BOD 06/2012

(Agenda Item: 8)

# Report to the Board of Directors

**For Information**

**25 January 2012**

**CQC Annual Report on the Use of the Mental Health Act**

**Executive Summary**

CQC published its second annual report on the use of the Mental Health Act on 8 December 2011. Although examples of good practice were identified CQC identified that considerable improvements were needed in 3 key areas:

* Patient involvement in planning their care
* Consent to treatment
* Patients’ experience of care and treatment - Minimising restrictions.

**Recommendation**

The Board is asked to receive the report for information, and note its content. Action arising from the report will be incorporated in the response to the CQC Trust Annual Statement (with respect to the Mental Health Act) which is expected soon.

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Lead Director: Dr C Meux, Medical Director

*A risk assessment has been undertaken around the legal issues that this paper presents and there are no issues that need to be referred to the Trust Solicitors.*

**Summary of CQC second annual report on the use of the Mental Health Act**

CQC published its second annual report on the use of the Mental Health Act on December 8th 2011. Although examples of good practice were identified CQC identified that considerable improvements were needed in 3 key areas:

* Patient involvement in planning their care
* Consent to treatment
* Patients’ experience of care and treatment - Minimising restrictions

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**Statistics**

The number of people subject to the Act continues to increase. On March 31st 2011 the number of people (20,938) subject to detention was 5% higher than on the same date the year before. Almost all this increase is due to the rise in number of people placed on Community Treatment Orders (CTOs)

The number of new CTOs made in 2011 was lower than the previous year. However more new CTOs were made than were discharged therefore the number of people subject to compulsion in the community continues to rise overall.

The number of detentions to a hospital place of safety (rather than a police station) under Police Powers (s 136) continues to rise. However it is unknown (due to inadequacies in data collection) what the total number of s 136 detentions are overall and currently what proportion of people are taken to a hospital POS compared to a police station.

**1. Patient involvement**

**Lack of patient involvement** in the care planning process continues to be one of the issues most frequently reported by Mental Health Act Commissioners after visits to hospitals. On many wards there was little evidence that staff had attempted to ascertain the patients’ own views and wishes nor was there much indication that patients had been given copies of their care plans. **Areas of good practice included patient councils and community meetings.**

CQC noted that whilst most people working in mental health are compassionate and professional, detaining authorities must always be vigilant against ill-treatment of patients. The issue of restraint was highlighted and good practice post restraint was discussed.

**CQC Recommendation**

Providers should make sure that the principle of patient participation in care planning is fully embedded in staff training programmes. Clinical leaders should be helped to create an environment in which patient participation is the norm.

All detaining authorities should give patients the opportunity to record their experience and views after restraint incidents, as a part of wider patient involvement in care planning and review.

**2. Consent to treatment**,

The assessing and recording of capacity and consent was another of the issues where CQC continued to highlight the need for significant improvement. This year’s report cites examples of both good and poor record-keeping of patient consultations across wards.

The report also says the legal powers available to providers in relation to community treatment orders (CTOs) are widely misunderstood, even among mental health professionals.

In 2008 the safeguard of second opinion certification was extended to CTO patients who consent to treatment. This group amount to two-thirds of the CTO second opinion referrals. A second opinion is not required for detained in-patients consenting to treatment. The Health and Social Care contains a clause, subject to the passage of the Bill that will exempt the need for consenting CTO patients to require SOAD certification.

**CQC Recommendation**

Providers should make sure that their staff take refresher courses on consent to treatment. Training should be provided in a range of formats – for example, e-learning and simulation/role play.

Revalidation and appraisal programmes for health care professionals should include assessments of knowledge and skills about capacity and consent.

Health care staff must understand the scope and limitations of CTOs.

**3. Minimising restrictions imposed on patients in hospital,**

CQC is still finding examples of poor or questionable practice, such as denying patients’ regular access to the internet, locking them out of their rooms during the daytime, or listening to their telephone calls. In some cases the restrictions seem minor, but they encourage the institutionalisation of the patients.

**4. Patients’ experience of care and treatment**

**(i) Lack of in-patient beds**

A major concern is one of delays in admissions to hospital due to lack of bed availability– a long-standing problem that in some cases places the patient at great risk. The report says: “It should be seen as a very serious matter when the admission of someone judged to need detention under the Act is delayed for any significant period because of a lack of resources or because more urgent cases are prioritised above them.”

**CQC Recommendation**

Commissioners of inpatient services should make sure that assessments of the local need for mental health services are robust, and that there are enough beds and alternatives to admission that meet the needs of local people

**5. Independent Mental Health Advocates.**

Commissioners have found that many patients detained under the Mental Health Act have a worrying lack of access to independent advocacy services. Although Hospital staff have a legal duty to inform patients and their relatives about the services of independent mental health advocates (IMHA) some staff appear to be unaware of these services.

Despite this, says the report, some IMHA services have waiting lists, which suggests they may be underfunded by the primary care trusts (PCTs) that commission them. PCTs have been under a statutory duty since April 2009 to commission IMHA services for patients who are detained or subject to community treatment orders. In the reorganisation of commissioning proposed in the Health and Social Care Bill, currently passing through Parliament, this duty will pass to local authorities (those councils with responsibility for social services).

**6. Deaths in detention [essential standard 19]**

Hospitals that detain patients under the Mental Health Act are already liable as **hospitals** to charges of corporate manslaughter, where their management of the organisation, coupled wit a gross breach of a relevant duty of care (such as a duty of clinical care), leads to the death of a detainee.

The coming into force in September 2011 of the custody provisions in the Corporate Manslaughter Act can be viewed to extend its scope to **all** duties implied by detention, which are potentially wider than those that are concerned with medical treatment and care.[[1]](#footnote-2)

CQC were notified of 283 patient deaths in 2010. The majority of these (75 per cent of all reported) were due to natural causes. About a third of patients who died of natural causes did so before their 61st birthday, supporting previous findings of a reduced life expectancy among people with serious mental health problems.

The report additionally identifies key areas of patient risk assessment which, if overlooked, can often result in failure to protect a patient’s safety. These include patient counselling and support, communication, observation and the potential to self-harm.

Julie Chalmers (December 2011)

1. http://www.justice.gov.uk/downloads/publications/circulars/moj/circular2011-07-corporate-manslaughter-act.pdf [↑](#footnote-ref-2)