Care Quality Commission

Monitoring the Mental Health Act in 2021/22

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Foreword

Over the previous 2 *Monitoring the Mental Health Act* reports, we have recognised the huge impact of the pandemic on inpatient mental health services and the extreme pressure that staff have been under. This year is no different – the effects of the pandemic continue to be felt, with increasing demand for services.

As stated in our 2021-22 State of care report, workforce issues and staffing shortages remain the greatest challenge for the sector. Not having the right staff levels and skill mix can prevent people from receiving the care and treatment they need, when they need it, and in the right environments. This can also have a detrimental effect on staff, with patients themselves telling us that they are concerned about staff wellbeing and the pressure they are under due to unmanaged workloads. Despite this, bright spots of good practice are to be found where services strive to be creative and flexible in a challenging environment.

Gaps in community care are adding to the pressure on mental health inpatient services, with many inpatient services struggling to provide appropriate places for people to receive inpatient care and treatment. As well as improving support in the community, more needs to be done to increase the availability of inpatient beds to ensure people who need treatment in hospital have access to the care they need. Currently, some areas do not have enough beds to meet this need, increasing the risk of people ending up in inappropriate environments. This continues to be a particular challenge for children and young people's mental health services with data from CQC notifications showing a 32% increase in the number of under 18s admitted to adult psychiatric wards in 2021/22 compared to 2020/21.

Where people need treatment in hospital, they should be able to access the inpatient services they need, for the shortest time possible, in a therapeutic environment close to home. Too many people, particularly people with a learning disability and autistic people, continued to be cared for in hospital settings far from home. As we have highlighted in other reports, people being placed in hospitals far from home and away from friends and family can increase the risk of closed cultures developing.

A closed culture is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm. Closed cultures, and the possibility of breaches of human rights, may occur across a wide range of health and social care settings. The knock-on effect of staff shortages, including the use of agency staff and the lack of continuity of care, are inherent risk factors in the development of closed cultures. However, we are particularly aware of the increased risk in services that care for people with a learning disability and people with a mental health condition.

Too many closed and abusive cultures persist. The light shone on people's poor experiences in recent media coverage should be the spur that leaders and stakeholders right across the board need to work promptly, transparently and

jointly, to prioritise the rights of people to be cared for in a safe environment that upholds and respects their dignity.

Yet again we are calling for urgent action to tackle the over-representation of people from some ethnic minority groups who are detained under the Mental Health Act, in particular the over-representation of Black people on a community treatment order.

It is now 20 years since the publication of Breaking the Circles of Fear, but progress in tackling long-standing inequalities in mental health care is woefully inadequate. We know from this and numerous other reports that the inequality faced by some people from ethnic minority groups is not just a result of current legislation, but is inexorably linked with wider personal experiences of racism, access to opportunities and socioeconomic circumstances. We want to work with stakeholders, including people who have experienced mental health services and their carers and families, to build on this research and drive real change.

As evidenced by NHS England's Advancing Mental Health Equalities Strategy, work is underway at a national level to build racial equality into mental health services. Despite this and proposals set out in the draft Mental Health Bill to address racial inequalities in mental health care, we are concerned about how these proposals will improve the care for people from ethnic minority groups, without measures such as investment in community services and culturally appropriate advocacy.

While these are systemic issues needing a system-wide response, change also needs to be driven at a practical level, between commissioning bodies and providers. For example, at a local level integrated care systems and services need to work together to take responsibility for identifying and addressing health inequalities. A key part of this will be improving how data to monitor equalities is captured and used.

We will continue to monitor how these challenges are being addressed, particularly in relation to inequalities.

Chris Dzikiti
Director of Mental Health

Summary

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

This report sets out CQC's activity and findings from our engagement with people subject to the MHA and review of services registered to assess, treat and care for people detained using the MHA during 2021/22.

How we work

CQC has a duty under the MHA to monitor how services exercise their powers and discharge their duties when patients are detained in hospital or are subject to community treatment orders or guardianship. We visit and interview people currently detained in hospital under the MHA, and we require actions from providers when we become aware of areas of concern or areas that could improve. We also have specific duties under the MHA, such as to provide a second opinion appointed doctor (SOAD) service, review MHA complaints, and make proposals for changes to the Code of Practice.

In addition to our MHA duties, we also work to highlight and seek action when we find practices that could lead to a breach of human rights standards during our MHA visits. This is part of our work as one of the 21 statutory bodies that form the UK's National Preventive Mechanism (NPM). The NPM carry out regular visits to places of detention to prevent torture, inhuman or degrading treatment. More information about this important role and our activities is at appendix B to this report.

Evidence used in this report

This report is based on the findings from our monitoring reviews of 609 wards carried out during 2021/22. These involved private conversations with 2,667 patients and 726 carers. We also spoke with advocates and ward staff. We have quoted from feedback letters from these monitoring reviews and, in the main, have not identified the services concerned, with some exceptions when we are describing good practice.

In addition, we have engaged at a policy level with a range of stakeholders in the use of the MHA, handled 2,434 new contacts in 2021/22 from patients and others, and took part in 82 Independent Care Education and Treatment Reviews (IC(E)TRs).

It is with thanks to all these people, especially people detained under the Act and their families, who have shared their experiences with us. This enables us to do our job to look at how services across England are applying the MHA and to make sure people's rights are protected.

Evidence in this report also draws on quantitative analysis of statutory notifications submitted by registered providers, complaints and/or concerns

submitted to us about the way providers use their powers or carry out their duties under the Act and activity carried out by our SOAD service. The second opinion appointed doctor (SOAD) service is an additional safeguard for people who are detained under the MHA, providing an independent medical opinion on the appropriateness and lawfulness of certain treatments given to patients who do not or cannot consent. While data validation and cleaning is undertaken in preparing the data for publication, this data can change over time as it is taken from a live system.

The evidence in this report has also been corroborated, and in some cases supplemented, with expert input from our subject matter experts and specialist MHA reviewers to ensure that the report represents what we are seeing in our regulatory activity. Where we have used other data, we reference this in the report.

Key messages

Workforce issues and staff shortages mean that people are not getting the level or quality of care they have a right to expect, and the safety of patients and staff is being put at risk.

Workforce issues and staffing shortages remain the greatest challenge for the mental health sector, with pre-existing difficulties exacerbated by the COVID-19 pandemic. Staffing shortages have affected patients' ability to access therapeutic care, with issues including a lack of involvement in decisions about their care, a reduction in ward activities and patients' leave being cancelled. We have heard that this lack of therapeutic interventions is increasing the risk of violence and aggression on the wards, threatening the safety of patients and staff. Issues with staffing shortages have affected how well staff are able to respond to these incidents.

The shortage of qualified mental health nurses is a systemic issue. Some providers have told us about how they are trying to mitigate staffing issues, including improving staff motivation, ensuring better skill mix of staff on duty, and increasing in-house training requirements. Others are seeking alternative solutions, such as employing ward managers and other professionals to substitute for nursing cover. However, this is having a detrimental effect on staff safety and wellbeing, with staff working under sustained pressure and having to take on responsibilities they may not be qualified for.

Gaps in community mental health care are compounding the rising demand on inpatient services, with delays in admission, transfer and discharge.

Demand for inpatient services has continued to increase in 2021/22. Gaps in community care is adding to the pressure on mental health inpatient services, with bed availability in many services running close to or above capacity. While some services are managing to accommodate patients without extended delays, many others are struggling to provide a bed, leading to people being cared for in inappropriate environments.

In particular, we continue to be concerned about the impact of the pandemic on children and young people's mental health services (CYPMH), with services struggling to meet rising demand. This is increasing the risk of children ending up in inappropriate environments, such as general children's wards. To manage delays to CYPMH beds, some services have been taking steps, including investing in new health-based places of safety, to care for people while they are waiting for a ward bed.

A lack of beds and gaps in community and social care services are also creating delays in discharging people from hospital. In some services this has led to the development of 'sub-acute' wards whose core purpose is to accommodate patients whose discharge from inpatient care is delayed.

Urgent action is needed to tackle the over-representation of people from some ethnic minority groups and, in particular, the over-representation of Black people on community treatment orders.

Despite numerous reports and plans for change, progress in tackling the over-representation of people from some ethnic minority groups subject to MHA powers, in particular the over-representation of Black people on community treatment orders, is too slow. Data from NHS Digital also shows that when ethnicity and deprivation are mapped together, the risks are interrelated.

We support the work underway at a national level to ensure racial equality is experienced across all mental health care, for example through the Advancing Mental Health Equalities Strategy and Patient and Carers Race Equalities Framework (PCREF). However, providers and integrated care systems must take responsibility for addressing health inequalities at a local level. More also needs to be done to understand why people from these groups are more likely to be detained under the mental health act, and what the barriers are to real change.

During 2021/22 we have seen some services taking a positive approach to addressing inequalities. This includes, for example, services identifying members of the staff team to take a leading role for diversity, promoting an equalities approach across wards and supporting staff and patients. In particular, we have frequently heard ward managers and others describe their service as a safe space for lesbian, gay, bisexual and transgender (LGBT+) people. However, further work is needed to ensure people feel respected and safe.

The quality of ward environments is an ongoing concern, with many inpatient environments in need of immediate update and repair.

We know how important it is for people to be cared for in environments that make them feel valued, with good quality spaces that respect their privacy and dignity. We have ongoing concerns around the physical environment and condition of wards, which has been made worse by the additional wear and tear created during lockdowns. Many inpatient environments are in urgent need of update and repair but are facing additional waits due to the backlogs in repairs created by the pandemic.

Where wards have been refurbished, we have seen the positive effects this had for patients and staff, with better physical environments improving patient experience and staff morale. However, the current state of repair and arrangement of many wards can have an impact on patient wellbeing. This includes issues around patients not being able to eat together and lack of lockable spaces for people to keep their belongings in.

The very nature of hospital environments means that they are not always suitable for the sensory needs of autistic people and people with accessibility requirements, such as hearing aids. The noise and bright lights of the hospital wards can cause people distress. In addition, we continue to have concerns around the use of dormitories and the non-therapeutic nature of these environments.

Despite the challenges facing services, we have seen examples of good practice around advance planning and applying the principle of least restriction.

We have found some good practice around advance planning for future care. However, we have ongoing concerns about how well people and their carers are being involved in care planning process. We also have concerns about the quality of people's care plans.

In addition, people need better access to advocacy support, and we welcome proposals in the draft Mental Health Bill to improve the availability and flexibility of Independent Mental Health Act Advocates (IMHAs).

Despite the pressures on many services, we have seen evidence of services continuing to take steps to apply the principle of least restriction. This includes challenging blanket restrictions and reducing the use of restraint. Services should continue to implement the Use of Force Act, and review their policies and procedures in line with it.

1 Staff shortages and the impact on patients

Key points

- Issues around workforce retention and staffing shortages remain the greatest challenge for the mental health sector, with pre-existing difficulties exacerbated by the COVID-19 pandemic and staff retiring or leaving for other jobs.
- Understaffing can affect the safety of patients and staff, with a lack of therapeutic interventions leading to an increased risk of violence and aggression on the wards. In addition, chronic staffing shortages have led to challenges around the ability of staff to respond to incidents, and to untrained staff being asked to take on responsibilities they may not be able to carry out safely. These factors can increase the risks of closed cultures developing.
- Staffing shortages have affected patients' ability to access therapeutic care, with a lack of patient involvement in decisions about care, reduction in ward activities, and patients' leave being cancelled.
- The shortage of qualified mental health nurses is a systemic issue, which has led to services seeking other solutions, such as employing ward managers and other professionals to substitute for nursing cover. However, this has led to staff taking on responsibilities they may not be qualified for, which is having an impact on their safety and wellbeing.
- A number of providers have told us about the work they are taking to mitigate staffing resource issues. This includes supporting staff motivation, ensuring a better mix of skills of staff on duty, particularly on night shifts, and increasing in-house training requirements.

In last year's Mental Health Act annual report we noted the impact of the COVID-19 pandemic on staff wellbeing and the knock-on effect this was having on staffing vacancies in the sector.[1] As highlighted in our 2021/22 State of Care report, issues around workforce and staffing shortages remain the greatest challenge for the mental health sector.[2]

During 2021/22, we have seen mental health services continuing to struggle with staffing levels. Staff sickness, including COVID-19 related sickness and self-isolation, have exacerbated difficulties posed by pre-existing staffing shortages.

Impact on patient care

Not having the right levels and skill mix of staff can affect services' ability to provide safe and effective care and treatment that is in line with the guiding principles of the MHA Code of Practice.

Through our monitoring visits, both staff and patients have told us that a lack of staff means people are not receiving the level and quality of care they have a right to expect. In one service, staff told us they did not have enough staff and recognised that the care they provided could be better if they had time to develop relationships with patients.

Staff reported that they were under a lot of pressure, with not enough staff to cover the work. They told me that they provided the best care that they could. They said that they could provide a better standard of care if they had time to develop relationships with patients.

Ward for older people with cognitive mental health conditions, mixed gender, August 2021

The importance of therapeutic relationships was reflected in feedback from patients who told us they preferred the staff they knew and had developed relationships with. However, we heard that patients were not always able to build these relationships because of the high use of agency staff. In some services, such as eating disorder wards, patients told us that agency staff seemed unfamiliar with their ward type, and as a result could appear unprofessional or unfeeling when working with them.

In our feedback to the Health and Social Care Committee on workforce in July 2022, we emphasised that reliance on agency staff who do not have an ongoing therapeutic relationship with patients can increase the risk of services using excessive levels of restraint and seclusion.[3] As we set out in our closed culture guidance, the use of restrictive practices including restraint and seclusion are both inherent risk factors and can be warning signs that closed cultures are developing.[4]

The ward did not have adequate staff to meet the needs of patients. There was a high use of agency and bank staff and this impacted on some patients care. For example, staff told us the patient in long-term segregation frequently had staff less familiar with him as he was nursed behind a locked door. This impacted on staff's willingness to open the door and engage with the patient. On the day of the visit we noted that the long-term segregated patient had one staff member who was new and the other was from an agency.

Assessment and treatment unit for patients with autism, April 2021

This year, we have continued to hear about the impact of staffing shortages on patients' access to therapeutic activities. This includes staff not having enough time to provide ward-based activities or one-to-one nursing, and

patients' leave being cancelled. Feedback from our MHA reviewers suggests that in some cases a lack of activities was also due to wards not putting these back in place following the COVID-19 pandemic. This lack of meaningful activities can affect patients' recovery.

Patients told us that staff were busy and more staff were needed, especially in the school holidays. Patients liked the activities that were available but told us that these got cancelled regularly and they watched films a lot instead. Patients told us that low staffing levels affected their access to regular named nursing sessions, supported activities and accessing the external areas. Staff were sometimes too busy to support access to the garden.

Acute ward for men and women, October 2021

Patients who I spoke with had mixed feelings about their care and treatment on the ward. They said that leave was cancelled most days because there were not enough staff to escort them. They also said that the sensory room, which could only be accessed with staff, was rarely used because there were no staff available to open it and support patients while using it. The advocate told me she had not seen any activities taking place on the ward since she started her post in January 2021 and leave was cancelled regularly.

Acute admission ward for women, April 2021

The availability of occupational therapists could affect what, if any, therapeutic activities were provided. In some services, occupational therapists or activity co-ordinators were only available during the weekday. This meant that on evenings and weekends it fell to nursing staff to provide these activities on top of their usual nursing tasks.

On some wards, we found that a lack of meaningful activities was in part due to vacancies in occupational therapy posts. On others, occupational therapy staff were being asked to help make up staffing numbers. While hospital managers in one service told us that this had helped in maintaining positive engagement with patients, having to cover nursing roles meant they were often not able to carry out their core role.

"There's been no meaningful activities, so you get from the patients that actually they're bored out of their minds and there's nothing happening. That's due to the fact that they didn't have an OT [occupational therapist], and you ask them how long there hasn't been an OT and they're like 'oh, well, months because we haven't been able to recruit one.'"

MHA reviewer

We have also seen the effect of staffing shortages on services' ability to follow least restrictive practices. This includes, for example, people having limited access to garden areas, with some patients telling us they were regularly unable to get fresh air. A number of services told us that staffing numbers or skill mix could affect whether they are able to open garden doors. As we raise in our guidance on closed cultures, failing to allow people to have regular access to fresh air could be an indicator of people's human rights being breached.[5]

All the patients that we spoke with told us that the ward was short staffed and that this affected many aspects of their care such as access to the garden, leave, visitors, activities, for example gym and communal rooms that required supervision such as the activity kitchen and laundry. One patient told us:

"I've been assessed and staff said that I should be able to use the kitchen and the gym but there are no staff to do it with me so I sit here colouring in everyday – and I had to buy those myself as well because the staff haven't got any resources."

Psychiatric Intensive Care Unit for women, September 2021

As highlighted in our last report, we continue to encourage services to challenge outdated, institutionalised and overly restrictive practices in favour of patient choice and a human rights-based approach.[6] We have seen examples of services taking steps to make improvements, including reviewing blanket restrictions, exploring availability of ward activities, improving patient access to staff for support, and increasing staff training to support patients in distress.

Impact on patient safety

Through our monitoring activities we heard how staffing shortages, and the lack of therapeutic activities, could put people's safety at risk. Patients told us that a lack of activities increased the risk of violence on the wards because people were bored. Staff shortages, and lack of appropriately trained staff, have also led to challenges around the ability of staff to respond to these incidents.

Patients described the ward as "violent" and some patients linked this to boredom. Patients on both wards told us there was not enough to do that interested them. Three patients commented that if you didn't like the activity or could not leave the ward you were left with nothing to do. We observed tension on the ward.

Acute wards for men and women, December 2021

Pressures caused by understaffing are creating issues with observation checks. In some cases inexperienced staff are given tasks, such as constant observation, that may be inappropriate for their level of training and responsibility. In other cases, we heard that staff shortages had led to observation checks being missed because staff were too busy. In addition, we heard of patients being left isolated, leading to concerns for their safety.

One patient told me that observation checks on patients were regularly missed by ward staff as they were too busy. They had timed their own observation checks and confirmed that they were not consistently carried out.

Acute ward for men and women, June 2021

When we started our visit, we found there were 12 staff on duty when the ward stated they needed 17. The 12 staff were needed to cover the constant observations which left no staff to deal with patients on intermittent observations, to administer medicines, complete seclusion reviews or complete other tasks. One patient told us that there weren't always enough staff so they could go off the ward. One carer said there were not always enough staff for them to take the patient off the ward. This carer felt seeing the patient on the ward was not always safe as staff were not available or nearby if there was an issue.

Assessment and treatment unit for patients with learning disability, March 2022

In particular, staff shortages are having a negative effect on patients who need constant observation. Enhanced, continuous observation provides an opportunity for prolonged therapeutic engagement. However, it can be difficult and exhausting for both patients and staff. As a result, we were concerned to see staff carrying out constant observations of particular patients for long periods. On one ward, staff told us they could be observing the same patient for over 8 hours without breaks, which MHA reviewers felt could have an impact on the quality of care patients receive.

We were told by senior staff that staff changed observations every 2 hours. This was not the case during our visit. Ward staff stated it was usual practice to be on constant observations for prolonged periods without breaks. During our visit, staff had been on the same patient observations from 7.30am to approximately 4pm and had not been able to take a break…

We are seriously concerned about the quality of the observations, alertness levels of staff and their wellbeing as well as the welfare of the patients. At the time of our visit there were not enough staff to enable ward staff to take a break from enhanced observations. Staff told us they moved from observation to observation. Staff looked worn out. This potentially could have an impact on the delivery of care to patients.

Learning disability ward for men, October 2021

Understaffing makes it difficult for any member of staff to give their full attention to their tasks at any point in time. For example, at one mental health ward for children and young people, patients told us that they were waiting for staff support. We witnessed staff being pulled in multiple directions and having to continually reprioritise the tasks at hand. Consistent staff shortages can be an inherent risk factor in the development of closed cultures.[7]

We observed that:

- *both registered nurses had to stop doing essential tasks on several occasions due to the need to reprioritise.*
- *registered nurses and the specialist nurse spent significant periods of time trying to juggle staff rotas to cover gaps and observations on the ward.*
- *staff were being asked to change what they were allocated to do and at times staff needed to recheck what they should be doing.*
- *a student nurse was asked to do a task that they seemed inexperienced to do.*
- *staff were rushing to complete tasks before deadlines, for example contacting the patient's bank 5 minutes before it closed and checking there was adequate medication for the weekend just before the deadline.*

Children and young people's mental health ward, October 2021

To address concerns related to understaffing, services told us about steps they were taking including, for example arranging training and support for staff, closer monitoring of staffing issues by managers, and more one-to-one protected time for patients and nurses. Other steps included employing additional activity co-ordinators and involving psychology staff in debriefs following incidents.

Staffing and staff welfare

A number of providers have told us about the actions they are taking to mitigate staffing resource issues. This includes employing ward managers, matrons and other professionals such as occupational therapists to substitute for nursing cover. In addition, we have heard of services moving substantive staff around hospital sites to provide cover, and staff working additional shifts. However, the juggling of staff cover across hospital sites can lead to periods of dangerous understaffing. For example, on one ward patients and staff told us how low staffing had led to staff working alone.

> *Patients and staff reported that the staffing establishment was too low to provide safe care and treatment. Patients and staff told us that shifts regularly ran on less than the establishment, had inexperienced or unfamiliar staff and did not have enough female staff to support the female side with observations and physical care. Staff told us that on occasions staff were working alone on the male side as others were pulled into the numbers on the female side.*
>
> **High dependency rehabilitation service,** July 2021

Hospital managers have told us about the challenges they face in managing staff shortages and skill mix. Agency nurses can earn substantially more than permanent NHS staff, and pay can be even higher for night shifts. This can affect the morale of permanent staff. For example, substantive staff in one unit told us that they felt that they had to work twice as hard for a much lower salary than agency staff, and that this potentially caused bad feeling.

It can also mean that it is difficult to ensure a mix of permanent and agency staff on night and day shifts. As a result, agency workers may not have the level of support and supervision they require. Many patients have told us that they dislike the fact that night-shift staff are largely unknown to them and that this makes them feel vulnerable. As stated in our guidance How CQC identifies and responds to closed cultures, we know that a high use of poorly inducted agency staff who do not know people's needs can be a warning sign of a closed culture.[8]

Some services are making additional efforts to ensure there are more permanent staff on night shifts so there is a better skill mix. Others have increased in-house training requirements as well as talking to staffing agencies about the training they provide.

The ward manager told us that she was aware of some issues around closed cultures within the night staff team when she started in post. Two members of staff have since left and issues appear to be resolved. The ward manager has also requested that night staff work some day shifts so that they can keep in touch with the ward ethos. She has also started a 6-monthly rotation for staff between the 2 wards which has received mixed reviews. Two staff were not happy and have left but other staff have embraced the new experiences and challenges.

Wards for older age adults, May 2021

We have also seen some services hiring staff from a limited pool of agency or bank staff to maintain continuity of staffing as much as possible. One provider told us that this has been made more difficult by changes to off-payroll working rules from April 2021 (IR35 legislation).[9] This meant that block booked agency or bank staff were choosing not to continue to work at its hospital. Services are also looking at packages to offer staff for recruitment and retention, including recruiting from overseas.

Many services hold frequent safe staffing meetings to review staffing resources across units, to anticipate and request bank and agency cover in advance of need. Some services have a constant 'dynamic' staffing allocation, to expand and reduce teams to mirror the needs of patients on each ward.

We have a proactive weekly 'huddle' that takes place each Friday chaired by the service manager along with all ward managers to review the staffing going forward for the next 7 days. At this meeting any gaps are identified, and plans are put in place to ensure that the wards are staffed to the establishment levels. The Daily Demand Management (DDM) meeting then reviews the dynamic staffing needs for the day covering all adult mental health wards including the rehabilitation inpatient units. This review identifies where the acuity peaks are balanced against our staffing profile, then if required staff are relocated to ensure that wards can deliver safer care. This DDM process also reviews the number of qualified staff available on each ward, ensures that preceptor [newly qualified] nurses are working alongside another qualified nurse, and that there are sufficient staff to effectively manage and lead ward rounds.

Redwood acute unit, Highbury Hospital, Nottingham Healthcare NHS Foundation Trust, July 2021

Some services continue to maintain cohesive and stable teams. Good management and support of motivated staff is a key factor in this. The geographical location of units can be another factor. Some units have little staff turnover because staff are settled and happy where they live. Others are in areas that struggle to attract staff for reasons ranging from expensive costs of living in some local areas, to lack of amenities and housing stock in others. Services situated in commuting distance of other units offering London-weighted pay can also struggle to recruit. Units that report stable staffing appear most likely be valued by staff and patients.

Patients told us:

"This ward is by far the best and I have seen a variety of hospitals"

"Everybody feels like family"

"Nurses speak to you like a human being"

"It is brilliant here. It has uplifted me"

"All the staff are great, caring and calm"

The staff told us:

"Considering the year we have had we have done exceptionally well"

"I love working here"

"The team is like a family. You feel safe. You will be backed up"

"Our ward is so well organised"

"The manager is literally the best"

"The consultant is always on the ward, very present"

Waterston ward (acute for men and women), Forston Clinic, Dorset Healthcare Trust, April 2021

However, many of the current measures to address staffing issues are not sustainable – the shortage of qualified mental health nurses is a systemic issue, which requires a system-wide response. These measures are also having a detrimental effect on staff wellbeing, with patients themselves telling us they were concerned about staff being overworked and exhausted.

Patients noted that staff were working extra hours to avoid agency staff being used, which they appreciated, but they were concerned about staff being overworked, exhausted and strained.

Personality disorder unit for women, November 2021

2 Pressures on services and patient pathways

Key points:

- A lack of community service alternatives is putting pressure on mental health services, with demand for inpatient services continuing to increase during 2021/22. Bed availability in many services is running close to or above capacity, leading to delays in admission, transfer and discharge.
- While some services are managing to accommodate patients without extended delays, many others are struggling to provide a bed. This can lead to people being cared for in unsuitable environments, such as health-based places of safety or psychiatric intensive care units for prolonged periods.
- Lack of beds and gaps in community and social care services are creating delays in discharging people from hospital. In some services this has led to the development of 'sub-acute' wards whose core purpose is to accommodate patients whose discharge from inpatient care is delayed.
- The impact of the COVID-19 pandemic on children and young people's mental health (CYPMH) services continues to be felt, with services struggling to meet rising demand. This is increasing the risk of children and young people ending up in inappropriate environments, such as general children's wards. To manage delays to beds on CYPMH wards, some services have been taking steps, including investing in new health-based places of safety, to care for people while they are waiting for a bed.

In both our 2019/20 and 2020/21 annual reports, we raised concerns about the increasing demand for services, which has been exacerbated by the COVID-19 pandemic. As reported in our 2020/21 State of Care report, this increasing demand, combined with a lack of capacity in community mental health services, means that people are not getting the care and support they need when they need it.[10] This was supported by the findings of our provider collaboration review on mental health care of children and young people during the COVID-19 pandemic. For example, one system told us how staff from a GP out-of-hours service felt there was no point in referring on to CYPMH services as demand and thresholds were so high.[11]

Similarly, in our community mental health survey 2021 41% of all respondents reported feeling they had 'definitely' seen NHS mental health services often enough for their needs in the last 12 months. This was the lowest score across the period from 2014 to 2021.[12]

Not being able to access the right care and support when it is needed increases the risk of people's mental health deteriorating, and people being admitted to mental health services with more severe mental ill-health.[13]

As part of NHS England's plans to improve mental health outcomes, the 2016 Five Year Forward View for mental health and subsequent action plan set out an ambition for Crisis Resolution and Home Treatment Teams (CRHTTs) to offer intensive home treatment as an alternative to acute inpatient admission

in each part of England by 2020/21.[14] NHS England reinforced their commitment to this aim in the NHS Long Term Plan.[15] However, the impact of the pandemic will have stalled a full implementation of this aim, while increasing demand. Staffing shortages will continue to frustrate the aim for some time to come.

Through our work looking at the progress from our thematic review 'Out of sight – Who Cares?',[16] NHS England and NHS Improvement told us they are also investing £2.3 billion of additional funding in mental health services by 2023/24 as part of the NHS Mental Health Implementation Plan. Some of the investment includes:

- almost £1 billion additional funding for new models of integrated primary and community services for adults with serious mental illness
- around £300 million in enhancing adult mental health crisis services, including a range of alternative crisis services in every part of the country
- all mental health crisis services to be 'open access', through 24-hour urgent mental health helplines, by 2024. This means that anyone can self-refer and there should be no exclusions. NHS England and NHS Improvement will share guidance on making reasonable adjustments for people with a learning disability and autistic people who call these lines
- ring-fenced investment in models such as crisis houses, sanctuaries and crisis cafes in all parts of the country.

While we welcome this additional funding, current gaps in community support mean that demand for inpatient services has again grown during 2021/22. This, combined with issues around staffing and bed availability, is putting pressure on inpatient services.

The development of integrated care systems (ICSs) as new commissioning models may be an opportunity for a more joined-up review of service provision, in the widest sense, across local areas.

Pressure on inpatient services

In February 2022, NHS Confederation published their report 'Running hot: the impact of the pandemic on mental health services'.[17] This showed the effect of increased demand on inpatient services, with services reporting a steep rise in the severity of the mental health needs of the people presenting to their services after the pandemic, and highlighted the pressure this is putting on them.

This echoes the findings from our MHA reviewer visits, with many mental health services telling us they have been busier since the COVID-19 pandemic, both in terms of volume and acuity of cases presenting to them. Acuity is defined as the severity of illness and/or level of attention or service required from professional staff.

The ward had experienced an unprecedented demand and you had observed that admitted patients had been more acutely disturbed than usual. You considered this to be due to the limitations placed on community services by the lockdown restrictions, meaning that relapsing and distressed patients were not being seen sufficiently to spot and address early signs of relapse. Furthermore, the strain of the last year has been felt by the whole community, thus likely negatively impacting on the general mental health of those vulnerable to mental illness.

Psychiatric Intensive Care Unit, May 2021

However, in line with last year's report, many services are running close to or above bed capacity. As highlighted in our 2018/19 and 2020/21 reports, high bed occupancy may also be a factor in rising levels of detention under the MHA.[18]

We have seen examples of wards that cannot physically accommodate all of their patients, even taking overnight leave into account. This is leading to contingency-planning arrangements for some patients to 'sleep-over' on other wards, which can disrupt their care and that of other wards' patients.

The [rehabilitation] ward had patients on the ward on what was described as a 'sleep-over'. These patients remained on the acute wards patient numbers rather than this wards patient numbers. While bed management tried to ensure the patients transferred to this ward fitted with the patient group this was not always possible. We were concerned that staffing on the ward may not reflect the increase in patients, as the acute ward patients were not within this ward's patient numbers. We were also concerned that these patients may not receive the care they needed or that their risk might not be fully understood or managed on the ward. There was a risk these patients fell between 2 different teams as the ward multidisciplinary team was different to the acute ward's team.

Rehabilitation ward for men, July 2021

We have also challenged services where they have routinely used seclusion rooms as bedrooms. By necessity, seclusion rooms are less welcoming spaces for patients and will rarely meet the standards of other patients' rooms. It also creates a problem should the ward need to use the seclusion room for its intended purpose.

You told me that the ward had 6 beds and that all were single occupancy rooms with toilet and shower. You told me that the ward had, on the day of the remote visit, 7 patients. You explained that the additional patient was located in the low stimulus/seclusion room. When I asked how often this happened you confirmed that use of the seclusion room as an ordinary bedroom was routine. Following a comment in the previous report you acknowledged that the routine use of the low stimulus/seclusion room as a bedroom remained in place with consequences in terms of the use of the room as a bedroom and the need to re-allocate bedrooms when a seclusion room was required.

Psychiatric Intensive Care Unit, May 2021

While some services are managing to accommodate patients without extended delays, many others are struggling to provide a bed. This can leave patients in crisis in vulnerable and unsafe positions, places community services under additional strain, and leads to people being cared for in unsuitable environments, such as health-based places of safety, for prolonged periods.

Under sections 135 and 136 of the MHA, patients may be admitted to a health-based place of safety for up to 24 hours. However, we have found that this time limit is regularly breached because of delays in accessing an inpatient bed.

In some services, we continue to find health-based places of safety being used as 'swing beds' attached to inpatient wards, with patients being held there until a bed becomes available. This can have the effect of worsening the overall situation, by preventing further admissions to the health-based place of safety.

A number of services have told us that the health-based places of safety are often fully occupied, so people are routinely taken to emergency departments. This echoes the concerns raised in our 2021/22 State of Care report, where we reported that we have continued to see increasing numbers of people in crisis and in need of support attending emergency departments.[19]

We have similar concerns around the pressure on psychiatric intensive care units (PICUs). These small, highly staffed units are designed to provide short periods of rapid assessment and intensive treatment, and help to stabilise patients before or during admission to inpatient care.[20] The PICU model relies on services' ability to manage admissions and discharges according to clinical need. Shortages of inpatient beds elsewhere can lead to use of PICU even though this is not the most appropriate clinical environment, and to discharge or transfer delays from both independent and NHS PICUs. Such delays create barriers to new appropriate admissions, with knock-on effects across patient pathways through inpatient care.

Discharge delays

As well as increasing pressure on inpatient services to admit patients, gaps in community and social care services can also lead to delays in discharging patients from hospital.

For example, at one PICU we visited we noted the delay in discharging a patient who was no longer detained under the MHA. We raised concerns that the restrictive environment of the PICU was not suitable for the person as an informal patient and was not following the principle of least restriction. In response, the unit took steps to support the person in line with least restrictive practices, and ensure the patient was transferred at the earliest possible opportunity.

This was not the only example we found where people have been discharged from formal detention but remain in hospital because of external delays. This has led, in some services, to the development of 'sub-acute' wards whose core purpose is to accommodate patients whose discharge from inpatient care is delayed. In other cases, external delays mean that people have remained detained under MHA powers, potentially past the time when this would be clinically justified.

> *The ward is an 8-bed ward for men and women who require additional time in hospital due to external delays which prevent discharge. It is part of the transition model within sub-acute care service and provides for patients who can be cared for in a less restrictive setting in preparation for discharge… Patients told us that they were in hospital because they had nowhere to be discharged to. They told us they were homeless, waiting for different accommodation or waiting for supported accommodation.*
>
> **Sub-acute ward,** June 2021

Planning for discharge and aftercare should begin from admission, and include social work input across every patient's pathway through services. However, we are concerned that social work support to some inpatient services has reduced during 2021/22.

On a visit to a forensic low secure unit in September 2021, we were told that the restructuring of community services meant social workers were no longer being allocated to the wards. As a result, requests for specific interventions had to be made via a referral. Staff told us that this reduction in the availability and input of social workers could lead to delays in patient pathways. Staff were also concerned that the time they spent completing health funding application forms was more time away from patient engagement. While the trust told us that this was an interim arrangement, it is clear that these types of arrangements cannot provide the best possible service to patients and their families.

Staff raised concerns regarding delayed discharges on the ward. The hospital holds a weekly delayed transfer of care meeting where delayed transfers of care patients are discussed with other agencies such as the local authority. Staff said patient discharges are delayed due to approval of funding for placements, sourcing an appropriate care/nursing home and the allocation of a social worker. Carers raised their frustration regarding delayed discharges but stated staff kept them up to date with any changes.

Admission ward for older adults, February 2022

Delays in discharge can be made worse where people have been placed in hospitals out of area. For example, this can increase challenges around communication with community mental health teams and securing appropriate community support back in the person's local area.

In addition, as highlighted in last year's report, it can also lead to issues around which local authority area is responsible for paying for the person's care. This year, we have seen many examples of delays due to commissioning and local authority disputes over who should be responsible for providing or paying for aftercare, together with problems with social care funding and placements.

All of these issues can have a negative impact on patients and lead to them staying longer in hospital.

Most patients were concerned about the distance they were from their homes. Patients felt they were disadvantaged due to this. Three patients told us they were waiting for suitable accommodation. The ward manager told us the average length of stay was approximately 45 days, and that at least 3 patients were delayed discharges. The ward manager told us about some of the difficulties with communication with external stakeholders from certain regions. These issues meant some patients were not discharged as quickly as they could be.

Acute ward for women, August 2021

Children and young people's mental health services

The broader problem of lack of capacity in mental health services, together with increased demand, is also seen in services for children and young people. Demand for these services has continued to increase during 2021/22. We have seen evidence of this increased demand leading to delays in people accessing help, and people being cared for in inappropriate settings such as acute medical units and general children's wards, sometimes for extended periods.

Children and young people who are being cared for in unsuitable settings are at increased risk of poor experiences when moving services and poorer outcomes. Care and discharge planning can be disjointed, staff can feel unprepared and unsupported, and the child or young person and their parents or carers can have a negative experience of care. In October 2022, we published our brief guide on the care of children and young people in unsuitable hospital settings, which shows the measures we hope to see to improve the suitability of placements.[21]

Carers commented on waiting too long for initial help, or struggling to get their children into hospital in a crisis. Children and adolescents are often subject to delayed admission, sometimes spending long periods in health-based places of safety or in the community. Some parents described difficulties with admission to the ward. For example, one patient was detained to a health-based place of safety for 5 days before admission.

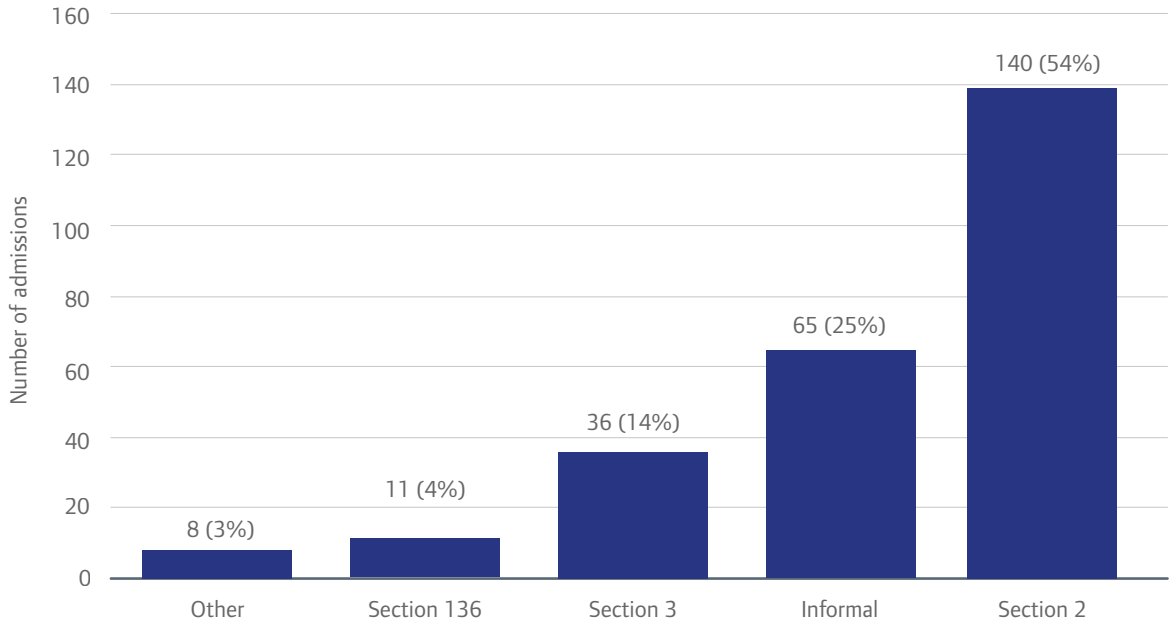
Children and young people's mental health ward, July 2021

Under the MHA, hospital managers have a duty to ensure that children and young people are cared for in an environment that is suitable for their age and needs.[22] Where a patient under 18 years of age is admitted to an adult ward for longer than 48 hours, the hospital managers must tell CQC.[23]

In 2021/22, these notifications showed there was a 32% rise in the number of under 18s admitted to adult psychiatric wards (260 admissions in 2021/22 compared with 197 in 2020/21). The main reason given for admitting the child to an adult ward (70%, 182 admissions) was because there was no alternative mental health inpatient or outreach service available for children and young people. In over half of the notifications received, providers recorded that the child needed to be admitted immediately for their safety (58%, 152 admissions). Only 13% of providers recorded that admission to the adult ward was clinically preferred and 4% that it was socially the preferred option. (Note: these figures are an update to those we reported in this year's State of care report, following updated analysis of the notification returns.)

Most of the admissions were under the MHA, with the most common legal status at admission (54%) being the MHA section 2 power of admission for assessment and/or treatment, lasting up to 28 days (figure 1).

Figure 1: **Admissions of children and young people to adult wards for longer than 48 hours, by MHA section, England, 2021/22**



Source: CQC, notifications data, 2021/22.

An MHA visit to a general children's ward

On an MHA review of a children and young people's mental health (CYPMH) ward in 2021, we found that 6 out of 7 of the people on the ward were transferred from the local general children's ward, rather than another mental health service. In response, in November 2021 we carried out an MHA monitoring visit to the local general children's ward and children's emergency department where the children and young people were being referred from.

We found that the number of children and young people with mental health problems, and the severity of their mental health needs, had dramatically increased during the pandemic. Before the pandemic, we heard the children's emergency department saw an average of 10 to 15 children and young people each month. This had risen to an average of 50 cases each month in the summer of 2021.

Staff in the children's emergency department told us that in order to keep patients who needed a CYPMH inpatient bed safe, they felt they had little choice but to admit them to a general children's ward. As a result, we were concerned these patients were not getting access to the full range of mental health care and treatment they needed. It was clear that staff on the frontline were under a level of pressure they had not experienced before. We were concerned about the personal impact on individuals, as well as morale overall, as they had to deal with ever increasing numbers and levels of acuity, which required a complex skill mix to be developed on the job.

The head of nursing for mental health in the acute hospital was committed to providing good quality services for patients with mental health needs. As well as plans to develop future joint services with CYPMH, we heard about plans for a psychiatric liaison service for under 18s and that the trust was considering putting in place a joint children's assessment unit shared with the mental health trust.

Without access to the right care at the right time, we have also seen children and young people ending up in emergency departments or health-based places of safety. Even with designated mental health spaces, emergency departments can be unsuitable places to hold and assess people with mental health needs.

We have concerns about safety in the event of an incident at the emergency department. For example:

- *people waiting for a mental health bed when the department closes at 10pm remain under the care of a lone staff member until transferred to a mental health ward. Staff told us they contacted porters or, in one case, the car park attendant, to provide support. Staff can activate a personal alarm in the event of an incident, but there may be little or no response in an area that has closed for the night.*
- *none of the hospital's staff have been trained in restraint; there are no security personnel based on site.*

Review of MHA admission pathways, West Midlands, November 2021

Where there are delays in accessing a mental health bed for children and young people, health-based places of safety can often be the least worst option. These are generally self-contained, relatively modern built environments and, if staffed appropriately, may be a tolerable experience for patients, provided the situation does not extend over many days.

Some CYPMH services are investing in dedicated health-based places of safety, echoing the model in adult acute care. While this is a welcome development, services should monitor the local use of section 136 powers for children and young people, as high use of this power could indicate gaps in service.

As highlighted in the section on staffing and impact on patient care, staffing shortages can also lead to delays in children and young people accessing mental health inpatient care. This includes shortages in specialists to carry out assessments, as well as issues with staffing levels on inpatient wards. In some cases, this has led to services reducing bed numbers. For example, on our visit to one CYPMH hospital in March 2021, we heard how issues with staffing levels and problems with recruitment had led to the hospital reducing its capacity by half, leaving 11 beds to serve the whole county in which the hospital was

located. At the time of our visit there were 26 children and young people from the county being accommodated in out of area mental health beds.

As noted in this year's State of Care, we are particularly concerned about delays in accessing eating disorder services, with some mental health units for children and young people struggling with increasing numbers of patients with eating disorders and higher levels of distress and clinical need.

The hospital had closed admissions to the ward due to the acuity of the current patient group. Staff told us the ward was seeing an increase in patients with a diagnosis of either an eating disorder or disordered eating requiring admission to a psychiatric intensive care unit. Staff explained they were not appropriately trained in caring for patients with these diagnoses. They had received support from the dietician and the eating disorder ward on site. All the qualified nursing staff were qualified in nasogastric tube feeding. At the time of our visit most patients on the ward had either an eating disorder or disordered eating. Staff had told us concerns had been escalated to NHS England.

Psychiatric Intensive Care Unit for children and adolescents, September 2021

As with other mental health services, CYPMH inpatient services are operating above recommended levels of occupancy and many have delayed discharges due to blockages in other parts of the care pathway. In some cases, we have seen patients remain in such placements beyond the age of 18 as they await a suitable follow-on placement.

The consultant psychiatrists told us that:

- *at least 5 out of 7 young people were awaiting community placements, which was due to blockages in social care and brokerage.*
- *parents, foster parents, social care and schools could be reluctant to shorten admissions as they did not wish to take on the risk.*
- *there were considerable backlogs in the local London boroughs involving children, especially looked after children, and insufficient staff to deal with the outstanding cases.*

Child and adolescent unit for patients with brain injury, severe learning disabilities or an eating disorder, April 2021

Pathways for people with a learning disability and autistic people

Care for people with a learning disability and for autistic people is still not good enough.

Two years ago, our report 'Out of sight – Who cares?' shone a light on the consequences of people not getting the right care and support in the community when they need it. This, we highlighted, can lead to crisis point and admission to a mental health hospital.[24] We also raised our concerns that while admission to hospital – where it is appropriate at all – should be temporary. However, poor environments, lack of discharge planning and difficulties in finding suitable community placements were leading to people staying in hospital for years.

In last year's report, we published the findings from our thematic reviews and involvement in the Independent Care (Education) and Treatment Reviews (IC(E)TRs). This again showed that a lack of community alternatives and poor commissioning decisions had led to people being admitted to hospitals that were a long way from home for prolonged periods of time. Over a third of the people we reviewed had been in hospital for between 10 and 30 years.[25]

In March this year, we published our update report on the progress made since our Out of Sight report.[26] Of the 17 recommendations made, we found that just 4 had been partially met and 13 had not been met. We also found that too many people with a learning disability and autistic people are still in hospital, many of whom are often subject to extreme delays in being discharged.

Being placed in hospitals that are far from friends, family and support networks for prolonged periods can increase the risk of closed cultures developing. This is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm.

While much of the focus on this group of people has centred around specialist assessment and treatment units, many people with a learning disability and autistic people are also stuck in other types of inpatient mental health services. These are often not therapeutic environments, with services struggling to meet people's needs.

> *There were some patients who were accommodated on the ward long term. Some of these patients were autistic. This was not a suitable environment for people to stay on a long-term basis. Despite the efforts of the staff team, we heard that there was too much sensory overload on the ward for this patient group.*
>
> **Psychiatric Intensive Care Unit,** November 2021

We welcome plans in the draft Mental Health Bill to stop using the MHA to detain people with a learning disability or autistic people in hospital where this is the sole reason for detention. Having a learning disability or autism can never justify this type of hospital care. However, we remain concerned that a lack of early intervention services in the community to avoid crisis and hospital admission, alongside a lack of community-based, bespoke placements is leading to people being detained in hospital. This, together with a lack of appropriate resources will lead to people continuing to be institutionalised through some means or other.

As an organisation, we are committed to improving the quality of care in community-based supported living services across the country. As outlined in our strategy, a key part of this will be listening to the experiences of people who use services. We believe that they, their unpaid carers, families, friends and advocates are the best sources of evidence about their lived experiences of care and how good it is from their perspective.

While we are aware of the pressure on commissioners to provide for people moving on from hospital care, our role is to ensure that any new service meets our Right support, right care, right culture guidance and will provide the best possible care for autistic people or people with a learning disability. We currently refuse a substantial proportion of applications to register services with us due to inappropriate models of care or the applicant's poor understanding of how care should be delivered. Over the last year we have also taken more enforcement action against adult social care providers of services for people with a learning disability and autistic people.

We are aware that people with a learning disability and autistic people may have mental health needs, unrelated to their disability or neurodiversity, that may need admission to a mental health hospital. As a result, services need to ensure that they are able to meet the needs of people with a learning disability and autistic people. In particular, they need to make sure that staff have the skills and training required to care for these people.

One patient said that staff did not have the right training and skills to work with his autism, leading to frustrated behaviour that is not de-escalated but rather resulting in unnecessary seclusion. In addition, one member of staff independently raised that staff on the ward had concerns about not having specialist training in autism. The training had been requested by staff on multiple occasions.

Low secure learning disability unit, February 2022

Lack of appropriate staff training and support in caring for autistic people is likely to seriously limit the quality of people's care. It can also contribute to longer hospital stays and to patients staying in secure services for prolonged periods.

One patient had a diagnosis of autism and had spent a significant amount of time in seclusion. However, there did not appear to be anything in her care plans regarding the specific support she needed in respect of her autism. There was no sensory needs assessment or care plan, no positive behaviour support plan or any plan regarding the use of restrictive interventions. We could not see any psychological assessment or formulation. We noted that this patient had been referred to forensic services and we were concerned that this had been done when it appeared that not all options to provide treatment to this patient in a less restrictive setting had been explored.

Acute ward for women, February 2022

From 1 July 2022, a new legal requirement introduced by the Health and Care Act 2022 requires all CQC registered providers to ensure their staff receive learning disability and autism training at a level appropriate to their role. This applies to all settings, including mental health hospitals, and providers need to consider the training needs of staff who deliver care directly as well as administrative staff, for example reception staff and call-handlers.

To support this new legislative requirement, the government is rolling out the Oliver McGowan training package. Co-designed by autistic people, people with a learning disability, family, carers and subject matter experts, this training is intended to ensure that health and social care staff have the skills and knowledge to provide safe, compassionate, and informed care.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) are an important part of the Mental Capacity Act (MCA) 2005 legislation. The DoLS can be used in care homes and hospitals of all types, and they are a vital safeguard to ensure that where someone who lacks capacity to consent is deprived of their liberty, this deprivation of liberty only occurs if necessary, proportionate and in their best interests.

As highlighted in our 2021/22 State of Care report, we are concerned that ongoing problems with the DoLS process mean that some people are at risk of being unlawfully deprived of their liberty, with no safeguards, rights or protection in place.

Lack of training for staff in mental health hospitals is an ongoing area of concern. Without appropriate training, staff struggle to understand people's legal rights under the MHA, MCA and DoLS. In some cases, this means that a DoLS application has not always been considered when at times it should have been. We have also found that there is a misconception that if people were happy to be on a ward, then they could be classed as informal patients, without considering whether they had capacity to consent. As a result, we are concerned that people could be confined in hospital without the appropriate legal framework to protect them or their human rights.

Staff informed us that the DoLS authorisations across both wards had expired. We saw evidence of incident forms being completed. However, we are concerned that these patients remain de facto deprived of liberty, with no legal framework authorising this. This means they have no safeguards available to them. The trust should seek advice from the local authority over the likely timescales for DoLS procedures to be completed and what priority is being given to its patients. It should also review the decisions as to which legal framework to use in each patient's case so that, where the MHA might be applicable, this is considered as a potential means to enable the patients to exercise their rights and have appropriate safeguards in place.

Wards for older men and women, March 2022

In some cases, we have found confusion among nursing staff over the legal status of patients who may be subject to DoLS on the basis of an application that is awaiting action from the local authority. We have also seen examples where the capacity and consent of patients is unclear.

A patient was awaiting a standard authorisation therefore was currently not under any legal framework. I saw staff had documented confusing entries in the records. For example, referring to the patient as being informal and at times on DoLS. I also saw two mental capacity assessments completed for this patient where the latter dated assessment stated the patient had capacity and was informal. It was unclear to me what the legal status of the patient was. I raised this issue with the ward manager during the visit and requested this patient is reviewed urgently.

Older person's ward for men and women, September 2021

We are aware that on some older people's wards, patients are admitted under section 2 of the MHA and when this expires, a DoLS authorisation is applied for to enable a continued stay on the ward if further hospital care is required. In very many cases, this is now effectively arranging for unauthorised detention to start immediately or, at best, in the 14 days after a renewed urgent DoLS authorisation expires and a longer-term authorisation has not yet been granted.

As reported last year, the DoLS process is due to be replaced by the Liberty Protection Safeguards (LPS). At the time of writing the government is considering responses to its consultation on the MCA and LPS code of practice and relevant regulations, held between March and July 2022.

3 Addressing inequalities and cultural needs

Key points

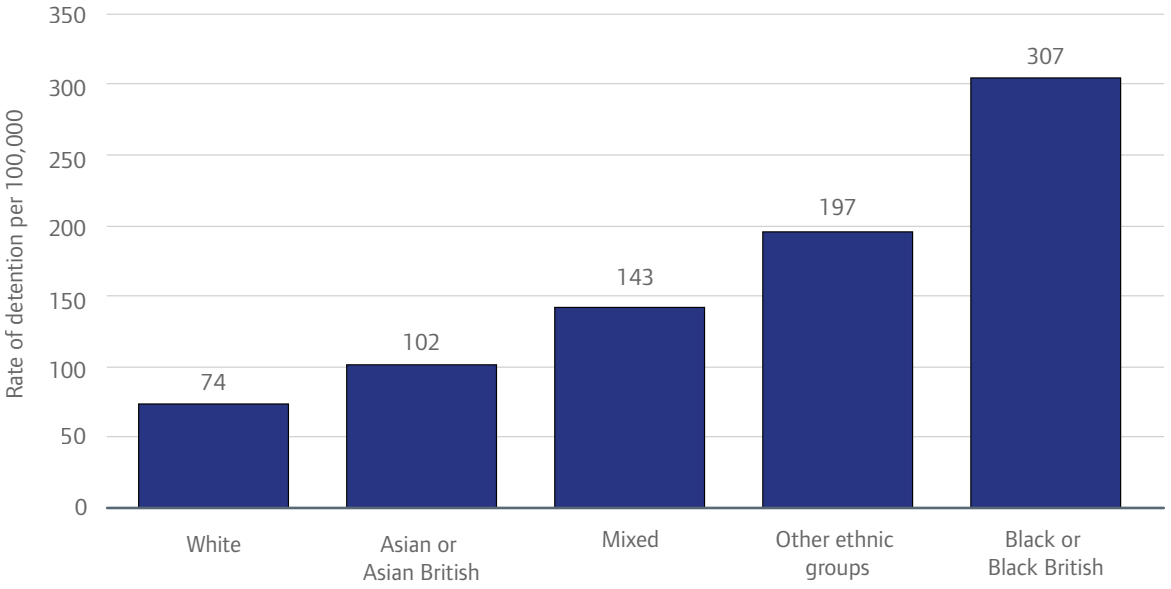
- Urgent action is needed to tackle the over-representation of people from some ethnic minority groups and, in particular, the over-representation of Black people detained in hospital or on community treatment orders.
- Providers and integrated care systems must take responsibility for addressing health inequalities at a local level. The Advancing Mental Health Equalities Strategy and Patient and Carers Race Equalities Framework (PCREF) provide national support to enable services to do this effectively.
- Some services are taking a positive approach to addressing inequalities. This includes services identifying members of the staff team to take a leading role for diversity, promoting an equalities approach across wards and supporting staff and patients.
- More widely, we have frequently heard ward managers and others describe their service as a safe space for lesbian, gay, bisexual and transgender (LGBT+) people, and such greater visibility and focus on LGBT+ as an equality issue is a very welcome development. However, further work is needed to ensure people feel respected and safe.

Over-representation of people from some ethnic minority groups

In last year's report, we highlighted the longstanding concerns that not everyone detained under the MHA is treated equally. In particular, we raised our ongoing concerns that Black people are more likely to be detained under the MHA, spend longer in hospital and have more subsequent re-admissions than White people. Figure 2 demonstrates this trend continues, with Black people 4 times more likely to be detained than White people.

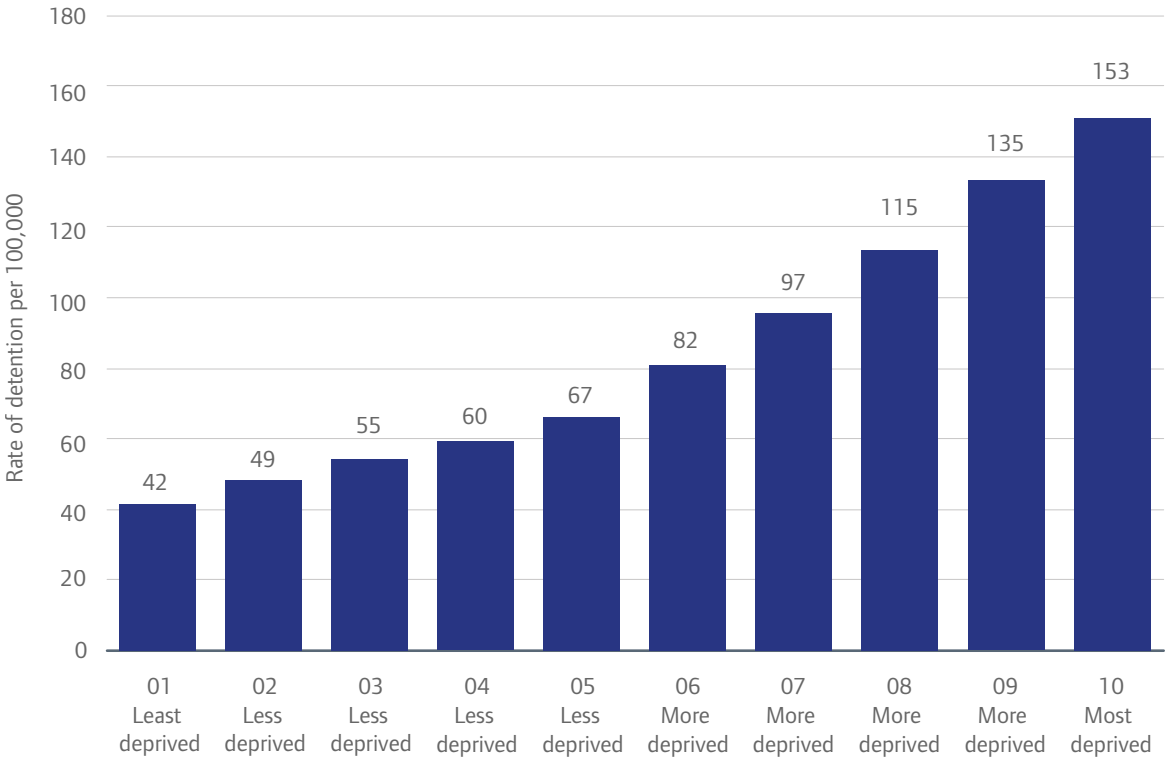
We know that MHA detention rates vary across England, with figures from NHS Digital showing that people living in the most deprived areas are at a much greater risk of being detained under the MHA (figure 3).

Figure 2: **Rate of MHA detention per 100,000 population, by broad ethnic categories, England, 2021/22**



Source: NHS Digital, Mental Health Act Statistics, Annual Figures, 2021-22.

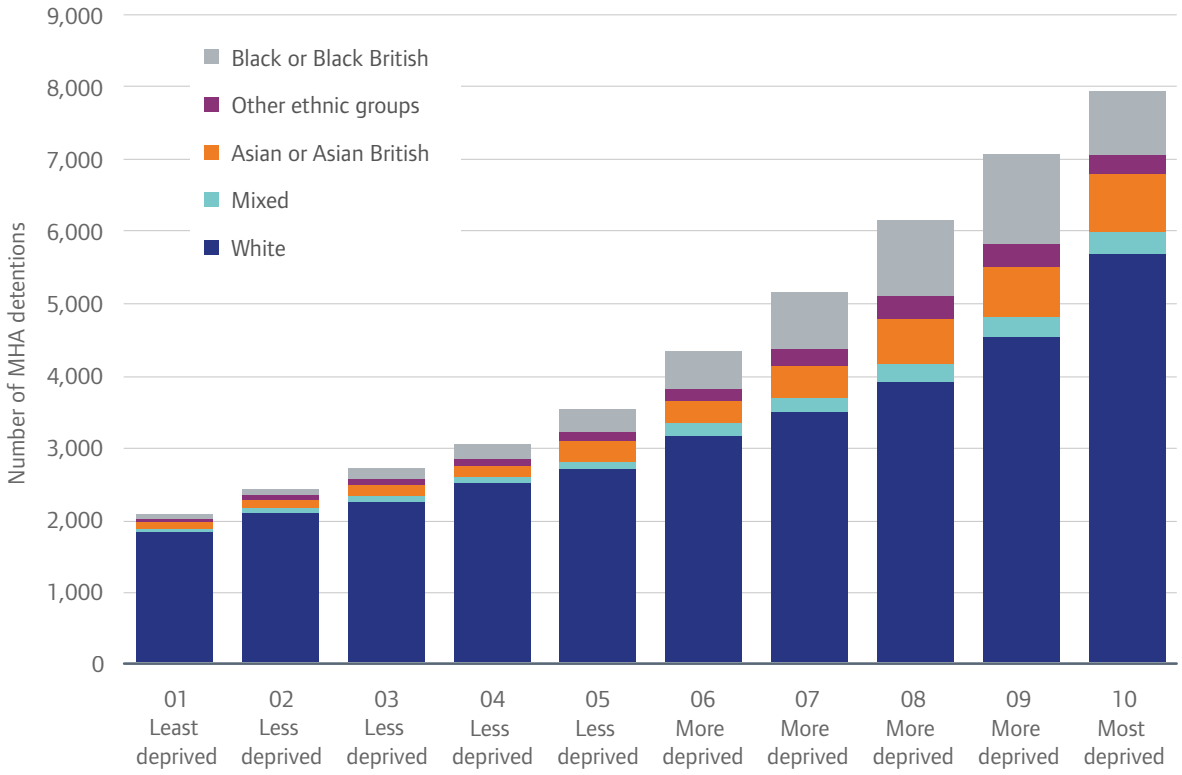
Figure 3: **Rate of MHA detention per 100,000 population, by index of multiple deprivation (IMD) decile, England, 2021/22**



Source: NHS Digital, Mental Health Act Statistics, Annual Figures, 2021-22.

When ethnicity and deprivation are mapped together it demonstrates these risks are inter-related (figure 4).

Figure 4: **Detentions under the MHA recorded in MHSDS, by index of multiple deprivation (IMD) decile and broad ethnic categories, England, 2021/22**



Source: Mental Health Act Statistics, Annual Figures - 2020-21 - NHS Digital.

A report from Account, a community interest company highlighted the impact of this on Black men detained under the MHA, based on a series of focus groups in secure hospitals. Participants of the focus groups described the inherent socioeconomic inequalities and racism they face as Black men from deprived areas.[27]

Participants were very aware of social inequalities and unfairness across the journey. Some pointed to racism which they saw as the bedrock on which society was built. They described being taught they were inferior to others from a young age and had experienced racism from individuals and agencies long before experiencing any mental ill health symptoms.

There was a sense that racism in society was repeated along with structural inequalities in areas such as housing, education and employment. Along with these, participants felt the impact of racial stereotypes which expected and suspected them of being criminals. Participants also talked about struggling against internalising these negative social expectations.

Black men's experiences of the secure care pathway [28]

A particular area of concern is the disproportionate use of community treatment orders (CTOs) for Black people. Figures from this year's Mental Health Services Data Set (MHSDS) suggest that rates of CTO use for the 'Black or Black British' group are over 11 times the rate for the White group.[29]

Our review of CTO use in London, published in November 2022, found that in most boroughs the ethnicity for about half of patients on CTOs was recorded as Black, despite the proportion of Black people living in the borough being lower. In one borough, we were told that Black patients were consistently over-represented among CTO patients by a factor of 6 to 7 based on the population data.

"I have been on a CTO for over 2 years. I had been discharged for a year previously and I was fine until I came into contact with the police and they delivered me back to psychiatric services. You cannot escape if you are mixed race. I have had too many appointments. They are always wanting to see me and this has made me suicidal. I want to be discharged and to have nothing to do with services and not to take medication because I am not mentally ill. I have no faith in the system and no faith in tribunals. All White panels, and especially White judges, will never take my word against that of the treating team."

Community patient, quoted in Mental Health Act community treatments orders (CTO) – focused visits report [30]

The government has stated that it wants to see a decrease in the overall use of CTOs, especially the disproportionate use of CTOs for Black people. While we welcome the government's objective to reduce the disproportionate use of CTOs for people from some ethnic minority groups, we are concerned about how this will be achieved as the causes underlying this are multifactorial.[31] We will continue to evaluate whether the opportunities provided by a revised MHA and a new code of practice will improve this situation. However, as highlighted in the foreword, we also want to work with stakeholders, including people who have experienced mental health services and their carers and families, to build on existing research to drive real change.

As highlighted in last year's report, we welcome NHS England's commitment to reducing mental health inequalities through the Advancing Mental Health Equalities Strategy and the development of a Patient and Carer Race Equality Framework (PCREF).[32] The government has committed to working with patients, carers, health system leaders and key stakeholders to develop the PCREF, with the goal of improving access, experience and outcomes for people from ethnic minority groups by supporting, incentivising and assuring targeted, localised actions in local health systems.

Over the last year, the PCREF has been piloted at a number of sites including South London and Maudsley Foundation NHS Trust. As part of the pilot, the trust has been working with Black Thrive Lambeth and Croydon BME Forum and has co-produced practical projects to test and learn if improvements are being made in key areas including:

- service use
- diagnosis of psychotic spectrum disorders
- use of medication for Black people with a diagnosis of psychotic spectrum disorders
- the use of detention
- the use of seclusion and restraint.

We look forward to developments in the PCREF model and are working to reflect its expectations as we develop our approach to regulation and monitoring.

Alongside efforts to tackle racism, services need to ensure that they are being inclusive of patient needs. This includes, for example, care plans being translated into languages other than English and meeting people's religious and cultural needs. Not meeting these needs can have a negative impact on people's experiences. This year, we have seen some services struggling in this area.

Some patients did not have care plans to meet their needs. This included patients from ethnic minority groups and those with physical disabilities. For example:

- *some patients from ethnic minority groups had care plans to meet their needs but others did not*
- *care plans did not routinely consider patient's cultural or religious dietary preferences*
- *specific diversity care plans did not consider the possibility of abuse, bullying or harassment.*

Some patients said staff did not treat them with respect because they were from an ethnic minority group. This is a serious concern, particularly in the light of poor care planning around patients' equality and diversity needs.

Rehabilitation wards, June 2021

However, we have also seen some examples of good practice with staff being inclusive of people's needs. In addition, many services have identified a lead for promoting equality and diversity across wards, and taking responsibility for supporting staff and patients.

Six patients on the ward were observing Ramadan last month and the ward made arrangements for patient meals and medication times to be outside of their fasting times. The ward staff worked closely with the Imam who supplied them with timetables for prayer and meal times. In addition, the hospital organised a celebratory meal for Eid, for all patients on the ward. This was very well received by all patients on the ward and positive feedback was given by the patients.

Medium dependency ward, Ashworth Hospital, Mersey Care NHS Foundation Trust, May 2021

The ward had a diversity lead in the staff team. One patient had been supported to use the multi faith room, take leave in a local mosque and the team had requested an Imam visit the patient on the ward. Two patients were being supported to attend a local LGBTQ+ event.

Fern ward (rehabilitation ward for women with personality disorders), Cheadle Royal Hospital, Affinity Healthcare, June 2021

Culturally appropriate advocacy

A lack of cultural understanding can negatively affect the outcomes of people from ethnic minority groups. Although advocacy can help patients to be involved in their care, it does not always meet people's specific needs and may be seen as less available or attractive to people from ethnic minority groups.

In our review of CTO use in London, we found that people on a CTO, many of whom were people from ethnic minority groups, were generally not accessing independent mental health advocacy and did not always know where to go for support.

Culturally appropriate advocacy should be adaptable and responsive to an individual's culture. This includes, for example, supporting people with advocates of the same ethnicity, understanding the importance of culture, cross-cultural relations and cultural difference, and adapting practice to meet culturally unique needs.

While larger advocacy services may be better able to meet contract requirements, they are not always best placed to support people from ethnic minority groups in the way that smaller advocacy and community organisations can. These smaller organisations are often more ethnically representative of communities they serve and have local experience of working with people from ethnic minority groups. Commissioning and supporting this type of culturally appropriate advocacy could help in addressing mental health inequalities.

Since 2021, a government-funded programme of pilots have been testing different models of culturally appropriate advocacy in both inpatient and community settings. The 3 pilots that ran as part of the first phase are as follows:

- In Manchester, advocacy provider Gaddum and the local community organisation African and Caribbean Mental Health Services piloted culturally appropriate advocacy in inpatient and community settings in areas with a high number of people from ethnic minority groups who are detained under the MHA.
- In London, Black Thrive provided culturally appropriate advocacy in a similar context, and also used an innovative 'living room' concept to create a more homely community space where both scheduled and drop-in advocacy sessions could take place.
- In the West Midlands and Oxfordshire, Pohwer piloted culturally appropriate advocacy in inpatient and community settings in areas with a low number of people from ethnic minority groups who are detained under the MHA.

We look forward to seeing the results of these pilots and hope that continued funding will be made available to strengthen the evidence base and inform the design of longer-term pilots, as was suggested at the start of the programme.

Inpatient services as a safe space for LGBT+ people

In last year's report, we highlighted some examples of excellent care we had seen for lesbian, gay, bisexual and transgender (LGBT+) people. We are encouraged that this year, ward managers and others have frequently described their service as a safe space for LGBT+ people.

The ward was a safe place for LGBT patients. An LGBT patient we spoke with confirmed this and told us staff were very welcoming to his husband and they felt valued as a couple. A staff member told us that all staff had diversity training. The unit also had diversity champions.

Avalon Centre, Swindon, Elysium Neurological Science (Badby) Ltd, January 2022

We are encouraged that, where staff or patients have told us that they were less confident over the ward culture being an LGBT+ safe space, staff have generally been keen to address this and to consider what practical measures can be taken. This has included obtaining and displaying information for LGBT+ support and services contacts, and discussion at patients and staff meetings.

Following discussion with the ward team we were provided with information on how they can promote a culture of LGBT+. The Rainbow Badge initiative has been introduced enabling staff to endorse non-judgemental and inclusive care for those who identify as LGBT. Wearing the Rainbow Badge provides a visual symbol for others to identify individuals who can be approached to feel comfortable talking about issues related to sexuality or gender. Ward staff have been provided with details of how to access the online training course to obtain the badge. In addition, ward staff have been asked to nominate themselves as ward champions to promote this initiative.

Response to visit letter, acute ward for men and women, June 2021

People who are detained under the MHA have, by definition, not chosen to come into hospital, and the experience can be frightening and upsetting for anyone. Many mental health services have been organised on the basis of binary gender separation. The elimination of mixed-sex accommodation (where accommodation is defined in terms of sleeping areas) and the creation of women-only safe spaces is an important aspect of ensuring that women are and feel safe from sexual threat on wards. We have seen many examples of services successfully providing LGBT+ safe spaces in this context.

The transgender patient was keen to point out that staff do not discriminate against transgender people and are really good at accepting people as they are. They are exemplary in this respect. The ward manager takes issues raised, such as hate speech, seriously.

Low secure rehabilitation ward for women, Oxleas NHS Foundation Trust, May 2021

Other units, for example some units for children and young people, have told us about the flexible approach they take to meeting people's needs. This includes ensuring they have single-gendered spaces if they are required, and that services ensure patient safety and security in the alternative arrangements.

Quiet rooms were no longer gendered, and staff told us that this was to reflect the gender fluid culture more appropriate to the young patients. Bedrooms had en suite shower and toilet facilities and the ward was not separated into gendered areas. Staff told us that this worked well, although patients were moved around according to risk assessments.

We were told that all staff were able to take a LGBT+ electronic learning questionnaire which would then allow them to wear a rainbow lanyard and support the promotion of an inclusive ward environment. One member of staff had done this.

We observed that the bedroom corridors and quiet rooms were no longer segregated by gender. Staff told us that patients had asked for gender specific signs to be removed from the quiet rooms and bedroom allocation was more fluid to respond to the ongoing range of risks, of which gender and sexual safety was considered.

Coral Ward for children and adolescents, Bowmere Hospital, Cheshire & Wirral Foundation Trust, August 2021

It is important to note that alongside evidence of good practice, we continue to find examples of poorer practice. For example, feedback from our MHA reviewers suggests that some transgender and non-binary patients are still not having their gender or pronoun preference acknowledged, with staff sometimes referring to a transgender or non-binary person by a name they used before transitioning. Work needs to continue to ensure LGBT+ people feel respected and safe.

4 Ward environments

Key points

- We have ongoing concerns around the physical environment and condition of wards, and the impact of these on patients and staff. Many inpatient environments are in urgent need of update and repair, but are facing additional waits due to the backlogs in repairs created by the COVID-19 pandemic.
- Despite improvements, many wards still have inadequate WiFi access and coverage, limiting people's ability to contact friends, family and advocates.
- Where wards have been refurbished, we have seen the positive effects this had for patients and staff, with better physical environments improving patient experience and staff morale.
- However, the current arrangement of many wards continues to create challenges for patients including a lack of space for patients to eat together and lack of lockable spaces for people to keep their belongings in, which can have an impact on patient wellbeing. In addition, older wards can lack space and ventilation and be unsuitable for people with physical disabilities.
- We continue to have concerns around the use of dormitories and urge that they are completely removed from inpatient mental health wards.
- Environmental problems such as noise, echoes and harsh lighting limit the therapeutic experience of all patients in some wards. Inpatient wards can be particularly distressing environments for autistic people and create challenges for people who have accessibility needs, such as hearing aids.

The physical environment and condition of mental health inpatient wards is still not good enough, with many wards in need of urgent update and repair. Issues that we have seen include broken windows, holes in walls, dirty wards, and fixtures and fittings in need of repair. In many cases, the condition of wards has been made worse by the additional wear and tear created during lockdowns.

Many inpatient wards are in old and outdated buildings that lack the space and ventilation of newer buildings. This can lead to issues around privacy and dignity for patients, as well as compromise the safety of patients and staff. In addition, outdoor spaces for such wards can be barren, visually impoverished environments dominated by security fencing. Not only can these environments be less pleasant to stay in, but they can affect patient and staff morale and have a detrimental impact on patient recovery.

"This is a good ward; people get better here. The thing I would like to change the most is the building; it's really industrial and the painted brick walls are like a prison."

Children and young people's mental health unit, September 2021

Patients had concerns about the environment on the wards. They told us that repairs to the ward often take a long time and gave us an example of a toilet seat being missing for a month before it was replaced. The toilets often run out of toilet paper and often smell.

The women's ward in particular had a plain and institutional feel with bare walls and lack of furnishings. This ward environment appeared dirty and there were a number of fixtures and fittings that were in need of repair.

Male and female rehabilitation wards, November 2021

In its response to the autumn 2021 government spending review, the Royal College of Psychiatrists stated that the mental health estate is some of the oldest and least suitable in the whole NHS. It reported that in 2019/20 there was a backlog of £31 million worth of repairs posing a high risk of catastrophic failure, major disruption to clinical services, or deficiencies in safety liable to cause serious injury and/or prosecution.[33]

Funding issues and backlogs due to the COVID-19 pandemic, mean that patients continue to be cared for in environments that are not suitable for their needs. We have also heard that bed pressures are creating delays as maintenance staff cannot access wards or patients' rooms.

In some cases, we found that wards had made temporary repairs. Not only could these be unsightly but they could be a visual reminder of past incidents on the wards and lead to patients feeling unsafe.

There were broken windows on both wards. Ward staff were told that they were not a priority for repair as they had been made safe by screwing a perspex panel over the top of the window. However, we were concerned about the psychological and emotional effects on patients of seeing evidence of previous aggression and violence on the ward.

Low secure wards for women, August 2021

In our last 2 annual reports, we have also raised concerns about inadequate WiFi access for patients. Lack of WiFi can limit patients' contact with family and friends, and cause issues with online meetings.[34,35] We are now seeing

examples of wards that have addressed WiFi issues, although many still have inadequate coverage.

Refurbishing services can have a hugely positive effect on patients and staff. Improvements we have seen include entirely new buildings for the new Broadmoor Hospital in West London (opened October 2019) and St Ann's Hospital, Haringey (opened August 2020).

We visited St Ann's Hospital shortly after it opened. Patients and relatives told us that the new building is "such an improvement", "amazing", "superb" and "like a 5-star hotel". We were impressed with the new environment and by innovations such as touch-screen walls in the seclusion rooms. We saw the effect this had on patients and staff. Patients comments such as "the staff are helpful and friendly"; "the service is excellent"; and "staff are very kind", with the provider reporting a 60% reduction in violent incidents since the move to the new building.

We have also seen similar improvements in staff and patient relationships in other services that have refurbished existing buildings.

Patients with whom we spoke were positive about the ward and its staff. They said that they felt supported and that the staff were helpful. They said the ward was kept clean and that the refurbishment of the ward was making a difference. Since our last visit, the bedroom doors had been replaced and the ward had been repainted. As a result, the quality of the environment had improved. There had been extensive upgrading of the Wi-Fi connectivity on the unit. There were new fish-eye mirrors installed in some ward blind spots. A new drinks station had been installed and there were new sofas and chairs.

Acute ward for women, February 2022

However, services must ensure that buildings are adapted to patient needs when carrying out refurbishment. In some services we visited, while the reception areas of wards were fully accessible, the wards behind them did not cater for people with physical disabilities or impairments.

"Issues around physical disability is interesting because I think a lot of the wards that I have visited, they're just not fit for purpose. So, if you have a physical disability, whether you're a wheelchair user or you're just using a walking aid, in some cases are just not fit for purpose... and people who have like a visual or hearing impairment, it just seems to be overlooked sometimes. It's not even recognised as something that's an issue."

MHA reviewer

The current arrangement of many wards continues to create other challenges for patients, for example a lack of space for patients to eat together. On a visit to a low-secure rehabilitation unit in November 2021, we noted that there were only 6 chairs in the dining area for a ward with 11 beds. Although patients rarely chose to eat together or at the same time, they had raised in community meetings that this stopped them from eating together on special occasions, such as Christmas. Following our visit we were assured that more chairs would be in place to allow Christmas lunch together.

In some cases we have seen examples where the number of beds on a ward has been increased, but the service has not been able to accommodate everyone in the lounge or dining areas. This should be a warning sign that the ward configuration needs to be reviewed.

We also continue to see examples where patients are not given a lockable space to keep their belongings in. A particular problem encountered over the last year has been the use of rooms as additional bedrooms that have not been designed or fitted for that purpose. If it is not practicable to provide a lockable space in these types of rooms, staff need to consider alternative ways patients' belongings can be kept securely.

The ward is an acute admission ward for men and has 14 bedrooms with another 2 rooms available for what were described as surge beds. One patient told us that he was in one of the surge beds which was an adapted therapy room and therefore did not have the fittings in the other bedrooms, including a lockable space to keep things. He indicated as a result of this some of his property had been stolen.

Acute unit for men, August 2021

We do see some improvement in progress. For example, in June 2021, we raised concerns about patient safety at a large mixed sex acute admission ward. This included concerns about the 'old and dated' environment, delays in repair works, and a lack of space for all patients to eat in the dining room at the same time. In response the trust told us that there was a capital funding programme in place for refurbishment. The programme included plans for the removal of ligature risks, moving on to a programme of work for reconfiguration.

Poor sensory environments

The very nature of hospital wards, including the lighting, noise levels and general environment, can be non-therapeutic. For example, on a visit to an acute ward for women in August 2021, patients told us about the negative effects that the bright lights and noise of the wards was having on them. When we told the service, they fitted dimmer-switches in bedrooms and corridors, repainted the wards and closed corridor doors at night.

Some patients had concerns about the environment. They told us it was too bright, and that noise carried too much and it interfered with their sleep. Three patients told us they had moved bedrooms due to this. Patients commented about banging doors. We found that lighting was bright and as the walls were white this increased this. We found that noise travelled from the central hub and that some doors were not fitted well leaving a gap. This meant when we spoke with patients in the quiet lounge, we could hear what was happening in the central hub area when the door was closed. The central hub area was about 3 rooms away. The IMHA [Independent Mental Health Advocate] told us that patients raised the issue of noise at night with them.

Acute ward for women, August 2021

These environments can present a particular sensory challenge for autistic people and cause them distress.

Two patients, all carers and the IMHA we spoke with raised concern about the noise levels within the ward. We noticed the noise levels were very high at times, even though nothing out of the ordinary was happening. This included banging doors, staff talking to each other and the television noise. We saw some patients' body language showed they were distressed by this. We found a lot of patients were autistic people and staff knew noise impacted on them. Staff and some carers told us that patients used seclusion to escape the noise of the ward.

Assessment and treatment unit for women patients with a learning disability, March 2022

Noise levels can also be a barrier to patients with hearing difficulties. On an eating disorder unit in May 2021, we met a patient who told us she did not wear her hearing aids because the environment was too noisy. Staff needed management support to access a portable hearing aid loop available to the ward, which reduces background noise in loud environments.

We also continue to have concerns around the use of dormitories. As highlighted in last year's report, dormitory wards, which are often a consequence of aging infrastructure, can be very noisy and nontherapeutic environments.[36] As well as concerns over noise, some patients have raised concerns about their safety and privacy when staying in dormitory wards.

Staff raised concerns regarding the dormitories. On the day of the visit, we were made aware of an incident in one of the female dormitories where there was an argument between two patients which resulted in a patient hitting a member of staff. Staff said this argument was due to one female patient believing the whole dormitory was her "bedroom".

Admission ward for older adults, February 2022

As stated previously, we do not think that dormitory accommodation should be acceptable in any mental health inpatient unit. In our last report we reported that the government has committed over £400 million to make progress on replacing dormitories.[37] We urge the government to continue to make funding available until all dormitory accommodation has been replaced.

Where services are waiting to have dormitories replaced, we continue to check that:

- beds are separated from one another and staff ensure the maximum privacy possible
- patients using these rooms have access to a lockable, personal storage facility
- patients are offered a choice of accommodation
- services ensure that patient flow and ward teams assess and consider each patient based on their diagnosis, clinical presentation and any other risks to determine whether admission to a dormitory would be acceptable or not to that patient and for the needs of the other patients on the ward.

5 Patient-centred care

Key points

- We have found some good practice around advance planning for future care. However, we have ongoing concerns about how well people are involved in their care planning process and about the quality of care plans.
- In line with the cultural shift called for by the independent review of the MHA, we have seen some very good practice of services supporting patients to have a voice in the running of services.
- Some carers have continued to tell us about a lack of involvement in their relative's care, including difficulty in contacting wards or arranging visits. However, we have also heard of some good practice examples of services involving carers in their relative's care and treatment.
- While we welcome proposals in the draft Mental Health Bill to improve the availability and flexibility of Independent Mental Health Act Advocates (IMHAs), we are concerned patients are not being given enough advocacy support.
- Despite the pressures on many services, they have put a sustained focus on challenging blanket restrictions.
- Services that focus on maintaining therapeutic relationships have reported a reduction in the use of restraint. Services should continue to implement the Use of Force Act and review their policies and procedures in line with it.

The importance of patient-centred care and involving people in decisions about their care is reflected in the MHA Code of Practice through the guiding principle of empowerment and involvement. A key element of this is empowering people to make, when they are well, advance statements about their wishes and feelings for their future care and treatment.[38]

The draft Mental Health Bill supports the use of advance planning as a way of involving patients in their care. The draft bill creates formal criteria to use the MHA to override a person's advance decision to refuse a specific treatment. Providers will need to show they have a 'compelling reason' to do this, for example that there is no alternative form of appropriate medical treatment available.[39] We welcome this emphasis on the role of advance decisions.

During 2021/22, we have found some good practice around advance planning. In one service we heard that patients had crisis plans in which they expressed their advanced wishes. At another service, the independent mental health advocate told us staff were working with the GP to support patients who had capacity to make advance decisions.

However, patient take-up of advance decision-making is uneven. This may be a reflection of pressures on staff time, but it may also simply be a reflection of the variable stages of a patient's pathway served by different types of service we visit.

Staff encouraged patients to complete advanced statements about their preferences for care and treatment in the future. Most patients had chosen not to.

High dependency unit and complex care units for men and women, June 2021

More broadly, we continue to have a focus on the quality of care plans and patient involvement in the care planning process. This is still an area for improvement in many services, and we are pleased to see that embedding patient involvement in care and treatment, even in the context of coercion, is a key aim of the draft Mental Health Bill.

Over the last year, we have seen examples of good practice in patient involvement, in line with the cultural shift called for in the 2018 Independent Review of the Mental Health Act. For example, patients have told us about being involved in decisions about their care and writing their care plans.

Patients told us that staff involved them in decisions about their care. They said that their key nurses review their care plans with them every 4 weeks. There was evidence of patients' views and how they had been considered in care plans and the minutes of individual patient reviews. Patients told us that doctors explained their medication to them and why they needed to take it. One patient in particular felt that her consultant had given her choice and control over decisions regarding which medication to take, which had made a real difference to her recovery.

Jordan and Kenly Wards (women's low secure), Chadwick Lodge, Elysium Healthcare No 2 Limited, August 2021

All patients said they have care plans and were involved in writing them. Patients were able to name their named nurse and said they spent time with them. Care plans we read showed patient involvement. Staff documented the patient and carer perspective (where appropriate), if the patient agreed with or disagreed with the content of their care plan and if the patient signed their care plan. Staff discussed care and treatment plans with patients.

Coniston ward (women's medium secure), Arnold Lodge Hospital, Nottinghamshire Healthcare NHS Foundation Trust, December 2021

We have also seen evidence of good practice in supporting patients to have a voice in the running of services, for example through community ward meetings.

We attended a patient community meeting. This took place on the ward. Nine patients and 7 staff were in attendance. Staff included the occupational therapy staff, deputy ward managers and healthcare support workers. Patients were encouraged to participate and share their views. Staff chaired the meeting and followed an agenda. The meeting was informal, and patients looked at ease in raising concerns. Staff provided updates from issues raised previously. Patients confirmed these meetings took place every week.

Kinver ward (mixed gender specialist eating disorder ward for patients aged 18 and over), St Georges Hospital, Midlands Partnership NHS Foundation Trust, December 2021

However, services should not rely solely on ward meetings as the only way patients can raise concerns with staff, as this may disadvantage some patients who may be unable or reluctant to speak in a group situation. Patients should always be offered an opportunity to meet individually with staff to raise concerns or issues.

For example, in a daily patient planning meeting at a neuropsychiatry unit for men in July 2021, we told the service that the meeting appeared difficult for patients to follow and could be overwhelming for patients with sensory issues or cognition difficulties. As well as noting our observations over communication style, the service introduced a set agenda for the daily meeting, with additional offers to any patient to meet the lead member of staff individually to discuss and plan their day.

During 2021/22 we have also increased our focus on how services provide patients with the feedback from our visits. We have always encouraged services to share our findings and comments with patients on the ward, but we now request information on how this will be done in all visit feedback letters.

Typically, services share our visit letter and its actions and findings with patients through community ward meetings, and through displaying a copy and any response on patient information boards or by simply copying the letter to each patient. Many services use community meetings to ask patients for suggestions to develop the action plan to address our findings. This builds our findings and recommendations into the ongoing conversation between staff and patients on quality improvement, and we encourage all services to do this where they can.

Involving carers

Some carers have told us they feel supported to be involved in the care and treatment of their relatives. This includes, for example, regular communication with the staff and involvement in their relative's care.

Carers told us:

- *They were very confident that their relatives were getting good care and treatment.*
- *They were contacted regularly by staff and were routinely involved in their relatives' care plans.*
- *They attended ward rounds, care programme approach meetings and tribunals remotely.*
- *They had spoken to a wide range of team members and felt that staff understood their relatives' needs well.*
- *Their relatives received individualised care which their relatives were engaging with.*
- *They had been asked for information about their relatives' life and could see that this was being actively used in their care. One carer told me that they had been asked to fill in a 'This is my life' book for their relative and that they believed this to be crucial information and demonstrated the quality of the care their relative received.*
- *One carer told me that staff had contacted them about their relative's distressed behaviour and gave detailed information about how they were supporting them. The carer told me that they valued this transparency and information very much and were reassured by this approach.*

Arbour Lodge, a ward for older men, August 2021

However, other carers have expressed concern that it can be difficult to get in telephone contact with wards and that when they do get through, staff who answer may be unfamiliar with the ward or the patient, so cannot be very helpful. Some carers have said that they are reluctant to try to call wards knowing how busy staff are. We heard that this caused them great anxiety, especially if they lived a long way from the ward and could not easily visit in person, or during the visiting restrictions of the COVID-19 pandemic.

For example, at one service we visited in July 2021, carers told us that they were not given the option of attending ward meetings via videocall, and we found no process for ensuring relatives were contacted regularly about patients' progress.

Following our visit, the ward introduced a process whereby the ward administrator would contact carers within 72 hours of admission to discuss what support they might require during the patient's stay, how often they want to be updated on the patient's progress and by what method, and their preferred method for attending ward meetings. Carers are offered face-to-face meetings as well as the option to dial in the meeting via telephone or

videocall. This preferred method is added to the ward meeting sheet and revisited after every meeting in case the carer's preference changes.

Advocacy

Independent mental health advocates (IMHAs) are an important source of support for people detained under the MHA to understand their rights and have their voice heard.

We welcome proposals in the draft Mental Health Bill to extend people's right to an IMHA service to informal patients, and introduce an opt-out approach so that advocates have a clear legal authority to approach patients and offer help.

However, as highlighted in our last report, we are concerned that a lack of resources and funding arrangements for IMHA services mean that people are not being given the advocacy support they have a legal right to expect.[40] In particular, we have concerns around people's access to culturally appropriate advocacy, as discussed in our section on Addressing inequalities and cultural needs.

We continue to find patients in some services have a limited understanding of, and access to, advocacy. We have found that some IMHA services are overstretched or limited by their contractual obligations. In some cases IMHA provision could also be limited by staff understanding or availability.

The IMHA told me:

- *There was a waiting list for patients at the unit to see an IMHA and this list was managed by the provider manager. (On the day of my visit, there were 7 patients recorded by the MHA department as being on the waiting list on one ward).*
- *The IMHA visited each ward every week in person. She was responsible for 33 cases over 3 wards. Not all these cases were IMHA related as she also acted as a general advocate for the service.*
- *Some staff were co-operative and helpful. Others did not appear to understand her role and could be dismissive and off-hand*
- *When she requested patient care notes, she had often not received them.*
- *The ward clerk on the ward was very helpful and made sure that she was made aware of patient meetings that she would wish to attend. There were a lot of nice staff on the ward, they just did not have enough time to work positively with the patients.*

Acute admission ward for women, April 2021

Some services have taken steps to improve this, including meeting with managers of local advocacy services to arrange support such as informal drop-in sessions for patients, and training on advocacy services for staff. While it is not always clear how these types of activities are funded in current arrangements, they should be a core part of the IMHA role.

We also heard of services recording patient contact with advocacy services so they could identify patients who may need further support and encourage them to contact IMHA services. While many services do follow our recommendation to refer all eligible patients for at least a meeting with an advocate, this is not always happening timely way. In some cases this may due to pressures on staff time.

The IMHA told us that staff referred eligible patients and there had been improvements in this process. However, the IMHA said staff needed to improve the timeliness of referrals for those patients subject to section 2 of the MHA to ensure adequate time for contact within the first 14 days.

Assessment and treatment unit for patients with learning disability, March 2022

A number of services have also introduced peer support worker roles. Peer support workers are people who use their own lived experience of mental health challenges to support people and their families. Peer support workers form part of an individual's care team to help support their wellbeing and provide inspiration for their recovery.[41] Peer support workers can provide a positive impact on patient experience through being someone patients can regularly communicate with and build up a positive rapport.

The peer support worker told us:

- *They supported communication between patient and family and from staff to family.*
- *They ran a mutual help group for patients.*
- *They supported patients following any incidents they witnessed on the ward and completed de-briefs.*
- *They took patient views to meetings.*

Hadrian Ward (acute mixed gender), Carleton Clinic, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, March 2021

People we spoke with on our visits were positive about the care and support peer support workers provided, and believed that it supported their recovery. In one service, peer support was offered to patients in long-term segregation

across the 3 high security hospitals, and helped patients to engage. However, peer support workers should not, and in law cannot, be a replacement for independent mental health advocacy.

Least restrictive practice

As highlighted in our section on staff shortages and the impact on patients, we have continued to see a focus on least restrictive practice and creating therapeutic, recovery-orientated environments in some services. This includes continuing to challenge the use of blanket restrictions.

The blanket restrictions identified on our last visit had been addressed. The pool room was no longer locked and use of the equipment was subject to individual review. The art room was kept open for unrestricted use unless there was a specific activity requiring individual risk assessment. Decisions as to whether to lock the communal bathroom were made at the ward's monthly reducing restrictive practice meeting, so this changed according to patient wishes. Staff and patients told us there was open access to the garden except at medication time. This restriction had been decided by the patients as they felt it caused delays to the medication round. We found the involvement of patients in making decisions about blanket restrictions on the ward to be good practice.

Medium secure unit for men with personality disorder, May 2021

It is encouraging that many services have also had an ongoing focus on reducing the use of force through improving staff knowledge and understanding of patients and the environment – known as relational security. The See Think Act guidance has been an important influence in supporting these improvements.[42]

In addition, in December 2021 the government published its statutory guidance on the Use of Force Act.[43] This requires services to have a policy, co-produced with patients, that commits to reducing the use of force. It also includes requirements over training, recording and reporting the use of force, and requires services to identify a person responsible for implementing the Use of Force Act.

The ward had taken part in a project about reducing restraint and gender and trauma informed care. Since this project there had been a 50% reduction in the use of restraint and lower use of rapid tranquilisation and intramuscular medication.

Shakespeare ward (acute admission ward, women) Lancashire and South Cumbria Foundation Trust, April 2021

As highlighted in the section on pressures on services and patient pathways, increasing demand and delays in getting help mean that patients' symptoms are often more severe on admission to hospital. In response, some wards have introduced increased levels of security on wards. While this may be necessary, it creates challenges for staff in ensuring least restrictive practice is used.

> *The acuity of patients has steadily increased and the extra care area (ECA) has been used occasionally for seclusion. The room has been damaged by the last occupant and the ward want to put a business case to turn it into a seclusion suite.*
>
> **Acute ward for older age patients,** May 2021

The MHA Code of Practice is clear that restrictive interventions such as physical restraint, mechanical restraint (such as handcuffs, soft wrist restraints or strong (untearable) clothing) and seclusion and long-term segregation should only be used in a way that respects people's human rights.[44] In particular, it states that mechanical restraint should only be used exceptionally, where other forms of restriction cannot be safely employed.[45]

This year, we were concerned to find at one service that mechanical restraint had been used to enable a patient in seclusion to access fresh air. Although the hospital's mechanical restraint procedures had been followed, the restraints were only necessary because the patient did not have easy access to fresh air from the seclusion room, and there was not another suitable long-term area that the patient could be moved to. The trust responded with an assurance that in future cases it would consider moving patients to alternative seclusion suites.

In another case, we saw no recorded rationale for a patient being kept in strong (untearable) clothing during a planned hospital appointment, even though she had requested to wear her own clothes. The patient also told us that the use of strong clothing was supposed to be reviewed daily, but staff did not discuss this with her and she did not know how to get her own clothing back. The service assured us that it would review the use of strong clothing, feedback to the patient and create a care plan outlining how the use of strong clothing would stop.

We accept that there may be situations where it is not possible to allow a patient to change out of strong clothing when attending another hospital, particularly in emergency situations such as after a person has self-harmed. However, we do expect services to carefully consider how to avoid the use of strong clothing in planned appointments. Where strong clothing is used, additional effort should be made to protect people's dignity by not subjecting them to public view when moving through the hospital.

6 Our activity 2021/22

Key points

In 2021/22:

- We carried out MHA monitoring reviews of 609 wards – 466 were on-site visits and 143 were remote reviews.
- We spoke with 2,667 patients (2,056 in private interviews and 611 in more informal situations) and 726 carers.
- MHA reviewers took part in Independent Care, Education and Treatment Reviews (ICETRs) for 30 patients between November 2021 and April 2022 and for 82 patients overall.
- Our complaints team received 2,434 new contacts in 2021/22, which were a mixture of complaints and matters dealt with as requests for advice. In addition, we received 6,500 contacts in respect of open cases, most of which relate to complainants that we are helping to use local complaints resolution.
- We arranged 12,005 second opinion appointed doctor visits, a significant decrease in demand from previous years.
- We were notified of 695 incidents of absence without leave.
- 325 deaths of people detained under the MHA or subject to a community treatment order (CTO) were reported to us.

Mental Health Act reviewer visits

In 2021/22, we carried out MHA monitoring reviews of 609 wards – 466 wards had an on-site visit and 143 wards had a remote review. We spoke with 2,667 patients (2,056 in private interviews and 611 in more informal situations) and 726 carers.

In addition, we have continued to review the care and treatment of people with a learning disability and autistic people. In 2021/22, MHA reviewers took part in Independent Care, Education and Treatment Reviews (ICETRs) for 82 patients.

Our MHA monitoring reviews are one way in which we fulfil our responsibilities as a part of the UK National Preventive Mechanism against torture and ill-treatment (see appendix B). After each monitoring review, our MHA reviewers issue a feedback letter setting out our observations and requesting an action plan in relation to any concerns. This feedback is intended to provide a constructive challenge to services to support them in developing the best approaches possible in providing patient care based on the principles set out in the MHA Code of Practice.

During 2021/22 a key focus of our feedback letters has been on how services pass on our feedback to patients on the ward and engage patients in their response. We discuss how services have responded to this feedback in the section on patient-centred care.

Complaints and contacts received by the Mental Health Act team

If people are unhappy with the use of powers or how duties have been carried out under the Mental Health Act, you can make a complaint to us and we will investigate. Complaints can be made by anyone – patients, staff or any member of the public.

The range of issues people raise with us varies. For example, some people ask for help in challenging detention or compulsory treatment. In these cases, we will signpost people to the appropriate way to do this, or to advocacy or Patient Advice and Liaison Services (PALS). Other people may ask us to investigate concerns that have not yet been considered through services' own local complaints resolution processes. In these cases it is usually appropriate for people to try to get the complaint resolved locally and we will signpost and, where appropriate, support people to complain to the service.

During the provider's investigation, if we receive information from either the individual making the complaint or the provider that raises immediate concerns we will pass this information on to the local authority safeguarding team and the safeguarding lead in the service without delay.

In addition, if the person making the complaint sends us more information about their complaint or raises a new matter during the provider's review, we pass this information to the provider and ask them to respond appropriately. We will also respond to any questions people have at this stage about our role and reassure them about how we are supporting them.

Once the provider has investigated the complaint, we expect them to tell the person making the complaint, and us, about the outcome. If the person is not happy with the outcome they can request further support from us.

If we are not satisfied with what the provider tells us about the outcome (for example it is not clear how they reached their decision, or they tell us the patient is 'happy' with the outcome, without providing any evidence of this) we will contact them to give us the information we require.

Where local complaints processes have been exhausted, and it is appropriate for us to carry out our own investigation, the complaint will be investigated by an MHA reviewer. In rare cases, we may decide to investigate a complaint without it being resolved locally first.

As part of their investigation, the MHA reviewer will request any evidence needed from the provider such as the complaint file, the relevant progress notes, incident forms, trust policies, CCTV (if relevant), and any documents they feel they need to review the issues. If necessary, the MHA reviewer may visit the location or provider – they may also contact the provider to talk with the appropriate senior staff.

Where relevant, the MHA reviewer may link in with other CQC inspection teams to make sure they are aware of any issues they may need to consider in line with our roles and responsibilities under the Health and Social Care Act. Depending on the issues, they may also seek advice from other CQC teams such as policy and legal.

We report the findings of our MHA reviewer investigation to the person making the complaint and the relevant services. In our report, we look at what happened, what should have happened and where there are any gaps. Where our findings identify failings in a service, we make recommendations for improvements, such as changes in policies, practice or financial compensation for the complainant. We then ask the provider to confirm the actions they will take to implement our recommendations and to tell us when they have done so.

Depending on the outcome of our review, the inspection team may decide to include the area of concern in the next inspection, the MHA reviewer may also decide that they need to do a monitoring visit.

In 2021/22, we received 2,434 new contacts, which comprised a combination of complaints (where a clear complaint is made about a service), other concerns and requests for advice.

We received an additional 6,500 contacts in relation to open cases. Most of these relate to complaints that are being followed up, with our help, through referral to hospitals or local authorities for them to deal with through their local complaints resolution.

During 2021/22, we opened 18 investigations by MHA reviewers of matters raised in complaints. Four were ongoing at the time of going to press. Of the 14 completed investigations, 5 upheld all aspects of the complaint, 6 upheld aspects of the complaint, and 3 did not uphold any aspect of the complaint. The most common upheld aspects related to failures to communicate effectively with nearest relatives and families or carers (7 upheld), and failures of services' own local complaints systems to address concerns in a timely or appropriate way (6 upheld). We also found failures in communication across teams (2 upheld) and failures to take appropriate account of advance statements of wishes or arrangements for lasting power of attorney (2 upheld).

In addition, we received 8 appeals from high security hospital patients or their correspondents against the withholding of mail or telephone monitoring. In 5 cases, we upheld the hospital's decision to withhold mail or carry out telephone monitoring. In the remaining 3 cases, monitoring stopped or withheld items of post were released in the course of our adjudication, so that we did not have to make a formal ruling.

The second opinion appointed doctor service

The second opinion appointed doctor (SOAD) service is an additional safeguard for people who are detained under the MHA, providing an independent medical opinion on the appropriateness and lawfulness of certain treatments given to patients who do not or cannot consent.

SOAD reviews are needed to allow the following treatments where consent is not given, except in an emergency:

- medicine for mental disorder after 3 months from first administration when a patient is detained under the MHA
- medicine for mental disorder after the first month of a patient being subject to a community treatment order (CTO)
- electroconvulsive therapy (ECT), at any point during the person's detention.

When we receive a request from the provider caring for the patient, we have a duty to appoint a SOAD to assess and discuss the proposed treatment with a minimum of 2 professionals involved in the patient's care. SOADs can issue certificates to approve treatment plans in whole, in part, or not at all depending on their assessment of the treatment plan in an individual case. CQC is responsible for the administration of the SOAD service, but SOADs are independent and reach their own conclusions by using their clinical judgment.

In 2021/22, SOADs provided 12,005 second opinions for patients. This is a marked decrease in the number of checks carried out annually, with an average of 14,372 checks carried out over each of the previous 5 years.

Not all requests for a second opinion lead to a completed review. Some will be cancelled before the SOAD visit, for reasons that will include patients regaining capacity and giving consent to treatment, and patients being discharged from detention. Delays in arranging SOAD visits may lead to increased numbers of such cancelled requests.

In 2021/22, we received 15,831 requests for second opinions, of which 3,005 (19%) were subsequently cancelled. In 2020/21 we received 15,586 requests, of which 1,378 (9%) were subsequently cancelled. In the 2 years previous to that, request rates were higher (by about 1,000 each year) with cancellation rates of between 14-15%.

The majority (9,085, 76%) of completed SOAD reviews were to consider treatment for patients detained in hospital where the proposal only involves continuing medicine for mental disorder after the initial 3-month period. A further 13% (1,509) of SOAD reviews were to consider treatment of patients detained in hospital with electroconvulsive therapy (ECT). In 270 of these, the proposed treatment also requested SOAD authorisation of medicine for mental disorder. The relatively small proportion of ECT requests for detained patients that also involve medicine (less than 1 in 5) is likely to be a reflection that patients requiring ECT may have been relatively recently admitted to hospital, so authority for any medicines would fall under the 3-month rule.

There were 1,411 SOAD reviews for patients on a community treatment order (CTO) in 2021/22. These reviews must take place after the patient has been on a CTO for 1 month or, if the patient was detained onto CTO within 3 months of them being detained, when that 3-month period expires, whichever is the later date.

The highest proportion of changes made to treatment plans as a result of a SOAD review takes place in the medicines group of detained patients (figures 5 and 6).

Figure 5: **Statutory second opinions provided for all treatments, detained patients, by outcome, England, 2021/22**

Outcome	ECT	%	Medication	%	Medication and ECT	%
Plan not changed	1,044	84%	6,546	72%	171	63%
Plan changed	92	7%	2,088	23%	89	33%
Missing data	41	3%	307	3%	3	1%
No form issued	62	5%	144	2%	7	3%
Number of second opinions	1,239	100%	9,085	100%	270	100%

Source: CQC, SOAD data, 2021/22.
Note: some percentages may not add to 100 due to rounding.

Figure 6: **Statutory second opinions provided for all treatments, CTO patients, by outcome, England, 2021/22**

Outcome	Second opinions provided	%
Plan not changed	1157	82%
Plan changed	209	15%
Missing data	33	2%
No form issued	12	1%
Total number of second opinions	1411	100%

Source: CQC, SOAD data, 2021/22.

Out of the 12,005 SOAD visits, ethnicity was recorded for 11,515 patients. Of these, 77% (8,829) of people were White, and 23% (2,686) of people were from ethnic minority groups. Treatment plans were approved without change in 75% (6,624 of 8,829) of cases for White people, and in 72% (1,922 of 2,686) of cases for people from ethnic minority groups.

Through the request forms for second opinions, which are completed by the treating doctor or MHA administrators, we were told that patients refused to consent to taking medicine on 1,104 occasions during 2021/22. Although some data is missing (for 58 cases, or roughly 6% of this total), it is clear that a very small number of these patients were subsequently determined to have capacity to give or refuse consent at the point of certification of treatment by the SOAD (figure 7).

Figure 7: **Capacity and consent status at request and certification, England, 2021/22**

Total patients reported to be 'refusing' consent at point of second opinion request,	1014	100%
of which:		
Patients determined to be incapable by SOAD at certification	922	91%
Patients determined to be refusing by SOAD at certification	22	2%
Patients determined to be consenting by SOAD at certification	12	1%
Blank (for example, no certificate issued or missing data)	58	6%

Source: CQC, SOAD data, 2021/22.

Overall, out of 10,765 second opinion requests regarding medicines, SOADs found that only 65 patients were refusing to consent to taking medicines. This comprises the 22 included in figure 5 above, and a further 43 where the responsible clinician had identified the patient to be incapable of consent at the point of the request for a SOAD review.

A very small number of SOAD reviews conclude that the patient is in fact consenting to the proposed treatment, or an agreed variant of such treatment. In 2021/22, SOADs issued 54 certificates of consent to treatment. Twelve of these certified consent to changing the proposed treatment plan, indicating a degree of negotiation as to what would be acceptable to the patient. In the other 31 cases, the reason could be that a patient regained capacity to consent to treatment while the visit was arranged, or that the process of an independent review may have provided reassurance needed for a previously refusing patient to consent. In the remaining 11 cases, either no form was issued by the SOAD (10 cases) or data is missing (1 case).

Notifications of absence without leave

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. In 2021/22, CQC were notified of 695 incidents of absence without leave.

The majority of these absences occur because the patient does not return on time from authorised leave (57%), which may reflect positive risk taking by providers. In a quarter of cases, absences relate to patients absconding while on escorted leave (25%). In a further 16% of cases, the patients absconded from hospital. In over half (58%) of cases, patients going absent were reported to have a history of doing so before.

We know that in around a third of cases (31%), the patient returned to hospital voluntarily. A similar proportion (32%) were returned to hospital by the police. For just under a quarter of patients (24%), the hospital was involved in the return.

Figure 8: **Method of return from unauthorised absence without leave, England, 2021/22**

Method of Return	Number of patients	%
Returned by police	220	32%
Returned voluntarily	218	31%
Returned by hospital or other	165	24%
Returned by family member(s)	30	4%
Other	27	4%
Not specified	35	5%
Total	695	100%

Source: CQC, notifications, 2021/22.

Notifications of deaths of detained patients

Providers have a legal duty to notify CQC of deaths of people detained, or liable to be detained, under the MHA. The data presented in this section is based on information included in notifications that providers have sent to us and or obtained through the coroner's courts. Our analysis of this data is based on the date of death provided on the notification.

The data does not include all deaths notified to CQC by providers under regulation 17 as we exclude deaths of people who were not detained, or liable to be detained at their time of death – that is, for example, people who were removed from section at their time of death.

Our notifications data may be updated over time leading to changes in overall numbers and/or the categorisation of deaths. These updates may relate to data cleaning, delays in notifying CQC of a death of a detained patient, or new or additional information received through the coroners' courts.

Unlike deaths of detained patients, providers are not required to notify CQC of deaths of people subject to CTO. As such, data is likely to fall below actual numbers of deaths of CTO patients.

Aggregated data on the causes of death of people detained under the MHA should be considered as indicative only (figures 12 and 13). Coding of this data is based on information collected through our death notification process and our approaches are not aligned to those employed in the production of official mortality statistics, such as those produced by ONS.

As at November 2022, we were notified that 325 people died while detained under the MHA or subject to a community treatment order between 1 April 2021 and 31 March 2022. This is a fall on the previous year (363 deaths in 2020/21).

Based on information received from the providers and/or through coroner's courts, we know that 3 in 5 (60%) people who died in detention or while subject to CTO died due to natural causes; 1 in 5 deaths notified to CQC were self-inflicted or accidental.

As at November 2022, the cause of death of 55 detained patients and 8 people subject to CTO were still to be determined. The cause of deaths in detention are usually determined through the coroners' courts, which can lead to a delay for accurate statistical reporting.

Figure 9: **Deaths of patients in detention or subject to CTO, England, 2021/22**

Classification	Natural	Unnatural	Undetermined	Total
Detained	165	50	55	270
Community Treatment Order (CTO)	31	16	8	55
Total	196	66	63	325

Source: CQC, death notifications, 2021/22.

Figure 10: **Deaths of patients in detention, England, 2017/18 to 2021/22**

Type	2017/18	2018/19	2019/20	2020/21	2021/22
Natural causes	189	136	143	268	165
Unnatural causes	48	34	32	33	50
Undetermined	10	25	65	62	55
Total	247	195	240	363	270

Source: CQC, death notifications, 2021/22.

Figure 11: **Deaths of patients subject to CTO, England, 2017/18 to 2021/22**

Type	2017/18	2018/19	2019/20	2020/21	2021/22
Natural causes	23	9	21	27	31
Unnatural causes	7	5	10	23	16
Undetermined	4	2	5	15	8
Total	34	16	36	65	55

Source: CQC, death notifications, 2021/22.

Figure 12: **Cause of natural deaths as notified to CQC, England, 2021/22**

Cause of Death	Detained	CTO	Total
Aspiration pneumonia	11	0	11
Cancer	11	3	14
Chronic Obstructive Pulmonary Disease	7	1	8
COVID-19	8	2	10
Heart disease	29	6	35
Myocardial infarction	8	0	8
Pneumonia	29	4	33
Pulmonary embolism	17	3	20
Respiratory problems	6	1	7
Unknown	4	1	5
Other	35	10	45
Total	165	31	196

Source: CQC, death notifications, 2021/22.

Figure 13: **Cause of unnatural deaths as notified to CQC, England, 2021/22**

Cause of death	Detained	CTO	Total
Accidental	6	0	6
Another person	0	0	0
Drowning	3	1	4
Hanging	7	5	12
Jumped from building	1	2	3
Jumped in front of vehicle / train	3	1	4
Method unclear / other	3	0	3
Self-poisoning by drug overdose	13	5	18
Self-strangulation / suffocation	12	0	12
Unsure suicide / accident	2	2	4
Total	50	16	66

Source: CQC, death notifications, 2021/22.

Figure 14: **Age at death of patients in detention and subject to CTO, England, 2021/22**

	Detained			CTO		
Age	Natural	Unnatural	Undetermined	Natural	Unnatural	Undetermined
17 and under	0	4	2	0	0	0
18 to 20	0	6	4	0	0	0
21 to 30	2	10	6	0	3	1
31 to 40	9	13	8	3	4	1
41 to 50	14	6	7	5	4	1
51 to 60	33	8	11	8	4	3
61 to 70	31	2	8	6	1	0
71 to 80	47	1	6	8	0	2
81 to 90	24	0	2	1	0	0
91 and over	5	0	1	0	0	0
Total	165	50	55	31	16	8

Source: CQC, death notifications, 2021/22.

Figure 15: **Recorded ethnicity at death of patients in detention, England, 2021/22**

	Natural Causes	Unnatural Causes	Undetermined	Total	% all detained deaths
White: British	117	32	33	182	67%
White: Irish	2	0	2	4	1%
White: Other	4	2	0	6	2%
Mixed: White/ Black Caribbean	2	1	2	5	2%
Mixed: White/ Black African	1	0	0	1	0%
Mixed: White/ Asian	0	1	0	1	0%
Mixed: Other mixed Background	0	1	1	2	1%
Asian or Asian British: Indian	4	1	1	6	2%
Asian or Asian British: Pakistani	1	0	0	1	0%
Asian or Asian British: Bangladeshi	0	0	1	1	0%
Asian or Asian British: Chinese	2	0	2	4	1%
Asian or Asian British: Any other Asian Background	2	0	0	2	1%
Black or Black British: African	5	3	4	12	4%
Black or Black British: Caribbean	9	1	1	11	4%
Black or Black British: Any other Black background	0	0	0	0	0%
Other Ethnic Groups	0	0	0	0	0%
Not stated	0	0	0	0	0%
Not known	16	8	8	32	12%
Total	165	50	55	270	100%

Source: CQC, death notifications, 2021/22.

Figure 16: **Recorded ethnicity at death of patients subject to CTO, England, 2021/22**

	Natural Causes	Unnatural Causes	Undetermined	Total	% all CTO deaths
White: British	23	10	5	38	69%
White: Irish	0	0	0	0	0%
White: Other	0	1	0	1	2%
Mixed: White/ Black Caribbean	1	2	0	3	5%
Mixed: White/ Black African	0	0	0	0	0%
Mixed: White/ Asian	0	0	0	0	0%
Mixed: Other mixed Background	0	0	0	0	0%
Asian or Asian British: Indian	0	0	0	0	0%
Asian or Asian British: Pakistani	0	0	0	0	0%
Asian or Asian British: Bangladeshi	0	0	0	0	0%
Asian or Asian British: Chinese	0	0	0	0	0%
Asian or Asian British: Any other Asian Background	0	1	0	1	2%
Black or Black British: African	2	1	0	3	5%
Black or Black British: Caribbean	1	0	0	1	2%
Black or Black British: Any other Black background	0	0	1	1	2%
Other Ethnic Group	0	0	0	0	0%
Not stated	0	0	0	0	0%
Not known	4	1	2	7	13%
Total	31	16	8	55	100%

Source: CQC, death notifications, 2021/22.

Appendix A: First-Tier Tribunal (Mental Health)

The First-Tier Tribunal (Mental Health) has provided their activity and outcome statistics for the year 2021/22.

Comparing figures for 'total discharge by Tribunal' against 'no discharge', it appears that success rates for appeals remain at previous years' levels. The Tribunal discharges patients in about 10% of its decisions relating to detention overall. Around 30% of restricted patients' appeals result in some form of discharge decision, in most cases using the powers given to the Tribunal to order the conditional discharge of restricted patients. Patients detained under the assessment and treatment power (section 2) are roughly twice as likely to successfully appeal as patients detained under treatment powers (section 3 and unrestricted hospital orders).

Figure 17: **Outcomes of applications against detention to the first-tier Tribunal (Mental Health), 2021/22**

		Section 2	Other unrestricted	Restricted	All detained patients
Activity of Mental Health Tribunal	Applications	10,101	15,719	3,175	28,995
	Withdrawn applications	1,167	3,867	1,040	6,074
	Discharges by clinician prior to hearing	3,793	5,507	31	9,331
	Cleared at Hearing [a,b]	7,242	11,878	2,427	21,547
	Heard [c]	6,670	8,530	2,446	17,646
Decisions of Mental Health Tribunal [d]	Absolute Discharge	349	303	77	729
	Delayed Discharge	239	114	0	353
	Conditional Discharge	0	0	404	404
	Deferred Conditional Discharge	0	0	102	102
	Total discharge by Tribunal	588	417	583	1,588
	No Discharge	4,865	8,748	1,350	14,963

a. The number of hearings and the number of applications will not match as hearings will be outstanding at the end of each financial year.

b. MHT are unable to distinguish CTO hearings disposed from the total number of other unrestricted hearing disposals.

c. Includes all cases heard irrespective of outcome including adjourned in the reporting period.

d. This data is based on all decisions both before and after the hearing.

Source: HM Courts and Tribunal Service, Analysis and Performance Team.

Just under 4% of decisions in relation to community treatment orders (CTOs) discharge the patient. This is generally less successful than detained patients overall, but only slightly less when compared to the 'other unrestricted' detained group, which may be the most appropriate comparison.

Figure 18: **Applications against CTOs to the First-Tier Tribunal (Mental Health), 2021/22**

	2021/22
Applications	4,754
Withdrawn applications	912
Hearings	4,597
Oral Hearings[a]	3,935
Paper Reviews (considered on papers and therefore patient not present)	662
Discharges by Tribunal	137
No discharge by Tribunal	3,422

a. The category 'oral hearings' is based upon the total number of hearings less the manual count of paper reviews.

Source: HM Courts and Tribunal Service, Analysis and Performance Team.

Note: Although care is taken when processing and analysing the data, this can change over time as the information is taken from a live system.

Appendix B: CQC as a part of the UK 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 carry out 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 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 NGO that works with NPMs across the world, has set out the following main elements of 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.

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