussions from these groups informed the development of government guidance.

To prepare for potentially difficult legal and ethical decisions, many services also established new governance bodies in the form of clinical ethics committees.[27] We welcomed such arrangements as an addition to existing governance arrangements in services and have heard that many will be continued post-pandemic. It is important that these committees also have involvement from people who use services and carers. One forensic service told us that it had found the involvement of the ethics committee useful in helping to discharge patients.

We were particularly impressed with the examples of committees that made space for patient and carer voices so as not to undermine the voice of people who use services in decision-making. A good example of this was the ethical 'cell' set up at Mersey Care NHS Foundation Trust. This included a person who had used the service, executive and non-executive directors. The cell looked at the impact of quarantine measures on patients and what could be done to minimise isolation while maintaining safety.

In April 2020, we were asked for a view where there was a conflict between a clinical ethics committee and the clinical staff of one hospital. The ethics committee had instructed that all detained patients' leave of absence should be cancelled. However, clinicians in the service thought that this was too stringent a measure and that exceptions should be made. We pointed out that the MHA provides responsible clinicians alone with the authority to grant, or refuse to grant, leave of absence to detained patients.[c] As such, neither hospital managers under the MHA, the trust executive, nor any committee of management, such as an ethics committee, has authority under the MHA to fetter the discretion of the responsible clinician to exercise that right. We are clear that clinicians must be free to exercise their powers in accordance with the principles of the MHA Code.

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c   MHA 1983, s.17(1). In the case of restricted patients, responsible clinicians must have the permission of the Secretary of State for Justice to exercise that power (see MHA s.41(3)(c)). No other fetter on the discretion to grant leave exists.

Ward reconfigurations, delays in patient movement, and the need for patient involvement

> *"Mental health trusts have had to ensure their inpatient services are equipped to deal with COVID-19 patients. That's been a particular challenge for those trusts with patients who are held in secure accommodation, where the flexibility to reconfigure physical space may be heavily constrained."*
>
> **NHS Providers[28]**

In March 2020, mental health, learning disability and autism services were specifically instructed by NHS England and NHS Improvement to identify areas where their patients could be most effectively isolated and cared for should they catch COVID-19. The recommendations included mental health single rooms, en-suite, or mental health wards on acute sites, and also suggested cohort-nursing in wards for COVID-19 positive patients.[29] The creation of cohort wards, alongside general reductions in occupied beds through early discharge of patients, created extensive ward reconfigurations.

This reconfiguration of hospital wards could have some potentially detrimental consequences for patients, creating challenges in maintaining previous levels of care:

> There was a complex mix of patients brought together by the reorganisation of the three wings to introduce an isolation wing, a female wing and a male wing… The [resulting] combination of patients with functional and organic disorders had had a significant impact on what activities were deemed safe, as some patients with dementia didn't have the required safety awareness.
>
> **Acute older person's ward, 22 July 2020**

In other services, the reorganisation was at the temporary cost of gender separation:

> Prior to the lockdown the ward had been separated into a female, five-bed corridor and a male, six-bed corridor. When patients tested positive for COVID-19, the decision was taken to segregate the ward according to infection and confinement requirements. This was no longer required, and the ward corridors were once again gender specific.
>
> **Dementia ward, 1 June 2020**

Such arrangements could generally operate without breaches of single-sex accommodation requirements. We did note some relatively minor breaches, such as where women-only day rooms would not be available to patients that needed to be cohort-nursed. We were pleased to see examples of services remaining sensitive to the purpose of the single-sex accommodation requirements:

> Overdale ward has been operating as a mixed ward for several weeks... Men and women all have their own en-suite bedrooms and they are accommodated on separate corridors. From now on, when a male patient is discharged, they will not be replaced with another man, and the ward will soon become a female-only ward again. At the time of admission if there are women who would find it difficult to be on a mixed ward, they can be accommodated on Bransdale ward, which has remained an all-female ward.
>
> **Tees, Esk and Wear Valleys NHS Foundation Trust, 18 June 2020**

In many hospitals, patients' progress towards discharge is measured by their movement from ward to ward, starting in acute wards and ending in various forms of step-down and rehabilitation wards. The reduction in the number of wards could result in patients being moved into less differentiated groups, with the risk of some feeling that their progress had been reversed.

> There were 14 patients on the ward, all of whom were detained under the MHA. Five of these patients had temporarily transferred to the ward as a result of COVID-19 from the step-down unit. These patients were due to return to the step-down unit the following week.
>
> **Women's low secure ward, 2 June 2020**

There were also systemic delays in transfers resulting from lockdown:

> During the COVID-19 lockdown period there had been little movement through the pathway. This was because prisons had not been accepting patients back… low secure beds were at a premium and step-down services were not receiving patients, which had caused the system to slow down preventing patients from moving on. This had caused some frustration for patients who were ready to move to a low secure environment and at times it was difficult to keep these patients motivated and engaged. Out of a 10-bedded ward, five patients were waiting for a low secure bed and four patients were ready to move back to prison.
>
> **High Dependency Medium Secure ward, 13 August 2020**
>
> Patients thought that COVID-19 was affecting their discharge plans. The acting clinical lead told us that this was the case for some patients. Patients told us they could no longer have home leave or overnight leave. The acting clinical lead told us this was because of issues travelling home, availability of support packages and the risk in patients doing their own shopping and not following lockdown rules.
>
> **Rehabilitation ward, 27 May 2020**

Services who coped better with the disruption found creative ways of involving patients in their care and working with staff from prospective placements:

> Staff told us about a patient who was preparing for discharge. Due to the pandemic they were unable to visit prospective placements. Photographs and video footage of prospective placements was shared with the patient. This enabled the patient to be involved in the discharge process in the safest way.
>
> **Learning disability and autism rehabilitation ward, 27 May 2020**
>
> Many of the providers that patients were due to transition and move on to had paused taking new admissions during the peak of the COVID-19 pandemic. Several of the patients were in the process of transitioning to new providers before COVID-19. Staff told us they had used the time to provide the staff from the new placements which patients were transitioning to with virtual training, and updating care plans and risk assessments ready for when patients moved.
>
> **Learning disability assessment and treatment ward, 29 May 2020**

All these examples highlight the importance of patients being kept fully informed and involved in decision-making. Without reassurance that delays are temporary or that new arrangements are not a step backwards, there is a risk that patients will relapse.

The reorganisation of staffing during the pandemic

Mental health services have experienced staffing pressures for many years.[30] The challenges of staffing wards adequately were increased by the pandemic. In mid-March, NHS England and NHS Improvement told services to maximise their staff availability in anticipation of pressures to come, including the possibility of increased staff sickness levels.[31]

Many services increased their staffing quotas even as they reduced bed occupancy. Although some services had access to bank or agency staff that could provide consistent cover, and agencies worked hard to keep staff in a single place,[32] reliance on short-term agency staffing could increase the risk of cross-infection between hospitals, at a time when most professional visits to wards had been suspended to avoid this and personal protective equipment (PPE) supply was uncertain. In addition, patients often tell us that a high turnover of agency staff is limiting to their therapeutic experience.

Some services did actively address this:

> There has been a higher use of agency staff because of staff sickness which has had an impact on relational security. However, this was mitigated by higher profile clinical leadership on the ward, prior planning and use of COVID-19 care plans for each patient.
>
> **Forensic rehabilitation ward for men, 5 May 2020**

Services showed creativity in sourcing additional staffing from nursing students, or from the redeployment of community staff or other allied professionals.

> During the COVID-19 period you had support from aspirant nurses who were furloughed from their training at the universities. In the initial stages of the crisis, the community memory assessment team staff had also joined the ward, but they had now returned to their substantive posts. You said that this extra support had meant that you had not used bank staff much during this time.
>
> **Acute ward, 15 July 2020**
>
> Staffing levels had been mildly affected and you told us that during the time when five patients had contracted COVID-19, staff volunteered for extra shifts and cancelled leave to support the ward. You also told us that the ward had received a lot of support from the onsite community mental health team and a range of staff from across the unit had attended the ward to support staff and care for patients during this time.
>
> **Dementia ward, 1 June 2020**

The redeployment of community health team members to inpatient services indicates the reduced capacity of community teams during the crisis. The use of allied professionals, such as psychologists and occupational therapists, to increase staff numbers could also have had a detrimental effect on their substantive roles and as such could only be a short-term arrangement. That said, some services found the redeployment approach had benefits. Increasing the presence of allied professionals on wards, and increasing ward-based

activities, were effective at supporting previously disengaged patients to be more involved.

Although staff had been off work due to COVID-19, the impact had been mitigated by taking on second and final year nursing students and by bringing some other professionals into the nursing numbers across the hospital, including occupational therapists, psychologists and dietitians. However, although these professionals continued to do some of their own work, their capacity for this was reduced. The professionals were now starting to return to their usual roles on a full-time basis. Staff said there had been some benefits, as Clover and Ivy ward had a dietitian working with them who was able to do more regular work with patients with dietary needs.

Wards for women with learning disability and/or autism, Roseberry Park Hospital, Tees, Esk and Wear Valleys NHS Foundation Trust, 3 August 2020

The ward occupational therapist has just been joined by a physiotherapist and clinical psychologist to expand the therapy team. Staff spoke positively about this development. The occupational therapist said that they felt part of the team, but had been pulled into ward numbers at times, rather than being able to work as an occupational therapist. The occupational therapist has been using some of the quiet time available to train staff in Positive Approach to Care.

Dementia assessment ward, 22 July 2020

Amendments to the Mental Health Act and delegated legislation

The Coronavirus Act 2020 was passed on 25 March 2020. This provided temporary amendments to many duties and responsibilities of public authorities in response to the crisis. It established a power for the Secretary of State to bring into operation the following amendments to the procedures of the MHA:

- one medical recommendation to be enough for an application for detention, rather than the two currently required

- longer time periods for holding powers, remand orders and transfers from prison

- treating clinicians to certify their own authority for treatment without consent in situations currently requiring the certification of an independent Second Opinion Appointed Doctor (SOAD).[33]

We are aware that some services lobbied the government for Coronavirus Act easements relating to single medical recommendations and increased timescales be brought into force. This is likely to have stemmed from existing and chronic resourcing difficulties rather than anything specific to do with the pandemic.

We are pleased to say that, to date, none of these amendments to the MHA have had to be brought into force, and on 30 September 2020, the secretary of state announced that they will be repealed.[34] All of them had the potential to reduce the procedural safeguards provided under the MHA to ensure that patients' rights are upheld. We discuss our move to remote working for the SOAD system in appendix A. This enabled independent review of treatment without consent to continue throughout the pandemic period.

We were pleased that NHS England and NHS Improvement agreed, in its guidance of 19 May 2020, that electronic forms should be deemed acceptable during the period of the crisis.[35] We suggested that of the use of electronic forms should be consolidated by regulation when time allowed and welcome that this has now been done.[36]

The First-Tier Tribunal Mental Health continued to hear appeals against detention and automatic referrals by adopting major procedural changes.[d] Like the SOAD service, the Tribunal moved to remote working using, at first, telephone then video technology. It also suspended pre-hearing examinations; extended the time allowed to list some hearings; and, for a limited time early in the lockdown period, cases were heard by a single judge rather than a panel. Some of these procedural changes are likely to impact on patient safeguards and experience.

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d   Pilot Practice Directions were made on 19 March 2020. The Tribunal Procedure (Covid-19) (Amendment) Rules 2020 SI No 416 were laid before parliament on 9 April 2020 and came into force on 10 April 2020.

We note the concern of Mind that such important changes to Tribunal procedure have been brought in through routes that parliament does not have oversight of, and without consultation. For example, the suspension of pre-hearing examination, discussed in the section on <u>video conferencing in clinical assessment, treatment and care</u>, was brought into force through practice directions. In 2018, when the Tribunal Procedure Committee suggested similar changes, it decided not to proceed after public consultation.[37] A similar public consultation was carried out before the pandemic outbreak on a proposal to extend the time allowed to list appeals against detention for assessment and/or treatment (MHA section 2) from seven to 10 days. In the event, the changes made in the context of the pandemic have overtaken any consideration of the results of that consultation. It is therefore important that the changes made to meet the immediate challenges of the pandemic are not made permanent without appropriate review.

3. Preventing and controlling the spread of COVID-19 among patients detained in hospital

Key points

- **Infection control worked best in services with a culture of co-production with patients and carers.** Many services reported that patients accepted and complied with the requirements of infection control. We found that services were more effective in reducing infection risk when they discussed the pandemic with patients, which demonstrates that when patients are communicated with, trusted, and supported to give their views and offer expertise on decisions about their care, services are more effective.

- In many services, **the mental health inpatient estates need to be modernised.** Larger, airier spaces with en-suite rooms and easy access to outdoors would improve patient experience generally and enable better infection control and this should be a key focus of any refurbishment plans.

- We have seen that health services require consistent access to **personal protective equipment**, including the supply of clear masks where appropriate. **Asymptomatic testing** of patients on admission should be similarly available, as this is the mainstay of infection control as of the time of publication.

- **Staff are at great risk of stress** due to highly pressurised working conditions and a high concentration of difficult decisions to take. Services must take this into account and offer extra professional and pastoral support where possible.

Co-production and communication with patients over infection control

"During the ward round that morning [after lockdown started], I was… struck by a different relationship which was being forged with patients. Talking with our first patient, it became clear that out of this situation had emerged a co-dependence that now existed between us.

"As clinicians we sat in hope that our patients detained under the MHA would support us in our efforts to maintain the service which depended on the cooperation of others. It was also no doubt the case that our patient was looking back at us in the hope that we knew what we were doing and any trust they had in us was well placed that the staff could keep everyone safe."

Roland Dix, Approved Clinician and Consultant Nurse in Psychiatric Intensive Care and Secure Recovery, Wotton Lawn Hospital, Gloucester[38]

It is notable that services found that many detained patients did accept and comply with the added restrictions that were put in place to manage the COVID-19 outbreak. People experiencing severe mental disorder should be presumed to be able to take responsibility for their actions, subject to any individual evidence to the contrary. This is in line with the UN Convention on Rights of Persons with Disabilities (CRPD) and the anti-stigma direction of better services, where decision-making is shared and patients treated with proper respect. We believe that the emphasis on least restriction and person-centred care in recent years helped good services prepare for COVID-19 management.

Co-production is about more than consultation with patients: it is a sharing of responsibility that can counter the disempowerment of compulsory admission to hospital. The recovery model that services are expected to follow expects patients to be supported and allowed to have active involvement in the assessment of risk and in creating associated management strategies. Although the implementation of this recovery model is not yet embedded in all services, evidence of its value in secure and forensic settings does exist.[39,40]

We also find such evidence in our monitoring activity:

> Patients that we spoke with gave some mixed feedback about the ward, but overall were positive about the care from the responsible clinicians and the ward staff. One patient told us that, 'They do believe in least restrictive practice here. They do listen to what we say, and they give you a chance even when you mess up. In most places you go back to square one after a blip, but here, they don't punish you, so you aren't scared that if you do have a blip there's the threat of taking everything off you. They give you responsibility instead'.
>
> **Edenfield Centre (women's secure unit), Greater Manchester Mental Health NHS Foundation Trust, 21 May 2020**
>
> Staff started conversions with patients early in the epidemic about the impact on them and the restrictions that were needed. As a result, patients and staff were well prepared for when the ward had a case of a patient becoming infected with the virus.
>
> All patients had COVID-19 care plans which included wishes expressed in advance and how they would want to be supported if they needed to self-isolate.
>
> **Forensic rehabilitation ward for men, Oxford Health NHS Foundation Trust, 5 May 2020**

Many services could demonstrate to us that they were communicating effectively with patients about the pandemic situation.

Staff told us that a restrictive practice group was held monthly as a minimum, but had been held more frequently recently to review changes linked to COVID-19, for example as leave and visiting restrictions were changed. The group was attended by patients, nursing staff, managers, the matron and was led by the assistant clinical director. Staff said that individual restrictions were reviewed in patients' ward rounds. Patients thought the rules and restrictions in place were reasonable.

Assessment, treatment and rehabilitation wards for women with learning disability and/or autism, Roseberry Park Hospital, Tees, Esk and Wear Valleys NHS Foundation Trust, 3 August 2020

Patients told us that staff were quite good at keeping them informed about COVID-19 and changes in the government rules. They spoke about it in the daily meetings and could talk to staff individually if they had any concerns. Patients told us they had a named nurse each day and were offered one-to-one time.

Acute ward, Norfolk and Suffolk NHS Foundation Trust, 8 June 2020

Since the outbreak of the virus, the weekly community meetings had initially been held daily and were currently held every two days. Updates as to any changes to the operation of the ward as a result of the lockdown were provided to patients and all patients were encouraged to watch, on television, the daily updates from the government. Patients interviewed confirmed that they had been kept up to date with any developments.

Medium secure ward, Greater Manchester Mental Health NHS Foundation Trust, 27 May 2020

Patients told us they were kept informed of the changes because of the pandemic. Easy read information including posters were displayed on the ward to remind patients of the pandemic and the changes to keep them safe.

Learning disabilities ward, Woodhouse Hospital (Elysium Healthcare), 16 June 2020

We actively engaged with services and government over legal and ethical issues raised by the need to enforce physical distancing or quarantine of detained patients who had or might have COVID-19. It was particularly important that we could explain our own approach to services that feared criticism from us as their regulator and as the monitoring body for the MHA.

Initial guidance on powers to quarantine detained patients who had or may have had COVID-19 was not helpful. The NHS Chief Executive's letter of 17 March stated only that, "case-by-case reviews will be required where any patient is unable to follow advice on containment and isolation".[41] Legal guidance from NHS England and NHS Improvement was issued on 30 March, stating that, "MHA powers must not be used to enforce treatment or isolation for any reason unrelated to the management of a person's mental health". Initial guidance to public health officers from Public Health England also appeared to give this impression.

From the start of the pandemic, some services approached us to ask whether we would expect them to approach public health officers to authorise the use of the COVID-19 Act powers (which would, in that case, only be enforceable on wards by a police officer).[42] We took the view that this was unlikely to be necessary or appropriate.

From the start of lockdown, we suggested that if a patient was legitimately detained under MHA powers for a proper purpose, then the powers of discipline and control inherent in such detention would be likely to provide authority for proportionate and reasonable action to enforce social distancing and quarantine of detained patients during the pandemic outbreak.[43]

We worked closely with NHS England and NHS Improvement and the Department of Health and Social Care (DHSC) to clarify the situation and the revised NHS England and NHS Improvement guidance of 19 May accepted that the MHA may indeed offer this authority in the terms we suggested.[44]

We take the view that keeping a patient apart from other patients for the purposes of quarantine during the COVID-19 emergency does not need to be identified as, or subject to the procedural safeguards for, seclusion or long-term segregation under the terms of the MHA Code of Practice. Both seclusion and long-term segregation are interventions based on the assumption of the need to contain severe behavioural disturbance. The procedural safeguards established by the Code are designed to ensure that the continuing need for such containment – that it is the only way to safely contain the behavioural disturbance – is independently reviewed on a regular and multidisciplinary basis. Such reviews in the case of COVID-19 isolation would serve no purpose, as the effective question is simply the presence or absence of communicable disease.

Some services made commendable governance arrangements over infection control measures, to provide a suitably tailored review process. For example, Mersey Care NHS Foundation Trust used MHA managers to review arrangements for patients who were finding it difficult to self-isolate, to ensure that these supported patients' human rights and were the least restrictive necessary.

We believe services should consider specific patient needs when requiring self-isolation on admission. The following example was from a discussion with patients on a children's ward:

> Both patients we spoke with described the period of isolation when they were initially admitted as, "scary". One said they could not really see staff properly because they were wearing full personal protective equipment. One told us it was made worse by hearing what was happening on the ward, but not being able to see. One of the patients said they thought staff checked on them every 15 minutes but the other said it was less. When asked, one patient told us they thought the situation might have been easier if there was a member of staff in the area. The other patient told us they were so anxious that one of the night staff stayed with them for a while, which helped.
>
> **Children's ward (13 to17 years), 17 August 2020**

Services must have regard to the guiding principles of the MHA Code of Practice in considering what are appropriate interventions. Where we saw little sign of co-production and active care planning, this could lead to serious concerns over patients' treatment:

> Whilst patients had COVID-19 care plans in place, these were generic and not specific to the needs for each patient. In two cases where capacity assessments were completed, the decision under consideration was too broad ("care and treatment")… In another case there were statements that a patient lacked capacity without a documented capacity assessment in place. Do not attempt resuscitation (DNAR) notices were in place in two out of the three cases reviewed… However, it was not clear if the patient and/or relatives had been consulted about these notices before they were put in place. If patients did not have the capacity to make end of life decisions, there were no documented capacity assessments regarding this on the clinical records.
>
> **Rehabilitation ward, 13 July 2020**

In October 2020 the Department of Health and Social Care commissioned CQC to investigate and report on the issue of 'do not attempt cardiopulmonary resuscitation' (DNACPR) orders. Our review will inform national learning and improvement, and support good practice development. We will publish an interim progress report later this year and a final report in early 2021.

The physical environment of wards – modernised services and infection control

We have previously expressed concern about the physical state of many mental health wards.[45] In February 2020, NHS Providers called for capital investment in the mental health sector, in part to address key matters we had identified such as fixed ligature points and dormitory wards.[46] The Royal College of Psychiatrists has also called for capital funding to address aging and unsuitable premises.[47] We are pleased to note the subsequent government announcement of funding towards the elimination of dormitory wards.[48] These are unacceptable at any time, but have posed particular problems for infection control during the pandemic.

> The ward had made relevant changes in light of the pandemic to promote social distancing and accommodate fewer patients by reducing bed occupancy from 24 to 14. The dormitories were used to accommodate two patients as opposed to four in normal circumstances.
>
> **Acute ward, 14 May 2020**

Mental health inpatient services also have much old and unsuitable accommodation. A survey by the Royal College of Psychiatrists in July this year, showed that a third of respondents were concerned about the negative impact of physical environments on the quality and safety of patient care during the pandemic.[49]

In the above example, although psychiatric inpatient wards have not previously been designed with infection control as a priority, it seems sensible that future builds and refurbishment should take this into account.

The following example shows that aspects of design that are intended to improve the general conditions of a ward (single, en-suite bedrooms; large and airy communal spaces; and access to outside) also can be key to effective infection control:

> Silk ward is a 15-bed ward for older adults with organic mental health problems. The ward had opened in January 2020 following an extensive refurbishment and redesign:
>
> - all bedrooms now had en-suite facilities.
>
> - the garden had been landscaped. There was an orchard containing apple trees. The paths were covered with a resin material to reduce the risk of trips and falls.
>
> - there were now large, airy communal rooms and living areas.
>
> - there was a circular wander pathway with seating areas to encourage patients to have regular breaks.
>
> **Cheshire and Wirral Partnership NHS Foundation Trust, 2 July 2020**

Although the refurbished ward was a much more therapeutic space to care for patients, the communal areas echoed and were noisy. Work to install vertical blinds and acoustic panels to reduce noise had been delayed during COVID-19, but such noise-abating measures are clearly important in future.

Access to personal protective equipment

Access to personal protective equipment (PPE) has been vital to protect health and social care professionals during the pandemic. This was no less important in mental health inpatient settings.

> *"We have limited PPE. We get it, we are not priority – but we are scared because we are locked into spaces with people who find it almost impossible to physically distance. We know that if one goes down, we all do."*
>
> **Anonymous staff member, 14 April 2020[50]**

We heard in a number of our contacts with wards that access to PPE had been difficult or patchy in the initial weeks of the crisis. In mid-April, a survey by

the Royal College of Psychiatrists found that one in five respondents reported difficulties in accessing PPE.[51] There were also some uncertainties over what should be worn and when. The National Association for Psychiatric Intensive Care Units (NAPICU) quickly provided a resource for all psychiatric inpatient services on coronavirus infection control measures that discusses ethical issues, but also provides practical advice on equipment and procedures.[52]

When monitoring an independent hospital for people with a learning disability in May 2020, staff told us that they had only been allocated PPE from the end of April, and that this was still not always adequate:

> Staff were concerned about the lack of consistency and availability of PPE, for example when they were responding to incidents on other wards. Staff told us there is insufficient eye protection available to staff on the ward. At present there are three out of the five patients who, as part of their behaviours, spit. We reviewed the care plans and positive behaviour support plans for these patients and found the use of PPE is not considered.
>
> **Rehabilitation ward for learning disability and/or autism, May 2020**

The majority of contacts made from June onwards reported no difficulty in accessing PPE.

> Since the start of government restrictions, the ward has been used as an admissions ward and patients were admitted there for the first 14 days of admission, pending the result of a swab test for COVID-19, before being moved to other beds within the trust. Staff wore scrubs and masks at all times and that started from when the ward became the initial admissions ward. Staff told us that at the start of government restrictions they had difficulty getting clinical waste bins and both manual and electronic thermometers. Personal protective equipment (PPE) had also come in in "drips and drabs" with more specialised SPF3 masks initially quite difficult to come by. However, staff told us that although there was a slow flow of PPE, they monitored it carefully and therefore they never ran out. Staff we spoke with also confirmed that the supply chain has since returned to normal.
>
> **Acute adult ward, 27 July 2020**

From 15 June, hospital staff were expected at the minimum to wear a surgical face mask at all times on shift.[53] Services have widely acknowledged staff needing to wear masks can be difficult for some patients. For example, on older people's wards patients can have trouble hearing or understanding the speech of masked staff. Deaf patients are obviously most disadvantaged in this way, although patients with high anxiety or paranoia can be frightened by the masks.

This requires additional staff awareness and sensitivity, and we were encouraged by some of the efforts we saw made on this. One service had staff badges made showing their smiling faces; others sought to obtain clear face masks.

> Staff found that due to wearing masks they found that some patients used lipreading and response to facial expressions more than they realised. They modified their communication to help with this, for example by slowing down or using hand gestures.
>
> **Wards for women with learning disability and/or autism, Roseberry Park Hospital, Tees, Esk and Wear Valleys NHS Foundation Trust, 3 August 2020**
>
> Staff acknowledged difficulties communicating with patients who had hearing difficulties. For example, a patient on the ward had a hearing impairment and was unable to lipread due to staff wearing facemasks. In order to communicate with this patient, the speech and language therapist provided guidance and support to staff on how to communicate effectively with this patient whilst they wore a face mask.
>
> **Learning disability ward for men, 9 September 2020**

We welcome the announcement made on 5 September that government had procured and would be distributing suitable clear masks to relevant NHS workers.[54] By the start of October a limited supply of these had been obtained by the national high secure deaf service at Rampton hospital.

COVID-19 testing

Services told us that there were concerned about their ability to access testing. Research suggests that unrecognised infections may have been widespread among hospital workers, perhaps due to repeated exposure to the virus.[55]

Before May, testing was available to staff or patients who showed symptoms of a high temperature and/or a new, continuous cough: anosmia (loss of sense of taste and smell) was recognised officially as a symptom on 18 May.[56]

> Patients were first tested for COVID-19 at the end of March and, of the 11 patients allocated to the ward, 10 tested positive. Sadly, five patients died. There had been no new positive tests for six weeks prior to our discussion.
>
> Staff had initially been tested when they had a high temperature and/or a cough. Six staff tested positive who had such symptoms. However, a lot of staff experienced a loss of taste and smell in the early weeks of the pandemic but were not tested. The hospital now provided tests for staff when any of these symptoms were present.
>
> **Older persons' organic illness ward, 17 July 2020**

As in the above example, over the summer we continued to find services that were only testing symptomatic staff, although asymptomatic testing for frontline NHS staff started to be rolled out at the end of April 2020.[57]

A fast turnaround of test results is particularly important in MHA settings to minimise the period in which patients, whose infection status is uncertain, must be kept isolated from others, in order to uphold their human rights. Many NHS trusts told us that in the period March to August 2020 that they were receiving results within 24 hours, as recommended.[58]

Mitigating the impact on staff

The COVID-19 pandemic put extraordinary pressure on ward staff as well as on patients. Some staff will have experienced increased workload, including taking on additional shifts to cover absences of others. Wearing PPE throughout a shift increases fatigue and, in some services, we heard that staff were not being afforded adequate breaks to rehydrate or rest. In addition, managing physical distancing may be extremely challenging where patients are undergoing mental health crises.

Staff will have been concerned at the possibility of viral infection or transmission. All BME backgrounds are to a greater or lesser degree associated with a higher risk of contracting COVID-19 and experiencing more severe symptoms and higher rates of death.[59] In certain parts of the country, people from BME backgrounds are highly represented in ward staff, and as such not all vulnerable staff were enabled to take a step back from frontline duties.

Against this backdrop, we noted services who both recognised and helped to mitigate the impact on staff:

> All staff we spoke with raised their concerns about low levels of morale. Staff we spoke with gave various reasons such as low staffing levels, 'COVID-19 fatigue', management changes, lack of support for support workers and change in patient profile (patients admitted to the hospital with complex needs).
>
> We spoke with eight patients about staff attitude and received a mixed response. Four out of eight patients described staff as kind, friendly and respectful. The other four patients found staff to be rude and horrible.
>
> We discussed this issue with the psychologist and head of care who said they were aware of low staff morale and are in the process of implementing an action plan to address this.
>
> **Learning disability ward for men, 9 September 2020**

The support provided to staff in some cases included Schwartz Rounds, a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. A modified version, TeamTime, has also been introduced in response to the pandemic.[60]

The King's Fund report *The Courage of Compassion* set out recommendations for services to better enable nursing staff to provide compassionate, high-quality care.[61] It identified core needs that must be met to ensure wellbeing and motivation, including autonomy to be able to act consistently with nursing values; to feel valued, respected and supported; and to deliver valued outcomes. It recognises that difficult working conditions have been exacerbated during COVID-19, and the need to ensure that these are positively addressed, alongside fairness and equality in workload and career paths. These are key aspects of an environment in which respect for human rights can flourish.

4. Preserving least restriction, respect and dignity

Key points

- Detaining authorities have a duty to keep patients safe and uphold the right to life, as well as a duty not to unlawfully infringe their other rights such as liberty and family life. This balance can be achieved through careful consideration of the **principles of the MHA Code of Practice** when making decisions.

- Many services continued to support patients to take **leave of absence from hospital**, at reduced levels to comply with social distancing requirements. Some did not, either because of local conditions or because of outbreaks of infection on a ward. We expect services that have to make blanket restrictions to document the rationale for this. We have challenged services whose restrictions extended long after the public lockdown eased. It is vital that patients have access to fresh air and outdoor space, irrespective of leave arrangements.

- Even during national bans on **hospital visits**, services are expected to allow for exceptions to be made for patients with mental disorder where lack of contact with carers could be distressing. We have urged some services to make exceptions where the needs of patients were not recognised. We have welcomed some services' innovative approaches to allowing safe visits and contacts with families.

- Many services invested in computer tablets and relaxed rules over use of mobile telephones to improve **patients' access to friends and family** during the first lockdown. This was commendable and should be continued after the crisis. Increased access highlighted common problems of WiFi coverage in wards, which should be considered in future estates development.

- We observed **changes in procedure** introduced during the pandemic and feel that these should not continue afterwards without further consultation and evidence of impacts from people who use services and others. This includes the use of remote technology in clinical situations, including assessments for possible detention and Tribunal hearings and changes to Tribunal procedure.

- **Advocacy services** moved to remote contact during lockdown and this highlighted the need for robust referral systems to ensure that patients are offered advocacy services from admission. We hope that commissioners of advocacy services will learn from this experience of the value of facilitating a regular advocacy presence on wards. In the longer-term, we believe the law should provide more stringent duties on services to refer patients immediately on admission, with advocacy as an 'opt-out' service. This was recommended by the Independent Review of the MHA and we hope to see it taken up in future reform.

Leave and access to fresh air

In normal circumstances, most detained patients are provided with leave of absence from hospital and a chance to engage with their local community. Therefore the greatest general impact of the COVID-19 pandemic for detained patients was the first lockdown instruction to 'stay at home' – or, in their case, in the facility in which they were held.

We welcomed guidance issued on 30 March reinforcing the point that hospitals should facilitate leave as far as possible, in line with public health guidance, for the health and wellbeing of patients and especially people with a learning disability and/or autistic people who suffer with changes in routine.[62]

Many services continued to support patients to take leave throughout the crisis, so that patients were afforded the same opportunity as the rest of the population for a daily hour of exercise during lockdown. But some services cancelled all leave, and some required patients to remain within hospital grounds at the peak of the crisis. One London-based forensic unit told us that, during this time, staff and patients undertaking escorted leave for exercise outside the hospital grounds were being challenged by the police.

We made it clear that we expect services to carefully document their rationale if making blanket restrictions to leave arrangements, in order to show that they are taking note of the guiding principles of the Code, and that decisions are proportionate and represent the least restrictive option. We challenged several services whose total restriction on leave outside the hospital grounds was extended long after it could be justified in line with the COVID-19 restrictions on the general population. For example:

> Leave had been suspended, including for patients who previously had unescorted leave. We were told this was the provider's policy. However, this is not in line with recently published legal guidance from NHS England and NHS Improvement, guidance from the Royal College of Psychiatrists, or least restrictive principles. Patients were unhappy with this, and examples of the impact of this were provided, for example not being able to access a smartphone, which was used on leave to make video calls to family and friends, because smartphones could only be used on leave outside of the building. We were advised that a discussion was due to be held that week regarding relaxing this restriction.
>
> **Medium secure ward, 19 June 2020**

In many services, where patients were confined to the hospital grounds, smoke-free requirements were relaxed. We hope that a renewed effort to encourage people who use services to stop smoking will reverse these backwards steps.[63]

During the first lockdown, many patients were unable to visit local shops, in part because of general government advice to restrict shopping to essentials. We were pleased to note that staff in many services showed great care for patients in helping to soften the impact of this:

> Staff are still supporting patients by continuing to do shop runs for additional personal supplies. This has come with its own set of challenges as at least one member of staff had been abused by a member of the public due to the amount of shopping they were buying.
>
> **Medium secure rehabilitation ward, Fromeside, Avon and Wiltshire Mental Health Partnership NHS Trust, 7 May 2020**

The meal preparation pathway, which formed a significant part of the recovery phase and discharge planning, had been paused because of the need for social distancing and essential shopping only. The staff team introduced alternatives to help patients to meet their goals of creating positive eating situations. For example, patients were supported to practise ordering takeaways and there were plans to introduce eating out in the garden as a social event. Staff planned to shop on behalf of patients as soon as the rules around shopping for essential items only were lifted.

Eating disorder ward, Addenbrookes, Cambridge University Hospitals NHS Foundation Trust, 6 May 2020

Staff told us that when the hospital shop closed, they wanted to ensure that patients would continue to have independent access to everyday items. 'The Moorland snack shack' was set up to provide free snacks and drinks and also other items such as toiletries. Staff had also obtained a budget to provide a daily e-burn while access to purchase these was limited for patients.

David Barlow unit, Northern Devon Healthcare NHS Trust, 23 June 2020

For most detained patients, leave is not simply for an opportunity to spend time off the ward, but also a step towards eventual discharge from detention and a key part of rehabilitation. This often came up in our conversations with patients and services, and we urge services to take this into account during the current, second lockdown.

> Patients told us that the lack of section 17 leave was the hardest thing about the lock down period. The advocates said this issue was the main cause of concern for patients. They told us that some patients thought it had gone on longer than needed, especially when the government rules changed.
>
> Patients said escorted leave had restarted the week of our review and they had allocated days to go out. You told us all patients would initially have escorted leave in order to support them to understand and comply with the rules about social distancing.
>
> Two patients told us that unescorted leave and participating in community-based activities formed part of their discharge plans. They raised concerns that their discharge might be delayed because of the current situation. You advised that this would not be the case and that unescorted leave would be considered for individual patients when they were confident about social distancing. You agreed to speak with the patients concerned.
>
> **Low secure ward for men with a learning disability and/or autistic spectrum disorder, 13 July 2020**

Contact with friends and family

A national ban on hospital visits was announced on 8 April 2020, although it did provide that exceptions might be made where visitors were supporting someone with a mental health issue such as dementia, a learning disability or autism, and not being present would cause the patient to be distressed. This ban was lifted on 5 June.[64] On 22 September, NHS England and NHS Improvement wrote to commissioners and providers to demand that providers take all steps possible to enable safe regular visits, unless a risk assessment has been carried out for the individuals that demonstrates that there are clear reasons specific to their individual circumstances as to why it would not be safe to have visits.[65]

Many of our monitoring visits involved discussion over the arrangements for contact with relatives, and for visiting. In many of these we raised the need to consider individual exceptions, or to question why hospital bans had continued long after government had advised they end in June.

> ## An MHA complaint over visiting access
>
> In mid-April we dealt with a complaint from a patient's mother. Her daughter was detained in a child and adolescent mental health service unit at an independent hospital and was fast approaching her 16th birthday. The mother was told that she could not visit, even on her daughter's birthday, due to a blanket ban on visits during COVID-19 lockdown that had been put in place by the provider's headquarters.
>
> On the eve of the daughter's birthday, we spoke to hospital staff, highlighting the government guidance and questioning whether this was a blanket ban. The hospital agreed to arrange a two-hour visit the next day, off the ward. These types of visits would also be used for visits by other relatives.
>
> The hospital had previously experienced COVID-19 infections and we were careful not to make demands that would put patients in danger. Sensible conditions were placed on visits, such as that they would be limited to one nominated family member, rather than different family members, and that it would not be possible for that family member to visit every day, to allow all patients the opportunity to have visits.

In some services we found that blanket bans had been imposed by hospital managers, even when clinicians disagreed. In such cases we were able to use the government guidance to support our challenge.

> Relatives I spoke with told me that they were not allowed to visit their relatives on the ward. You confirmed that this was the case, that it was trust policy and that you had asked senior management to relax this rule, without success. Staff and relatives felt that the lack of face-to-face contact between patients and their loved ones could be detrimental to their care.
>
> **Dementia Assessment Unit, 22 July 2020**

In contrast, we have seen outstanding examples of individualised, needs-based interventions by staff who were supported to implement the government guidance and consider exceptions to visiting restrictions. One such service is the Greenways Learning Disabilities Unit, Cheshire and Wirral Partnership NHS Foundation Trust. Here, bespoke arrangements were made after individual discussions with patients and their families, taking into account what visits or activities were most important to each patient's continued wellbeing. For example, one patient's weekend pub lunches with his father were rearranged to be meetings in a country park. We heard

from patients, carers and the advocate for the ward that the high level of engagement with families and carers was a reflection of a very compassionate, skilled team being continually focused on least restrictive practice and individualised care.

Many wards relied on telephone and/or video calls to connect patients with their relatives and wider support networks, with many services buying computer tablets to enable this.

> *"It's such a good team there, so caring, they can't do enough to try and understand her, even tiny things, they are always looking for clues to what she is trying to tell them. They will ask me and take what I say and use it – it's made such a difference because it feels like all the concentration is on getting her well, working with us, working together, with her as the focus. And they are always looking at her discharge, it's such a relief for all of us, knowing she is there with people on her side."*
>
> **Carer of patient at Greenways Learning Disabilities Unit, Cheshire and Wirral Partnership NHS Foundation Trust, September 2020**

For many secure services, the use of information technology to maintain contact with friends and family required an extension of access to mobile telephones and the internet. In this way the crisis has hastened changes that were already underway, as many such services had started to relax rules over mobile telephones before the pandemic.

> Patients could have access to their mobile phones for six hours a day. All the patients that we spoke with told us that the system worked well and was very valued by patients. Patients told us that they were concerned that when the lockdown was lifted, their access to mobile phones would be restricted once again.
>
> **Medium secure ward for women, 21 May 2020**
>
> Restrictions on smartphones had been relaxed and patients could use these at any time except during group sessions, meal times and during education. Staff said that patients had drawn up their own set of guidelines about phone usage.
>
> **Child and adolescent mental health services ward, Leeds and York Partnership NHS Foundation Trust, 17 July 2020**

We expect services to maintain this extended access after the pandemic, unless there are clear reasons to do otherwise.

Services used many methods to ensure patients had privacy when interacting online.

> Patients were able to maintain phone contact with their families and recently virtual visits through Skype were introduced. These visits were supervised where staff were to remain within the line of sight of the equipment and screen. We discussed the rationale for this and the impact on patient privacy with the ward manger and IMHA. They advised this was not identified as an issue by the patients with it being relatively new. The IMHA advised they can be vigilant to any potential impingement and the ward manager advised they will discuss this in their monthly reducing restrictive monitoring group.
>
> **Medium secure learning disability ward, 19 May 2020**

The most common concern arising from this was the quality of internet connection on wards:

> Neither carer had been invited to a ward round and both told us that it was very difficult to speak to their relatives, there was no access to video calls, and this was exacerbated by the poor WiFi connection and a lack of IT equipment provided to staff. Both carers told us that staff had used their own mobile phones to support video calls with their relatives. This was very much appreciated, but connections had broken down regularly which had caused distress on occasions and the small screens made it difficult to see properly.
>
> **Dementia ward, 1 June 2020**

There were also issues around poor IT infrastructure:

> The IMHAs we spoke with and some relatives told us that the ward did not have adequate facilities to manage meetings during this period of remote working. The ward manager told us that the trust's conference facility had expired two weeks before our visit. This had impacted on people being able to contribute to meetings and hear effectively. Patient's relatives and staff told us the tablet computer had been broken for about two to three weeks. Some relatives and the IMHAs felt that some staff were not clear on the use of technology.
>
> **Older person's organic illness ward, 28 July 2020**

We believe these issues need to be addressed through future estates work. There were also issues around inequality of access, which some services did a lot to counter:

> One carer told us how well staff had supported them to stay in touch with their family, including bringing a tablet to their home, as they did not have any electronic devices, so that they could speak to and physically see their relative. We also heard that staff had collected home-made puddings and cakes that they had made for their relative in hospital.
>
> **Haytor Unit, Torbay and South Devon NHS Foundation Trust, 14 May 2020**

Access to advocacy

As services restricted visits to wards, advocacy services moved to access via telephone, text or videocall. While we applaud this effort to represent patient interests during such a difficult time, we suspect that the loss of opportunity to visit the ward regularly will have limited the way they would usually be able to interact with patients. It prevents being able to move freely within the ward environment and make informal contact with patients; being able to approach patients without the assistance of staff members to build up visibility and trust; and can also lead to uncertainty over the privacy of discussions.

> The advocates were speaking with patients by telephone. One advocate told us patients were not engaging with them as well as they usually did when they were able to visit the ward.
>
> **Low secure personality disorder ward, 12 May 2020**

We are pleased to note examples of staff attempting to compensate for the physical absence of IMHAs by promoting the service or making referrals:

> All detained patients received a personalised letter from the IMHA service jointly designed by the Devon advocacy service and the MHA administrators, which gave patients a personal introduction to their local IMHA while the wards are closed to face-to-face contact with IMHAs. The IMHA told us that a patient had already directly contacted them as a result of this new practice. This was a trust-wide initiative in direct response to COVID-19 and is good practice.
>
> **David Barlow unit, Northern Devon Healthcare NHS Trust, 23 June 2020**
>
> Onside advocacy reported a significant drop in referrals during the lockdown period. They attributed this in part to being unable to introduce themselves to patients in person during the pandemic as they can no longer visit the wards. Staff at the trust and the advocacy service have considered automatic referrals to all detained patients during the current COVID-19 outbreak, to replace the lost opportunity for IMHA to introduce themselves during a ward visit.
>
> We would support this approach, providing that information for patients includes an appropriate explanation for the IMHA contact.
>
> **Worcestershire Health and Care Trust, 2 September 2020**

However, we also found wards where staff did not routinely refer any eligible patients to an IMHA, even where the patient lacked capacity to do so themselves. In the physical absence of the advocate on the ward, this effectively undermined some patients' right to advocacy at a very vulnerable time.

In addition, one advocate told us about situations where they were not told about patients detained under section 2 until some time after these patients' admission. This meant these same patients missed the 14-day deadline for making an application to the Mental Health Tribunal, which would have had a considerable negative impact on them. These experiences reinforce our view that the law should be able to compel services to refer patients to advocacy immediately on admission, and that the service should run on an 'opt-out' basis. This was recommended by the Independent Review of the MHA and we hope to see it taken up in future reform.[66]

During June, many services were lifting their restrictions on professional visitors, so IMHAs were returning to wards. We hope that the experience of lockdowns have shone a light on the vital role that advocates play and that we will see a regular presence for advocates in future, which will enable patient access to advocacy.

Video conferencing in clinical assessment, treatment and care

During the first lockdown, we saw an increase in the use of video conferencing for the assessment, care and treatment of mental health patients. Benefits of this included:

- Wide participation leading to enhanced joint working between health professionals, particularly at ward rounds. For example, we were told that care coordinators were able to join in meetings more frequently than before.

- Greater involvement of carers during ward rounds or treatment reviews.

- Improving families' involvement in carer events, including families that lived a long distance from the hospital or even abroad.

However, patients' experiences of using video conferencing were mixed, with some finding it more difficult to talk or feeling isolated from the people supporting their case:

> Patients told us they saw the doctors, including their consultant, on the ward but their reviews were done through a video call. One patient told us it worked very well and they were surprised at how personal it felt. However, another patient said they found it difficult to talk and they did not always hear or understand what was being said. The two carers said they had phoned in to the reviews and had not had any difficulties.
>
> **Older person's ward, Norfolk and Suffolk NHS Foundation Trust, 31 July 2020**

In particular, we noted that it must not be assumed that younger patients will be comfortable with using technology for their clinical care:

> One of the patients told us they did not like the remote ward rounds because they found it difficult to talk to people on a screen.
>
> **Children's ward (13 to 17 years), 17 August 2020**

The majority of respondents to the Royal College of Psychiatrists survey also supported a return to face-to-face contact when possible.[67]

It is clear that technology can have a beneficial role to play in supporting and caring for people detained in hospital. However, the degree to which this is used must be proportionate and is an area that needs to be reviewed in the next iteration of the MHA Code of Practice and for future review of the law.

From August 2020, we heard that some services are working to evaluate changes made to their procedures during lockdown, to lock in beneficial changes and recover or restore services where this is needed. For example, Lancashire and South Cumbria NHS Foundation Trust has arranged with Healthwatch, Positive Practice[68] and the University of Central Lancashire to work with people who use services to look at their experiences, particularly of digital services, so the trust can keep what works for them and adapt or reject what does not.

Changes to Tribunal procedure as discussed in the section on 'Amendments to the Mental Health Act and delegated legislation', also included a move to remote hearings in March 2020. We heard mixed patient experiences. For example, one patient liked interacting with the screen rather than in person, while another remarked that it felt as if she was isolated from those supporting her case. Again, there was frustration at internet connections on wards.

> Tribunals were taking place remotely, but there were often problems with the quality of the remote links. Patients could find tribunals difficult because of this… Last time we visited there was an action to get WiFi internet on the ward for patients. I was told that this was now available, but that the quality and speed of the connection was poor and affected the patients experience, especially of Tribunals.
>
> **Psychiatric Intensive Care Unit for men, 8 July 2020**

Both hospital manager and Tribunal hearings generally aim to encourage and facilitate the patient's active participation in their hearings. Video hearings place an additional burden on panels (and specifically judges in the case of the Tribunal) to ensure that the process is fair to all parties and particularly the patient. In one Tribunal, the patient's video-link was muted due to her interruptions of other witnesses, and she successfully appealed for the decision to be set aside on the grounds that she had not been able to hear all witnesses and had no way to alert the Tribunal of this. It was accepted that, had the judge gone back to the patient after each witness and checked with the patient that she had heard and understood, or had the patient's representative raised the problem during the proceedings, the proceedings could have been fair.[69]

The suspension of pre-hearing examinations by the medical member of the Tribunal, as discussed in the section on 'Amendments to the Mental Health Act and delegated legislation', could remove one opportunity for patients to engage directly with the Tribunal process and overcome fears over speaking at the hearing itself or reticence to engage over video technology. This was recognised by the Tribunal in August 2020, when it held that a video-enabled preliminary hearing should take place in the case of a voluntarily mute patient where there was disagreement by professionals as to what, if any, mental disorder diagnosis was appropriate.[70] This shows the potential value of such procedures. Guidance from HM Courts and Tribunals Service issued shortly after the above decision continued to say that even "limited tribunal examinations over video" cannot be arranged in mental health cases due to capacity issues.[71] It is not clear to us why this cannot be addressed and we urge pre-hearing examinations to be restarted in some format as soon as is practicable in routine hearings.

We would welcome ongoing debate around the issue of digital support and care for patients with mental health conditions. We will continue to feed our reflections and insight into those cross-sector forums that have been established by government and the NHS – for example, the Mental Health and Dementia Digital Steering Group on the future of digitally-facilitated care.

Access to psychiatric medicine and electroconvulsive therapy

Although it was anticipated that COVID-19 might interrupt supply chains for medicines,[72] we are not aware of any problems to date with access to psychiatric medication linked to the COVID-19 outbreak.

We have found some difficulties related to the administration of the antipsychotic drug clozapine, used widely for treatment-resistant schizophrenia. An important part of clozapine safety is monitoring for a potential side effect of reduced types of blood cells; left unchecked this can lead to life-threatening conditions. At the height of the first-wave of infections, some services struggled to take blood samples from community-based patients, including people subject to community treatment orders. Many patients were fearful of leaving home during lockdown and a lot of public transport was not running, limiting attendance at community team clinical premises, and staff or PPE might not always be available for home visits. We were pleased to note the practice guidance produced during this time for professionals, set out clear advice on managing the risk.[73,74]

Guidance also provided advice on helping patients to distinguish between COVID-19 related heart difficulties and secondary infections, as opposed to those caused by the serious side effects of clozapine so that it need only be interrupted where necessary for patient safety.[75]

> You told us that COVID-19 infection can be problematic for those patients treated with clozapine. Two patients had to stop their clozapine treatment and as a result their mental state deteriorated.
>
> **Low secure learning disability ward, 20 August 2020**

However, COVID-19 does seem to have limited the availability of electro-convulsive therapy (ECT). The Royal College of Psychiatrists' ECT Accreditation Service has acknowledged that, during the crisis, the majority of clinics responding to its survey reported that they were rationing services because of the pandemic, mainly because the required infection control procedures have reduced treatment capacity but also due to lack of staff and PPE when it was not available.[76]

At the height of the crisis, it would be understandable that anesthetists might be deployed away from ECT clinics to support intensive care units. We would hope that this limitation, alongside the availability of suitable PPE, is no longer a significant issue. However, we do understand that ECT clinics have had to reorganize their procedures to provide infection control:

> The ECT service was initially temporarily halted due to COVID-19 until infection prevention control (IPC) measures could be put in place to ensure a safe delivery of the service. These measures included the fit testing FFP3 masks due to ECT being an aerosol generating procedure. The ECT service is now running at reduced capacity due to strict enforcement of IPC regulations. These include the donning and doffing of PPE, air flow circulation/changes between each service user and the clean down of the treatment and recovery area and equipment between each service user. Consequently, the capacity is limited to three patients per session as opposed to the previous maximum of nine patients. The ECT service is now accepting all referrals for treatment but this will be limited by capacity due to the aforementioned changes in how the treatment can be safely delivered.
>
> **Acute ward, 18 May 2020 (service response to our letter)**

Services should be monitoring the local availability of this potentially life-saving treatment.

5. Deaths of detained patients during the pandemic

> "For me, the first thought is that services have survived their greatest test in living memory. Care, compassion and determination have been evident just about everywhere one chooses to look in the mental health service and beyond. The coalition of patients, staff and service leaders have succeeded in maintaining service integrity while at the same time maximising the safety of all of us.
>
> "It has to be acknowledged, however, that there have been casualties in the battle against COVID-19. Many of us will know patients and colleagues who have been lost to the invisible enemy. It is often pronounced that COVID-19 is an indiscriminate adversary, although more recently there is good evidence to suggest that many of us are more vulnerable than others. Like many mental health services around the world, the UK inpatient mental health service is profoundly dependent upon the skills and contribution of staff members from the BME community. As with all societies that benefit from rich diversity, many of those requiring mental health services are also from higher risk groups, both by demographic description and as a consequence of physical health issues that often accompany mental health problems."
>
> **Roland Dix, Approved Clinician and Consultant Nurse in Psychiatric Intensive Care and Secure Recovery, Wotton Lawn Hospital, Gloucester[77]**

Specific guidance on supporting patients with COVID-19 in mental health units was published by NHS England and NHS Improvement on 30 April 2020.[78] At the start of May we wrote out to services highlighting the rise in COVID-19 related deaths, drawing attention to the guidance, and stating that we would use our contact with services to seek assurance that they were taking all measures necessary to be able to manage cases of COVID-19, including having enough supplies of PPE and adequate training and staffing.[79]

It would be unreasonable to expect services to be able to avoid any outbreaks, given the limitations of the information about the disease available to them and the highly infectious nature of COVID-19. On many of our visits we were told of isolated infections among patients that were dealt with through quarantine or cohort nursing. Despite these measures, some services experienced high numbers of COVID-19 infections, with related deaths. As well as losing patients, some services also lost members of staff to the pandemic.

The unit as a whole had suffered as three members of staff had died. This had impacted upon morale but the resilience of the staff group had been remarkable, with good support from psychology and trust managers and there was excellent team cohesion in place currently.

Park Royal Centre for Mental Health, Central and North West London NHS Foundation Trust, 28 May 2020

We recognise the huge amount of distress these deaths caused for patients and staff alike, and note the resilience and bravery of staff who have continued to provide care during this period.

The ward had recently been through an outbreak of COVID-19. All except two patients had positive results and at one point 35 members of staff were off work. Some patients and some members of staff had been hospitalised. By the time of our visit, there were no positive patient cases and all staff except one had returned to work.

Personality disorder ward for women, 17 June 2020

The ward had 12 beds for women, with nine patients detained under section 2 or 3. All patients on the ward had contracted COVID-19 but none of the patients had the virus now. A number of staff also contracted COVID-19 and one was still not in work.

Following the death from COVID-19 of one of the staff on the ward, there was support from managers, who were visible on the ward. There was psychological support and the staff team supported each other.

Psychiatric intensive care unit for women, 27 May 2020

I was saddened to learn of the devastating impact of the COVID-19. You told me that three patients had died due to COVID-19. You told me that the charity's chaplains had visited the ward and a memorial service was being held. Additionally, sessions with the charity's trauma service had been arranged for staff.

Dementia ward for men, 15 June 2020

Since the lockdown you said that five patients had tested positive for COVID-19 and unfortunately two patients had died following transfer to a medical ward. One other patient who was receiving end of life care had also died on the ward and it was strongly suspected that he may have had COVID-19, although this was not confirmed. I acknowledged the distress that this must have caused for patients and staff but was reassured by the level of support you described that the ward had received from psychology and senior managers.

Rehabilitation ward, 16 July 2020

We were notified of 107 deaths of detained patients attributed to COVID-19, where death occurred up to 6 November 2020 (figure 6). Most of these were during the peak of the first wave in April and May. This data may be subject to change as further details emerge. We will continue to publish data on the notifications of deaths of detained patients throughout the pandemic, using our regular COVID-19 Insight reports, giving further breakdowns of the data.

Figure 6: **Weekly totals of notifications to CQC of deaths of patients detained under the MHA, 1 March to 6 November 2020**

COVID-19 deaths   Non COVID-19 deaths
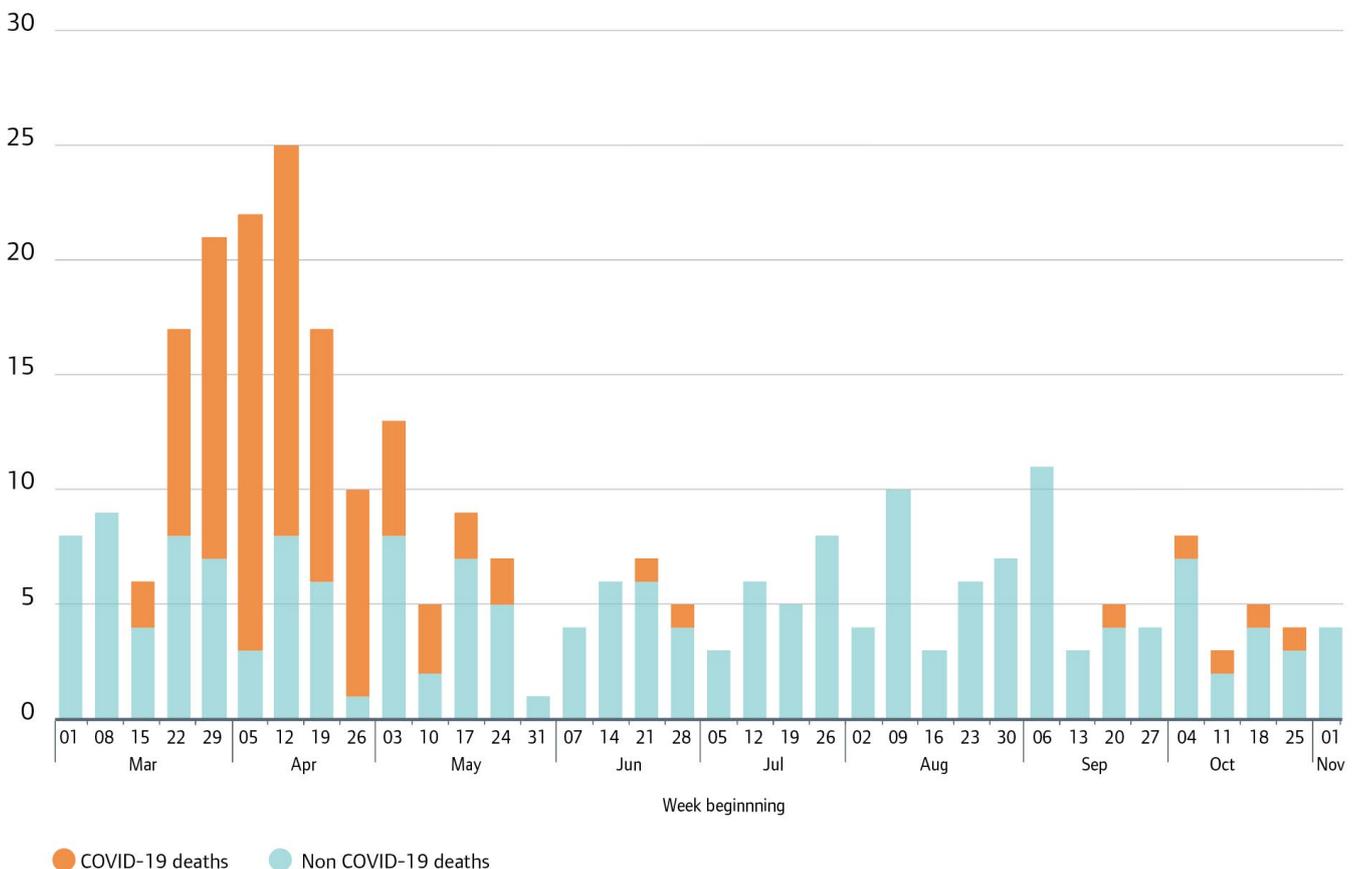
Source: CQC

6. Activity in monitoring the Mental Health Act in 2019/20

Key points

- We carried out 1,052 visits, met with 3,916 detained patients and spoke with 266 carers, and required 3,638 actions from providers.

- Our Second Opinion Appointed Doctor service carried out 14,263 visits to review patient treatment plans. Resulting certificates changed the treatment proposal in 23% of visits, and in a further 4% of visits no certificate authorising treatment was issued.

- We were notified of 877 absences without leave from secure hospitals.

- We received 2,231 enquiries about the way the MHA was applied to patients, and investigated complaints from 14 people.

- We were notified of 240 deaths of detained patients, of which 143 were known to be of natural causes, and 36 deaths of patients on community treatment orders, of which 21 were known to be natural causes.

- This data from our monitoring and other activities in 2019/20 will be further analysed and discussed in our next annual report, to be published in 2021.

In 2019/20, we carried out 1,052 visits, met with 3,916 detained patients and spoke with 266 carers, and required 3,638 actions from providers.

All but 17 of our visits were to particular inpatient wards (others were to places of safety or acute hospitals). Only four wards were visited twice over the year (figure 7). The total number of visits was slightly less than in previous years. There were no visits during the last two weeks of March 2020 as we suspended threshold-crossing activity due to COVID-19. In March 2020, 40 visits took place compared with 109 in March 2019.

We contacted 266 carers, mostly by telephone. We have highlighted above that our remote monitoring methodology since April 2020 has increased our contact with carers, and with advocates, and that this is something that we wish to retain when we return to regular on-site visits.

Figure 7: **MHA reviewer visiting activity 2015/16 to 2019/20**

|	Number of visits	Total wards visited	Distinct wards visited	Patients met
2015/16	1,358	1,350	1,307	4,295
2016/17	1,214	1,211	1,193	4,157
2017/18	1,165	1,155	1,127	3,993
2018/19	1,190	1,199	1,178	4,436
2019/20	1,052	1,035	1,031	3,916

We raised 3,638 action points for detaining hospitals. Each referred to a principle or specific point in the MHA Code of Practice. Figure 8 shows the principles or specific points that were cited more than 100 times in the year. The most frequently cited was the Code's principle of empowerment and involvement, in 12.4% of all actions.

Figure 8: **The most commonly cited MHA Code of Practice references in action points requested by MHA Reviewers, 2019/20**

| CoP Category	Total 19/20
Chapter 1: (b) Empowerment and involvement	452
Chapter 4: Information for patients, nearest relatives, carers and others	411
Chapter 1: (d) Purpose and effectiveness	305
Chapter 8: Privacy, dignity and safety	269
Chapter 24: Medical treatment	267
Chapter 27: Leave of absence	263
Chapter 26: Safe and therapeutic responses to behavioural disturbance	246
Chapter 25: Treatments subject to special rules and procedures	239
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A key aspect of empowerment and involvement is care planning. Over 2019/20 we continued to note overall progress in services enabling patients' involvement in their care plans, and such care plans showing consideration of patients' views (figure 9).

Figure 9: **Patients' involvement in care planning, 2018/19 and 2019/20**

Care plans show evidence of the patient's involvement

	Apr 2018 - Mar 2019 (4,082)	Apr 2019 - Mar 2020 (5,151)
Yes	89	93
No	11	7

Care plans show evidence of consideration of the person's view about their treatment

|	Apr 2018 - Mar 2019 (3,176)	Apr 2019 - Mar 2020 (4,485)
Yes	90	93
No	10	7

Source: CQC

● Yes ● No
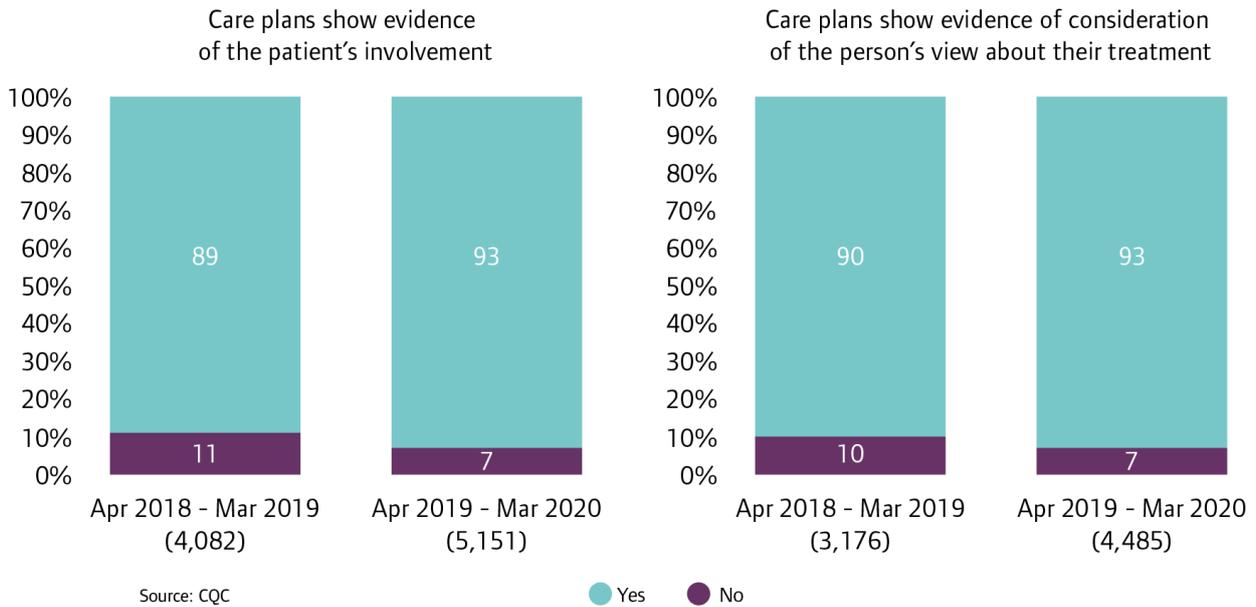
In the section on 'The discharge of patients at the start of the pandemic' we noted that some patients were discharged from hospital without adequate support at the start of the pandemic, when services aimed to reduced numbers of occupied beds. This highlighted the need for dynamic care planning, with a focus on discharge planning from the start of inpatient admission. Over 2019/20 we continued to see improvements in these areas of our focus on visits (figure 10).

Figure 10: **Care planning and discharge plans, 2018/19 and 2019/20**

Care plans are re-evaluated and updated following changes to care needs

	Apr 2018 - Mar 2019 (4,014)	Apr 2019 - Mar 2020 (5,118)
Yes	96	97
No	4	3

Care plans show evidence of discharge planning

|	Apr 2018 - Mar 2019 (3,724)	Apr 2019 - Mar 2020 (4,764)
Yes	86	91
No	14	9

Source: CQC

● Yes ● No
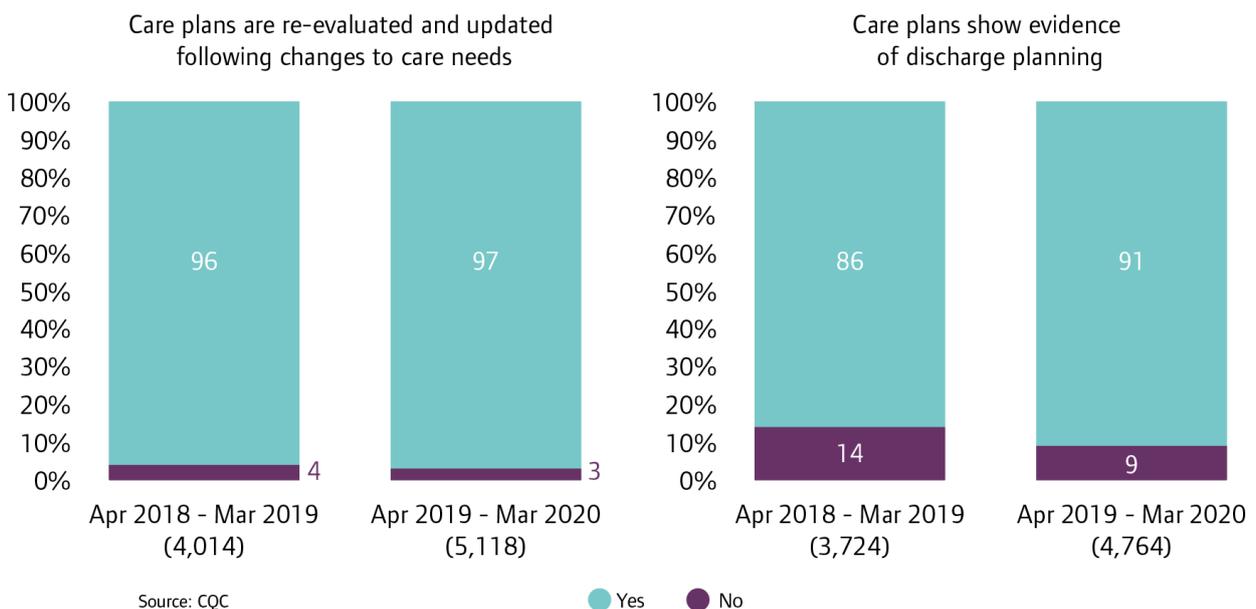
Another important focus of our reviews of patient involvement and empowerment is on how services carry out their statutory duty to provide information to detained patients on their legal position and rights (figure 11).

Figure 11: **Services' explanation to patients of their legal position and rights, 2018/19 and 2019/20**

Discussions about rights (on detention) and an assessment of the patient's level of understanding

Further attempts to explain rights where necessary or to the Nearest Relative where appropriate

Apr 2018 - Mar 2019 (4,088)	Apr 2019 - Mar 2020 (5,157)
95	96
5	4

Apr 2018 - Mar 2019 (3,758)	Apr 2019 - Mar 2020 (4,823)
89	93
11	7

Source: CQC   ● Yes   ● No
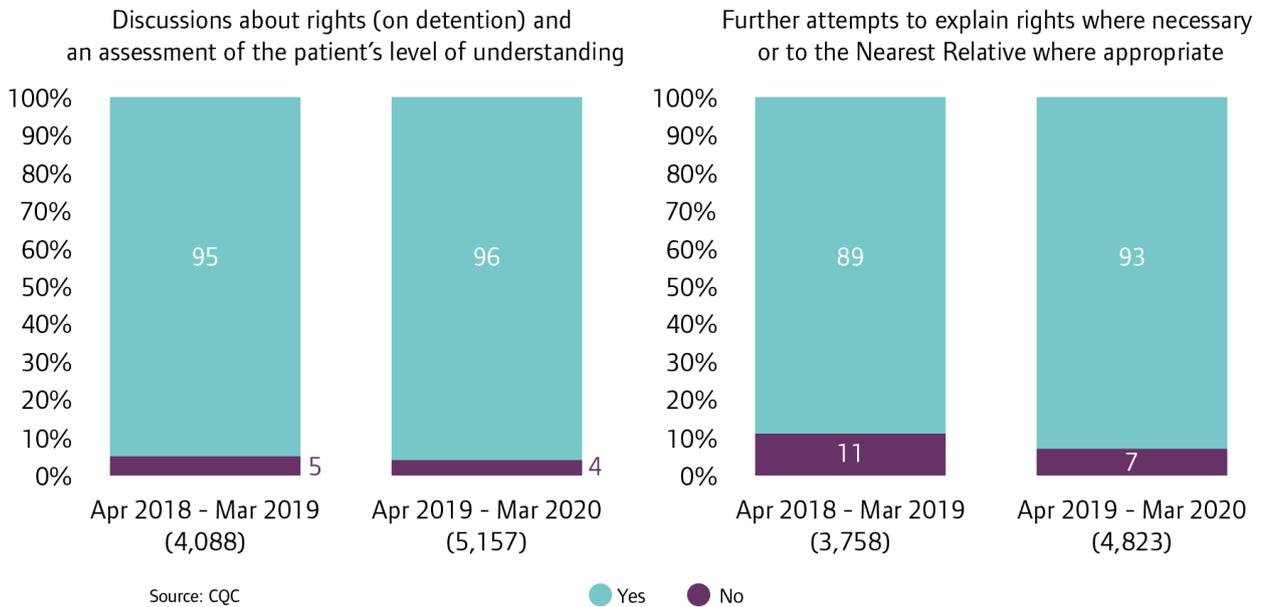
In chapter 4, we noted that the pandemic lockdown required all services to address patients' access to communications technology. This is an area that we have focused on for a number of years, with general if gradual improvements noted (figure 12). As mentioned above, we have noted much faster progress in the pandemic, including in the ways in which secure services have found ways to have safe access to technology.

Figure 12: **Detained patients' access to mobile phones and the internet, 2018/19 and 2019/20**

Patients able to access mobile phones

Patients able to access internet

Apr 2018 - Mar 2019 (1,248)	Apr 2019 - Mar 2020 (1,052)
80	86
20	14

Apr 2018 - Mar 2019 (1,248)	Apr 2019 - Mar 2020 (1,052)
74	82
26	18

Source: CQC   ● Yes   ● No
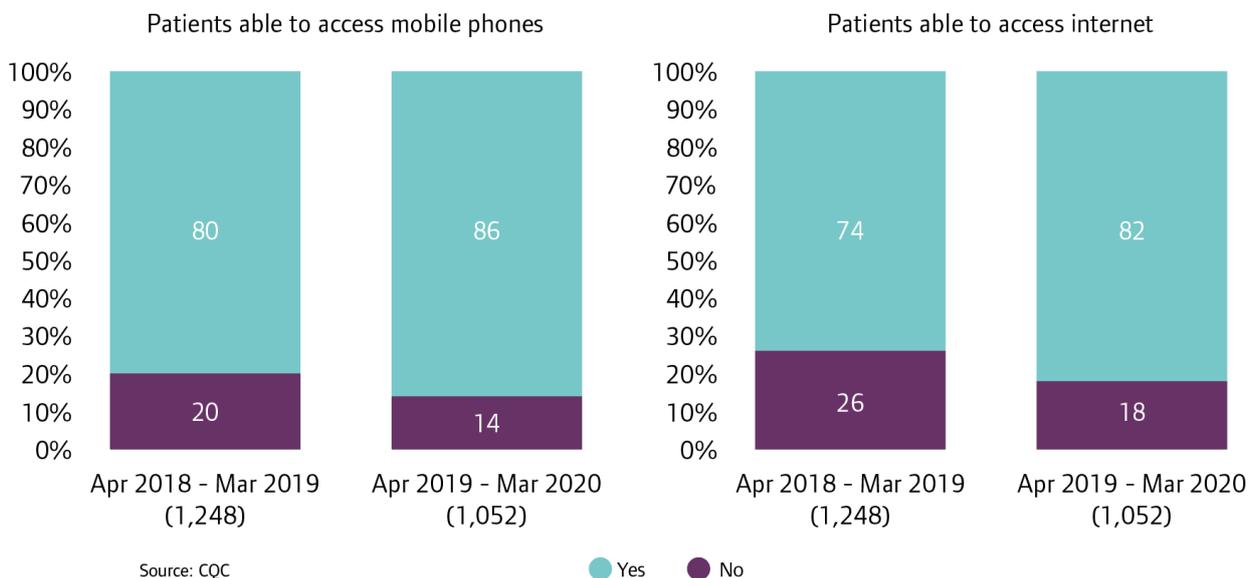
Use of the MHA in 2019/20

Official statistics report 50,893 new detentions in 2019/20, of which 32,320 took place at the point of admission to hospital. A further 14,576 occurred following informal admission. The majority of the remainder (3,805) were detentions following a place of safety order. These figures are incomplete and must be treated with caution. NHS Digital estimate a less than 1% increase in detentions overall from the previous year.[80]

The data does enable some important analysis comparing patient groups. The well-known overrepresentation of patients from BME backgrounds continues, with detention rates for the broad 'Black or Black British' group (321.7 detentions per 100,000 population) over four times those of the White group (73.4 per 100,000 population). Such overrepresentation is even starker when specific BME groups are considered.[81]

For 2019/20, NHS Digital has for the first-time analysed rates of detention by Indices of Multiple Deprivation (IMD). Rates of detention increased with deprivation. The most deprived areas had the highest rates of detention (147.9 detentions per 100,000 population), around three and a half times higher than the rate of detention in the least deprived areas (42.8 detentions per 100,000 population).[82]

Second Opinion Appointed Doctor service

Our Second Opinion Appointed Doctor (SOAD) service carried out 14,263 visits to review patient treatment plans. Resulting certificates changed the treatment proposal in 23% of visits, and in a further 4% of visits no certificate authorising treatment was issued.

We will be including analysis of SOAD data in our next annual report. Initial analysis suggests that patients from BME backgrounds accounted for 25% of visits to consider treatment with medication, and 12% for electroconvulsive therapy (ECT). The difference between these two figures is likely to be accounted for by age (ECT is more likely to be proposed for older patients). The difference between such proportions and those in the general population, although it reflects overrepresentation of some BME groups in the detained population, merits further study.

MHA enquiries

We received 2,231 enquiries about the way the MHA was applied to patients, and investigated complaints from 14 people.

Many contacts made from patients or relatives do not proceed towards complaints investigation, often because we advise that local complaints procedures are an appropriate initial route or because initial contacts resolve the matter. We discuss the changing pattern of contacts and complaints in appendix A. There was a general fall in complaints and contacts received towards the end of the financial year, with the start of the pandemic, rising to higher than normal levels in subsequent months.

Absences without leave

We were notified of 877 absences without leave from secure hospitals.

Hospitals designated as low or medium security must notify us when any patient liable to be detained under the MHA is absent without leave, if that absence continues past midnight on the day it began. Many such absences occur when patients stay away longer than has been authorised: these cases, in particular, may reflect positive risk taking by providers. As such, data on absences without leave is most useful when viewed in context at a local level. It forms one of the many measures we use in this way.

Deaths of detained patients

We were notified of 240 deaths of detained patients from 1 April 2019 to 31 March 2020, of which 143 were known to be of natural causes, and 36 deaths of patients on community treatment orders, of which 21 were known to be natural causes. Please note that there is therefore a one month overlap with the data on deaths during the COVID-19 period reported on page 60.

The cause of deaths in detention are usually determined through the coroners' courts, which leads to a delay for accurate statistical reporting. We understand such delays to have been exacerbated during the pandemic. We will provide an analysis of deaths in detention, and of patients subject to community treatment order (CTO), in our next annual report. Figure 13 shows the data for all years from 2012/13 to 2019/20.

Figure 13: **Deaths reported to CQC 2012/13 to 2019/20**

Deaths of detained patients

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Natural Causes	200	126	182	201	186	189	136	143
Unnatural Causes	48	36	34	46	54	48	34	32
Undetermined	27	36	11	19	7	10	25	65
Total	275	198	227	266	247	247	195	240

Deaths of patients subject to community treatment orders

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Natural causes	26	21	29	27	29	23	9	21
Unnatural causes	9	7	15	11	12	7	5	10
Undetermined	10	6	2	2	1	4	2	5
Total	45	34	46	40	42	34	16	36

Appendix A
Our approach to our MHA functions during the pandemic

- Throughout the pandemic period, where we have had specific and urgent concerns we have been engaging with services and have carried out on-site visits alongside CQC regulatory inspectors. However, we moved routine visits to a digitally enabled format. Some aspects of this have been positive and we will look to build them into our routine practice.

- From 20 November 2019 to the end of the programme in September 2020, Independent Care, Education and Treatment Reviews reviewed the care of 77 patients. From 23 March 2020, these were digitally enabled in response to the COVID-19 lockdown, and found many examples of restrictive practice.

- On 18 March, we moved our Second Opinion Appointed Doctor Service to a remote system of assessment, which has avoided use of Coronavirus Act easements. Some aspects have been positive and we will look to build on them in future.

- We are carrying out survey consultation on all of our COVID-19 pandemic methodology with patients, clinicians and others. We will build this into any further development of our methodology in future.

Visiting patients detained under the Mental Health Act

The MHA requires that CQC visits and interviews patients who are detained in hospital under its powers. Such visits also play a key role in our duties as a member of the UK's National Preventive Mechanism (NPM) against torture and inhuman and degrading treatment (see appendix B).

In March, we discussed our visiting duties within the UK NPM and, through our UK NPM coordination, with international NPM bodies. On 20 March the Committee for the Prevention of Torture (CPT) issued a statement of principles, which included that:

> "…monitoring by independent bodies, including National Preventive Mechanisms (NPMs) and the CPT, remains an essential safeguard against ill-treatment. States should continue to guarantee access for monitoring bodies to all places of detention, including places where persons are kept in quarantine. All monitoring bodies should, however, take every precaution to observe the 'do no harm' principle, in particular when dealing with older persons and persons with pre-existing medical conditions." [83]

Given the possibility that our physical visits could affect our overarching duty to do no harm, we suspended them on 24 March once the first lockdown was announced.

On 8 April we reinstated MHA monitoring through digitally enabled contact with individual mental health wards, where we spoke to staff, patients, carers and advocates by telephone or video conference. We narrowed the visit focus to identify, support or seek response to the impact on patients of the COVID-19 pandemic.

As of the end of October, we have carried out monitoring of more than 355 wards (figure 14). We have spoken with over 1,000 patients and 570 carers.

Figure 14: **Remote monitoring 'visits' to mental health wards, April to October 2020**

April	May	June	July	Aug	Sept	Oct	**Total**
13	64	71	61	40	55	54	**358**

Source: CQC

Remote monitoring methods cannot entirely replicate the function of our ward visits. Reviewers are limited in what they can see and hear of the ward environment and culture of care, and contact with interviewees is largely facilitated by staff. This could compromise the anonymity of interviewees, and even raises the possibility of a certain amount of selection of patients we encountered.[84] This is a particular difficulty given our ongoing concern to identify and address 'closed' cultures, meaning deliberate or unintentionally

poor cultures that increase the risk of harm including abuse and human rights breaches.[e] In some cases, staff have been helpful in their support to us. For example, during video calls with MHA reviewers, some ward managers have provided a virtual tour of the ward with their tablet computer held face outwards, so that the MHA reviewer could both see and communicate with any person encountered and see the ward environment.

There were some aspects of our remote monitoring that we found improved our practice, and will continue after we return to on-site visits. For example, remote visits have facilitated a greater degree of contact with carers and families of detained patients, and with Independent Mental Health Act Advocates.

As the first lockdown eased, we restarted on-site MHA monitoring visits in cases of particular concern, using PPE. Throughout the pandemic, where we have had specific and urgent concerns, we have been engaging with services and have carried out on-site visits alongside CQC regulatory inspectors.

Independent Care, Treatment and Education Reviews

In May 2019 we published the interim report of our thematic review on the use of long-term segregation in mental health wards for children and young people and wards for people with a learning disability and/or autism.[85] We recommended that, over the following 12 months, there should be an independent and in-depth review of the care provided to, and the discharge plan for, each individual person subject to segregation in these circumstances, led by experts with the necessary experience including people with lived experience and/or advocates.

We were pleased that government agreed to this immediately and, led by the Department of Health and Social Care and NHS England and NHS Improvement, established a programme of independently chaired reviews building on the existing framework.[86]

Independent Care, Education and Treatment Reviews (ICETRs) are carried out by a panel comprising of an independent chair, Expert by Experience, clinical expert, commissioner and Mental Health Act reviewer. The focus of the ICETR is to make recommendations to improve the quality of care and treatment and to identify any barriers to discharge.

From 20 November 2019 to the end of the programme in September 2020, ICETRs reviewed the care of 77 patients. From 23 March 2020, these were digitally enabled in response to the first lockdown.

Common themes found in ICETRs showed serious failings in providing appropriate and suitable care to this group of patients. We found overly restrictive care; unsuitable environments and inappropriate placements with inadequate specialist involvement; poor discharge and/or transition planning; and failures of communication with patients, their families or carers.

Each ICETR resulted in a report by the independent chair, setting out actions for the hospital to take and NHS England and NHS Improvement to monitor.

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e   Closed cultures are more likely to develop in services where: people are removed from their communities; people stay for months or years at a time; there is weak leadership; staff lack the right skills, training or experience to support people; and there is a lack of positive and open engagement between staff and with people using services and their families. See CQC webpage, 'Our work on closed cultures'.

In addition, in three-quarters of cases, MHA reviewers on the panel were so concerned about the quality of care that they escalated it within CQC, leading to a range of activities such as raising concerns in engagement meetings; asking for action plans; doing focused inspections; and, in one case, closing the service down.

We have been working with Baroness Hollins, who chairs the ICETR oversight panel, over broader recommendations for policy and practice change. In October 2020 we published revised updated guidance on the regulation of services for autistic people and/or people with a learning disability.[87]

In some cases, ongoing segregation was not being recognised as long-term segregation in the terms of the MHA Code of Practice, and as such the procedural safeguards recommended by the Code were not in place.[88] In these cases, some services told us that they did not recognise the situation as long-term segregation because the Code defines this as an intervention to manage "a sustained risk of harm posed by the patient to others", whereas the patients in question were segregated because social contact could cause distress and therefore a risk of harm to themselves through behavioural disturbance.[89]

Under the MHA, we have a formal remit to advise the Secretary of State at any time as to the content of the Code.[90] We have asked the Department of Health and Social Care to reconsider the definition of long-term segregation in the Code, so as not to provide any excuse for services not to recognise situations as long-term segregation on what is, in our view, an irrelevant detail of definition. In the meantime, we will be urging services to accept that patients who are segregated for long periods of time for any reason should be afforded equivalent procedural reviews and conditions as the Code sets out for long-term segregation.

Complaints

On 11 May 2020, we made changes to the way we respond to people contacting us with a complaint about the MHA. To ensure that during the COVID-19 pandemic we are focusing on protecting the human rights of the most vulnerable people, we are prioritising contacts received from, or about, people who are currently detained on an inpatient ward in hospital. These contacts are then allocated to our MHA reviewers so that they can consider the concern raised and use their MHA monitoring powers to reach a resolution with the provider. These interventions over complaints have provided an opportunity for MHA reviewers to identify services for remote monitoring activity where a serious concern or high numbers of concerns have been raised.

Figure 15 shows the numbers of complaints received in each month from the start of 2019/20. In February 2020, the numbers of complaints received fell to about half the usually expected level, and only began to return to previous levels in May. In June and July we received more complaints than ever before. We have no certain explanation for this pattern: we cannot point to any material barriers posed by the pandemic to the making of complaints. It may simply be that people did not feel able or willing to make complaints at the peak of the pandemic, perhaps especially when it was clear that health

services were under stress. As such, the increased contacts we received when the crisis abated may be the result of deferred complaints. If there was such reticence to make complaints at the height of the crisis, in combination with the suspension of our physical visits, this would have increased the vulnerability of patients. This suggests a need to make increased efforts to promote our MHA complaints function in hospitals when COVID-19 restrictions are at their peak.

Figure 15: **Total complaints received by month, March 2019 to August 2020**
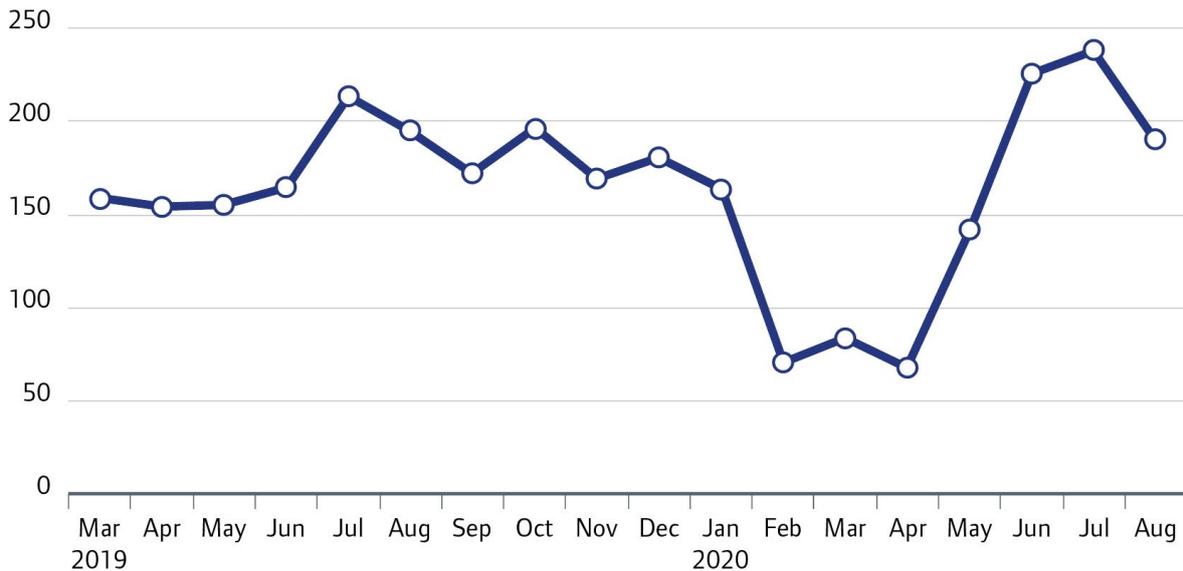

Source: CQC

The categorisations of complaints received suggests a considerable number deal with serious matters, such as alleged assault and abuse, and concerns for safety (figures 16 and 17). Many of these complaints will not progress to full investigation after an initial exploratory intervention (for example, detention and compulsory treatment may be itself experienced by some patients to be abusive, even if carried out with regard to the Code of Practice principles). However, it does seem likely, given our findings earlier in this report, outlined in the section on 'Patterns of Mental Health Act admissions and discharges during the pandemic', that some acute wards would have seen increased acuity in admissions that may have led to increased disturbed behaviour and a more unsettled atmosphere than usual. The restrictions imposed during the pandemic may have contributed to patient distress. Complaints that patients did not feel safe sometimes also referred to the pandemic itself and its management.

Figure 16: **Complaints received by month, March 2019 to August 2020: complaints over nursing care, safety, abuse, and medical treatment**
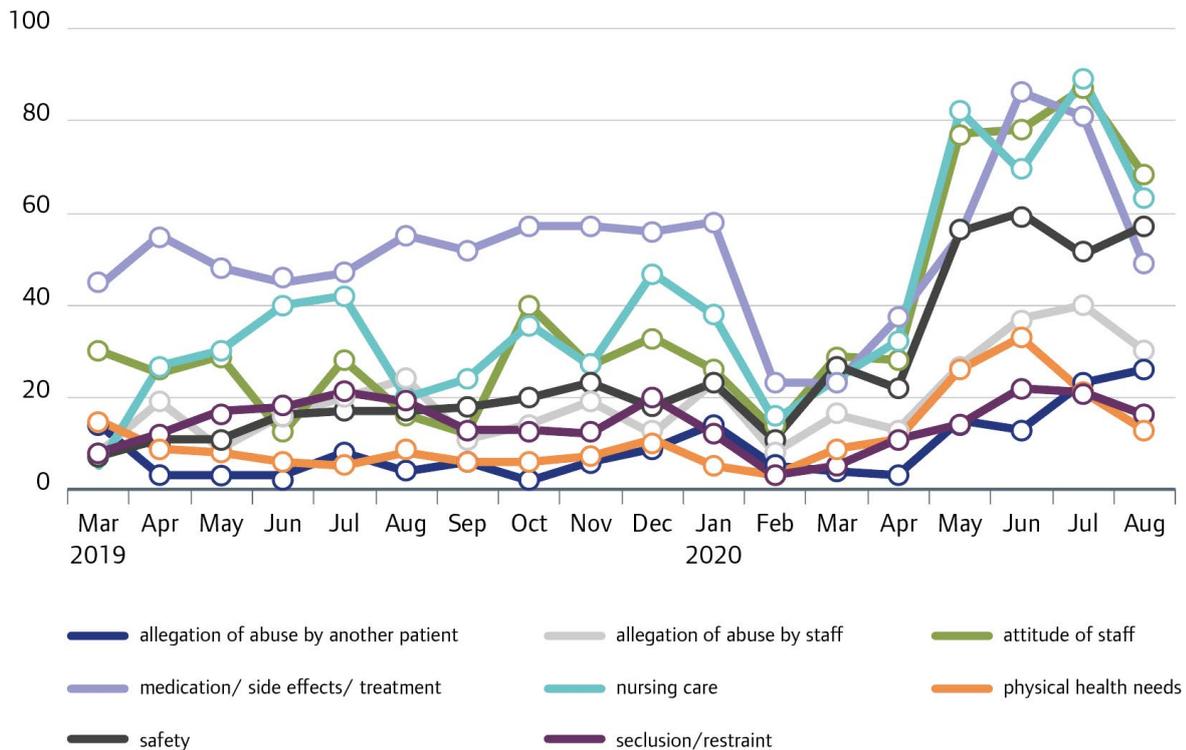
Source: CQC

Figure 17: **Complaints received by month, March 2019 to August 2020: communication, information, leave and facilities**
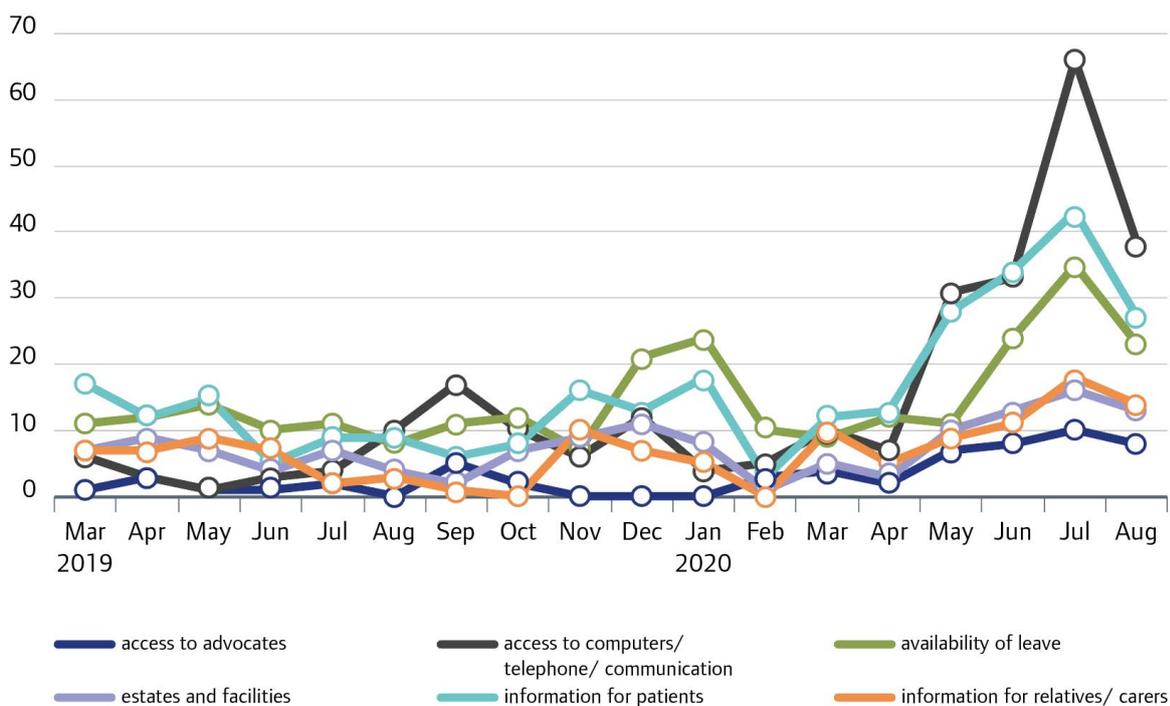
Source: CQC

Another possible explanation for the rise in complaints over June and July may be that patients felt services were too slow to undo specific measures introduced in the first lockdown, or too slow to address problems that emerged with such measures.

Complaints about the availability of leave of absence from hospital rose sharply from May to July. Complaints about problems with communications – including access to telephones and computers – were notable throughout lockdown, even though many services had increased access to mobile telephones and the internet to unprecedented levels. As we note above, this exposed many services' poor WiFi connections and IT infrastructure at a time when remote communications technology was more important than ever.

Statutory second opinions

On 18 March 2020, we moved the Second Opinion Appointed Doctor (SOAD) service to a remote system of assessment. Consultations are carried out by telephone and video conference. We ask the service to arrange telephone or, where possible, video consultation for any patients who wish to speak with a SOAD.

Under the new arrangements, SOADs send their certificates electronically to services, rather than sending paper copies by post. Our experience is that electronic certification offers improvements in accessibility, timeliness and data security and we welcome the regulatory amendment to ensure that this can continue (see also the section on 'Amendments to the Mental Health Act and delegated legislation').

Our reorganisation of the service on a remote basis has avoided the need for the suspension proposed through the potential 'easements' in the Coronavirus Act.

We are consulting on all of our COVID-19 pandemic methodology with patients, clinicians and others and will build this into any further development of our methodology in future.

Appendix B
Monitoring the MHA as a part of the UK's National Preventive Mechanism

The UK ratified the United Nations' Optional Protocol to the Convention against *Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT) in 2003. In doing so it committed to establish a 'National Preventive Mechanism' (NPM), which is an independent monitoring body to carry out regular visits to places of detention to prevent torture and other ill-treatment. An NPM must have, as a minimum, the powers to:

- regularly examine the treatment of persons deprived of their liberty in all places of detention

- make recommendations to relevant authorities with the aim of improving the treatment and conditions of persons deprived of their liberty

- submit proposals and observations on existing or draft legislation.

The UK NPM, established in 2009, consists of separate statutory bodies that independently monitor places of detention. CQC is the designated NPM for deprivation of liberty in health and social care across England. We operate as an NPM whenever we undertake regulatory or other visiting activity to health and social care providers where people may be deprived of their liberty. A key focus of our NPM visiting role is our activity undertaken in monitoring the MHA.

Being part of the NPM brings both recognition and responsibilities. NPM members' powers to inspect, monitor and visit places of detention are formally recognised as part of the UK's efforts to prevent torture and ill-treatment. At the same time, NPM members have the responsibility to ensure that their working practices are consistent with standards for preventive monitoring established by OPCAT. There is also an expectation that NPMs will cooperate and support each other internationally.

The Association for the Prevention of Torture, an international non-governmental organisation that works with NPMs across the world, has set out the following main elements an approach that prevents ill-treatment:

- **Proactive rather than reactive:** Preventive visits can take place at any time, even when there is no apparent problem or specific complaints from detainees.

- **Regular rather than one-off:** Preventive detention monitoring is a systematic and ongoing process, which means that visits should occur on a regular basis.

- **Global rather than individual:** Preventive visits focus on analysing the place of detention as a system and assessing all aspects related to the deprivation of liberty, to identify problems that could lead to torture or ill-treatment.

- **Cooperation rather than denunciation:** Preventive visits are part of an ongoing and constructive dialogue with relevant authorities, providing concrete recommendations to improve the detention system over the long term.

The NPM publishes an annual report of its work, which is presented to Parliament by the Lord Chancellor and Secretary of State for Justice. Its website is at www.nationalpreventivemechanism.org.uk.

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